Healthy Louisiana

Medicaid Managed Care Entities System Companion Guide

Version 1
March 12, 2025

LDH will provide maintenance of all documentation changes to this Guide using the Change Control Table below.

Change Control Table

Author of Change	Section Changed	Description	Reason	Date
Susan Bryson	MES SCG Forms	Encounter Data Certification Form	**Updated:** Language from MCO to MCE	1/6/2023
Susan Bryson	MES SCG Narrative	Links to other documents	**Checked:** All links are working **Updated:** Non-working links to working links throughout document	1/20/2023
Susan Bryson	Narrative	Section 1: 3.2.2.	**Remove: Quality** Profiles Submission File from list of FI Proprietary Reports and file transfers	1/26/2023
Susan Bryson	Narrative	Section 2.9.4 and 3.1.5	**Updated:** Link to Appendices	2/3/2023
Susan Bryson	Narrative	Section 2.10.1	**Updated:** Link to TPL Inquiries	2/3/2023
Susan Bryson	Tables	Comprehensive Edits Table	**Updated:** Entire Table	4/14/2023
Susan Bryson	Narrative	10.2. Non-EDI File Layouts	**Add:** CCN-W-010 to list	4/26/2023
Susan Bryson	Tables	CCN-M-010	**Add:** CCN-M-010 file layout	4/26/2023
Susan Bryson	Appendices	Appendix F-System Generated Files & Reports	**Add:** Link to Edits Comprehensive in CCN-W-010 **Add:** CCN-M-010 (monthly) description	5/9/2023
Susan Bryson	Narrative		**Add:** Timely Filing information	5/9/2023
Susan Bryson	Tables	Provider Type – PT	**Remove:** PT AG – Behavioral Hlth Rehab Agency	5/25/2023
Susan Bryson	Tables	Provider Type_Specialty	**Remove:** PT AG from PS 8E – CsoC /Behavioral Health	5/25/2023
Susan Bryson	Narrative	Section 2.9.8	**Add:** U1 modifier added to Atypical Providers	9/18/2023
Susan Bryson	Narrative	Throughout	**Corrections** to spelling, grammar, acronyms	8/8/2024
Susan Bryson	Narrative	Section 2.12.2	**Clarify:** Character 1 for ILOS characters L, U and B as valid with DOS >= 1/1/2024	9/5/2024

General Disclaimer:

The Louisiana Department of Health (LDH) maintains this System Companion Guide (SCG). This is a service which is continually under development. Users of the SCG should do so in conjunction with other LDH guidance and regulations. LDH will make every effort to keep the SCG current and to correct errors brought to LDH's attention.

Table of Contents

Section One

1. Overview

This System's Companion Guide (SCG) provides additional guidance to the Managed Care Entities (MCE) in addition to the Request for Proposal, X12N 837 version 5010 implementation guide for Health Care Claims, Batch Pharmacy Encounters Companion Guide v. 1.12. and federally required billing guidelines regarding LDH's requirements for storing, submitting and reporting encounter data. The MCE is required to submit encounters to the Fiscal Intermediary (FI) using HIPAA-compliant Provider-to Payer-to Provider COB 837P (Professional) and 837I (Institutional) transactions.

2. Encounter Data

Encounter data is a distinct set of health care services provided to a Medicaid member enrolled with an MCE on the dates that the services were delivered.

2.1. Detailed data about individual services provided by a capitated managed care entity. The level of detail about each service reported is similar to that of a standard claim form.

2.2. An encounter is comprised of the following components: Procedure(s) and/or services rendered during the contract; services paid for fee-for-service (FFS); and, services paid under a capitated provider arrangement.

2.3. Health care encounter data includes:

2.3.1. All data capture during the course of a single health care encounter that specify the diagnoses, co-morbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with member receiving services during the encounter;

2.3.2. The identification of the member receiving and provider(s) delivering the health care services during the single encounter; and

2.3.3. A unique, i.e. unduplicated, identifier for the single encounter.

2.4. The MCE must report all services, paid or denied, including services paid at $0.

2.5. Purpose: Collecting encounter data is vital to LDH as it is utilized in contract compliance monitoring, rate setting and quality management and improvement.

3. Responsibilities

3.1 Louisiana Department of Health (LDH)

3.1.1. LDH is responsible for the oversight of the managed care contracts and MCE activities. As related to encounter data, LDH is responsible for:

1. The production, maintenance and dissemination of the SCG.
2. Monitoring encounter data submissions and file transfers between the MCEs and the Fiscal Intermediary (FI).
3. Coordinating activities between the FI and the MCEs.

3.2. Fiscal Intermediary (FI) –

3.2.1. The FI is responsible for the accepting, editing and storing encounter data using the Health Insurance Portability and Accountability Act of 1996 (HIPAA) standard 837 and National Council for Prescription Drug Problems (NCPDP) formats as received from the MCEs. This includes:

- Providing technical assistance to LDH and the MCEs during testing, including: MCE Electronic Database Interchange (EDI) Submitter Enrollment and testing;

- EDI Test Plan – Tier I Registration and Credentialing Phase, Tier II Claims Testing Phase, and Tier III Production Phase; see Appendix E.
- File Exchange Schedule;
- Electronic Data Interchange (EDI) – EDI Protocols, MCE EDI Submitter Enrollment Testing (Section 3);
- Data Management of File and Encounter submissions (Section 4);
- X12 Reporting, including:
    - 999 – Files containing syntactical errors in segments and elements are reported in the 999 Functional Acknowledgements.
    - TA1 – The TA1 report is generated and utilized to report receipt of individual interchange envelopes that contain corrupt data or an invalid trading partner relationship.
- 837 (Remittance Advice) – After encounter adjudication, an ANSI ASX X12N 835 (Remittance Advice) is delivered to the MCE, if requested. The MCE must prearrange for receipt of the 835 transactions.

3.2.2. Proprietary Reports and file transfers as directed by LDH including but not limited to:

- Encounter Claims Summary
- Encounter Edit Disposition Summary
- Edit Code Detail
- Claims Processing Flowchart
- Provider File
- Provider Rates File
- 820 File
- Prior Authorization File
- Diagnosis File for Pre-Admission Certification
- Procedure File for Prior Authorization

3.3. Enrollment Broker (EB)

The EB is responsible for providing, on a daily, weekly and monthly basis, the 834 X12 transactions. For details on the 834, see:
https://ldh.la.gov/assets/docs/BayouHealth/CompanionGuides/LA_EB_834_Companion_Guide.pdf

3.4. Managed Care Entities (MCE) –

3.4.1. The MCE is responsible for ensuring accurate and complete encounter reporting from the submission from their provider to MCE submission to the FI.

3.4.2. The MCE must evaluate the adequacy of, and revise if necessary, the encounter data collection instruments and processes being used by its providers; and, ensure that provider identification (NPI, taxonomy, and 9-digit zip code) is appropriate and submitted correctly in each transaction. Provider taxonomy and 9-digit zip codes are used as tie-breakers for provider NPI for the 837s. Refer to Gainwell LA Medicaid – Health Care Professional Companion Guide; see Appendix I: MCE SCG Links to Other Documents for link.

3.4.3. The MCE must investigate encounter denials and issues and be prepared to explain any underlying reasons for the denials or issues as required by LDH.

3.4.4. The MCE must ensure accurate and complete reporting of support files required for encounter processing including but not limited to the Provider registry/directory, Prior Authorization file, and Pharmacy (RX) Supplemental file.

3.4.5. As encounter data issues are discussed, the MCE must incorporate correction action steps into the Encounter Data Quality Improvement Plan. Any issues that are not fully addressed on a timely basis may be escalated into a Correction Action Plan (CAP). The CAP must include, but is not limited to, the following:

- Listing of each outstanding issue(s)
- Name of responsible party
- Projected resolution date

3.4.6. The MCE must be able to transmit, receive and process data in HIPAA-compliant or LDH specific formats and/or methods, including but not limited to, Secure File Transfer Protocol (FTP) over a secure connection such as Virtual Private Network (VPN), that are in use at the start of the Systems Readiness Review activities.

3.4.7. The MCE must ensure adequate testing of file exchange methods between the MCE and State or its representative.

Section Two

1. Encounter Data Instructions

1.1. LDH requires encounter data to follow HIPAA transaction and code set regulations that require covered entities to exchange electronic data using the appropriate ANSI ASC X12 EDI formats. LDH utilizes the 837I (Institutional), 837P (Professional) and 837D (Dental) Provider-to-Payer-to-Provider Coordination of Benefits (COB) Model as defined in the HIPAA Implementation Guides (IG) and Batch Pharmacy Encounters Companion Guide v. 1.12. MCEs shall create their 837 transactions for LDH using HIPAA IG for Version 5010.

1.1.1. Specific instruction on how transactions should be defined and implemented are provided in detail in the ASC X12 Technical Report Type 3 (TR3), version 005010A1 (https://x12.org/) which define how each loop, segment and data element in a specified transaction set is used. The ASC X12 (Accredited Standards Committee X12) is developed and maintained by the American National Standards Institute (ANSI).

1.1.2. The Louisiana-specific 837 Healthcare Care Claim – Institutional (I) and Professional (P) Companion Guides are intended for use in conjunction with the ANSI ASC X12 National Implementation Guide.

The FI HIPAA Companion Guides can be found at www.lamedicaid.com. The Guides may be accessed by selecting HIPAA Information Center from the left-hand menu of the LMMIS site. Refer to Gainwell LA Medicaid – Health Care Companion Guides; see Appendix I: MCE SCG Links to Other Documents for link.

1.2. LDH's FI provides Electronic Data Interchange (EDI) services. The EDI validates submission of ANSI X12 formats.

1.3. The following EDI Delimiters cannot be part of a Data Element (field) value. If any of the EDI Delimiters are part of a field value from a paper Claim record, the Encounter record value should substitute a <space> Character where the Delimiter Character was located.

Character	Name	Delimiter
*	Asterisk	Data Element Separator
^	Carat	Repetition Separator
:	Colon	Component Separator
~	Tilde	Separator Segment Terminator

2. Encounter Submission Information – 837I/837P/837D

2.1. Batch File Limitations at FI

2.1.1. The MCE may submit batch encounters up to 99 files per day, Monday through Sunday. The maximum number of encounters per file is 5,000. There is no limit on the number of files that can be submitted per day.

2.1.2. The FI's weekly cutoff for accepting encounters is Thursday at 12:00 (noon) CT (Central Time). Encounters received after this deadline will be processed during the next week's cycle.

2.1.3. MCEs may not submit Pharmacy batch encounters to the FI on Thursdays. The weekly deadline for NCPDP encounter submissions is Wednesdays at 12:00 (noon) on a normal processing week. The TA! Rejection code 505 would be applied after that time.

2.2. File Naming Conventions

Encounter files must be submitted using specific extensions. See MCE SCG Tables

Tables | La Dept. of Health file for File Naming Conventions.

2.3. Header Record Information

2.3.1. Claim/Encounter Identifier (BHT06)

- The BHT06 is used to indicate the type of billed service being sent:
  - Fee-for-Service (Claim)
  - Encounter
- The ST-SE envelop must contain encounters only indicated with a value of "RP" in BHT06. If the "RP" value is not used when sending encounters, the entire batch of encounters will be rejected, or the batch will be processed as claims which will result in the denial of each claim.

2.4. Loop 1000A/1000B

Encounters should be submitted in accordance with the appropriate 837 Companion Guide for these loops.

2.5. Loop 2000A/2010AA – Provider Identifiers

2.5.1. The MCE is required to submit the provider's NPI, taxonomy code and 9-digit zip code in each encounter. If the last four (4) digits of the zip code are unknown, then the MCE may substitute "9999".

2.6. Loop 2000B/2010BA/2010BB

Encounters should be submitted in accordance with the appropriate 837 Companion Guide for

this loop.

2.7. Loop 2000C/2010CA – Patient Details

Encounters should be submitted in accordance with the appropriate 837 Companion Guide for this loop.

2.8. Loop 2100 – Pay and Chase

For Pay and Chase type records (reference Pay and Chase IB 16-17), the MCE shall include the 835 Loop 2100 NM1*PR (Corrected Priority Payer Name) segment in the 835 response to the billing provider. The 835 Loop NM1*PR segment shall include the Other Insurance Company name in NM103 and the six-character LA Medicaid Third Party Liability (TPL) Carrier Code value in NM109.

2.9. Loop 2300

2.9.1. The MCE is required to send the Patient Control Number value from the Billing Provider's Claim record as the Loop 2300.

2.9.2. CLM01 value in the associated encounter record. Match the provider Patient Control Number in the claim to the CLM01 segment of the 837.

2.9.3. The MCE is require to submit the provider's NPI, taxonomy code and 9-digit zip code in each encounter. If the last four (4) digits of the zip code are unknown, then the MCE may substitute "9999".

2.9.4. When conducting 837 transactions, LDH requires the MCE to adhere to the HIPAA standards governing Medical data code sets. Specifically, LDH require the MCE to adopt the ICD-10 standard for Medical code sets and/or their successor code sets. Refer to Appendix C for Code Sets:
https://ldh.la.gov/page/4476

2.9.5. Balancing Claim Level

To ensure internal claim integrity, amounts reported in the 837 **MUST** balance at two different levels – the claim and the service line.

- **Claim Level**
  There are two different ways the claim information must balance:
  - **Claim Charge Amounts**
    The total claim charge amount reported in Loop 2300 CLM02 must balance to the sum of all service line charge amounts reported in Loop 2400 SV102.
  - **Claim Payment Amounts**
    Balancing of claim payment information is done payer by payer. For a given payer, the sum of all line level payment amounts (Loop 2430 SVD02) less any claim level adjustment amounts (Loop 2320 CAS adjustments) must balance to the claim level payment amount (Loop 2320 AMT02).

    Expressed as a calculation for given payer: {Loop 2320 AMT02 payer payment} = {sum of Loop 2430 SVD02 payment amounts} minus {sum of Loop 2320 CAS

adjustment amounts}.

- **Line Level Payment Amounts**
  Line level payment information is reported in Loop 2430 SVD02. In order to perform the balancing function, the receiver must know which payer the line payment belongs to. This is accomplished using the identifier reported in Loop 2430 SVD01. This identifier must match the identifier of the corresponding payer identifier reported in Loop 2330B NM109.

2.9.6. FI ICN Format

The format of the FI ICN is as follows:

Digit	Description
1	Last digit of year of receipt
2 - 4	Julian date of the year of receipt
5	Media Code: 0 = Paper 1 = EDI or Electronic Claim 2 = Paper Adjustment 3 = System Void 4 = Void 5 = Paper Claim with Attachment
6 - 8	3-digit Batch Number
9 - 11	3-digit Sequential Number in Batch
12 - 13	Claim Line Number

2.9.7. Encounters for Claims with Multiple Lines

The MCE is required to bill encounters with multiple claim lines at the document level. The claim types identified in the File Naming Convention and Claim Type Description table (located in MCE SCG Tables: Tables | La Dept. of Health billed for the same recipient, same billing provider, and same date of service (DOS) must be billed as one encounter in Loop 2300.

- The FI's system assigns an ICN (Internal Control Number) including 2-digit line item number at the header level. Subsequent lines will be assigned the same ICN with sequential line item numbers.
- **Claim Received Date** – The MCE is required to submit the MCE's Claim Received Date in 837P and 837I encounter data. The Claim Received Date will be sent in Loop 2300 in the REF*D9 segment using date format yyyymmdd.
- **Line Adjustment Process** – In the case of encounter adjustments, the MCE is required to follow the detailed payer-specific instructions provided in the FI's Companion Guides found at:
  www.lamedicaid.com/provweb1/HIPAA/5010v_HIPAA_Index.htm

To adjust an encounter with a line level denial, the MCE must make the correction(s) to the encounter and resubmit the corrected encounter. See Section 5 for Edits.

- **Claim Frequency Type Code –** The MCE is required to submit the Claim Frequency Type Code in 837P in Loop 2300 in the CLM05-3 segment for data element 1325 to adjust a previously submitted claim, submit a value of "7". See also 2300/REF02.

- **Reference Identification Qualifier** – The MCE is required to submit the Reference Identification Qualifier in Loop 2300 in the REF01 segment for data element 128 to adjust a previously submitted claim, submit "F8" to identify the Original Reference Number.
- **Original Reference Number** – The MCE is required to submit the Original Reference Number in Loop 2300 in the REF02 segment for data element 127 to adjust a previously submitted claim, submit the 13-digit FI's ICN assigned by the adjudication system and printed on the Remittance Advice (RA) for the previously submitted claim that is being adjusted.

2.9.8. Atypical Providers

- **Non-Emergency Medical Transportation (NEMT)**
  The MCE is required to follow the guidelines below for submitting encounters for NEMT claims:

  - Report trip ID/number from the transportation vendor/provider claim to Loop 2300 CLM01 segment of the 837 NEMT encounter transaction. Trip ID is a required field.
    - MCE: Trip ID must be a minimum 4 bytes
    - SETI FFS transportation vendor (submitter ID 4509620): Trip ID/number must be 2 characters (LA) and 4 byte integers (2 characters + 4 integers).
  - Encounters for Electronic and Web-based claims submitted by an NEMT provider shall use the following guidelines:
    - The MCE ICN length can be up to 30 characters.

    - **Character 1:** Claim Submission Media Type
      - P = Paper Claim
      - E = Electronic Claim
      - W = Claim submitted over a web portal

      If any other characters are submitted, the MCE shall provide a Data Dictionary.

    - **Character 2:** Claim Status
      - P = Paid Claim
      - D = Denied Claim

      If any other characters are submitted, the MCE shall provide a Data Dictionary.

    - **Characters 3-4:** Vendor Information
      Each MCE must provide a Data Dictionary to indicate the vendor or organization that adjudicated the claim.

      A unique MCE ICN is to be populated for each service line in Loop 2400 REF*6R.

  - **Modifiers Specific to NEMT Encounters**
    For NEMT service claims, the MCEs should report an origin and destination modifier for each NEMT trip. Origin and destination modifiers used for NEMT services are created by combining two alpha characters. Each alpha character represents an origin code or destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second positional alpha code equals destination. Origin and destination codes and their descriptions are:

    - **D** = Diagnostic or therapeutic site other than P or H when these are used as

origin codes

- **E** = Residential, domiciliary, custodial facility (other than 1819 facility)
- **G** = Hospital based ESRD facility
- **H** = Hospital
- **J** = Freestanding ESRD facility
- **N** = Skilled nursing facility
- **P** = Physician's office
- **R** = Residence
- **XE** = This modifier should only be used in the second modifier field to describe separate NEMT transportations on the same date of service (DOS), same billing provider, same NEMT procedure code and same origination and destination modifiers.
- **U1**= Modifier must be used in the first modifier field to identify value added service NEMT trips to and from non-medical sites.

While combinations of these items may duplicate other HCPCS modifiers, when billed with a NEMT code, the reported modifiers can only indicate origin/destination.

- Encounters for gas reimbursement services may use the transportation vendor's NPI as billing and rendering provider.

2.10. Loop 2310A/B/C/D – Provider Information

2.10. Loop 2310AB, AF/2320/2330B – Claim Information

Encounters should be submitted in accordance with the appropriate 837 Companion Guide for this loop. See 837 Health Claim – Professional at:
Medicaid | Department of Health | State of Louisiana | (lamedicaid.com)

PS.pdf (lamedicaid.com) – Professional Services Manual

2.10.1. Loop 2320 – Other Subscriber Information

- The MCE must submit the Provider-to-Payer-to-Provider COB Model of the 837.
- LDH requires the MCE to report other subscriber and other pay information. There can be multiple COB loops. The loops in the 837 HIPAA implementations that are used to convey information regarding adjudication are:
  - 2320 (Other Subscriber Information),
  - 2330B (Other Payer Information), and
  - 2430 (Service Line Adjudication Information).

In the first set of COB loops, the MCE shall place their unique LDH carrier code in loop 2330B, NM109. If there is Medicare TPL, the MCE shall place Medicare's unique LDH carrier code, 999999, in the second set of COB loops. The MCE shall provide LDH with any third-party payments, in subsequent COB loops, the MCE must include the LDH carrier code of the other payer in loop 2330B, NM109. There can be only one single subsequent loop per unique

payer.

- **MCE and Medicare Unique LDH Carrier Code Assignment**

  - **ACLA:** 999991
  - **HBL:** 999992
  - **LHC:** 999993
  - **UHC:** 999994
  - **ABH:** 999995
  - **MCNA:** 999997
  - **DentaQuest:** 999990
  - **SETI:** 999998
  - **Traditional Medicare:** 999999

  - **Medicare Advantage Plans: H – Carrier Codes**
    - For Medicare Advantage Plans, use the H-Carrier Code available in the LMMIS TPL Carrier File Listing accessed at: https://www.lamedicaid.com/provweb1/Forms/Carrier_Code/Carrier_Code.pdf
    - LMMIS TPL Carrier File Listing contains all currently available Carrier Codes. If a Carrier Code is missing, contact the LDH MES TPL unit and request a "new carrier code number". The TPL Unit may be contacted by email at: **TPL.Inquiries@la.gov.**
      The TPL Unit will require, at a minimum, the name and address of the company.

2.10.2. Loop 2320 – Encounter Reporting of Financial Fields

LDH requires MCEs to report the following financial fields at the Header and Line Item levels:

- **Submitted Charge Amount** – MCEs are required to report the provider's charge or billed amount, even when the amount is zero dollars ($0).

- **MCE Paid Amount** – If the MCE paid the provider for a service, then Paid Amount shall reflect the amount paid.

  - If the service was not covered by the MCE or was covered under a capitation arrangement, zero ("$0") is the appropriate paid amount. The MCE Paid Amount is sent in the first set of COB data.

- **Adjustment Amount** – If the paid amount reflects any adjustments to the submitted line item Charge Amount, then 837 CAS segment data must be sent to fully explain the difference between the submitted charges and the amount paid.

  - The CAS segment data must include monetary Adjustment Amount values along with associated Claim Adjustment Reason Code (CARC) values to account for the difference between the submitted charges and the amount paid; this is required even when the amount paid is zero and when the claim was denied
  - If the MCE responded to the Billing Provider with proprietary reason codes, then the MCE is required to convert those proprietary codes to standard CARC codes for reporting of encounter records.

- **Interest Paid Amount** – Interest Paid by the MCE and the date of that interest payment is required to be submitted in the second or third set of COB data in the 837P and 837I Encounter Data.

  - In the Claim Interest set of COB Loops, a value in INT99X format will be used (instead of using the MCE's unique LDH Carrier Code – 99999x) where the last digit is the same last digit from the MCE's unique LDH Carrier Code value.
    - For Inpatient records, in the Claim Interest set of COB Loops, the Interest Paid Amount will be sent in the CAS03 of Loop 2320 using CAS02 value 225. The Interest Paid Amount will also be sent in AMT02 of the Loop 2320 AMT*D segment. The Interest Paid Date will be sent in Loop 2330B DTP*573 segment.
    - For non-Inpatient records, in the Claim Interest set of COB Loops, the Interest Paid Amount will be sent in DAS03 of Loop 2430 using CAS02 value 225. The Interest Paid Amount will also be sent in Loop 2430 SVD02. The Interest Paid Date will be sent in the Loop 2430 DTP*573 segment.

- **Claim Received Date** – The MCE is required to submit the MCE's Claim Received Date in 837P and 837I encounter data. The Claim Received Date will be sent in Loop 2300 in the REF*D9 segment using date format yyyymmdd.

  The instructions for determination of the received date for claims are:

  - **Original Encounters** – The date the MCE received the claim record from the billing provider.
  - **Adjustment Encounters**
    - When the adjustment is initiated by the billing provider, the MCE receive date value is the date the MCE received the claim adjustment record from the billing provider.
    - When the adjustment is initiated by the MCE, then the MCE receive date value is the same as the MCE payment date of the adjustment.
    - When the adjustment is requested by LDH or FI, the MCE receive date value is the MCE receive date.
  - **Void Encounters**
    - For voids initiated by the billing provider, the MCE received date value is the date the MCE received the claim void record from the billing provider.
    - For voids initiated by the MCE, the MCE received date value is the date the MCE processed the void record.
    - For voids requested by LDH or FI, the original MCE receive date value is the MCE receive date.

  The FI provides to the MCE a file of encounter records that are missing the MCE receive date. The MCE is required to retrieve the file, populate the records with the missing data, and return the file to the FI. The MCE may retrieve the file from the MCE's non-EDI "from_Molina" folder. The file name is:

  MCO_missing RecDate_DDMonYYYY.zip

- **Claim Paid Date** – The MCE is required to submit the MCE's Claim Paid Date in the 837P and 837I encounter data.

- Inpatient Records – Send the Claim Paid Date in Loop 2330B in the DTP*573 segment.
- Non-Inpatient Records – Send the Claim Paid Date in Loop 2430 in the DTP*573 segment.

2.10.3. Timely Filing Guidelines

Timely Filing Guidelines are presented in the MCO Contract and include:

- The Contractor shall require providers to file Louisiana Medicaid Program-only Claims within three hundred sixty-five (365) Calendar Days of the date of service.
- Electronic submission of pharmacy Claims (reversals and resubmittals) shall be allowed to process electronically within three hundred sixty-five (365) Calendar Days of the date of service.
- The Contractor shall require Network Providers to file Claims involving third party liability (excluding Medicare) within three hundred sixty-five (365) Calendar Days from the date of service.
- When Medicare is the primary insurer, the Contractor shall require Network Providers to file the Claim within one hundred eighty (180) Calendar Days from Medicare's EOB of payment or denial.
- LDH will identify and address any exceptions to these provisions in the **MCO Manual**.

2.11. Additional Encounter Requirements

2.11.1. Newborn Birth Weight

The birth weight of a newborn is required on encounters for delivery services; and, it must be reported in Value Code segments of the 837I Loop 2300 HI value code 54 (Newborn Birth Weight in Grams). It may be necessary for the MCE to crosswalk the diagnosis code from deliveries to populate the patient information for birth weight.

2.11.2. Billing for Newborns

The MCE is required to submit the baby's facility bill, for the newborn only at the time of delivery, using the baby's Medicaid ID. The baby's Medicaid ID is to be used on the following newborn claims:

- Well babies
- Babies with extended stays (sick babies) past the mother's stay
- All aftercare and professional encounters

The MCE is required to hold the encounter until the newborn Medicaid ID can be obtained and submitted on the encounter.

2.11.3. Transformed Medicaid Statistical Information System (T-MSIS)

LDH, due to Centers for Medicare & Medicaid Services (CMS) mandates, will work with MCEs regarding required system changes for all Data Elements. MCEs are required to fully populate 837 transactions in accordance with the existing 5010 Implementation Guide and this System Companion Guide in order to ensure that their systems comply with this Federal mandate.

- **Provider Supplemental File** – On a weekly basis, the MCE is required to submit a Provider Supplemental File to the FI. The layout for this file can be found in the MCE SCG File Layouts document:
  File Layouts | La Dept. of Health

  - MCE Enrollment Begin and End Dates
    - If a MCE/Provider contract is signed mid-month, that is the date being used for Enrollment. If the MCE pays for services rendered earlier in that month, T-MSIS flags those claims as errors, for the provider not being enrolled on the date-of-service. Therefore, the Enrollment dates need to be the dates in which a MCE will pay for services.
      - For example, if a contract is signed on the 15th, but states that services from the 1st of that month will be accepted, the Enrollment date would be the 1st and not the 15th.

- **CMS Technical Instruction: Reporting Financial Allowed Amounts on Claims Files for T-MSIS Reporting**
  - T-MSIS data dictionary defines "allowed amount" as the maximum amount "determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment."
  - CMS has advised that reporting may differ by how MCEs and states determine the allowed amount.
    - The state is required to obtain this information directly from MCEs rather than rely on calculations.
    - Report "allowed amount" on the 837 repricing segments in:
      - Item HCP01 loop 2300 (header) or loop 2400 (line)
        - Only valid values ("00" through "14") are acceptable and should be submitted.
      - Item HCP02 loop 2300 (header) or loop 2400 (line).
  - For Pharmacy claims, MCEs are required by regulation to report Other Payer Amount Paid (431-DV) information as well as all available and applicable fields associated with Other Payer-Patient Responsibility Amount (352-NQ) on the NCPDP Billing claim (to the department). The department (itself) will utilize these information on NCPDP to calculate/determine allowed amount.

Additional information and updates will be provided to MCEs via this SCG as approved by LDH.

2.11.4. Value Added Services (VAS)

- **Adult Dental**

  LDH requires the MCE to use ICD-10 diagnosis code Z01.20 when reporting value added dental services on the 837D encounter record. This code is ONLY required when the provider does not use a diagnosis on the value added dental claim.

  In addition, tooth numbers, when used by the MCE, should be place in the Procedure Code Modifier field of the 837D.

  - Procedure Code Modifier fields are 2 character fields; they must be 2 character values to pass 5010 validation. Therefore, for Tooth Numbers less than 10, use a zero (0) in front of the Tooth Number to make it 2 characters (ex. Tooth Number 8

would be reported as Modifier 1 value 08). The Tooth Number should be placed in SV101-3 (Procedure Modifier).

- When Tooth Surface Codes are used by the MCE, the single character Tooth Surface Code values should be reported in Loop 2400, TOO03 – 1, TOO03 – 2, TOO03 -3, TOO03 – 4, and TOO03 – 5. Tooth Surface is required when the procedure code requires tooth surface codes. Tooth Surface Codes identify the surface of the tooth treated:
  - Code Description
  - B Buccal
  - D Distal
  - F Facial
  - I Incisal
  - L Lingual
  - M Mesial
  - O Occlusal

- **Other VAS**

  Information on other VAS may be located in the VAS document "Compare Health Plans" (VAS Per MCO LAEB_MedicalCompChart – ENG 2022.03.17).

2.12. Loop 2400 – Service Line Number

2.12.1. FI ICN Format – See item 2.9.6. above.

2.12.2. MCE ICN Format

The unique MCE ICN must be populated in Loop 2400 REF*6R (Line Item Control Number) segment. The maximum number of characters that the FI can store is 30, which includes the 4-digit prefix. The ICN the MCE transmits in this segment is echoed back to the submitter in the 835. This permits the MCE to use the value in this field as a key in their system to match the encounter back to the information returned in the 835 transaction.

- LDH requires MCEs to modify their ICN to contain a 4-digit prefix as follows:
  - **Character 1** – Claim Submission Media Type
    - **P** – indicates submission of claim via paper form
    - **Q –** indicates submission of a value added service via paper form
    - **L -** to indicate ILOS billed to the MCE via paper form (valid with DOS >=1/1/2024)
    - **E** – indicates submission of claim via electronic submission
    - **F** – indicates submission of value added service via electronic submission
    - **U -** to indicate ILOS billed to the MCE via EDI (valid with DOS >=1/1/2024)
    - **W** – indicates the submission of claim via web portal
    - **V** – indicates submission of value added service via web portal
    - **B -** to indicate ILOS billed to the MCE via web portal (valid with DOS >=1/1/2024)

The MCE must provide a Data Dictionary if other media types are submitted.

- **Character 2** – Claim Status

  The MCE and/or subcontractor must indicate the status of the claim as follows:

  - **P** – for paid encounters
  - **D** – for denied encounters

- **Characters 3 – 4** – Vendor (Sub-contractor) Information

  The MCE determines a two-character code for each of its vendors. The MCE must provide LDH with a Data Dictionary to identify the two-character code and the full name of the vendor it represents. As vendors are added or deleted, LDH must be furnished with an updated Data Dictionary.

2.12.3. Identifying Encounters for Non-covered EPSDT Services

MCE must identify Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services that may be authorized by the MCE but is a non-covered service by Medicaid. When billing these services, MCE must bill via 837P v5010, Loop 2400. Service line SV1-11 (EPSDT indicator) value must be "Y".

2.12.4. Category II CPT Codes

LDH requires the use of applicable Category II CPT Codes for performance measurement. These codes will facilitate data collection about the quality of care rendered by coding certain services and test results that support nationally established performance measures. Refer to the American Medical Association (AMA) for the Category II CPT Codes at https://www.ama-assn.org/practice-management/cpt.

On the ASC X12N 837 Professional Health Care Claim Transaction, Category II CPT and HCPCS Level II Codes are submitted in the SV1 "Professional Service" segment of the 2400 "Service Line" Loop. The data element for the procedure code SV101-2 "Product/Service ID".

It is also necessary for the MCE to identify that a Category II CPT/HCPCS Level II G-code is being provided. This is done by submitting "HC" code in data element SV101-1.

2.12.5. Special PA to Bypass Duplicate Ambulance Trip Edit 828 – Same Day Ambulance Claims

A special Prior Authorization number '000000828' was established to allow the MCE to bypass Encounter Edit 828. After the MCE has validated that the additional same day Ambulance trip is not a duplicate billing, then the MCE can bypass Encounter Edit 828 by including the special PA number in the Encounter 837 data. The special PA number should be sent in the normal 837 Prior Authorization segment, that is at either Loop 2300 REF*G1 or Loop 2400 REF*G1.

2.12.6. Special PA to Bypass Ambulance Treatment-In-Place (TIP) and Ambulance Transport Same Day Edit 900

When ambulance treatment-in-place (A0427, A0429 (W second position of the destination modifier))

and emergency ambulance transport (A0427 or A0429) encounters are billed for the same DOS, same recipient and same billing provider, the last encounter processed will deny for edit 900 except when the MCE send 9-digit PA number 000000900 in Loop 2300 REF*G1 or Loop 2400 REF*GR, certifying the services were rendered for unique occurrences within the same day.

2.12.7. Tracking of Evidence Based Practices (EBP)

The MCE is required to report the billing provider submitted EBP tracking code value in the encounter record submitted to MES in the 837P's Loop 2400 SV101-7 data element.

The following table contains the current list of EBP tracking codes, associated with CPT/HCPCS codes, as well as guidance on appropriate documentation of provider qualifications that should be linked to use of EBP tracking codes via credentialing. The MES adjudication system will be set up with Edits to deny MCE encounter records when an EBP tracking code is used with a mismatched CPT/HCPCS code.

Evidence-Based Practice	EBP Tracking Code	Valid CPT/HCPCS Codes	Credentialing documentation to provide the EBP
Functional Family Therapy-Child Welfare (FFT-CW)	EB01	H0036 with modifier HE	Agency FFT License with FFT-CW specialty from FFT, LLC.
Child-Parent Psychotherapy (CPP)	EB02	90837, 90834, 90832, 90847, 90846	Certificate stating that the clinician has fulfilled the requirements of an implementation level course in Child-Parent Psychotherapy, from a trainer endorsed by the University of California, San Francisco.
Parent-Child Interaction Therapy (PCIT)	EB03	90837, 90834, 90832, 90847, 90846	Certification from PCIT, International. http://www.pcit.org/united-states.html
Youth PTSD Treatment (YPT)	EB04	90837, 90834, 90832, 90847, 90846	Advanced Certificate from Tulane Psychiatry in Youth PTSD Treatment.
Preschool PTSD Treatment (PPT)	EB05	90837, 90834, 90832, 90847, 90846	Advanced Certificate from Tulane Psychiatry in Preschool PTSD Treatment.
Triple P-Standard Level 4	EB06	90837, 90834, 90832, 90847, 90846	Accreditation Certificate in Triple P –Standard Level 4, issued by Triple P America.
TF-CBT	EB07	90837, 90834, 90832, 90847, 90846	Documentation of certification through the TF-CBT National Therapist Certification Program. Certified TF-CBT therapists are listed on a national registry at https://tfcbt.org/therapists/
EMDR Therapy - Eye Movement Desensitization and Reprocessing	EB08	90837, 90834, 90832, 90839	Documentation of completion of EMDRIA Approved Basic Training. A directory of practitioners who have completed EMDIRA Approved Basic Training can be found at www.emdria.org.

Section Three

1. Electronic Data Interchange (EDI) Certification and Testing

1.1. Introduction

The intake of encounter data from each MCE is treated as HIPAA compliant transactions by LDH and its FI. As such, the MCE is required to undergo Trading Partner testing with the FI prior to electronic submission of encounter data. Testing is conducted to verify that the transmission is free of format errors. In order to simulate a production environment, the MCE is required to send real transmission data. LDH requires a minimum set of encounters for each transaction type based on testing need.

1.2. EDI Protocols

The Electronic Data Interchange (EDI) protocols are available at:

http://www.lamedicaid.com/provweb1/HIPAA/5010v_HIPAA_Index.htm

1.3. MCE EDI Submitter Enrollment and Testing

Enrollment as an EDI submitter is achieved through completion of the LDH/FI approval process and successful testing of encounters by transaction type and claim type.

Enrollment is processed through the following steps:

1.3.1. Upon request from a LDH approved MCE, the FI will provide application and approval forms for completion by the MCE. Once complete, the forms must be mailed to the FI's Provider Enrollment Unit.

1.3.2. During the authorization process, the MCE can call the EDI Department (225-216-6303) to receive EDI specifications that contain the data and format requirements for creating EDI claims. Using these specifications, the submitter develops and tests application software to create EDI encounters.

- The FI requires the MCE to certify with a third-party vendor, EDIFECS, prior to submitting test encounters to the FI.

- When the submitter is ready to send a test file of encounters, the encounters are required to be submitted to the FI EDI Coordinator using the submitter number: 4509999. The test submission is run through Louisiana Medicaid Enterprise Systems (MES) programs that validate the data and format. Reports produced from this testing are reviewed by the FI. The test results are verified and the submitter is contacted to review any problems with the submission. If necessary, the MCE is required to submit additional test encounters until an acceptable test run is completed. See Forms: MCE Testing Protocol at:
  Forms | La Dept. of Health

  NOTE: The test submitter number (4509999) shall be used for TEST submission

encounters ONLY.

1.3.3. When all forms have been received and approved by the FI's Provider Enrollment Unit, and the EDI Department has verified the test claims as successful, then the submitter will be notified that EDI encounters may be submitted to Production.

1.4. Encounter Submission Process for Approved MCE EDI Submitters

1.4.1. Upon receipt of Production Encounter Submissions

- The FI's EDI Department logs the submission and verifies completeness.
- Incomplete submissions are rejected, submitter notified of reject reason(s) via electronic message or telephone call.
- MCE is required to submit EDI Certification Form annually. For completed certification forms, the EDI Department enters submitted encounters into a pre-processor production run.

  The pre-processor generates the following:

  - Encounter data file
  - Claims Transmittal Summary Report – this report lists the status (Accepted or Rejected) of a batch of encounters. Rejected encounters are identified and include:
    - Provider Number
    - Dollar ($) amount of encounter
    - Number of encounters rejected

1.5. MCEs are required to submit to LDH and its FI a Test Plan with systemic plans for testing the ASC X12N 837 COB. The three-tier (3) Test Plan is outlined in the MCE SCG Appendix E:

https://ldh.la.gov/page/4476

1.6. Timing

The MCE may initiate EDIFECS testing at any time. LDH's FI Business Support Analysts are available to answer technical questions and to arrange testing schedules and EDIFECS enrollment. Please refer to the FI Companion Guide for specific instructions at:

http://www.lamedicaid.com/provweb1/HIPAA/5010v_HIPAA_Index.htm

1.7. Encounter Data Certification

The Balanced Budget Act (BBA) requires certification of data submitted by the MCE when State Payments are to be made to a MCE based on the data submitted by the MCE.

Based on CFR §438.606, the certification must attest, based on best knowledge, information and belief, to the accuracy, completeness, and truthfulness of the data and any documents submitted as required by the State. Encounter files submitted by the MCE which are used to create payments and/or capitated

rates, must be submitted with a certified complete and signed Encounter Data Certification Form; the form is required to be submitted concurrently with each encounter file submission.

The certification applies to:

1.7.1. Enrollment Data – See the MCO Manual and Benefit and Enrollment Maintenance (834) Companion Guide for more information:

https://ldh.la.gov/assets/medicaid/MCO_Manual.pdf

Benefit Enrollment and Maintenance (834) (la.gov)

1.7.2. Encounter Data

- Based on encounter files submitted by MCE to FI
- Completed Data Certification Forms at:

  Forms | La Dept. of Health

  - Must be signed/authorized by authorized MCE person (see MCO Manual)
  - Required to be submitted concurrently with each encounter file submission
  - One form may be submitted for all encounter files submitted in one (1) day
    - Form's **"For The Period Ending"** field value should use the same date as the **"Date File Sent"** field value
    - Form's **"Date File Sent"** should be the same date value for all files listed on Form; the Form shall not contain span dates
  - Form should be sent to LDH daily via SalesForce at https://ldh.force.com/Reporting, but may be submitted weekly. If submitting weekly, the MCE is required to submit multiple reports with no file containing more than 200 ISA file numbers per report.
  - Any other information specified by the State
  - Encounter data must be certified by one of the following MCE individuals:
    - MCE's Chief Executive Officer (CEO)
    - MCE's Chief Financial Officer (CFO)
    - An individual who has the delegated authority to sign for and reports directly to the CEO or CFO

Section Four

1. Data Management of File and Encounter Submissions

1.1. Encounter data is submitted through the FI's Electronic Data Interchange (EDI). Once received, the 837 transactions are subject to initial edits. Additional edits are applied during the FI's MES encounter process.

1.2. File Rejection and Encounter Denial

1.2.1. Incoming 837 files are subjected to Front-end processing which may be rejected by Front-end level edits. There are four (4) Front-end level edits:

- **EDI File Encryption Level (Entire File)**
  - EDI files to FI must be encrypted and named according to current sFTP guidelines for FI's EDI Department
  - EDI files not properly encrypted or named will be automatically deleted by FI system and no notification is sent back to submitter
  - Properly encrypted and named EDI files will be processed through the TA1 level edits
    - Accepted or rejected TA1 will be returned to submitter
    - No receipt of TA1 should cause submitter to check if file was correctly encrypted and named
    - Successful EDI files proceed to TA1 Level edits

- **TA1 Level Edits** – A set of edits that validate the file's Interchange format and acknowledges receipt of the file, along with other LA Medicaid specific data content conventions.
  - Files rejected ("R") at the TA1 level will be returned to submitter and entire EDI file is not processed further. Returned rejected files include an error code for the file's problem. A list of TA1 Edit (error) codes and descriptions are included in the EDI General Companion Guide found at: https://www.lamedicaid.com/provweb1/hipaa/5010v_hipaa_index.htm
  - Accepted files ("A") are accepted into the FI's processing system and proceed to 999 Level.

- **999 Level (Entire File)** – Functional Acknowledgement Validation validates the Functional Group (GS-GE) format and data content through a set of 999 edits
  - Files successfully passing 999 edits return an accepted 999 to the submitter and file will process through the Pre-processor level edits.
  - Problems at the 999 level return a rejected 999 to the submitter and the entire EDI will not process further.
    - Files with rejected 999 will need to be resubmitted using a new Interchange Control Number (ICN) (ISA13) value.

- **Pre-processor Level (Entire File)** – Validation of LA Medicaid specific data content
  LA Medicaid specific data content is reported in Companion Guides on LAMedicaid.com: https://www.lamedicaid.com/Provweb1/Providermanuals/ProviderManuals.htm
  - Failures at Pre-processor Level will be notified by FI EDI Department to the submitter and the entire EDI file will not process further. These files need to be resubmitted using a new ICN (ISA 13) value.
  - Submitter is not notified if EDI file successfully passes Pre-processor Level editing and each of the individual transaction records is independently adjudicated.

  Refer to the MCE SCG Tables for comprehensive list of encounter edits with dispositions, list of repairable edits, and list of non-repairable edits.

1.3. Correction of File and Encounter Errors

The MCE is required to correct all rejected files and repairable encounter edits applied to service line

denials and resubmit corrected files and encounters to the FI as indicated below:

1.3.1. **Entire File Rejection -** When the entire file (batch) is rejected, the MCE will receive one of the following:

- For **EDI File Encryption rejections**, the absence of a TA1 is the notification of a problem at this level.
- For **TA1 rejections,** the TA1 transaction reports the details of the problem.
- For **999 rejections,** the 999 transaction reports the details of the problem.
- For **Pre-processor rejections,** the FI's Business Support Analyst is to determine the cause of the error. MCE is required to work with the FI Business Support Analyst to determine the cause of error.
- The MCE will receive an X12 835 (RA) for **Header Level rejections.**

MCEs are required to adhere to the implementation guide, code sets, and looping structures, as well as the LDH-specific data rules as defined in the FI's Companion Guide and Section 2 of this SCG, to correct these transactions.

1.3.2. **Individual Record Denial** – MCE will receive an X12 835 for transaction claims that have processed through the MES system.

1.3.3. **EDI Resolution** – If after implementing correction processes, unresolved edits remain, the MCE may present the unresolved issue(s) to LDH and/or its FI for clarification and resolution. LDH/FI will triage issue(s) to appropriate entity for resolution and respond findings to the MCE.

- If outcome is not agreeable to MCE, the MCE may resubmit the outstanding issue(s) with supporting documentation to LDH for reconsideration. The LDH determined outcome will prevail.

1.3.4. **EDI Dispute Resolution –** The MCE has the right to file a dispute regarding denied encounters. Disputes must be filed within thirty (30) days of identifying an issue for dispute. The MCE may believe a denied encounter results from a FI error.

- An FI error is defined as a denied encounter that:
  - The FI acknowledges to be the result of its own error, or
  - Requires a change to FI's systems programming (i.e. an update to the MES reference tables or further research by the FI and therefore requires FI resolution.

- MCE must notify LDH in writing within thirty (30) calendar days of belief that denied encounter is a FI issue rather than a MCE issue.
  - MCE to submit memorandum describing issue.
  - FI's edit report(s) may be attached to memorandum as part of written request.
  - Denied encounter(s) requiring research must be highlighted or otherwise identified.

- FI, on behalf of LDH, will respond within thirty (30) calendar days of receipt of such notification.
  - FI will review MCE's written request and, if needed, may request additional

substantiating documentation from the MCE.
- FI's response will identify the disposition of each denied encounter issue in question.
- If FI disagrees with the MCE claim of FI error because documentation does not support the claim, the MCE will be required to correct the encounter, if repairable, and resubmit during the next billing cycle.

Section Five

1. Denial Edit Codes and Descriptions

Refer to the MCE SCG Tables spreadsheet for comprehensive list of edits with dispositions, list of repairable edits and list of non-repairable edits.
Tables | La Dept. of Health

1.1. LDH has modified edits specifically for MCE encounter processing.

1.2. For LDH to have the most complete data for rate setting and data analysis, MCEs are required to repair denial edit codes when possible.

2. Encounter Edit Reports

2.1. Encounter reports are posted by FI to the MCEs sFTP site weekly.

2.2. Reports are produced one (1) day after the MES adjudication cycle.

2.3. MCE is required to correct and resubmit repairable encounters:

2.3.1. Service lines to which a repairable edit has been applied

2.3.2. Encounters denied in entirety

3. Repairable and Non-Repairable Edits

3.1 Repairable vs. Non-Repairable Edits

When an encounter is assigned an edit that results in an EOB or Denial, the submitting plan receives the corresponding reason codes on 835. The error codes also appear on the remittance advice generated for the plan.

The original descriptions of "repairable" vs "non-repairable" as it is used in the System Companion Guide refers to items that can be updated on the encounter that will allow it to be resubmitted for adjudication on a new processing cycle. An example of this would include missing referring provider information, or a servicing provider that has not yet been added to the MCE's provider registry/directory (but will be). A "non-repairable" edit should not be resubmitted, as it is core aspect of the encounter that cannot be appropriately (e.g. the claim recipient is not linked to the plan as of the DOS).

If an encounter is submitted, and it is denied in adjudication, a resubmission should be done as an Original, rather than an Adjustment or Voids. Denied claims and encounters are not written to history, and do not have to be cleared in order for another instance of the new claim to be submitted.

A non-repairable edit that is assigned to an encounter cannot be expected to be resolved if the encounter is resubmitted. In the example above with a recipient, unless that linkage information is updated by Maximus to align with the serviced claim there can be no expectation of approval of the encounter.

Section Six

1. Medicare Recovery Process

1.1. The FI runs a monthly query to identify Managed Care members who have retrospectively enrolled in Medicare (i.e. QMB, SLMB, and Part A/B).

1.1.1. Once members have been identified, the FI generates and processes voids to recover Per Member Per Month (PMPM) payments made on behalf of these members to a MCE.

1.1.2. FI will generate an 820 File with detailed information regarding the voids. Refer to MCE File Layouts for 820 File format at:
File Layouts | La Dept. of Health

1.1.3. Only MCEs with impacted members will receive a CP-0-12C report -Medicare Recovery Project - Claim Detail. This report identifies retrospectively enrolled members for which PMPM payments were made and the 820 File which is placed on MCEs sFTP site for retrieval.

1.1.4. Upon receipt of 820 File, MCE is required to contact the Enrollment Broker to request disenrollment information for impacted members if they have not received it in a previous 834 file.

1.1.5. MCE must notify the provider of the disenrollment prior to recovery of payments made to the provider.

Section Seven

1. Medicaid Administrative Retroactive Enrollment Correction Process

LDH has determined that in some instances, Administrative Retroactive Correction to member linkages are necessary to ensure compliance with internal policies and the approved Medicaid State Plan. These corrections are known as retro-enrollments and may address multiple months and impact PMPMs.

Refer to the MCO Manual: Administrative Retroactive Corrections section.

Section Eight

1. PMPM Payment Recovery for Duplicate Recipient Medicaid IDs

1.1. LDH identified instances in which Medicaid members are assigned more than one Medicaid ID. Medicaid performs retrospective reviews to identify and invalidate duplicate member Medicaid ID(s).

1.2. The FI conducts a monthly PMPM recovery process for duplicate PMPM payments paid for Member Medicaid IDs when the valid (current) Medicaid ID and invalidated Medicaid ID are made to the **same HLA Plan.**

1.3. The HLA Plan 820 File has been modified to report valid (current) ID in Reference Information (8^{th} occurrence). The HLA Plan should use the valid (current) ID reported in the 820 to crosswalk to the member invalidated ID from which the PMPM recovery is made.

1.4. The HLA Plans shall not recover provider claim payments for Invalidated ID(s) unless duplicate claim payments are identified (same claim paid to both Invalid and Valid ID).

Section Nine

Provider Directories/Networks and Subcontractor Registries

1. MCO Provider Registry-Directory/Network and Subcontractor Registry

MCEs are required to provide an adequate network of providers including but not limited to PCPs, specialists, hospitals and auxiliary services needed to ensure member access to covered services that meets standards for distance, timeliness, amount, duration and scope as defined in the contract with LDH. Plans are required to provide LDH with a listing of all contracted providers. Providers in an MCO network are not required to be enrolled in Louisiana Medicaid, but all are required to be included in the listing submitted to LDH.

At the onset of the contract and periodically as changes are necessary, LDH shall publish a list of NPIs of Medicaid providers that will include provider types, specialty, and sub-specialty coding schemes to the MCE and/or its contractor. The MCE and/or its contractor shall utilize these codes within their provider file record, at the individual provider level. The objective is to coordinate the provider enrollment records of the MCE with the same provider type, specialty and sub-specialty codes as those used by LDH and the Enrollment Broker.

The MCE will submit their list of contracted providers electronically through the state's Fiscal Intermediary (FI) using the Provider registry/directory, which requires one record per the unique combination of NPI and Taxonomy. If a provider practices at multiple sites, the MCE should submit only the primary site in the Provider registry/directory, with secondary sites for PCPs and specialists submitted through the Site Provider registry/directory, all described in the MCE SCG File Layouts at:

File Layouts | La Dept. of Health

Providers no longer accepting patients must be clearly identified. The FI will process these submissions and provide an edit report listing acceptances and rejects.

Additional fields are needed for CMS required T-MSIS reporting. The FI's Provider Supplemental record is used for this purpose. Note - a record must first exist in the MCE's Provider registry/directory for this record to be accepted.

Many of the data elements are publicly available from National Plan and Provider Enumeration System (NPPES) through the Freedom of Information Act (FOIA). The complete listing of the Provider registry/directory data elements and file specifications are in the MCE SCG File Layout document.

The MCE is responsible for:

- Submitting a Provider registry/directory record for every provider in their network that provides covered services for Louisiana members.
- Submitting a Site Provider registry/directory record for PCPs and specialists if needed.
- Submitting a Provider Supplemental record for every record in the Provider registry/directory.
- Ensuring the completeness and accuracy of the data submitted.
- Timely submission of all updates to the FI on a weekly basis (each Wednesday and/or Friday by close of business 5 PM CT).

2. SMO Provider Registry-Directory/Network and Subcontractor Registry

SMOs are required to provide an adequate network of providers including but not limited to PCPs, specialists, hospitals and auxiliary services needed to ensure member access to covered services that meets standards for distance, timeliness, amount, duration and scope as defined in the contract with LDH. Plans are required to provide LDH with a listing of all contracted providers. Providers in an SMO network are not required to be enrolled in Louisiana Medicaid, but all are required to be included in the listing submitted to LDH.

At the onset of the contract and periodically as changes are necessary, LDH shall publish a list of NPIs of Medicaid providers that will include provider types, specialty, and sub-specialty coding schemes to the SMO and/or its contractor. The SMO and/or its contractor shall utilize these codes within their provider file record, at the individual provider level. The objective is to coordinate the provider enrollment records of the SMO with the same provider type, specialty and sub-specialty codes as those used by LDH and the Enrollment Broker.

The SMO will submit their list of contracted providers electronically through the state's Fiscal Intermediary (FI) using the Provider registry/directory, which requires one record per the unique combination of NPI and Taxonomy. If a provider practices at multiple sites, the SMO should submit only the primary site in the Provider registry/directory, with secondary sites for PCPs and specialists submitted through the Site Provider registry/directory, all described in:

File Layouts | La Dept. of Health

Providers no longer accepting patients must be clearly identified. The FI will process these submissions and provide an edit report listing acceptances and rejects.

Additional fields are needed for CMS required T-MSIS reporting. The FI's Provider Supplemental record is used for this purpose. Note - a record must first exist in the SMO's Provider registry/directory for the record to be accepted.

Many of the data elements are publicly available from National Plan and Provider Enumeration System (NPPES) through the Freedom of Information Act (FOIA). The complete listing of the Provider registry/directory data elements and file specifications are the MCE SCG File Layouts at: File Layouts | La Dept. of Health

The SMO is responsible for:

- Submitting a Provider registry/directory record for every provider in their network that provides covered services for Louisiana members.
- Submitting a Site Provider registry/directory record for provider offices if needed.
- Submitting a Provider Supplemental record for every record in the Provider registry/directory.
- Ensuring the completeness and accuracy of the data submitted.
- Timely submission of all updates to the FI on a weekly basis (each Wednesday and/or Friday by close of business 5 PM CT).

3. Transportation Plan Directory/Network and Subcontractor Registry

The Transportation Plan is required to provide an adequate network of providers needed to ensure member access to covered services that meets standards for distance, timeliness, amount, duration and scope as defined in the contract with LDH. The Plan is required to provide LDH with a listing of all contracted providers. Providers in the Plan's network are not required to be enrolled in Louisiana Medicaid, but all are required to be included in the listing submitted to LDH.

At the onset of the contract and periodically as changes are necessary, LDH shall publish a list of NPIs of Medicaid providers that will include provider types, specialty, and sub-specialty coding schemes to the Plan and/or its contractor. The Plan and/or its contractor shall utilize these codes within their provider file record, at the individual provider level. The objective is to coordinate the provider enrollment records of the Plan with the same provider type, specialty and sub-specialty codes as those used by LDH and the Enrollment Broker.

The Plan will submit their list of contracted providers electronically through the state's Fiscal Intermediary (FI) using the Provider registry/directory, which requires one record per the unique combination of NPI and Taxonomy. Providers that are no longer accepting patients must be clearly identified. The FI will process these submissions and provide an edit report listing acceptances and rejects.

Additional fields are needed for CMS required T-MSIS reporting. The FI's Provider Supplemental record is used for this purpose. Note - a record must first exist in the Plan's Provider registry/directory for this record to be accepted.

Many of the data elements are publicly available from National Plan and Provider Enumeration System

(NPPES) through the Freedom of Information Act (FOIA). The complete listing of data elements and file specifications are detailed in MCE SCG Transportation file at https://ldh.la.gov/page/4481

The Plan is responsible for:

- Submitting a Provider registry/directory record for every provider in their network that provides covered services for Louisiana members.
- Submitting a Provider Supplemental record for every record in the Provider registry/directory.
- Ensuring the completeness and accuracy of the data submitted.
- Timely submission of all updates to the FI on a weekly basis (each Wednesday and/or Friday by close of business 5 PM CT).

4. Provider Supplemental File

The Provider Supplemental file was created to capture additional information needed by T-MSIS for analysis by CMS. Plans are required to generate a supplemental record for each record in the Provider registry/directory. The Provider Supplemental can capture up to 5 time frames of provider enrollment per provider. The Provider registry/directory only shows the "current" period, therefore all encounters with a date-of-service prior to what is on the Provider registry/directory shows up as "Not Enrolled at the time of service".

- **ALL providers** that have had a claim on/after 10/01/2015 should have a Provider Supplemental record, as that is when this information has claims which are reviewed by CMS.
- For **disenrolled** providers, the end-date for the MCE enrollment should be reported, along with the disenrollment reason (MCO-STATUS-CODE).
- The Provider Supplemental file was created to provide "**CMS Required**" fields reported via T-MSIS, such as, but not limited to Date-of-Birth and SSN for individual providers and FEIN for Businesses.
- **License** information is required to be reported to CMS via T-MSIS
    a) Business Licenses
    b) Medical Licenses
        a. Board Licenses for each specialty
        b. CLIA Certification
        c. DEA License for prescribing scheduled drugs
            i. Note: this license is frequently requested for data analysis, especially the AG.
- **Provider Enrollment Periods** are required to be reported to CMS via T-MSIS
    a) Only periods where a break occurs require end-date
    b) This is where most errors in T-MSIS reporting are occurring, and increasing.
- **Taxonomies** are required to be reported to CMS via T-MSIS
    a) Up to 10 Taxonomies can be reported, as each will show which services are allowed to be performed/billed by the provider.

Refer to Provider Supplemental file layout in the MCE SCG File Layouts at:
File Layouts | La Dept. of Health

Section Ten

Supplemental Documents

10.1. Tables

The Tables document contains those files which are readily accessed for submission of claims and encounters as well as the response files the MCE receives from the FI. Most of these files are not specifically discussed within the SCG but are included for convenience:

- 820 File - FI to MCE
- Back-End Rejections
- Capitation Codes
- Category of Assistance (COA)
- Category of Service (COS)
- EDI Mainframe File Rejections
- Edits – Categorized
- File Naming Convention
- Inbound Files to FI
- Line Adjustment Process
- Outbound Files from FI
- Patient Status Code
- Place of Service (POS)
- Place of Service Codes Cross-Walk
- Post-Processing Edits
- Provider Subspecialties
- Provider Type
- Provider Type/Specialty
- Recipient Type Case
- Scope of Coverage (SOC)
- Types of Bill
- Types of Service (TOS)

Refer to the MCE SCG Tables at Tables | La Dept. of Health

10.2. Non-EDI File Layouts

The Non-EDI File Layout Workbook contains both the file layouts the MCE must submit to the FI and the file layouts of files received from the FI. Within this workbook, there is a description of each file and frequency of the file in the Table of Contents. File layouts in this workbook include:

- MCO Provider registry/directory Record
- MCO Provider registry/directory Edit File
- MCO Registry Errors PDF
- MCO Registry Edits-Errors
- MCO Provider Site Registry
- MCO Provider Site Registry Edit
- MCO Site Registry Error Rpt

- MCO Site Registry Edits-Errors
- MCO Prov Reg Recon - FI to MCO
- Provider Supplemental
- Provider Supplemental Error Rpt
- Prov Suppl Edits-Errors
- CCN-W-001
- CCN-W-005
- CCN-W-010
- CCN-M-010
- Prior Authorization-FI to MCO
- Provider File - FI > MCO
- PES Provider File - FI > MCO
- Provider Rates - FI > MCO
- Diag File For Pre_Admin-FI>MCO
- CLIA File-FI to MCO
- PCP Linkages-Submission
- PCP Linkages-Error File
- PCP Linkages Error Codes
- HLA TPL Submission File
- HLA TPL Error Files
- HLA TPL Error Codes
- TPL File to Plan
- TPL Carrier Code File
- TPL Full Recon File
- Rx Encounter Suppl Submission
- Rx Encounter Suppl Error File
- Rx Encounter Suppl Error Codes
- PA Request File-MCO to FI
- T1019 Criteria-Error Msgs
- PA Recon File-FI to MCO
- PA Recon Errors-FI to MCO
- Suppl to Fee Schedule-Extract
- Hospice Enrollment-FI to MCO
- Retro Cancel Closure-FI to MCO
- Chisholm CSOC Information
- Psych Resid Treatment Facility
- 17P Preterm Birth-ULM
- 17P Preterm Birth-FI>MCO
- LEERS - FI to MCO
- LEER Elect Delv-OPH Submissions
- LEER Elec Delv-FI to MCO
- LDH AAC Drug - FI to MCO
- IMD Long-Stay
- ESRD Fee Schedule
- RA File for ACLA

- PES Provider File

Refer to the MCE SCG File Layouts at

File Layouts | La Dept. of Health

PES Provider File - FI > MCE - PES_Provider_List_yyyymmdd.txt File Information

DESCRIPTION
A comprehensive list of Medicaid providers on the PES Boss file for Managed Care Entity – only and fee for service (MCE-only and FFS), updated by the Provider Enrollment System.

HISTORICAL USE OF THE FILE
The PES Provider File was devised in early 2021 to act as a replacement for the older MCE Provider File (which gives the MCE plans all FFS providers enrolled on/after 1/1/2011), except that it would include the MCE-only Provider Enrollment Short-term Initiatives (PESI) providers, AND report the PESI status of all PESI providers (FFS and MCE-only). The old MCE Provider File was devised during the early days of the MCE program (2011 and 2012) to send FFS providers to all of the MCE plans, so that they may know who is active or dis-enrolled in the FFS program. The intent was for them to possibly use this data to build-out their provider networks.

CURRENT USE OF THE FILE
Primarily to let MCE plans know the PESI status of FFS and MCE-only providers. Since the plans continue to receive the old MCE Provider File, there is duplication between the MCE file and the existing PES Provider file (with respect to FFS providers).

IMPLEMENTATION TIMELINE
The approved changes to the PES daily file sent to the plans has been moved to production. Processing should begin by 11:00am CT Thursday December 15, 2022. File processing and distribution to the MCE's FTP site could take up to 2 hours before it appears for download by the plans.

- The current production process run to create this file runs at 3:00pm on Monday and 11:00am Tue – Fri.

10.3. Forms

- EDI ANNUAL CERTIFICAT ION OF ELECTRONIC FILES 2022
- Annual EDI – Cover Letter
- MCE TESTING PROTOCOL
- EDI Transmission Research Request Form
- Encounter Data Certification Form
- MES Inquiry Request Form
- MCO Registration Packet

- TPL – Links to Update Recipient Insurance

Refer to the MCE SCG Forms at https://ldh.la.gov/page/4479

10.4. Appendices

- Appendix A_ Acronyms, Definition and Data Elements
- Appendix B_Frequently Asked Questions
- Appendix C_Code Sets
- Appendix D_How to be MCE – Onboarding and Encounter Testing
- Appendix E_EDI Test Plan and File Exchange Schedule
- Appendix F_System Generated Files and Reports
- Appendix G_Helpful Websites
- Appendix I_MCE SCG Links to Other Documents
- Appendix J_ Medicaid MES Claims and Encounter Inquiry Procedure

Refer to the MCE SCG Appendices at https://ldh.la.gov/page/4476

Previous Change Control Log

Author of Change	Section Changed	Description	Reason	Date
Susan Bryson	Appendices	**Appendix J**	**Add**: Medicaid MES Claims and Encounter Inquiry Procedure	7/15/2022
Susan Bryson	2.10.1.	Medicare Carrier Code	**Change:** Medicare to Traditional Medicare for Carrier Code 999999	7/22/2022
Susan Bryson	2.10.1.	Medicare Advantage Carrier Code	**Add:** Use of H- Carrier Codes for Medicare Advantage Plans	7/22/2022
Susan Bryson	2.10.1.	New Carrier Code Request	**Add:** Instructions on requesting a new Carrier Code through MES/TPL Unit	7/22/2022

Susan Bryson	2.10	Loop 2310AB, AF/2320/2330B	**Remove:** Link to 837I **Add:** Links to GW 837 Manuals and 837P	8/2/2022
Susan Bryson	File Layouts	PES Provider File	**Add:** First-Letter-Date in Field Number 171	8/5/2022
Susan Bryson	Tables	File Naming Conventions	**Add:** Dental DNE **Update:** TRA and NAM – remove PT	8/5/2022
Susan Bryson	5.3.1	Repairable vs. Non-Repairable Edits	**Add:** Description of Repairable and Non-Repairable Edits	9/9/2022
Susan Bryson	File Layouts	PES Provider File	**Add:** Application Received Date	9/15/2022
Susan Bryson	Dental File Layouts	PES Provider File	**Add:** Application Received Date	9/15/2022
Susan Bryson	Transportation File Layouts	PES Provider File	**Add:** Application Received Date	9/15/2022
Angela Marshall	BH	BH PT/PS Table	**Add:** Behavioral Health Provider Type/Provider Specialty Table	9/27/2022
Susan Bryson	Tables	PSS/PS/PT	**Add:** PSS 6X, 6Y, 6Z to PSS Table – include PSs and PTs per PSS	10/06/2022
Susan Bryson	Tables	PSS/PS/PT	**Add:** PS 'CV' with PTs 31, 73, AH, AK	10/17/2022
Susan Bryson	File Layouts	Retro Cancel Closure-FI to MCO	**Update:** Field length corrected from 9 to 7 characters.	10/17/2022
Susan Bryson	File Layouts	MCO Prov Reg Recon - FI to MCO	**Add:** Field definitions	10/24/2022
Susan Bryson	File Layouts	TPL Full Recon File	**Add:** Field "Last Activity Date	10/24/2022
Susan Bryson	File Layouts	TPL File to Plan	**Add:** Field "Last Activity Date	10/24/2022
Susan Bryson	File Layouts	New Payable/Non-Payable NDCs for MCOs	**Add:** New Payable/Non-Payable NDCs	10/31/2022
Susan Bryson	File Layout	Non-EDI File Layout	**Add:** 'XX' PES Status	12/06/2022
Susan Bryson	File Layout	Non-EDI File Layout	**Add:** TDUR Review File	12/06/2022
Susan Bryson	File Layout	BH DENT SMO Non-EDI File Layout	**Add:** 'XX' PES Status	12/06/2022
Susan Bryson	File Layout	Transportation Non-EDI File Layout	**Add:** 'XX' PES Status	12/06/2022
Susan Bryson	MCE SCG Narrative	All relevant sections	**Change:** Provider Registry to Provider Registry/Directory to correspond to MCO Contract language	12/09/2022
Susan Bryson	Section 10.2	Non-EDI File Layouts	**Add:** Description and information for PES Provider File – FI > MCE	12/19/2022
Susan Bryson	MCE SCG Non-EDI File Layout	PES File Layout – FI >MCE	**Add:** Description and information for PES Provider File – FI > MCE	12/19/2022
Susan Bryson	MCE SCG Transportation Non-EDI File Layout	PES File Layout – FI >MCE	**Add:** Description and information for PES Provider File – FI > MCE	12/19/2022

Susan Bryson	MCE SCG BH Dent SMO Non-EDI File Layout	PES File Layout – FI >MCE	**Add:** Description and information for PES Provider File – FI > MCE	12/19/2022
Susan Bryson	Section 3	Link to MCO Manual	**Updated:** Link to MCO Manual	12/29/2022