ATTACHMENT K
Encounter Data and Other Data Requirements

1.0 Encounter Data

The CONTRACTOR shall collect service information in the federally mandated Health Insurance Portability and Accountability Act (HIPAA) transaction formats and code sets, and submit this data in a standardized format approved by the State. The CONTRACTOR must make all collected data available to the State after it is tested for compliance, accuracy, completeness, logic, and consistency. The CONTRACTOR(S) shall follow the encounter data protocol provided in this Attachment and Appendix 1 — MCO Data Submission Manual.

1.1 Compliance with HIPAA-Based Code Sets

The CONTRACTOR systems that are required to or otherwise contain the applicable data type shall conform to the following HIPAA-based standard code sets; the processes through which the data are generated should conform to the same standards as needed:

1.1.1

Health Care Common Procedure Coding System (HCPCS)- This code set, established and maintained by the Centers for Medicare & Medicaid Services (CMS), primarily represents items and supplies and non-physician services not covered by the American Medical Association Current Procedure Terminology (CPT)-4 codes. This file does not contain the CPT-4 codes. CPT-4 codes can be purchased from the American Medical Association at 1-800-621-8335.

1.1.2

CPT codes- The CPT-4 codes are used to describe medical procedures and physicians services, and is maintained and distributed by the American Medical Association (AMA). For more information on the CPT-4 codes, please contact the AMA.

1.1.3

International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volumes 1 & 2 (diagnosis codes) is maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

1.1.4

International Classification of Diseases, 9th revision, Clinical Modification ICD-9-CM Volume 3 (procedures) is maintained by CMS and is used to report procedures for inpatient hospital services.

1.1.5

International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM is the new diagnosis coding system that was developed as a replacement for ICD-9-CM, Volume 1 & 2. International Classification of Diseases, 10th revision, Procedure Coding System ICD-10-PCS is the new procedure coding system that was developed as a replacement for ICD-9-CM, volume 3. The compliance date for ICD-10-CM for diagnoses and ICD-10-PCS for inpatient hospital procedures is October 1, 2013.

1.1.6

National Drug Codes (NDC)- The NDC is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the Federal Drug Administration (FDA). It is maintained and distributed by HHS, in collaboration with drug manufacturers.

1.1.7

Code on Dental Procedures and Nomenclature (CDT)- The CDT is the code set for dental services. It is maintained and distributed by the American Dental Association (ADA).

1.1.8

Place of Service Codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided. CMS maintain point of service (POS) codes used throughout the health care industry.

1.1.9

Claim Adjustment Reason Codes (CARC) explain why a claim payment is reduced. Each CARC is paired with a dollar amount, to reflect the amount of the specific reduction, and a Group Code, to specify whether the reduction is the responsibility of the provider or the patient when other insurance is involved.

1.1.10

Reason and Remark Codes (RARC) are used when other insurance denial information is submitted to the medicaid management information system (MMIS) using standard codes defined and maintained by CMS and the National Council for Prescription Drug Programs (NCPDP).

NOTE - Professional and institutional claims contain CARC and RARC codes, while pharmacy claims contain NCPDP reject codes. RARCs are used in conjunction with CARCs to further explain a payment decision or to relay additional information. NCPDP reject codes are used to document other insurance denial reasons for pharmacy claims.

1.2 Compliance with Other Code Sets

CONTRACTOR systems that are required to or otherwise contain the applicable data type shall conform to the following non-HIPAA-based standard code sets:

1.2.1

As described in all State Medicaid reimbursement handbooks, for all "covered entities," as defined under HIPAA, and which submit transactions in paper format (non-electronic format).

1.2.2

As described in all State Medicaid reimbursement handbooks for all "non-covered entities," as defined under HIPAA.

1.3 Encounter Data Submission Standards

1.3.1

The CONTRACTOR shall have a comprehensive automated and integrated encounter data system capable of meeting the requirements below:

1.3.1.1

All CONTRACTOR encounters shall be submitted to the State or the State's fiscal agent in the standard HIPAA transaction formats, namely the ANSI X12N 837 transaction formats (P – Professional and I - Institutional) and, for pharmacy services, in the NCPDP format. Health Plan paid amounts shall be provided.

1.3.1.2

The CONTRACTOR shall collect, and submit to the State‘s fiscal agent, enrollee service level encounter data for all covered services. The CONTRACTOR shall be held responsible for errors or noncompliance resulting from their own actions or the actions of an agent authorized to act on their behalf.

1.3.2

The CONTRACTOR shall conform to HIPAA-compliant standards for information exchange effective the first day of operations. Batch and Online Transaction Types are as follows:

1.3.2.1

Batch transaction types

1.3.2.1.1

ASC X12N 820 Premium Payment Transaction

1.3.2.1.2

ASC X12N 834 Enrollment and Audit Transaction

1.3.2.1.3

ASC X12N 835 Claims Payment Remittance Advice Transaction

1.3.2.1.4

ASC X12N 837I Institutional Claim/Encounter Transaction

1.3.2.1.5

ASC X12N 837P Professional Claim/Encounter Transaction

1.3.2.1.6

ASC X12N 837D Dental Claim/Encounter Transaction

1.3.2.1.7

NCPDP D.0 Pharmacy Claim/Encounter Transaction

1.3.2.2

Online transaction types

1.3.2.2.1
ASC X12N 270/271 Eligibility/Benefit Inquiry/Response
1.3.2.2.2
ASC X12N 276 Claims Status Inquiry
1.3.2.2.3
ASC X12N 277 Claims Status Response
1.3.2.2.4
ASC X12N 278/279 Utilization Review Inquiry/Response
1.3.2.2.5
NCPDP D.0 Pharmacy Claim/Encounter Transaction

1.3.3
The CONTRACTOR shall convert all information that enters its claims system via hard copy paper claims or other proprietary formats to encounter data to be submitted in the appropriate HIPAA-compliant formats.

The transaction and code sets can be found at www.cms.gov.

1.4 Encounter Data Completeness, Accuracy, Timeliness, and Error Resolution
The CONTRACTOR(S) shall provide complete and accurate encounters to the State. The CONTRACTOR(S) shall implement review procedures to validate encounter data submitted by providers. The following standards are hereby established:
1.4.1
Completeness
A CONTRACTOR must be submitting encounters that represent at least 98% of the covered services provided by the Health Plan network and non-network providers. The CONTRACTOR shall strive to achieve a 100% complete submission rate. All data submitted by the providers to the CONTRACTOR must be included in the encounter submissions.
1.4.2
Accuracy
1.4.2.1
Transaction type (X12): 98% of the records in a CONTRACTOR's encounter batch submission pass X12 EDI compliance edits and the MMIS threshold and repairable compliance edits. The X12 electronic data interface (EDI) compliance edits are established through strategic national implementation process (SNIP) levels 1 through 4. MMIS threshold and repairable edits that report exceptions are defined in the Encounter Data Submission Guide (Appendix 1).
1.4.2.2
Transaction type (NCPDP): 98% of the records in a CONTRACTOR's encounter batch submission pass NCPDP compliance edits and the pharmacy benefits system threshold and repairable compliance edits. The NCPDP compliance edits are described in the NCPDP Telecommunications Standard Guides. Pharmacy benefits system threshold and repairable edits that report exceptions are defined in the Encounter Data Submission Guide (Appendix 1).
1.4.3
Timeliness
Encounter data shall be submitted weekly, and within five (5) working days of the end of each weekly period and within 30 days of claim payment. All encounters must be submitted, both paid and denied claims. The paid claims must include the CONTRACTOR paid amount.
1.4.4
Error resolution
1.4.4.1
For all encounters submitted after the submission start date, including historical and ongoing claims, if the State or its fiscal agent notifies the CONTRACTOR of encounters failing X12 EDI compliance edits or MMIS threshold and repairable compliance edits, the CONTRACTOR shall remediate all such encounters within 30 calendar days after such notice. Failure to do so could result in a corrective action plan (CAP) or liquidated damages as specified in Attachment G.

1.4.4.2
Encounters cannot be adjusted, therefore they must be updated through the Void and Replacement process. (See process described in the MCO data submission Manual starting on page 38). Encounters must be voided and a replacement sent within 30 days of identifying that the original encounter was in error.
1.4.5
The CONTRACTOR shall participate in State-sponsored workgroups directed at continuous improvements in encounter data quality and operations. For additional information regarding Encounter Data submission, please reference the Encounter Data Submission Guide (Appendix 1).

1.5 Eligibility and Enrollment Data Exchange Requirements
1.5.1
Provider Roster
The CONTRACTOR shall receive a member roster once per month with daily updates. The CONTRACTOR shall update its eligibility/enrollment databases within 24 hours after receipt of said files. The CONTRACTOR shall transmit to the State or its agent, in a periodicity schedule, format and data exchange method to be determined by the State, specific data it may garner from an enrollee, including third party liability (TPL) data.

1.6 Information Management and Systems
The following system requirements shall be met by the CONTRACTOR:

1.6.1
Availability of Critical Systems Functions
The CONTRACTOR shall ensure that critical systems functions available to enrollees and providers, functions that if unavailable would have an immediate detrimental impact on enrollees and providers, are available 24 hours a day, seven (7) days a week, except during periods of scheduled system unavailability agreed upon by the State and the CONTRACTOR. Unavailability caused by events outside of the CONTRACTOR's span of control is outside the scope of this requirement. The CONTRACTOR shall make the State aware of the nature and availability of these functions prior to extending access to these functions to enrollees and/or providers.

1.6.2
Availability of Data Exchange Functions
The CONTRACTOR shall ensure that the systems and processes within its span of control associated with its data exchanges with the State and/or its agent(s) are available and operational according to specifications and the data exchange schedule.

1.6.3
Availability of Other Systems Functions
The CONTRACTOR shall ensure that at a minimum all other system functions and information is available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m., in the time zone where the user is located, Monday through Friday.

1.6.4
Problem Notification
1.6.4.1
Upon discovery of any problem within its span of control that may jeopardize or is jeopardizing the availability and performance of all systems functions and the availability of information in said systems, including any problems affecting scheduled exchanges of data between the CONTRACTOR and the State and/or its agent(s), the CONTRACTOR shall notify the applicable State staff via phone, fax and/or electronic mail within one (1) hour of such discovery. In its notification, the CONTRACTOR shall explain in detail the impact to critical path processes such as enrollment management and claims submission processes.
1.6.4.2

The CONTRACTOR shall provide to appropriate State staff information on system unavailability events, as well as status updates on problem resolution. At a minimum these updates shall be provided on an hourly basis and made available via electronic mail and/or telephone.

1.6.5
Recovery from Unscheduled System Unavailability
Unscheduled system unavailability caused by the failure of systems and telecommunications technologies within the CONTRACTOR's span of control will be resolved, and the restoration of services implemented, within forty-eight (48) hours of the official declaration of system unavailability.

1.6.6
Exceptions to System Availability Requirement
The CONTRACTOR shall not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the CONTRACTOR's span of control.

1.6.7
Information Systems CAP
If at any point there is a problem with a critical systems function, at the request of the State, the CONTRACTOR shall provide to the State full written documentation that includes a CAP that describes how problems with critical systems functions will be prevented from occurring again. The CAP shall be delivered to the State within five (5) business days of the problem's occurrence. Failure to submit a CAP and to show progress in implementing the CAP shall make the CONTRACTOR subject to liquidated damages.

1.6.8
Business Continuity, Risk Management and Disaster Recovery Plan
The CONTRACTOR shall provide to the State within 90 days following contract award the Business Continuity, Risk Management and Disaster Recovery plans. Regardless of the architecture of its systems, the CONTRACTOR shall develop, and be continually ready to invoke, a business continuity, risk management, and disaster recovery plan that is reviewed and prior-approved by the State. If the approved plan is unchanged from the previous year, the CONTRACTOR shall submit each year, a certification to the State that the prior year's plan is still in place. This certification must be submitted on or before the CONTRACTOR's contract anniversary. Changes in the plan are due to State within 10 business days after the change. Additionally, all data associated with this contract and other contract documents and records must be protected against hardware and software failures, human, error, natural disasters, and other emergencies which could interrupt services.
1.6.8.1
Risk Management should address the CONTRACTOR's identified risks and their proposed solution or action to be taken to alleviate or minimize the consequences in the event that those risks become actuality.
1.6.8.2
Business Continuity should encompass Risk Management, Disaster Recovery, as well as providing additional analysis of the impact of potential risks, disasters, and so on. Further, it should address personnel replacement plans, both short term and long term. At a minimum, the CONTRACTOR's plan shall address the following:
1.6.8.2.1
Recovery of business functions, business units, business processes, human resources, and technology infrastructure.
1.6.8.2.2
Identify core business processes
1.6.8.2.2.1
Identification of potential system failures for the process
1.6.8.2.2.2
Risk analysis
1.6.8.2.2.3
Impact analysis

1.6.8.2.2.4
Definition of minimum acceptable levels of outputs
1.6.8.2.2.5
Documentation of contingency plans
1.6.8.2.2.6
Definition of triggers for activating contingency plans
1.6.8.2.2.7
Discussion of establishment of a business resumption team
1.6.8.2.3
Maintenance of updated disaster recovery plans and procedures that include, but not limited to:
1.6.8.2.3.1
Central computer installation and resident software are destroyed or damaged
1.6.8.2.3.2
System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage
1.6.8.2.3.3
System interruption or failure resulting from network, operating hardware, software or operational errors that compromise the integrity of data maintained in a live or archival system
1.6.8.2.3.4
System interruption or failure resulting from network, operating hardware, software or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but do prevent access to the system, (i.e. cause unscheduled system unavailability)
1.6.8.2.4
Plan for replacement of personnel
1.6.8.2.4.1
Replacement in the event of loss of personnel before or after signing this contract
1.6.8.2.4.2
Replacement in the event of inability by personnel to meet performance standards
1.6.8.2.4.3
Allocation of additional resources in the event of the CONTRACTOR's inability to meet performance standards
1.6.8.2.4.4
Replacement/addition of personnel with specific qualifications
1.6.8.2.4.5
Timeframes necessary for replacement
1.6.8.2.4.6
CONTRACTOR's capability of providing replacements/additions with comparable experience
1.6.8.2.4.7
CONTRACTOR shall ensure that quality of service is not compromised by excessive staff turnover
1.6.8.2.4.8
Process for replacement of personnel in the event of loss of key personnel or other personnel before or after signing of the contract, including the State's role in getting the replacement personnel
1.6.8.2.4.9
Replacement of staff with key qualifications and experience with new staff with similar qualifications and experience
1.6.8.3
The CONTRACTOR shall periodically, but no less than annually, on or before the CONTRACTOR's contract anniversary, of each contract year, perform comprehensive tests of its plan through simulated disasters and lower level failures in order to demonstrate to the State that it can restore system functions per the standards outlined in the contract.

In the event that the CONTRACTOR fails to demonstrate in the tests of its plan that it can restore system functions per the standards outlined in this contract, the CONTRACTOR shall be required to submit to the State a CAP in accordance with Section 2.3.4.2, that describes how the failure will be resolved. The CAP shall be delivered within 10 business days of the conclusion of the test.

1.6.9
Notification and Discussion of Potential System Changes
The CONTRACTOR shall notify the State of the following changes to systems within its span of control at least 90 calendar days before the projected date of the change. If so directed by the State, the CONTRACTOR shall discuss the proposed change with the applicable State staff. This includes:
1.6.9.1
software release updates of core transaction systems: claims processing, eligibility and enrollment processing, service authorization management, provider enrollment and data management;
1.6.9.2
conversions of core transaction management systems; and
1.6.9.3
new system implementations.

1.6.10
Response to State Reports of Systems Problems Not Resulting in System Unavailability
The CONTRACTOR shall respond to State reports of system problems not resulting in system unavailability according to the following timeframes:
1.6.10.1
Within seven (7) calendar days of receipt, the CONTRACTOR shall respond in writing to notices of system problems.
1.6.10.2
Within 20 calendar days, the correction shall be made or a requirements analysis and specifications document will be due.
1.6.10.3
The CONTRACTOR shall correct the deficiency by an effective date to be determined by the State.

1.6.11
Valid Window for Certain System Changes
Unless otherwise agreed to in advance by the State as part of the activities described in this section, scheduled system unavailability to perform system maintenance, repair and/or upgrade activities shall not take place during hours that could compromise or prevent critical business operations.

1.6.12
Testing
The CONTRACTOR shall work with the State pertaining to any testing initiative as required by the State. Upon the State's written request, the CONTRACTOR shall provide details of the test regions and environments of its core production information systems, including a live demonstration, to enable the State to corroborate the readiness of the CONTRACTOR's information systems.

1.7 Documentation Requirements
1.7.1
Types of Documentation
The CONTRACTOR shall develop, prepare, print, maintain, produce, and distribute distinct system process and procedure manuals, user manuals and quick-reference guides, and any updates thereafter, for the State and other applicable State staff. The CONTRACTOR shall provide this documentation in outline form electronically for approval by the State.
1.7.2
Content of System Process and Procedure Manuals
The CONTRACTOR shall ensure that written system process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.
1.7.3
Content of System User Manuals
The system user manuals shall contain information about, and instructions for, using applicable system functions and accessing applicable system data.
1.7.4

Changes to Manuals
When a system change is subject to the State's written approval, the CONTRACTOR shall draft revisions to the appropriate manuals prior to State approval of the change. Updates to the electronic version of these manuals shall occur in real time.
1.7.5
Availability of/Access to Documentation
All of the aforementioned manuals and reference guides shall be available electronically and on-line. If so prescribed, the manuals will be published in accordance with the appropriate State and/or Federal standard. Additionally, the documentation shall be provided in printed form upon request.

1.8 Encounter Data - Staffing Requirements
1.8.1
Claims/Encounter Manager: The CONTRACTOR shall have a designated person qualified by training and experience to oversee claims and encounter submittal and processing, where applicable, and to ensure the accuracy, timeliness and completeness of processing payment and reporting.
1.8.2
The CONTRACTOR shall designate sufficient resources to perform these encounter functions as determined by generally accepted best industry practices.

2.0 Other Requirements

2.1 Methods for Data Exchange
The CONTRACTOR and the State and/or its agent shall make predominant use of secure file transfer protocol (SFTP) and EDI in their exchanges of data.

2.2 State-Based Formatting Standards and Methods
CONTRACTOR systems shall exchange the following data with the State and/or its agent in a format to be jointly agreed upon by the CONTRACTOR and the State:
2.2.1
Provider network data: The CONTRACTOR shall submit provider information electronically to the fiscal agent in a provider roster format approved by the State. This information will be updated monthly by the CONTRACTOR and will be a full file replacement each month
2.2.2
Case management fees, if applicable
2.2.3
Payments
2.2.4
Member and services data: CONTRACTOR(S) must report separately on those Members receiving care for chronic behavioral health conditions (i.e. SPMI, SUD etc.), disabilities (i.e. DD, PD, TBI etc.), long term care (LTC) services and physical health services. CONTRACTOR(S) must also report separately on services including but not limited to outpatient (OP) behavioral health services and inpatient (IP) behavioral health services.
2.2.5
Pharmaceutical Report
The CONTRACTOR (or their subcontractors) shall report all pharmacy data in an NCPDP format in the event that the CONTRACTOR utilizes a Pharmacy Benefit Manager and pharmacy data is not included in the encounter data. The CONTRACTOR shall also provide claims summary reports, drug utilization review (DUR) reporting and also a yearly pharmacy program summary. This includes utilization, expenditures, trend reporting, spending by types of medications, etc.
2.2.6
Mental Health (MH) Outcomes Data
The CONTRACTOR(S) (and/or their subcontractors) shall report all MH outcomes data in compliance with the automated information management system (AIMS) data collection requirements. The CONTRACTOR shall also provide summary and detail reports on data completeness and accuracy, as defined in the AIMS manual.

2.3 Substance Use Disorder (SUD) Data System Requirements

The CONTRACTOR(S) shall work with the Kansas Client Placement Criteria (KCPC) or other SUD specific data system/data collection tool. This tool incorporates the American society of addiction medicine (ASAM) criteria and must be used in making SUD service authorization decisions. The State will monitor both the CONTRACTOR(S)' application and documentation of the Kansas definition of medical necessity and the ASAM criteria as contained in the KCPC system through ongoing reviews including, but not limited to, external audits. The CONTRACTOR(S) confirms it will document all authorizations and any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than the request in the CONTRACTOR's records and that documentation shall reference the Kansas medical necessity definition and ASAM criteria as contained in the KCPC system. The CONTRACTOR(S) information systems must be compatible or will become compatible with the KCPC system used by providers in Kansas. The CONTRACTOR shall ensure that it as well as its subcontracted providers uses the required Kansas medical necessity definition, ASAM criteria as contained in the KCPC system for determination of level of service, even when prior authorization (PA) from the CONTRACTOR is not required.

2.4 Data Certifications

Data submitted by the CONTRACTOR including, but not limited to, all documents specified by the State, enrollment information, encounter data, and other information required as a deliverable in the contract, must be certified. The Attestation Form shall include the following:

2.4.1

Authority to Certify. All data and documents requiring certification the CONTRACTOR submits to the State shall be certified by one of the following:

2.4.1.1

CONTRACTOR's Chief Executive Officer

2.4.1.2

CONTRACTOR's Chief Financial Officer

2.4.1.3

An individual who has delegated authority to sign for, and who reports directly to, the CONTRACTOR's Chief Executive Officer or Chief Financial Officer.

2.4.2

Content of Certification: The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data.

2.4.3

Timing of Certification: The CONTRACTOR must submit the certification concurrently with the certified data and documents.

2.4.4

Data Specifications: Include the complete file name, the file size, and the date range of the contained in the submitted file.

MCO Data Submission Manual

MCO Data Submission Manual

REVISED: DECEMBER 2, 2010

VERSION 5.6

Address any comments concerning the contents of this manual to:
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Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 4.3	04/27/2007	Full Manual	New formatting, process clarifications	
Version 4.4	06/02/2007	Page 11	Field Name – Trailer Total Changes	
Version 4.5	06/08/2007	Page 2 Page 3 Page 8	1.a Third bullet, MCO Medicaid Number and Srv Location Provider Social Security Number	
Version 4.6	06/25/2007	Pages 4, 5 Page 6 Page 9 Page 10 Page 11 Page 12	Naming Conventions Formatting Guidelines Provider Name Indicator, Provider Name Filler Trailer Total Changes Error File Layout	
Version 4.7	09/18/2007	Page 4 Page 6 Page 8 Pages 10, 11 Pages 19, 20 Pages 23-32	PR1 Request File File Layouts File Layout Updates Provider Specialty Codes Provider Type, Specialty, and Taxonomy	
Version 4.8	08/05/08	Page 1 Pages 2, 3 Page 4 Page 5 Page 5 Page 12 Page 13 Page 20 Pages 25, 29	Introduction PR1 Process Naming Conventions, File Transfer, and Folder Structure Initial and Weekly Provider File Layouts Provider Weekly File Detail Record PR1 Error File Layout PR1 NPI Addition E-mail Report Layout Provider Specialty Codes Provider Type, Specialty, and Taxonomy	Greg Wallace
Version 4.9	08/15/08	Page 4	Naming Conventions	Greg Wallace
Version 5.0	10/5/09	Full Manual	Incorporated multiple documents into one,	Greg Wallace

			including the PR1 Companion Guide (Appendix 1) Added KM1 file processes Added KM1 file layout (Appendix II) Added updates to the PR1 file layout Removed recommended fields section Added Unsolicited 277 section Added POA section Updated Code Tables in Appendix I Added NEMT broker information. Active Indicator Description Provider Enrollment Indicator field added Reduced size of filler Updated all code tables	
Version 5.1	06/03/10	Full Manual	Added new error code E795 (CO11951) Replaced all references of EDS to HP Updated the email address for the MCO Liaison distribution list. Changed the email address for Provider Enrollment. Added information on KMAP response files Added contact information under section 2. PRVLST file layout updated on the formatting of the Provider Name. PR1 Request file layout updated on the formatting of the Provider Name. Removed all references to the Record Change Indicator of "C"	Joyce Dillon
Version 5.2	06/14/10	Full Manual	Detail Record requirements updated on the PR1 Request File	Joyce Dillon

			layout (MCO Assigned Number)	
Version 5.3	0713/10	Full Manual	Added clarification for the Other1 and Other2 Provider fields in the KM1 file layout.	Joyce Dillon
Version 5.4	08/02/10	Full Manual	Added a clarification for the ZIP-code requirements on the PR1 Request File layout.	Joyce Dillon
Version 5.5	09/10/10	Full Manual	Merged the revision history from appendix 1 into the revision history for the entire manual. Section 3: Clarification added for Pharmacy claims and the KM1.Section 4: Clarification added on the void and replace process. Section 5: Clarifications added on unsolicited 277 responses. Section 7: Clarifications added on the PR1 process. Appendix I: Naming convention requirements were added for encounter files. Daily and monthly roster information was added. Appendix II: Updated the Claim_Detail_Number field description in the KM1 file layout section. Added information regarding pharmacy processing with the KM1 for duplicate encounters. The following provider ID's in the KM1 file layout have been referenced to the corresponding loops on the 837: BILLING_PROVIDER_KMAP_BASE PERF_PROVIDER_KMAP_BASE REFER1_PROVIDER_KM	Joyce Dillon

			AP_BASE REFER2_PROVIDER_KMAP_BASE ATTEND_PROVIDER_KMAP_BASE OTHER1_PROVIDER_KMAP_BASE OTHER2_PROVIDER_KMAP_BASE FACILITY_PROVIDER_KMAP_BASE PRESCRIBER_PROVIDER_KMAP_BASE	
Version 5.6			Appendix III: Added MCO Submission Checklist with hyperlinks to reference material on encounter submission requirements. Added examples of the naming conventions for each file type and their corresponding KM1 file. Reformatted Manual to Business Practice Manual standard format.	Joyce Dillon
Version 5.6	12/2/10	Full Manual	Complete Manual overhaul; sent to KHPA for approval on 12-2-10.	Jenn Tibbits

Table of Contents

Overview

The Managed Care Organization (MCO) Data Submission Manual is the working document for the MCO's. The purpose of this manual is to provide direction for both new and established MCO's in coordinating the submission of encounter data so that it is accepted and properly processed by the interChange MMIS system.

This document will cover these main topics:

- Provider Enrollment Process (PR1) process
- Encounter Submission Process (837 file)
- KMAP ID/Service Location Match Process (KM1) file
- Void and Replacement Process
- Encounter Claim Response Information
- Eligibility Roster
- Encounter Data Attestations
- Tips and Troubleshooting

It is important to understand that these processes are inter-related and inter-dependant. If one fails, all will fail.

Section 2: ***Provider Enrollment Process (PR1)***

PR1 Process

Initial Provider Enrollment Process (PR1) Setup

The initial PR1 setup is the most crucial step in the whole encounter process. This section will explain the initial PR1 process from beginning to end in a step by step format.

Provider List File (PRVLST)

The PRVLST file is a file of the Medicaid providers (both active and inactive) and PR1 providers (active only). Kansas Medical Assistance Program (KMAP) uses File Transfer Protocol (FTP) to send the PRVLST to a predefined folder on the MCOs FTP server. This is the first step in creating the MCO Provider Request File (PR1 file). The MCOs use the PRVLST file to build their initial PR1 file. The file layout for the PRVLST file is located in Appendix A.

The PRVLST file name and predefined folder name is illustrated below:

Naming Convention	**Folder Name**
F.<SAK>.<MCO Medicaid Number>.PRVLST.<YYMMDDhhmmss>.dat PRVLST indicates Provider Listing file *(i.e. F.390663.299999999A.PRVLST.070608190000.dat)*	Provider_FullListing

Provider Request File (PR1 file)

The MCO reviews the data on the PRVLST file and attempts to match their providers to a KMAP provider to build their initial PR1 file. When trying to determine if a provider on the PRVLST file is a match to a provider in your MCO network the following criteria should be considered:

- National Provider Identifier (NPI)
- Employer Identification Number (Tax ID)
- Provider Name
- Provider Address
- Provider Type
- Provider Specialty
- Social Security Number (SSN) or License Number (if submitted in the request file)

Adding providers or adding MCO program eligibility:

When determining which KMAP ID/Service Location (KMAP ID/SL) to activate for your MCO provider eligibility, the following logical progression must be followed. Please be sure to refer to the end of the PR1 section for the PR1 Program Specific Instructions for your MCO:

1. Active KMAP ID/SL combination with Medicaid program eligibility
2. Active KMAP ID/SL combination PR1 number with another MCO
3. Inactive KMAP ID/SL combination with Medicaid program eligibility
4. Create new number through the add process

The first four options must always be exhausted before creating a new KMAP ID/SL through the add process.

Note: A valid KMAP ID/SL is a 10 digit number, the first 9 are numeric values followed by an alpha character.

There are indicators on the PRVLST file that will assist the MCOs with the hierarchy listed above.

Medicaid Indicators:

- **M** – If the Medicaid indicator is an 'M', this means the provider has or has had Medicaid eligibility.
- **N** – If the Medicaid indicator is an 'N', this means that the provider has never had Medicaid eligibility.

Active Indicators:

- **M** – An indicator of M means the provider is active for you. In other words, a PR1 request record has previously been sent in and program eligibility for the MCO already exists. If you find this provider is a match, no further action is needed.
- **C** – An indicator of C means the provider has active MCO program eligibility, but not for you. If you find this provider is a match, a PR1 request record would need to be submitted to activate program eligibility for you.
- **O** – An indicator of O means the provider has one or more MCO program eligibility records, but they are all inactive. If you find this provider is a match, a PR1 request record would need to be submitted to activate program eligibility for you.
- **A** – An indicator of A means the provider is an active Medicaid provider and there are no MCO program eligibility records, active or inactive. If

you find this provider is a match, a PR1 request record would need to be submitted to activate program eligibility for you.

- **I** – An indicator of I means the provider is an inactive Medicaid provider and there are no MCO program eligibility records, active or inactive. If you find this provider is a match, a PR1 request records would need to be submitted to activate program eligibility for you.
  Note: This would only apply to the MCOs that are not required to map to an active Medicaid provider.

If a match **is found** on the PRVLST file, the MCO updates the mandatory fields on the PR1 record and marks the record change indicator as 'A' to add their MCO eligibility to the specified KMAP provider. Please keep in mind the KMAP ID/SL **must** be included in the request. Refer to the PR1 Request File layout in Appendix A for the mandatory fields.

Note: If the MCO is mapping to an existing Medicaid Provider, it is essential to make sure all of the information matches for the MCO. For instance, on existing Medicaid providers the MCOs can not add a new specialty to the Medicaid provider. If the specialty for the MCO does not match to the existing Medicaid provider then the next process should be followed for if a match is not found.

If a match **is not found** on the PRVLST file, the MCO marks the record change indicator as 'A' and fills out all of the mandatory fields as indicated in the PR1 Request File layout in Appendix A. Please keep in mind when performing this task a KMAP ID/SL would **not** be included in the request. This process will create a new KMAP ID/SL. This occurs when a provider in the MCO network is **not** found in the PRVLST file, meaning the MCO provider is not a KMAP provider.

In either case, whether mapping to an existing provider or requesting to add a new one, the 'A' indicator must be used.

The MCO may send updates to any of the PR1 fields; however, only the following fields are updated in the MMIS:

- Record Type
- Record Change Indicator
- MCO Medicaid Number
- MCO Service Location
- Provider Start Date
- Provider End Date
- PAR/Non-PAR

Note: After the initial PR1 activation, providers should only be added to the process as services are provided by that provider to KMAP eligible beneficiaries

or if a provider joins your MCO that is actively providing services to KMAP eligible beneficiaries. These updates will follow the Weekly PR1 process as outlined in the next subsection.

Deleting providers:

During your initial PR1 process ***and*** when using the PRVLST file as the source file for creation of the PR1 Request file, **all** other providers on the PRVLST file that are **not** being added or activated for your MCO must be deleted from the file.

NOTE: Medical, Prepaid Inpatient Health Plan (PIHP), Prepaid Ambulatory Health Plan (PAHP) MCOs, and Non Emergency Medical Transportation Brokers (NEMT) doing their initial PR1 provider load **MUST NOT** load their entire provider database. There are tens of thousands of providers in some MCO networks that will never provide services to a KMAP eligible beneficiary. During the initial PR1 provider activation, only MCO providers that match the first three conditions in the matching criteria should be added as eligible MCO providers.

Failure to follow this process will create unneeded providers that extend the PRVLST and create confusion when adding new MCO providers through the PR1 request process.

Once the MCO has completed the add and delete processes outlined above and have a finalized initial PR1 file, the MCO then sends this file back to KMAP by copying the file to a predefined folder on the MCOs FTP server. The KMAP EDI jobs, which consists of 5 jobs per submitter, picks up the files from that folder every 15 minutes and transfers the file(s) to the MMIS servers for processing. KMAP processes the PR1 request file from the MCOs once every week on Monday night at 7 p.m. and generates response and error files.

The PR1 Request file name and predefined folder name is illustrated below:

PR1 Request File Naming Convention	Folder Name
HW<19 or 21>_<MCO Medicaid Number>_PR1_<YYMMDDhhmmss>.dat PR1 indicates PR1 request file *(i.e. HW21_299999999A_PR1_070608190000.dat)*	Provider_Request

PR1 Response File (PRRP)

KMAP generates the PRRP file after the PR1 Request file has been processed. The PRRP file contains the KMAP ID/SL that has been assigned to the newly added Medicaid Providers. This file is copied to the predefined folder on the MCOs FTP server. The file layout for the PRRP file is located in Appendix A.

The PRRP file name and predefined folder name is illustrated below:

PR1 Response File Naming Convention	Folder Name
F.<SAK>.<MCO Medicaid Number>.PRRP.<YYMMDDhhmmss>.dat PRRP indicates PR1 response file *(i.e. F.390663.299999999A.PRRP.070226210420.dat)*	Provider_Response

PR1 Error File (PRER)

KMAP generates the PRER file after the PR1 Request file has been processed. The PRER file returns information to the MCOs regarding PR1 records that failed the PR1 Request process. This file is copied to the predefined folder on the MCOs FTP server. The file layout for the PRER file is located in Appendix A.

The PRER file name and predefined folder name is illustrated below:

PR1 Provider Error File Naming Convention	Folder Name
F.<SAK>.<MCO Medicaid Number>.PRER.<YYMMDDhhmmss>.dat PRER indicates PR1 provider error file *(i.e. F.390663.299999999A.PRER.070226210420)*	Provider_Error

Weekly PR1 Process

Once the MCOs have completed the initial PR1 activiation, KMAP sends a weekly PRVLST file every Thursday at 12:00 a.m.. The weekly PRVLST file must be used by the MCOs to maintain their PR1 file built with the initial PR1 process. This can be accomplished by creating 'add' records for any new provider that has joined the MCO network or adding the MCO eligibility to any new KMAP providers. The MCO can also perform 'delete' records to remove or end date MCO program eligibility from providers. The file layout for the PRVLST file is located in Appendix A.

PR1 File:

The MCO reviews the data on the PRVLST file and attempts to match their providers to a KMAP provider. When trying to determine if the provider on the PRVLST file is a match to a provider in the MCO network, the following criteria should be considered:

- NPI
- Tax ID
- Provider Name
- Provider Address
- Provider Type
- Provider Specialty

- SSN or License Number (if submitted in the request file)

Adding providers or adding MCO program eligibility:

When determining which KMAP ID/Service Location (KMAP ID/SL) to activate for your MCO provider eligibility, the following logical progression must be followed Please be sure to refer to the end of PR1 section for the PR1 Program Specific Instructions for your MCO:

1. Active KMAP ID/SL combination with Medicaid program eligibility
2. Active KMAP ID/SL combination PR1 number with another MCO
3. Inactive KMAP ID/SL combination with Medicaid program eligibility
4. Create new number through the add process

The first four options must always be exhausted before creating a new KMAP ID/SL through the add process.

Note: A valid KMAP ID/SL is a 10 digit number, the first 9 are numeric values followed by an alpha character.

There are indicators on the PRVLST file that will assist the MCOs with the hierarchy listed above.

Medicaid Indicators:

- **M** – If the Medicaid indicator is an 'M', this means the provider has or has had Medicaid eligibility.
- **N** – If the Medicaid indicator is an 'N', this means that the provider has never had Medicaid eligibility.

Active Indicators:

- **M** – An indicator of M means the provider is active for you. In other words, a PR1 request record has previously been set in and program eligibility for the MCO already exists. If you find this provider is a match, no further action is needed.
- **C** – An indicator of C means the provider has active MCO program eligibility, but not for you. If you find this provider is a match, a PR1 request record would need to be submitted to activate program eligibility for you.
- **O** – An indicator of O means the provider has one or more MCO program eligibility records, but they are all inactive. If you find this provider is a match, a PR1 request record would need to be submitted to activate program eligibility for you.
- **A** – An indicator of A means the provider is an active Medicaid provider and there are no MCO program eligibility records, active or inactive. If

you find this provider is a match, a PR1 request record would need to be submitted to activate program eligibility for you.

- **I** – An indicator of I means the provider is an inactive Medicaid provider and there are no MCO program eligibility records, active or inactive. If you find this provider is a match, a PR1 request records would need to be submitted to activate program eligibility for you.
  Note: This would only apply to the MCOs that are not required to map to an active Medicaid provider.

If a match **is found** on the PRVLST file, the MCO updates the mandatory fields on the PR1 record and marks the record change indicator as 'A' to add their MCO eligibility to the specified KMAP provider. Please keep in mind the KMAP ID/SL **must** be included in the request. Refer to the PR1 Request File layout in Appendix A for the mandatory fields.

Note: If the MCO is mapping to an existing Medicaid Provider, it is essential to make sure all of the information matches for the MCO. For instance, on existing Medicaid providers the MCOs can not add a new specialty to the Medicaid provider. If the specialty for the MCO does not match to the existing Medicaid provider then the next process should be followed for if a match is not found.

If a match **is not found** on the PRVLST file, the MCO marks the record change indicator as 'A' and fills out all of the mandatory fields as indicated in the PR1 Request File layout in Appendix A. Please keep in mind when performing this task a KMAP ID/SL would **not** included in the request. This process will create a new KMAP ID/SL. This occurs when a provider in the MCO network is **not** found in the PRVLST file, meaning the MCO provider is not a KMAP provider.

The MCO may send updates to any of the PR1 fields; however, only the following fields are updated in the MMIS:

- Record Type
- Record Change Indicator
- MCO Medicaid Number
- MCO Service Location
- Provider Start Date
- Provider End Date
- PAR/Non-PAR

Activating A Provider No Longer Active:

If the MCO is needing to activate a provider no longer active in their network in order to submit historical claims for the provider to the MMIS the following steps must be followed in order to be successful.

- Send in "**Add**" records with an open "**End Date**" of 2299/12/31. When you receive the response file, you'll see the KMAP ID's for all the processed records.
  Note: If the end-date is equal to or prior to the processing date of the PR1 request file then it is considered a delete record. The provider record will be updated with program eligibility, however; a response will not be returned to the MCO.

- After you've received the KMAP ID's, send in "**Delete**" records with the actual "**end date**" that you want the provider to be active for.

For example, Provider "A" has been activated with an open ended date of 2299/12/31 but the Provider's actual program end date is 2010/10/01. In order to change the end date from 2299/12/31 to 2010/10/01, a "Delete" record needs to be sent in with an end date of "2010/10/01".

This will ensure that the encounters will process correctly for the dates of service the Provider is active for.

Note: Only those providers who were added to the MCO network since the last PR1 request to the MMIS should be marked as an 'add' record. The PR1 job should not be setup on an automatic scheduler on the MCO network.

Changing Program Eligibility Effective Date:

If the MCO needs to change their program eligibility effective date the following steps must be followed in order to be successful.

- Send in a "**Delete**" record with the corresponding **KMAP ID/SL** that needs to be updated. . If the record was created with the wrong effective date, the delete record should have an end date the same as the effective date.

- After the Delete request has been processed, send in "**Add**" records with the **KMAP ID/SL** and include the new program eligibility effective date.

Note: The KMAP ID/SL on both the Delete and the Add requests is required when making changes to the program eligibility effective date. Delete records will be dropped to the error report and the requested record will not be end dated if the KMAP ID/SL is not submitted.

Deleting providers:

When a program code is activated for a provider in error, mapped to the wrong provider, etc., the end date for the program eligibility needs to be the same as what the effective date is. When the program code has the same effective and end dates, this indicates the provider record is not valid.

If any of the providers are dropped from the MCO network, a 'delete' record should be created for the provider with the *Provider End Date* field populated. The MMIS will not delete the provider from the system, but update their *End Date* field to indicate that the provider is no longer active in the MCO network.

Note: Delete records do not generate a response record, so you will not see it on the provider response file. If the request record does not error off and report on the provider error file, the delete request was successful.

Once the MCO has completed the add and delete processes outlined above and have a finalized PR1 file, the MCO then sends this file back to KMAP by copying the file to a predefined folder on the MCOs FTP server. The KMAP EDI jobs, which consist of 5 jobs per submitter, pick up the files from that folder every 15 minutes and transfers the file(s) to the MMIS servers for processing. KMAP processes the PR1 request file from the MCOs once every week on Monday night at 7 p.m. and generates response and error files.

The PR1 Request file name and predefined folder name is illustrated below:

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PR1 Response File (PRRP)

KMAP generates the PRRP file after the PR1 Request file has been processed. The PRRP file contains the KMAP ID/SL that has been assigned to the newly added Medicaid Providers. This file is copied to the predefined folder on the MCOs FTP server. The file layout for the PRRP file is located in Appendix A.

The PRRP file name and predefined folder name is illustrated below:

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F.<SAK>.<MCO Medicaid Number>.PRRP.<YYMMDDhhmmss>.dat PRRP indicates PR1 response file *(i.e. F.390663.299999999A.PRRP.070226210420.dat)*	Provider_Response

PR1 Error File (PRER)

KMAP generates the PRER file after the PR1 Request file has been processed. The PRER file returns information to the MCOs regarding PR1 records that failed the PR1 Request process. This file is copied to the predefined folder on the MCOs FTP server. The file layout for the PRER file is located in Appendix A.

The PRER file name and predefined folder name is illustrated below:

PR1 Provider Error File Naming Convention	Folder Name
F.<SAK>.<MCO Medicaid Number>.PRER.<YYMMDDhhmmss>.dat PRER indicates PR1 provider error file *(i.e. F.390663.299999999A.PRER.070226210420)*	Provider_Error

Encounter Data Submission (837 Files)

Overview

MCO's must submit encounter data to KMAP using HIPAA X12 formatted 837 files for Institutional and Professional services, as well as NCPDP formatted files for pharmacy encounters. Please refer to the following HIPAA Companion Guides, located on the KMAP public website, for formatting questions:

- 837 Institutional Health Care Claim and Encounter Transactions
- 837 Professional Health Care Claim and Encounter Transactions
- NCPDP Transactions

837 File Creation

Production 837 and NCPDP files are limited to a HIPAA standard maximum of 25,000 claims total per file. There are no restrictions on the number of files an MCO can submit per day. All files will be stored in a queue at Hewlett-Packard (HP). As those files are processed, HP sends an email at approximately 7 a.m. and again around 7 p.m. to the loc-ksxix-mco-contact@external.groups.hp.com distribution list titled 'KSXIX - Encounter claims' with a listing of all the files that are **still waiting** to be processed.

Note: Along with the 837 or NCPDP files, KMAP requires a corresponding KM1 file be submitted before any processing of the 837 or NCPCP files will occur. The order of receipt does not matter on the 837 and KM1 files. The KM1 file process is described in Section 4: KMAP ID/SL Match File (KM1).

837 Billing Provider Specifics

For KMAP purposes, the Billing Provider is always the Pay-To Provider, so Loop 2010AB (Pay-To Provider Loop) should not be sent. When the Pay-To-Provider is different than the Billing Provider, HP will overlay the Pay-To-Provider with the Billing Provider information.

Note: With the implementation of the ANSI X12 5010 version of the 837 transactions on January 1, 2012, the definition of the Pay-To Provider fields are changing. The Pay-To Provider data will no longer be used when performing an NPI crosswalk for the Billing Provider.

The Billing Provider Loop 2010AA is preceded by Loop 2000A, the taxonomy code that will be associated with the Billing Provider Loop that follows. Taxonomy can be submitted in either the Loop 2000A or Loop 2310B, but KMAP prefers it to be submitted in Loop 2000A.

837 Test Files

MCOs are required to submit test files when first establishing a new MCO program, implementing new systems, or when there are MMIS directed format changes.

Since each MCO is different, when setting up test files for the very first time, the MCO needs to coordinate with HP to setup their test folder. The MCO will use their specific test folder for all testing with HP. Test files that are placed in the MCO‘s test folder will get picked up for our test region.

When submitting test files the MCOs need to notify HP by email with the Test file name, size and purpose for testing at loc-ksxix-mcoliaison@external.groups.hp.com.

Test files should be no larger than 25 claims. This is due to the tasks HP needs to complete prior to test files being processed in the MMIS. These tasks include the beneficiary and provider baseline process from the test files; this is a time consuming process if there are a high number of beneficiaries and providers to baseline. HP asks if the MCO’s test file fails the compliance test to not build new files with new beneficiaries and new providers. Please use the same beneficiaries and providers from the previous test file. This will expedite testing since HP will not have to baseline new beneficiaries and new providers.

If there is a need to test a larger sample of data, larger than 25 claims, please contact HP loc-ksxix-mcoliaison@external.groups.hp.com.

Compliance Testing

When testing compliance of an 837 file, an indicator of “T” for test must be used in ISA-15. Test files with a “T” in ISA-15 will pass through HP’s HIPAA translator to verify it

passes, and then be ignored. The file does not pass to the MMIS claims engine, no file or transaction processing occurs, and no automated notifications are sent. If the MCO wants to receive the 997 they must send a request to the MCOLiaison distribution list.

File Processing Testing

When testing file processing of an 837 file an indicator of "P" for production must be used in ISA-15. When test files are submitted with a "P" indicator, the response files are automatically generated and will prevent delays in getting the response files posted.

997 Functional Acknowledgement

The 997 transaction is an acknowledgement only to the sender that the submitted file has been accepted. Acceptance of the file does not mean that data is good. If you submitted an 837 file and it is missing, please make sure that you received a 997. If a 997 is not received within a day, please check for 837 compliance errors prior to sending an inquiry to HP.

Control Line Feed

When MCO's build their files it is important to remember that the MMIS requires the line feed to be a single byte, an Unix newline. If the file has a two byte Control Line Feed (CRLF) at the end of each data line, this will create an extra character. The unexpected extra character generates an error indicating an invalid header and/or trailer record. If the MCO is using a windows tool a two byte is returned.

Each end of text character should be immediately followed by a beginning of text character. This convention holds true for the entire file, including the header and trailer segments. MMIS is expecting no data (not even empty spaces) between each end of text and beginning of text markers. Following these guidelines will prevent extra spaces after the header and transaction segments in files.

HIPAA compliance problems support information

If HIPPA compliance problems occur, the MCO should contact the EDI Help Desk. All other processing concerns should be brought to the attention of the MCO Liaison. This includes questions about file processing or issues regarding the KMAP response files.

Contact information for support:

HP Technical Team after 5:00 PM	kspage.oncall@external.groups.hp.com
HP Cycle Technical Team after 5:00 PM	loc-ksxix.cycle.monitor@external.groups.hp.com
HP MCO Liaison Team	loc-ksxix-mcoliaison@external.groups.hp.com
HP EDI Help Desk	loc-ksxix-edikmap@external.groups.hp.com

KMAP ID/SL Match File (KM1)

Overview

The KM1 file is a companion file to the 837 used to designate the KMAP ID/SL associated with each NPI provider submitted in the 837. This file uses the MCO ICN to tie each record back to the 837 transaction. The KM1 is required for all encounter submissions.

The concept of the KM1 file was produced out of the need to create a one to one match between submitted provider information and the KMAP ID/SL used for processing encounters. The previous design of using the NPI crosswalk process resulted in an unacceptable number of defaulted rather than matched KMAP ID/SL codes. This new concept of using a KM1 file was proposed to KHPA and approved by KHPA in 2009.

Using this approach results in a direct one-to-one match of the KMAP ID/SL in all cases. This prevents improper processing of encounter data and greatly improves the quality of encounter data in MMIS. This solution also removes the need to manually manipulate provider records in MMIS to allow the NPI Crosswalk function to work correctly with the PR1 data in the many cases where the NPI, Provider Name, Taxonomy and Zip Code used by NPI crosswalk are identical for multiple KMAP ID/SL combinations.

KM1 File Creation

The information included in the KM1 file will allow HP to table the KMAP ID/SL information keyed to the MCO's specific internal ICN (Patient Account Number field in the 837 file). This key will tie to every provider ID included in the corresponding 837 file for that ICN. If a particular provider type is NOT used for that particular encounter, those fields in the match file record should be blank filled, as the KM1 file is a fixed record length file. The file layout for the KM1 file is located in Appendix A.

The KM1 record for header 0 corresponds to the providers submitted in loop 2310x. Edit 1056 (No match on either KM1 file or NPI) will post if a loop 2310x is submitted without a corresponding KMAP ID/SL on header 0 of the KM1 file. Likewise, KM1 detail records from 1 through N correspond to the providers submitted in loop 2420x. Edit 1057 (No match on either KM1 file or NPI) will post if the detail KMAP ID/SL are not submitted.

In order for the encounter process to work appropriately for MCOs required to submit KM1 files, all the provider information that is on the 837 must match accordingly to the KM1 file. For instance, if there is a Performing Provider NPI on the 837 file there has to be a KMAP ID/SL on the KM1 at the detail level.

If a rendering provider is submitted in loop 2310B (asserting that the rendering provider is the same for the entire claim except details containing loop 2420A), the KM1 file

should follow the same convention. The rendering provider KMAP ID/SL should only be submitted on the KM1 for details with a corresponding loop 2420A on the 837.

The naming convention for the KM1 File **must** follow the naming convention used for 837 file submission, with the exception of replacing the (837) in the file name with (KM1).

For example: If the created 837 submission file is named HW19**837**P20090605000001.dat, then the corresponding Match File would be named HW19**KM1**P20090605000001.dat. The only difference between the 2 file names is the 837 and the KM1 in the transaction section of the file name. See specific examples below for each file type.

File Type	Naming Convention
837 Professional	HW <19 or 21> <trx> <time stamp> *(e.g. HW19837P20071229190136)*
KM1	HW <19 or 21> <trx> <time stamp> *(e.g. HW19KM1P20071229190136)*

File Type	Naming Convention
837 Institutional	HW <19 or 21> <trx> <time stamp> *(e.g. HW19837I20071229190136)*
KM1	HW <19 or 21> <trx> <time stamp> *(e.g. HW19KM1I20071229190136)*

File Type	Naming Convention
NCPDP	HW <19 or 21> <trx> <time stamp> *(e.g. HW19NCP20071229190136)*
KM1	HW <19 or 21> <trx> <time stamp> *(e.g. HW19KM120071229190136)*

Processing the KM1 file

HP checks the 837 file upon receipt to see if the file requires a KM1 file. If it does, HP then checks to see if the KM1 file is available. If the KM1 file is not available then the 837 file moves to the KM1-hold directory.

When HP receives KM1 files the information is automatically stored in a table and then checks to see if there is an 837 file in the KM1-hold directory. If there is a corresponding 837 file present it is then moved to the TODAY directory for processing. If there is not a corresponding 837 file present then no processing occurs until it is received. If there are any files awaiting a corresponding file in the hold directory for more than a day, HP will notify the MCO via email.

Prior to processing an encounter, the claims engine performs two verifications to validate the submitted provider information.

1. The first will be to make sure there is a match on the T_CLM_KM1 table with the submitted ICN, showing that the KM1 file has processed and that encounter's ICN is on the table.

2. The second will be a check of the NPI submitted in the 837 file for that ICN compared to the NPI number on file for the KMAP ID/SL submitted in the KM1 file. This check will apply to every provider type included in the file that has a submitted NPI in the 837 file.

If either of these two conditions fails to be met, the encounter will be denied and a response for that ICN will be included in the unsolicited 277 response file.

Denied professional and institutional encounters that were submitted incorrectly to MMIS will need to be corrected by following the void and replacement instructions, see Section 6: Void and Replacement Process.

KM1 Program Specific Instructions
MCOs

Pharmacy encounters are submitted in NCPDP 5.1 format, which does not have an ICN field. To compensate for this in the KM1 file, the MCO_ICN field will need to be created from the information submitted in the NCPDP file.

To accomplish this, the MCO_ICN field in the KM1 file is formatted as follows:

> Date Dispensed in YYJJJ Julian date format + 7 digit Prescription number (left zero filled) + Beneficiary ID minus the first three characters (usually 001). This will result in a 20 digit ICN that uniquely identifies the prescription.

For example, a prescription filled on February 1st, 2009 for Beneficiary ID 00101234567 with a prescription number of 134 would have an ICN of 09032000013401234567.

It is not uncommon to receive the same pharmacy claim numerous times on the same day since providers frequently resubmit until the claim goes through to a paid status. By using the combination of the Date Dispensed, Prescription Number (7 digits) and the Beneficiary ID (minus the first three characters) to create the unique MCO ICN, this is creating duplicate records in the KM1 file. If duplicate MCO ICN's are submitted on the same KM1 file, the first occurrence will be used to process all subsequent submissions of the same encounter. The possibility exists that if the subsequent submissions of the duplicated encounter had a change in the billing or prescribing provider, the encounter would not reflect this. If the MCO receives edit 1056 on their pharmacy encounters for this reason, they can void the encounter and resubmit with the correct information.

When ANSI X12 5010 format goes live on January 1, 2012, incorporating NCPDP D.0, this process may change because NCPDP D.0 has a new ICN field incorporated in it. The current solution was arrived at to leave the NCPDP 5.1 format unchanged and not require the inclusion of any new information.

Section 3: ***Encounter Claim Response Information***

Unsolicited 277 Response

The 277 Health Care Payer Unsolicited Claims Status (277) transaction provides claim status information for processed encounters. The generation of 277's occurs twice daily, approximately 7:00 a.m. and 7:00 p.m.. Please refer to the following Companion Guide, located on the KMAP public website, for formatting questions:

- 277 Health Care Payer Unsolicited Claims Status

MCO responsibility for 277 receipts

Once the 277 is received the following should occur:

- Review the Claim Status Category Code for each response. These status codes will appear at both the header and detail level.

Claim Status Category Code	**MMIS Claim Status**
F2	Deny
F1	Pay and List
F1	Pay

- Review the encounters returned with an F2 status code to determine the reason for the denial and to see if the encounter should be re-processed. Use the HIPAA Claim Status Codes, along with the current Edit/Audit Listing, to determine which submissions should be resubmitted for processing.

  Example:
  STC*F2:20*101025*NA*53.44****** ~
  REF*1K*7010298000314~
  DTP*472*RD8*20100608-20100608
  SVC*HC:A0100*53.44*0****2~
  STC*F2:53**NA*53.44******F2:585*F2:20*5001,4021~

  277 Example:

STC*F2:20*101025*NA*53.44	Header information: STC is the Claim Level Status Information F2, 20 is the claim status category and the claim status code respectively 101025 is the processing date 53.44 is the claim billed amount

REF*1K*7010298000314	7010298000314 is the MMIS ICN assigned to the encounter
DTP*472*RD8*20100608-20100608	Header information: 20100608-20100608 Claim dates of service
SVC*HC:A0100*53.44*0****2	Detail information: SVC is the Service Line Information A0100 is the detail procedure code 53.44 is the detail billed amount 0 is the amount paid for that detail 2 is the units of service billed on the detail
STC*F2:53**NA*53.44******F2:585*F2:20*5001,4021	STC here is the Service Line Status Information 53, 585 –Claim Status codes 5001, 4021 are the KMAP error codes

Note: It is possible to see responses with both F1 at the header indicating a paid claim, however, receiving an F2 at the detail level indicating a denied detail. The F2 detail line must be reviewed to determine the reason for the denial and to see if the encounter should be re-processed.

When encounter files are received and processed, and returned in a denied status, this should not be considered a 'rejection'. The encounter data has been accepted into the MMIS, processed and is available for analysis. Encounter files that fail the HIPAA Compliance check are considered rejects. When calculating acceptance rates the only true rejections would be reported on the 997's.

It is possible for a claim to reach a point in processing where the claims engine would not have the needed information to properly adjudicate (i.e. invalid provider or beneficiary information). When this happens, the information returned on the 277 could be from the header level of the claim only, and not the detail level. Claims will be processed to the fullest extent allowed by the submitted information. If the claim was denied at the header then the 277 will only report the header level information, no detailed information will be returned.

There could also be informational codes on encounter claims. Informational codes are generated throughout the processing of the encounter, and even if it results in a "paid" status at both the header and detail level, the informational codes should be reviewed for

data quality and content issues. There is no hard fast rule for what should or should not be investigated.

There is a spreadsheet that is shared with the MCO's that contains a list of edits and audits that could be returned on a 277. The spreadsheet is titled MCO Edit/Audit Listing ccyy (v.#). This list of edits and audits are ones the MCO's should always monitor to determine which submissions should be voided and resubmitted for processing.

Claims Status Code can be returned on a 277 which do NOT fall on the MCO Edit/Audit list, but should elicit a change/response from the MCO. For instance, if you should suddenly see a large volume of responses with 'invalid diagnosis code' you will need to see if a change occurred in your system, or contact HP at loc-ksxix-mcoliaison@external.groups.hp.com to verify if there was a change in our processing, that would have caused that code to suddenly return for so many encounters.

MCO responsibility for missing 277's

When an MCO submits an encounter data file, they may not receive a 277 transaction for all the data within that file at the same time. The 277 transaction is generated as HP processes encounters in the processing queue. They may not all be processed at the same time, this is due to the HP fee for service claims that get processed prior to encounter claims. It is very important that when HP sends out the 'KSXIX - Encounter claims' processing queue emails, each MCO needs to check to ensure the claim count has zeroed out before anymore data is submitted or prior to contacting HP regarding missing 277 transactions.

NCPDP Response

The NCPDP Response transaction provides claim status information for processed encounters. The generation of the NCPDP Response occurs once per submitted file and is created once the file has completed. Please refer to the following Companion Guide, located on the KMAP public website, for file specifics:

- KMAP NCPDP Companion Guide

MCO responsibility for NCPDP receipts

HP created a new spreadsheet for the NCPDP Reject Codes. This is a listing of every edit/audit in MMIS that has an NCPDP reject code assigned, regardless of the edit/audit disposition (pay, pay and list or deny). If there is an edit/audit in MMIS that does not have a reject code assigned, it will not be on this list. The formatting of this spreadsheet is similar to the Edit/Audit Listing and is titled NCPDP Reject Codes v#.##.

When the MCO receives the NCPDP responses, it is important to utilize this spreadsheet to determine what edits/audits posted on the encounters. If an NCPDP reject code is tied to an edit/audit in MMIS, the reject code is returned on the response file, not the EOB

code. However; if there is not a reject code tied to an edit/audit, the EOB code is returned. Reject codes will also be returned on the response file when the disposition for the edit/audit is set to pay. The following is an example of a claim in MMIS and the reject codes on the response file:

A pharmacy claim posted two edits;

- 1001 – Billing Provider Not Eligible For DOS
- 0556 – Claim Past 24 Month Filing

Both of these edits have reject codes in MMIS and both were on the response file:

- Reject code 40 is assigned to edit 1001
- Reject code 81 is assigned to edit 0556

Edit 1001 is set to deny on encounters but edit 0556 is set to pay.

The MCO will need to look to see which edits/audits have the reject code(s) from the response file. Then will need to determine if those edits/audits are ones that need to be monitored and resubmitted.

Void and Replacement Process

Overview

Encounters cannot be adjusted, therefore they must be updated through the Void and Replacement process. A void request is submitted for processing whenever an MCO needs to update claim information previously submitted through encounter data. The MCO may submit a new encounter to replace the voided encounter **after** the void action has completed and the MCO has received the response file for that void.

Before a void is sent the MCO needs to ensure they have a mechanism in place to prevent a void transaction from being sent on a claim that has not been accepted in MMIS as an encounter, and to ensure the void transaction is for an encounter that the MCO had submitted.

The chart displays a general outline of the Void and Replacement process.

Action	**Response**
Submit Original	Encounters get a paid or denied status and returned on 277 (region 70 ICN).
Void	Voids get a denied status (adjustment x-ref to link original/void) and returned on 277 (region 77 ICN)
Replacement	Replacement encounters get a paid or denied status and returned on 277 (new region 70 ICN)

A void transaction can be submitted for an encounter that has been paid or denied by the MMIS; however, it may not be necessary to submit a void claim when data correction is necessary. The following situations should be considered to determine if an encounter should be resubmitted with corrected information or a void transaction and a new encounter should be sent:

- Original claim received a "paid" MMIS status – send void and replacement
- Original claim received a "denied" MMIS status – this is situational; therefore, you can send a void and replacement or submit a new encounter with the corrected data.
    - If the denial is due to something you can fix to receive a MMIS "paid" status (such as a KMAP provider ID or NPI), send an updated transaction.
    - If you are correcting data on an encounter that a MMIS can't pay (such as a non-covered procedure code), send void and replacement.

Submitting Voids

Voids are completed at the header level and all details are voided. The MCO should send a separate file for 837P, 837I, and NCPDP voids. Successful voids will appear on the 277 and NCPDP response files.

Voids do not require a corresponding KM1 'record', but they do require a KM1 'file' to process. For example, if a pharmacy batch contains only voids, a corresponding KM1 file needs to be submitted but does not have to contain any data records. A KM1 file is required for all file types, however; voids to not require a record within the KM1 file.

Professional and Institutional Void process

The MCO will submit a void claim for the original encounter claim. The void must have:

- Code claim frequency of 8 (CLM05-3 - 2300 loop - cde_clm_frequency on Claim "header" tables).
- REF segment with F8 qualifier and KMAP's region 70 Internal Control Number (ICN) in the REF01 & REF02 - 2300 loop assigned to the original encounter claim that needs to be voided.

The MMIS process:

- Claims engine will check all of the following for a match:
    - Original ICN
    - Beneficiary ID
    - First Date of Service
    - Claim Billed Amount
- Links the void claim to the original claim by creating an entry in a cross-reference table.
- Assigns the void claim region 77 ICN.

- Turns on the new MMIS "action indicator" in the adjustment x-ref table that indicates the type of operation as re-submit.

Voided claims are sent on the 277 file.

Pharmacy Void process

Voids for pharmacy encounters are submitted in an NCPDP B2 transaction. Required data elements for the B2 transaction are specified in the KMAP NCPDP Companion Guide. Please refer to the KMAP NCPDP Companion Guide at the KMAP public website or by using the link below.

- KMAP NCPDP Companion Guide

Voids will appear on the NCPDP response files.

Note: Pharmacy encounters that are in a denied status in the MMIS cannot be voided.

Unsuccessful voids

Unsuccessful voids are reported on the "Bad Encounter Claims Report" produced internally at HP, which are then forwarded by email to the specific MCO reporting on the report. This report will have the following information:

- ICN (MMIS ICN to be voided)
- Patient Account Number (MCO ICN)
- Error Code
- Error Description

Most generally the error code that is reported will be 837-E11, which means that the original claim (MMIS ICN) could not be found. This error will be generated if all of the matching criteria (Original ICN, Beneficiary ID, First Date of Service, Claim Billed Amount) is not met.

If a void request is sent for an encounter that has already been successfully voided, the 277 will show a new 70 region ICN, but will also have an error 550 (Manual Deny Of Adjustments) at the end of the STC*F2 segment. This is NOT a new claim; it is a denied claim showing that the void failed. No further action for this is required.

Submitting Replacements

After a void is accepted, the 'replacement' is just sending the corrected encounter as if the voided encounter no longer exists in MMIS. The correct way to submit a replacement claim is by having the Claim code frequency (CLM05-3) of '1' indicating an original claim and REF F8 should not be submitted.

Section 4: ***Eligibility Rosters***

Overview

Enrollment rosters provide a detailed listing of assignments for beneficiaries in Managed Care. These rosters are created on a daily and monthly basis. These files may be generated on paper or electronic media. The electronic format files are generated in the HIPAA 834 transaction format. For questions on the 834 format please refer to the following HIPAA Companion Guide located on the KMAP public website or by accessing the link below:

- 834 Benefits Enrollment and Maintenance

Daily Rosters

The rosters are generated daily. New and terminated Primary Medicaid Providers (PMP) Assignments are reported in the daily process as usual. However, for continuing assignments, the daily process only lists those who have had a change in capitation category or a change in demographics. This significantly reduces the duplication of roster records from day to day, which makes the reports clearer and simpler to read/process.

Monthly Rosters

The monthly rosters are generated for all Managed Care programs. Unlike the daily process, all continuing assignments are listed in the roster reports/files. New records are also provided as usual. Monthly rosters are generated through the month end process which is scheduled to run on the 6th working day from the end of the month, beginning at 1:00 AM. The following chart is a list of dates for this fiscal year on which month end is scheduled to run in MMIS. Since month end does not run every month on the same date, please check to make sure month end has run before inquiring on the monthly 834 files.

Month	KAECSES Monthly Processing dates by HP (1AM on the day given below)
July 2010	07/23/2010
Aug 2010	08/24/2010
Sep 2010	09/23/2010
Oct 2010	10/22/2010
Nov 2010	11/19/2010
Dec 2010	12/22/2010
Jan 2011	01/22/2011
Feb 2011	02/19/2011
Mar 2011	03/24/2011

Apr 2011	04/22/2011
May 2011	05/21/2011
Jun 2011	06/23/2011

If the date is past the KAECSES monthly processing date and the roster has not been received, the MCO's need to contact HP loc-ksxix-mcoliaison@external.groups.hp.com.

Section 5: ***Encounter Data Attestations***

Overview

CMS requires that MCOs have administrative and management arrangements or procedures to guard against fraud and abuse. Part of those procedures includes the attestation or certification statements required from Managed Care Organizations regarding the accuracy, completeness and truthfulness of the data that is submitted. Below is the link to the Code of Federal Regulations requirement regarding certifications.

Electronic Code of Federal Regulations, Title 42: Public Health, PART 438 – Managed Care.

KDHE-DHCF has created a distribution group for all MCOs to use when sending their attestation forms. The group only contains members who have a need to receive the attestation forms.

KHPA_MCO_Attestation_Forms@khpa.ks.gov

If your MCO has an obligation to send your attestation forms to someone outside of KDHE, please continue to add those persons.

MCO Submission Checklist

This checklist should be used for each file submission to ensure that files are created and submitted correctly. If problems are encountered, please review the checklist to ensure that all requirements were met in the submission of the file.

Use the links in the checklist below for guidance within this manual.

	File Creation and Naming Conventions
☐	Designate file as Test or Prod
☐	Is File Naming Convention correct?
☐	Do the KM1 and 837 file names match including the file extension?
☐	Ensure that the file is using Unix newline rather than CRLF (carriage return line feed)
	837 File
☐	Are valid NPIs populated on the 837?
☐	Ensure that the 837 file has no more than 25,000 claims.
	KM1 file
☐	Has a corresponding KM1 file been built? (Optional for NEMT)
☐	Does the KM1 include the Billing Provider KMAP ID/SL?
	Notifications
☐	If Production File, send notification to Loc-ksxix-MCOLiaison@external.groups.hp.com when file(s) are submitted
☐	Send Attestation email to KHPA_MCO_Attestation_Forms@khpa.ks.gov and other appropriate State contact on the date of file submission
☐	If test file for more than HIPAA compliance check, send notification to Loc-ksxix-MCOLiaison@external.groups.hp.com.
	Problem Resolution
☐	Send email notification to Loc-ksxix-MCOLiaison@external.groups.hp.com if files are sitting on the FTP server for more than 2 hours
☐	Who to contact

Building Files

When MCO's build their files it is important to remember that the MMIS requires the line feed to be a single byte, a Unix newline. If the file has a two byte CRLF at the end of each data line, this will create an extra character. The unexpected extra character generates an error indicating an invalid header and/or trailer record.

Each end of text character should be immediately followed by a beginning of text character. This convention holds true for the entire file, including the header and trailer segments. MMIS is expecting no data (not even empty spaces) between each end of text

and beginning of text markers. Following these guidelines will prevent extra spaces after the header and transaction segments in files.

It also depends on the tool that is used to generate files. For instance, in Unix a single byte is returned, but in any windows tool a two byte is returned.

POA Field Inclusion

In December 2007, CMS distributed a POA Fact Sheet that explains how to format the POA data for submission electronically. That PDF document is available at http://www.cms.gov/HospitalAcqCond/downloads/POAFactsheet.pdf.

The full list of exempt provider types is available on the CMS website at http://www.cms.gov/HospitalAcqCond/03_AffectedHospitals.asp#TopOfPage.

The full description for proper coding of POA information can be found on the CMS website at http://www.cms.hhs.gov/HospitalAcqCond/05_Coding.asp#TopOfPage.

The editing for POA in MMIS is done by claim type, however; the claim type is assigned based on the type of bill submitted. When an encounter claim is submitted, the type of bill determines what the claim type will be. When we edit for POA, we do not look for type of bill 111, 112, 113, etc., we look for claim type 'I", which identifies an inpatient claim.
On the 837 Institutional claims, the CLM05-1 (Facility Code Value) and CLM05-2 (Facility Code Qualifier) are used to assign the claim type.

The following are the type of bills and their definitions that define Inpatient claims (claim type " I ") in MMIS:

110	Hospital - Inpatient (including Medicare Part A) - Nonpayment/zero Claim
111	Hospital - Inpatient (including Medicare Part A) - Admit thru discharge claim
112	Hospital - Inpatient (including Medicare Part A) - Interim - First claim
113	Hospital - Inpatient (including Medicare Part A) - Interim -Continuing claim
114	Hospital - Inpatient (including Medicare Part A) - Last claim (thru date is discharge date)
117	Hospital - Inpatient (including Medicare Part A) - Replacement of Prior Claim
118	Hospital - Inpatient (including Medicare Part A) - Void / Cancel of Prior Claim
120	Hospital - Inpatient (including Medicare Part B only) - Nonpayment/zero Claim
121	Hospital - Inpatient (including Medicare Part B only - Admit thru discharge claim
122	Hospital - Inpatient (including Medicare Part B only) - Interim - First claim
123	Hospital - Inpatient (including Medicare Part B only) - Interim - Continuing claim
124	Hospital - Inpatient (including Medicare Part B only) - Last claim (thru date is discharge date)
127	Hospital - Inpatient (including Medicare Part B only) - Replacement of Prior

	Claim
128	Hospital - Inpatient (including Medicare Part B only) - Void / Cancel of Prior Claim

Rejected vs. Denied

When inquiring with HP on the status of encounters it is crucial to use the correct terminology. When encounter files are received and processed, and returned in a 277 response file in a denied status, this is called a 'denied' encounter and should **not** be considered a 'rejection'. The encounter data has been accepted into the MMIS, processed, and is available for analysis.

Encounter files that fail the HIPAA Complicance check are considered 'rejects'. When calculating acceptance rates the only true rejections would be reported on the 997's.

Supplemental Delivery Payments

On a monthly basis, the previous month's claims are used to determine which encounter claims have procedure codes that will cause a "one-time lump sum delivery" payment to be generated. The "one-time lump sum delivery" payment covers the additional costs incurred by the MCO for the delivery of a child.

Criteria for Generating Lump Sum Payments

Professional (837P)

a) Professional encounter claim (encounter amount > 0);
b) Claim status from MCO is in 'paid' status;
c) Claim must go through financial and should be in history (aim01) database;
d) Date final or paid date is between the last and current run date of the beneficiary monthly cycle;
e) Claim has one of the following procedure code: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622, and Y9512;
f) Claim must be received from one of the HW19 medical MCOs;

Institutional (837I)

a) Institutional encounter claim (encounter amount > 0);
b) Claim status from MCO is in 'paid' status;
c) Claim must go through financial and should be in history (aim01) database;
d) Date final or paid date is between the last and current run date of the beneficiary monthly cycle;
e) For claims with a date of service prior to 10/01/2008, claim has a DRG code between '370' and '375' (inclusive);

f) For claims with a date of service on or after 10/01/2008, claim has one of the following DRG codes: 765, 766, 767, 768, 774, and 775;
g) Claim must be received from one of the HW19 medical MCOs;

Detailed Criteria

a) Beneficiary is female;
b) Beneficiary is over the age of 12;
c) Claim has not been adjusted;
d) Beneficiary has a non-historied assignment in the HW19M program as of the claim's From Date of Service;
e) Claim was billed within 13 months of the From Date of Service;
f) Payment has not already been made for the beneficiary for other delivery claim within 10 months of current claim's from Date of Service

TPL Files

TPL Proprietary File

The TPL Proprietary File is used to update the MCOs' systems for the beneficiaries that have other insurance. This file ensures all systems have the most accurate data in relation to beneficiaries other insurance policies. Currently, a TPL Proprietary file is sent monthly to the MCOs so they can update their systems with the same information that is in the MMIS. The file name is t_mc_tpl_ext.dat and is used as a companion to the 834 monthly roster transaction. The file layout can be found in Appendix A: File Layouts.

TPL Lead Spreadsheet

The MCOs are responsible for returning a TPL Lead Spreadsheet to HP on the first of each month with the information from their system. The distribution to send the spreadsheet to is Loc-ksxix-MCO-TPL@external.groups.hp.com. HP uses this information to update the MMIS with the most up to date information. The spreadsheet layout can be found in Appendix A: File Layouts.

How to send the spreadsheet

It is KDHE Protected Health Information (PHI) policy that when sending PHI related information by electronic means, to ensure that PHI is protected:

- All documents must be password protected
- The password for the document needs to be sent in a separate email.
- The password must consists of eight characters with four unique character types (UPPER CASE, lower case, numbers (1 2 3), and symbols (.,-))
- The email must be encrypted

PRVLST Initial and Weekly File

The Initial and Weekly PRVLST layouts are the same as the PR1 Request File layout, except that the detail records in the PRVLST provider file have four additional fields:

- Medicaid Indicator
- Active Indicator
- Latitude
- Longitude

All records (that is, header, details, and trailer records) are fixed length records.

Note: Some of the MCO specific fields such as the following may not be populated in a PRVLST file.

- MCO Medicaid Number
- MCO Service Location
- MCO Assigned Number
- Provider Start Date
- Provider End Date

Header Record

Data Element:	Description:	Comments:	Field Length:	Type:	Required:
Header Record ID	Header record indicator	Value "HD#"	3	C	Y
Header Record Number			5	C	
Header Control Care Code			8	C	
Header Control Sequence			3	C	
Header Submitter ID	10 character KMAP ID for the submitter MCO, i.e. 9-digit Medicaid number and 1 character service location code.	Populate with 10 character KMAP ID assigned to the submitter MCO and populate rest of the field with spaces	24	C	Y
Header Submitter Number			7	C	

Data Element:	Description:	Comments:	Field Length:	Type:	Required:
Header Test/Production Indicator		Values: "T" = Test "P" = Production	1	C	Y
Header Submit Date		CCYYMMDD	8	C	Y
Header Submit Time		HHMMSS	6	C	
Header Version			6	C	
MCO Medicaid Number	9-digit Medicaid number for the MCO	Billing Provider	9	C	Y
MCO Service Location	1 character service location code for the MCO	Alpha character	1	C	Y
FILLER	Spaces	Spaces	329	C	

Detail Record

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
Record Type	Roster record type	Always populate with "PR1"	3	C		Y
Record Change Indicator	This field indicates if the record is for adding, changing or deleting the PR1 provider	Valid values: "A" = Add "D" = Delete	1	C		Y
MCO Medicaid Number	9-digit Medicaid number for the MCO		9	C	Y	Y
MCO Service Location	1 character service location code for the MCO	Alpha character	1	C	Y	Y
Provider Medicaid Number	9-digit Medicaid number for the provider	If available	9	C	Y	
Provider Service Location	1 character service location for the provider	If available	1	C	Y	

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
Provider NPI	National Provider Identifier number assigned by the government to the provider	If applicable/available	10	C		
Provider License Number	State license number for the provider	If applicable/available	11	C		
Provider SSN	Provider's 9 digit Social Security Number without the dashes		9	C		Y
Provider FEIN	Federal Employer ID Number for the provider		9	C		Y
MCO Assigned Number	Internal provider number assigned to a provider by the MCO (MCO's internal number)	If applicable/available	15	C		
Provider Type	2-digit Kansas Medical Assistance Program (KMAP) provider type code	See valid provider type, specialty and taxonomy combinations from the Provider Type, Specialty and Taxonomy Code Table in the *PR1 Companion Guide*	2	C		Y
Provider Specialty	3-digit Kansas Medical Assistance Program (KMAP) provider specialty code	See valid provider type, specialty and taxonomy combinations from the Provider Type, Specialty and Taxonomy Code Table in the *PR1 Companion Guide*	3	C		Y
Provider Taxonomy	10 character provider taxonomy code	See valid provider type, specialty and taxonomy combinations from the Provider Type, Specialty and Taxonomy Code Table in the *PR1 Companion Guide*	10	C		

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
Primary Language	Primary language spoken by provider	See 2 character code from Language Codes Table in *PR1 Companion Guide*	2	C		
Secondary Language	Any secondary language spoken by provider	See 2 character code from Language Codes Table in *PR1 Companion Guide*	2	C		
Hospital Admit Privileges	Medicaid-specific provider number (4 occurrences of X(12) characters each)		48	C	Y	
Provider Name Indicator	Type of name	"B" = Business "P" = Personal	1	C		Y
Provider Name	Name of provider	Personal – last name X(25), first name X(13), middle name X(12), title X(5) filler X(35) Business – business name X(50) filler X(40)	90	C		Y
Street Address 1	Provider's street address	Numeric street address, direction, name of street and suite number	32	C		Y
Street Address 2	2nd line of provider's street address		20	C		
City	Provider's city		18	C		Y
State	2 character state abbreviation	e.g. KS, MO	2	C		Y

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
ZIP Code	Provider's ZIP code + 4	**ZIP Code +4:** All 9 characters must have numeric values – if not numeric it will be rejected. **Zip code (first 5 characters):** Required. Must be present and numeric – if 5 numeric values are not present, it will be rejected. **+4 field (last 4 characters):** Not required. If present it must be numeric – if not numeric it will be rejected. 1. If present the characters must = 4 (values greater than or = to 1 but less than 4 should be rejected.) 2. If all 4 characters are = 9 (9999) – drop the +4 3. If all 4 characters are = 0 (0000) – drop the +4	9	C		Y
Provider UPIN	Universal Provider Identification Number	If available	12	C		
Phone Number	Provider's office phone number		10	C		
Provider Start Date	Effective date provider contracted with the MCO	CCYYMMDD e.g. 20070101	8	C		Y

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
Provider End Date	Termination date of provider's contract with the MCO	CCYYMMDD Use 22991231 as an open end date	8	C		Y
County Code	County code associated with this location of the provider's practice	Use the 2 character county code from County Code Table in *PR1 Companion Guide*	2	C		Y
PAR/Non-PAR	Used to indicate whether the provider is a participating (PAR) or a non-participating (Non-PAR) provider	1 -indicates PAR 2 -indicates Non-PAR	1	C		Y
Medicaid Indicator	This indicates if the provider ID has Medicaid program eligibilities	'M' – Medicaid 'N' – Non-Medicaid	1	C	Y	
Active Indicator	Used to indicate the Active/inactive status and relationship to the MCO	M = Active for this MCO C = Active for at least one MCO, but not for this MCO O = Inactive Provider for at least one MCO, but no Active MCO Provider ID A = Active KMAP ID, but no Active or Inactive MCO Provider ID I = Inactive KMAP ID, but no Active or Inactive MCO Provider ID	1	C	Y	

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
Latitude	This is the latitude of the provider address		15	C		
Longitude	This is the longitude of the provider address		15	C		
Provider Enrollment Indicator	This indicates whether the provider is enrolled as an individual or as a group	I=Individual G=Group	1	C		
FILLER	Spaces	Spaces	19	C		

Trailer Record

Data Element	Description	Comments:	Field Length:	Type:	Required:
Trailer Record ID	Trailer record indicator	Value "TR#"	3	C	Y
Trailer Record Number		Value "#####"	5	C	
Trailer Control Card Code		Values "PR"	8	C	
Trailer Control Card Sequence			3	C	
Trailer Submitter ID	10 character KMAP ID for the submitter MCO, i.e. 9-digit Medicaid number and 1 character service location code.	Populate with 10 character KMAP ID assigned to the submitter MCO and populate rest of the field with spaces	24	C	Y
Trailer Submitter Number			7	C	
Trailer Test/Production Indicator		Values: "T" = Test "P" = Production	1	C	Y
Trailer Record Count	Total number of detail records in the PR1 file, i.e. the number of records in the file excluding the header and the trailer.		7	C	Y
Trailer Total Changes		COBOL PIC 9(7)V99	9	C	
FILLER	Spaces	Spaces	343	C	

PR1 Request File Layout

All records (i.e. header, details, and trailer records) are fixed length records. If any of the optional fields do not have data, spaces are to be inserted into the field to ensure that all records are of equal length. For example, if the *Street Address 2* field (20 characters) is not populated, insert 20 spaces into the field.

The header record is the first record of a PR1 Request File followed by multiple detail records and one trailer record as the last record. The field layout for all three record types in the PR1 Request Files is shown below.

Header Record

Data Element:	Description:	Comments:	Field Length:	Type:	Required:
Header Record ID	Header record indicator	Value "HD#"	3	C	Y
Header Record Number			5	C	
Header Control Care Code			8	C	
Header Control Sequence			3	C	
Header Submitter ID	10 character KMAP ID for the submitter MCO, i.e. 9-digit Medicaid number and 1 character service location code.	Populate with 10 character KMAP ID assigned to the submitter MCO and populate rest of the field with spaces	24	C	Y
Header Submitter Number			7	C	
Header Test/Production Indicator		Values: "T" = Test "P" = Production	1	C	Y
Header Submit Date		CCYYMMDD	8	C	Y
Header Submit Time		HHMMSS	6	C	
Header Version			6	C	
MCO Medicaid Number	9-digit Medicaid number for the MCO	Billing Provider	9	C	Y
MCO Service Location	1 character service location code for the MCO	Alpha character	1	C	Y
FILLER	Spaces	Spaces	329	C	

Detail Record

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
Record Type	Roster record type	Always populate with "PR1"	3	C		Y
Record Change Indicator	This field indicates if the record is for adding, changing or deleting the PR1 provider	Valid values: "A" = Add "D" = Delete	1	C		Y
MCO Medicaid Number	9-digit Medicaid number for the MCO		9	C	Y	Y
MCO Service Location	1 character service location code for the MCO	Alpha character	1	C	Y	Y
Provider Medicaid Number	9-digit Medicaid number for the provider	If available	9	C	Y	
Provider Service Location	1 character service location	If available	1	C	Y	
Provider NPI	National Provider Identifier (NPI) number assigned by the government to the provider	If applicable/available	10	C		
Provider License Number	State license number for the provider	If applicable/available	11	C		
Provider's SSN	Provider's 9 digit SSN without the dashes		9	C		Y
Provider FEIN Number	Federal Employer ID Number for the provider		9	C		Y
MCO Assigned Number	Internal provider number assigned to a provider by the MCO (MCO's internal number)		15	C		Y
Provider Type	Kansas Medical Assistance Program (KMAP) provider type code	See valid provider type, specialty, and taxonomy combinations from the Provider Type, Specialty and Taxonomy Code Table in the *PR1 Companion Guide*	2	C		Y

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
Provider Specialty	Kansas Medical Assistance Program (KMAP) provider specialty code	See valid provider type, specialty, and taxonomy combinations from the Provider Type, Specialty and Taxonomy Code Table in the *PR1 Companion Guide*	3	C		Y

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
Provider Taxonomy	10 character provider taxonomy code	See valid provider type, specialty, and taxonomy combinations from the Provider Type, Specialty and Taxonomy Code Table in the *PR1 Companion Guide*	10	C		
Primary Language	Primary language spoken by provider	See 2 character code from Language Codes Table in *PR1 Companion Guide*	2	C		
Secondary Language	Any secondary language spoken by provider	See 2 character code from Language Codes Table in *PR1 Companion Guide*	2	C		
Hospital Admit Privileges	Medicaid-specific provider number (4 occurrences of X(12) characters each)		48	C	Y	
Provider Name Indicator	Type of name	"B" = Business "P" = Personal	1	C		Y
Provider Name	Name of provider	Personal – last name X(25) first name X(13) middle name X(12) title X(5)	90	C		Y

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
		filler X(35) Business – business name X(50) filler X(40)				
Street Address 1	Provider's street address	Numeric street address, direction, name of street and suite number	32	C		Y
Street Address 2	2nd line of provider's street address		20	C		
City	Provider's city		18	C		Y
State	2 character state abbreviation	e.g. KS, MO	2	C		Y
ZIP Code	Provider's ZIP code + 4	**ZIP Code +4:** All 9 characters must have numeric values – if not numeric it will be rejected. **Zip code (first 5 characters):** Required. Must be present and numeric – if 5 numeric values are not present, it will be rejected. **+4 field (last 4 characters):** Not required. If present it must be numeric – if not numeric it will be rejected. 1. If present the characters must = 4 (values greater than or = to 1 but less than 4 should be rejected.) 2. If all 4 characters are = 9 (9999) – drop the +4 3. If all 4 characters	9	C		Y

Data Element:	Description:	Comments:	Field Length:	Type:	Medicaid Specific:	Required:
		are = 0 (0000) – drop the +4				
Provider UPIN	Universal Provider Identification Number	If available	12	C		
Phone Number	Provider's office phone number		10	C		
Provider Start Date	Effective date provider contracted with the MCO	CCYYMMDD e.g. 20070101	8	C		Y
Provider End Date	Termination date of provider's contract with the MCO	CCYYMMDD Use 22991231 as an open end date	8	C		Y
County Code	County code associated with this location of the provider's practice	Use the 2 character county code from County Code Table in *PR1 Companion Guide*	2	C		Y
PAR/Non-PAR	Used to indicate whether the provider is a participating (PAR) or a non-participating (Non-PAR) provider.	1 = indicates PAR 2 = indicates Non-PAR	1	C		Y
FILLER	Spaces	Spaces	52	C		

Trailer Record

Data Element	Description	Comments:	Field Length:	Type:	Required:
Trailer Record ID	Trailer record indicator	Value "TR#"	3	C	Y
Trailer Record Number		Value "#####"	5	C	
Trailer Control Card Code		Values "PR"	8	C	
Trailer Control Card Sequence			3	C	
Trailer Submitter ID	10 character KMAP ID for the submitter MCO, i.e. 9-digit Medicaid number and 1 character service location code.	Populate with 10 character KMAP ID assigned to the submitter MCO and populate rest of the field with spaces	24	C	Y
Trailer Submitter Number			7	C	
Trailer Test/Production Indicator		Values:	1	C	Y

Data Element	Description	Comments:	Field Length:	Type:	Required:
		"T" = Test "P" = Production			
Trailer Record Count	Total number of detail records in the PR1 file, i.e. the number of records in the file excluding the header and the trailer.		7	C	Y
Trailer Total Changes		COBOL PIC 9(7)V99	9	C	
FILLER	Spaces	Spaces	343	C	

PR1 Response File Layout

Data Element:	Description:	Field Length:	Type:
MCO Medicaid Provider Number	9-digit Medicaid number for the MCO	9	N
MCO Provider Service Location	1 character service location code for the MCO	1	C
Medicaid Provider Number	9-digit Medicaid number for the provider	9	N
Medicaid Provider Service Location	1 character service location code for the provider	1	C
MCO Assigned Number	Internal provider number assigned to a provider by the MCO.	15	C
Provider NPI	National Provider Identifier number assigned by the government to the provider	10	N
Provider Taxonomy	This is the 10 character provider taxonomy code	10	C
Address Separator character	This is the one character separator (~) between previous fields and provider address fields	1	C
Street Address 1	Provider's street address	30	C
Street Address 2	2nd line of provider's street address	20	C
City	Provider's city	15	C
State	2 character state abbreviation	2	C
Provider FEIN Number	Federal Employer ID Number or tax ID for the provider	9	N
FILLER	FILLER field reserved for future expansions, e.g. future additions of new fields to the response file.	120	C

PR1 Error File Layout

The Provider Error File contains the MCO's input record and the error code. The error file layout is the same as the PR1 detail record layout except the last field (i.e. 52 character FILLER field) contains an alphanumeric error code at the end, indicating why the record could not be processed. The error codes and corresponding error descriptions are listed below.

Error Code:	Error Short Description:	Detailed Description:
E700	Missing Rec Chg Ind	Missing Record Change Indicator should be A for ADD or D for Delete.
E705	Invalid Rec Chg Ind (A/D)	Invalid Record Change Indicator, should be A or D.
E710	Invalid Taxonomy Code	Invalid provider taxonomy code.
E715	Missing PAR Ind	Missing PAR/Non-PAR Indicator, should be 1 for PAR or 2 for Non-PAR.
E720	Invalid PAR Ind	Invalid PAR/Non-PAR Indicator, should be 1 or 2.
E725	Invalid Primary Lang Code	Invalid Primary Language Code.
E730	Invalid Secondary Lang Code	Invalid Secondary Language Code.
E735	Invalid Provider ID	Invalid Provider ID, i.e. the provider ID was not found in MMIS.
E740	Missing MCO Assigned Prov ID	No value was found in the MCO assigned Provider ID field.
E745	Missing or invalid provider ID	Missing or invalid provider ID.
E750	MCO-Provider relation not found	Provider is not part of the MCO network, cannot process a Delete record.
E755	Provider is inactive in MCO network	Provider is already inactive in the MCO network, cannot process a Delete record.
E760	Provider NPI is invalid	Provider's NPI is invalid.
E765	Provider NPI is not in MMIS	Provider's NPI is not in MMIS.
E770	Tax ID update not allowed for this provider	Tax ID update not allowed for this provider because it has multiple program eligibilities.
E775	Invalid or missing state abbreviation	Invalid or missing state abbreviation.
E780	Missing City Name	Missing City Name.
E785	Missing ZIP code	Missing ZIP code.
E786	Invalid ZIP code	ZIP Code +4: All 9 digits must have numeric values - if not numeric, it will be rejected. ZIP Code (first 5 digits): Required. Must be present and have 5 numeric values - if 5 numeric values are not present, it will be rejected. +4 (last 4 digits): Not required. If present it must be 4 numeric values - if not numeric it will be rejected. Values greater than or equal to 1 but less than 4 will be rejected. If all 4 values are equal to 0 (0000) or 9 (9999), it will be rejected.
E790	Provider NPI is not matching with MMIS	Provider's NPI in MMIS is different from the NPI that came via the PR1 record; therefore, the NPI update for this provider is not allowed due to its enrollment in other networks.
E795	Dental Providers are not allowed in PR1	Dental Providers are not allowed to be created through the PR1 process ***Note:*** This edit is no longer active effective 12/03/10
E800	Invalid MCO ID	MCO's provider ID is blank or invalid in MMIS.

Error Code:	Error Short Description:	Detailed Description:
E830	Invalid Effective Date	Date effective is invalid or blank.
E835	Invalid End Date	Date end is invalid or blank.
E925	Invalid Provider Name	Provider name is blank.
E930	Invalid Provider Name Ind	Provider name indicators can only be B =Business or P =Personal.
E935	Invalid SSN	Provider SSN is missing or invalid.
E940	Invalid FEIN	Provider FEIN is missing or invalid.
E945	Invalid License Num	Invalid provider license number.
E950	Invalid Address	First street address is blank.
E955	Invalid County Code	County code field is missing or invalid
E960	Invalid Type/Spec	Provider type, specialty code or the combination is invalid.
E965	Required info missing	Any of the required information is missing.
E970	Prov Service Loc exhausted	Provider service location has been maxed out and reached 'Z'.
E975	MCO ID in HDR does not match DTL	MCO provider on the header is different from the provider on each detail line.
E980	Unable to process PR1 record	PR1 record could not be processed due to some unknown reason, i.e. database failure.
E985	Future Effective Date	Date effective is greater than today's date.

PR1 NPI Addition E-mail Report Layout

If an MCO submits a provider number with an NPI for a provider for which HP does not have an NPI on file, the NPI will be added to the MMIS provider NPI table and an e-mail report will be sent to the Provider Enrollment unit (i.e. loc-ksxix-provider-enrollment@groups.hp.com). The PE unit will confirm the number with the provider and work with the MCO liaison if any communication between HP and the MCO is necessary. As the PR1 process is a weekly process this report is expected to be a weekly report.

Data Element:	Description:	Field Length:	Type:
MCO Medicaid Provider Number	9-digit Medicaid number for the MCO	9	N
MCO Provider Service Location	1 character service location code for the MCO	1	C
Medicaid Provider Number	9-digit Medicaid number for the provider	9	N
Medicaid Provider Service Location	1 character service location code for the provider	1	C
Provider NPI	National Provider Identifier (NPI) number assigned by the government to the provider	10	N
Provider Name	Name of provider	90	C

KM1Provider Match File

Column Name	Description	Type	Length	Required
MCO_SUBMITTER_ID	KMAP assigned Submitter ID for the submitting MCO.	ALPHA-NUMERIC	10	Required
MCO_ICN	MCO assigned key which uniquely identifies a claim in the system. For Pharmacy Claims submitted in NCPDP format, this field will be built as follows: Fill Date in YYJJJ Julian date format + 7 digit Prescription number (left zero filled) + Beneficiary ID minus the first three characters (usually 001). This will result in a 20 digit ICN that uniquely identifies the prescription.	ALPHA-NUMERIC	20	Required
CLAIM_DETAIL_ NUMBER	Line Number of the Service line in the 837 file (LX01). The line number for claim level Providers should be 0. Detail lines increment starting with 1. Any information at the Claim level or the Service line level on the 837 should have a corresponding match on the KM1 file.	NUMERIC	6	Required
BILLING_PROVIDER_KMAP_BASE	KMAP ID of billing provider submitted in the header loop of the claim. This information should correspond to the NPI submitted in the 2010AA loop on the 837.	NUMERIC	9	Required

Column Name	Description	Type	Length	Required
BILLING_PROVIDER _SL_CODE	Service Location Code of billing provider submitted in the header loop of the claim.	ALPHA	1	Required
PERF_PROVIDER_KMAP_BASE	KMAP ID of performing provider submitted in the header loop or detail loop of the claim. This information should correspond to the NPI submitted in the 2310B loop on the 837.	NUMERIC	9	Situational If not used, then blank fill
PERF_PROVIDER _SL_CODE	Service Location Code of performing provider submitted in the header loop or detail loop of the claim.	ALPHA	1	Situational If not used, then blank fill
REFER1_PROVIDER_KMAP_BASE	KMAP ID of first referring provider submitted in the header loop or detail loop of the claim. On a Professional claim, this information should correspond to the NPI submitted in the 2310A loop on the 837. On an Institutional claim, this information should correspond to the NPI submitted in the 2310D loop on the 837.	NUMERIC	9	Situational If not used, then blank fill
REFER1_PROVIDER _SL_CODE	Service Location Code of first referring provider submitted in the header loop or detail loop of the claim.	ALPHA	1	Situational If not used, then blank fill

Column Name	Description	Type	Length	Required
REFER2_PROVIDER_KMAP_BASE	KMAP ID of second referring provider submitted in the header loop or detail loop of the claim. On a Professional claim, this information should correspond to the NPI submitted in the 2310A loop on the 837. On an Institutional claim, this information should correspond to the NPI submitted in the 2310D loop on the 837.	NUMERIC	9	Situational If not used, then blank fill
REFER2_PROVIDER _SL_CODE	Service Location Code of second referring provider submitted in the header loop or detail loop of the claim.	ALPHA	1	Situational If not used, then blank fill
ATTEND_PROVIDER_KMAP_BASE	KMAP ID of attending provider submitted in the header loop or detail loop of the claim. This is applicable to UB92 claims only. This information should correspond to the NPI submitted in the 2310A loop on the 837.	NUMERIC	9	Situational If not used, then blank fill
ATTEND_PROVIDER _SL_CODE	Service Location Code of attending provider submitted in the header loop or detail loop of the claim. This is applicable to UB92 claims only.	ALPHA	1	Situational If not used, then blank fill

Column Name	Description	Type	Length	Required
OTHER1_PROVIDER_KMAP_BASE	KMAP ID of other1 (performing/rendering) provider submitted in the header loop or detail loop of the claim. This is applicable to UB92 claims only. This information should correspond to the NPI in the 2310B loop on the 837	NUMERIC	9	Situational If not used, then blank fill
OTHER1_PROVIDER _SL_CODE	Service Location Code of other1 (performing/rendering) provider submitted in the header loop or detail loop of the claim. This is applicable to UB92 claims only.	ALPHA	1	Situational If not used, then blank fill
OTHER2_PROVIDER_KMAP_BASE	KMAP ID of other2 (referring physician) provider submitted in the header loop or detail loop of the claim. This is applicable to UB92 claims only. This information should correspond to the NPI in the 2310C loop on the 837	NUMERIC	9	Situational If not used, then blank fill
OTHER2_PROVIDER _SL_CODE	Service Location Code of other2 (referring physician) provider submitted in the header loop or detail loop of the claim. This is applicable to UB92 claims only.	ALPHA	1	Situational If not used, then blank fill

Column Name	Description	Type	Length	Required
FACILITY_PROVIDER_KMAP_BASE	KMAP ID of facility provider submitted in the header loop or detail loop of the claim. On a Professional claim, this information should correspond to the NPI submitted in the 2330G loop on the 837. On an institutional claim, this information should correspond to the NPI submitted in the 2330H loop on the 837.	NUMERIC	9	Situational If not used, then blank fill
FACILITY_PROVIDER _SL_CODE	Service Location Code of facility provider submitted in the header loop or detail loop of the claim.	ALPHA	1	Situational If not used, then blank fill
PRESCRIBER_PROVIDER_KMAP_ BASE	KMAP ID of prescribing provider submitted in the header loop or detail loop of the claim. This is applicable to pharmacy provider only. This information should correspond to the Prescriber segment of the claim on the NCPDP file.	NUMERIC	9	Situational If not used, then blank fill
PRESCRIBER_PROVIDER _SL_CODE	Service Location Code of prescribing provider submitted in the header loop or detail loop of the claim. This is applicable to pharmacy provider only.	ALPHA	1	Situational If not used, then blank fill

TPL Proprietary File Layout

Column Name	Type	Length
Beneficiary ID	CHAR	12
SSN	CHAR	9
Carrier Name	CHAR	45
Carrier Address 1	CHAR	30
Carrier Address 2	CHAR	30
Carrier City	CHAR	15
Carrier State	CHAR	2
Carrier Zip	CHAR	9
Policy Number	CHAR	16
Group Number	CHAR	16
Carrier Code	CHAR	7
Carrier Phone	CHAR	10
Policy Holder Name	CHAR	32
Policy code coverage	CHAR	1
Policy Start Date	CHAR	8
Policy End Date	CHAR	8
Relationship code	CHAR	1
Date Added	CHAR	8
Pay and Chase	CHAR	1

TPL Lead Spreadsheet Layout

Column	Column Name
A	BENEFICIARY NAME
B	BENE ID
C	SSN #
D	DOB
E	CARRIER NAME
F	CARRIER ADDRESS
G	CARRIER CITY
H	CARRIER STATE
I	CARRIER ZIP
J	POLICY #
K	GROUP #
L	PHONE #
M	POLICY HOLDER NAME IF OTHER THAN THE BENE
N	RELATIONSHIP
O	EFFECTIVE DATE
P	TERM DATE

PRVLST and PR1 Files

Initial and Weekly PRVLST File

Naming Convention	Folder Name
F.<SAK>.<MCO Medicaid Number>.PRVLST.<YYMMDDhhmmss>.dat PRVLST indicates Provider Listing file *(i.e. F.390663.299999999A.PRVLST.070608190000.dat).*	Provider_FullListing

PR1 Request File

Naming Convention	Folder Name
HW<19 or 21>_<MCO Medicaid Number>_PR1_<YYMMDDhhmmss>.dat PR1 indicates PR1 request file *(i.e. HW21_299999999A_PR1_070608190000.dat)*	Provider_Request

PR1 Response File

Naming Convention	Folder Name
F.<SAK>.<MCO Medicaid Number>.PRRP.<YYMMDDhhmmss>.dat PRRP indicates PR1 response file *(i.e. F.390663.299999999A.PRRP.070226210420.dat)*	Provider_Response

PR1 Error File

Naming Convention	Folder Name
F.<SAK>.<MCO Medicaid Number>.PRER.<YYMMDDhhmmss>.dat PRER indicates PR1 provider error file *(i.e. F.390663.299999999A.PRER.070226210420)*	Provider_Error

837, NCPDP, and KM1 Files

The KMAP scripts will pick up any file in the target directory. However, the following naming conventions **must** be used:

File Type	Naming Convention
837 Professional	HW <19 or 21> <trx> <time stamp> *(e.g. HW19837P20071229190136)*
KM1	HW <19 or 21> <trx> <time stamp> *(e.g. HW19KM1P20071229190136)*

File Type	Naming Convention
837 Institutional	HW <19 or 21> <trx> <time stamp> *(e.g. HW19837I20071229190136)*
KM1	HW <19 or 21> <trx> <time stamp> *(e.g. HW19KM1I20071229190136)*

File Type	Naming Convention
NCPDP	HW <19 or 21> <trx> <time stamp> *(e.g. HW19NCP20071229190136)*
KM1	HW <19 or 21> <trx> <time stamp> *(e.g. HW19KM120071229190136)*

- <trx> is the transaction type of the file – 837I, 837P, NCP, KM1
- <timestamp> is a timestamp to help make the filename unique (CCYYMMDDHHmmss or YYMMDDHHmmss)

Note: File extensions and suffixes may be used for additional identification, but if used the file extension (or suffix) **must be the same** for both the KM1 and 837 file.

Other KMAP Response Files

File Type	Naming Convention
Response files	<media>.<SAK>.<TPID>.<txn type>.<timestamp>.rsp.zip

- <media> is the transmission method - F for FTP, W for web upload, D for diskette
- <SAK> is either the SAK_DOWNLOAD assigned to the file or "0" to indicate that this file is not a direct response to an uploaded file (there is no SAK_UPLOAD associated with this file)
- <TPID> is the Trading Partner ID of the intended recipient of the file
- <txn type> is the transaction type of the file (such as 834, 277) - this value is used to route the file to the appropriate destination
- <timestamp> is a timestamp to help make the filename unique (CCYYMMDDHHmmss or YYMMDDHHmmss)
- rsp.zip - extensions to indicate that this is a zipped response file.

Examples:

File Type	Naming Convention
834 X12 - daily	out.2004945.29999999A.834.20071213121428.rsp.zip
834 X12 - monthly	out.2004945.29999999A.834.20071213121428m.rsp.zip
TPL Information	F.2004945.29999999A.MCOTPL.zip
997 X 12	F.3690.299999999A.997.rsp.zip
NCPDP	F.2004945.29999999A.NCP.txt.zip
Batch Submit Reports	batch_submit.3400.299999999A.rpt.zip
Unsolicited 277	out.2004945.29999999A.277PC.20071213121428.rsp.zip
820 X12	out.2004945.29999999A.820.20071213121428.rsp.zip

County Codes

County Number	County Abbreviation	County Name
001	AL	Allen
002	AN	Anderson
003	AT	Atchison
004	BA	Barber
005	BT	Barton
006	BB	Bourbon
007	BR	Brown
008	BU	Butler
009	CS	Chase
010	CQ	Chautauqua
011	CK	Cherokee
012	CN	Cheyenne
013	CA	Clark
014	CY	Clay
015	CD	Cloud
016	CF	Coffey
017	CM	Comanche
018	CL	Cowley
019	CR	Crawford
020	DC	Decatur
021	DK	Dickinson
022	DP	Doniphan
023	DG	Douglas
024	ED	Edwards
025	EK	Elk
026	EL	Ellis
027	EW	Ellsworth
028	FI	Finney
029	FO	Ford
030	FR	Franklin
031	GE	Geary
032	GO	Gove
033	GH	Graham
034	GT	Grant
035	GY	Gray

County Number	County Abbreviation	County Name
036	GL	Greeley
037	GW	Greenwood
038	HM	Hamilton
039	HP	Harper
040	HV	Harvey
041	HS	Haskell
042	HG	Hodgeman
043	JA	Jackson
044	JF	Jefferson
045	JW	Jewell
046	JO	Johnson
047	KE	Kearney
048	KM	Kingman
049	KW	Kiowa
050	LB	Labette
051	LE	Lane
052	LV	Leavenworth
053	LC	Lincoln
054	LN	Linn
055	LG	Logan
056	LY	Lyon
057	MN	Marion
058	MS	Marshall
059	MP	McPherson
060	ME	Meade
061	MI	Miami
062	MC	Mitchell
063	MG	Montgomery
064	MR	Morris
065	MT	Morton
066	NM	Nemaha
067	NO	Neosho
068	NS	Ness
069	NT	Norton
070	OS	Osage
071	OB	Osborne
072	OT	Ottawa
073	PN	Pawnee
074	PL	Phillips
075	PT	Pottawatomie
076	PR	Pratt
077	RA	Rawlins
078	RN	Reno

County Number	County Abbreviation	County Name
079	RP	Republic
080	RC	Rice
081	RL	Riley
082	RO	Rooks
083	RH	Rush
084	RS	Russell
085	SA	Saline
086	SC	Scott
087	SG	Sedgwick
088	SW	Seward
089	SN	Shawnee
090	SD	Sheridan
091	SH	Sherman
092	SM	Smith
093	SF	Stafford
094	ST	Stanton
095	SV	Stevens
096	SU	Sumner
097	TH	Thomas
098	TR	Trego
099	WB	Wabaunsee
100	WA	Wallace
101	WS	Washington
102	WH	Wichita
103	WL	Wilson
104	WO	Woodson
105	WY	Wyandotte
106	OO	Out-Of-State
107	CO	Colorado
108	MO	Missouri
109	NE	Nebraska
111	OK	Oklahoma
112	AR	Arkansas

Language Codes

Language Code	Language
AR	Arabic
BN	Bosnian
CA	Cantonese
CH	Chinese
CM	Cambodian
CZ	Czech
DU	Dutch
EN	English
FR	French
GE	German
GK	Greek
GU	Gujarathi
HM	Hmong
HN	Hindi
IT	Italian
JP	Japanese
KA	Kannada
KN	Korean
LA	LAO
MA	Mandarin
MK	Mon-Khmer
NN	None
OT	Other
PE	Persian
PL	Polish
PT	Portuguese
RU	Russian
SC	Serbo-Croatian
SM	Somali
SP	Spanish
SU	Sudanese
TA	Tamil
TG	Tagalog
TH	Thai
UN	Unknown
UR	Urdu
VN	Vietnamese

Provider Type Codes

Type Code	Type Description
01	Hospital
02	Ambulatory Surgical Center (ASC)
03	Custodial Care Facility
04	Rehabilitation Facility
05	Home Health Agency
06	Hospice
07	Capitation Provider
08	Clinic
09	Advance Practice Nurse
10	Mid-Level Practitioner
11	Mental Health Provider
12	Local Education Agency
13	Public Health Agency
14	Podiatrist
15	Chiropractor
16	Nurse
17	Therapist
18	Optometrist
19	Optician
20	Audiologist
21	Case Manager (Targeted)
22	Hearing Aid Dealer
23	Nutritionist
24	Pharmacy
25	DME/Medical Supply Dealer
26	Transportation Provider
27	Dentist
28	Laboratory
29	X-Ray Clinic
30	Renal Dialysis Center
31	Physician
36	Personal Care Services
38	Respite Care
41	Adult Day Care
42	Teaching Institution
43	Homemaker Services
44	Home Modifications
45	QMB
53	Head Start Facility
55	HCBS
56	Work
70	Data Access Entity

Provider Specialty Codes

Specialty Code	Specialty Description
010	Acute Care
011	Psychiatric
012	Rehabilitation
013	Residential Treatment Center
014	Critial Access
015	Children's Specialty
016	Emergency
017	Tuberculosis
018	State Institution
019	State Mental Hospital
020	Ambulatory Surgical Center (ASC)
030	Nursing Facility
031	ICF/MR Extra Care
032	Pediatric Nursing Facility
033	Residential Care Facility
034	ICF/MR Private
035	Skilled Nursing Facility
036	Respite Care - Facility Based
037	Assisted Living
040	Rehabilitation Facility
041	Head Injury Rehabilitation
042	Non-CMHC Partial Hospitalization
050	Home Health Agency
051	Specialized Home Nursing Services
053	Respite Care Home and Community Based Services
054	Waivered Case Management
059	Independent Living Counseling
060	Hospice
071	Managed Care Organization (MCO)
072	Family Preservation Contract
073	Adoption Contract
074	Foster Care Contract
075	PACE
076	Care Management
080	Federally Qualified Health Clinic (FQHC)
081	Rural Health Clinic (RHC)
082	Medical Clinic
083	Family Planning Clinic
084	Nurse Practitioner Clinic
085	EPSDT Clinic

Specialty Code	Specialty Description
086	Dental Clinic
087	Therapy Clinic
088	Pediatric Clinic
089	Tuberculosis Clinic
090	Pediatric Nurse Practitioner
091	Obstetric Nurse Practitioner
092	Family Nurse Practitioner
093	Nurse Practitioner (Other)
094	Certified Registered Nurse Anesthetist (CRNA)
095	Certified Nurse Midwife
096	Psychiatric Nurse Practitioner
100	Physician Assistant
101	Anesthesiology Assistant
108	Licensed Master.s Level Psychologist -LMLP **effective DOS 1/1/11
109	Licensed Clinical Psychotherapist -LCP **effective DOS 1/1/11
110	Outpatient Mental Health Clinic
111	Community Mental Health Center (CMHC)
112	Psychologist
113	Residential Alcohol/Drug Abuse Treatment Facility
114	Health Service Provider in Psychology(HSPP)
115	Licensed Mental Health Professional-LMHP
116	Licensed Clinical Mental Health Professional-LCMHP
117	Psychiatric Nurse
118	Mental Health - DMHSAS
119	Marriage and Family Counselor
120	Local Education Agency
122	Non-CMHC Affiliate
123	Children with Severe Emotional Disturbances
124	CMHC Partial Hospitalization
130	County Health Department
131	Public Health or Welfare Agency and Clinic
140	Podiatrist
150	Chiropractor
160	Registered Nurse(RN)
161	Licensed Practical Nurse(LPN)
162	Registered Nurse Clinical(RNC)
163	Skilled Nursing Agency
170	Physical Therapist
171	Occupational Therapist
172	Respiratory Therapist

Specialty Code	Specialty Description
173	Speech/Hearing Therapist
174	Occupational Therapy Assistant
175	Physical Therapy Assistant
176	Alcohol and Drug Rehabilitation
177	Behavioral Therapy
178	Cognitive Therapy
180	Optometrist
181	Maternity
182	Speech/Hearing Clinic
183	Early Intervention Services
184	Hospital Based Rural Health Clinic
185	Free Standing Rural Health Clinic
186	Family Service Coordination for ECI
190	Optician
191	Ocularist
200	Audiologist
220	Hearing Aid Dealer
230	Nutritionist
231	Assistive Technology
232	Behavior Management/PRTF
233	Community Developmental Disability Organization
236	Screening
237	Targeted Case Management
238	Non-CDDO Affiliate
240	Pharmacy
241	Institutional Pharmacy
242	Pharmacy Mail (Out of State)
250	DME/Medical Supply Dealer
252	Emergency Response - Installation
253	Emergency Response - Rental
254	Optical Supplier
255	Vaccine Administration
256	Van Lifts
257	Wheelchair Modifications
260	Ambulance
261	Air Ambulance
262	Bus
263	Taxi
264	Common Carrier (Ambulatory)
265	Common Carrier (Non-ambulatory)
266	Family Member
267	Driver
268	Medical Alert

Specialty Code	Specialty Description
270	Endodontist
271	General Dentistry Practitioner
272	Oral Surgeon
273	Orthodontist
274	Pediatric Dentist
275	Periodontist
276	Oral Pathologist
277	Prosthesis
280	Independent Lab
281	Mobile Lab
282	KDHE Lab Billing
283	Pathology Lab
290	Free Standing X-Ray Clinic
291	Mobile X-Ray Clinic
292	Mammography
293	Diagnostic X-Ray
300	Renal Dialysis Center
310	Allergist
311	Anesthesiologist
312	Cardiologist
313	Cardiovascular Surgeon
314	Dermatologist
315	Emergency Medicine Practitioner
316	Family Practitioner
317	Gastroenterologist
318	General Practitioner
319	General Surgeon
320	Geriatric Practitioner
321	Hand Surgeon
322	Internist
323	Neonatologist
324	Nephrologist
325	Neurological Surgeon
326	Neurologist
327	Nuclear Medicine Practitioner
328	Obstetrician/Gynecologist
329	Oncologist
330	Opthamologist
331	Orthopedic Surgeon
332	Otologist, Laryngologist, Rhinologist
333	Pathologist
334	Pediatric Surgeon
335	Maternal Fetal Medicine
336	Physical Medicine and Rehabilitation Practitioner

Specialty Code	Specialty Description
337	Plastic Surgeon
338	Proctologist
339	Psychiatrist
340	Pulmonary Disease Specialist
341	Radiologist
342	Thoracic Surgeon
343	Urologist
344	General Internist
345	General Pediatrician
346	Dispensing Physician
347	Radiation Therapist
348	Addiction Medicine
349	Exempt License Physician
350	Preventative Medicine
351	Indian Health Services
360	Personal Care - Individual
361	Personal Care - Agency
362	Family/Individual Supports
363	Personal Services - HI
364	Residential Supports
365	Supportive Home Care
366	Night Support - HI
367	Personal Services - PD
368	Sleep Cycle Support - MRDD
369	Supported Employment Services - MRDD
370	Personal Assistant Services - MRDD
380	Respite Care - Community Based
381	Respite Care - Home Based
410	Adult Day Care
430	Homemaker Services
440	Assistive Services
441	Assistive Technology Services
450	QMB
500	Assistive Services - PD
501	Attendant Care for Independent Living (ACIL)
502	Communication Devices
503	Assistive Services - HI
506	Independent Living Counselor
509	Medication Reminder
510	Attendant Care - Level I
511	Attendant Care - Level II
512	Respite Care - MRDD
513	Sleep Cycle Support
514	Wellness Monitoring - FE

Specialty Code	Specialty Description
515	Nursing Evaluation
516	Respite Care - FE
517	Wellness Monitoring - MRDD
518	Comprehensive Support Services - FE
520	Day Supports
521	Specialized Medical Care RN/MRDD
522	Assessment Service
523	Specialized Medical Care LPN/MRDD
526	Assistive Services
540	Transitional Living Skill
550	Autism Specialist
551	Intensive Individual Support - AU
552	Respite Care - AU
553	Parent Support - AU
554	Family Adjustment Counseling - AU
555	Case Management/Care Coordination/TA
556	Medical Respite/TA
557	Medical Service Technician/TA
558	Personal Service Attendant/TA
559	Home Modifications/TA
700	Eligibility Inquiry/Verification
999	Mixed Specialty for SURS

Provider Type, Specialty, and Taxonomy Codes

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
01	Hospital	010	Acute Care	282N00000X
01	Hospital	011	Psychiatric	283Q00000X
01	Hospital	012	Rehabilitation	283X00000X
01	Hospital	013	Residential Treatment Center	323P00000X
01	Hospital	014	Critial Access	282N00000X
01	Hospital	015	Children's Specialty	282NC2000X
01	Hospital	016	Emergency	282N00000X
01	Hospital	017	Tuberculosis	281P00000X
01	Hospital	018	State Institution	315P00000X
01	Hospital	019	State Mental Hospital	283Q00000X
01	Hospital	351	Indian Health Services	282N00000X
02	Ambulatory Surgical Center (ASC)	020	Ambulatory Surgical Center (ASC)	261QA1903X
03	Custodial Care Facility	011	Psychiatric	283Q00000X
03	Custodial Care Facility	030	Nursing Facility	313M00000X
03	Custodial Care Facility	031	ICF/MR Extra Care	315P00000X
03	Custodial Care Facility	032	Pediatric Nursing Facility	313M00000X
03	Custodial Care Facility	033	Residential Care Facility	314000000X
03	Custodial Care Facility	034	ICF/MR Private	315P00000X
03	Custodial Care Facility	035	Skilled Nursing Facility	314000000X
03	Custodial Care Facility	036	Respite Care - Facility Based	314000000X
03	Custodial Care Facility	037	Assisted Living	311Z00000X
03	Custodial Care Facility	410	Adult Day Care	311Z00000X
03	Custodial Care Facility	510	Attendant Care - Level I	311Z00000X
03	Custodial Care Facility	511	Attendant Care - Level II	311Z00000X
03	Custodial Care Facility	513	Sleep Cycle Support	311Z00000X
03	Custodial Care Facility	514	Wellness Monitoring - FE	311Z00000X
03	Custodial Care Facility	515	Nursing Evaluation	314000000X
03	Custodial	516	Respite Care - FE	311Z00000X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
	Care Facility			
04	Rehabilitation Facility	040	Rehabilitation Facility	261QR0400X
04	Rehabilitation Facility	041	Head Injury Rehabilitation	283X00000X
04	Rehabilitation Facility	042	Non-CMHC Partial Hospitalization	283Q00000X
05	Home Health Agency	050	Home Health Agency	251E00000X
05	Home Health Agency	051	Specialized Home Nursing Services	251E00000X
05	Home Health Agency	053	Respite Care Home and Community Based Services	251E00000X
05	Home Health Agency	054	Waivered Case Management	251E00000X
05	Home Health Agency	059	Independent Living Counseling	251E00000X
05	Home Health Agency	252	Emergency Response - Installation	251E00000X
05	Home Health Agency	253	Emergency Response - Rental	251E00000X
05	Home Health Agency	268	Medical Alert	251E00000X
05	Home Health Agency	363	Personal Services - HI	251E00000X
05	Home Health Agency	366	Night Support - HI	251E00000X
05	Home Health Agency	367	Personal Services - PD	251E00000X
05	Home Health Agency	501	Attendant Care for Independent Living (ACIL)	251E00000X
05	Home Health Agency	510	Attendant Care - Level I	251E00000X
05	Home Health Agency	511	Attendant Care - Level II	251E00000X
05	Home Health Agency	513	Sleep Cycle Support	251E00000X
05	Home Health Agency	514	Wellness Monitoring - FE	251E00000X
05	Home Health Agency	515	Nursing Evaluation	251E00000X
05	Home Health Agency	516	Respite Care - FE	251E00000X
05	Home Health Agency	517	Wellness Monitoring - MRDD	251E00000X
05	Home Health Agency	521	Specialized Medical Care RN/MRDD	163W00000X
05	Home Health	523	Specialized Medical Care	164W00000X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
	Agency		LPN/MRDD	
05	Home Health Agency	556	Medical Respite/TA	385H00000X
05	Home Health Agency	557	Medical Service Technician/TA	3747A0650X
06	Hospice	060	Hospice	315D00000X
07	Capitation Provider	071	Managed Care Organization (MCO)	302R00000X
07	Capitation Provider	072	Family Preservation Contract	251B00000X
07	Capitation Provider	073	Adoption Contract	251B00000X
07	Capitation Provider	074	Foster Care Contract	251B00000X
07	Capitation Provider	075	PACE	314000000X
07	Capitation Provider	076	Care Management	251B00000X
08	Clinic	080	Federally Qualified Health Clinic (FQHC)	261QF0400X
08	Clinic	081	Rural Health Clinic (RHC)	261QR1300X
08	Clinic	082	Medical Clinic	261QP2300X
08	Clinic	083	Family Planning Clinic	261QA0005X
08	Clinic	084	Nurse Practitioner Clinic	363L00000X
08	Clinic	085	EPSDT Clinic	261QP0904X
08	Clinic	086	Dental Clinic	261QD0000X
08	Clinic	087	Therapy Clinic	261QP2000X
08	Clinic	088	Pediatric Clinic	261QH0100X
08	Clinic	089	Tuberculosis Clinic	261QH0100X
08	Clinic	181	Maternity	261QB0400X
08	Clinic	182	Speech/Hearing Clinic	261QH0100X
08	Clinic	183	Early Intervention Services	251B00000X
08	Clinic	184	Hospital Based Rural Health Clinic	261QR1300X
08	Clinic	185	Free Standing Rural Health Clinic	261QR1300X
08	Clinic	186	Family Service Coordination for ECI	251B00000X
09	Advance Practice Nurse	090	Pediatric Nurse Practitioner	363LP0200X
09	Advance Practice Nurse	091	Obstetric Nurse Practitioner	363LX0001X
09	Advance Practice Nurse	092	Family Nurse Practitioner	363LF0000X
09	Advance Practice Nurse	093	Nurse Practitioner (Other)	363L00000X
09	Advance Practice Nurse	094	Certified Registered Nurse Anesthetist (CRNA)	367500000X
09	Advance	095	Certified Nurse Midwife	367A00000X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
	Practice Nurse			
09	Advance Practice Nurse	096	Psychiatric Nurse Practitioner	363LP0808X
10	Mid-Level Practitioner	100	Physician Assistant	363A00000X
10	Mid-Level Practitioner	101	Anesthesiology Assistant	367500000X
11	Mental Health Provider	108	Licensed Master.s Level Psychologist -LMLP ** effective 1-1-2011	103T00000X
11	Mental Health Provider	109	Licensed Clinical Psychotherapist – LCP ** effective 1-1-2011	103T00000X
11	Mental Health Provider	110	Outpatient Mental Health Clinic	261QM0801X
11	Mental Health Provider	111	Community Mental Health Center (CMHC)	261QM0801X
11	Mental Health Provider	112	Psychologist	103T00000X
11	Mental Health Provider	113	Residential Alcohol/Drug Abuse Treatment Facility	324500000X
11	Mental Health Provider	114	Health Service Provider in Psychology(HSPP)	103T00000X
11	Mental Health Provider	115	Licensed Mental Health Professional-LMHP	104100000X
11	Mental Health Provider	116	Licensed Clinical Mental Health Professional-LCMHP	1041C0700X
11	Mental Health Provider	117	Psychiatric Nurse	163WP0808X
11	Mental Health Provider	118	Mental Health - DMHSAS	261QM0801X
11	Mental Health Provider	119	Marriage and Family Counselor	106H00000X
11	Mental Health Provider	122	Non-CMHC Affiliate	261QM0801X
11	Mental Health Provider	123	Children with Severe Emotional Disturbances	261QM0801X
11	Mental Health Provider	124	CMHC Partial Hospitalization	261QM0801X
11	Mental Health Provider	176	Alcohol and Drug Rehabilitation	261QM0801X
11	Mental Health Provider	178	Cognitive Therapy	261QM0801X
11	Mental Health Provider	232	Behavior Management/PRTF	323P00000X
12	Local Education Agency	120	Local Education Agency	261QS1000X
13	Public Health	130	County Health Department	251K00000X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
	Agency			
13	Public Health Agency	131	Public Health or Welfare Agency and Clinic	251K00000X
13	Public Health Agency	181	Maternity	251K00000X
13	Public Health Agency	510	Attendant Care - Level I	251K00000X
13	Public Health Agency	511	Attendant Care - Level II	251K00000X
13	Public Health Agency	514	Wellness Monitoring - FE	251K00000X
13	Public Health Agency	515	Nursing Evaluation	251K00000X
14	Podiatrist	140	Podiatrist	213E00000X
15	Chiropractor	150	Chiropractor	111N00000X
16	Nurse	160	Registered Nurse(RN)	163W00000X
16	Nurse	161	Licensed Practical Nurse(LPN)	164W00000X
16	Nurse	162	Registered Nurse Clinical(RNC)	163W00000X
16	Nurse	163	Skilled Nursing Agency	251J00000X
16	Nurse	514	Wellness Monitoring - FE	163WG0000X
16	Nurse	515	Nursing Evaluation	163WG0000X
16	Nurse	517	Wellness Monitoring - MRDD	163WG0000X
17	Therapist	170	Physical Therapist	225100000X
17	Therapist	171	Occupational Therapist	225X00000X
17	Therapist	172	Respiratory Therapist	227800000X
17	Therapist	173	Speech/Hearing Therapist	235Z00000X
17	Therapist	174	Occupational Therapy Assistant	224Z00000X
17	Therapist	175	Physical Therapy Assistant	225200000X
17	Therapist	176	Alcohol and Drug Rehabilitation	103TR0400X
17	Therapist	177	Behavioral Therapy	103TR0400X
17	Therapist	178	Cognitive Therapy	103TR0400X
17	Therapist	540	Transitional Living Skill	225100000X
18	Optometrist	180	Optometrist	152W00000X
19	Optician	190	Optician	156FX1700X
19	Optician	191	Ocularist	156FX1700X
20	Audiologist	200	Audiologist	231H00000X
21	Case Manager (Targeted)	186	Family Service Coordination for ECI	251B00000X
21	Case Manager (Targeted)	231	Assistive Technology	251B00000X
21	Case Manager (Targeted)	232	Behavior Management/PRTF	251B00000X
21	Case Manager (Targeted)	233	Community Developmental Disability Organization	251B00000X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
21	Case Manager (Targeted)	237	Targeted Case Management	251B00000X
21	Case Manager (Targeted)	238	Non-CDDO Affiliate	251B00000X
21	Case Manager (Targeted)	520	Day Supports	251B00000X
22	Hearing Aid Dealer	220	Hearing Aid Dealer	332S00000X
23	Nutritionist	230	Nutritionist	133V00000X
24	Pharmacy	240	Pharmacy	333600000X
24	Pharmacy	241	Institutional Pharmacy	333600000X
24	Pharmacy	242	Pharmacy Mail (Out of State)	333600000X
24	Pharmacy	250	DME/Medical Supply Dealer	333600000X
24	Pharmacy	346	Dispensing Physician	330000000X
24	Pharmacy	351	Indian Health Services	332800000X
25	DME/Medical Supply Dealer	250	DME/Medical Supply Dealer	332B00000X
25	DME/Medical Supply Dealer	252	Emergency Response - Installation	332B00000X
25	DME/Medical Supply Dealer	253	Emergency Response - Rental	332B00000X
25	DME/Medical Supply Dealer	254	Optical Supplier	332H00000X
25	DME/Medical Supply Dealer	255	Vaccine Administration	332B00000X
25	DME/Medical Supply Dealer	256	Van Lifts	332BC3200X
25	DME/Medical Supply Dealer	257	Wheelchair Modifications	332BC3200X
25	DME/Medical Supply Dealer	268	Medical Alert	332B00000X
25	DME/Medical Supply Dealer	277	Prosthesis	335E00000X
25	DME/Medical Supply Dealer	440	Assistive Services	332B00000X
25	DME/Medical Supply Dealer	441	Assistive Technology Services	332B00000X
25	DME/Medical Supply Dealer	500	Assistive Services - PD	332BC3200X
25	DME/Medical Supply Dealer	503	Assistive Services - HI	332BC3200X
26	Transportation Provider	260	Ambulance	3416L0300X
26	Transportation Provider	261	Air Ambulance	3416A0800X
26	Transportation Provider	262	Bus	343900000X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
26	Transportation Provider	263	Taxi	343900000X
26	Transportation Provider	264	Common Carrier (Ambulatory)	343900000X
26	Transportation Provider	265	Common Carrier (Non-ambulatory)	343900000X
26	Transportation Provider	266	Family Member	347C00000X
26	Transportation Provider	267	Driver	347C00000X
27	Dentist	270	Endodontist	1223E0200X
27	Dentist	271	General Dentistry Practitioner	122300000X
27	Dentist	272	Oral Surgeon	1223S0112X
27	Dentist	273	Orthodontist	1223X0400X
27	Dentist	274	Pediatric Dentist	1223P0221X
27	Dentist	275	Periodontist	1223P0221X
27	Dentist	276	Oral Pathologist	1223P0106X
27	Dentist	277	Prosthesis	229200000X
28	Laboratory	280	Independent Lab	291U00000X
28	Laboratory	281	Mobile Lab	261QR0208X
28	Laboratory	282	KDHE Lab Billing	291U00000X
28	Laboratory	283	Pathology Lab	291U00000X
29	X-Ray Clinic	290	Free Standing X-Ray Clinic	261QR0200X
29	X-Ray Clinic	291	Mobile X-Ray Clinic	335V00000X
29	X-Ray Clinic	292	Mammography	261QR0208X
29	X-Ray Clinic	293	Diagnostic X-Ray	261QR0200X
30	Renal Dialysis Center	300	Renal Dialysis Center	163WH0500X
31	Physician	150	Chiropractor	111N00000X
31	Physician	272	Oral Surgeon	1223S0112X
31	Physician	310	Allergist	207K00000X
31	Physician	311	Anesthesiologist	207L00000X
31	Physician	312	Cardiologist	207R00000X
31	Physician	313	Cardiovascular Surgeon	208G00000X
31	Physician	314	Dermatologist	207N00000X
31	Physician	315	Emergency Medicine Practitioner	207P00000X
31	Physician	316	Family Practitioner	208D00000X
31	Physician	317	Gastroenterologist	207RG0100X
31	Physician	318	General Practitioner	207Q00000X
31	Physician	319	General Surgeon	208600000X
31	Physician	320	Geriatric Practitioner	207QG0300X
31	Physician	321	Hand Surgeon	2086S0105X
31	Physician	322	Internist	207R00000X
31	Physician	323	Neonatologist	2080N0001X
31	Physician	324	Nephrologist	207RN0300X
31	Physician	325	Neurological Surgeon	207T00000X
31	Physician	326	Neurologist	2084N0400X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
31	Physician	327	Nuclear Medicine Practitioner	207U00000X
31	Physician	328	Obstetrician/Gynecologist	207V00000X
31	Physician	329	Oncologist	207RH0003X
31	Physician	330	Opthamologist	207W00000X
31	Physician	331	Orthopedic Surgeon	207X00000X
31	Physician	332	Otologist, Laryngologist, Rhinologist	207Y00000X
31	Physician	333	Pathologist	207ZP0105X
31	Physician	334	Pediatric Surgeon	2086S0120X
31	Physician	335	Maternal Fetal Medicine	2080N0001X
31	Physician	336	Physical Medicine and Rehabilitation Practitioner	208100000X
31	Physician	337	Plastic Surgeon	2086S0122X
31	Physician	338	Proctologist	208C00000X
31	Physician	339	Psychiatrist	2084P0800X
31	Physician	340	Pulmonary Disease Specialist	207RP1001X
31	Physician	341	Radiologist	2085R0202X
31	Physician	342	Thoracic Surgeon	208G00000X
31	Physician	343	Urologist	208800000X
31	Physician	344	General Internist	207R00000X
31	Physician	345	General Pediatrician	208000000X
31	Physician	347	Radiation Therapist	2085R0203X
31	Physician	348	Addiction Medicine	207QA0401X
31	Physician	349	Exempt License Physician	207Q00000X
31	Physician	350	Preventative Medicine	2083P0901X
31	Physician	351	Indian Health Services	207Q00000X
36	Personal Care Services	236	Screening	3747P1801X
36	Personal Care Services	360	Personal Care - Individual	3747P1801X
36	Personal Care Services	361	Personal Care - Agency	251J00000X
36	Personal Care Services	362	Family/Individual Supports	225C00000X
36	Personal Care Services	364	Residential Supports	3747P1801X
36	Personal Care Services	365	Supportive Home Care	3747P1801X
36	Personal Care Services	368	Sleep Cycle Support - MRDD	3747P1801X
36	Personal Care Services	502	Communication Devices	3747P1801X
36	Personal Care Services	512	Respite Care - MRDD	385H00000X
38	Respite Care	380	Respite Care - Community Based	3747P1801X
38	Respite Care	381	Respite Care - Home Based	3747P1801X
41	Adult Day	410	Adult Day Care	261QA0600X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
	Care			
42	Teaching Institution	010	Acute Care	282N00000X
42	Teaching Institution	011	Psychiatric	283Q00000X
42	Teaching Institution	012	Rehabilitation	283X00000X
43	Homemaker Services	430	Homemaker Services	376J00000X
43	Homemaker Services	510	Attendant Care - Level I	376J00000X
44	Home Modifications	440	Assistive Services	171WH0202X
44	Home Modifications	441	Assistive Technology Services	171WH0202X
44	Home Modifications	500	Assistive Services - PD	171WH0202X
44	Home Modifications	503	Assistive Services - HI	171WH0202X
45	QMB	450	QMB	101Y00000X
53	Head Start Facility	345	General Pediatrician	208000000X
55	HCBS	053	Respite Care Home and Community Based Services	251E00000X
55	HCBS	054	Waivered Case Management	251E00000X
55	HCBS	059	Independent Living Counseling	251E00000X
55	HCBS	170	Physical Therapist	225100000X
55	HCBS	171	Occupational Therapist	225X00000X
55	HCBS	173	Speech/Hearing Therapist	235Z00000X
55	HCBS	176	Alcohol and Drug Rehabilitation	103TR0400X
55	HCBS	177	Behavioral Therapy	103TR0400X
55	HCBS	178	Cognitive Therapy	103TR0400X
55	HCBS	236	Screening	3747P1801X
55	HCBS	237	Targeted Case Management	251B00000X
55	HCBS	252	Emergency Response - Installation	332B00000X
55	HCBS	253	Emergency Response - Rental	332B00000X
55	HCBS	256	Van Lifts	332BC3200X
55	HCBS	257	Wheelchair Modifications	3747P1801X
55	HCBS	268	Medical Alert	251E00000X
55	HCBS	360	Personal Care - Individual	3747P1801X
55	HCBS	362	Family/Individual Supports	225C00000X
55	HCBS	363	Personal Services - HI	251E00000X
55	HCBS	364	Residential Supports	3747P1801X
55	HCBS	365	Supportive Home Care	3747P1801X
55	HCBS	366	Night Support - HI	3747P1801X
55	HCBS	367	Personal Services - PD	251E00000X
55	HCBS	368	Sleep Cycle Support - MRDD	3747P1801X

Provider Type	Type Description	Provider Specialty	Specialty Description	Taxonomy
55	HCBS	369	Supported Employment Services - MRDD	372600000X
55	HCBS	370	Personal Assistant Services - MRDD	251S00000X
55	HCBS	410	Adult Day Care	261QA0600X
55	HCBS	440	Assistive Services	171WH0202X
55	HCBS	441	Assistive Technology Services	332B00000X
55	HCBS	500	Assistive Services - PD	332BC3200X
55	HCBS	502	Communication Devices	3747P1801X
55	HCBS	503	Assistive Services - HI	332BC3200X
55	HCBS	509	Medication Reminder	251E00000X
55	HCBS	510	Attendant Care - Level I	251E00000X
55	HCBS	511	Attendant Care - Level II	251E00000X
55	HCBS	512	Respite Care - MRDD	3747P1801X
55	HCBS	513	Sleep Cycle Support	251E00000X
55	HCBS	514	Wellness Monitoring - FE	251E00000X
55	HCBS	515	Nursing Evaluation	251E00000X
55	HCBS	516	Respite Care - FE	251E00000X
55	HCBS	517	Wellness Monitoring - MRDD	251E00000X
55	HCBS	518	Comprehensive Support Services - FE	372600000X
55	HCBS	520	Day Supports	251C00000X
55	HCBS	521	Specialized Medical Care RN/MRDD	163W00000X
55	HCBS	523	Specialized Medical Care LPN/MRDD	164W00000X
55	HCBS	540	Transitional Living Skill	225100000X
55	HCBS	550	Autism Specialist	171M00000X
55	HCBS	551	Intensive Individual Support - AU	222Q00000X
55	HCBS	552	Respite Care - AU	385HR2055X
55	HCBS	553	Parent Support - AU	222Q00000X
55	HCBS	554	Family Adjustment Counseling - AU	222Q00000X
55	HCBS	555	Case Management/Care Coordination/TA	171M00000X
55	HCBS	558	Personal Service Attendant/TA	3747P1801X
55	HCBS	559	Home Modifications/TA	171WH0202X
56	Work	506	Independent Living Counselor	251E00000X
56	Work	522	Assessment Service	225C00000X
56	Work	526	Assistive Services	332BC3200X
70	Data Access Entity	700	Eligibility Inquiry/Verification	251K00000X