

# **Supplement 7**

## **DATA CONVERSION REQUIREMENTS**

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## Overview

This document outlines the data conversion requirements for MITS. Overall, this document meets two purposes: First, it describes the conversion requirements, secondly: It lays out the high level details on the potential systems that could be candidates for conversion, along with the data volumes, the table /file layouts etc, this is to assist the MITS vendor to plan for data conversion. The existing Medicaid interfaces are also an area that will need to be understood in-depth for the conversion effort. For the current integrations please refer to MITS integration requirements document.

Please note: If the full functionality for the following systems (Perseus, MDS, Athena and Buy-in) exists in the proposed transfer system, then the Contractor will be responsible for ensuring that the data in these systems is converted from these systems into the MITS database. If the proposed transfer system does not provide the functionality contained in the systems identified above, then the Contractor must build an interface to the existing system. Please review the Business Requirements, Integration Architecture and Data Conversion Documents to assess the functionality of the systems identified above.

## MIT Conversion Requirements

The following are set of requirements of data conversion :

#	Requirement
1	<p>A minimum of seven years of legacy Medicaid data must be converted to MIT, unless specified explicitly in the business requirements. All the specific business area historical /conversion requirements that are defined in the business requirements document for MIT have to be met the day MIT goes live. The scope of conversion needs to cover history for all areas MIT encompasses including:</p> <ol style="list-style-type: none"> <li>1.1 A minimum of seven (7) years or eleven spans of pricing history.</li> <li>1.2 A minimum of seven (7) years or 11 date spans of data in the DRG file.</li> <li>1.3 All current and the greater of seven (7) years of history or at least eleven date spans of reference files have to be maintained online.</li> <li>1.4 Maintain online invoicing and rebating information for at least the most recent twelve (12) quarters, with prior history stored in an easily retrievable format.</li> <li>1.5 A minimum of seven (7) complete state fiscal years of claims data (Processing data and Adjustment data) including the most current claims data. Seven (7) complete years of claims data must be available in an on-line format that is easily assessable and retrievable to all users. <ul style="list-style-type: none"> <li>• The State fiscal year is from July 1st to June 30th of the following year.</li> <li>• All detailed claims files and eligibility files (i.e., including all data elements down to an individual claim and recipient level) on a monthly rolling basis for the past seven years.</li> </ul> </li> <li>1.6 Claims history for the last seven (7) years must be converted</li> <li>1.7 Seven (7) years of online adjudicated (paid and denied) claims history including all other claims for procedures exempt from regular claims history purge criteria as defined by the State. Adjudicated claims history data includes: <ul style="list-style-type: none"> <li>• 837 transaction data</li> <li>• NCPDP data</li> <li>• 834 transaction data</li> <li>• 820 transaction data</li> <li>• 835 transaction data</li> <li>• 275 transaction data</li> <li>• 277 transaction data</li> <li>• 278 transaction data</li> </ul> </li> <li>1.8 Thirty-six (36) months of prior authorization history except for dental</li> </ol>

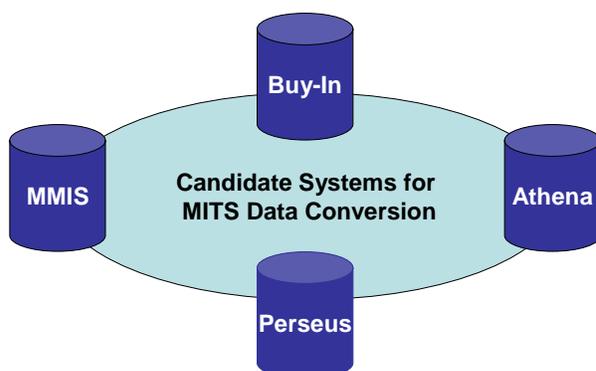
	<p>and/or other services whose approval period exceeds that period.</p> <p>1.9 EDI 835 remittance advice history starting 01/01/2004.</p> <p>1.10 The drug data set must contain all of the data for the contracted drug pricing service including the Previous NDC (for three (3) years).</p> <p>1.11 Category specific pricing and the VFC administration rates for periods not spanning less than 7 years.</p> <p>1.12 All information generated on the annual 1099 reports for previous years as defined by state</p> <p>1.13 Seven years of premium payment data</p> <p>1.14 Budget data for the past seven years</p> <p>1.15 Seven years of claims adjustment activity based on review/audit findings for both Full and Limited Scope Reviews.</p>
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## Medicaid Data Sources - Systems

The following is a synopsis of the key ODJFS Medicaid systems that are potential candidates for the conversion effort. The final scope of the conversion will have to be determined by the system proposed by the vendor and the ODJFS defined business requirements of the new Medicaid system.

The key candidate systems for the MITS conversion are

1. MMIS
2. Buy-In
3. Perseus
4. Athena



Given below are some details on the above candidate systems. This information will help the vendor better plan for the conversion effort.

## Medicaid Management Information System (MMIS)

### 1. Overview

MMIS is the core system in the Medicaid enterprise. It is an automated system that supports claims adjudication and processing. For eligible Medicaid recipients, reimbursements for rendered services are paid to providers. The MMIS system processes approximately 55 to 60 million claims per year.

### 2. System Summary

The following table represents a system summary of the MMIS.

<b>Platform</b>	Mainframe
<b>Age</b>	20 years
<b>Main Programming Language</b>	COBOL
<b>User Interface</b>	TN3270
<b>Security</b>	RACF
<b>Database</b>	VSAM Files
<b>Registered Users</b>	2000
<b>Data Available</b>	Back to 1987. The data between 1966 and 1987 is in an older file format on tapes.
<b>Users /Business units Supported</b>	Counties, OHP, Sister Agencies
<b>Maintained by</b>	MIS
<b>Primary Contact for information</b>	

### 3. Data source

There are several subsystems which exist within MMIS that support OHP operations: The files have been categorized under each of the subsystems based on the data the file contains.

**Claims** – Contains information on rates in addition to the business logic surrounding payment for services. This subsystem is supported by the Reference Procedural Diagnosis and Drug (PDD).

File Names	Volume (Records)	Comments	Layouts – Refer to
Claim Control	859,702 Records	39,561,856 bytes	Appendix 3
Claim Index Files - Recipient	N/A	This is derived data and so need not be a candidate for Conversion	Appendix 3
Claim Index Files - TCN	N/A	This is derived data and so need not be a candidate for Conversion	Appendix 3
Claim Index Files - Provider	N/A	This is derived data and so need not be a candidate for Conversion	Appendix 3
Claim Index Files - Provider Intermediate	N/A	This is derived data and so need not be a candidate for Conversion	Appendix 3
Claims Processing Data	77,394,712 (1 year of claims)	72,176,901,518 bytes	Appendix 3
Cross-over	450-500k per month	Cross-overs are a type of claim, there is no separate file maintained. This need not be a candidate for conversion	Appendix 3
Master Reference Data (PDD)	Proc - 52,893 Diag - 15,653 Drug - 213,067 Total - 281,613	Proc - 19,542,150 bytes Diag - 1,487,035 bytes Drug- 42,642,116 bytes Total - 63,671,301 bytes	Appendix 3
Health Maintenance Organization (HMO) Encounter Data	37,635,080 Records	25 GB	Relational Data base
Warrant Writer File	80,000 per month	All this data is in the Claims file, so need not be a candidate for conversion	Appendix 3
CRIS-E Extract Record (GDE410FA)	450-500k per month	This represents an input file to a process, any new system would be required to accept the file as input, there would be no conversion.	Appendix 3

**Recipient Master File (RMF)** – Acts as the central repository for Medicaid recipient information.

File Names	Volume (Records)	Comments	Layouts – Refer to
Recipient Master Data	6,184,085	Max of 60 Spans for active /inactive records; 2,335,078,443 bytes	Appendix 3
Claims History Recipient Index File	N/A	Identifies months of history for which the provider has claims records.	Appendix 3

**Provider Master File (PMF)** – Acts as the central repository for State approved providers who provide services to the Medicaid population within OH.

File Names	Volume (Records)	Comments	Layouts – Refer to
Nursing Home Provider Record	408,786	WELF.CMMIS.R1260IA.DATA	Appendix 3
Provider Charge File	14,552	WELF.CMMIS.F5010IA.DATA	Appendix 3
Provider Group Affiliation	141,809	WELF.CMMIS.P2600IA.DATA	Appendix 3
Provider Intermediary	76,401	WELF.CMMIS.P2700IA.DATA	Appendix 3
Provider Master Data	152,498	A current record for each active / in active spans; 85,528,165 bytes	Appendix 3
Provider Medicare Provider	143,055	WELF.CMMIS.P2500IA.DATA	Appendix 3
Provider Summary	24,653	WELF.CMMIS.C3630ID.DATA	Appendix 3
Special Program -Provider Record	2,636,680	WELF.CMMIS.R1280IA.DATA	Appendix 3

**Prior Authorization** – Stores information on cases where prior authorizations were required and/or obtained.

File Names	Volume (Records)	Comments	Layouts – Refer to
Prior Authorization Data	651,401	170,262,790 bytes	Appendix 3

**Surveillance Utilization Review (SURS)** – Measures utilization patterns for recipients and providers and reports outliers in an attempt to prevent fraud and abuse.

File Names	Volume	Comments	Layouts – Refer to
Surveillance and Review (SURS) Data	N/A	15 years of data available on Tapes. This is derived data and so need not be a candidate for Conversion	Appendix 3
Report History	N/A	N/A This is the file used for SURS	Appendix 3

**Medicaid Accounting and Reporting (MARS)** – Used for federal and state reporting purposes.

File Names	Volume (Records)	Comments	Layouts – Refer to
Management and Administrative Reporting (MARS) Data	800 M / year	This is derived data and so need not be a candidate for Conversion	Appendix 3

**EPSDT** – Ensures that all children who are receiving Medicaid services are receiving the full level of care they are entitled to receive.

File Names	Volume (Records)	Transactional data	Comments	Layouts – Refer to
Early Periodic Screening and Diagnostic Testing (EPSDT) Data	60 M /Year		This is derived data so need not be a candidate for Conversion	Appendix 3

**Reference /Control Files /Data** –Maintains reference data for claims processing and contains data such as pricing, procedures, and diagnosis

File Names	Volume (Records)	Comments	Layouts – Refer to
Exception Control (ECF)	NA	This is derived data and so need not be a candidate for Conversion	Appendix 3
Generic Finder Record	NA	This is derived data and so need not be a candidate for Conversion	Appendix 3
Text	28,915	6,742,983 bytes	Appendix 3
TPL	263,882	WELF.CMMIS.R1300IA.DATA	Appendix 3
UR Criteria	1,391	WELF.CMMIS.C3600IA.DATA	Appendix 3



## Perseus

### 1. Overview

Perseus is a client/server based application and was designed to replace the old Mapper system. The main function of Perseus is to set rates on an annual basis utilizing the MS score, which is interfaced from the MMIS mainframe system.

### 2. System Summary

<b>Platform</b>	Client Server
<b>Age</b>	2 Years
<b>Main Programming Language</b>	Delphi
<b>User Interface</b>	GUI
<b>Security</b>	Oracle
<b>Database</b>	Oracle
<b>Registered Users</b>	60 – 80
<b>Data Available</b>	Back to 1986
<b>Users /Business units Supported</b>	LTC, Office of Research and Accountability
<b>Maintained by</b>	MIS
<b>Primary Contact for information</b>	

### 3. Data source

Perseus is comprised of three major subsystems, which encompasses the system functionality. They are as follows:

- **Provider:** The repository of all nursing home, facility, and demographic information
- **Automated Cost Reports (ACR):** Creates the rate which OHP pays to the facilities and nursing homes, which is then sent to the MMIS mainframe system
- **Pegasus:** This is used for statistical purposes to analyze rates. It pulls information from MMIS and within Perseus for this purpose.

TABLE NAME	SIZE (Bytes)	COMMENTS	Layouts Refer to
ADD_ON_COST_CTR	150	5 records	<b>Appendix 2</b>
ADD_ON_REAS	2964	78 records	<b>Appendix 2</b>
ADDR_TYPE	264	11 records	<b>Appendix 2</b>
ADDRESS	3888218	46846 records	<b>Appendix 2</b>
ADJCD_LOG	1135915	20653 records	<b>Appendix 2</b>
ADJCD_LOG_HIST	598647	20643 records	<b>Appendix 2</b>
ADJCD_STATUS	232	8 records	<b>Appendix 2</b>
ADMIN_CEIL	180	12 records	<b>Appendix 2</b>
ADMIN_DATE	555024	11563 records	<b>Appendix 2</b>

<b>TABLE NAME</b>	<b>SIZE (Bytes)</b>	<b>COMMENTS</b>	<b>Layouts Refer to</b>
ADMIN_DISALLOW	992	32 records	<b>Appendix 2</b>
ADMIN_FY2002_MAPPER	12303616	7394 records	<b>Appendix 2</b>
ADMIN_LIC	89725	2425 records	<b>Appendix 2</b>
ADMINISTRATOR	809643	11091 records	<b>Appendix 2</b>
AGMT_TYPE	36	2 records	<b>Appendix 2</b>
ANN_PARAM	1080	12 records	<b>Appendix 2</b>
ASSET	1486639	34573 records	<b>Appendix 2</b>
ASSET_CHANGE	66804	3516 records	<b>Appendix 2</b>
AUDIT_25_75_STAT	648	18 records	<b>Appendix 2</b>
AUDIT_ADJ	672037	11017 records	<b>Appendix 2</b>
AUDIT_ADJ_TYPE	621	23 records	<b>Appendix 2</b>
AUDIT_CTRL	45	5 records	<b>Appendix 2</b>
AUDIT_FINAL	86008	1654 records	<b>Appendix 2</b>
AUDIT_FY2002_MAPPER	70840	1288 records	<b>Appendix 2</b>
AUDIT_LIST_FY2003	4600	460 records	<b>Appendix 2</b>
AUDIT_NARR	73002	3174 records	<b>Appendix 2</b>
AUDIT_PCT	972	18 records	<b>Appendix 2</b>
AUDIT_REASON	24780	1652 records	<b>Appendix 2</b>
AUDIT_REASON_CODE	693	11 records	<b>Appendix 2</b>
AUDIT_RISK_DETAIL	162000	1350 records	<b>Appendix 2</b>
AUDIT_SEL_INPUT	481422	4223 records	<b>Appendix 2</b>
AUDIT_SPL_NARR	24255	99 records	<b>Appendix 2</b>
AUDIT_SRC	81	3 records	<b>Appendix 2</b>
AUDIT_TRANS_HIST_MAPPER	33046	1066 records	<b>Appendix 2</b>
AUDIT_TYPE	60	4 records	<b>Appendix 2</b>
AUDIT_TYPE_HIST_MAPPER	47160	1572 records	<b>Appendix 2</b>
AUDITOR	208	8 records	<b>Appendix 2</b>
BAL_SHEET	5846092	208789 records	<b>Appendix 2</b>
BAL_SHEET_TOTAL	1994160	66472 records	<b>Appendix 2</b>
BATCH_JOB	1136	16 records	<b>Appendix 2</b>
BATCH_JOB_SCHED	322752	7872 records	<b>Appendix 2</b>
BED_CHANGE	25312	904 records	<b>Appendix 2</b>
BED_COUNT	928004	33143 records	<b>Appendix 2</b>
BED_RPT_BASE	1676675	9581 records	<b>Appendix 2</b>
BED_RPT_DETAIL	141504	737 records	<b>Appendix 2</b>
CAP_ADDITION	278760	4040 records	<b>Appendix 2</b>
CAP_COST			<b>Appendix 2</b>
CAP_PROT_MEDIAN	504	24 records	<b>Appendix 2</b>
CEIL_ACTIVE_PROV	627120	5226 records	<b>Appendix 2</b>
CHART_OF_ACCT	9504	288 records	<b>Appendix 2</b>
CHART_OF_ACCT_WORK_POSITION	7982	614 records	<b>Appendix 2</b>
CHOP_SUMMARY	11176	127 records	<b>Appendix 2</b>
CHOP_TYPE	114	6 records	<b>Appendix 2</b>
COMM_SUB_TYPE			<b>Appendix 2</b>
COMM_TABLE	640	20 records	<b>Appendix 2</b>
COMM_TYPE			<b>Appendix 2</b>

<b>TABLE NAME</b>	<b>SIZE (Bytes)</b>	<b>COMMENTS</b>	<b>Layouts Refer to</b>
COMM_TYPE_BAK	483	23 records	Appendix 2
COMMON_OWNER	3262272	67964 records	Appendix 2
CONTINUING_EDUCATION	196878	5181 records	Appendix 2
CONTRACTOR	582939	9253 records	Appendix 2
CORP_CEIL	57675	2307 records	Appendix 2
COST	40348907	1090511 records	Appendix 2
COST_CTR	2030	58 records	Appendix 2
COST_RECONCIL	2492323	57961 records	Appendix 2
COST_TOTAL	9145072	194576 records	Appendix 2
COUNTY	2340	90 records	Appendix 2
COUNTY_ALLOW	80	8 records	Appendix 2
CPAO_ANNUAL	526588	5602 records	Appendix 2
CPAO_LIST	141372	1428 records	Appendix 2
CPAO_MONTHLY	20600	206 records	Appendix 2
CR_CTRL	308	14 records	Appendix 2
CR_DESC_STAT	6600	200 records	Appendix 2
CR_DESC_STAT_DEF	2150	25 records	Appendix 2
CR_EXAM	850	25 records	Appendix 2
CR_STAT	394404	2858 records	Appendix 2
CR_STATUS	162	9 records	Appendix 2
CR_SUMM	386780	4660 records	Appendix 2
CR_SUMM_PEN	56240	703 records	Appendix 2
CR_SUMM_PEN_CTRL	315	15 records	Appendix 2
CR_TYPE	160	8 records	Appendix 2
D_OS_BOX_STATUS	180	9 records	Appendix 2
D_OS_REASON	72	3 records	Appendix 2
D_OS_RECORD_TYPE	448	14 records	Appendix 2
D_OS_RECRD_STATUS	140	7 records	Appendix 2
D_OS_WORK_AREA	134	2 records	Appendix 2
DATA_ELEM_NUM	455532	2958 records	Appendix 2
DESK_EDIT	1386	33 records	Appendix 2
DESK_EDIT_REAS	1326	3 records	Appendix 2
DIR_CEIL_MEDIAN	1872	72 records	Appendix 2
DISALLOW_MAPPER	27846	663 records	Appendix 2
DISALLOW_TYPE	310	10 records	Appendix 2
DISALLOWANCE	507150	12075 records	Appendix 2
DISPOSITION	70	5 records	Appendix 2
DISPUTED_COST	8400	120 records	Appendix 2
DIST_HEALTH	70	5 records	Appendix 2
DIST_ODHS	75	5 records	Appendix 2
DOC_FACIL_TYPE	63	3 records	Appendix 2
DOCUMENT	691058	8326 records	Appendix 2
ERROR	12090	155 records	Appendix 2
EVENT	1120	40 records	Appendix 2
EXCEPTIONS	5364992	83828 records	Appendix 2
EXCESS_PAY	283185	3045 records	Appendix 2

<b>TABLE NAME</b>	<b>SIZE (Bytes)</b>	<b>COMMENTS</b>	<b>Layouts Refer to</b>
FACIL_TYPE	192	6 records	<b>Appendix 2</b>
FACIL_UNIT	72	4 records	<b>Appendix 2</b>
FACILITY_PERSEUS	26999	1421 records	<b>Appendix 2</b>
FIXED_ADJ	1224576	38268 records	<b>Appendix 2</b>
FS_FLAG	66	2 records	<b>Appendix 2</b>
INDIR_CEIL_MEDIAN	3240	120 records	<b>Appendix 2</b>
INFL_FACTOR	1440	60 records	<b>Appendix 2</b>
INPATIENT_DAY	3550092	91028 records	<b>Appendix 2</b>
LIC_AUTH	54	3 records	<b>Appendix 2</b>
LIC_BED	116012	4462 records	<b>Appendix 2</b>
LICENSE	190298	5597 records	<b>Appendix 2</b>
LINE	28658	623 records	<b>Appendix 2</b>
LOCKED_STATUS	216	4 records	<b>Appendix 2</b>
LTC_ADDR	178610	3370 records	<b>Appendix 2</b>
LTC_BED_XFER	4650	155 records	<b>Appendix 2</b>
LTC_HOME	70308	1953 records	<b>Appendix 2</b>
LTC_HOME_ADDR	105516	1954 records	<b>Appendix 2</b>
LTC_HOME_COMM	107134	2329 records	<b>Appendix 2</b>
LTC_HOME_FRAN_FEE	114960	5748 records	<b>Appendix 2</b>
LTC_HOME_NAME_HIST	133472	3104 records	<b>Appendix 2</b>
LTC_HOME_STATUS			<b>Appendix 2</b>
LTC_HOME_STATUS_HIST			<b>Appendix 2</b>
LTC_HOME_TYPE	51	1 records	<b>Appendix 2</b>
MAPPER_ADD_ON_REAS	481	13 records	<b>Appendix 2</b>
MAPPER_AMENDED_TRANS	42264	1174 records	<b>Appendix 2</b>
MAPPER_COO_CEIL	2745	183 records	<b>Appendix 2</b>
MAPPER_DEPR	555420	9257 records	<b>Appendix 2</b>
MAPPER_DEPR_ADD_ON	12960	720 records	<b>Appendix 2</b>
MAPPER_OFFSITE_STRG	7646464	56224 records	<b>Appendix 2</b>
MAPPER_OWNER_HIST	33028	1436 records	<b>Appendix 2</b>
MAPPER_PKG_TYPE	184	8 records	<b>Appendix 2</b>
MAPPER_RATE_PKG	1798179510	19785 records	<b>Appendix 2</b>
MDS_SCORE_TYPE	1053	9 records	<b>Appendix 2</b>
MEAN_CALC_DETAIL	231428	4924 records	<b>Appendix 2</b>
MEDICARE_COST	525683	18127 records	<b>Appendix 2</b>
MEDICARE_COST_OFFSET	1027775	41111 records	<b>Appendix 2</b>
MEDICARE_REV	939884	22924 records	<b>Appendix 2</b>
MLOG\$ PROV_MMIS_DAY	60503300	1100060 records	<b>Appendix 2</b>
MMIS_CTRL_TYPE	80	5 records	<b>Appendix 2</b>
NAME_TYPE	88	4 records	<b>Appendix 2</b>
NARR_TYPE	65	5 records	<b>Appendix 2</b>
NARRATIVE	309160	262 records	<b>Appendix 2</b>
NS_RATE_ADD_ON	9900	275 records	<b>Appendix 2</b>
NS_RATE_PKG	79248	1016 records	<b>Appendix 2</b>
NS_RATE_PKG_LINE	680320	17008 records	<b>Appendix 2</b>
NS_RATE_XFER_BED	10856	236 records	<b>Appendix 2</b>

<b>TABLE NAME</b>	<b>SIZE (Bytes)</b>	<b>COMMENTS</b>	<b>Layouts Refer to</b>
NUMERIC_RANGE			<b>Appendix 2</b>
NUMERIC_RANGE_CODE	150	5 records	<b>Appendix 2</b>
NURSE_AIDE_TRAINED	167276	5396 records	<b>Appendix 2</b>
OFFSITE_STRG_BOX	131683	3559 records	<b>Appendix 2</b>
OFFSITE_STRG_BOX_TRACKING	114548	4091 records	<b>Appendix 2</b>
OFFSITE_STRG_REC RD	3382740	56379 records	<b>Appendix 2</b>
OFFSITE_STRG_REC RD_REQ	68	1 records	<b>Appendix 2</b>
OFFSITE_STRG_REC RD_REQ_TRACK	26	1 records	<b>Appendix 2</b>
ORG_TYPE	92	4 records	<b>Appendix 2</b>
OTHER_COST	2457962	72293 records	<b>Appendix 2</b>
OTHER_TRIAL_BAL	1221033	37001 records	<b>Appendix 2</b>
OWNER			<b>Appendix 2</b>
OWNER_ADDR			<b>Appendix 2</b>
OWNER_ID_TYPE	144	4 records	<b>Appendix 2</b>
OWNER_OR_REL	828422	8813 records	<b>Appendix 2</b>
OWNER_REL_PAID_ELSEWHERE	3145280	39316 records	<b>Appendix 2</b>
PAID_NON_MEDICAID_LEAVE_DAY	660681	31461 records	<b>Appendix 2</b>
PARTNER_CORP_OFFICER_NAME	3127218	50439 records	<b>Appendix 2</b>
PERSEUS_AUDIT_TRAIL	9731520	50685 records	<b>Appendix 2</b>
PERSEUS_COMM	3573456	16392 records	<b>Appendix 2</b>
PERSEUS_TRIGGER_ERRORS	442705	2393 records	<b>Appendix 2</b>
PERSON	1417020	24860 records	<b>Appendix 2</b>
PERSON_TYPE	51	3 records	<b>Appendix 2</b>
PLAN_TABLE	1207	17 records	<b>Appendix 2</b>
PROV_ADD_ON	14186	346 records	<b>Appendix 2</b>
PROV_ADDR	689497	10291 records	<b>Appendix 2</b>
PROV_AGMT	2008832	35872 records	<b>Appendix 2</b>
PROV_BED	280975	11239 records	<b>Appendix 2</b>
PROV_CHOP	105204	797 records	<b>Appendix 2</b>
PROV_COMM_BAK	1663617	10463 records	<b>Appendix 2</b>
PROV_COMM_NEW	716754	14054 records	<b>Appendix 2</b>
PROV_COMM_NEW_BAK	531400	10628 records	<b>Appendix 2</b>
PROV_COST_OF_OWNER	75276	2788 records	<b>Appendix 2</b>
PROV_CPTL_EXCPT	104	8 records	<b>Appendix 2</b>
PROV_CR_EXTN	19320	920 records	<b>Appendix 2</b>
PROV_GRANT	3400	85 records	<b>Appendix 2</b>
PROV_GRANT_PER_YEAR	2040	85 records	<b>Appendix 2</b>
PROV_LTC_HOME	31801	2891 records	<b>Appendix 2</b>
PROV_MDS_NOT_USED	4743	153 records	<b>Appendix 2</b>
PROV_MDS_SCORE	613848	25577 records	<b>Appendix 2</b>
PROV_MMIS_DAY	23372508	508098 records	<b>Appendix 2</b>
PROV_MMIS_DAY_MT	596403	22089 records	<b>Appendix 2</b>
PROV_MMIS_PYMT	3933	207 records	<b>Appendix 2</b>
PROV_NAME_HIST	166926	3882 records	<b>Appendix 2</b>
PROV_PEER_GROUP	182825	7313 records	<b>Appendix 2</b>
PROV_RATE_IBM	1961494	63274 records	<b>Appendix 2</b>

<b>TABLE NAME</b>	<b>SIZE (Bytes)</b>	<b>COMMENTS</b>	<b>Layouts Refer to</b>
PROV_RATE_IBM_EXCPT	12606	382 records	<b>Appendix 2</b>
PROV_REL_EXCPT	225	15 records	<b>Appendix 2</b>
PROV_STATUS	70	5 records	<b>Appendix 2</b>
PROV_STATUS_HIST	95346	5297 records	<b>Appendix 2</b>
PROV_SUB_STATUS	180	9 records	<b>Appendix 2</b>
PROV_SUB_STATUS_HIST	8334	463 records	<b>Appendix 2</b>
PROV_WAIVER	3016	116 records	<b>Appendix 2</b>
PROV_XREF	57840	2892 records	<b>Appendix 2</b>
PROVIDER	133032	2892 records	<b>Appendix 2</b>
PRS_CEIL_EXCPT	1798	62 records	<b>Appendix 2</b>
PRS_CEIL_EXCPT_1			<b>Appendix 2</b>
PRS_CEIL_EXCPT_HIST	9594	246 records	<b>Appendix 2</b>
PRS_LOCKED_DATA	196768	1376 records	<b>Appendix 2</b>
PRS_LOCKED_DATA_1			<b>Appendix 2</b>
PRS_LOCKED_DATA_HIST	1301944	9716 records	<b>Appendix 2</b>
PRS_MDS_LOCKED_DATA	74547	2761 records	<b>Appendix 2</b>
PRS_MDS_LOCKED_DATA_HIST	281962	8293 records	<b>Appendix 2</b>
QUESTION	630686	33194 records	<b>Appendix 2</b>
QUESTION_TEXT	1086	6 records	<b>Appendix 2</b>
RATE_ADD_ON	18964	431 records	<b>Appendix 2</b>
RATE_COMP_FY2002	234100	4682 records	<b>Appendix 2</b>
RATE_DESK_EDIT	5831	119 records	<b>Appendix 2</b>
RATE_EXCPT_PROV	430	10 records	<b>Appendix 2</b>
RATE_LINE	86925	1425	<b>Appendix 2</b>
RATE_PARAM	1608	12 records	<b>Appendix 2</b>
RATE_PKG	1513920	18924 records	<b>Appendix 2</b>
RATE_PKG_COMP	459971	10697 records	<b>Appendix 2</b>
RATE_PKG_LINE	96172750	1923455 records	<b>Appendix 2</b>
RATE_PKG_LINE_AC_OC	48761908	920036 records	<b>Appendix 2</b>
RATE_PKG_LINE_NC	8358273	170577 records	<b>Appendix 2</b>
RATE_PKG_MAPPER_HIST	5378999	125093 records	<b>Appendix 2</b>
RATE_PKG_TIME_SLICE	3940551	66789 records	<b>Appendix 2</b>
RATE_PKG_TIME_SLICE_REL	9333302	160919 records	<b>Appendix 2</b>
RATE_SCHED	10017	189 records	<b>Appendix 2</b>
RATE_SCHED_BAK	4524	87 records	<b>Appendix 2</b>
RATE_SELN	1286775	17157 records	<b>Appendix 2</b>
RATE_SELN_CALN	630	30 records	<b>Appendix 2</b>
RATE_SELN_FS_FY2002	61171	913	<b>Appendix 2</b>
RATE_SELN_REAS	286	11 records	<b>Appendix 2</b>
RATE_SRC_PKG_CTRL	1924	52 records	<b>Appendix 2</b>
RAW_DATA	99135459	67577 records	<b>Appendix 2</b>
REC_STATUS	24	2 records	<b>Appendix 2</b>
REIMB_COST	3219372	82548 records	<b>Appendix 2</b>
RENOVATION	124840	3121 records	<b>Appendix 2</b>
REV_TRIAL_BAL	11644020	431260 records	<b>Appendix 2</b>
RISK_MEDIAN	2030	70 records	<b>Appendix 2</b>

<b>TABLE NAME</b>	<b>SIZE (Bytes)</b>	<b>COMMENTS</b>	<b>Layouts Refer to</b>
ROE_CAP	2414580	57490 records	<b>Appendix 2</b>
ROE_FIXED	108512	3391	<b>Appendix 2</b>
ROE_PCT	26184	1091 records	<b>Appendix 2</b>
ROE_VAR	304656	6347 records	<b>Appendix 2</b>
RS_ACTIVE_PROV	11115400	55577 records	<b>Appendix 2</b>
RS_ACTIVE_PROVO2JC5600000	7560423	42237 records	<b>Appendix 2</b>
RS_TYPE	220	10 records	<b>Appendix 2</b>
SCHEDULE	792	22 records	<b>Appendix 2</b>
SMP_VDS_REPOS_VERSION			<b>Appendix 2</b>
STATE	832	52 records	<b>Appendix 2</b>
SWAMA_CEIL	336	24 records	<b>Appendix 2</b>
TABLE_XREF	1428	42 records	<b>Appendix 2</b>
TEMP_AUDIT_TRANS_HIST	1131314	15934 records	<b>Appendix 2</b>
TEMP_AUDIT_TYPE_HIST	115710	3857 records	<b>Appendix 2</b>
TEMP_FRAN_BED	24966	1314 records	<b>Appendix 2</b>
TEMP_FRAN_FEE	230672	4436 records	<b>Appendix 2</b>
TRACK_EVENT	2334112	61424 records	<b>Appendix 2</b>
TRACKING	499560	8326 records	<b>Appendix 2</b>
UPLOAD_DOC	23	1 records	<b>Appendix 2</b>
VAR_ADJ	8883240	148054 records	<b>Appendix 2</b>
VENDORS	984	8 records	<b>Appendix 2</b>
WAGE_AND_HOUR	4771200	136320 records	<b>Appendix 2</b>
WAIVER_TYPE	93	3 records	<b>Appendix 2</b>
WHO_CEIL	3294	183 records	<b>Appendix 2</b>
WORK_POSITION	2880	90 records	<b>Appendix 2</b>

## Buy In

### 1. Overview

The Buy In system was designed to pay the Medicare premium for a subset of the State of Ohio's Medicaid recipients who cannot afford premiums. This, in effect, is a mechanism for cost avoidance, as Medicare becomes the primary insurer.

The new "Buy In" system, went live in Oct 2004, it replaced an outdated legacy system with a new web-based, relational database system.

### 2. System Summary

<b>Platform</b>	Windows
<b>Age</b>	Less than an year
<b>Main Programming Language</b>	Java, COBOL
<b>User Interface</b>	GUI
<b>Security</b>	Novell
<b>Database</b>	DB2
<b>Registered Users</b>	15,000
<b>Data Available</b>	Back to 20 years (1 year in DB2, rest in VSAM)
<b>Users /Business units Supported</b>	Counties, OHP, Sister Agencies
<b>Maintained by</b>	MIS
<b>Primary Contact for information</b>	

### 3. Data Sources

The historical data in DB2 tables goes back only one year, rest of the data is still in VSAM Files.

<b>TABLE NAME</b>	<b>SIZE (Bytes)</b>	<b>COMMENTS</b>	<b>Layouts Refer to</b>
KBY_PERSON	32 M	350000 Records	Appendix 1
KBY_PRSN_ADDT_INFO	64 M	700000 Records	Appendix 1
KBY_ELIGIBILITY	36 M	750000 Records	Appendix 1
KBY_BILLING	750 M	12 Million Records	Appendix 1
KBY_BILLING_PARTA	250 M	12 Million Records	Appendix 1
KBY_BILLING_PARTB	250 M	12 Million Records	Appendix 1
KBY_TRANSACTION	1.2 GB	20 Million Records	Appendix 1
KBY_SSI_ELIGIBLE	12 M	200000 Records	Appendix 1
KBY_CRISE_ELLGBTY	128 M		Appendix 1
KBY_STATE_OB_FILE	36 M	300000 Records	Appendix 1
KBY_ALERT	128 M		Appendix 1
KBY_COMMENT	500 M	500000 Records	Appendix 1

TABLE NAME	SIZE (Bytes)	COMMENTS	Layouts Refer to
KBY_PERSON_COMMENT	64 M	100000 Records	Appendix 1
KBY_CRISE_ASSIT_GRP	32 K	60 Records	Appendix 1
KBY_COMMENT_TYPE	16 K	30 Records	Appendix 1
KBY_TRANS_CODE	128 K	1000 Records	Appendix 1
KBY_TRANS_SUBCODE	128 K	1000 Records	Appendix 1
KBY_AGENCY_CODE	32 K	300 Records	Appendix 1
KBY_ELIG_CODE	32 K	100 Records	Appendix 1
KBY_RUN_CONTROL	2 M	3000 Records	Appendix 1
KBY_RUN_STEP	2 M	6000 Records	Appendix 1
KBY_RUN_REJECT	1 M		Appendix 1
KBY_ERROR_MSSG_DEF	64K		Appendix 1
KBY_ALERT_DEF	2M		Appendix 1
KBY_ALT_ROTATION	96 K	2000 Records	Appendix 1
KBY_USER	64 K	200 Records	Appendix 1
KBY_ALERT_STATUS	128 K		Appendix 1
KBY_USER_STATUS	32 K	30 Records	Appendix 1
KBY_DATASRC_TYPE	32 K	30 Records	Appendix 1
KBY_SSI_STS_CODE	32 K	30 Records	Appendix 1
KBY_GENDER_DEF	32 K	30 Records	Appendix 1
KBY_COUNTY_DEF	32 K	88 Records	Appendix 1
KBY_ELIG_STATUS	32 K	60 Records	Appendix 1
KBY_AID_CAT	32 K	30 Records	Appendix 1
KBY_SPENDDOWN	32 K	30 Records	Appendix 1
KBY_MMIS_LIV_ARR	32 K	60 Records	Appendix 1
KBY_PRE_PAY	32 K	30 Records	Appendix 1
KBY_EXTD_MCAID	32 K	30 Records	Appendix 1
KBY_CASE_TYPE	32 K	30 Records	Appendix 1
KBY_RRB_CONV	64 K	100 Records	Appendix 1
KBY_CREDIT_DEF	64 K	4 Records	Appendix 1
KBY_SURCHARGE	64 K	4 Records	Appendix 1
KBY_REDUCED_RATE	64 K	4 Records	Appendix 1
KBY_RECIP_LIV_ARG	64 K	4 Records	Appendix 1
KBY_COMMENT_SOURCE	64 K	20 Records	Appendix 1
KBY_TRANS_TYPE	32 K	10 Records	Appendix 1
KBY_BATCH_PROC_DEF	32 K	10 Records	Appendix 1
KBY_ALERT_COMMENT	2M		Appendix 1
KBY_TRANS_CD_ALERT	100K		Appendix 1
KBY_ALERT_TO_DEF	32 K		Appendix 1

## Athena

### 1. Overview

The Athena application is used primarily to monitor quality of care provided to recipients by managed care plans (MCPs). This is achieved by retrieving enrollment data from MMIS, and collecting treatment data from the MCPs through mandated treatment data uploads through SFTP transfers. OHP inputs/updates data and uses Athena's extensive reporting functionality to analyze quality of care to evaluate MCP performance. In addition, Athena provides data extracts to the Data Warehouse for their own use and forwarding through DW to MedStat. The Athena group also owns a mainframe process - Encounter Data. This subsystem, as is the rest of the HMO group, is used to evaluate patient quality of care. In addition, it processes birth payments and through this process does input data into MMIS.

As of 11/25/2004, 510,000 are enrolled into MCP programs. It is anticipated that MCP will grow to over 750k within two years.

### 2. System Summary

<b>Platform</b>	Windows
<b>Age</b>	5 years
<b>Main Programming Language</b>	Delphi
<b>User Interface</b>	GUI
<b>Security</b>	Novell
<b>Database</b>	Oracle
<b>Registered Users</b>	10 - 15
<b>Data Available</b>	5 years
<b>Users /Business units Supported</b>	OHP
<b>Maintained by</b>	MIS
<b>Primary Contact for information</b>	

### 3. Data Sources

There are multiple types of data, each with it's own source:

1. Managed Care Plan data: Provided by OHP, usually via email.
2. MCP Recipient enrollment data: In an online process, specific recipients' data can be extracted from the RMF via a database link from Oracle. Also, batch extracted from RMF monthly and transferred to Athena via FTP.
3. Recipient care data: Provided by the MCP plan via monthly FTP to Athena.
4. Appeals/Grievances data: Manual entry by OHP staff in response to phone/letter contact from MCP /Recipient.
5. Recipient care comments: Manual entry by OHP staff at time of recipient care file load.

## Medicaid Data Sources – Images

The paper claims and the prior authorizations that are mailed for claims processing to MMIS are shipped to imaging vendors, who then scan these documents into images. The CDs containing these images are shipped to MMIS for use and safekeeping.

Claim images are viewed using a stand alone windows based systems called Claims Image Storage System (see below for details.) Even though Prior Authorizations are imaged, at this time they have no index by which a retrieval system may search for a specific document. As of December 21, 2004, there were 686 CDs with images of Prior Authorizations on them. Typically a CD may store 600-1500 Prior Authorizations images. A CD is created for all the Prior Authorizations entered in to the MMIS Prior Authorizations Subsystem.

### Claims Image Storage System (CISS)

#### *1. Overview*

The Claims Processing Section archives all paper claims received by various vendors on CDs (Compact Disk).

The archive procedure is as follows:

- Complete the receipt logs so the media (CD, film, fiche) can be physically filed in cabinets. The Log identifies the contents, date created and volume or roll number.
- Complete external labels for micro film and fiche or CD, required for filing in the customary manner.
- Download CD indexes and contents to PC/Server for access online as needed. File the physical media for later retrieval if needed.

The images of paper claims on CDs are loaded to a local server (for use by CISS). Claims are indexed by Billing number, Provider number and by Transaction Control Number (TCN). Due to the large storage size required for these paper claims, only the most recent 12 months are stored online. The estimated number of paper claims for twelve months is 7 million. A master index file can holds up to 15 years of claims index history.

There are two scenarios to recreate a paper claim:

1. Claim on local server - CISS would find the claim image on the local server and display it on the workstation.
2. Claim not on local server - The CISS application checks the index and then the CD volume number is displayed. The operator would then locate and insert the CD and the application would find the claim image on the CD and display it on the workstation.

## 2. System Summary

<b>Platform</b>	Windows
<b>Age</b>	2 years
<b>Main Programming Language</b>	Delphi
<b>User Interface</b>	GUI
<b>Security</b>	Oracle
<b>Database</b>	Oracle
<b>Registered Users</b>	70
<b>Data Available</b>	2 years online, rest on CDs
<b>Users /Business units Supported</b>	CSP
<b>Maintained by</b>	MIS
<b>Primary Contact for information</b>	

## 3. Data Sources

The historical paper claim data is on CDs. For conversion, it may be best to convert the data directly out of the CDs and map them to the Master index file in CISS. The images are in TIFF format and there are 6800 CDs whose create dates range from present to 1998. On an average every CD has 3500 images on it.

<b>File NAME</b>	<b>SIZE (Bytes)</b>	<b>COMMENTS</b>	<b>Layout</b>
Master Index File	±28k	The master CD file is a CSV file. The format is inconsistent but generally consists of fields for the TCN No, Recipient ID, Provider ID and the path to the image for the first page of the claim.	NA

## Existing Data Reporting/ data extraction Tools

The following is a list of reporting tools used within various Medicaid user groups, these may be available for data extractions:

1. **COGNOS:** This reporting tool is a business intelligence analytical reporting tool. It is used for both operational and strategic reporting within MIS.
2. **Microstrategy:** This tool has been utilized within the Medicaid enterprise for several years and will soon be phased out and replaced by COGNOS. It is used primarily to support ad hoc reporting needs out of the source transaction systems.
3. **EasyTrieve:** This is a legacy reporting tool which users can utilize in order to generate ad hoc reports.
4. **ReportNet:** This is a web-based tool, which is accessible from a web browser so that the end user can easily access a report.
5. **Informatica:** This tool is used to load the data warehouse. The data warehouse is currently used to meet strategic as well operational reporting needs.

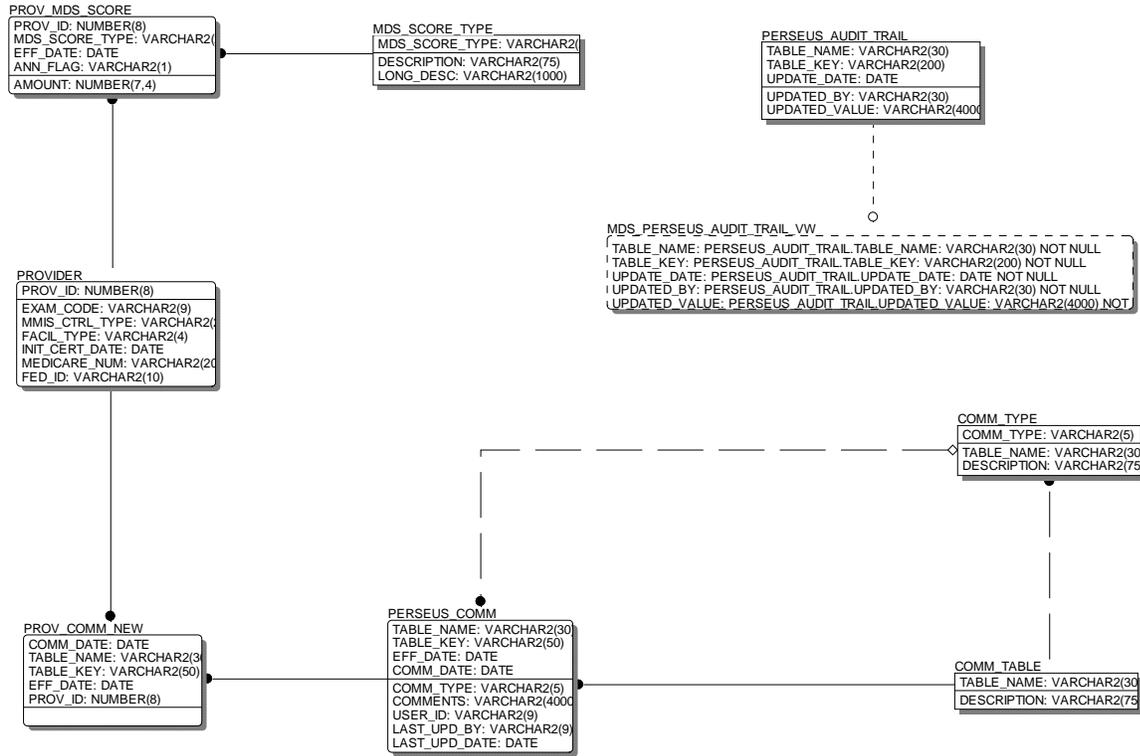
## References: Document

#	Reference Name	Date	Version /Comment
1	MIT: Phase 1 Deliverables	June 2004	
2	MIT: Phase II Business Requirements	February 2005	
	Documents (soft copy) made available by Medicaid MIS	NA	There were emails and soft copies of documents made available by key contacts after the meetings/interviews. They have been incorporated within this document as applicable.



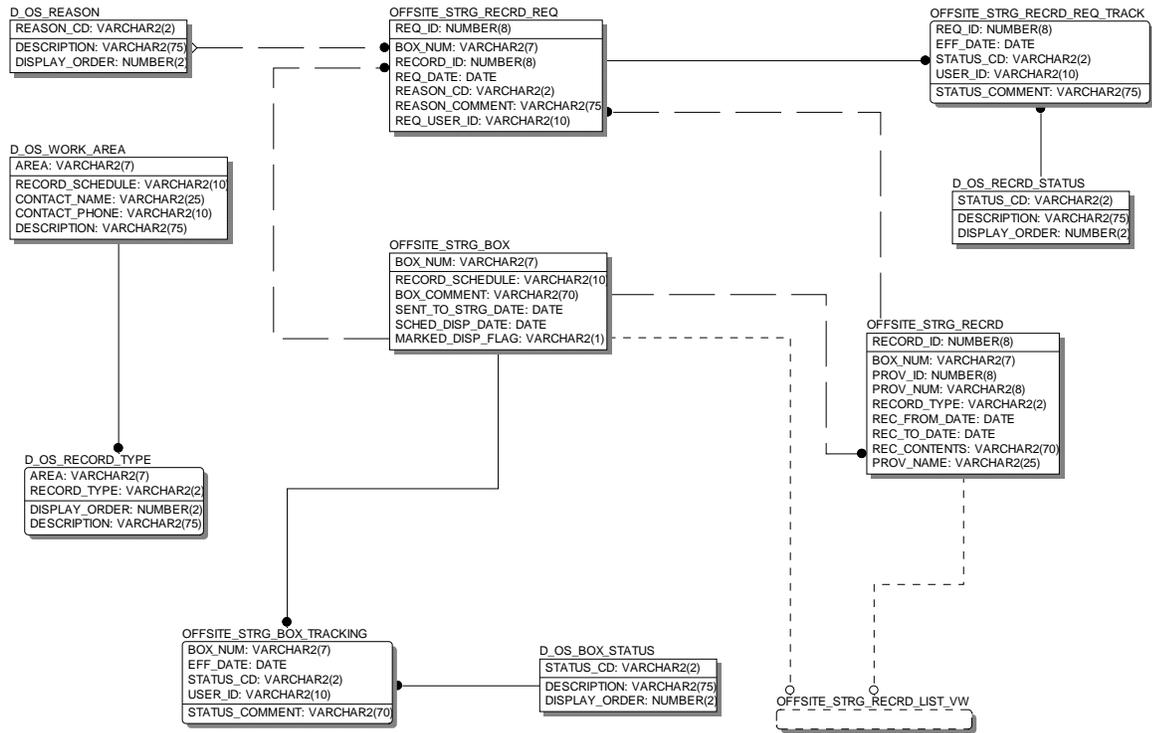
## APPENDIX 2 – Layouts of the Source tables: Perseus

### ER Diagram : MDS DB MODEL

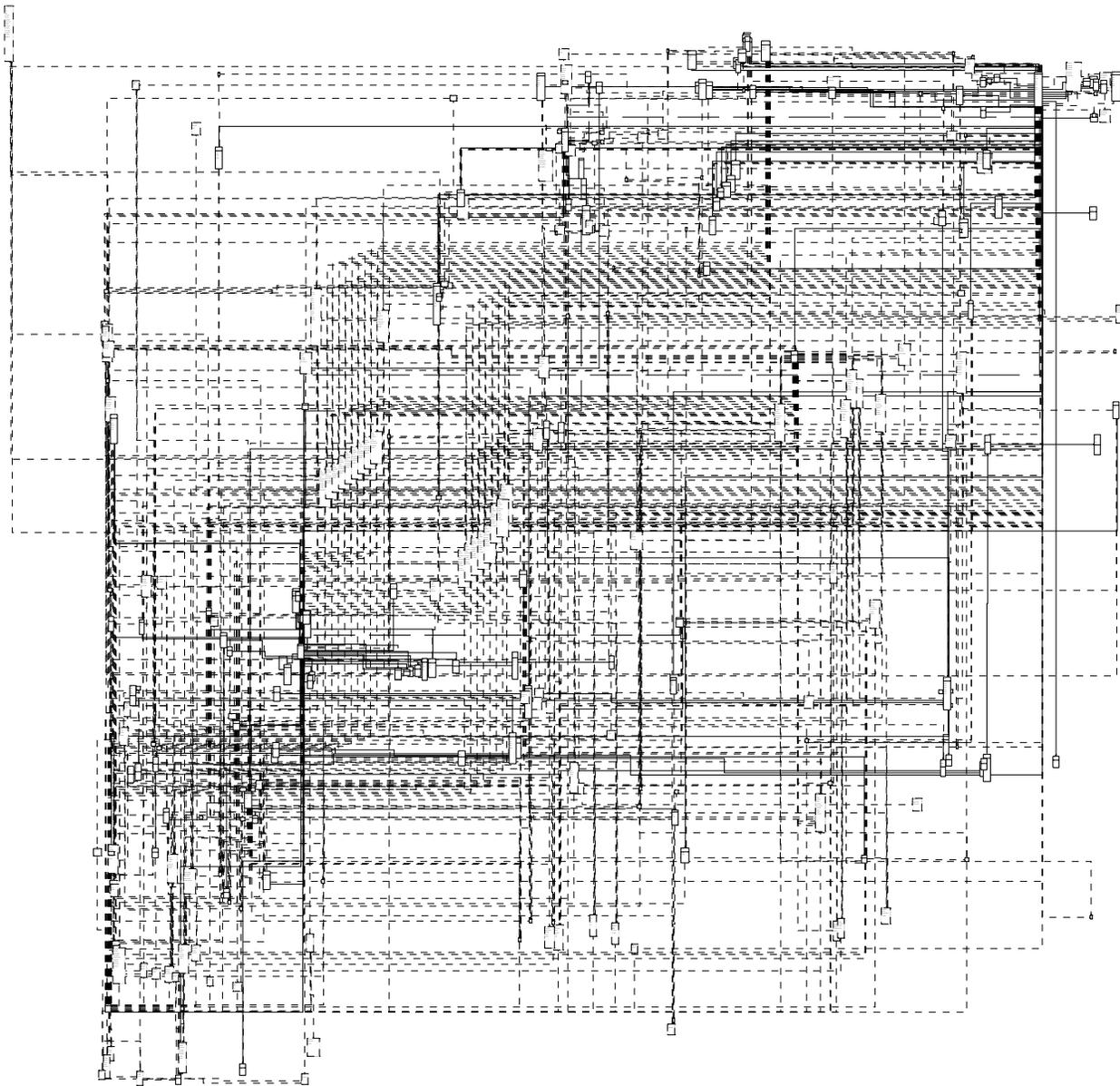




*ER Diagram : OFFSITE STORAGE DB MODEL*



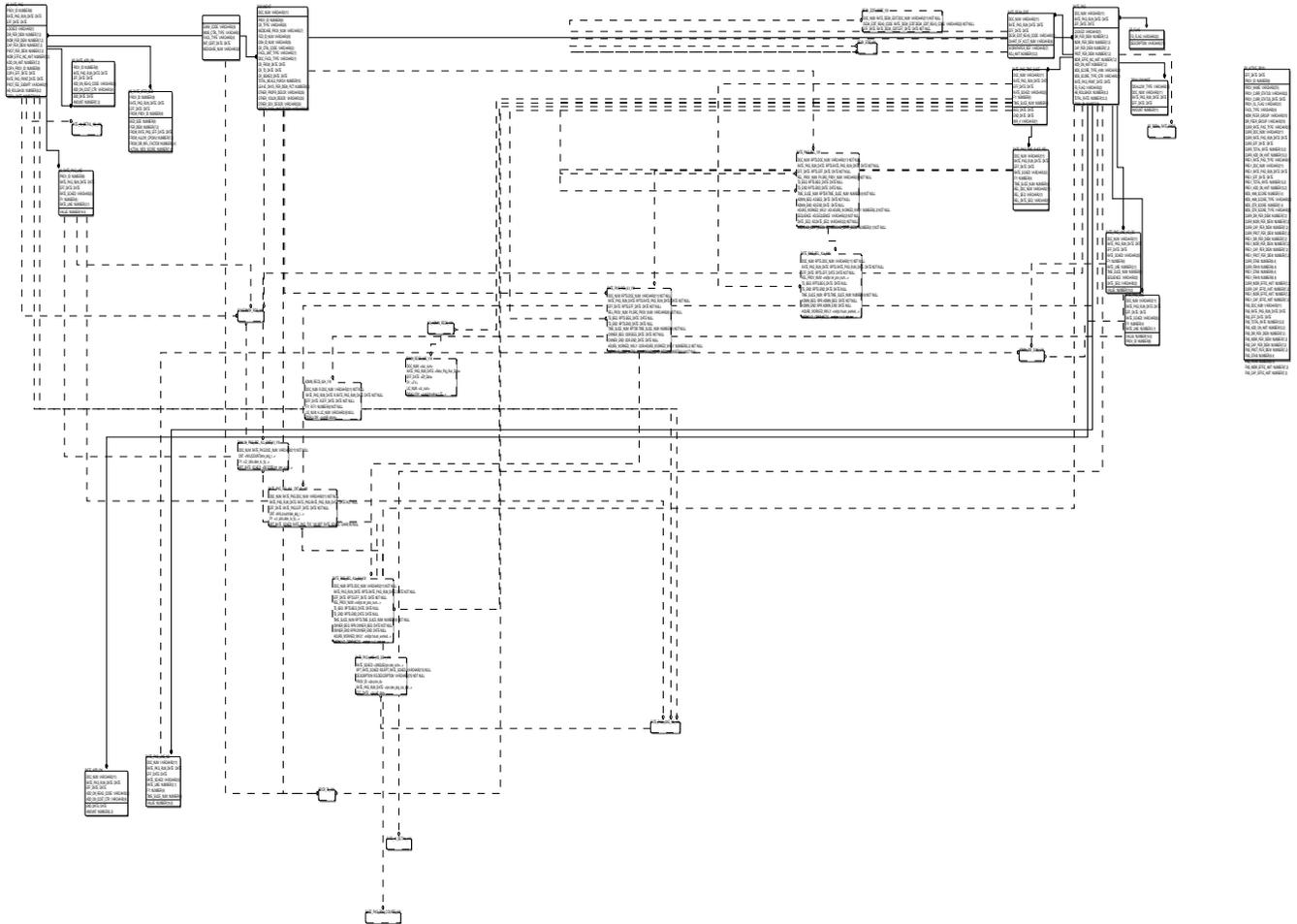
*ER Diagram : PROVIDER DB MODEL*



*Please note that the above picture will be included in the final CD where it can be viewed properly.*



**ER Diagram : RATE SETTING DB MODEL**



**Please note that the above picture will be included in the final CD where it can be viewed properly.**

## APPENDIX 3 – Layouts of the Source files: MMIS

### Claim record

#### Contents/ Comments : MMIS CLAIM RECORD

The MMIS Claim and History record is a multiple variable record. All intermediate claim files from the output of the Preprocessor thru Payment have the same format, as does Exam Entry and Suspense. There are five record types:

Record.....	RCD-ID	Copy Lib Member
Date Header	00	W1400100
Institutional	61	W1415200
Pharmacy	62	W1415400
Medical	60	W1415500
Credit or Adjust	66	W1416100
High Risk	—	W1445500

Except for the High Risk and Date Header records, all records have a common header area, followed by a unique claim header area, and then the various variable areas. Only the Institutional and Medical records have variable line items.

	Size	From	To
Fixed Common Header			
Common Header.....	319.....	1...	319
Instit Filler.....	335.....	320...	654
Instit Header.....	393.....	655..	1047
Pharmacy Header.....	241.....	320...	360
Medical Header.....	40.....	320...	359
Common Variable Areas (in order)			
Expand Variable.....	275	max	
Current Exception.....	525	max	
Committed Exception.....	100	max	
Third Party Liab.....	168	max	
Misc Providers.....	35	max	
Unique Variable Areas			
Instit Line Items.....	30,600	max	
Medical Line Items.....	1,512	max	

File Common Name.....	DSN.....
Adjudicated Not Paid	WELF.CMMIS.C4070IC.DATA
Exam Entry	WELF.CMMIS.C4070IA.DATA
Suspended	WELF.CMMIS.C4070IB.DATA
Month-to-Date History	WELF.CMMIS.C4070ID.DATA
Monthly Histories	WELF.CMMIS.C4070mmm.DATA
Lifetime History	WELF.CMMIS.C4070LIF.DATA
Audit History	WELF.CMMIS.C4070AUD.DATA
Quarterly History	WELF.MMIS.HIST.mmmmyy.nnnny
	where nnn & mmm = JAN, etc; yy = 92, etc

### Layout :

```

3DSN:      See above                                     3
-----
3FILE-AID MAP:  CLAIMSF          3DCB: LRECL=4096, BLKSIZE=32000  3
-----
3FD: N/P2407000 3 Length: 2397 3 Blk: 23470 3 Mode: VB      3
-----

```

MITS: Data Conversion requirements

<sup>3</sup>I/O MODULE: BOI4070A thru BOI4070I

3

			CLASS	OC	FROM	TO
01	W1400100-DATE-HEADER. . . . .					
05	W1400111-RECORD-CODE	PIC X(2)	C	1	1	2
05	W1400111-SORT-KEY	PIC X(30)	C	1	3	32
05	W1400131-NUM-OF-LINE-ITEMS	PIC S9(3)	P	1	33	34
05	W1400131-NUM-OF-CURR-EXCEP	PIC S9(3)	P	1	35	36
05	W1400131-NUM-OF-COMM-EXCEP	PIC S9(3)	P	1	37	38
05	W1400131-NUM-OF-TPL-SEGMENTS	PIC S9(3)	P	1	39	40
05	W1400131-NUM-OF-MISC-PROV	PIC S9(3)	P	1	41	42
05	W1400131-NUM-OF-EXPANDS	PIC S9(3)	P	1	43	44
05	W1400191-TRANS-CONTROL-NUM.					
10	W1400122-CLM-INPUT-MEDIUM-IND	PIC 9	Z	1	45	45
10	W1400122-BATCH-DATE	PIC 9(5)	Z	1	46	50
10	W1400122-MICROFILM-MACHINE-NO	PIC 9	Z	1	51	51
10	W1400122-MICROFILM-ROLL-NO	PIC 9	Z	1	52	52
10	W1400122-BATCH-NUMBER	PIC 9(3)	Z	1	53	55
10	W1400122-DOCUMENT-NUMBER	PIC 9(4)	Z	1	56	59
10	W1400122-LINE-NUMBER	PIC 99	Z	1	60	61
05	W1400111-CYCLE-DATE	PIC X(6)	C	1	62	67
05	W1400121-CYCLE-DATE	PIC 9(6)	Z	1	68	73
05	W1400131-CYCLE-DATE	PIC S9(5)	P	1	74	76
05	W1400151-CYCLE-DATE	PIC X(8)	C	1	77	84
05	W1400161-CYCLE-DATE	PIC 9(5)	P	1	85	87
05	FILLER	PIC X(233)	C	1	88	320

			CLASS	OC	FROM	TO
01	W1415200-INSTITUTIONAL-CLAIM. . . . .					
10	W1415292-CLM-HEADER-COMMON.					
15	W1415213-RECORD-CODE	PIC X(2)	C	1	1	2
15	W1415213-SORT-KEY	PIC X(30)	C	1	3	32
15	W1415293-OCCURRENCE-COUNTERS.					
20	W1415234-NUM-OF-LINE-ITEMS	PIC S9(3)	P	1	33	34
20	W1415234-NUM-OF-CURR-EXCEP	PIC S9(3)	P	1	35	36
20	W1415234-NUM-OF-COMM-EXCEP	PIC S9(3)	P	1	37	38
20	W1415234-NUM-OF-TPL-SEGMENTS	PIC S9(3)	P	1	39	40
20	W1415234-NUM-OF-MISC-PROV	PIC S9(3)	P	1	41	42
20	W1415234-NUM-OF-EXPANDS	PIC S9(3)	P	1	43	44
15	W1415293-TRANS-CONTROL-NUM.					
20	W1415224-CLM-INPUT-MEDIUM-IND	PIC 9	Z	1	45	45
20	W1415224-BATCH-DATE	PIC 9(5)	Z	1	46	50
20	W1415224-MICROFILM-MACHINE-NO	PIC 9	Z	1	51	51
20	W1415224-MICROFILM-ROLL-NO	PIC 9	Z	1	52	52
20	W1415224-BATCH-NUMBER	PIC 9(3)	Z	1	53	55
20	W1415224-DOCUMENT-NUMBER	PIC 9(4)	Z	1	56	59
20	W1415224-LINE-NUMBER	PIC 9(2)	Z	1	60	61
15	W1415293-CLAIM-TRANS-CODE.					
20	W1415214-ACCOUNTING-CODE	PIC X(1)	C	1	62	62
20	W1415214-CLAIM-STATUS	PIC X(1)	C	1	63	63
15	W1415233-REMITTANCE-ADVISE-NO	PIC 9(6)	P	1	64	67
15	W1415233-WARRANT-NUMBER	PIC 9(6)	P	1	68	71
15	W1415233-VOUCHER-NUMBER	PIC 9(6)	P	1	72	75
15	W1415213-CLM-INPUT-FORM-IND	PIC X(1)	C	1	76	76
15	W1415233-CLERK-IDENTIFICATION	PIC 9(3)	P	1	77	78

			CLASS	OC	FROM	TO
01	W1415200-INSTITUTIONAL-CLAIM (cont'd). . . . .					
15	W1415293-CLAIM-PROV-DATA.					
20	W1415234-PROV-NUMBER	PIC S9(7)	P	1	79	82
20	W1415294-PAY-TO-PROV-NUM.					
25	W1415235-PAY-TO-PROV-NUM	PIC 9(7)	P	1	83	86
25	W1415215-PROV-TYPE	PIC X(2)	C	1	87	88
20	W1415214-PROV-CAT-OF-SVC-CODE					
		PIC X(2)	C	1	89	90
20	W1415214-PROV-SPEC-CODE	PIC X(2)	C	1	91	91
20	W1415214-PROV-TYPE	PIC X(2)	C	1	93	94
20	W1415214-PROV-COUNTY-CODE	PIC X(2)	C	1	95	96
20	W1415224-PROV-ZIP-CODE	PIC 9(9)	Z	1	97	105

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15	W1415293-CLAIM-DATES.							
20	W1415234-DATE-BILLED	PIC S9(5)	P	1	106	108		
20	W1415234-ENTRY-DATE	PIC S9(5)	P	1	109	111		
20	W1415234-SUSPENSE-DATE	PIC S9(5)	P	1	112	114		
20	W1415234-LAST-CYCLE-DATE	PIC S9(5)	P	1	115	117		
20	W1415234-DATE-OF-ADJUDICATION	PIC S9(5)P		1	118	120		
20	W1415234-DATE-PAID	PIC S9(5)	P	1	121	123		
20	W1415234-ORIG-PAYMENT-DATE	PIC S9(5)	P	1	124	126		
20	W1415234-DATE-TO-HIST	PIC S9(5)	P	1	127	129		
20	W1415234-FIRST-DATE-OF-SVC	PIC S9(5)	P	1	130	132		
20	W1415234-LAST-DATE-OF-SVC	PIC S9(5)	P	1	133	135		
15	W1415293-EOB-CODE.							
20	W1415234-EOB-CODE	PIC 9(3)	P	2	136	139		
15	W1415233-OVERRIDE-EXCEP-CODE	PIC 9(3)	P	1	140	141		
15	W1415213-OVERRIDE-LOC-CODE	PIC X(2)	C	1	142	143		
15	W1415293-CURR-LOCATION-DATA.							
20	W1415214-CLAIM-LOCATION-CODE	PIC X(2)	C	1	144	145		
20	W1415234-DATE-ENTERED-LOC	PIC S9(5)	P	1	146	148		
15	W1415293-PREV-LOCATION-DATA.							
20	W1415214-CLAIM-LOCATION-CODE	PIC X(2)	C	1	149	150		
20	W1415234-DATE-ENTERED-LOC	PIC S9(5)	P	1	151	153		
15	W1415293-CLAIM-RECIP-DATA.							
20	W1415294-RECIP-IDENT-NUMBER.							
25	W1415215-RECIP-CASE-NUMBER	PIC X(10)	C	1	154	163		
25	W1415215-RECIP-ADC-NUMBER	PIC X(2)	C	1	164	165		
20	W1415214-LAST-NAME-FIRST-2	PIC X(2)	C	1	166	167		
20	W1415214-RECIP-1ST-NAME-INIT	PIC X	C	1	168	168		
20	W1415214-RECIP-LIV-ARRNG	PIC X	C	1	169	169		
20	W1415214-RECIP-CASE-TYPE	PIC X	C	1	170	170		
20	W1415214-RECIP-AID-CATEGORY	PIC X	C	1	171	171		
20	W1415214-RECIP-COUNTY-CODE	PIC X(2)	C	1	172	173		
20	W1415214-RECIP-ZIP-CODE	PIC X(5)	C	1	174	178		
20	W1415294-RECIP-NAME.							
25	W1415215-RECIP-LAST-NAME	PIC X(14)	C	1	179	192		
25	W1415215-RECIP-FIRST-NAME	PIC X(11)	C	1	193	203		
25	W1415215-RECIP-MIDDLE-INIT	PIC X	C	1	204	204		
20	W1415214-RECIP-EXCEP-INDIC	PIC X	C	1	205	205		
20	W1415234-RECIP-DATE-OF-BIRTH	PIC S9(7)	P	1	206	209		
20	W1415234-RECIP-AGE	PIC S9(3)	P	1	210	211		
20	W1415214-RECIP-SEX-CODE	PIC X	C	1	212	212		
20	W1415214-RECIP-RACE-CODE	PIC X	C	1	213	213		
20	W1415214-EXTENDED-MCAID-IND	PIC X	C	1	214	214		
20	W1415214-RECIP-SPENDDOWN-IND	PIC X	C	1	215	215		
20	W1415214-RECIP-MCARE-IND	PIC X	C	1	216	216		
20	W1415214-RECIP-NH-INDIC	PIC X	C	1	217	217		
20	W1415214-MODEL50-IND	PIC X	C	1	218	218		
15	W1415233-NUMBER-OF-CYCLES	PIC S9(3)	P	1	219	220		
15	W1415233-TAPE-DOC-NUMBER	PIC 9(7)	P	1	221	224		
15	W1415233-TAPE-BATCH-NUMBER	PIC 9(3)	P	1	225	226		
15	W1415213-MEDICAL-RCD-NUM	PIC X(9)	C	1	227	235		
15	W1415293-PRESCRIPTION-NUMBER							
	REDEFINES W1415213-MEDICAL-RCD-NUM.							
20	W1415214-PRESCRIPTION-NUMBER	PIC X(6)	C	1	227	240		
20	FILLER	PIC XXX	C	1	233	235		
15	W1415213-OTHER-INSURANCE-IND	PIC X	C	1	236	236		
15	W1415213-TRAUMA-REL-IND	PIC X	C	1	237	237		
15	W1415293-CLAIM-PAYMENT-DATA.							
20	W1415234-TOTAL-CLAIM-CHARGE	PIC S9(7)V99	P	1	238	242		
20	W1415274-TOT-NON-COV-CHRG	PIC S9(7)V99	P	1	243	247		
20	W1415234-CLM-RECIP-PMT-AMT	PIC S9(5)V99	P	1	248	251		
20	W1415234-COMPUTED-RECIP-PMT	PIC S9(5)V99	P	1	252	255		
20	W1415234-COMPUTED-INTEREST	PIC S9(5)V99	P	1	256	259		
20	W1415234-THIRD-PARTY-PMT-AMT							
		PIC S9(7)V99	P	1	260	264		
20	W1415234-AMT-PAID-BY-MCARE	PIC S9(7)V99	P	1	265	269		
20	W1415234-NET-CLAIM-CHARGE	PIC S9(7)V99	P	1	270	274		
20	W1415234-REIMBURSEMENT-AMOUNT							
		PIC S9(7)V99	P	1	275	279		
15	W1415213-FUND-CODE	PIC X	C	1	280	280		
15	W1415293-CLAIM-CREDIT-DATA.							
20	W1415214-ADJUSTMENT-REASON	PIC X(2)	C	1	281	282		

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20	W1415214-CLAIM-CREDIT-IND	PIC X	C	1	283	283
20	W1415234-TCN-TO-CREDIT	PIC 9(17)	P	1	284	292
20	W1415234-TCN-OF-CREDIT	PIC 9(17)	P	1	293	301
20	W1415294-CASH-CONTROL-INFO.					
25	W1415215-CASH-CTL-WARRANT-IND	PIC X	C	1	302	302
25	W1415295-CASH-CONTROL-NUM.					
30	W1415226-CASH-CONTROL-DATE					
		PIC S9(5)	Z	1	303	307
30	W1415226-CASH-CONTROL-SEQ-NUM					
		PIC 9(4)	Z	1	308	311
25	W1415295-RETURNED-WARRANT-NUM					
	REDEFINES W1415295-CASH-CONTROL-NUM.					
30	W1415226-RETURNED-WARRANT-NUM					
		PIC 9(6)	Z	1	303	308
30	FILLER					
		PIC X(3)	Z	1	309	311
20	W1415294-MARS-CODES					
	REDEFINES W1415294-CASH-CONTROL-INFO.					
25	W1415225-MARS-CLM-IND	PIC S9	Z	1	302	302
25	W1415215-SPLIT-CLAIM-IND	PIC X	Z	1	303	303
25	W1415215-FFP-FUND-CD	PIC X	Z	1	304	304
25	W1415215-FED-CAT-SVC	PIC XX	Z	1	305	306
25	W1415215-FED-MAINT-ASST-CD	PIC X	Z	1	307	307
25	W1415215-FED-AID-CAT	PIC X	Z	1	308	308
25	W1415265-PD-UNIT-SVC	PIC S9(3)	P	1	309	310
25	W1415215-EXP-AID-CAT	PIC X	C	1	311	311
15	W1415293-SPECIAL-INDICATOR.					
20	W1415214-HR-ASSESSMENT-IND	PIC X	C	1	312	312
20	W1415214-SPECIAL-INDICATOR	PIC X	C	3	313	315
15	W1415233-PRIOR-AUTH-NUM	PIC 9(6)	P	1	316	319
15	N1415292-CLM-FILLER-AREA.					
20	FILLER					
		PIC X(335)	C	335	320	654
10	N1415292-CLM-HEADER-VARIABLE.					
15	N1415293-TYPE-BILL.					
20	N1415224-TYPE-OF-FACILITY	PIC 9	Z	1	655	655
20	N1415224-CLASS	PIC 9	Z	1	656	656
20	N1415224-FREQUENCY	PIC 9	Z	1	657	657
15	N1415233-ATTENDING-PHYSICIAN	PIC 9(7)	P	1	658	661
15	N1415213-MCARE-PROV-NUMBER	PIC X(6)	C	1	662	667
15	N1415233-PERFORM-PROV-NUMBER	PIC 9(7)	P	1	668	671
15	N1415293-ADMISSION-DATA.					
20	N1415234-ADMISSION-DATE	PIC S9(5)	P	1	672	674
20	N1415224-ADMISSION-HOUR	PIC 9(2)	Z	1	675	676
20	N1415214-ADMIT-SOURCE	PIC X	C	1	677	677
20	N1415214-ADMIT-TYPE	PIC X	C	1	678	678
15	N1415223-DISCHARGE-HOUR	PIC 9(2)	Z	1	679	680
15	N1415233-CONSENT-DATE	PIC S9(5)	P	1	681	683
15	N1415213-PATIENT-STATUS	PIC X(2)	C	1	684	685
15	N1415233-COVERED-DAYS	PIC S9(3)	P	1	686	687
15	N1415233-NH-COV-LEAVE-DAYS					
	REDEFINES N1415233-COVERED-DAYS					
15	N1415233-NONCOVERED-DAYS	PIC S9(3)	P	1	688	689
15	N1415233-NH-NONCOV-LEAVE-DAYS					
	REDEFINES N1415233-NONCOVERED-DAYS					
15	N1415233-COINSURANCE-DAYS	PIC S9(3)	P	1	690	691
15	N1415213-NH-LEVEL-OF-CARE	PIC X	C	1	692	692
15	N1415223-SPECIAL-PROGRAM-IND	PIC 99	Z	1	693	694
15	N1415243-MEDICAL-RCD-NUM	PIC X(17)	C	1	695	711
15	N1415213-PROVIDER-WARD-IND	PIC X	C	1	712	712
15	N1415293-OCCURRENCE-DATA.					
20	N1415294-OCCURRENCE-DATA			7	713	747
25	N1415225-OCCURRENCE-CODE	PIC 99	Z		713	714
25	N1415235-OCCURRENCE-DATE	PIC S9(5)	P		715	717
15	N1415293-CONDITION-DATA.					
20	N1415294-CONDITION-DATA			10	748	767
25	N1415225-CONDITION-CODE	PIC 99	Z		748	649
15	N1415293-VALUE-DATA.					
20	N1415294-VALUE-DATA			12	768	851
25	N1415225-VALUE-CODE	PIC 99	Z		768	769
25	N1415235-VALUE-DOLLAR-AMOUNT					
		PIC S9(7)V99	P		770	774
15	N1415293-PAYER-DATA.					

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	20	N1415294-PAYER-DATA				3	852	860
	25	N1415225-PAYER-ID	PIC 9(3)	Z			852	854
15	N1415243-ALLOWED-CHARGE		PIC S9(7)V99	P	1		861	865
15	N1415213-ALLOWED-CHRG-SOURCE		PIC X	C	1		866	866
15	N1415293-MCARE-PART-A-DATA.							
	20	N1415254-MCARE-DEDUCTIBLE-AMT						
			PIC S9(7)V99	P	1		867	871
	20	N1415254-MCARE-COINS-AMT						
			PIC S9(7)V99	P	1		872	876
	20	N1415234-DATE-PAID-BY-MCARE						
			PIC S9(5)	P	1		877	879
	20	N1415234-LIFETIME-RES-DAYS						
			PIC S9(3)	P	1		880	881
15	N1415293-PRIOR-PAYMENT.							
	20	N1415294-PRIOR-PAYMENT				3	882	896
	25	N1415235-PRIOR-PAYMENT					882	886
15	N1415293-INSURED-DATA.							
	20	N1415294-INSURED-DATA				2	897	900
	25	N1415225-PATIENT-RELATIONSHIP					897	898
15	N1415293-DIAGNOSIS-DATA.							
	20	N1415214-DIAG-STERIL-IND						
			PIC X	C	1		901	901
	20	N1415214-DIAG-ABORT-IND						
			PIC X	C	1		902	902
	20	N1415214-DIAG-FAM-PLAN-IND						
			PIC X	C	1		903	903
	20	N1415294-DIAG-CODE-ICD-9.						
	25	N1415216-PRINC-DIAG-CODE-ICD-9						
			PIC X(6)		1		904	909
	25	N1415295-DIAG-CODE-ICD-9						
					8		910	957
	30	N1415216-DIAG-CODE-ICD-9						
			PIC X(6)	C			910	915
15	N1415293-PROCEDURE-DATA.							
	20	N1415214-PROC-STERIL-IND						
			PIC X	C	1		958	958
	20	N1415214-PROC-ABORT-IND						
			PIC X	C	1		959	959
	20	N1415214-PROC-FAM-PLAN-IND						
			PIC X	C	1		960	960
	20	N1415214-PROC-HYSTER-IND						
			PIC X	C	1		961	961
	20	N1415294-PROCEDURE-DATA.						
	25	N1415216-PRINC-PROC-CODE						
			PIC X(5)	C			962	966
	25	N1415236-PRINC-DATE-OF-SURGERY						
			PIC S9(5)	P			967	969
	25	N1415295-PROCEDURE-DATA				5	970	1009
	30	N1415216-PROC-CODE						
			PIC X(5)	C			970	974
	30	N1415236-DATE-OF-SURGERY						
			PIC S9(5)	P			975	977
15	N1415293-PSRO-DATA.							
	20	N1415214-PSRO-CODE						
			PIC X	Z	1		1010	1010
	20	N1415234-CERT-BEGIN-DATE						
			PIC S9(5)	P	1		1011	1013
	20	N1415234-CERT-END-DATE						
			PIC S9(5)	P	1		1014	1016
15	N1415293-DRG-DATA.							
	20	N1415224-PERCENT-OF-PAYMENT						
			PIC 9V99	Z	1		1017	1019
	20	N1415224-DRG-CODE						
			PIC 9(3)	Z	1		1020	1022
	20	N1415294-DRG-PEER-GROUP.						
	25	N1415215-DRG-PEER-GROUP-NUM						
			PIC X(2)	C	1		1023	1024
	25	N1415215-DRG-PEER-GROUP-ALP						
			PIC X	C	1		1025	1025
	20	N1415234-DRG-OUTLIER-DAYS						
			PIC S9(3)	P	1		1026	1027
	20	N1415234-DRG-OUTLIER-AMOUNT						
			PIC S9(7)V99	P	1		1028	1032
	20	N1415234-DRG-AMOUNT						
			PIC S9(7)V99	P	1		1033	1037
	20	N1415214-DRG-PAY-TYPE						
			PIC XX	C	1		1038	1039
	20	N1415214-MDC-CODE						
			PIC XX	C	1		1040	1041
	20	N1415294-DRG-PROCEDURE-DATA.						
	25	N1415295-PROCEDURE-CHARACTER				6	1042	1047
	30	N1415216-PROCEDURE-CHARACTER						
			PIC X	C			1042	1042
10	N1415292-EXPAND-AREA.							
15	N1415293-EXPAND-AREA.							
							-----LENGTH-	
	20	N1415294-EXPAND-AREA					D 25	11
	25	N1415215-EXPAND-AREA-ID-CODE						1
	25	FILLER						10
			PIC X(10)	C				
10	N1415292-CURRENT-EXCEPTION.							
15	N1415293-CURRENT-EXCEPTION.							
	20	N1415294-CURRENT-EXCEPTION					D 75	7
	25	N1415235-EXCEPTION-CODE						2
	25	N1415215-LINE-ITEM-CODE						2
	25	N1415215-EXCEPTION-STATUS						1
	25	N1415235-CLERK-IDENTIFICATION						2
10	N1415292-COMMITTED-EXCEPTION.							
15	N1415293-COMMITTED-EXCEPTION.							
	20	N1415294-COMMITTED-EXCEPTION					D 25	4

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	25	N1415235-EXCEPTION-CODE	PIC 9(3)	P		2
	25	N1415215-LINE-ITEM-CODE	PIC X(2)	C	2	
10		N1415292-RECIP-TPL-DTL-DATA.				
	15	N1415293-RECIP-TPL-DTL-DATA		D	3	55
	20	N1415234-CARRIER-ID	PIC 9(5)	P		3
	20	N1415214-POLICY-NUMBER	PIC X(15)	C		15
	20	N1415214-TPL-GROUP-NUMBER	PIC X(12)	C		12
	20	N1415214-POLICY-HOLDER-NAME	PIC X(26)	C		26
10		N1415292-MISC-PROVIDERS.				
	15	1415293-MISC-PROVIDERS		D	7	5
	20	N1415214-MISC-PROV-IND	PIC X(1)	C		1
	20	N1415234-MISC-PROV-NUMBER	PIC 9(7)	P		4
10		N1415292-CLM-DETAIL.				
	15	N1415293-LINE-ITEM		D	450	68
	20	N1415214-LINE-ITEM-CODE	PIC 9(3)	P		2
	20	N1415234-FIRST-DATE-OF-SVC	PIC S9(5)	P		3
	20	N1415214-PROC-CODE	PIC X(5)	C		5
	20	N1415214-PROC-CODE-MODIFIER-1	PIC X(2)	C		2
	20	N1415214-PROC-CODE-MODIFIER-2	PIC X(2)	C		2
	20	N1415214-REVENUE-CODE	PIC X(3)	C		3
	20	N1415234-UNITS-OF-SERVICE	PIC S9(5)	P		3
	20	N1415234-ROOM-RATE	PIC S9(5)V99	P		4
	20	N1415234-LI-SUBMITTED-CHARGE	PIC S9(7)V99	P		5
	20	N1415234-NON-COVERED-CHARGE	PIC S9(7)V99	P		5
	20	N1415244-ALLOWED-CHARGE	PIC S9(7)V99	P		5
	20	N1415214-ALLOWED-CHRG-SOURCE	PIC X(1)	C		1
	20	N1415234-OVERRIDE-EXCEP-CODE	PIC 9(3)	P		2
	20	N1415294-EOB-CODE.				
	25	N1415295-EOB-CODE			2	
	30	N1415236-EOB-CODE	PIC 9(3)	P		2
	20	N1415294-SPECIAL-INDICATOR.				
	25	N1415295-SPECIAL-INDICATOR			2	
	30	N1415216-SPECIAL-INDICATOR	PIC X(1)			1
	20	FILLER	PIC X(20)			
-----END INSTITUTIONAL RECORD-----						
01		W1415400-PHARMACY-CLAIM . . . . . CLASS	OC	FROM	TO	
10		W1415492-CLM-HEADER-COMMON (SAME AS INSTITUTIONAL)		1	319	
10		W1415492-CLM-HEADER-VARIABLE.				
	15	W1415433-DATE-PRESCRIBED	PIC S9(5)	P	1	320 322
	15	W1415413-DIAG-CODE-ICD-9	PIC X(6)	C	1	323 328
	15	W1415433-PRESC-PHYS-PROV-NUM	PIC 9(7)	P	1	329 332
	15	W1415413-DRUG-CODE	PIC X(10)	C	1	333 342
	15	W1415413-DRUG-THERA-CLASS	PIC X(3)	C	1	343 345
	15	W1415413-REFILL-INDICATOR	PIC X	C	1	346 346
	15	W1415433-NO-REFILLS-ALLOWED	PIC S9(3)	P	1	347 348
	15	W1415433-SUBMITTED-UNITS	PIC S9(5)	P	1	349 351
	15	W1415433-DRUG-QUANTITY	PIC S9(5)	P	1	352 354
	15	W1415413-PRIOR-AUTH-LINE-NO	PIC X	C	1	355 355
	15	W1415433-ALLOWED-CHARGE	PIC S9(5)V99	P	1	356 359
	15	W1415413-ALLOWED-CHRG-SOURCE	PIC X	C	1	360 360
10		W1415492-EXPAND-AREA.				
	15	W1415493-EXPAND-AREA			-----LENGTH-	
	20	W1415494-EXPAND-AREA		D	25	
	25	W1415415-EXPAND-AREA-ID-CODE	PIC X	C		1
	25	FILLER	PIC X(10)	C		10
10		W1415492-CURRENT-EXCEPTION.				
	15	W1415493-CURRENT-EXCEPTION.				
	20	W1415494-CURRENT-EXCEPTION		D	25	
	25	W1415435-EXCEPTION-CODE	PIC 9(3)	P		2
	25	W1415415-LINE-ITEM-CODE	PIC XX	C		2
	25	W1415415-EXCEPTION-STATUS	PIC X	C		1
	25	W1415435-CLERK-IDENTIFICATION	PIC 9(3)	P		2

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10	W1415492-COMMITTED-EXCEPTION.							
15	W1415493-COMMITTED-EXCEPTION.							
20	W1415494-COMMITTED-EXCEPTION		D	25				
25	W1415435-EXCEPTION-CODE	PIC 9(3)	P				2	
25	W1415415-LINE-ITEM-CODE	PIC XX	C				2	
10	W1415492-RECIP-TPL-DTL-DATA.							
15	W1415493-RECIP-TPL-DTL-DATA		D	3				
20	W1415434-CARRIER-ID	PIC 9(5)	P				3	
20	W1415414-POLICY-NUMBER	PIC X(15)	C				15	
20	W1415414-TPL-GROUP-NUMBER	PIC X(12)	C				12	
20	W1415414-POLICY-HOLDER-NAME	PIC X(26)	C				26	
10	W1415492-MISC-PROVIDERS.							
15	W1415493-MISC-PROVIDERS		D	7				
20	W1415414-MISC-PROV-IND	PIC X	C				1	
20	W1415434-MISC-PROV-NUMBER	PIC 9(7)	P				4	
-----END PHARMACY RECORD-----								
01	W1415500-MEDICAL-CLAIM . . . . . CLASS		OC	FROM	TO			
10	W1415592-CLM-HEADER-COMMON	(SAME AS INSTITUTIONAL)		1	319			
10	W1415592-CLM-HEADER-VARIABLE.							
15	W1415513-EPSDT-IND	PIC X	C	1	320	320		
15	W1415593-DIAGNOSIS-DATA.							
20	W1415514-DIAG-STERL-IND	PIC X	C	1	321	321		
20	W1415514-DIAG-ABORT-IND	PIC X	C	1	322	322		
20	W1415514-DIAG-FAM-PLAN-IND	PIC X	C	1	323	323		
20	W1415594-DIAG-CODE-ICD-9.							
25	W1415595-DIAG-CODE-ICD-9.							
30	W1415516-DIAG-CODE-ICD-9	PIC X(6)	C	2	324	335		
20	W1415594-EPSDT-HEADER-DATA							
	REDEFINES W1415594-DIAG-CODE-ICD-9.							
25	W1415515-IMMUNIZATION-IND	PIC X	C	1	324	324		
25	W1415515-SICKLE-CELL-IND	PIC X	C	1	325	325		
25	W1415515-COMMUN-DISEASE-IND	PIC X	C	1	326	326		
25	W1415515-DENTAL-REFERRAL-IND	PIC X	C	1	327	327		
25	FILLER	PIC X(8)	C	1	328	335		
15	W1415533-CONSENT-DATE	PIC S9(5)	P	1	336	338		
15	W1415533-REFERRING-PROV-NUM	PIC 9(7)	P	1	339	342		
15	W1415513-FAMILY-PLANNING-CODE	PIC X	C	1	343	343		
15	W1415593-MCARE-PART-B-DATA.							
20	W1415534-MCARE-APPROVED-AMT	PIC S9(7)V99	P	1	344	348		
20	W1415534-MCARE-DEDUCTIBLE-AMT	PIC S9(5)V99	P	1	349	352		
20	W1415534-MCARE-COINS-AMT	PIC S9(5)V99	P	1	353	356		
20	W1415534-DATE-PAID-BY-MCARE	PIC S9(5)	P	1	357	359		
10	W1415592-EXPAND-AREA.							
15	W1415593-EXPAND-AREA							
20	W1415594-EXPAND-AREA		D	25				
25	W1415515-EXPAND-AREA-ID-CODE	PIC X	C				1	
25	FILLER	PIC X(10)	C				10	
10	W1415592-CURRENT-EXCEPTION.							
15	W1415593-CURRENT-EXCEPTION.							
20	W1415594-CURRENT-EXCEPTION		D	25				
25	W1415535-EXCEPTION-CODE	PIC 9(3)	P				2	
25	W1415515-LINE-ITEM-CODE	PIC XX	C				2	
25	W1415515-EXCEPTION-STATUS	PIC X	C				1	
25	W1415535-CLERK-IDENTIFICATION	PIC 999	P				2	
10	W1415592-COMMITTED-EXCEPTION.							
15	W1415593-COMMITTED-EXCEPTION.							
20	W1415594-COMMITTED-EXCEPTION		D	25				
25	W1415535-EXCEPTION-CODE	PIC 9(3)	P				2	
25	W1415515-LINE-ITEM-CODE	PIC XX	C				2	
10	W1415592-RECIP-TPL-DTL-DATA.							
15	W1415593-RECIP-TPL-DTL-DATA		D	3				
20	W1415534-CARRIER-ID	PIC 9(5)	P				3	

MITS: Data Conversion requirements

	20	W1415514-POLICY-NUMBER	PIC X(15)	C		15
	20	W1415514-TPL-GROUP-NUMBER	PIC X(12)	C		12
	20	W1415514-POLICY-HOLDER-NAME	PIC X(26)	C		26
01	W1415500-MEDICAL-CLAIM (cont'd)			CLASS	OC FROM	TO
10	W1415592-MISC-PROVIDERS.					
	15	W1415593-MISC-PROVIDERS		D	7	
	20	W1415514-MISC-PROV-IND	PIC X	C		1
	20	W1415534-MISC-PROV-NUMBER	PIC 9(7)	P		4
10	W1415592-CLM-DETAIL.					
	15	W1415593-LINE-ITEM		D	21	
	20	W1415514-LINE-ITEM-CODE	PIC XX	C		2
	20	W1415514-PLACE-OF-SERVICE	PIC XX	C		2
	20	W1415534-FIRST-DATE-OF-SVC	PIC S9(5)	P		3
	20	W1415594-PROCEDURE-DATA.				
	25	W1415515-TYPE-OF-SERVICE	PIC X	C		1
	25	W1415515-PROC-CODE	PIC X(5)	C		5
	25	W1415515-PROC-CODE-MODIFIER	PIC XX	C		2
	25	W1415515-PROC-STERIL-IND	PIC X	C		1
	25	W1415515-PROC-ABORT-IND	PIC X	C		1
	25	W1415515-PROC-FAM-PLAN-IND	PIC X	C		1
	25	W1415515-PROC-HYSTER-IND	PIC X	C		1
	25	W1415515-LIFETIME-SERVICE-IND	PIC X	C		1
	25	W1415515-DUP-CHECK-IND	PIC X	C		1
	20	W1415594-EPSDT-LINE-DATA.				
	25	W1415515-DIAG-CODE-ICD-9	PIC X(6)	C		6
	25	W1415515-DIAGNOSTIC-STATUS	PIC X	C		1
	25	W1415515-FOLLOW-UP-CODE	PIC X	C		1
	25	W1415515-NO-FOLLOW-UP-CODE	PIC X	C		1
	20	W1415594-TOOTH-DATA				
		REDEFINES W1415594-EPSDT-LINE-DATA.				
	25	W1415515-TOOTH-NUMBER	PIC XX	C		2
	25	W1415595-TOOTH-SURFACE.				
	30	W1415596-TOOTH-SURFACE			6	
	35	W1415517-TOOTH-SURFACE	PIC X	C		1
	25	W1415515-PRESCRIPTION-NUMBER				
		REDEFINES W1415595-TOOTH-SURFACE				
			PIC X(6)	C		6
	25	FILLER	PIC X	C		1
	20	W1415534-FOLLOW-UP-DATE-LIMIT	PIC S9(5)	P		3
	20	W1415534-SUBMITTED-UNITS	PIC S9(5)	P		3
	20	W1415534-UNITS-OF-SERVICE	PIC S9(5)	P		3
	20	W1415514-PRIOR-AUTH-LINE-NO	PIC X	C		1
	20	W1415534-PROCEDURE-CHARGE	PIC S9(5)V99	P		4
	20	W1415534-ALLOWED-CHARGE	PIC S9(5)V99	P		4
	20	W1415514-ALLOWED-CHRG-SOURCE	PIC X	C		1
	20	W1415594-EOB-CODE.				
	25	W1415535-EOB-CODE	PIC 9(3)	P	2	2
	20	W1415534-OVERRIDE-EXCEP-CODE	PIC 9(3)	P		2
	20	W1415514-PROC-MULT-SURG-IND	PIC X	C		1
	20	W1415594-SPECIAL-INDICATOR.				
	25	W1415515-SPECIAL-INDICATOR	PIC X	C		1
-----END MEDICAL RECORD-----						
01	W1416100-CREDIT-ADJUSTMENT.			CLASS	OC FROM	TO
10	W1416192-CLM-HEADER-COMMON (SAME AS INSTITUTIONAL)				1 319	
10	W1416192-EXPAND-AREA.					
	15	W1416193-EXPAND-AREA			-----LENGTH-	
	20	W1416194-EXPAND-ARE		D	25	
	25	W1416115-EXPAND-AREA-ID-CODE	PIC X	C		1
	25	FILLER	PIC X(10)	C		10
10	W1416192-CURRENT-EXCEPTION.					
15	W1416193-CURRENT-EXCEPTION.					

MITS: Data Conversion requirements

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20 W1416194-CURRENT-EXCEPTION          D      25
25 W1416135-EXCEPTION-CODE      PIC 9(3)  P      2
25 W1416115-LINE-ITEM-CODE      PIC X(2)  C      2
25 W1416115-EXCEPTION-STATUS    PIC X      C      1
25 W1416135-CLERK-IDENTIFICATION PIC 999  P      2

10 W1416192-COMMITTED-EXCEPTION.
15 W1416193-COMMITTED-EXCEPTION.
20 W1416194-COMMITTED-EXCEPTION          D      25
25 W1416135-EXCEPTION-CODE      PIC 9(3)  P      2
25 W1416115-LINE-ITEM-CODE      PIC X(2)  C      2

10 W1416192-RECIP-TPL-DTL-DATA.
15 W1416193-RECIP-TPL-DTL-DATA          D      3
20 W1416134-CARRIER-ID          PIC 9(5)  P      3
20 W1416114-POLICY-NUMBER        PIC X(15) C     15
20 W1416114-TPL-GROUP-NUMBER     PIC X(12) C     12
20 W1416114-POLICY-HOLDER-NAME   PIC X(26) C     26

10 W1416192-MISC-PROVIDERS.
15 W1416193-MISC-PROVIDERS          D      7
20 W1416114-MISC-PROV-IND        PIC X      C      1
20 W1416134-MISC-PROV-NUMBER     PIC 9(7)  P      4
-----END CREDIT RECORD-----

```

## Recipient

### Contents/ Comments :

```

RECIPIENT   WORK   AREA

VSAM
-----
3DSN: WELF.CMMIS.R1000IA.DATA          3DDNAME:  R1000IA  3
-----3
3ALT. 1: WELF.CMMIS.R1000IC.PATH      3DDNAME:  R1000IA1 3
-----3
3ALT. 2: WELF.CMMIS.R1000ID.PATH      3DDNAME:  R1000IA2 3
-----3
3ALOC SPACE: 554,554 Cyl              3
-----3
3I/O MODULE: BOI1000A  3PACK:          3DEL/DEF JOB: RR1000IA/C 3
-----3
3FD: N1100000  3 Length: 11761  3 Blk: 32K  3 Mode: VB  3
-----3

QSAM
-----
3DSN: WELF.PMMIS.R1000IA.TAPE(GDG)    3DDNAME:  R1000SA  3
-----3
3I/O MODULE: BOI1001A  3GD Limit: 54  3RETPD: 30  3
-----3
3W/S COPY: W1190000  3
-----3

```

The records have a fixed area and up to fifteen (15) variable areas:

Fixed portion	1-736
Eligibility Spans	60 737-3856
HMO Spans	24 3857-5032
ECM Spans	5 5033-5192
WAIVER Spans	24 5193-5912
SVC UCAP spans	24 5913-6608
PARTA Spans	12 6609-6992

PARTB Spans	12	6993-7376
PARTC Spans	12	7377-7736
PARTD Spans	20	7737-8456
NH Spans	36	8457-10544
LOC Spans	24	10545-10856
PACT Spans	24	10857-11288
TPL Spans	3	11289-11369
COPAY Spans	12	11370-11561
HOSPICE Spans	5	11562-11761

**Layout :**

```

        BLOCK CONTAINS      0
        LABEL RECORDS ARE STANDARD
        DATA RECORDS ARE
            N1200000-PROVIDER-MASTER-REC
            N1299900-PROV-TOTAL-REC.

01  N1200000-PROVIDER-MASTER-REC.
03  N1200000-FIXED-PORTION.
05  N1200011-RECORD-CODE
                                     PIC X(2).
05  N1200091-RECORD-KEY.
    10 N1200022-PROV-NUMBER
                                     PIC 9(07).
05  N1200011-PROV-NAME
                                     PIC X(31).
05  N1200011-PROV-SORT-NAME
                                     PIC X(31).
05  N1200011-PROV-COUNTY-CODE
                                     PIC X(02).
05  N1200011-OUT-OF-STATE-PROV-CD
                                     PIC X(1).
05  N1200031-PROV-APPL-DATE
        USAGE IS COMP-3
                                     PIC S9(05).
05  N1200031-DATE-OF-LAST-TRANS
        USAGE IS COMP-3
                                     PIC S9(05).
05  N1200031-CLERK-IDENTIFICATION
        USAGE IS COMP-3
                                     PIC 9(3).
05  N1200011-PROV-SSN-IRS-NUM-IND
                                     PIC X(1).
05  N1200011-PROV-EMPLR-IDENT-NUM
                                     PIC X(10).
05  N1200091-PROV-SS-NUM
        REDEFINES N1200011-PROV-EMPLR-IDENT-NUM.
    10 N1200012-PROV-SS-NUM
                                     PIC X(9).
    10 FILLER
                                     PIC X(001).
05  N1200031-TRANSFER-OF-FUNDS-IND
                                     PIC X(1).
05  N1200031-LIEN-HOLDER-PROV-NUM
        USAGE IS COMP-3
                                     PIC 9(07).
05  N1200031-LIEN-AMOUNT
        USAGE IS COMP-3
                                     PIC S9(08)V9(02).
05  N1200031-ORIGINAL-LIEN-AMT
        USAGE IS COMP-3
                                     PIC S9(7)V99.
05  N1200031-LIEN-INCREASE-AMT
        USAGE IS COMP-3
                                     PIC S9(5)V99.
05  N1200031-LIEN-DECREASE-AMT
    
```

8928602  
8928602

MITS: Data Conversion requirements

	USAGE IS COMP-3	
	PIC S9(5)V99.	
05	N1200031-ACCUM-LIEN-AMT	
	USAGE IS COMP-3	
	PIC S9(8)V99.	
05	N1200031-LIEN-MAX-CHK-DED-AMT	
	USAGE IS COMP-3	
	PIC S9(8)V99.	
05	N1200031-LIEN-MAX-CHK-DED-PCT	
	USAGE IS COMP-3	
	PIC S9V99.	
05	N1200011-LIEN-ZERO-DEL-IND	
	PIC X(1).	
05	N1200031-PREV-PROV-NUMBER	
	USAGE IS COMP-3	
	PIC 9(07).	
05	N1200031-NEW-PROV-NUMBER	
	USAGE IS COMP-3	
	PIC 9(07).	
05	N1200011-PROV-TYPE	
	PIC X(02).	
05	N1200011-PROV-TYPE-PRAC-ORGAN	
	PIC X(01).	
05	N1200011-PROV-LICENSE-NUM	
	PIC X(09).	
05	N1200011-PROV-LIC-BOARD-CODE	
	PIC X(1).	
05	N1200031-PROV-LICENSE-DATE	
	USAGE IS COMP-3	
	PIC S9(05).	
05	N1200011-NH-ADM-NAME	
	PIC X(28).	
05	N1200011-NH-ADM-CERTIFICATION	
	PIC X(09).	
05	N1200031-NH-ADM-RECERT-DATE	
	USAGE IS COMP-3	
	PIC S9(5).	
05	N1200031-NH-PROV-AGR-EXT-DATE	
	REDEFINES N1200031-NH-ADM-RECERT-DATE	
	USAGE IS COMP-3	
	PIC 9(5).	
05	N1200011-DEA-NUMBER	
	PIC X(9).	
05	N1200031-PROV-YEAR-END-DATE	
	USAGE IS COMP-3	
	PIC S9(04).	
05	N1200031-PROV-RECERT-DATE	
	USAGE IS COMP-3	
	PIC S9(05).	
05	N1200091-PROV-SPECIALTY-DATA	
	OCCURS 0002 TIMES	
	INDEXED BY NX1200091-PROV-SPECIALTY-DATA.	
10	N1200032-PROV-SPEC-CERT-DATE	
	USAGE IS COMP-3	
	PIC S9(05).	
10	N1200012-PROV-SPEC-CODE	
	PIC X(02).	
05	N1200031-PROV-TELE-NUM	
	USAGE IS COMP-3	
	PIC 9(10).	
05	N1200011-CTL-MED-FACILITY.	8928602
10	N1200011-1ST-BYTE	8928602
	PIC X(1).	8928602
10	N1200011-2ND-BYTE	8928602
	PIC X(1).	8928602
10	N1200011-3RD-BYTE	8928602
	PIC X(1).	8928602
05	N1200011-ALT-PRACT-LOC	
	PIC X(1).	
05	N1200091-PROV-REMIT-MEDIA.	
10	N1200012-PROV-REMIT-MEDIA	

MITS: Data Conversion requirements

		PIC X(1).
10	N1200012-PROV-REMIT-TYPE	PIC X(1).
		PIC X(1).
10	N1200012-PROV-REMIT-SEQ	PIC X(1).
		PIC X(1).
05	N1200011-PROV-CORRESP-MEDIA	PIC X(1).
		PIC X(1).
05	N1200011-TAPE-BILL-IND	PIC X(1).
		PIC X(1).
05	N1200011-PROV-SPLIT-BILL-IND	PIC X(1).
		PIC X(1).
05	N1200011-PROV-PUBLISH-IND	PIC X(01).
		PIC X(01).
05	N1200011-INTM-TAPE-RECFM	PIC X(1).
		PIC X(1).
05	N1200011-INTM-TAPE-BPI	PIC X(1).
		PIC X(1).
05	N1200091-PHARM-DISP-FEE-TYPE	OCCURS 0002 TIMES
		INDEXED BY NX1200091-PHARM-DISP-FEE-TYPE.
10	N1200012-PHARM-DISP-FEE-TYPE	PIC X(01).
		PIC X(01).
10	N1200032-PHRM-DISP-FEE-EFF-DT	USAGE IS COMP-3
		PIC S9(05).
10	N1200032-DRUG-DISPENSING-FEE	USAGE IS COMP-3
		PIC S9(3)V99.
05	N1200031-NUM-CAT-SVC-DATA	USAGE IS COMP-3
		PIC S9(03).
05	N1200031-PROV-ENROL-PERIODS	USAGE IS COMP-3
		PIC S9(01).
05	N1200031-PROV-CHARGE-DATA-CTR	USAGE IS COMP-3
		PIC S9(03).
05	N1200031-NUM-HOLD-REVIEW-DATA	USAGE IS COMP-3
		PIC S9(03).
05	N1200031-PROV-BED-DATA-CTR	USAGE IS COMP-3
		PIC S9(01).
05	N1200031-NUM-CLASSIF-CODES	USAGE IS COMP-3
		PIC S9(03).
05	N1200031-NUM-INTERMED-MEMBERS	USAGE IS COMP-3
		PIC S9(05).
05	N1200031-NUM-INTERMED-GROUPS	USAGE IS COMP-3
		PIC S9(05).
05	N1200031-NUM-PROV-GROUPS	USAGE IS COMP-3
		PIC S9(03).
05	N1200031-NUM-PROV-IN-GROUP	USAGE IS COMP-3
		PIC S9(05).
05	N1200031-NUM-RECOUPMENTS	USAGE IS COMP-3
		PIC S9(1).
05	N1200011-NUM-PROV-ADDRESS	PIC 9(1).
		PIC 9(1).
05	N1200091-PROV-ADDRESS.	
10	N1200092-PROV-ADDRESS	OCCURS 0003 TIMES
		INDEXED BY NX1200092-PROV-ADDRESS.
15	N1200013-PROV-ADDR-LINE-1	PIC X(28).
		PIC X(28).
15	N1200013-PROV-ADDR-LINE-2	PIC X(28).
		PIC X(28).

MITS: Data Conversion requirements

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15 N1200013-PROV-CITY
PIC X(18).
15 N1200013-PROV-STATE
PIC X(02).
15 N1200033-PROV-ZIP-CODE
USAGE IS COMP-3
PIC 9(9).
03 N1200000-VARIABLE-PORZION.
05 N1200091-PROV-CAT-SVC-DATA.
10 N1200092-PROV-CAT-SVC-DATA
OCCURS 0 TO 10 TIMES
DEPENDING ON W1200031-NUM-CAT-SVC-DATA
INDEXED BY NX1200092-PROV-CAT-SVC-DATA.
15 N1200033-PROV-BEGIN-SVC-DATE
USAGE IS COMP-3
PIC S9(05).
15 N1200033-PROV-END-SVC-DATE
USAGE IS COMP-3
PIC S9(05).
15 N1200013-PROV-CAT-OF-SVC-CODE
OCCURS 0008 TIMES
INDEXED BY NX1200013-PROV-CAT-OF-SVC-CODE
PIC X(02).
05 N1200091-PROV-ENROL-STAT-CD.
10 N1200092-PROV-ENROL-STAT-CD
OCCURS 0 TO 3 TIMES
DEPENDING ON W1200031-PROV-ENROL-PERIODS
INDEXED BY NX1200092-PROV-ENROL-STAT-CD.
15 N1200013-PROV-ENROL-STAT-CD
PIC X(1).
15 N1200033-PROV-ENROL-STAT-DATE
USAGE IS COMP-3
PIC S9(05).
05 N1200091-PROV-CHARGE-DATA.
10 N1200092-PROV-CHARGE-DATA
OCCURS 0 TO 32 TIMES
DEPENDING ON W1200031-PROV-CHARGE-DATA-CTR
INDEXED BY NX1200092-PROV-CHARGE-DATA.
15 N1200033-PROV-RATE-EFF-DATE
USAGE IS COMP-3
PIC S9(05).
15 N1200013-PROV-CHARGE-MODE
PIC X(1).
15 N1200033-PROV-CHARGE-FACTOR
USAGE IS COMP-3
PIC S9(03)V9(02).
15 N1200053-PROV-CHARGE-FACTOR
REDEFINES N1200033-PROV-CHARGE-FACTOR
USAGE IS COMP-3
PIC S9(02)V9(03).
15 N1200073-PROV-CHARGE-FACTOR
REDEFINES N1200053-PROV-CHARGE-FACTOR
USAGE IS COMP-3
PIC S9(05).
05 N1200091-HOLD-REVIEW-DATA.
10 N1200092-HOLD-REVIEW-DATA
OCCURS 0 TO 6 TIMES
DEPENDING ON W1200031-NUM-HOLD-REVIEW-DATA
INDEXED BY NX1200092-HOLD-REVIEW-DATA.
15 N1200013-PROV-EXCEP-INDIC
PIC X(02).
15 N1200093-HOLD-REVIEW-RANGE.
20 N1200014-HOLD-REVIEW-RNG-TYPE
PIC X(1).
20 N1200014-HOLD-REVIEW-RNG-LOW
PIC X(6).
20 N1200014-HOLD-REVIEW-RNG-HIGH
PIC X(6).
15 N1200033-HOLD-REVIEW-BGN-DATE
USAGE IS COMP-3
PIC S9(05).

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MITS: Data Conversion requirements

```
15 N1200033-HOLD-REVIEW-END-DATE
    USAGE IS COMP-3
    PIC S9(05).
05 N1200091-PROV-NUM-OF-BEDS.
10 N1200092-PROV-NUM-OF-BEDS
    OCCURS 0 TO 2 TIMES
    DEPENDING ON W1200031-PROV-BED-DATA-CTR
    INDEXED BY NX1200092-PROV-NUM-OF-BEDS.
15 N1200033-PROV-BED-EFFECT-DATE
    USAGE IS COMP-3
    PIC S9(05).
15 N1200033-NUM-BEDS-TOTAL
    USAGE IS COMP-3
    PIC S9(05).
15 N1200033-NUM-BEDS-INTER
    USAGE IS COMP-3
    PIC S9(05).
15 N1200033-NUM-BEDS-MR
    USAGE IS COMP-3
    PIC S9(05).
15 N1200033-NUM-BEDS-SKILLED
    USAGE IS COMP-3
    PIC S9(05).
15 N1200033-NUM-BEDS-OTHER
    USAGE IS COMP-3
    PIC S9(05).
15 N1200033-NUM-BEDS-INPATIENT
    USAGE IS COMP-3
    PIC S9(05).
05 N1200091-PROV-CLASSIF-DATA.
10 N1200092-PROV-CLASSIF-DATA
    OCCURS 0 TO 50 TIMES
    DEPENDING ON W1200031-NUM-CLASSIF-CODES
    INDEXED BY NX1200092-PROV-CLASSIF-DATA.
15 N1200033-PROV-CLASSIF-BEG-DT
    USAGE IS COMP-3
    PIC S9(05).
15 N1200033-PROV-CLASSIF-END-DT
    USAGE IS COMP-3
    PIC S9(05).
15 N1200013-PROV-CLASSIF-CD
    PIC X(3).
05 N1200091-INTERMED-PROV-NUM.
10 N1200092-INTERMED-PROV-NUM
    OCCURS 0 TO 6 TIMES
    DEPENDING ON W1200031-NUM-INTERMED-GROUPS
    INDEXED BY NX1200092-INTERMED-PROV-NUM.
15 N1200033-INTERMED-PROV-NUM
    USAGE IS COMP-3
    PIC 9(07).
05 N1200091-PROV-GROUP.
10 N1200092-PROV-GROUP
    OCCURS 0 TO 10 TIMES
    DEPENDING ON W1200031-NUM-PROV-GROUPS
    INDEXED BY NX1200092-PROV-GROUP.
15 N1200033-PROV-GROUP
    USAGE IS COMP-3
    PIC 9(07).
05 N1200091-RECOUPMENT-DATA.
10 N1200092-RECOUP-DATA-TABLE
    OCCURS 0 TO 5 TIMES
    DEPENDING ON W1200031-NUM-RECOUPMENTS
    INDEXED BY NX1200092-RECOUP-DATA-TABLE.
15 N1200033-CREDIT-BAL-AMT
    USAGE IS COMP-3
    PIC S9(08)V9(02).
15 N1200033-MAX-CHK-BAL-DED-AMT
    USAGE IS COMP-3
    PIC S9(8)V99.
15 N1200033-MAX-CHK-BAL-DED-PCT
    USAGE IS COMP-3
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MIT: Data Conversion requirements

			PIC S9V99.	
	15	N1200013-ADJUSTMENT-REASON	PIC X(2).	
	15	N1200093-PROV-CAT-OF-SVC-CODE		
	20	N1200014-PROV-CAT-OF-SVC-CODE	PIC X(02).	
	15	N1200033-ORIGINAL-RECOUP-AMT		
		USAGE IS COMP-3		
			PIC S9(7)V99.	
	15	N1200033-ACCUM-RECOUP-AMT		
		USAGE IS COMP-3		
			PIC S9(8)V99.	
	15	N1200033-RECOUP-INCREASE-AMT		
		USAGE IS COMP-3		
			PIC S9(5)V99.	
	15	N1200033-RECOUP-DECREASE-AMT		
		USAGE IS COMP-3		
			PIC S9(5)V99.	
	15	N1200033-RECOUP-BEGIN-DT-SVC		
		USAGE IS COMP-3		
			PIC S9(5).	
	15	N1200033-RECOUP-END-DT-SVC		
		USAGE IS COMP-3		
			PIC S9(5).	
	15	N1200013-RECOUP-ZERO-DEL-IND		
			PIC X(1).	
01		N1299900-PROV-TOTAL-REC.		
	05	N1299911-RECORD-CODE		
			PIC X(2).	
	05	N1299991-RECORD-KEY.		
	10	FILLER		
			PIC X(007).	
	05	N1299931-DATE-OF-LAST-TRANS		
		USAGE IS COMP-3		
			PIC S9(05).	
	05	N1299931-BATCH-DATE		
		USAGE IS COMP-3		
			PIC 9(5).	
	05	N1299931-RECORD-COUNT		
		USAGE IS COMP-3		
			PIC 9(7).	
	05	N1299931-NUM-OF-TOTAL-ENTRIES		
		USAGE IS COMP-3		
			PIC S9(3).	
	05	N1299991-TOTAL-COUNT-DATA		
*		OCCURS 0064 TIMES		
		OCCURS 0075 TIMES		8926802
		INDEXED BY NX1299991-TOTAL-COUNT-DATA.		
	10	N1299932-TOTAL-MONTH-BEGIN		
		USAGE IS COMP-3		
			PIC S9(7).	
	10	N1299932-TOTAL-MTHLY-ADDS		
		USAGE IS COMP-3		
			PIC S9(7).	
	10	N1299932-TOTAL-MTHLY-CHANGES		
		USAGE IS COMP-3		
			PIC S9(7).	
	10	N1299932-TOTAL-MTHLY-TERM		
		USAGE IS COMP-3		
			PIC S9(7).	
	10	N1299932-TOTAL-DAILY-ADDS		
		USAGE IS COMP-3		
			PIC S9(7).	
	10	N1299932-TOTAL-DAILY-CHANGES		
		USAGE IS COMP-3		
			PIC S9(7).	
	10	N1299932-TOTAL-DAILY-TERM		
		USAGE IS COMP-3		
			PIC S9(7).	
	10	N1299932-TOTAL-DAILY-DELETES		
		USAGE IS COMP-3		

```

PIC S9(7).
10 N1299932-TOTAL-DAILY-BEGIN
    USAGE IS COMP-3
PIC S9(7).
10 N1299932-CURRENT-OHIO
    USAGE IS COMP-3
PIC S9(7).
10 N1299932-CURRENT-OHIO-FIVE
    USAGE IS COMP-3
PIC S9(7).
10 N1299932-CURRENT-OUT-OF-STATE
    USAGE IS COMP-3
PIC S9(7).
01 NDUMMY-PROVIDER-MASTER-REC PIC X(3621).
    
```

## Provider File

### Contents/ Comments :

```

PROVIDER MASTER WORK AREA
VSAM
-----
3DSN: WELF.CMMIS.P2000IA.DATA 3DDNAME: P2000IA 3
3-----3
3Alt. WELF.CMMIS.P2000IB.DATA 3DDNAME: P2000IB 3
3-----3
3Alt. WELF.CMMIS.P2000IC.DATA 3DDNAME: P2000IC 3
3-----3
3Aloc Space: 140,20 Cyl 3File-Aid Map: PROVF 3
3-----3
3I/O Module: BOI2000A 3Pack: WELF94 3Del/Def Job: RP2000IA-C 3
3-----3
3FD: N2200000 3 Mode: VB 3 Length: 3621 3Blk: 7250 3
3-----3
    
```

```

QSAM
-----
3DSN: WELF.PMMIS.P2000IA.TAPE 3DDNAME: P2000SA 3
3-----3
3I/O Module: BOI2000A 3GDG Limit: 14 3Retpd: 30days 3
3-----3
3W/S Copy: W1200000 3
3-----3
    
```

The records have a fixed common area and nine (9) variable areas.

	Max. Occurs	
Common Fixed Area.....	521	CHARS
Variable Areas.....		
Service Categories	10	22-220 chars
Enroll Status	3	4- 12 chars
Charge Data	32	0-224 chars
Hold Review Data	6	0-126 chars
Bed Data	2	0- 42 chars
Classifications	50	0-450 chars
Intermediary Groups	6	0- 24 chars
Provider Groups	10	0- 40 chars
Recoupment Data	5	0-220 chars

All data records have a record code value of '21' and a maximum length of 1878 characters. The last record is a total record, record code value of '24', and is a fixed length record of 3621 characters. Be careful in sequential reading of this file, if you are using the I/O (BOI2000A) module. It sets the end-of-file flag when the '24' record is reached but also moves the total record into the work area. It is longer than the provider data record and will overflow, UNLESS you set up the

MITS: Data Conversion requirements

work area for the maximum length, with redefines for data and total record, as is shown below:

Layout :

```

01 W1200000-PROV-REC          PIC X(3621)          CLASS OC FROM TO
***** Above is the max sized record (= the Totals Record)
01 W1200000-PROVIDER-MASTER-REC REDEFINES
    W1200000-PROV-REC.
    05 W1200011-RECORD-CODE          PIC XX          C    1    1-  2
    05 W1200091-RECORD-KEY.
        10 W1200022-PROV-NUMBER          PIC 9(7)          Z    1    3-  9
    05 W1200011-PROV-NAME          PIC X(31)          C    1   10- 40
    05 W1200011-PROV-SORT-NAME      PIC X(31)          C    1   41- 71
    05 W1200011-PROV-COUNTY-CODE     PIC XX            C    1   72- 73
    05 W1200011-OUT-OF-STATE-PROV-CD PIC X              C    1   74- 74
    05 W1200031-PROV-APPL-DATE      PIC S9(5)          P    1   75- 77
    05 W1200031-DATE-OF-LAST-TRANS  PIC S9(5)          P    1   78- 80
    05 W1200031-CLERK-IDENTIFICATION PIC 999            P    1   81- 82
    05 W1200011-PROV-SSN-IRS-NUM-IND PIC X              C    1   83- 83
    05 W1200011-PROV-EMPLR-IDENT-NUM PIC X(10)          C    1   84- 93
    05 W1200091-PROV-SS-NUM
        REDEFINES W1200011-PROV-EMPLR-IDENT-NUM
        10 W1200012-PROV-SS-NUM          PIC X(9)
        10 FILLER                          PIC X
    05 W1200031-TRANSFER-OF-FUNDS-IND PIC X              C    1   94- 94
    05 W1200031-LIEN-HOLDER-PROV-NUM PIC 9(7)          P    1   95- 98
    05 W1200031-LIEN-AMOUNT          PIC S9(8)V99       P    1   99-104
    05 W1200031-ORIGINAL-LIEN-AMT    PIC S9(7)V99       P    1  105-109
    05 W1200031-LIEN-INCREASE-AMT    PIC S9(5)V99       P    1  110-113
    05 W1200031-LIEN-DECREASE-AMT    PIC S9(5)V99       P    1  114-117
    05 W1200031-ACCUM-LIEN-AMT       PIC S9(8)V99       P    1  118-123
    05 W1200031-LIEN-MAX-CHK-DED-AMT  PIC S9(8)V99       P    1  124-129
    05 W1200031-LIEN-MAX-CHK-DED-PCT  PIC S9V99          P    1  130-131
    05 W1200031-LIEN-ZERO-DEL-IND     PIC X              C    1  132-132
    05 W1200031-PREV-PROV-NUMBER      PIC 9(7)          P    1  133-136
    05 W1200031-NEW-PROV-NUMBER       PIC 9(7)          P    1  137-140
    05 W1200011-PROV-TYPE             PIC XX            C    1  141-142
    05 W1200011-PROV-TYPE-PRAC-ORGAN  PIC X             C    1  143-143
    05 W1200011-PROV-LICENSE-NUM      PIC X(9)          C    1  144-152
    05 W1200011-PROV-LIC-BOARD-CODE   PIC X             C    1  153-153
    05 W1200031-PROV-LICENSE-DATE     PIC S9(5)          P    1  154-156
    05 W1200011-NH-ADM-NAME           PIC X(28)         P    1  157-184
    05 W1200011-NH-ADM-CERTIFICATION  PIC X(9)          C    1  185-193
    05 W1200031-NH-ADM-RECERT-DATE    PIC S9(5)          P    1  194-196
    05 W1200031-NH-PROV-AGR-EXT-DATE  REDEFINES
        W1200031-NH-ADM-RECERT-DATE     PIC S9(5)          P
    05 W1200011-DEA-NUMBER            PIC X(9)          C    1  197-205
    05 W1200031-PROV-YEAR-END-DATE     PIC S9(4)          P    1  206-208
    05 W1200031-PROV-RECERT-DATE      PIC S9(5)          P    1  209-211
    05 W1200091-PROV-SPECIALTY-DATA
        INDEXED BY WX1200091-PROV-SPECIALTY-DATA
        2 212-221
        10 W1200032-PROV-SPEC-CERT-DATE PIC S9(5)          P
        10 W1200012-PROV-SPEC-CODE      PIC XX            C
    05 W1200031-PROV-TELE-NUM          PIC 9(10)         P    1  222-227
    05 W1200011-CTL-MED-FACILITY
        10 W1200031-CTL-MED-FACILITY-1  PIC X              C    1  228-228
        10 W1200031-CTL-MED-FACILITY-2  PIC X              C    1  229-229
        10 W1200031-CTL-MED-FACILITY-3  PIC X              C    1  230-230
    05 W1200011-ALT-PRACT-LOC          PIC X              C    1  231-231

    05 W1200091-PROV-REMIT-MEDIA.          CLASS OC FROM TO
        10 W1200012-PROV-REMIT-MEDIA    PIC X              C    1  232-232
        10 W1200012-PROV-REMIT-TYPE     PIC X              C    1  233-233
        10 W1200012-PROV-REMIT-SEQ      PIC X              C    1  234-234
    05 W1200011-PROV-CORRESP-MEDIA      PIC X              C    1  235-235

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05	W1200011-TAPE-BILL-IND	PIC X	C	1	236-236
05	W1200011-PROV-SPLIT-BILL-IND	PIC X	C	1	237-237
05	W1200011-PROV-PUBLISH-IND	PIC X	C	1	238-238
05	W1200011-INTM-TAPE-RECFM	PIC X	C	1	239-239
05	W1200011-INTM-TAPE-BPI	PIC X	C	1	240-240
05	W1200091-PHARM-DISP-FEE-TYPE			2	
	INDEXED BY WX1200091-PHARM-DISP-FEE-TYPE.				241-254
10	W1200012-PHARM-DISP-FEE-TYPE	PIC X.			
10	W1200032-PHRM-DISP-FEE-EFF-DT	PIC S9(5)	P		
10	W1200032-DRUG-DISPENSING-FEE	PIC S999V99	P		
05	W1200031-NUM-CAT-SVC-DATA	PIC S9(3)	P	1	255-256
05	W1200031-PROV-ENROL-PERIODS	PIC S9	P	1	257-257
05	W1200031-PROV-CHARGE-DATA-CTR	PIC S999	P	1	258-259
05	W1200031-NUM-HOLD-REVIEW-DATA	PIC S999	P	1	260-261
05	W1200031-PROV-BED-DATA-CTR	PIC S9	P	1	262-262
05	W1200031-NUM-CLASSIF-CODES	PIC S999	P	1	263-264
05	W1200031-NUM-INTERMED-MEMBERS	PIC S9(5)	P	1	265-267
05	W1200031-NUM-INTERMED-GROUPS	PIC S9(5)	P	1	268-270
05	W1200031-NUM-PROV-GROUPS	PIC S9(3)	P	1	271-272
05	W1200031-NUM-PROV-IN-GROUP	PIC S9(5)	P	1	273-275
05	W1200031-NUM-RECOUPMENTS	PIC S9	P	1	276-276
05	W1200011-NUM-PROV-ADDRESS	PIC 9		1	277-277
05	W1200091-PROV-ADDRESS.				
10	W1200092-PROV-ADDRESS			3	278-520
	* OCCUR 1 = PRACTICE ADDRESS				
	* OCCUR 2 = PAYTO ADDRESS				
	* OCCUR 3 = GROUP ADDRESS				
	INDEXED BY WX1200092-PROV-ADDRESS.				
15	W1200013-PROV-ADDR-LINE-1	PIC X(28)	C		
15	W1200013-PROV-ADDR-LINE-2	PIC X(28)	C		
15	W1200013-PROV-CITY	PIC X(18)	C		
15	W1200013-PROV-STATE	PIC XX	C		
15	W1200033-PROV-ZIP-CODE	PIC 9(9)	P		
05	W1200091-PROV-CAT-SVC-DATA.				
10	W1200092-PROV-CAT-SVC-DATA			10	521-XXX
	INDEXED BY WX1200092-PROV-CAT-SVC-DATA.				
15	W1200033-PROV-BEGIN-SVC-DATE	PIC S9(5)	P		
15	W1200033-PROV-END-SVC-DATE	PIC S9(5)	P		
15	W1200013-PROV-CAT-OF-SVC-CODE	PIC X(2)		8	
	INDEXED BY WX1200013-PROV-CAT-OF-SVC-CODE				
05	W1200091-PROV-ENROL-STAT-CD.				
10	W1200092-PROV-ENROL-STAT-CD			3	
	INDEXED BY WX1200092-PROV-ENROL-STAT-CD.				
15	W1200013-PROV-ENROL-STAT-CD	PIC X	C		
15	W1200033-PROV-ENROL-STAT-DATE	PIC S9(5)	P		
05	W1200091-PROV-CHARGE-DATA.		CLASS	OC	
10	W1200092-PROV-CHARGE-DATA			32	
	INDEXED BY WX1200092-PROV-CHARGE-DATA.				
15	W1200033-PROV-RATE-EFF-DATE	PIC S9(5)	P		
15	W1200013-PROV-CHARGE-MODE	PIC X	C		
15	W1200033-PROV-CHARGE-FACTOR	PIC S999V99	P		
15	W1200053-PROV-CHARGE-FACTOR				
	REDEFINES W1200033-PROV-CHARGE-FACTOR				
				PIC S99V999	P
15	W1200073-PROV-CHARGE-FACTOR				
	REDEFINES W1200053-PROV-CHARGE-FACTOR				
				PIC S9(5)	P
05	W1200091-HOLD-REVIEW-DATA.				
10	W1200092-HOLD-REVIEW-DATA			6	
	INDEXED BY WX1200092-HOLD-REVIEW-DATA.				
15	W1200013-PROV-EXCEP-INDIC	PIC XX	C		
15	W1200093-HOLD-REVIEW-RANGE.				
20	W1200014-HOLD-REVIEW-RNG-TYPE	PIC X	C		
20	W1200014-HOLD-REVIEW-RNG-LOW	PIC X(6)	C		
20	W1200014-HOLD-REVIEW-RNG-HIGH	PIC X(6)	C		
15	W1200033-HOLD-REVIEW-BGN-DATE	PIC S9(5)	P		
15	W1200033-HOLD-REVIEW-END-DATE	PIC S9(5)	P		
05	W1200091-PROV-NUM-OF-BEDS.				
10	W1200092-PROV-NUM-OF-BEDS			2	

MITS: Data Conversion requirements

		INDEXED BY WX1200092-PROV-NUM-OF-BEDS.						
	15	W1200033-PROV-BED-EFFECT-DATE	PIC S9(5)	P				
	15	W1200033-NUM-BEDS-TOTAL	PIC S9(5)	P				
	15	W1200033-NUM-BEDS-INTER	PIC S9(5)	P				
	15	W1200033-NUM-BEDS-MR	PIC S9(5)	P				
	15	W1200033-NUM-BEDS-SKILLED	PIC S9(5)	P				
	15	W1200033-NUM-BEDS-OTHER	PIC S9(5)	P				
	15	W1200033-NUM-BEDS-INPATIENT	PIC S9(5)	P				
05	W1200091-PROV-CLASSIF-DATA.							
10	W1200092-PROV-CLASSIF-DATA					50		
		INDEXED BY WX1200092-PROV-CLASSIF-DATA.						
	15	W1200033-PROV-CLASSIF-BEG-DT	PIC S9(5)	P				
	15	W1200033-PROV-CLASSIF-END-DT	PIC S9(5)	P				
	15	W1200013-PROV-CLASSIF-CD	PIC XXX	C				
05	W1200091-INTERMED-PROV-NUM.							
10	W1200092-INTERMED-PROV-NUM					6		
		INDEXED BY WX1200092-INTERMED-PROV-NUM.						
	15	W1200033-INTERMED-PROV-NUM	PIC 9(7)	P				
05	W1200091-PROV-GROUP							
10	W1200092-PROV-GROUP					10		
		INDEXED BY WX1200092-PROV-GROUP.						
	15	W1200033-PROV-GROUP	PIC 9(7)	P				
05	W1200091-RECOUPMENT-DATA.				CLASS		OC	
10	W1200092-RECOUP-DATA-TABLE.						5	
		INDEXED BY WX1200092-RECOUP-DATA-TABLE						
	15	W1200033-CREDIT-BAL-AMT	PIC S9(8)V99	P				
	15	W1200033-MAX-CHK-BAL-DED-AMT	PIC S9(8)V99	P				
	15	W1200033-MAX-CHK-BAL-DED-PCT	PIC S9V99	P				
	15	W1200013-ADJUSTMENT-REASON	PIC XX	C				
	15	W1200093-PROV-CAT-OF-SVC-CODE.						
	20	W1200014-PROV-CAT-OF-SVC-CODE	PIC XX	C				
	15	W1200033-ORIGINAL-RECOUP-AMT	PIC S9(7)V99	P				
	15	W1200033-ACCUM-RECOUP-AMT	PIC S9(8)V99	P				
	15	W1200033-RECOUP-INCREASE-AMT	PIC S9(5)V99	P				
	15	W1200033-RECOUP-DECREASE-AMT	PIC S9(5)V99	P				
	15	W1200033-RECOUP-BEGIN-DT-SVC	PIC S9(5)	P				
	15	W1200033-RECOUP-END-DT-SVC	PIC S9(5)	P				
	15	W1200033-RECOUP-ZERO-DEL-IND	PIC X	C				
		Total Record (trailer) Copy member W1299900						
01	W1299900-PROV-TOTAL-REC	REDEFINES			CLASS		OC	FROM TO
	W1200000-PROV-REC							
	05	W1299911-RECORD-CODE	PIC XX	C		1		1 2
	05	W1299991-RECORD-KEY.						
	10	FILLER	PIC X(7)					3 9
	05	W1299931-DATE-OF-LAST-TRANS	PIC S9(5)	C		1		10 12
	05	W1299931-BATCH-DATE	PIC 9(5)	C		1		13 15
	05	W1299931-RECORD-COUNT	PIC 9(7)	C		1		16 19
	05	W1299931-NUM-OF-TOTAL-ENTRIES	PIC S9(3)	C		1		20 21
	05	W1299991-TOTAL-COUNT-DATA	OCCURS 75 TIMES			75		22 3621
		INDEXED BY WX1299991-TOTAL-COUNT-DATA						
	10	W1299932-TOTAL-MONTH-BEGIN	PIC S9(7)	P				
	10	W1299932-TOTAL-MTHLY-ADDS	PIC S9(7)	P				
	10	W1299932-TOTAL-MTHLY-CHANGES	PIC S9(7)	P				
	10	W1299932-TOTAL-MTHLY-TERM	PIC S9(7)	P				
	10	W1299932-TOTAL-DAILY-ADDS	PIC S9(7)	P				
	10	W1299932-TOTAL-DAILY-CHANGES	PIC S9(7)	P				
	10	W1299932-TOTAL-DAILY-TERM	PIC S9(7)	P				
	10	W1299932-TOTAL-DAILY-DELETES	PIC S9(7)	P				
	10	W1299932-TOTAL-DAILY-BEGIN	PIC S9(7)	P				
	10	W1299932-CURRENT-OHIO	PIC S9(7)	P				
	10	W1299932-CURRENT-OHIO-FIVE	PIC S9(7)	P				
	10	W1299932-CURRENT-OUT-OF-STATE	PIC S9(7)	P				

## Reference - PDD

### Contents/ Comments :

REFERENCE	WORK	AREA
VSAM		
-----		
3DSN: WELF.CMMIS.F5000IA.DATA		3DDNAME: F5000IA 3
-----		
3Aloc Space: 50,15 CYL		3File-Aid Map: PDDF 3
-----		
3I/O Module: BOI5000A	3Pack: WELF	3Del/Def Job: RF5000IA 3
-----		
3FD: N/P2500100	3MODE: VB	3LENGTH: 308 3BLK: 32000 3
3N/P2500000		3
-----		
QSAM		
-----		
3DSN: WELF.PMMIS.F5000IA.TAPE()		3DDNAME: F5000SA 3
-----		
3I/O Module: BOI5001A	3GDG Limit: 14	3Retpd: 20 3
-----		

### Layout :

W/S Copy:	Record:	Record-Code
W1500100	- Procedure	51
W1500200	- Drug	53
W1500300	- Diagnosis	52
W1599700	- Total Record	99

Record Key set-up for key read:

Key (Except Drug):

05 W1500191-RECORD-KEY

10 W1500112-RECORD-CODE	PIC X(2)	PIC X(2)
10 W1500112-TYPE-OF-SERVICE	PIC X	
10 W1500112-PROC-CODE	PIC X(5)	PIC X(10)
10 FILLER	PIC X(5)	PIC X

Drug Key:

3 Procedure	3 HCPC/CPT Codes	3	3	3	3	3
3	3	3 ICD-9	3 Waivered	3 Output	3 UB82	3
3 Records:	3 Medicaid	3 GA/DA	3 HCPC	3 UB82	3 RCC	3
3	3	3	3	3	3	3
3Record Code	3 '51'	3 '51'	3 '51'	3 '51'	3 '51'	3 '51'
3Type Service	3 '1'	3 '3'	3 'S'	3 'W'	3 '2'	3 'I/O'
3Procedure Code	3 'HCPC'	3 'HCPC'	3 'ICD9'	3 'HCPC'	3 'HCPC'	3 '00RCC'
3Filler	3 Spaces	3 Spaces	3 Spaces	3 Spaces	3 Spaces	3 Spaces

3Diagnosis Records:	3 Drug Records:	3
3	3	3
3Record Code	3 '52'	3 '53'
3Type Service	3 'I'	3 N/A
3Procedure Code	3 'ICD-9' (Left Just.)	3 'Drug Code'
3Filler	3 Spaces	3 Space

W1500100	- PROCEDURE	(R.C. - 51)
W1500200	- DRUG	(R.C. - 53)
W1500300	- DIAGNOSIS	(R.C. - 52)
W1500100	- PROCEDURE	CLASS OC FROM TO

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01	W1500100-PROCEDURE-MASTER.							
05	W1500191-RECORD-KEY.							
10	W1500112-RECORD-CODE	PIC X(2)	C	1	1	2		
10	W1500112-TYPE-OF-SERVICE	PIC X	C	1	3	3		
10	W1500112-PROC-CODE	PIC X(5)	C	1	4	8		
10	FILLER	PIC X(5)	C	1	9	13		
05	W1500111-PROC-NAME	PIC X(40)	C	1	14	53		
05	W1500111-PROC-CD-REQ-IND	PIC X	C	1	54	54		
05	W1500111-PROC-CONTROL-CODE	PIC X(2)	C	1	55	56		
05	W1500191-AGE-RANGE-INDIC.							
10	W1500132-MINIMUM-AGE	PIC 9(3)	P	1	57	58		
10	W1500132-MAXIMUM-AGE	PIC 9(3)	P	1	59	60		
05	W1500111-VALID-SEX-INDIC	PIC X	C	1	61	61		
05	W1500131-DATE-OF-LAST-TRANS	PIC S9(5)	P	1	62	64		
05	W1500131-CLERK-IDENTIFICATION	PIC S9(3)	P	1	65	66		
05	W1500131-PROC-POST-OP-DAYS	PIC S9(3)	P	1	67	68		
05	W1500191-PROV-CLASSIF-CD							
10	W1500112-PROV-CLASSIF-CD	PIC X(3)	C	5	69	83		
	INDEXED BY WX1500112-PROV-CLASSIF-CD							
05	W1500191-PROC-CODE-MODIFIER.							
10	W1500112-PROC-CODE-MODIFIER	PIC X(2)	C	17	84	117		
	INDEXED BY WX1500112-PROC-CODE-MODIFIER							
05	W1500111-PROC-CD-MODIF-IND	PIC X	C	1	118	118		
05	W1500111-PROC-PROV-TYPE-IND	PIC X	C	1	119	119		
05	W1500191-PROC-PROV-TYPE							
10	W1500112-PROC-PROV-TYPE	PIC X(2)	C	20	120	159		
	INDEXED BY WX1500112-PROC-PROV-TYPE							
05	W1500111-PROC-PL-OF-SVC-IND	PIC X	C	1	160	160		
05	W1500191-PLACE-OF-SERVICE.							
10	W1500112-PLACE-OF-SERVICE	PIC X(2)	C	10	161	180		
	INDEXED BY WX1500112-PLACE-OF-SERVICE							
05	W1500191-PROV-SPEC-CODE.							
10	W1500112-PROV-SPEC-CODE	PIC X(2)	C	2	181	184		
	INDEXED BY WX1500112-PROV-SPEC-CODE							
05	W1500111-LIFETIME-SERVICE-IND	PIC X	C	1	185	185		
05	W1500111-TOOTH-NO-IND	PIC X	C	1	186	186		
05	W1500191-TOOTH-NUMBER							
10	W1500112-TOOTH-NUMBER	PIC X(2)	C	32	187	250		
	INDEXED BY WX1500112-TOOTH-NUMBER							
05	W1500111-TOOTH-SURFACE-IND	PIC X	C	1	251	251		
05	W1500111-PROC-HYSTER-IND	PIC X	C	1	252	252		
05	W1500111-PROC-STERIL-IND	PIC X	C	1	253	253		
05	W1500111-PROC-ABORT-IND	PIC X	C	1	254	254		
05	W1500111-PROC-FAM-PLAN-IND	PIC X	C	1	255	255		
05	W1500111-MCARE-COVERAGE-IND	PIC X	C	1	256	256		
05	W1500111-DUP-CHECK-IND	PIC X	C	1	257	257		
	W1500100 - PROCEDURE		CLASS	OC	FROM	TO		
05	W1500111-PROC-MULT-SURG-IND	PIC X	C	1	258	258		
05	W1500111-PROC-NURSE-HOME-IND	PIC X	C	1	259	259		
05	W1500111-PROC-REFERRAL-IND	PIC X	C	1	260	260		
05	W1500131-PROC-PRICE-ENTRIES	PIC S9(3)	P	1	261	262		
05	FILLER	PIC X(10)	C	1	263	272		
05	W1500191-PROC-PRICE-DATA			11	273	503		
	INDEXED BY WX1500191-PROC-PRICE-DATA.							
10	W1500132-PROC-PRICE-BEG-DATE	PIC S9(5)	P					
10	W1500132-PROC-PRICE-END-DATE	PIC S9(5)	P					
10	W1500112-PROC-FACTOR-CODE	PIC X	C					
10	W1500132-PROC-FACTOR	PIC S9(5)V99	P					
10	W1500112-PRIOR-AUTH-IND	PIC X	C					
10	W1500112-IN-OFFICE-IND	PIC X	C					
10	W1500112-OUTPATIENT-IND	PIC X	C					
10	W1500112-ASC-IND	PIC X	C					
10	W1500112-PRICING-LEVEL	PIC X	C					
10	FILLER	PIC X(5)						
	W1500200 - DRUG		CLASS	OC	FROM	TO		
01	W1500200-DRUG-MASTER							
05	W1500291-RECORD-KEY							
10	W1500212-RECORD-CODE	PIC X(2)	C	1	1	2		
10	W1500212-DRUG-CODE	PIC X(10)	C	1	3	12		
10	FILLER	PIC X	C	1	13	13		

MITs: Data Conversion requirements

05	W1500211-DRUG-THERA-CLASS	PIC X(3)	C	1	14	16
05	W1500211-DRUG-GENERIC-CODE	PIC X(5)	C	1	17	21
05	W1500251-DRUG-NAME	PIC X(30)	C	1	22	51
05	W1500211-DRUG-GENERIC-NAME	PIC X(30)	C	1	52	81
05	W1500211-DRUG-STRENGTH-DESC	PIC X(10)	C	1	82	91
05	W1500211-DRUG-MANUFACT-NAME	PIC X(17)	C	1	92	108
05	W1500211-DRUG-FORMUL-IND	PIC X	C	1	109	109
05	W1500231-DRUG-PACKAGE-SIZE	PIC S9(5)	P	1	110	112
05	W1500211-DRUG-UNIT-MEASURE	PIC X(2)	C	1	113	114
05	W1500231-DATE-OF-LAST-TRANS	PIC S9(5)	P	1	115	117
05	W1500231-CLERK-IDENTIFICATION	PIC 9(3)	P	1	118	119
05	W1500291-AGE-RANGE-INDIC					
10	W1500232-MINIMUM-AGE	PIC 9(3)	P	1	120	121
10	W1500232-MAXIMUM-AGE	PIC 9(3)	P	1	122	123
05	W1500211-VALID-SEX-INDIC	PIC X	C	1	124	124
05	W1500211-DRUG-CONTROL-CODE	PIC X	C	1	125	125
05	W1500211-DRUG-DEA-CODE	PIC X	C	1	126	126
05	W1500211-DRUG-DESI-INDIC	PIC X	C	1	127	127
05	W1500211-DRUG-MAC-IND	PIC X	C	1	128	128
05	W1500211-DRUG-CONFIG-IND	PIC X	C	1	129	129
05	W1500211-DRUG-N-H-IND	PIC X	C	1	130	130
05	W1500231-NO-REFILLS-ALLOWED	PIC S9(3)	P	1	131	132
05	W1500211-UNIT-DOSE-INDICATOR	PIC X	C	1	133	133
05	W1500231-DRUG-PRICE-ENTRIES	PIC S9(3)	P	1	134	135
W1500200 - DRUG (CONT'D) CLASS OC FROM TO						
05	W1500291-DRUG-PRICE-DATA			11	136	355
	INDEXED BY WX1500291-DRUG-PRICE-DATA.					
10	W1500232-DRUG-PRICE-BEG-DATE	PIC S9(5)	P			
10	W1500232-DRUG-PRICE-END-DATE	PIC S9(5)	P			
10	W1500232-DRUG-MIN-SUPPLY	PIC 9(5)	P			
10	W1500232-DRUG-MAX-SUPPLY	PIC 9(5)	P			
10	W1500232-DRUG-MAX-DAYS	PIC 9(5)	P			
10	W1500232-DRUG-EAC	PIC 9(3)V9999	P			
10	W1500212-PRIOR-AUTH-IND	PIC X	C			
W1500300 - DIAGNOSIS CLASS OC FROM TO						
01	W1500300-DIAGNOSIS-MASTER.					
05	W1500391-RECORD-KEY.					
10	W1500312-RECORD-CODE	PIC X(2)	C	1	1	2
10	W1500312-DIAG-SCHEME-CODE	PIC X	C	1	3	3
10	W1500312-DIAG-CODE-ICD-9	PIC X(6)	C	1	4	9
10	FILLER	PIC X(4)	C	1	10	13
05	W1500311-DIAG-NAME	PIC X(40)	C	1	14	53
05	W1500391-AGE-RANGE-INDIC.					
10	W1500332-MINIMUM-AGE	PIC 9(3)	P	1	54	55
10	W1500332-MAXIMUM-AGE	PIC 9(3)	P	1	56	57
05	W1500311-VALID-SEX-INDIC	PIC X	C	1	58	58
05	W1500311-DIAG-ACCID-INDIC	PIC X	C	1	59	59
05	W1500331-DATE-OF-LAST-TRANS	PIC S9(5)	P	1	60	62
05	W1500331-CLERK-IDENTIFICATION	PIC 9(3)	P	1	63	64
05	W1500311-PRIOR-AUTH-IND	PIC X	C	1	65	65
05	W1500311-EMERG-TRMNT-IND	PIC X	C	1	66	66
05	W1500311-DIAG-CONTROL-CODE	PIC X	C	1	67	67
05	W1500311-DIAG-STERL-IND	PIC X	C	1	68	68
05	W1500311-DIAG-ABORT-IND	PIC X	C	1	69	69
05	W1500311-DIAG-FAM-PLAN-IND	PIC X	C	1	70	70
05	FILLER	PIC X(12)	C	1	71	82

Text

Contents/ Comments :

TEXT FILE

MITS: Data Conversion requirements

```

VSAM -----
 ³DSN: WELF.CMMIS.F5016IA.DATA          ³DDNAME: F5016IA          ³
-----³-----³
 ³Aloc Space: 10,1 CYL                   ³File-Aid Map: TEXTF      ³
-----³-----³
 ³I/O Module: BOI5016A ³Pack: WELF03 ³Del/Def Job: RF5016IA ³
-----³-----³
 ³FD: N2501600 ³ MODE: VB ³ LENGTH: 308 ³BLK: 32000 ³
-----³-----³
    
```

```

QSAM -----
 ³DSN: WELF.PMMIS.F5016IA.TAPE()        ³DDNAME: F5016SA          ³
-----³-----³
 ³I/O Module: BOI5016A ³GDG Limit: 13 ³Retpd: 30          ³
-----³-----³
    
```

```

W/S
Copybook: Record: Record-Code
W1501600 - Exception Text 56
W1502200 - Provider Text 57
W1502400 - Explanation of Benefit Text 59
W1502300 - EOB Response Text 67
W1502500 - Location Text 74
W1502600 - Carrier Text 76
W1502700 - Procedure Range Text 77
W1502800 - News Letter Text 78
W1599500 - Total Record 99
    
```

W1501600 - EXCEPTION TEXT RECORD

Layout :

```

01 W1501600-EXCEPTION-TEXT-REC          CLASS OC FROM TO
05 W1501691-RECORD-KEY.
 10 W1501612-RECORD-CODE (56) PIC X(2) C 1 1 2
 10 W1501622-EXCEPTION-CODE PIC 9(3) Z 1 3 5
 10 FILLER PIC X(3) C 1 6 8
 10 W1501622-TEXT-KEY-SEQ-NUMBER PIC S9(5) Z 1 9 13
05 W1501631-DATE-OF-LAST-TRANS PIC S9(5) P 1 14 16
05 W1501621-CLERK-IDENTIFICATION PIC 9(3) Z 1 17 19
05 W1501611-TEXT-DATA PIC X(95) X 1 20 114
    
```

W1502200 PROVIDER TEXT RECORD

```

01 W1502200-PROV-TEXT-RECORD          CLASS OC FROM TO
05 W1502291-RECORD-KEY.
 10 W1502212-RECORD-CODE (57) PIC X(2) C 1 1 2
 10 W1502232-PROV-NUMBER PIC S9(7) P 1 3 6
 10 FILLER PIC X(2) C 1 7 8
 10 W1502222-TEXT-KEY-SEQ-NUMBER PIC S9(5) Z 1 9 13
05 W1502231-DATE-OF-LAST-TRANS PIC S9(5) P 1 14 16
05 W1502221-CLERK-IDENTIFICATION PIC 9(3) Z 1 17 19
05 W1502211-TEXT-DATA PIC X(95) C 1 20 114
    
```

W1502400 - EOB TEXT RECORD

```

01 W1502400-EOB-TEXT-RECORD          CLASS OC FROM TO
05 W1502491-RECORD-KEY.
 10 W1502412-RECORD-CODE (59) PIC X(2) C 1 1 2
 10 W1502422-EOB-CODE PIC 9(3) Z 1 3 5
 10 FILLER PIC X(3) C 1 6 8
 10 W1502422-TEXT-KEY-SEQ-NUMBER
    
```

MITS: Data Conversion requirements

		PIC S9(5)	Z	1	9	13
05	W1502431-DATE-OF-LAST-TRANS	PIC S9(5)	P	1	14	16
05	W1502421-CLERK-IDENTIFICATION	PIC 9(3)	Z	1	17	19
05	W1502411-TEXT-DATA	PIC X(95)	C	3	20	304
W1502300 - EOB RESPONSE TEXT RECORD						
01	W1502300-EOB-TEXT-RECORD		CLASS	OC	FROM	TO
05	W1502391-RECORD-KEY.					
10	W1502312-RECORD-CODE (67)	PIC X(2)	C	1	1	2
10	W1502322-EOB-CODE	PIC 9(3)	Z	1	3	5
10	FILLER	PIC X(3)	C	1	6	8
10	W1502322-TEXT-KEY-SEQ-NUMBER					
		PIC S9(5)	Z	1	9	13
05	W1502331-DATE-OF-LAST-TRANS	PIC S9(5)	P	1	14	16
05	W1502321-CLERK-IDENTIFICATION	PIC 9(3)	Z	1	17	19
05	W1502311-TEXT-DATA	PIC X(95)	C	3	20	114
W1502500 - LOCATION TEXT RECORD						
01	W1502500-LOCATION-TEXT-RECORD		CLASS	OC	FROM	TO
05	W1502591-RECORD-KEY.					
10	W1502512-RECORD-CODE (74)	PIC X(2)	C	1	1	2
10	W1502512-LOCATION-CODE	PIC 9(2)	Z	1	3	4
10	FILLER	PIC X(4)	C	1	5	8
10	W1502522-TEXT-KEY-SEQ-NUMBER					
		PIC S9(5)	Z	1	9	13
05	W1502531-DATE-OF-LAST-TRANS	PIC S9(5)	P	1	14	16
05	W1502521-CLERK-IDENTIFICATION	PIC 9(3)	Z	1	17	19
05	W1502511-LOCATION-DESC	PIC X(10)	C	1	20	29
05	W1502511-SUSPENSE-CORR-MODE	PIC X	C	1	30	30
W1502600 - CARRIER TEXT RECORD						
01	W1502600-CARRIER-TEXT-RECORD		CLASS	OC	FROM	TO
05	W1502691-RECORD-KEY.					
10	W1502612-RECORD-CODE (76)	PIC X(2)	C	1	1	2
10	W1502632-CARRIER-ID	PIC 9(5)	P	1	3	5
10	FILLER	PIC X(3)	C	1	6	8
10	W1502622-TEXT-KEY-SEQ-NUMBER					
		PIC S9(5)	Z	1	9	13
05	W1502631-CARRIER-DATES.					
10	W1502631-DATE-OF-ORIGIN	PIC S9(5)	P	1	14	16
10	W1502631-DATE-OF-VERIFY	PIC S9(5)	P	1	17	19
10	W1502631-DATE-OF-LAST-TRANS	PIC S9(5)	P	1	20	22
05	W1502621-CLERK-ORIGIN-ID	PIC 9(3)	P	1	23	24
05	W1502621-CLERK-VERIFY-ID	PIC 9(3)	P	1	25	26
05	W1502621-CLERK-LAST-TRANS-ID	PIC 9(3)	P	1	27	28
05	W1502621-SOURCE-CODE	PIC X	C	1	29	29
05	W1502611-CARRIER-ADDRESS	PIC X(31)	C	3	30	122
	INDEXED BY WX1502611-CARRIER-ADDRESS					
05	W1502611-CARRIER-CITY	PIC X(20)	C	1	123	142
05	W1502611-CARRIER-STATE	PIC X(2)	C	1	143	144
05	W1502611-CARRIER-ZIP-5	PIC 9(5)	P	1	145	147
05	W1502611-CARRIER-ZIP-4	PIC 9(4)	P	1	148	150
05	W1502611-CARRIER-PHONE-AREA	PIC 9(3)	P	1	151	152
05	W1502611-CARRIER-PHONE-EXCH	PIC 9(3)	P	1	153	154
05	W1502611-CARRIER-PHONE-NUM	PIC 9(4)	P	1	155	157
05	W1502611-CARRIER-FAX-AREA	PIC 9(3)	P	1	158	159
05	W1502611-CARRIER-FAX-EXCH	PIC 9(3)	P	1	160	161
05	W1502611-CARRIER-FAX-NUM	PIC 9(4)	P	1	162	164
05	W1502611-CARRIER-NOTE	PIC X(46)	C	3	165	302
	INDEXED BY WX1502611-CARRIER-NOTE					
05	FILLER	PIC X(2)	C	1	303	304
W1502700 - TEXT PROCEDURE RANGE RECORD						
01	W1502700-TEXT-PROC-RANGE-REC		CLASS	OC	FROM	TO
05	W1502791-RECORD-KEY.					
10	W1502712-RECORD-CODE (77)	PIC X(2)	C	1	1	2
10	W1502712-TYPE-OF-SERVICE	PIC X	C	1	3	3

**MIT: Data Conversion requirements**

10	W1502712-PROC-CODE	PIC X(5)	C	1	4	8
10	W1502722-TEXT-KEY-SEQ-NUMBER					
		PIC S9(5)	C	1	9	13
05	W1502731-DATE-OF-LAST-TRANS	PIC S9(5)	P	1	14	16
05	W1502721-CLERK-IDENTIFICATION	PIC 9(3)	Z	1	17	19
05	W1502711-PROC-CODE	PIC X(5)	C	1	20	24
05	W1502711-TEXT-DATA	PIC X(95)	C	1	25	109
W1502800 - NEWS LETTER TEXT RECORD						
01	W1502800-NEWS-LETTER-TEXT		CLASS	OC	FROM	TO
05	W1502891-RECORD-KEY.					
10	W1502812-RECORD-CODE (78)	PIC X(2)	C	1	1	2
10	W1502812-PROV-TYPE	PIC X(2)	C	1	3	4
10	FILLER	PIC X(4)	C	1	5	8
10	W1502822-TEXT-KEY-SEQ-NUMBER					
		PIC S9(5)	C	1	9	13
05	W1502831-DATE-OF-LAST-TRANS	PIC S9(5)	P	1	14	16
05	W1502821-CLERK-IDENTIFICATION	PIC 9(3)	C	1	17	19
05	W1502811-TEXT-DATA	PIC X(95)	C	1	20	114

## Exception Control File

### Contents/ Comments :

EXCEPTION CONTROL WORK AREA

VSAM

```

_____
3DSN: WELF.CMMIS.F5014IA.DATA           3DDNAME: F5014IA           3
-----3-----3
3Aloc Space:  2,1  CYL           3File-Aid Map:  EXPTCTLF 3
-----3-----3
3I/O Module:  BOI5014A  3Pack:  WELF03  3Del/Def Job:  RF5014IA 3
-----3-----3
3FD:  N2501400  3 MODE:  VB  3 LENGTH:  308  3BLK:  32000  3
-----3-----3

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QSAM

```

_____
3DSN: WELF.PMMIS.F5014IA.TAPE()         3DDNAME: F5014SA           3
-----3-----3
3I/O Module:  BOI5014A  3GDG Limit:  14  3Retprd:   30 days 3
-----3-----3
3W/S Copy:  W1501400  3W/S Copy Tot Rcd:  W1599600  3
-----3-----3

```

Layout :

01	W1501400-EXCEPTION-CONTROL		CLASS	OC	FROM	TO
05	W1501411-RECORD-CODE	PIC X(2)	C	1	1	2
05	W1501491-RECORD-KEY					
10	W1501412-EXCEPTION-CODE	PIC X(3)	C	1	3	5
10	W1501422-EXCEPTION-CODE					
	REDEFINES W1501412-EXCEPTION-CODE					
		PIC 9(3)				
05	W1501411-EXCEP-SHORT-DESC	PIC X(30)	C	1	6	35
05	W1501491-EXCEP-LONG-DESC.					
10	W1501412-EXCEP-LONG-DESC	PIC X(72)	C	4	36	323
	INDEXED BY WX1501412-EXCEP-LONG-DESC					
05	W1501411-EXCEP-PRINT-CODE	PIC X	C	1	324	324
05	W1501411-CLAIM-LOCATION-CODE	PIC X(2)	C	1	325	326
05	W1501411-CLAIM-LOC-CODE-OVRD	PIC X	C	1	327	327
05	W1501421-DATE-OF-LAST-TRANS	PIC 9(6)	C	1	328	333

MITS: Data Conversion requirements

05	W1501421-CLERK-IDENTIFICATION	PIC 9(3)	C	1	334	336
05	W1501491-TYPE-OF-CLAIM.					
10	W1501492-TYPE-OF-CLAIM			21	337	861
	INDEXED BY WX1501492-TYPE-OF-CLAIM.					
15	W1501413-CLM-INPUT-FORM-IND					
	PIC X(1).					
15	W1501493-EXCEPTION-IND.					
20	W1501494-EXCEPTION-IND			3		
	INDEXED BY WX1501494-EXCEPTION-IND					
25	W1501415-CLM-INPUT-MEDIUM-IND					
	PIC X(1).					
25	W1501415-EXCEP-DISPOSITION					
	PIC X(1).					
25	W1501415-FORCE-INDICATOR					
	PIC X(1).					
25	W1501415-DENY-INDICATOR					
	PIC X(1).					
25	W1501435-ADJUDICATION-EOB					
	PIC 9(3)			P		
25	W1501435-SUSPENSE-EOB					
	PIC 9(3)			P		

UR Criteria

Contents/ Comments :

W14133900 UR LIST OF PROCEDURES WORK AREA

Layout :

01	W1413900-UR-LIST-OF-PROC.					
05	W1413991-RECORD-KEY.					
10	W1413912-RECORD-CODE	PIC X(2)				
10	W1413922-UR-LIST-NUM	PIC 9(4)				
10	FILLER	PIC X(3)				
05	W1413911-LIST-TYPE	PIC X				
05	W1413911-DESCRIPTION	PIC X(30)				
05	W1413931-LAST-UPDATE-DATE	PIC S9(5)			P	
05	W1413931-CLERK-IDENTIFICATION	PIC 9(3)			P	
05	W1413931-NUM-OF-RANGES	PIC S9(3)			P	
05	W1413991-RANGE-OF-CODES.					
10	W1413992-RANGE-OF-CODES			99		
	INDEXED BY WX1413992-RANGE-OF-CODES.					
15	W1413913-FIRST-PROC-IN-RANGE					
	PIC X(5).					
15	W1413913-LAST-PROC-IN-RANGE					
	PIC X(5).					
	W1414000 UR LIST OF DIAGNOSES WORK AREA					
01	W1414000-UR-LIST-OF-DIAG.					
05	W1414091-RECORD-KEY.					
10	W1414012-RECORD-CODE	PIC X(2)				
10	W1414022-UR-LIST-NUM	PIC 9(4)				
10	FILLER	PIC X(3)				
05	W1414011-LIST-TYPE	PIC X				
05	W1414011-DESCRIPTION	PIC X(30)				
05	W1414031-LAST-UPDATE-DATE	PIC S9(5)			P	
05	W1414031-CLERK-IDENTIFICATION	PIC 9(3)			P	
05	W1414031-NUM-OF-RANGES	PIC S9(3)			P	
05	W1414091-RANGE-OF-CODES.					
10	W1414092-RANGE-OF-CODES			99		
	INDEXED BY WX1414092-RANGE-OF-CODES.					
15	W1414013-FIRST-DIAG-IN-RANGE					

MITS: Data Conversion requirements

					PIC X(6)	
	15	W1414013-LAST-DIAG-IN-RANGE				
					PIC X(6)	
		W1414100 UR MEDICAL CRITERIA WORK		AREA		
01		W1414100-UR-MED-CRITERIA.				
	05	W1414191-RECORD-KEY.				
	10	W1414112-RECORD-CODE			PIC X(2)	
	10	W1414112-TYPE-OF-SERVICE			PIC X	
	10	W1414112-PROC-CODE			PIC X(5)	
	10	FILLER			PIC X	
	05	W1414111-I-E-DIAGNOSIS-IND			PIC X	
	05	W1414111-FIRST-DIAG-IN-RANGE			PIC X(6)	
	05	W1414111-LAST-DIAG-IN-RANGE			PIC X(6)	
	05	W1414121-UR-DIAG-LIST-NUM			PIC 9(4)	
	05	W1414191-UR-PARAM-NUM.				
	10	W1414122-UR-PARAM-NUM			PIC 9(4)	10
		INDEXED BY WX1414122-UR-PARAM-NUM				
	05	W1414131-LAST-UPDATE-DATE			PIC S9(5)	P
	05	W1414131-CLERK-IDENTIFICATION			PIC 9(3)	P
01		W1414200-UR-INST-CRITERIA.				
	05	W1414291-RECORD-KEY.				
	10	W1414212-RECORD-CODE			PIC X(2)	
	10	W1414212-TYPE-OF-FACILITY			PIC X	
	10	W1414212-DIAG-CODE-ICD-9			PIC X(6)	
	05	W1414231-PAS-LOS-PERCENTILE			PIC 9(3)	P
	05	W1414291-LOS-CRITERIA.				
	10	W1414292-SINGLE-OR-MULT-DIAG				2
		INDEXED BY WX1414292-SINGLE-OR-MULT-DIAG.				
	15	W1414293-SURG-OR-NOT				2
		INDEXED BY WX1414293-SURG-OR-NOT.				
	20	W1414294-AGE-RANGE				5
		INDEXED BY WX1414294-AGE-RANGE.				
	25	W1414235-LENGTH-OF-STAY			PIC 9(3)	P
	05	W1414291-UR-PARAM-NUM.				
	10	W1414222-UR-PARAM-NUM			PIC 9(4)	10
		INDEXED BY WX1414222-UR-PARAM-NUM				
	05	W1414231-LAST-UPDATE-DATE			PIC S9(5)	P
	05	W1414231-CLERK-IDENTIFICATION			PIC 9(3)	P
		W1414400 UR LIMIT PARAMETER WORK		AREA		
01		W1414400-UR-LIMIT-PARAM.				
	05	W1414491-RECORD-KEY.				
	10	W1414412-RECORD-CODE			PIC X(2)	
	10	W1414422-UR-PARAM-NUM			PIC 9(4)	
	10	FILLER			PIC X(3)	
	05	W1414411-PARAM-TYPE			PIC X	
	05	W1414431-UR-EFF-BEG-DATE			PIC S9(5)	P
	05	W1414431-UR-EFF-END-DATE			PIC S9(5)	P
	05	W1414411-DESCRIPTION			PIC X(30)	
	05	W1414431-EXCEPTION-CODE			PIC 9(3)	P
	05	W1414411-I-E-PLACE-OF-SVC-IND			PIC X	
	05	W1414411-PLACE-OF-SERVICE			PIC X(2)	
	05	W1414411-I-E-ANESTHESIA-IND			PIC X	
	05	W1414411-I-E-ASST-SURGERY			PIC X	
	05	W1414411-I-E-OTHER-SVC-IND			PIC X	
	05	W1414491-PARAM-DIAG-DATA.				
	10	W1414412-I-E-DIAGNOSIS-IND			PIC X	
	10	W1414412-FIRST-DIAG-IN-RANGE			PIC X(6)	
	10	W1414412-LAST-DIAG-IN-RANGE			PIC X(6)	
	10	W1414422-UR-DIAG-LIST-NUM			PIC 9(4)	
	05	W1414491-PARAM-PROC-DATA.				
	10	W1414412-FIRST-PROC-IN-RANGE			PIC X(5)	
	10	W1414412-LAST-PROC-IN-RANGE			PIC X(5)	
	10	W1414422-UR-PROC-LIST-NUM			PIC 9(4)	
	05	W1414411-SAME-DIFF-PROVIDER			PIC X	

MITS: Data Conversion requirements

05	W1414411-SAME-DIFF-PROV-TYPE	PIC X		
05	W1414411-SAME-DIFF-PROV-SPEC	PIC X		
05	W1414411-SAME-DIFF-TOOTH-IND	PIC X		
05	W1414411-SAME-DIFF-TOOTH-SUR	PIC X		
05	W1414411-SAME-DIFF-SVC-IND	PIC X		
05	W1414411-SAME-DIFF-PROCEDURE	PIC X		
05	W1414411-SAME-DIFF-ANES-IND	PIC X		
W1414400 UR LIMIT PARAMETER WORK AREA (cont'd)				
05	W1414431-UR-TIME-PERIOD	PIC 9(5)	P	
05	W1414411-TYPE-OF-TIME-PERIOD	PIC X		
05	W1414411-UR-TYPE-OF-LIMIT	PIC X		
05	W1414431-UR-LIMIT-QTY	PIC S9(5)	P	
05	W1414431-LAST-UPDATE-DATE	PIC S9(5)	P	
05	W1414431-CLERK-IDENTIFICATION	PIC 9(3)	P	
W1414500 UR CONTRA PARAMETER WORK AREA				
01	W1414500-UR-CONTRA-PARAM.			
05	W1414591-RECORD-KEY.			
10	W1414512-RECORD-CODE	PIC X(2)		
10	W1414522-UR-PARAM-NUM	PIC 9(4)		
10	FILLER	PIC X(3)		
05	W1414511-PARAM-TYPE	PIC X		
05	W1414531-UR-EFF-BEG-DATE	PIC S9(5)	P	
05	W1414531-UR-EFF-END-DATE	PIC S9(5)	P	
05	W1414511-DESCRIPTION	PIC X(30)		
05	W1414531-EXCEPTION-CODE	PIC 9(3)	P	
05	W1414511-I-E-ANESTHESIA-IND	PIC X		
05	W1414511-I-E-ASST-SURGERY	PIC X		
05	W1414511-I-E-OTHER-SVC-IND	PIC X		
05	W1414511-SAME-DIFF-PROVIDER	PIC X		
05	W1414511-SAME-DIFF-DIAG	PIC X		
05	W1414511-SAME-DIFF-DATE-SVC	PIC X		
05	W1414511-SAME-DIFF-PROV-TYPE	PIC X		
05	W1414511-SAME-DIFF-PROV-SPEC	PIC X		
05	W1414511-SAME-DIFF-TOOTH-IND	PIC X		
05	W1414511-SAME-DIFF-TOOTH-SUR	PIC X		
05	W1414511-SAME-DIFF-SVC-IND	PIC X		
05	W1414511-SAME-DIFF-ANES-IND	PIC X		
05	W1414511-BEFORE-AFTER-HISTORY	PIC X		
05	W1414531-UR-TIME-PERIOD	PIC 9(5)	P	
05	W1414591-PARAM-PROC-DATA.			
10	W1414512-FIRST-PROC-IN-RANGE	PIC X(5)		
10	W1414512-LAST-PROC-IN-RANGE	PIC X(5)		
10	W1414522-UR-PROC-LIST-NUM	PIC 9(4)		
05	W1414531-LAST-UPDATE-DATE	PIC S9(5)	P	
05	W1414531-CLERK-IDENTIFICATION	PIC 9(3)	P	
W1414600 UR ANCILLARY PARAMETER WORK AREA				
01	W1414600-UR-ANCILLARY-PARAM.			
05	W1414691-RECORD-KEY.			
10	W1414612-RECORD-CODE	PIC X(2)		
10	W1414622-UR-PARAM-NUM	PIC 9(4)		
10	FILLER	PIC X(3)		
05	W1414611-PARAM-TYPE	PIC X		
05	W1414631-UR-EFF-BEG-DATE	PIC S9(5)	P	
05	W1414631-UR-EFF-END-DATE	PIC S9(5)	P	
05	W1414631-EXCEPTION-CODE	PIC 9(3)	P	
05	W1414611-FROM-REVENUE-CODE	PIC X(3)		
05	W1414611-TO-REVENUE-CODE	PIC X(3)		
05	W1414611-UR-TYPE-OF-LIMIT	PIC X		
05	W1414631-UR-LIMIT-QTY	PIC S9(5)	P	
05	W1414611-DESCRIPTION	PIC X(30)		
05	W1414631-LAST-UPDATE-DATE	PIC S9(5)	P	
05	W1414631-CLERK-IDENTIFICATION	PIC 9(3)	P	

TPL

Contents/ Comments :

THIRD PARTY LIABILITY (TPL) WORK AREA

VSAM

```

_____
³DSN: WELF.CMMIS.R1300IA.DATA          ³DDNAME: R1300IA          ³
-----³
³ALT. 1: WELF.CMMIS.R1300IB.AIX        ³DDNAME: R1300IB          ³
-----³
³ALT. 2: WELF.CMMIS.R1300IC.AIX        ³DDNAME: R1300IC          ³
-----³
³Aloc Space: 350,50 CYL                 ³File-Aid Map: TPL800F    ³
-----³
³I/O Module: NONE                       ³Pack: WELF29             ³Del/Def Job: DR1300IA    ³
³      :                               ³      : WELF31           ³
-----³
³FD: N2130TPL ³ MODE: FB ³ LENGTH: 800 ³BLK: 32000          ³
-----
    
```

QSAM

```

_____
³DSN: WELF.PMMIS.R1300IA.TAPE()        ³DDNAME: R1300SA          ³
-----³
³I/O Module: BOI1300A ³GDG Limit: 14 ³Retpd: 14 days        ³
-----³
³W/S Copy: W1130TPL ³
-----
    
```

Layout :

		CLASS	OC	FROM	TO
01	W1130000-TPL-MASTER-RECORD.				
05	W1130091-TPL-RECORD-CODE				
	PIC 9(02).	Z	1	01	02
05	W1130091-TPL-KEY-AREA-1.				
10	W1130091-TPL-ALTERNATE-INDEX-2.				
15	W1130091-TPL-RECIPIENT-SSN				
	PIC 9(09).	Z	1	03	11
15	W1130012-TPL-RECIP-ID-2				
	PIC X(12).	C	1	12	23
10	FILLER				
	PIC X(24).	C	1	24	47
05	W1130091-TPL-KEY-AREA-2 REDEFINES				
	W1130091-TPL-KEY-AREA-1.				
10	FILLER				
	PIC X(09).	C	1	03	11
10	W1130091-TPL-RECORD-KEY.				
15	W1130012-TPL-RECIPIENT-ID				
	PIC X(12).	C	1	12	23
15	W1130092-TPL-ALTERNATE-INDEX-1.				
20	W1130013-TPL-SEGMENT-TYPE				
	PIC X(01).	C	1	24	24
20	W1130023-TPL-CARRIER-CODE				
	PIC 9(05).	Z	1	25	29
20	W1130013-TPL-POLICY-NUMBER				
	PIC X(15).	C	1	30	44
15	W1130033-TPL-POLICY-BEG-DATE				
	USAGE IS COMP-3				
	PIC S9(05).	P	1	45	47
05	W1130090-COMMON-DATA.				
10	W1130092-TPL-CASE-ID				
	PIC X(10).	C	1	48	57
10	W1130031-TPL-DATES.				

MIT: Data Conversion requirements

15	W1130031-TPL-POLICY-END-DATE						
	USAGE IS COMP-3						
	PIC S9(05).	P	1	58	60		
15	W1130031-TPL-CLOSURE-DATE						
	REDEFINES W1130031-TPL-POLICY-END-DATE						
	USAGE IS COMP-3						
	PIC S9(05).						
15	W1130031-TPL-ORIGIN-DATE						
	USAGE IS COMP-3						
	PIC S9(05).	P	1	61	63		
15	W1130031-TPL-COST-AVOID-DATE						
	USAGE IS COMP-3						
	PIC S9(05).	P	1	64	66		
15	W1130031-TPL-VERIFICATION-DATE						
	USAGE IS COMP-3						
	PIC S9(05).	P	1	67	69		
15	W1130031-TPL-DATE-LAST-TRANS						
	USAGE IS COMP-3						
	PIC S9(05).	P	1	70	72		
10	W1130011-TPL-POLICY-HOLDER-ID						
	PIC X(15).	C	1	73	87		
10	W1130021-TPL-CONTROL-NUMBER						
	PIC 9(08).	Z	1	88	95		
10	W1130021-TPL-ENTRY-ID						
	USAGE IS COMP-3						
	PIC S9(03).	P	1	96	97		
10	W1130021-TPL-VERIFY-ENTRY-ID						
	USAGE IS COMP-3						
	PIC S9(03).	P	1	98	99		
10	W1130011-TPL-VERIFIED-CODE						
	PIC X.	C	1	100	100		
10	W1130011-TPL-COST-AVOID-CODE						
	PIC X.	C	1	101	101		
10	W1130011-TPL-DATA-SOURCE						
	PIC X.	C	1	102	102		
10	W1131013-TPL-GROUP-NUMBER						
	PIC X(20).	C	1	103	122		
10	W1130011-TPL-CASE-TYPE						
	PIC X(02).	C	1	123	124		
10	W1130011-TPL-POLICY-PRIORITY						
	PIC X.	C	1	125	125		
10	W1130011-TPL-RELATIONSHIP						
	PIC X(03).	C	1	126	128		
10	W1130011-TPL-POLICY-HOLD-NAME						
	PIC X(31).	C	1	129	159		
10	W1130011-TPL-POL-HOLDER-ADDR-1						
	PIC X(25).	C	1	160	184		
10	W1130011-TPL-POL-HOLDER-ADDR-2						
	PIC X(25).	C	1	185	209		
10	W1130011-TPL-POL-HOLDER-CITY						
	PIC X(18).	C	1	210	227		
10	W1130011-TPL-POL-HOLDER-STATE						
	PIC X(02).	C	1	228	229		
10	W1130011-TPL-POL-HOLDER-ZIP						
	PIC X(05).	C	1	230	234		
10	W1130011-TPL-EMPLOYER-NAME						
	PIC X(31).	C	1	235	265		
10	W1131011-TPL-EMPLOYER-ADDR-1						
	PIC X(25).	C	1	266	290		
10	W1131011-TPL-EMPLOYER-ADDR-2						
	PIC X(25).	C	1	291	315		
10	W1131011-TPL-EMPLOYER-CITY						
	PIC X(18).	C	1	316	333		
10	W1131011-TPL-EMPLOYER-STATE						
	PIC X(02).	C	1	334	335		
10	W1131011-TPL-EMPLOYER-ZIP						
	PIC X(05).	C	1	336	340		
10	W1130011-TPL-NOTES.						
15	W1130011-TPL-NOTES-1						

MITS: Data Conversion requirements

		PIC X(50).	C	3	341	390
15	W1130011-TPL-NOTES-2					
		PIC X(50).	C	3	391	440
15	W1130011-TPL-NOTES-3					
		PIC X(50).	C	3	441	490
10	W1130011-TPL-NOTE-ARRAY REDEFINES W1130011-TPL-NOTES.					
15	W1130011-TPL-NOTE-LINE					
	OCCURS 3 TIMES					
	INDEXED BY WX113011-TPL-NOTE-LINE					
		PIC X(50).				
05	W1130090-TPL-INSURANCE.					
10	W1130021-INS-SEND-LETTER-TYPE					
		PIC 9(02).	Z	1	491	492
10	W1130031-INS-SEND-VER-LET-DATE					
	USAGE IS COMP-3					
		PIC S9(05).	P	1	493	495
10	W1130011-INS-PRINT-CARD-PRI					
		PIC X.	C	1	496	496
10	W1130011-INS-COVERAGE-XREF					
		PIC X(01).	C	1	497	497
10	W1130011-INS-STATE-PD-PREMIUM					
		PIC X.	C	1	498	498
10	W1130031-INS-COURT-ORDER-DATE					
	USAGE IS COMP-3					
		PIC S9(05).	P	1	499	501
10	W1130021-INS-LAST-ENTRY-ID					
	USAGE IS COMP-3					
		PIC S9(03).	P	1	502	503
10	W1130021-INS-POLICY-HOLDER-SSN					
		PIC 9(09).	Z	1	504	512
10	W1130021-INS-EMP-CARRIER-CODE					
		PIC 9(05).	Z	1	513	517
10	FILLER					
		PIC X(243).	C	1	518	760
10	W1130091-INS-COVERAGE.					
15	W1130091-INS-COVERAGE-IND					
	OCCURS 40 TIMES					
	INDEXED BY WX1130012-INS-COVERAGE-TYPE.					
20	W1130012-INS-COVERAGE-TYPE					
		PIC X.	C	40	761	800
05	W1131090-TPL-TORT REDEFINES W1130090-TPL-INSURANCE.					
10	W1131021-TRT-CASE-STAT-NUMBER					
		PIC X(07).				
10	W1131021-TRT-WEL-NUMBER					
		PIC X(06).				
10	W1131021-TRT-LAST-TRANS-ID					
	USAGE IS COMP-3					
		PIC 9(03).				
10	W1131011-TRT-SEGMENT-XREF					
		PIC X.				
10	W1131011-TRT-PRINT-CARD-PRTY					
		PIC X.				
10	W1131021-TRT-6613-CLAIM-NUMBER					
		PIC X(20).				
10	W1131023-TRT-FEASOR-COUNT					
		PIC 99.				
10	W1131011-TRT-FEASOR-NAME					
		PIC X(31).				
10	W1131011-TRT-FEASOR-ADDR-1					
		PIC X(25).				
10	W1131011-TRT-FEASOR-ADDR-2					
		PIC X(25).				
10	W1131011-TRT-FEASOR-CITY					
		PIC X(18).				
10	W1131011-TRT-FEASOR-STATE					

```

PIC X(02).
10 W1131011-TRT-FEASOR-ZIP
PIC X(05).
10 FILLER
PIC X(45).
10 W1131091-TRT-DIAGNOSIS-CODES OCCURS 10 TIMES
INDEXED BY WX131091-TRT-DIAGNOSIS-CODES.
15 W1131012-TRT-LOW-CATEGORY.
20 W1131012-TRT-LOW-CATEGORY-3 PIC X(03).
20 FILLER PIC X(03).
15 W1131012-TRT-LOW-CAT REDEFINES
W1131012-TRT-LOW-CATEGORY.
20 W1131012-TRT-LOW-CATEGORY-4.
25 W1131012-TRT-LOW-CATEGORY-1 PIC X.
25 FILLER PIC X(05).
15 W1131012-TRT-HIGH-CATEGORY.
20 W1131012-TRT-HIGH-CATEGORY-3
PIC X(03).
20 FILLER PIC X(03).
15 W1131012-TRT-HIGH-CAT REDEFINES
W1131012-TRT-HIGH-CATEGORY.
20 W1131012-TRT-HIGH-CATEGORY-4.
25 W1131012-TRT-HIGH-CATEGORY-1 PIC X.
25 W1131012-TRT-HIGH-CATEGORY-4-3
PIC X(03).
25 FILLER PIC X(02).

```

## Claim Control File

### Contents/ Comments :

```

CLAIM CONTROL FILE WORK AREA

VSAM -----
3DSN: WELF.CMMIS.C3000IA.DATA 3DDNAME: C3000IA 3
-----3
3Aloc Space: 20, 5 CYL 3File-Aid Map: CLMCNTLF 3
-----3
3I/O Module: BOI3000A 3Pack: WELF01 3Del/Def Job: RC3000IA 3
-----3
3FD: N1300000 3 MODE: VB 3 LENGTH: 4096 3BLK: 32000 3
-----

QSAM -----
3DSN: WELF.PMMIS.C3000IA.TAPE() 3DDNAME: C3000SA 3
-----3
3I/O Module: BOI3000A 3GDG Limit: 14 3Retpd: 5 days 3
-----3
3W/S Copy: 3
3 W1300100 - Batch Control Record 3
3 W1300300 - System Parameter Record 3
3 W1300900 - Control Total Record 3
-----

Record-Code: 02 - Claim Control Record
              04 - System Parameter

Batch Ctl-Sub-Key - First 11 characters of TCN

```

### Layout :

```

01 W1300100-BATCH-CNTL-REC. CLASS OC FROM TO

```

MITS: Data Conversion requirements

05	W1300191-RECORD-KEY.							
10	W1300112-RECORD-CODE	PIC X(2)		1	01	02		
10	W1300132-BATCH-CTL-SUB-KEY	PIC 9(11)	P	1	03	08		
10	FILLER	PIC X(2)		1	09	10		
05	W1300131-BEG-DOCUMENT-NUM	PIC 9(7)	P	1	11	14		
05	W1300131-END-DOCUMENT-NUM	PIC 9(7)	P	1	15	18		
05	W1300131-NUM-OF-DOCUMENTS	PIC 9(8)	P	1	19	23		
05	W1300111-ACCOUNTING-CODE	PIC X		1	24	24		
05	W1300111-BATCH-TYPE	PIC X		1	25	25		
05	W1300131-BATCH-ENTRY-DATE	PIC S9(5)	P	1	26	28		
05	W1300111-BATCH-STATUS	PIC X		1	29	30		
05	W1300131-BATCH-STATUS-DATE	PIC S9(5)	P	1	30	32		
05	W1300131-DATE-OF-LAST-TRANS	PIC S9(5)	P	1	33	35		
05	W1300131-CLERK-IDENTIFICATION	PIC 999	P	1	36	37		
05	W1300131-ONLINE-DOCS-TOTAL	PIC S9(6)	P	1	38	42		
05	FILLER	PIC X(5)		1	42	46		
	W1300300 - SYSTEM PARAMETER		CLASS	OC	FROM	TO		
01	W1300300-SYSTEM-PARAMETER.							
05	W1300391-RECORD-KEY.							
10	W1300312-RECORD-CODE	PIC X(2)	C	1	1	2		
10	FILLER	PIC X(4)	C	1	3	6		
10	W1300312-SYSTEM-PARAMETER-NUM	PIC X(4)	C	1	7	10		
05	W1300311-SYSTEM-PARAM-DESC	PIC X(40)	C	1	11	50		
05	W1300331-DATE-OF-LAST-TRANS	PIC S9(5)	P	1	51	53		
05	W1300331-CLERK-IDENTIFICATION	PIC 9(3)	P	1	54	55		
05	FILLER	PIC X(10)	C	1	56	65		
05	W1300391-SYSTEM-PARAMETER.							
10	W1300392-SYSTEM-PARAMETER			5	66	155		
	INDEXED BY WX1300392-SYSTEM-PARAMETER.							
15	W1300333-SYSTEM-PARAM-EFF-DTE	PIC S9(5)	P					
15	W1300323-SYSTEM-PARAM-EFF-DT2	PIC 9(6)	P					
15	W1300313-SYSTEM-PARAM-TYPE	PIC X	C					
15	W1300313-SYSTEM-PARAM-SIGN	PIC X	C					
15	W1300313-SYSTEM-PARAMETER	PIC X(9)	C					
15	W1300393-SYSTEM-PARAM-DOLLAR							
	REDEFINES W1300313-SYSTEM-PARAMETER.							
20	W1300324-SYSTEM-PARAM-DOLLAR	PIC 9(7)V99	C					
15	W1300393-SYSTEM-PARAM-PERCENT							
	REDEFINES W1300393-SYSTEM-PARAM-DOLLAR.							
20	W1300324-SYSTEM-PARAM-PERCENT	PIC 9V9999	Z					
20	FILLER	PIC X(4)	C					
15	W1300393-SYSTEM-PARAM-DATE							
	REDEFINES W1300393-SYSTEM-PARAM-PERCENT.							
20	W1300324-SYSTEM-PARAM-DATE	PIC 9(6)	Z					
20	W1300314-SYSTEM-PARAM-DATE							
	REDEFINES W1300324-SYSTEM-PARAM-DATE							
		PIC X(6)	C					
20	FILLER	PIC X(3)	C					
15	W1300393-SYSTEM-PARAM-VALUE							
	REDEFINES W1300393-SYSTEM-PARAM-DATE.							
20	W1300324-SYSTEM-PARAM-VALUE	PIC 9(9)	C					

## Prior Authorization

### Contents/ Comments :

```

PRIOR   AUTHORIZATION   WORK   AREA

VSAM
-----
³DSN: WELF.CMMIS.C3700IA.DATA          ³DDNAME: C3700IA          ³
-----
³Alt. WELF.CMMIS.C3700IB.PATH          ³DDNAME: C3700IA1        ³
-----
³Aloc Space: 50,15 Cyl                  ³File-Aid Map: PA        ³
-----
³I/O Module: BOI3700A   ³Pack: WELF05   ³Del/Def Job: RC370IA1-C  ³
-----
³FD: N/P2370000   ³                      ³                      ³
-----
³Mode: VB   ³Length: 3621   ³Blk: 7250   ³
-----

QSAM
-----
³DSN: WELF.PMMIS.C3700IA.TAPE          ³DDNAME: C3700SA          ³
-----
³I/O Module:                      ³GDG Limit: 14   ³Retpd: 14 days          ³
-----
³W/S Copy: W1200000   ³
-----

```

### Layout :

		CLASS	OC	FROM	TO
01	W1370000-PRIOR-AUTH-RECORD.				
05	W1370091-FIXED-PORTION.				
10	W1370092-ALTERNATE-INDEX.				
15	W1370093-RECIP-IDENT-NUMBER.				
20	W1370014-RECIP-CASE-NUMBER				
		PIC X(10)	C	1	10
20	W1370014-RECIP-ADC-NUMBER				
		PIC X(2)	C	11	12
15	W1370013-PROV-CAT-OF-SVC-CODE				
		PIC X(2)	C	1	13
15	W1370033-DATE-ENTERED				
		PIC S9(5)	P	1	15
15	W1370093-RECORD-KEY				
20	W1370034-PRIOR-AUTH-NUM				
		PIC 9(6)	P	1	18
10	W1370092-OCCURRENCE-COUNTERS.				
15	W1370033-NUM-OF-LETTER-TEXT				
		PIC S9(3)	P	1	22
15	W1370033-NUM-OF-COMMENT-TEXT				
		PIC S9(3)	P	1	24
15	W1370033-NUM-OF-CURR-EXCEP				
		PIC S9(3)	P	1	26
15	W1370033-NUM-OF-LINE-ITEMS				
		PIC S9(3)	P	1	28
		CLASS	OC	FROM	TO
10	W1370092-UPDATE-INFORMATION.				
15	W1370033-CLERK-IDENTIFICATION				
		PIC 9(3)	P	1	30
15	W1370033-DATE-OF-LAST-TRANS				
		PIC S9(5)	P	1	32
15	W1370033-PA-CLAIM-UPDATE-DATE				
		PIC S9(5)	P	1	35
15	W1370033-PA-STATUS-DATE				
		PIC S9(5)	P	1	38
15	W1370033-PA-AUTHORIZED-DATE				
		PIC S9(5)	P	1	41
10	W1370032-PROV-NUMBER				
		PIC S9(7)	P	1	44
10	W1370032-EXPIRATION-DATE				
		PIC S9(5)	P	1	48

MITS: Data Conversion requirements

10	W1370022-PRIOR-AUTH-REASON	PIC 9(3)	Z	1	51	53		
10	W1370012-PRIOR-AUTH-STATUS	PIC X	C	1	54	54		
05	W1370091-VARIABLE-PORTION.							
10	W1370092-LETTER-TEXT.							
15	W1370093-LETTER-TEXT			4	55	314		
	INDEXED BY WX1370093-LETTER-TEXT.							
20	W1370014-LETTER-TEXT	PIC X(65)	C					
10	W1370092-COMMENT-TEXT.							
15	W1370093-COMMENT-TEXT			2	315	444		
	INDEXED BY WX1370093-COMMENT-TEXT.							
20	W1370014-COMMENT-TEXT	PIC X(65)	C					
10	W1370092-CURRENT-EXCEPTION.							
15	W1370093-CURRENT-EXCEPTION			25	445	619		
	INDEXED BY WX1370093-CURRENT-EXCEPTION.							
20	W1370014-LINE-ITEM-CODE							
		PIC X(2)	C					
20	W1370034-EXCEPTION-CODE							
		PIC 9(3)	P					
20	W1370014-EXCEPTION-STATUS							
		PIC X(1)	C					
20	W1370034-CLERK-IDENTIFICATION							
		PIC 9(3)	P					
				CLASS	OC	FROM	TO	
10	W1370092-LINE-ITEM.							
15	W1370093-LINE-ITEM			6	620	1081		
	INDEXED BY WX1370093-LINE-ITEM.							
20	W1370014-PRIOR-AUTH-LINE-NO							
		PIC X(1)	C					
20	W1370034-EFFECTIVE-BEGIN-DATE							
		PIC S9(5)	P					
20	W1370034-EFFECTIVE-END-DATE							
		PIC S9(5)	P					
20	W1370014-PRIOR-AUTH-STATUS							
		PIC X(1)	C					
20	W1370034-PROV-NUMBER	PIC S9(7)	P					
20	W1370014-TYPE-OF-SERVICE							
		PIC X(1)	C					
20	W1370014-PROC-CODE	PIC X(5)	C					
20	W1370014-PROC-CODE-MODIFIER							
		PIC X(2)	C					
20	W1370014-TOOTH-NUMBER	PIC X(2)	C					
20	W1370014-DRUG-CODE	PIC X(10)	C					
20	W1370094-PRIOR-AUTH-REASON.							
25	W1370095-PRIOR-AUTH-REASON			3				
	INDEXED BY WX1370095-PRIOR-AUTH-REASON.							
30	W1370026-PRIOR-AUTH-REASON							
		PIC 9(3)	Z					
20	W1370034-AMOUNT-REQUESTED							
		PIC S9(7)V99	P					
20	W1370034-UNITS-REQUESTED							
		PIC S9(5)	P					
20	W1370034-AMOUNT-APPROVED							
		PIC S9(7)V99	P					
20	W1370034-UNITS-APPROVED							
		PIC S9(5)	P					
20	W1370034-AMOUNT-USED							
		PIC S9(7)V99	P					
20	W1370034-UNITS-USED	PIC S9(5)	P					
20	W1370034-APPROVED-UNIT-PRICE							
		PIC S9(7)V99	P					
20	W1370034-PDD-MAX-UNIT-PRICE							
		PIC S9(7)V99	P					
20	W1370034-OVERRIDE-EXCEP-CODE							
		PIC 9(3)	P					

## Report history

### Contents/ Comments :

REPORT HISTORY FILE

This file series is created from the MMIS history file for the purpose of Medicaid information retrieval. The series consists of separate files of:

1. Paid claims
2. Denied Claims
3. Matched original claims with credits/adjustments
4. Mass adjustments and unmatched credit/adjustments

RECORD CONTAINS 2293 CHARACTERS  
 BLOCK CONTAINS 32000 CHARACTERS

DCB=(RECFM=VB,LRECL=2297,BLKSIZE=32000)

CODE	DATA RECORD	RECORD SIZE
-	NCH-CLM-HEADER-COMMON	236
61	N61-INSTITUTIONAL-CLAIM	503-2267
62	N62-PHARMACY-CLAIM	279
60	N60-MEDICAL-CLAIM	311-1171
66	N66-CREDIT-ADJUSTMENT	236

FD's:	WELF.COPYLIB NAME....	Field Name Leading Character
INPUT:	NHISTFD	N
	CHISTFD	C
OUTPUT:	PHISTFD	P
	DHISTFD	D
	FHISTFD	F

All files are created on a calendar quarter basis, starting with year 1988. Histories from 1981 through 1987 are on a year basis. The more recent quarter histories are used frequently and have been placed in the silo mass storage.

Data set names:

Paid history: WELF.CLM.HIST.mmmmyy.nnnnyy  
 Paid history copy: WELF.COPY.HIST.mmmmyy.nnnnyy  
 Denied history: WELF.CLM.DENIED.mmmmyy.nnnnyy  
 Denied history copy: WELF.COPY.DENIED.mmmmyy.nnnnyy, where

mmm = JAN, APR, JUL or OCT  
 nnn = MAR, JUN, SEP or DEC  
 yy = Last two digits of the year

### Layout :

01	NCH-INSTITUTIONAL-CLAIM.	CLASS	OC	FROM	TO
10	NCH-CLM-HEADER-COMMON.				
15	NCH-RECORD-CODE	PIC X(2)	C	1	2
15	NCH-NUM-LINES	PIC S99	COMP	1	4
15	NCH-TRANS-CONTROL-NUM.				
20	NCH-CLM-INPUT-MEDIUM-IND	PIC 9	Z	1	5
20	NCH-BATCH-DATE	PIC 9(5)	Z	1	6

MIT: Data Conversion requirements

20	NCH-MICROFILM-MACHINE-NO	PIC 9	Z	1	11	11
20	NCH-MICROFILM-ROLL-NO	PIC 9	Z	1	12	12
20	NCH-BATCH-NUMBER	PIC 9(3)	Z	1	13	15
20	NCH-DOCUMENT-NUMBER	PIC 9(4)	Z	1	16	19
20	NCH-LINE-NUMBER	PIC 9(2)	Z	1	20	21
15	NCH-TCN REDEFINES NCH-TRANS-CONTROL-NUM.					
20	NCH-CLAIM-ENTRY-DATE	PIC 9(5)	P			
20	NCH-DOC-CTL-NUM	PIC 9(7)	P			
20	NCH-DOC-LINE-NUM	PIC 99	P			
20	NCH-CLM-BATCH-NUM	PIC 9(3)	P			
20	FILLER	PIC X(6)	C			
15	NCH-CLAIM-TRANS-CODE.					
20	NCH-ACCOUNTING-CODE	PIC X(1)	C	1	22	22
20	NCH-CLAIM-STATUS	PIC X(1)	C	1	23	23
15	NCH-REMIT-NBR	PIC X(6)	C	1	24	29
15	NCH-REMIT-NBR-R REDEFINES					
	NCH-REMIT-NBR	PIC 9(6)				
15	NCH-WARRANT-NUMBER	PIC 9(7)	P	1	30	27
15	NCH-CLM-INPUT-FORM-IND	PIC X(1)	C	1	34	34
15	NCH-CLAIM-PROV-DATA.					
20	NCH-GROUP-PROV-NUM	PIC 9(7)	P	1	35	38
20	NCH-SERVICING-PROV-NUM	Redefines NCH-GROUP-PROV-NUM				
20	NCH-PROV-NUM	PIC 9(7)	P	1	39	42
20	NCH-PAYTO-PN redefines NCH-PROV-NUM					
20	NCH-PROV-TYPE	PIC X(2)	C	1	43	44
20	NCH-PROV-CAT-SVC	PIC X(2)	C	1	45	46
20	NCH-PROV-SPEC	PIC X(2)	C	1	47	48
20	NCH-GROUP-PROV-TYPE	PIC X(2)	C	1	49	50
20	NCH-PAYTO-PROV-TYPE redefines NCH-GROUP-PROV-TYPE.					
20	NCH-PROV-COUNTY	PIC X(2)	C	1	51	52
15	NCH-CLAIM-DATES.					
20	NCH-DATE-BILLED	PIC S9(5)	P	1	53	55
20	NCH-ENTRY-DATE	PIC S9(5)	P	1	56	58
20	NCH-ADJ-DATE	PIC S9(5)	P	1	59	61
20	NCH-DATE-PAID	PIC S9(5)	P	1	62	64
20	NCH-FIRST-DATE-OF-SVC	PIC S9(5)	P	1	65	67
20	NCH-LAST-DATE-OF-SVC	PIC S9(5)	P	1	68	70
15	NCH-CLAIM-RECIP-DATA.					
20	NCH-RECIP-IDENT-NUMBER.					
	25 NCH-RECIP-CASE-NBR	PIC X(10)	C	1	71	80
	25 NCH-RECIP-ADC-NBR	PIC X(2)	C	1	81	82
20	NCH-RECIP-LIV-ARRNG	PIC X	C	1	83	83
20	NCH-RECIP-CASE-TYPE	PIC X	C	1	84	84
20	NCH-RECIP-AID-CAT	PIC X	C	1	85	85
20	NCH-RECIP-COUNTY	PIC X(2)	C	1	86	87
20	NCH-RECIP-NAME.					
	25 NCH-RECIP-LAST-NAME	PIC X(14)	C	1	88	101
	25 NCH-RECIP-FIRST-NAME	PIC X(11)	C	1	102	112
20	NCH-RECIP-EXCEP-INDIC	PIC X	C	1	113	113
INSTIT.	CLAIM (CONT'D) . . . . .	CLASS	OC	FROM	TO	
20	NCH-RECIP-DATE-OF-BIRTH	PIC S9(7)	P	1	114	117
20	NCH-RECIP-AGE	PIC S9(3)	P	1	118	119
20	NCH-RECIP-SEX	PIC X	C	1	120	120
20	NCH-RECIP-RACE	PIC X	C	1	121	121
20	NCH-EXTENDED-MCAID-IND	PIC X	C	1	122	122
20	NCH-RECIP-SPENDDOWN-IND	PIC X	C	1	123	123
20	NCH-RECIP-MCARE-IND	PIC X	C	1	124	124
20	NCH-RECIP-NH-INDIC	PIC X	C	1	125	125
20	NCH-MODEL50-IND	PIC X	C	1	126	126
20	NCH-MED-RCD-NBR	PIC X(9)	C	1	127	135
20	FILLER REDEFINES NCH-MED-RCD-NBR					
	25 NCH-PRES-NUM	PIC X(6)	C			
	25 FILLER	PIC X(3)	C			
20	NCH-OTH-INS-IND	PIC X	C	1	136	136
20	NCH-TRAUMA-REL-IND	PIC X	C	1	137	137
15	NCH-CLAIM-PAYMENT-DATA.					
20	NCH-TOTAL-CLAIM-CHRG	PIC S9(7)V99	P	1	138	142
20	NCH-TOT-NON-COV-CHRG	PIC S9(7)V99	P	1	143	147
20	NCH-CLM-RECIP-PMT-AMT	PIC S9(5)V99	P	1	148	151
20	NCH-COMPUTED-RECIP-PMT	PIC S9(5)V99	P	1	152	155

MITS: Data Conversion requirements

20	NCH-COMPUTED-INTEREST	PIC S9(5)V99	P	1	156	159
20	NCH-THIRD-PARTY-PMT-AMT	PIC S9(7)V99	P	1	160	164
20	NCH-AMT-PAID-BY-MCARE	PIC S9(7)V99	P	1	165	169
20	NCH-NET-CLAIM-CHRG	PIC S9(7)V99	P	1	170	174
20	NCH-REIMB-AMT	PIC S9(7)V99	P	1	175	179
15	NCH-FUND-CODE	PIC X	C	1	180	180
15	NCH-CLAIM-CREDIT-DATA.					
20	NCH-ADJUST-REASON	PIC X(2)	C	1	181	182
20	NCH-CLAIM-CREDIT-IND	PIC X	C	1	183	183
20	NCH-TCN-TO-CREDIT	PIC 9(17)	P	1	184	192
20	NCH-TCN-OF-CREDIT	PIC 9(17)	P	1	193	201
15	NCH-FED-CAT-SVC	PIC XX	C	1	202	203
15	NCH-SPECIAL-IND	PIC X	C	4	204	207
15	NCH-PRIOR-AUTH-NUM	PIC 9(6)	P	1	208	211
10	NCH-EXCEPTIONS			5	212	236
15	NCH-EXCEPTION	PIC 9(3)	P			
15	NCH-LINE-ITEM-CODE	PIC X(2)	C			
15	NCH-EXCEPT-STAT	PIC X	C			
10	N61-CLM-HEADER-VARIABLE.					
15	N61-TYPE-BILL.					
20	N61-TYPE-OF-FACILITY	PIC 9	Z	1	237	237
20	N61-CLASS	PIC 9	Z	1	238	238
20	N61-FREQUENCY	PIC 9	Z	1	239	239
15	N61-ATTENDING-PHYSICIAN	PIC 9(7)	P	1	240	243
15	N61-MCARE-PROV-NUMBER	PIC X(6)	C	1	244	249
15	N61-PERFORM-PROV-NUMBER	PIC 9(7)	P	1	250	253
15	N61-ADMISSION-DATA.					
20	N61-ADMISSION-DATE	PIC S9(5)	P	1	254	256
20	N61-ADMISSION-HOUR	PIC 9(2)	Z	1	257	258
20	N61-ADMIT-SOURCE	PIC X	C	1	259	259
20	N61-ADMIT-TYPE	PIC X	C	1	260	260
15	N61-DISCHARGE-HOUR	PIC 9(2)	Z	1	261	262
15	N61-CONSENT-DATE	PIC S9(5)	P	1	263	265
INST.	CLAIM (CONT'D)			CLASS	OC	FROM TO
15	N61-PATIENT-STATUS	PIC X(2)	C	1	266	267
15	N61-COVERED-DAYS	PIC S9(3)	P	1	268	269
15	N61-NH-COV-LEAVE-DAYS					
	REDEFINES N61-COVERED-DAYS					
15	N61-NONCOVERED-DAYS	PIC S9(3)	P	1	270	271
15	N61-NH-NONCOV-LEAVE-DAYS					
	REDEFINES N61-NONCOVERED-DAYS					
15	N61-COIN-DAYS	PIC S9(3)	P	1	272	273
15	N61-NH-LEVEL-OF-CARE	PIC X	C	1	274	274
15	N61-SPEC-PGM-IND	PIC 99	Z	1	275	276
15	N61-MED-RCD-NBR	PIC X(17)	C	1	277	293
15	N61-PROV-WARD	PIC X	C	1	294	294
15	N61-OCCUR-DATA			5	295	319
20	N61-OCCUR-CODE	PIC 99	Z			
20	N61-OCCUR-DATE	PIC S9(5)	P			
15	N61-CONDITION-DATA			5	320	329
20	N61-CONDITION-CODE	PIC 99	Z			
15	N61-VALUE-DATA			3	330	350
20	N61-VALUE-CODE	PIC 99	Z			
20	N61-VALUE-AMOUNT	PIC S9(7)V99	P			
15	N61-PAYER-DATA			3	351	359
20	N61-PAYER-ID	PIC 9(3)	Z			
15	N61-ALLOWED-CHARGE	PIC S9(7)V99	P	1	360	364
15	N61-MCARE-PART-A-DATA.					
20	N61-MCARE-DEDUCTIBLE-AMT					
		PIC S9(7)V99	P	1	365	369
20	N61-MCARE-COINS-AMT	PIC S9(7)V99	P	1	370	374
15	N61-PRIOR-PAYMENT.					
20	N61-PRIOR-PAYMENT	PIC S9(7)V99	P	3	375	389
15	N61-DIAGNOSIS-DATA.					
20	N61-DIAG-STERL-IND	PIC X	C	1	390	390
20	N61-DIAG-ABORT-IND	PIC X	C	1	391	391
20	N61-DIAG-FAM-PLAN-IND	PIC X	C	1	392	392
20	N61-DIAG-CODE-ICD-9	PIC X(5)	C	5	393	417

MITS: Data Conversion requirements

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15 N61-PROCEDURE-DATA.
20 N61-PROC-STERIL-IND      PIC X      C      1  418  418
20 N61-PROC-ABORT-IND      PIC X      C      1  419  419
20 N61-PROC-FAM-PLAN-IND  PIC X      C      1  420  420
20 N61-PROC-HYSTER-IND    PIC X      C      1  421  421
20 N61-PROC-CODE-ICD-9    PIC X(5)   C      3  422  435
15 N61-DRG-DATA.
20 N61-PERCENT-OF-PAYMENT PIC 9V99   Z      1  437  439
20 N61-DRG-CODE           PIC 9(3)   Z      1  440  442
20 N61-DRG-PEER-GRP      PIC X(3)   C      1  443  445
20 N61-DRG-OUTLIER-DAYS  PIC S9(3)  P      1  446  447
20 N61-DRG-OUTLIER-AMOUNT PIC S9(7)V99 P      1  448  452
20 N61-DRG-AMOUNT        PIC S9(7)V99 P      1  453  457
20 N61-DRG-PAY-TYPE      PIC X(2)   C      1  458  459
20 N61-DRG-MDC-CODE      PIC X(2)   C      1  460  461
20 N61-DRG-PROC-CHAR     PIC X      C      6  462  467

10 N61-CLM-DETAIL.
15 N61-LINE-ITEM          D      50 468  XXX
20 N61-LINE-ITEM-CODE    PIC X(2)   C           2
20 N61-LINE-SVC-DATE     PIC S9(5)   P           3
20 N61-PROC-CODE         PIC X(5)   C           5
20 N61-REVENUE-CODE      PIC X(3)   C           3
20 N61-UNITS-SVC         PIC S9(5)   P           3
20 N61-ROOM-RATE         PIC S9(5)V99 P           4
20 N61-SUBMIT-CHRG       PIC S9(7)V99 P           5
20 N61-NON-COV-CHRG      PIC S9(7)V99 P           5
20 N61-ALLOWED-CHRG     PIC S9(7)V99 P           5
20 N61-ALLOWED-CHRG-SOURCE PIC X      C           1
-----END INSTITUTIONAL RECORD-----36-TOTAL LINE

01 NCH-PHARMACY-CLAIM . . . . . CLASS OC FROM TO
10 N62-CLM-HEADER-COMMON (SAME AS INSTITUTIONAL) 1 236

10 N62-CLM-HEADER-VARIABLE.
15 N62-DATE-PRESCRIBED   PIC S9(5)   P      1  237  239
15 N62-DIAG-CODE-ICD-9   PIC X(5)   C      1  240  244
15 N62-PRESC-PHYS-PROV-NUM PIC 9(7)   P      1  245  248
15 N62-DRUG-CODE         PIC X(10)  C      1  249  258
15 N62-DRUG-CLASS        PIC X(3)   C      1  259  261
15 N62-REFILL-INDICATOR  PIC X      C      1  262  262
15 N62-NO-REFILLS-ALLOWED PIC S9(3)  P      1  263  264
15 N62-SUBMITTED-UNITS   PIC S9(5)   P      1  265  267
15 N62-DRUG-QUANTITY     PIC S9(5)   P      1  268  270
15 N62-PRIOR-AUTH-LINE-NO PIC X      C      1  271  271
15 N62-ALLOWED-CHRG     PIC S9(5)V99 P      1  272  275
15 N62-ALLOWED-CHRG-SOURCE PIC X      C      1  276  276
15 N62-DISP-FEE          PIC 9V99   P      1  277  279

-----END PHARMACY RECORD-----

-----CREDIT RECORD-----

01 N66-CREDIT-ADJUSTMENT. . . . . CLASS OC FROM TO
10 N66-CLM-HEADER-COMMON (SAME AS INSTITUTIONAL) 1 236

-----END CREDIT RECORD-----

01 N60-MEDICAL-CLAIM . . . . . CLASS OC FROM TO
10 N60-CLM-HEADER-COMMON (SAME AS INSTITUTIONAL) 1 236

10 N60-CLM-HEADER-VARIABLE.
15 N60-EPSDT-IND         PIC X      C      1  237  237
15 N60-DIAGNOSIS-DATA.
20 N60-DIAG-STERL-IND    PIC X      C      1  238  238
20 N60-DIAG-ABORT-IND    PIC X      C      1  239  239
20 N60-DIAG-FAM-PLAN-IND PIC X      C      1  240  240
20 N60-DIAG-CODE-ICD-9  PIC X(5)   C      2  241  250

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20	N60-EPSDT-HEADER-DATA						
	REDEFINES N60-DIAG-CODE-ICD-9.						
25	N60-IMMUNIZATION-IND	PIC X	C	1			
25	N60-SICKLE-CELL-IND	PIC X	C	1			
25	N60-COMMUN-DISEASE-IND	PIC X	C	1			
25	N60-DENTAL-REFERRAL-IND	PIC X	C	1			
25	FILLER	PIC X(6)	C	1			
15	N60-REFERRING-PROV-NUM	PIC 9(7)	P	1	251	254	
15	N60-FAMILY-PLANNING-CODE	PIC X	C	1	255	255	
15	N60-MCARE-PART-B-DATA.						
20	N60-MCARE-APPROVED-AMT	PIC S9(7)V99	P	1	256	260	
20	N60-MCARE-DEDUCTIBLE-AMT	PIC S9(5)V99	P	1	261	264	
20	N60-MCARE-COINS-AMT	PIC S9(5)V99	P	1	265	268	
10	N60-CLM-DETAIL.						
15	N60-LINE-ITEM		D	21	269		
20	N60-LINE-ITEM-CODE	PIC XX	C			2	
20	N60-PLC-SVC	PIC XX	C			2	
20	N60-LINE-SVC-DATE	PIC S9(5)	P			3	
20	N60-PROCEDURE-DATA.						
25	N60-TYPE-SVC	PIC X	C			1	
25	N60-PROC-CODE	PIC X(5)	C			5	
25	N60-PROC-CODE-MOD	PIC XX	C			2	
25	N60-STERIL-IND	PIC X	C			1	
25	N60-ABORT-IND	PIC X	C			1	
25	N60-FAM-PLAN-IND	PIC X	C			1	
25	N60-HYSTER-IND	PIC X	C			1	
20	N60-EPSDT-LINE-DATA.						
25	N60-EPSDT-DIAG-CODE	PIC X(5)	C			5	
25	N60-DIAGNOSTIC-STATUS	PIC X	C			1	
25	N60-FOLLOW-UP-CODE	PIC X	C			1	
25	N60-NO-FOLLOW-UP-CODE	PIC X	C			1	
20	N60-TOOTH-DATA						
	REDEFINES N60-EPSDT-LINE-DATA.						
25	N60-TOOTH-NUMBER	PIC XX	C				
25	N60-TOOTH-SURFACE	PIC X	C	6			
25	N60-PRESCRIPTION-NUMBER						
	REDEFINES N60-TOOTH-SURFACE						
		PIC X(6)	C				
20	N60-SUBMITTED-UNITS	PIC S9(5)	P			3	
20	N60-UNITS-SVC	PIC S9(5)	P			3	
20	N60-PRIOR-AUTH-LINE-NO	PIC X	C			1	
20	N60-PROCEDURE-CHRG	PIC S9(5)V99	P			4	
20	N60-ALLOWED-CHRG	PIC S9(5)V99	P			4	
20	N60-ALLOWED-CHRG-SOURCE	PIC X	C			1	
-----END MEDICAL RECORD-----							

## Provider Index File

### Contents/ Comments :

INDEX FILE FD's .....

#### Provider Index Files:

CLAIMS HISTORY PROVIDER INDEX FILE: WELF.CMMIS.C3625IE.DATA  
 MONTH TO DATE HISTORY PROVIDER INDEX FILE: WELF.CMMIS.C3625ID.DATA  
 ADJUDICATED CLAIMS PROVIDER INDEX FILE: WELF.CMMIS.C3625IC.DATA  
 SUSPENDED CLAIMS PROVIDER INDEX FILE: WELF.CMMIS.C3625IB.DATA

The Provider Index Files identifies the months of history for which the provider has claim records. The month-of-history values are 1 thru 9, A thru E --- see note on next page. Because most providers generally have more than 100 claims on history, there will be more than one provider history index record for the same provider.

Such records are uniquely identified by the key field DUP-INDEX-REC-COUNT field (1, 2, 3, etc).

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VSAM -----
3DSN:      (above)                               3DCB: VB, 4124 x 32K   3
3-----3
3                               3Length:      3824      3
3-----3
3Del/Def: RC3625B-E   3File-Aid Map: CLMPROVX 3FD: N2362500 3
-----
```

```
QSAM -----
3DSN: WELF.PMMIS.C3625IE.TAPE(GDG) 3GDG Limit: 183 RETPD: 45 3
3DSN: WELF.PMMIS.C3625ID.TAPE(GDG) 3GDG Limit: 103 RETPD: 32 3
3DSN: WELF.PMMIS.C3625IC.TAPE(GDG) 3GDG Limit: 143 RETPD: 14 3
3DSN: WELF.PMMIS.C3625IB.TAPE(GDG) 3GDG Limit: 143 RETPD: 14 3
3-----3
3W/S Copy: W1362500   3File-Aid Map: CLMPROVX3FD: N2362500 3
-----
```

### Layout :

01	N1362500-CLM-PROV-INDEX-REC . . . . .	.CLASS	OC	FROM	TO
05	N1362591-RECORD-KEY				
10	N1362532-PROV-NUMBER	PIC S9(7)	P	1	4
10	N1362592-RECIP-IDENT-NUMBER				
15	N1362513-RECIP-CASE-NUMBER	PIC X(10)	C	1	14
15	N1362513-RECIP-ADC-NUMBER	PIC XX	C	15	17
10	N1362532-FIRST-DATE-OF-SVC	PIC S9(5)	P	17	19
10	N1362542-DUP-INDEX-REC-COUNT	PIC S9(4)	B	20	21
10	FILLER	PIC X	C	22	22
05	N1362531-NUM-OF-LINE-ITEMS	PIC S999	P	23	24
05	N1362591-CLAIM-INDEX-ENTRIES			1-100	25 3824
15	N1362593-CLAIM-FILE-KEY				
20	N1362594-RECIP-IDENT-NUMBER				
25	N1362515-RECIP-CASE-NUMBER	PIC X(10)	C	1	
25	N1362515-RECIP-ADC-NUMBER	PIC XX	C	1	
20	N1362534-FIRST-DATE-OF-SVC	PIC S9(5)	P	1	
20	N1362534-LAST-DATE-OF-SVC	PIC S9(5)	P	1	
20	N1362534-TRANS-CONTROL-NUM	PIC 9(17)	P	1	
15	N1362543-TOTAL-PAID-AMOUNT	PIC S9(7)V99	P	1	
15	N1362533-TOTAL-CLAIM-CHARGE	PIC S9(7)V99	P	1	
15	N1362513-MONTH-OF-HISTORY	PIC X	C	1	

### Claims history recipient Index file

#### Contents/ Comments :

CLAIMS HISTORY RECIPIENT INDEX FILE:

The Recipient Index Files identifies the months of history for which the provider has claim records. The HISTORY-FILE-IND values are either N or Y; the first occurrence being January month history the twelfth December, thirteenth Lifetime, fourteenth Audit. The last two occurrences are value N and reserved for future expansion.

```
VSAM -----
3DSN: WELF.CMMIS.C3680IE.DATA           3DCB: 4096 X 32000   3
3-----3
3                               3Length:      3824      3
3-----3
3Aloc space: 100,25Cyl 3File-Aid Map: RECIPX   3FD: N2368000 3
```

MITS: Data Conversion requirements

```

-----3
3 I/O Module: None          3Pack:WELF06,23,113Del/Def: RC3680IE  3
-----3
QSAM
-----3
3DSN: WELF.PMMIS.C3680IE.TAPE(GDG)3GDG Limit: 18 3RETPD: 99365 3
-----3
3W/S Copy: None          3File-Aid Map: RECIPX  3FD: N2362500  3
-----3

```

Layout :

```

01 N1368000-RECIP-INDEX-RECORD          CLASS OC FROM TO
05 N1368091-RECORD-KEY
10 N1368092-RECIP-IDENT-NUMBER
15 N1368013-RECIP-CASE-NUMBER    PIC X(10)    C  1  1  10
15 N1368013-RECIP-ADC-NUMBER    PIC XX      C  1  11  12
05 N1368091-MONTH-OF-HISTORY
10 N1368092-MONTH-OF-HISTORY          16  13  28
15 N1368013-HISTORY-FILE-IND    PIC X      C
Value 'N' or 'Y'

```

TCN

Contents/ Comments :

The Transaction Control Number Index files identifies which month of history on which the claim is located. The month-of-history values are 1 thru 9, A thru E

Note: Below values of HISTORY-FILE-IND apply to the Provider and TCN History Index files:

- 1 = January
- 2 = February
- 3 = March
- 4 = April
- 5 = May
- 6 = June
- 7 = July
- 8 = August
- 9 = September
- A = October
- B = November
- C = December
- D = Lifetime
- E = Audit

Transaction Control Number Index Files:

```

Claims History TCN Index File:          WELF.CMMIS.C3690IE.DATA
Month-To-Date History TCN Index File:   WELF.CMMIS.C3690ID.DATA
Adjudicated Claims TCN Index File:      WELF.CMMIS.C3690IC.DATA
Suspended Claims TCN Index File:        WELF.CMMIS.C3690IB.DATA

```

Intermediate TCN Index Files:

```

History      WELF.PMMIS.C3690SAM.DISK(GDG)
Suspense     WELF.PMMIS.C3690SAS.DISK(GDG)
Adjudication WELF.PMMIS.C3690SAA.DISK(GDG)
History      WELF.PMMIS.C3690mmm.TAPE(GDG), where mmm = month
History      WELF.PMMIS.C3690SMq.TAPE(GDG), where q = quarter

```

```

VSAM -----3
3DSN: (above)          3DCB: 28 x 31976  3
-----3

```

```

3                                     3Length: 28                                     3
3-----3
3Aloc Space:      ,      Cyl 3File-Aid Map: CLMTCNX  3FD: N2369000  3
3-----3
3I/O Module: None      3Pack:                      3Del/Def: RC3690IE/IB  3
3-----3

QSAM
-----3
3DSN: WELF.PMMIS.C3690IE.TAPE()      3GDG Limit: 18  3RETPD: 45  3
3DSN: WELF.PMMIS.C3690ID.TAPE()      3GDG Limit: 10  3RETPD: 32  3
3DSN: WELF.PMMIS.C3690IC.TAPE()      3GDG Limit: 14  3RETPD: 14  3
3DSN: WELF.PMMIS.C3690IB.TAPE()      3GDG Limit: 3   3RETPD: 14  3
3DSN: WELF.PMMIS.C3690SAA.DISK()     3GDG Limit:     3RETPD:     3
3DSN: WELF.PMMIS.C3690SAM.DISK()     3GDG Limit:     3RETPD:     3
3DSN: WELF.PMMIS.C3690SAS.DISK()     3GDG Limit:     3RETPD:     3
3-----3
3W/S Copy: None      3File-Aid Map: CLMTCNX  3FD: N2369000  3
3-----3

```

**Layout :**

			CLASS	OC	FROM	TO
01	N1369000-TCN-INDEX-RECORD					
05	N1369091-RECORD-KEY					
10	N1369092-RECIP-IDENT-NUMBER					
15	N1369013-RECIP-CASE-NUMBER	PIC X(10)	C	1	1	10
15	N1369013-RECIP-ADC-NUMBER	PIC XX	C	1	11	12
10	N1369032-FIRST-DATE-OF-SVC	PIC S9(5)	P	1	13	15
10	N1369032-LAST-DATE-OF-SVC	PIC S9(5)	P	1	16	18
10	N1369092-RECORD-KEY					
15	N1369033-TRANS-CONTROL-NUM	PIC 9(17)	P	1	19	27
05	N1369011-MONTH-OF-HISTORY	PIC X	C	1	28	28

**Provider Intermediate Index file**

Contents/ Comments :

Provider Intermediate Index Files:

These are Provider Index Files that: 1) have no equivalent on-line disks, 2) are intermediary files (and of different format) used to eventually create the Provider Index Files described on page b-39 that do become on-line files.

```

MTD          WELF.PMMIS.C3620SAM.DISK(GDG)
Suspense     WELF.PMMIS.C3620SSM.DISK(GDG)
Suspense     WELF.PMMIS.C3620SAS.DISK(GDG)
Suspense     WELF.PMMIS.C3620SSS.DISK(GDG)
Adjudicated  WELF.PMMIS.C3620SAA.DISK(GDG)
Adjudicated  WELF.PMMIS.C3620SSA.DISK(GDG)
History      WELF.PMMIS.C3620SMM.DISK(GDG)
WELF.PMMIS.C3620mmm.TAPE(GDG), WHERE mmm = MONTH
WELF.PMMIS.C3620SMq.TAPE(GDG), WHERE q = QUARTER
WELF.PMMIS.C3620SMH.TAPE(GDG)

```

```

3DSN:      (above)                                     3DCB:  64  X  32000  3
3-----3
3                                     3Length:   64      3
3-----3
3Aloc Space:      ,      Cyl 3File-Aid Map: CLMPROVX  3FD: N2362000  3
3-----3
3I/O Module:      3Pack:                      3Restore:      3
3-----3

```

**Layout :**

01	N1360000-CLM-INDEX-DATA-REC . . . . .	.CLASS	OC	FROM	TO
05	N1360011-RECORD-CODE	'83'	PIC X(2)	C	1 1 2

MITS: Data Conversion requirements

05	N1360091-CLAIM-FILE-KEY							
10	N1360092-RECIP-IDENT-NUMBER							
	15 N1360013-RECIP-CASE-NUMBER	PIC X(10)	C	1	3	12		
	15 N1360013-RECIP-ADC-NUMBER	PIC X(2)	C	1	13	14		
	10 N1360032-FIRST-DATE-OF-SVC	PIC S9(5)	P	1	15	17		
	10 N1360032-LAST-DATE-OF-SVC	PIC S9(5)	P	1	18	20		
	10 N1360032-TRANS-CONTROL-NUM	PIC 9(17)	P	1	21	29		
05	N1360011-MONTH-OF-HISTORY	PIC X	C	1	30	30		
05	N1360011-CLAIM-STATUS	PIC X	C	1	31	31		
05	N1360011-CLAIM-LOCATION-CODE	PIC XX	C	1	32	33		
05	N1360011-ACCOUNTING-CODE	PIC X	C	1	34	34		
05	N1360031-PROV-NUMBER	PIC S9(7)	P	1	35	38		
05	N1360011-CLM-INPUT-FORM-IND	PIC X	C	1	39	39		
05	N1360031-REMITTANCE-ADVICE-NO	PIC 9(6)	P	1	40	43		
05	N1360031-WARRANT-NUMBER	PIC 9(6)	P	1	44	47		
05	N1360031-DATE-PAID	PIC S9(5)	P	1	48	50		
05	N1360031-TOTAL-CLAIM-CHARGE	PIC S9(7)V99	P	1	51	55		
05	N1360031-REIMBURSEMENT-AMOUNT	PIC S9(7)V99	P	1	56	60		
05	N1360031-COMPUTED-INTEREST	PIC S9(5)V99	P	1	61	64		

## Provider Summary

### Contents/ Comments :

PROVIDER HISTORY M-T-D, MONTHLY SUMMARY RECORD

The Provider Summary File contains a record of the last three payments for the Provider. It can be accessed in MMISPROD in the Claims Inquiry application.

VSAM -----

```

3DSN: WELF.CMMIS.C3630ID.DATA          3DCB: 81  x  31995      3
3      WELF.CMMIS.C3630mmm.DATA        3-----3
3      where mmm=JAN/LIF                3Length:  81          3
3-----3
3File-Aid Map: PROVSUM  3FD: N2363000, P2363000 3W/A: W13630003
3-----3
3I/O Module: BOI3630A  3Restore: RC3630ID, RC3630mm 3
-----

```

QSAM -----

```

3DSN: WELF.PMMIS.C3630ID.TAPE (GDG)    3DCB: 81  x  31995      3
3      WELF.PMMIS.C3630mmm.TAPE (GDG)  3-----3
3-----3
3Length:  81          3
3-----3
3File-Aid Map: PROVSUM  3FD: N2363000, P2363000 3W/A: W136300 3
3-----3
3I/O Module: BOI3630A  3Pack:                3Restore: RC3630ID 3
-----

```

### Layout :

```

01 P1363000-SUMMARY-MTD-HIST-REC . . . . . CLASS OC FROM TO
05 P1363091-RECORD-KEY.
   10 P1363032-PROV-NUMBER          PIC S9(7)      P  1  1  4
05 P1363031-TOTAL-PAID-CLAIMS     PIC S9(11)    P  1  5  11
05 P1363031-TOTAL-PAID-AMOUNT     PIC S9(13)V99 P  1  11 18
05 P1363031-TOTAL-DENIED-CLAIMS   PIC S9(11)    P  1  19 24
05 P1363091-PROV-SUM-CHECK-DATA.
   10 P1363092-PROV-SUM-CHECK-DATA          3  25 81
      INDEXED BY PX1363092-PROV-SUM-CHECK-DATA.

```

15	P1363033-REMITTANCE-ADVICE-NO	PIC 9(6)	P	1
15	P1363033-WARRANT-NUMBER	PIC 9(6)	P	1
15	P1363033-TOTAL-PAID-AMOUNT			
		PIC S9(13)V99	P	1
15	P1363033-DATE-PAID	PIC S9(5)	P	1

## Generic Finder Record

Contents/ Comments :

QSAM

```

³DSN: WELF.PMMIS.C3600SA.DISK()      ³DDNAME: C3600SA³
³-----³
³DSN: WELF.PMMIS.EC2500SA.DISK()      ³DDNAME: C4061SA³
³-----³
³DSN: WELF.PMMIS.EC2500SB.DISK()      ³DDNAME: C4061SB³
³-----³
³Alloc Space: Varies      ³File-Aid Map: None      ³
³-----³
³I/O Module: BOI4061A,B      ³GDG Limit: 1      ³RETPD:      ³
³      *BOI4090A,B      ³      ³      ³
³-----³
³W/S Copy: W1418100      ³FD: N2406100, P2406100,      ³
³      *N2409000,*P2409000      ³
³-----³
³MODE: VB      ³Length: 324      ³BLK: 23476      ³DCB: See JCL      ³
³-----³

```

\*BOI4090A,B and N/P2409000 are for the normal claims records plus the finder. Others are only the finder.

This is a generic format used for various "finder" records:

Record-Code	Finder.....	Programs.....
69	Drug code	BOMC2000,BOMC2100,BOMC2500
70	HCPC Procedure	BOMC2000,BOMC2100,BOMC2500
71	Diagnosis code	BOMC2000,BOMC2100,BOMC2500
72	DRG code	Not used
73	TCN number	BOMC3600, BOMC4000

## Layout :

```

01 W1418100-PDD-FINDER-REC.                CLASS OC FROM TO
05 W1418111-RECORD-CODE                    PIC X(2) C 1 1- 2
05 W1418111-SORT-KEY                       PIC X(30) C 1 3-32
05 W1418131-NUM-OF-LINE-ITEMS              PIC S9(3) P 1 33-34
05 W1418131-NUM-OF-CURR-EXCEP             PIC S9(3) P 1 35-36
05 W1418131-NUM-OF-COMM-EXCEP             PIC S9(3) P 1 37-38
05 W1418131-NUM-OF-TPL-SEGMENTS           PIC S9(3) P 1 39-40
05 W1418131-NUM-OF-MISC-PROV               PIC S9(3) P 1 40-41
05 W1418131-NUM-OF-EXPANDS                 PIC S9(3) P 1 42-43
05 W1418111-TYPE-FINDER-REC-IND           PIC X(1) C 1 44-44
05 W1418111-DRUG-CODE                      PIC X(10) C 1 45-54
05 W1418191-PROC-CODE
    REDEFINES W1418111-DRUG-CODE.
10 W1418112-TYPE-OF-SERVICE                PIC X(1) C 1 45-45
10 W1418112-PROC-CODE                      PIC X(5) C 1 46-50
10 FILLER                                  PIC X(4) C 1 51-54
05 W1418191-DIAG-CODE-ICD-9
    REDEFINES W1418191-PROC-CODE.
10 W1418112-DIAG-SCHEME-CODE              PIC X C 1 45-45
10 W1418112-DIAG-CODE-ICD-9               PIC X(6) C 1 46-51
10 FILLER                                  PIC X(3) C 1 52-54
05 W1418191-TCN-TO-CREDIT
    REDEFINES W1418191-DIAG-CODE-ICD-9.
10 W1418132-TCN-TO-CREDIT                  PIC 9(17) P 1 45-53

```

MITS: Data Conversion requirements

10	FILLER	PIC X	C	1	54-54
05	W1418131-ACCUMULATOR	PIC S9(9)	P	1	55-59

### Provider Charge File

#### Contents/ Comments :

```

VSAM -----
  3DSN:  WELF.CMMIS.F5010IA.DATA          3DDNAME:  F5010IA          3
-----
  3Alloc Space:  CYL(1,1)                  3File-Aid Map:  PROVCHRG  3
-----
  3I/O Module:  BOI5010A  3Pack:  WELF03  3Del/Def Job:  RF5010IA  3
-----
  3FD:  N2500500  3Mode:  VB  3Length 4092  3Blk:  32760          3
-----

QSAM -----
  3DSN:  WELF.PMMIS.F5010IA.TAPE(0)      3DDNAME:  F5010SA          3
-----
  3I/O Module:  BOI5010A  3GDG Limit: 13  3RETPD:  14          3
-----
  3W/S Copy:  W1500500, W150050L  3
-----
  
```

#### Layout :

			CLASS	OC	FROM	TO
01	N1500500-PROV-CHARGE-REC.					
05	N1500591-RECORD-KEY.					
10	N1500512-RECORD-CODE '55'	PIC X(2)	C		1	2
10	N1500522-PROV-NUMBER	PIC 9(7)	Z		3	9
10	N1500512-TYPE-OF-SERVICE	PIC X	C		10	20
10	N1500512-PROC-CODE	PIC X(5)	C		11	15
05	N1500531-DATE-OF-LAST-TRANS	PIC S9(5)	P		16	18
05	N1500531-CLERK-IDENTIFICATION	PIC 9(3)	P		19	129
05	N1500591-MCAID-CUST-CHRG-DATA				11	
	INDEXED BY NX1500591-MCAID-CUST-CHRG-DATA.					
10	N1500532-MEDICAID-CUST-CHRG	PIC S9(5)V99	P			
10	N1500532-MCAID-CUST-BEGIN-DTE	PIC S9(5)	P			
10	N1500532-MCAID-CUST-END-DATE	PIC S9(5)	P			
01	N1599900-PROV-CHARGE-TOT-REC.		CLASS	OC	FROM	TO
05	N1599911-RECORD-CODE '94'	PIC X(2)	C		1	2
05	N1599991-RECORD-KEY.					
10	FILLER	PIC X(13)	C		3	15
05	N1599931-DATE-OF-LAST-TRANS	PIC S9(5)	P		16	18
05	N1599931-NUM-OF-TOTAL-ENTRIES	PIC S9(3)	P		19	20
05	N1599991-TOTAL-COUNT-DATA.					
10	N1599932-TOTAL-MONTH-BEGIN	PIC S9(7)	P		21	24
10	N1599932-TOTAL-CURRENT	PIC S9(7)	P		25	28
10	N1599932-TOTAL-MTHLY-ADDS	PIC S9(7)	P		29	32
10	N1599932-TOTAL-DAILY-DELETES	PIC S9(7)	P		33	36
10	N1599932-TOTAL-MTHLY-CHANGES	PIC S9(7)	P		37	40

### Special Program Provider File

#### Contents/ Comments :

```

SPECIAL PROGRAM PROVIDER FILE

VSAM -----
  3DSN:  WELF.CMMIS.R1280IA.DATA          3DDNAME:  R1280IA          3
-----
  
```

MITS: Data Conversion requirements

```

³Alloc Space: CYL(30,5)                ³File-Aid Map:  SPECPROV  ³
-----
³I/O Module:  BOI1280A  ³Pack:  WELF04  ³Del/Def Job:  RR1280IA  ³
-----
³FD:  N2128000  ³Mode:  VB  ³Length 4092  ³BLK:  32760  ³
-----

QSAM  -----
³DSN:  WELF.PMMIS.R1280IA.TAPE(0)    ³DDNAME:  R1280SA  ³
-----
³I/O Module:  BOI5010A  ³GDG Limit:  11  ³RETPD:  14  ³
-----
³W/S Copy:  W1128000  ³
-----
    
```

Layout :

01	W1128000-SPEC-PROG-PROV-REC.						
05	W1128091-RECORD-KEY.						
10	W1128012-SPECIAL-PGM-IND	PIC X	C		1	1	
10	W1128022-PROV-NUMBER	PIC 9(7)	Z		2	8	
10	W1128012-RECIP-IDENT-NUMBER	PIC X(12)	C		9	20	
05	W1128031-DATE-OF-LAST-TRANS	PIC S9(5)	P		21	23	
05	FILLER	PIC X(5)	C		24	28	

Nursing Home Provider File

Contents/ Comments :

```

                                NURSING HOME PROVIDER FILE

VSAM  -----
³DSN:  WELF.CMMIS.R1260IA.DATA    ³DDNAME:  R1260IA  ³
-----
³Alloc Space:  CYL(75,10)                ³File-Aid Map:  NHPROV  ³
-----
³I/O Module:  BOI1260A  ³Pack:  WMED01  ³Del/Def Job:  RR1260IA  ³
-----
³FD:  N1126000  ³Mode:  VB  ³Length 27  ³BLK:  32760  ³
-----

QSAM  -----
³DSN:  WELF.PMMIS.R1260IA.TAPE(0)    ³DDNAME:  R1260SA  ³
-----
³I/O Module:  None  ³GDG Limit:  14  ³RETPD:  14  ³
-----
³W/S Copy:  W1126000  ³
-----
    
```

Layout :

01	W1126000-NURS-HOME-PROV-REC.						
05	W1126091-RECORD-KEY.						
10	W1126022-PROV-NUMBER	PIC 9(7)	Z	1	1	7	
10	W1126012-RECIP-IDENT-NUMBER	PIC X(12)	C	1	8	19	
05	W1126031-DATE-OF-LAST-TRANS	PIC S9(5)	P	1	20	22	
05	FILLER	PIC X(5)	C	1	23	27	

## Warrant Writer File

### Contents/ Comments :

WARRANT WRITER FILE

The Warrant Writer File tape copy version (WELF.HCWF06T1.Gnnn) is used by CAS and the State Auditor to create the warrants. The below proposed format was NEVER installed. It remains in the Guide for future possible installation. The first 230 characters and corresponding data fields are fixed by CAS and State Auditor and can not be altered locally.

The last 70 characters are optional to each state department's program needs. Medicaid requires a warrant number and a pay-to provider number. N1410011-DASHES is reserved for future development of dash indicators for the ODJFS Mail Room Pitney-Bolles equipment operation.

```

QSAM
1. 3DSN: WELF.PMMIS.C7500SA.DISK(0)          3Limit: 6  3
-----3
3  MODE: FB  3 LENGTH: 300  3BLKSIZE: 9000  3WELF06  3
-----3
2. 3DSN: WLFT.HCWF06T1.Gnnn, where nnn = sequential number  3
-----3
3  MODE: FB  3 LENGTH: 300  3BLKSIZE: 9000  3RETPD: 45  3
-----3
**3. 3DSN: WELF.CAS.VSU.MEDICAID.D(yymmdd).BA(voucher)  3
-----3
3  MODE: FB  3 LENGTH: 252  3BLKSIZE: 2520  3WELF06  3
-----3
3 I/O Module: NONE  3FD: N2410000  3W/S: NONE  3
-----3
3 W/S Copy: NONE  3File-Aid Map:  3
-----3
    
```

\*\* Discontinued in \_\_\_\_\_ 199\_.

### Layout :

		CLASS	OC	FROM	TO
01	N1410000-WARRANT-TAPE-RECORD				
05	N1410021-RECORD-ID	PIC X(3)	C	1	3
	VALUE 'MED'				
05	N1410021-EFT-FLAG	PIC X	C	1	4
	VALUE 'N'				
05	N1410021-PROV-TAX-ID	PIC X(9)	C	1	5
05	N1410021-PROV-ADDR-CODE	PIC XX	C	1	14
	VALUE ' '				
05	N1410071-PROV-NAME	PIC X(26)	C	1	16
05	FILLER	PIC X(9)	C	1	42
05	N1410071-PROV-ADDR-LINE-1	PIC X(26)	C	1	51
05	FILLER	PIC X(9)	C	1	77
05	N1410071-PROV-ADDR-LINE-2	PIC X(26)	C	1	86
05	FILLER	PIC X(9)	C	1	112
05	FILLER	PIC X(35)	C	1	121
05	N1410071-PROV-ADDR-LINE-3.				
10	N1410012-PROV-CITY	PIC X(22)	C	1	156
10	FILLER	PIC X	C	1	178
10	N1410071-PROV-STATE	PIC XX	C	1	179
10	FILLER	PIC X	C	1	181
10	N1410041-PROV-ZIP-CODE	PIC 9(9)	Z	1	182
05	FILLER	PIC X(2)	C	1	191
05	N1410051-DATE-PAID	PIC 9(6)			

MITS: Data Conversion requirements

10	N1410051-DATE-YY	PIC 99	Z	1	193	194
10	N1410051-DATE-MM	PIC 99	Z	1	195	196
10	N1410051-DATE-DD	PIC 99	Z	1	197	198
05	N1410041-VOUCHER-NUMBER	PIC 9(6)	Z	1	200	204
05	N1410021-WARRANT-DEPT	PIC 9(3)	Z	1	205	207
	VALUE	400				
05	N1410071-WARRANT-X	PIC 99	Z	1	208	209
	VALUE	00				
05	N1410081-WARRANT-AMOUNT	PIC S9(7)V99	Z	1	210	218
05	N1410021-DIST-DEPT	PIC X(3)	Z	1	219	221
	VALUE	'HUM'				
05	N1410021-FUND-CODE	PIC XX	Z	1	222	223
	VALUE	'01'				
05	FILLER	PIC XX	Z	1	224	225
05	N1410041-SEQUENCE-NUMBER	PIC 9(5)	Z	1	226	230
05	N1410071-WARRANT-NUMBER	PIC 9(7)	Z	1	231	237
05	N1410071-PAY-TO-PROV-NUM	PIC 9(7)	Z	1	238	244
05	N1410011-DASHS	PIC XXX	C	1	245	247
05	N1410011-WRNT-TYPE	PIC X	C	1	248	248
	VALUE	'H'				
05	N1410011-WRNT-SRCE	PIC X	C	1	249	249
	VALUE	'E'				
05	FILLER	PIC X(53)	C	1	250	300

## Provider Medicare Provider Cross Over

### Contents/ Comments :

PROVIDER MEDICARE PROVIDER CROSS-OVER

```

VSAM -----
 3DSN: WELF.CMMIS.P2500IA.DATA      3DDNAME: P2500IA      3
 3-----3
 3ALT: WELF.CMMIS.P2500IB.PATH      3DDNAME: P2500IB      3
 3-----3
 3Alloc Space: CYL(30,5)             3File-Aid Map: NHPROV   3
 3-----3
 3I/O Module: BOI2500A 3Pack: WELF04 3Del/Def Job: RP2500IA 3
 3          3          3          3          RP2500IB 3
 3-----3
 3FD: N2250000 3Prime: Mode: FB 3Length: 30 3BLK: 6210 3
 3  N1250000 3 Alt: VB 3 766 3 32000 3
 3-----3
    
```

```

QSAM -----
 3DSN: WELF.PMMIS.P2500IA.TAPE(0)    3DDNAME: P2500SA      3
 3-----3
 3I/O Module: None 3GDG Limit: 14 3RETPD: 14 3
 3-----3
 3W/S Copy: W1250000 3
 3-----3
    
```

### Layout :

			CLASS	OC	FROM	TO
01	W1250000-MCARE-MCAID-IDX-REC.					
05	W1250011-RECORD-CODE	PIC X(2)	C	1	1	2
05	W1250091-RECORD-KEY.					
10	W1250012-MEDICARE-PROV-NUM	PIC X(12)	C	1	3	14
10	W1250032-PROV-NUM-EFF-DATE	PIC S9(5)	P	1	15	17

MITS: Data Conversion requirements

05	W1250011-PROV-NUMBER	PIC X(7)	C	1	18	24
05	W1250011-CLERK-IDENTIFICATION	PIC X(3)	C	1	25	27
05	W1250031-DATE-OF-LAST-TRANS	PIC S9(5)	P	1	28	30

## Provider Group Affiliation

### Contents/ Comments :

PROVIDER GROUP AFFILIATION

```

VSAM -----
 ³DSN:  WELF.CMMIS.P2600IA.DATA      ³DDNAME:  P2600IA      ³
-----
 ³Alloc Space:  CYL( 5,5)            ³File-Aid Map:      ³
-----
 ³I/O Module:  BOI2600A  ³Pack:  WELF02  ³Del/Def Job:  RP2600IA  ³
-----
 ³FD:  N2260000  ³Mode:  FB  ³Length:  16  ³BLK:   6224  ³
 ³      N1260000  ³      ³      ³      ³      ³
-----

QSAM -----
 ³DSN:  WELF.PMMIS.P2600IA.TAPE(0)    ³DDNAME:  P2600SA      ³
-----
 ³I/O Module:  None  ³GDG Limit:  14  ³RETPD:   14  ³
-----
 ³W/S Copy:  W1260000  ³
-----
    
```

### Layout :

			CLASS	OC	FROM	TO
01	W1260000-GROUP-PROV-REC.					
05	W1260011-RECORD-CODE	PIC X(2)	C	1	1	2
05	W1260091-RECORD-KEY.					
10	W1260022-PROV-NUMBER	PIC 9(7)	Z	1	3	9
10	W1260022-PROV-MEMBER-NUM	PIC 9(7)	Z	1	10	16

## Provider Intermediary

### Contents/ Comments :

PROVIDER INTERMEDIARY

```

VSAM -----
 ³DSN:  WELF.CMMIS.P2700IA.DATA      ³DDNAME:  P2700IA      ³
-----
 ³Alloc Space:  CYL( 2,1)            ³File-Aid Map:      ³
-----
 ³I/O Module:  BOI2700A  ³Pack:  WELF02  ³Del/Def Job:  RP2700IA  ³
-----
 ³FD:  N2270000  ³Mode:  FB  ³Length:  16  ³BLK:   6224  ³
 ³      N1270000  ³      ³      ³      ³      ³
-----

QSAM -----
 ³DSN:  WELF.PMMIS.P2700IA.TAPE(0)    ³DDNAME:  P2700SA      ³
-----
 ³I/O Module:  None  ³GDG Limit:  14  ³RETPD:   14  ³
-----
 ³W/S Copy:  W1270000  ³
-----
    
```

Layout :

			CLASS	OC	FROM	TO
01	W1270000-GROUP-INTERMED-REC.					
05	W1270011-RECORD-CODE	PIC X(2)	C	1	1	2
05	W1270091-RECORD-KEY.					
10	W1270022-PROV-NUMBER	PIC 9(7)	Z	1	3	9
10	W1270022-INTERMED-PROV-NUM	PIC 9(7)	Z	1	10	16

CRIS-E Extract record

Contents/ Comments :

CRIS-E EXTRACT RECORD

The Provider Summary File contains a record of the last three payments for the Provider. It can be accessed in MMISPROD in the Claims Inquiry application.

VSAM -----  
<sup>3</sup>DSN: WELF.CMMIS.C3630ID.DATA <sup>3</sup>DCB: 81 x 31995 <sup>3</sup>  
<sup>3</sup> WELF.CMMIS.C3630mmm.DATA <sup>3</sup>-----<sup>3</sup>  
<sup>3</sup> where mmm=JAN/LIF <sup>3</sup>Length: 81 <sup>3</sup>  
<sup>3</sup>-----<sup>3</sup>  
<sup>3</sup>File-Aid Map: PROVSUM <sup>3</sup>FD: N2363000, P2363000 <sup>3</sup>W/A: W1363000 <sup>3</sup>  
<sup>3</sup>-----<sup>3</sup>  
<sup>3</sup>I/O Module: BOI3630A <sup>3</sup>Restore: RC3630ID, RC3630mm <sup>3</sup>  
<sup>3</sup>-----<sup>3</sup>

QSAM -----  
<sup>3</sup>DSN: WELF.PMMIS.C3630ID.TAPE (GDG) <sup>3</sup>DCB: 81 x 31995 <sup>3</sup>  
<sup>3</sup> WELF.PMMIS.C3630mmm.TAPE (GDG) <sup>3</sup>-----<sup>3</sup>  
<sup>3</sup> <sup>3</sup>Length: 81 <sup>3</sup>  
<sup>3</sup>-----<sup>3</sup>  
<sup>3</sup>File-Aid Map: PROVSUM <sup>3</sup>FD: N2363000, P2363000 <sup>3</sup>W/A: W136300 <sup>3</sup>  
<sup>3</sup>-----<sup>3</sup>  
<sup>3</sup>I/O Module: BOI3630A <sup>3</sup>Pack: <sup>3</sup>Restore: RC3630ID <sup>3</sup>  
<sup>3</sup>-----<sup>3</sup>

Layout :

			CLASS	OC	FROM	TO
01	P1363000-SUMMARY-MTD-HIST-REC . . . . .					
05	P1363091-RECORD-KEY.					
10	P1363032-PROV-NUMBER	PIC S9(7)	P	1	1	4
05	P1363031-TOTAL-PAID-CLAIMS	PIC S9(11)	P	1	5	11
05	P1363031-TOTAL-PAID-AMOUNT	PIC S9(13)V99	P	1	11	18
05	P1363031-TOTAL-DENIED-CLAIMS	PIC S9(11)	P	1	19	24
05	P1363091-PROV-SUM-CHECK-DATA.					
10	P1363092-PROV-SUM-CHECK-DATA			3	25	81
	INDEXED BY PX1363092-PROV-SUM-CHECK-DATA.					
15	P1363033-REMITTANCE-ADVICE-NO	PIC 9(6)	P	1		
15	P1363033-WARRANT-NUMBER	PIC 9(6)	P	1		
15	P1363033-TOTAL-PAID-AMOUNT					
		PIC S9(13)V99	P	1		
15	P1363033-DATE-PAID	PIC S9(5)	P	1		

## Generic Finder Record/ PDD Finder

### Contents/ Comments :

```

GENERIC    FINDER    RECORD

QSAM
-----3-----
3DSN:  WELF.PMMIS.C3600SA.DISK()      3DDNAME: C3600SA3
-----3-----
3DSN:  WELF.PMMIS.EC2500SA.DISK()    3DDNAME: C4061SA3
-----3-----
3DSN:  WELF.PMMIS.EC2500SB.DISK()    3DDNAME: C4061SB3
-----3-----
3Aloc Space:  Varies                3File-Aid Map:  None      3
-----3-----
3I/O Module:  BOI4061A,B            3GDG Limit:  1      3RETPD:      3
3                *BOI4090A,B      3                3
-----3-----
3W/S Copy:  W1418100                3FD:  N2406100, P2406100,
3                3                3*N2409000, *P2409000
-----3-----
3MODE:  VB      3Length: 324      3BLK: 23476  3DCB: See JCL  3
-----3-----
*BOI4090A,B and N/P2409000 are for the normal claims
records plus the finder. Others are only the finder.
    
```

This is a generic format used for various "finder" records:

Record-Code	Finder.....	Programs.....
69	Drug code	BOMC2000, BOMC2100, BOMC2500
70	HCPC Procedure	BOMC2000, BOMC2100, BOMC2500
71	Diagnosis code	BOMC2000, BOMC2100, BOMC2500
72	DRG code	Not used
73	TCN number	BOMC3600, BOMC4000

### Layout :

```

01  W1418100-PDD-FINDER-REC.                CLASS  OC  FROM  TO
05  W1418111-RECORD-CODE                    PIC X(2)  C   1    1- 2
05  W1418111-SORT-KEY                       PIC X(30) C   1    3-32
05  W1418131-NUM-OF-LINE-ITEMS              PIC S9(3) P   1   33-34
05  W1418131-NUM-OF-CURR-EXCEP             PIC S9(3) P   1   35-36
05  W1418131-NUM-OF-COMM-EXCEP             PIC S9(3) P   1   37-38
05  W1418131-NUM-OF-TPL-SEGMENTS           PIC S9(3) P   1   39-40
05  W1418131-NUM-OF-MISC-PROV              PIC S9(3) P   1   40-41
05  W1418131-NUM-OF-EXPANDS                PIC S9(3) P   1   42-43
05  W1418111-TYPE-FINDER-REC-IND          PIC X(1)  C   1   44-44
05  W1418111-DRUG-CODE                     PIC X(10) C   1   45-54
05  W1418191-PROC-CODE
      REDEFINES W1418111-DRUG-CODE.
10  W1418112-TYPE-OF-SERVICE                PIC X(1)  C   1   45-45
10  W1418112-PROC-CODE                     PIC X(5)  C   1   46-50
10  FILLER                                  PIC X(4)  C   1   51-54
05  W1418191-DIAG-CODE-ICD-9
      REDEFINES W1418191-PROC-CODE.
10  W1418112-DIAG-SCHEME-CODE              PIC X     C   1   45-45
10  W1418112-DIAG-CODE-ICD-9              PIC X(6)  C   1   46-51
10  FILLER                                  PIC X(3)  C   1   52-54
05  W1418191-TCN-TO-CREDIT
      REDEFINES W1418191-DIAG-CODE-ICD-9.
10  W1418132-TCN-TO-CREDIT                 PIC 9(17) P   1   45-53
10  FILLER                                  PIC X     C   1   54-54
05  W1418131-ACCUMULATOR                   PIC S9(9) P   1   55-59
    
```

# **Supplement 8**

## **MIS STANDARDS AND BEST PRACTICES**

# **ODJFS Standards & Best Practices**

## ***ODJFS MIS Policies, Standards, and Procedures (PSPs)***

The following ODJFS MIS Policies, Standards, and Procedures are officially published in the ODJFS Intranet and will be made available to the Contractor upon request.

<b>PSP #</b>	<b>Title</b>
MIS:048	DB2 Object Naming Standards

## ***Other ODJFS Technology Standards and Best Practices***

These documents, which address various platforms and types of technologies, are contained within this repository. Although they are included in this packet, some documents are in draft format. As technology progresses and standards and best practices evolve, it should be assumed that ODJFS' practices and procedures will evolve accordingly. Additionally, these documents cover technologies widely used in ODJFS; should the Contractor propose alternate technology, the Contractor should adhere to industry standards and best practices relevant for the technology.

- SQL Server 2000 Security and Best Practices
- UNIX and WebSphere Standards & Best Practices

## ***ODAS Office of Information Technology Standards & Best Practices***

These documents address the various services, standards, and procedures administered by the Department of Administrative Services' Office of Information Technology (OIT). The Contractor should plan to adhere to the standards and procedures outlined in these documents. These documents are contained within this repository.

- OIT Secured Hosting Service
- OIT UNIX Systems Services (CG210031105)
- OIT Windows System Services Policies & Procedures Manual

## ***Industry Standard Specifications for the J2EE Platform***

The State adheres to, and expects the Contractor to adhere to, the following commonly accepted and industry standard specifications for the J2EE platform if that technology is utilized. If the successful Contractor utilizes an alternate platform, just as .NET, the Contractor should adhere to similar industry standards for that platform.

[http://java.sun.com/j2ee/j2ee-1\\_4-fr-spec.pdf](http://java.sun.com/j2ee/j2ee-1_4-fr-spec.pdf)

[http://java.sun.com/j2ee/j2ee-1\\_3-fr-spec.pdf](http://java.sun.com/j2ee/j2ee-1_3-fr-spec.pdf)

<http://java.sun.com/j2ee/download.html#platformspec>

## I. PURPOSE

This standard establishes the naming format to be used for DB2 objects by Management Information Services (MIS).

## II. SCOPE

This standard will provide a reference for naming standards for DB2 objects. These standards will provide recognition, functionality and consistency within the agency.

## III. REQUIREMENTS

### A. NAMING STANDARDS

1. Database - a grouping of Database objects. Assigned by: DBA

WassxxDe

W Constant to show the database belongs to ODJFS.

a Application identifier code (i.e. Q for SETS and G for CRIS-E).

ss System identifier code (i.e., CR for Case Reporting).

xx Alphanumeric sequence number for version of the database within the given environment.

D Constant to show this is a database object.

e Environment indicator (i.e., U for Unit Test, S for System Test, A for Acceptance Testing, T for Training and P for Production).

2. Storage Group - a group of DASD volumes. Assigned by: DBA

WassxxGe

W Constant to show the database belongs to ODJFS.

a Application identifier code (i.e., Q for SETS and G for CRIS-E).

ss System identifier code (i.e., CR for Case Reporting).

xx Alphanumeric sequence number for storage group.

G Constant to show this is a storage group object.

e Environment indicator (i.e., U for Unit Test, S for System Test, A for Acceptance Testing, T for Training and P for Production).

3. Tablespace - a data set for storing tables. Assigned by: DBA

WassxxTS

W Constant to show the database belongs to ODJFS.

a Application identifier code (i.e., Q for SETS and G for CRIS-E).

ss System identifier code (i.e., CR for Case Reporting).

xx Alphanumeric for sequential tablespace number.

TS Constant to show this is a tablespace object.

4. Table Creator - identifies the owner of the table.

WxnnPe

W Constant to show the database belongs to ODJFS.

x Application identifier code (i.e., Q for SETS and G for CRIS-E).

nn Denotes that this id is the table creator.

P Constant, this character identifies DB2 primary authorization id.

e Denotes one of the environments listed below:

'U' - Unit Test.

'C' - Conversion Unit Test.

'D' - Conversion System Test.

'I' - Integration Test.

'S' - System Test.

'A' - Acceptance Test.

'P' - Production.

'T' - Training.

5. Table - Structure of columns and rows maintained by DB2. Assigned by: DBA/Application  
Example: Creator.table-name

Creator The creator is the table creator name where the table is defined. Tables are unique based on the creator identifier. Therefore, the same table-name can be assigned to a given database multiple times with each being unique based on the creator.

Table-name The business or logical entity name of the object.

6. Views Names - Alternate names for tables or table extracts. Assigned by: DBA

Creator.Vnn\_View-name

Creator The creator is the table creator name (see above) where the view was created. Views are unique based on the creator identifier. Therefore, the same view name can be assigned to the same table multiple times with each being unique based on the creator.

Nn A unique number identifying each view. (Ex: V01\_View-name)

Vnn\_view-name The name of the table for a base view or the business or logical entity name of the object with tokens separated by the literal '\_'.

7. Index - a set of pointers to data in a table. Assigned by: DBA

Creator.WassxxIx

Creator The creator for an index is the same as the database name.

WassxxIx

- W - Constant to show the database belongs to ODJFS.
- a - Application identifier code (i.e, Q for SETS and G for CRIS-E).
- ss - Minor system identifier code. (i.e., JI for Employment Services Job Insurance).
- xx - Alphanumeric sequence number for index group.
- I - Constant to show this is an index object.
- x - Alphanumeric sequence number to indicate how many indexes are assigned to a table.

(Example: WOJIA0DU.WOJIAAI1 (first index), WOJIA0DU.WOJIAAI2 (second index), etc.)

8. Synonym names - Alternate names for Tables. Assigned by:DBA

9. Alias names - A locally defined name for a table or view in the same local DB2 subsystem or in a remote DB2 subsystem. Assigned by: DBA

## B. DB2 COMPONENT OBJECTS

1. Stored Procedure - a DB2 subroutine share by DB2 programs.

Procedure-name - This is any six character program name.

Example: WA01PU.ASP001

2. Schema\_name - identifies the owner of the procedure. Same as creator. Assigned by: DBA

WxnnPe

- W Constant to show the database belongs to ODJFS.
- x Application identifier code (i.e., Q for SETS and G for CRIS-E).
- nn Denotes that this id is the table creator.
- P Constant this character identifies DB2 primary authorization id.
- e Denotes one of the environments listed below:

- 'C' - Conversion Unit Test.
- 'D' - Conversion System Test.
- 'I' - Integration Test.
- 'S' - System Test.
- 'A' - Acceptance Test.

- 'P' - Production.
- 'T' - Training.
- 'U' - Unit Test.

3. Plan - relates the application to the DB2 subsystem. Assigned by: DBA

WassxxPe

- W Constant to show the database belongs to ODJFS.
- a Application identifier code (i.e., Q for SETS and G for CRIS-E).
- ss System identifier code (i.e., CR for Case Reporting).
- xx Alphanumeric identifier for each plan.
- P Constant to show this is a plan object.
- e Denotes the environment.

4. Package - relates the plan to the bound SQL statements grouped by a collection. Assigned by: Applications

Package names will be the same as the program name that uses them.

5. Collection - a group of packages. Assigned by: DBA

WassnnCe.package\_name

- W Constant to show the database belongs to ODJFS.
- a Major application identifier code (i.e., Q for SETS and G for CRIS-E).
- ss System identifier code (i.e., CR for Case Reporting).
- nn Numeric sequence number for collection.
- C Constant to show this is a collection object.
- e Environment indicator (i.e., U for Unit Test, S for System Test, A for Acceptance Testing, T for Training and P for Production).

6. Check Constraint Name - Meaningful 8 character name describing the relationship and following assembler naming constraints. Assigned by: DBA

7. Referential Constraint - Foreign key relationships between tables. Assigned by: DBA

Fxxyynn

- F Denotes the unique identifier for a foreign key constraint.
- xx Denotes the parent tablespace identifier.
- yy Denotes the child tablespace identifier.
- nn Denotes a sequence number (00 - 99).

An example of a foreign key constrain .... F022300.

8. Trigger Collection - A group of triggers within a schema. Assigned by: DBA

WaTRnnCe

- W Constant to show the database belongs to ODJFS.  
a Major application identifier code (i.e., Q for SETS and G for CRIS-E).  
TR Constant to identify a trigger collection.  
nn A sequence number commencing from 01.  
C Constant to show a collection.  
e Environment identifier (i.e., U for Unit Test, S for System Test, A for Acceptance Testing, T for Training and P for Production).

An example of a trigger collection .... WRTR01CU.

9. Trigger Name - Name given to a trigger. Assigned by: DBA

WassxxNC

- W Constant to show the database belongs to ODJFS.  
a Application identifier code (i.e., Q for SETS and G for CRIS-E).  
ss Minor application identifier code (i.e., CR for Case Reporting).  
xx Denotes the tablespace identifier.  
N Constant to identify a trigger name.  
c Denotes a letter (A - Z) or a number (0 - 9).

An example of a trigger name .... WRWF04N1.

10. Non-Expiring RACF-ID's - Secondary authorization group. Assigned by: Security

WaxxNe

- W Constant to show the database belongs to ODJFS.  
a Application identifier code (i.e., Q for SETS and G for CRIS-E).  
xx Denotes sequence number.  
N Constant to show non-expiring.  
e Environment indicator.

11. DB2 Database Job Name - DB2 DBA's job names. Assigned by DBA

WaDBxxxP

- “W” = For ODJFS  
“a” = Application identifier code  
“DB” = Constant code  
“xxx” = Numeric range depending on the type of job.  
“P” = For Production

(i.e., WFDB201P, image copy job)

C. DB2 Utilities

1. Image copy 200 to 299, 2AA to 2ZZ
2. Recovery 300 to 399
3. Reorg 400 to 499
4. Runstats 500 to 599
5. Modify 600 to 699
6. Quiesce 700 to 799
7. Check 800 to 899
8. Miscellaneous 900 to 999

(i.e., WFDB201P, image copy job)

**IV. APPROVALS**

The signature of the chairperson of the MIS Standards Committee and the Deputy Director will be evidence that this standard has been accepted and approved in its entirety.

**V. REFERENCES**

MIS:002 Standard Format for MIS Policies, Standards and Procedures  
MIS:034 Standard Naming Conventions

Approved:

Author/Author Group or Project Lead

Approved:

Standards Administration

Approved:

Deputy Director

**Revision History**

Rev	Author/ Bureau	Date	Remarks
0.00	Kelly Kassor/BISS	11/21/02	Original document
0.01	Kelly Kassor/Kathy Kruczynski BISS	12/05/03	Maintenance Review - no changes at this time

Revisions are changes made to existing MIS policies, standards or procedures. There are two types of revisions, substantive and non-substantive:

Substantive revisions deal with the essential elements or meaning of the policy, standard or procedure. Example, changes to the purpose, requirements or scope would be substantive revisions. In addition, substantive revision can be further defined as major (e.g. a complete re-write) or minor (e.g. changing several sentences or adding steps).

Non-substantive revisions deal with the non-essential elements of a policy, standard or procedure. These would be changes that do not affect the meaning of the original document. Example, grammar corrections, format changes, adding references, or fixing typographical errors, maintenance revision no changes would be non-substantive revisions.

The MIS BSCM Standards Administration Group will determine whether a requested revision is major substantive, minor substantive, or non-substantive, and enter the revision number appropriately.

Remarks enter a general statement indicating the recent change to the MIS PSP.

Author/Bureau enter the author's name and bureau.

# SQL Server 2000 SP3 Security Features and Best Practices: Security Best Practices Checklist

## Security Best Practices Checklist

Updated: May 16, 2003



### Administrator Checklist

Setting Up the Environment Prior to Installation	
Physical security	<ul style="list-style-type: none"> <li>Ensure the physical security of your server.</li> </ul>
Firewalls	<ul style="list-style-type: none"> <li>Put a firewall between your server and the Internet.</li> <li>Always block TCP port 1433 and UDP port 1434 on your perimeter firewall. If named instances are listening on additional ports, block those too.</li> <li>In a multi-tier environment, use multiple firewalls to create screened subnets.</li> </ul>
Isolation of services	<ul style="list-style-type: none"> <li>Isolate services to reduce the risk that a compromised service could be used to compromise others.</li> <li>Never install SQL Server on a domain controller.</li> <li>Run separate SQL Server services under separate Windows accounts.</li> <li>In a multi-tier environment, run Web logic and business logic on separate computers.</li> </ul>
Service accounts	<ul style="list-style-type: none"> <li>Create Windows accounts with the lowest possible privileges for running SQL Server services.</li> </ul>
File System	<ul style="list-style-type: none"> <li>Use NTFS.</li> </ul>

	<ul style="list-style-type: none"> <li>Use RAID for critical data files.</li> </ul>
<b>Installation</b>	
Latest version and service pack	<ul style="list-style-type: none"> <li>Always install the latest service packs and security patches.</li> </ul>
Service accounts	<ul style="list-style-type: none"> <li>Run SQL Server services with the lowest possible privileges.</li> <li>Use Enterprise Manager to associate services with Windows accounts.</li> </ul>
Authentication mode	<ul style="list-style-type: none"> <li>Require Windows Authentication for connections to SQL Server.</li> </ul>
Strong passwords	<ul style="list-style-type: none"> <li>Always assign a strong password to the <b>sa</b> account, even when using Windows Authentication.</li> <li>Always use strong passwords for all SQL Server accounts.</li> </ul>
<b>Configuration Options and Settings After Installation</b>	
Delete or secure old setup files	<ul style="list-style-type: none"> <li>Delete or archive the following files after installation: sqlstp.log, sqlsp.log, and setup.iss in the &lt;systemdrive&gt;:\Program Files\Microsoft SQL Server\MSSQL\Install folder for a default installation, and the &lt;systemdrive&gt;:\Program Files\Microsoft SQL Server\MSSQL\$&lt;Instance Name&gt;\Install folder for named instances.</li> <li>If the current system is an upgrade from SQL Server 7.0, delete the following files: setup.iss in the %Windir% folder, and sqlsp.log in the Windows Temp folder.</li> </ul>
Choose static ports for named instances	<ul style="list-style-type: none"> <li>Assign static ports to named instances of SQL Server.</li> </ul>
Set login auditing level	<ul style="list-style-type: none"> <li>Set login auditing level to <b>failure</b> or <b>all</b>.</li> </ul>

<p>Enable security auditing</p>	<ul style="list-style-type: none"> <li>• Enable security auditing of <b>Sysadmin</b> actions, fixed role membership changes, all login related activity, and password changes.</li> <li>• After selecting appropriate auditing options, you should script the audit, wrap it in a stored procedure, and mark that stored procedure for AutoStart.</li> </ul>
<p>Secure <b>sa</b> even in Windows Authentication Mode</p>	<ul style="list-style-type: none"> <li>• Assign a strong password to the <b>sa</b> account, even on servers that are configured to require Windows Authentication.</li> </ul>
<p>Remove sample databases</p>	<ul style="list-style-type: none"> <li>• Remove sample databases from production servers.</li> </ul>
<p><b>Secure Operation</b></p>	
<p>Security model</p>	<ul style="list-style-type: none"> <li>• Learn to work with the SQL Server security model.</li> </ul>
<p>Backup policy</p>	<ul style="list-style-type: none"> <li>• Back up all data regularly and store copies in a secure off-site location.</li> <li>• Test your disaster recovery system.</li> </ul>
<p>Surface and feature reduction</p>	<ul style="list-style-type: none"> <li>• Reduce the surface area of your system that is exposed to attack by running only those services and features needed in your environment.</li> </ul>
<p>Administrator reduction</p>	<ul style="list-style-type: none"> <li>• Restrict membership of the <b>sysadmin</b> fixed server role to a few trusted individuals.</li> </ul>
<p>Strong passwords</p>	<ul style="list-style-type: none"> <li>• Ensure that you use complex passwords for all SQL Server accounts.</li> </ul>
<p>Cross database ownership chaining</p>	<ul style="list-style-type: none"> <li>• Disable cross database ownership chaining if your system does not use it.</li> </ul>

<p>Xp_cmdshell</p>	<ul style="list-style-type: none"> <li>By default, only members of the sysadmin role can execute xp_cmdshell. You should not change this default.</li> <li>Do not grant execute permission on xp_cmdshell to users who are not members of the sysadmin role.</li> </ul>
<p>Encryption</p>	<ul style="list-style-type: none"> <li>Install a certificate to enable SSL connections.</li> <li>Certificates should use the fully-qualified DNS name of the server.</li> <li>Use the SQL Server service account to encrypt database files with EFS.</li> <li>If your application requires data encryption, consider using the products of such vendors as Protegrity and Application Security Inc.</li> </ul>
<p>Roles and groups</p>	<ul style="list-style-type: none"> <li>Collect users into SQL Server roles or Windows groups to simplify permissions administration.</li> </ul>
<p>Permissions</p>	<ul style="list-style-type: none"> <li>Never grant permissions to the <b>public</b> database role.</li> </ul>
<p>Distributed queries</p>	<ul style="list-style-type: none"> <li>When setting up SQL Server in an environment that supports distributed queries, use linked servers rather than remote servers.</li> <li>Allow linked server access only to those logins that need it.</li> <li>Disable ad hoc data access on all providers except SQL OLE DB, for all users except members of the <b>sysadmin</b> fixed server role.</li> <li>Allow ad hoc data access only on trusted providers.</li> </ul>

Guest accounts	<ul style="list-style-type: none"> <li>Do not enable the guest account.</li> </ul>
Service accounts	<ul style="list-style-type: none"> <li>If you need to change the account associated with a SQL Server service, use SQL Server Enterprise Manager.</li> <li>If you change multiple services, you must apply the changes to each service separately using Enterprise Manager.</li> </ul>
<b>Recommended Periodic Administrative Procedures</b>	
Microsoft Baseline Security Analyzer	<ul style="list-style-type: none"> <li>Add MBSA to your weekly maintenance schedule, and follow up on any security recommendations that it makes.</li> </ul>
Scanning logins	<ul style="list-style-type: none"> <li>Periodically scan for accounts with NULL passwords and remove them or assign them strong passwords.</li> <li>Delete unused accounts.</li> </ul>
Enumerate fixed role membership	<ul style="list-style-type: none"> <li>Periodically scan fixed server and database roles to ensure that membership is only granted to trusted individuals.</li> </ul>
Start-up procedures	<ul style="list-style-type: none"> <li>Verify the safety of stored procedures that have been marked for AutoStart.</li> </ul>
Login-to-user mapping	<ul style="list-style-type: none"> <li>Ensure that the mapping between database users and logins at the server level is correct.</li> <li>Run <b>sp_change_users_login</b> with the <b>report</b> option regularly to ensure that the mapping is as expected.</li> </ul>
Direct catalog updates	<ul style="list-style-type: none"> <li>Do not allow direct catalog updates.</li> </ul>

<p>Cross database ownership chaining</p>	<ul style="list-style-type: none"> <li>● Use <b>sp_dboption</b> to enumerate and validate databases for which cross database ownership chaining has been enabled.</li> </ul>
<p><b>Best Practices for Patching Instances</b></p>	
<p>Instance detection and enumeration</p>	<ul style="list-style-type: none"> <li>● Keep an inventory of all versions, editions, and languages of SQL Server for which you are responsible.</li> <li>● Include instances of MSDE in your inventory.</li> <li>● Use SQL Scan and SQL Check, available from the Microsoft Web site, to scan for instances of SQL Server within your domain.</li> </ul>
<p>Bulletins</p>	<ul style="list-style-type: none"> <li>● Subscribe to Microsoft security bulletins.</li> </ul>
<p>Patch application</p>	<ul style="list-style-type: none"> <li>● Maintain test systems that match the configuration of you production systems, and are readily available for testing new patches.</li> <li>● Test patches carefully before applying them to production systems.</li> <li>● Consider patching development systems with relatively little testing.</li> </ul>

## Software Vendor Checklist

In addition to all of the items above, the following security development practices have proven useful in increasing the quality and security of code in various development environments.

Security Processes	
<p>Understanding various security issues</p>	<ul style="list-style-type: none"> <li>● Ensure that members of your development team understand major security issues: current threats, security trends, changing security environments, and attack scenarios.</li> <li>● Require relevant security training for all developers and testers.</li> <li>● Increase the awareness of issues like cross-site scripting, buffer overflows, SQL injection, and dangerous APIs.</li> <li>● Identify specific categories of threats that apply to your product — for example, denial of service, escalation of privileges, spoofing, data tampering, information disclosure and repudiation.</li> <li>● Analyze security threats to your product, component-by-component.</li> <li>● Create a security threat checklist based on your product.</li> <li>● Add security reviews to all stages (from design to testing) of your product development cycle.</li> </ul>
<p>MSDE installations</p>	<p>If you distribute MSDE with your application, the following additional guidance applies:</p> <ul style="list-style-type: none"> <li>● Install MSDE using "Windows security mode" as the default.</li> <li>● Never install a blank <b>sa</b> password.</li> <li>● When distributing MSDE to your customers, you should use the Microsoft-supplied installer rather than merge modules.</li> </ul>

## Security Processes

- When installing an instance of MSDE that will operate only as a local data store, you should disable the Server Net-Libraries.
- If your product includes MSDE, you should make this known to your customers. In the future, they may need to install or accept MSDE-specific software updates.
- MSDE installs SQL Server Agent by default, but leaves the Service startup type to "Manual." If your application does not use SQL Server Agent, you should change this to "Disabled." Include security best practice information in your product documentation.

# Bureau of Information Systems Support

## UNIX and WebSphere Policies, Standards, Best Practices and Procedures

(Standards apply to all architectures whether, ORACLE platform, Web Logic, .net, etc)

Ohio Department of Job and Family Services  
Bureau of Information Systems and Support  
Effective Date August 15, 2005

### **Capacity and Architectural Planning**

This section of the standards document discusses best practices and recommendations that should be followed when determining topology, as well as hardware and software resources. When planning topology, consider the practical limits of a large configuration. The number of nodes, servers, complexities in administering, as well as physical constraints such as memory, CPU and network bandwidth available should be carefully determined.

#### Place the Deployment Manager on a Dedicated System

The deployment manager for a cell can be co-located on a system with a node agent and application server. However, sharing a system can introduce contention for system resources and interfere with administration performance. Additionally, the deployment manager is the central point of administration for the entire cell, and anything that compromises the deployment manager process also compromises the ability to manage and monitor the cell. Therefore, the deployment manager should be placed on a dedicated system.

#### Put One or a Small Number of Applications in Each Application Server

It is possible to put many applications in each server, however the more typical and preferred deployment is a single application, or a small set of closely related applications. Keeping applications separated is best from a standpoint of security, isolation, and manageability.

#### Provide For Fail-Over in All Cases (multiple nodes, clusters)

There should be at least two nodes (at minimum), to provide for fail-over. Using cluster capabilities, each application is set up and managed as a cluster across the nodes.

#### Meet Each Application's Performance and Scalability Requirements

It may be possible for many application performance and scalability requirements to be satisfied by just two application servers across two nodes, other applications may have additional needs. Make sure to consider performance needs in case of maintenance or failures. If one server in a two-node cluster is brought down, the site is immediately at 50% capacity. If two nodes are required to meet performance goals, a three-node cluster is the appropriate number to maintain ongoing capacity. Also consider how many servers will be needed to handle user load. If two servers are insufficient, the easiest scalability solution is to add additional nodes, but ensuring to scale any shared resources such as databases and directory servers.

### Maximize Each Server's Hardware Utilization

Determine how many nodes will be needed for each application and how many application servers as well, then turn the focus to maximizing the hardware resources available. Ensure that the processing capacity of the servers is utilized. Under expected load conditions, check the processor utilization. If the processor is already heavily utilized, don't add more application servers. Adding more servers to an already utilized machine doesn't improve performance.

### Keep Application Server in Physical Memory (number of applications vs. system memory, application heap)

Determining the number of application servers per node requires an understanding of the available memory. Never create more application servers than the available system memory can support. This condition leads to paging that adversely affects performance across the system. Minimum and maximum heap sizes should be looked at closely. The system default for starting heap is 50MB minimum and 256MB maximum heap size, neither of which are desirable settings. Starting a JVM at the aforementioned level of memory means that the application must immediately switch context to allocate memory resources. This will slow down the execution of the application until it reaches the heap size it needs to run. A JVM that can grow too large does not perform garbage collection often enough, which can leave the machine littered with unused objects. To plan the maximum number of application servers for a single node, include the memory requirements for the operating system, node agent, deployment manager (if they co-exist), and the maximum size of the application servers.

### Know When to Stop (Know how many applications is too many to cram into a cell)

Find the right balance to meet the needs by understanding the administrative processes and performance requirements.

Do not begin adding resources to the application environment until it is known that the environment has been properly tuned for the resources it currently uses.

Adding resources usually affects the dynamics of the system and can potentially shift a bottleneck from one resource to another. Thus it is recommended to always perform a scalability test to identify how well a site is performing after a hardware change.

## **Ideal Environment Architecture**

### Development Environment

This environment will be the responsibility of the application development team/application owner to maintain. This environment should consist of a number of development workstations, a source code management tool, and an integration workstation. Ideally, application developers should use a product that is tightly integrate with the product that is running in the production environment. Testing should be an on-going process as development is taking place. Development environment that is corrupted will only be restored to the last backup.

### System Test/Integration

This environment is a carefully controlled formal test environment and is required for all applications being developed. Development team runs their applications on this environment on a regular basis as significant changes are introduced into the application. This environment should mirror the production environment as closely as possible. It will not contain any development tools, so testing will depend on the use of test scripts and tracing to determine correctness and identify problems. The key to this environment is formality. The purpose of this environment is to ensure that the application will truly deploy and run as required in production. Functional (does the application execute the business rules as defined, does the application behave as required from the user's perspective, etc) and non-functional (installation, backup, failure procedures, etc) aspects of the application should be tested here. It should be clear that this environment will have many different activities that need to be carefully controlled, scheduled, and managed. This environment will be managed by the WebSphere Administration group and not developers.

### Performance/Load Test

Performance and load testing is performed to find load-related problems in applications, thus it is also a carefully controlled formal test environment. Development teams run their applications on this environment on a less frequent basis. This environment should mirror production in its complexity, but on a small scale. It will be utilized to identify load related problems (validation of ability to meet response and scalability criteria, determination of scaling factors, search for latent bugs, etc), clustering validation, fail-over. During load testing runs, the testing team will carefully monitor various aspects of performance (CPU, memory usage, disk usage, response time, etc). This information will used to determine if the system meets the response and scalability criteria and determine how well the system is scaled to production. The testing team will work to push applications as close as possible to the breaking point to find latent bugs. This environment will be managed by the WebSphere Administration group and operated by someone who has specialized load testing skills. The F5, firewalls, switches, web servers, load balances, databases, and other required resources should be available in the environment. Additionally, the environment will include tools for generating the load needed. In this environment, only one application should be tested at a time. Load Testing Applications Is a Must in the System Test Phase and Prior to deploying EAR to production and is required for all applications being developed.

### Pre-production/User Acceptance Test

This environment will be fully managed by the WebSphere Administration group and is required for all applications being developed. The purpose of this environment is to mimic production as much as possible (exactly). This is the final chance to ensure that things will really work in production and should serve four purposes (to give operations team a final place to familiarize themselves with the application and its procedures, validate unrelated application ability to run together if there is a shared deployment environment, provides operations team the change to test operational procedures (backup, failover, etc) and it will be utilized for application user acceptance testing and validation prior to promoting code to production. No application or configuration changes will be made at this stage. Anything not signed off by UAT group will be moved back to the development or system test environments to resolve. Once application is signed off on by UAT group no changes should be made prior production deployment.

### Training

This environment will be fully managed by the WebSphere Administration group. It shall reside in the production environment along side of the production application that it is being used to training for. It is the responsibility of the application owner to ensure that all training accounts are established in LDAP.

### Production

This environment will be fully managed by the WebSphere Administration group. This is where the application will run and no changes are permitted at this level.

## Naming Conventions

This section of the standards document discusses naming convention standards as determined by Bureau of Network Services, Bureau of Information Systems Support, and the Department of Administrative Services for DNS entries, URLs, application servers, logs, etc.

WebSphere Application Server & Portal names will be set by the WebSphere Administration groups and name must follow JFS standard (i.e. icms\_uat\_srv1).

WebSphere & Portal Node names will be set by the WebSphere Administration groups and names must follow JFS standard JFS\_<environment>\_<cell number>\_<node number> (i.e. JFS\_DEV\_C01\_N01).

WebSphere & Portal Cell names will be set by the WebSphere Administration groups and names must follow JFS standard JFS\_<environment>\_<cell number>.

All URLs are required to be fully qualified domain names.

URL name for application developed and deployed within system test, UAT, and training environments must follow JFS standard. No short name will be used (i.e. icmsuat.odjfs.state.oh.us).

URL name for application within production environment must follow JFS and DAS standards. For all internal only accessed applications (i.e. icms.jfs.ohio.gov). For internal and external accessed applications (i.e. icms.ohio.gov).

Installation directory for WebSphere & Portal will be appropriate to the latest supported version installed as well as platform (i.e. /usr/WebSphere/AppServer, /opt/IBM/WebSphere/AppServer or c:\Program Files\IBM\WebSphere\AppServer)

Installation directory for Network Deployment Manager will be appropriate to the latest supported version installed as well as platform (i.e. /usr/WebSphere/DeploymentManager, /opt/IBM/WebSphere/DeploymentManager or c:\Program files\IBM\WebSphere\DeploymentManager)

Installation directory for IBM HTTP will be appropriate to the latest supported version installed as well as platform (i.e /usr/IBMIHS, /opt/IBMIHS, or c:\Program Files\IBM\IBMIHS)

DataSource names must follow the JFS standard to allow within JFS standard monitoring tool Omegamon (Candle) (i.e. ICMSDataSource).

Virtual host definitions will be set by the WebSphere Administration groups and names must follow JFS standard <application\_name><environment>\_host (i.e. icms\_dev\_host)

Applications shouldn't need to call the web module URI when accessing the URL (<http://buyinformedicaredev.odjfs.state.oh.us> vs. <http://buyinformedicare.odjfs.state.oh.us/BuyIn>)

Namebased Virtual Hosting should be utilized with HTTP configuration if multiple application sites will share same webserver.

```
<VirtualHost <IP address>:<listening port>  
    ServerName <fully qualified URL>  
    DocumentRoot /<root directory for HTTP>/www/<application name>  
</VirtualHost>
```

i.e.

```
<VirtualHost 10.9.19.117:81>  
    ServerName icmsuat.odjfs.state.oh.us  
    DocumentRoot /usr/IBMIHS/www/tanfuat  
</VirtualHost>
```

## Installation, Configuration and Administration

This section of the standards document discusses product installation, configuration, and administration standards as determined by Bureau of Information Systems Support and the Department of Administrative Services as well as documented vendor best practices.

All products will be installed as recommended by product vendor out of the box and will not be changed or reconfigured upon installation.

All product configuration changes and upgrades will be conducted by the appropriate administrators.

Product levels should be maintained at the latest product vendor supported level to be kept consistent between all environments

Log file maximum 10MB for both SystemOut and SystemErr

Define Resources at the Cell Level

Resources defined at the cell level are available to application servers throughout the cell. When configuration changes or updates are necessary to the resource the need only be made once and then applied across the cell.

Use Naming Conventions

To assist in administering multiple servers, establish a good naming convention to keep better track of the topology. Also consider renaming the log files with the application name or node number.

Use Filters to Navigate the Admin Console

Faster navigation is possible by setting a large number of applications per page or filtering the application servers on the list.

Use Scripting to Improve Stop and Startup for Multiple, Non-clustered Servers

The \$AdminControl startServer/StopServer script command issues a request to either start or stop an application server and waits for the request to complete. To speed up startup for multiple servers, use a script with a reduced wait time. A small wait time enables server start request to process in parallel, which takes advantage of multiple CPUs in a system, or multiple systems.

Don't Autostart Applications Unnecessarily

If there are applications installed that don't need to run until later, disable autostart for these applications and start the applications as needed.

Development, system test and UAT environments should be installed and configured to match what the final production environment will look like.

HTTP transport hosts will be set by the WebSphere Administration group to the default values generated by the product installation unless application functionality is dependent on a specific transport value.

HTTP server listening ports within production environments in all cases will be set based on the DAS or ODJFS network standards. Within UAT and test environments will be set by the WebSphere Administration groups.

Manual alteration of the product configuration files is prohibited. All necessary configuration changes should be performed at the console level by a WebSphere Administrator only.

Applications shouldn't be deployed on server1 or WebSphere\_Portal. A unique application server should be defined.

There should be only one instance of WebSphere installed per machine unless there is a specific requirement to run multiple version of the product.

J2C Authentication configuration user ID and password will be provided by application owner and entered by the WebSphere Administration group.

Data Source configuration values will be provided by application owner and entered by the WebSphere Administration group: JNDI name, container-managed persistence, category, statement cache size, data source helper name, authentication alias, mapping-configuration alias, mapping configuration alias.

Custom values for data source configuration will be set based on load testing, and performance results within test environment.

DB2 JDBC provider configuration: scope of resource will be determine based on overall environment configuration (i.e. if there are multiple application servers (server level), if there will only be one application server (cell, node, server level); JDBC provider used will be based on the database product used (i.e. DB2, ORACLE, etc).

MQ JMS Provider values will be set at the server level if there are multiple application servers or may be set at either the node, cell, or server level is there will only be one application server. The values for each Queue type will be provided by the application owner.

Use the WebSphere Web Service Engine  
The WebSphere SOAP runtime can help with application performance.

Use Caching of Web Services As Provided By the Platform  
Set up to cache information at the application server level as well as Web Services requests to save processing time.

## Security

This section of the standards document discusses recommendation for securing an environment at the OS, webserver, and application server levels as determined by Bureau of Information Systems Support and the Department of Administrative Services as well as documented vendor best practices.

Developers will not be granted access to environments maintained by WebSphere Administrators.

The wasadm user with a group of wasadmg will be created as the administrative account for WebSphere & WebSphere Portal.

The httpadm user with a group of httpadmg will be created as the administrative account for IBM HTTP.

The db2inst1 (or something similar) user with a group of db2iadm (or something similar) will be created as the administrative

Remote logins will not be granted for the aforementioned accounts.

The wasadm user will not be part of the db2 instance, or HTTP user account groups nor will it have su capabilities.

WebSphere Administrators will be part of the aforementioned groups and must su to each account and not access the account directly.

No user id or password should be hard coded within the application or application properties files (i.e. database user, MQ user, etc).

## Application Development Best Practices or Performance and Scalability

This section of the standards document discusses coding best practices for developing WebSphere Application Server based applications that perform well and are scalable and robust. Additionally, best practices for general Java coding as well as guidelines for Servlets, JSPs, EJBs, HTTP Sessions, Web Services and service-oriented architecture, and the use of J2EE resources are also discussed.

Although the aforementioned areas will be covered, a prerequisite is to ensure that the application has a good design and architecture.

### **Web Services**

#### WS-I Compliance

The application should follow industry conformance standards with regards to interoperability. If development tool being used supports development of WS-I compliant Web Services it should be turned on.

#### Use Simple Data Types

Use simple (integers and strings) and compound (struts and records) data types where possible. Java collection classes and complex data types should be avoided altogether.

#### Avoid Nillable Primitives

Use dedicated flags to signal the condition that a value doesn't exist

#### Avoid Fine-Grained Web Services

Design Web Services that perform more complex business logic. Also allow for bulk processing instead of multiple invocations with one parameter only.

#### Avoid Web Services for Intra-Application Communication

There is no need to allow for an interoperable interface in the case of intra-application communication.

#### Use Short Attribute, Property, and Tag Names

The shorter the attribute, property, and tag names are, the shorter the transmitted message and the faster the communication and processing.

#### Avoid Deep Nesting of XML Structures

Parsing of deeply nested XML structures increases processing time as well as increases comprehension of the data type and should both be avoided.

## J2EE

The Java 2 Platform, Enterprise Edition (J2EE) is a set of coordinated specifications and practices that together enable solutions for developing, deploying, and managing multi-tier server-centric applications. Building on the Java 2 Platform, Standard Edition (J2SE), and the J2EE platform adds the capabilities necessary to provide a complete, stable, secure, and fast Java platform to the enterprise level. It provides value by significantly reducing the cost and complexity of developing and deploying multi-tier solutions, resulting in services that can be rapidly deployed and easily enhanced.

The primary technologies in the J2EE platform are: Java API for XML-Based RPC (JAX-RPC), JavaServer Pages, Java Servlets, Enterprise JavaBeans components, J2EE Connector Architecture, J2EE Management Model, J2EE Deployment API, Java Management Extensions (JMX), J2EE Authorization Contract for Containers, Java API for XML Registries (JAXR), Java Message Service (JMS), Java Naming and Directory Interface (JNDI), Java Transaction API (JTA), CORBA, and JDBC data access API. Additionally, the J2EE platform can interoperate with WS-I implementations if the implementations are WS-I compliant.

### Always use Model-View-Controller

Cleanly separate controller logic (servlets/struts) from business logic (java beans, EJB components).

### Apply Automated Unit Tests and Test Harnesses at Every Level

Avoid testing the application GUI only. Layered testing or testing the application in pieces should be utilized.

### Develop To the J2EE Specifications, Not the Application Server

Avoid going around what J2EE allows as this can and will affect performance, migrations, and upgrades.

### Plan for Using J2EE Security from the Onset of Development

WebSphere security should be turned on immediately. All URLs and EJBs should be locked down to allow at least only authenticated users. Not utilizing J2EE security is betting that a better security infrastructure can be built and is risky.

### Build What You Know

Build small, vertical slices through the application rather than everything at once. The small vertical slices should be tested and validated before proceeding forward.

### Always Use Session Facades Whenever EJBs Components Are Utilized

Entity beans shouldn't be exposed directly to any client type. Only the use of local EJB interface for entity types should be considered.

### Use Stateless Session Beans Instead of Stateful Session Beans

Use the HttpSession to store user-specific state, this makes the more able to failover is necessary when considering high availability.

### Use Container-Managed Transactions

Rely on J2EE 2-phase commit transactions rather than implementing customized transaction management. This is best for when the application begins and ends a transaction or if the application needs to access multiple resources as part of the same operation.

### Utilize JSPs as the First Choice of Presentation Technology

Use XML/XSLT only in the cases where there are multiple presentation output types that must be supported by a single controller and back-end.

### Session Persistence

Store only as much state as is needed for the current business transaction and no more. Avoid caching information that is easily recreated. Session persistence should be enabled.

### Dynamic Caching and WebSphere Servlet Caching

In order to realize performance gains and minimize overhead, dynamic caching should be turned on and WebSphere servlet caching should be utilized. In the case, the programming model remains unaffected.

### CMP Entity Beans

Optimize performance through the WebSphere framework (read ahead, caching options, isolation levels, etc) as a first pass solution for O/R mapping to achieve performance goals.

## HTTP Sessions

### Enable Security integration for securing HTTP sessions

Due to vulnerabilities, all requests going over the network should be secure connections (HTTPS). Security in WebSphere should also be enabled to add another layer of protection.

### Release HttpSession objects when completed

HttpSession objects live inside of the Web container until released explicitly/programmatically or WebSphere destroys the session upon expiration (default 30 minutes) thus utilize `javax.servlet.http.HttpSession.invalidate` when completed to release/invalidate the session.

### Avoid Saving and Reusing HttpSession Objects

The HttpSession object is a function of the HttpRequest and a copy of it is valid only for the life of the service method of the servlet or JSP file. Thus, attempts shouldn't be made to cache the HttpSession object and refer to it outside of the scope of the servlet or JSP file.

Implement the `java.io.Serializable` Interface When Developing New Objects to Be Stored in the HTTP Session. The aforementioned action allows the object to properly serialize when using distributed sessions. Without it, the object can't serialize correctly and throws an error.

### The HttpSession API Doesn't Dictate Transactional Behavior for Sessions

Use transactional aware resources like enterprise Java beans to guarantee the transaction integrity required by the application.

### Ensure Java Objects That Are Added TO A Session Is In the Correct Path

When adding Java objects to a session, place the class files for those object in the correct classpath or in the directory containing other servlets used in WebSphere.

### Avoid Storing Large Object Graphs in the HttpSession Object

Placing the data in the HttpSession object as one large object, forces WebSphere Application Server to process all of the data each time.

### Utilize Session Affinity to Help Achieve Higher Cache Hits

To increase the use of the in-memory cache and to reduce hits to the database or another application server instance, session affinity should be utilized. WebSphere has functionality in the HTTP server plug-in that helps with session affinity.

### Maximize Use of Session Affinity and Avoid Breaking Affinity

In order to improve performance avoid breaking session by combining all web applications into a single application server instance and use modeling or cloning to provide failover, and/or by creating the session for the frame page but not within the frame when using multi-frame JSPs.

## Servlet and JSP Security

Secure all pages when applying security to servlets and JSP files that use sessions with security integration enabled.

## Applications That Read Session Data and Update Frequently

Use manual update and either the sync method or time-based write.

Do not create HTTP Session in JSPs by default.

## Database & DataSource

Use of JDBC connection pooling to avoid the overhead of acquiring and closing JDBS connections is recommended. Acquiring database resource connections is a very expensive process and performance will suffer.

Closing JDBC connections for quicker reuse in all circumstances will improve performance and is recommended. Users will experience long waits for connections if the recommendation is not followed.

For better performance, and to avoid the high expense due to JNDI lookups, acquire cache and reuse JDBC DataSources.

Use read-only methods in EJBs to avoid unnecessary database updates.

Use type two driver for two-tiered application to communicate from java client to database.

Use type four driver for applet to database communication.

Use type one driver if there is no driver for the database.

Use type three driver to communicate between client and proxy server for three-tiered applications.

Pass database specific properties if the database supports them.

Choose the right isolation levels as per the application requirements.

Use prepared statement when it is necessary to execute the same statement more than once.

Use callable statement when it is necessary for a result from multiple and complex statements for a single request.

Use batch update facility available in statements.

Use batch retrieval facility available in statements or result set.

Set up proper direction for processing rows.

Use proper get methods.

Write precise SQL queries.

Cache read-only and read-mostly tables data.

Fetch small amount of data iteratively rather than whole data at once when retrieving large amounts of data (i.e. searching the database).

### **Using Common Files**

Do not add utility JARs or classes to the following directories or classpath (<install\_root>/lib, <install\_root>/lib/ext, <install\_root>/bin, or <install\_root>/java) as this might alter the WebSphere runtime environment and cause unexpected errors.

Using the JVM classpath is not a preferred way to add utility JARs to WebSphere it WebSphere classes can be overwritten and it can be detrimental to the overall functionality of the environment.

Determine where to place the utility file. Future configuration will be effected by the location. Consider the possibility that multiple applications may need to use the same utility but may need for it to change based on the implementation.

Determine if different copies of the utility are needed ahead of time in the event that multiple applications need to access and change it. Using application associated shared libraries is the best solution.

Server associated libraries allows all applications running on a particular server to access it.

If it is necessary for any module of the enterprise archive to use a utility class or JAR, then place them at the root of the EAR file. If this is not necessary, then place the individual utility in a JAR file.

If utility classes or JARs are not needed outside of the individual module, then include it within.

Consideration to override WebSphere included files (i.e. parent first, parent last) should be made only after placement of the utility JAR has been determined and set.

## Deployment Process, Application EAR Requirements, Recommendations

This section of the standards document discusses best practices and recommendations that should be followed when packaging an ear file and deploying an ear file as determined by Bureau of Information Systems Support and the Department of Administrative Services as well as documented vendor best practices.

Application should use configuration settings within the WebSphere or WebSphere Portal console (i.e. datasource, security, MQ)

WebSphere should be utilized to call to invoke variables, values, or settings (i.e. name space bindings, managed WebSphere variables, shared libraries, etc) that can't be set via the aforementioned configuration settings.

Application shouldn't contain hard coded entries which will differ from environment to environment (i.e. database or MQ user ids/passwords, directory structures within backend database, LDAP/eDirectory location, userid/passwords, etc.)

Application should contain all information necessary for deployment; there should not be external properties or configuration files which need to be copied or ftp'd to specific locations after deployment of application is completed.

The same application file should be deployable across multiple stages – development through production.

The application file should be deployable across multiple stages – such as NT and UNIX without any changes.

The configuration of the application in WebSphere should be scripted and the install should either be automated or be executed by administrators.

If multiple web applications are to be deployed on the same application server, each application's WebSphere configuration should be independent so that each application can be maintained independently.

The application shouldn't require any OS level changes.

Deployment administrators should not need to make changes to an application file before, during or after deployment in order to get the application deployed successfully.

Production deployments should be submitted through the ODJFS standard release and change management system.

Production deployments should be scheduled prior to 8:00am or after 5:00pm unless it is an application down issue or the application is unstable.

Application troubleshooting will not be done in the production environment.

Application changes/upgrades will not be promoted directly to the production environment. The changes/upgrades must go through test levels and user acceptance allow for validation.

Application deployments should be automated utilizing standardized scripting.

EAR files to be deployed to test environments will be deployed by the application owner utilizing standardized scripting.

EAR files to be deployed to UAT environments will be deployed by the WebSphere Administration group utilizing standardized scripting.

Email notification will be submitted to the ODJFS WebSphere Administrator for UAT environment deployments along with the bundled ear file and installation date.

All production EAR deployments will be handled by Production Deployment Administrators. Production deployments will happen only after the application has been fully load tested and validation has occurred in the UAT region. The ear file will be provided along with production location, deployment date, etc utilizing the ODJFS standard deployment request tool.

The use of log4j (<http://logging.apache.org/log4j/docs/>) for logging purposes is highly recommended for debugging applications.

Avoid or minimize synchronization in servlets.

Time synchronization between the servers, especially between the web and application servers. While troubleshooting application problems it becomes important to cross-reference on different servers to track the flow of the application. NTP can be used for this.

## WebSphere and HTTP Performance Tools

This section of the standards document discusses recommended tools to use for application development, load testing, determining application availability and performance monitoring. This is a short list and shouldn't be viewed as the only tools that are available.

### **Load Testing, Performance and Availability**

#### Runtime Performance Advisor

Running in the background of the application server, this advisor gathers the necessary performance data from PMI, analyzes it, and provides recommendations based on the current system load. Since the advisor uses PMI data, you must first enable the performance monitoring service on the application server; then the runtime advisor automatically enables the individual PMI counters required.

#### Tivoli Performance Viewer

The Tivoli Performance Viewer (TPV) enables administrators and programmers to monitor the overall health of WebSphere Application Server without leaving the administrative console. It is a stand-alone performance monitoring tool that retrieves and displays the PMI data. The performance advisor in TPV uses this PMI data and displays its recommendations in the TPV GUI.

#### IBM Tivoli Omegamon (Candle)

The IBM Tivoli OMEGAMON systems management integration tool provides the ability to manage systems graphically, dynamically and flexibly, with a browser-enabled interface that helps transform systems management data into the information needed to keep systems up and running.

#### WebSphere Thread Analyzer

Thread Analyzer gathers and analyzes thread dumps from WebSphere Application Server. Thread Analyzer can obtain a thread dump or open an existing thread dump. Thread usage can be analyzed at several different levels, starting with a high-level graphical view, and drilling down to a detailed tally of individual threads. If any deadlocks exist in the thread dump, Thread Analyzer will detect and report them.

#### WebSphere Studio Application Monitor (Cyanea)

WebSphere Studio Application Monitor is an integrated application management solution, that monitors J2EE application server performance, availability, and related environmental factors to help IT staff and application developers better construct and manage J2EE applications.

### Tivoli Monitoring For Transaction Performance

IBM Tivoli Monitoring for Transaction Performance helps improve the availability and performance of business-critical applications. It can proactively recognize performance problems at the end user quickly isolate the source and help fix problems fast, before they impact customers.

### Mercury LoadRunner

Mercury LoadRunner is the industry-standard performance and load testing product for predicting system behavior and performance. Using limited hardware resources, LoadRunner emulates hundreds or thousands of concurrent users to put the application through the rigors of real-life user loads. It makes possible the ability to stress an application from end-to-end and measure the response times of key business processes. Simultaneously, LoadRunner collects system and component-level performance information through a comprehensive array of system monitors and diagnostics modules. These metrics are combined into a sophisticated analysis module that provides the ability to drill down to isolate bottlenecks within the architecture. LoadRunner supports a wide range of enterprise environments, including Web Services, J2EE, and .NET.

## Code Profilers

### IBM Rational PurifyPlus

IBM Rational PurifyPlus is a runtime analysis solution designed to help developers write faster, more reliable code. Runtime analysis includes four basic functions: memory corruption detection, memory leak detection, application performance profiling, and code coverage analysis.

### J2EE Code Validation Preview

J2EE Code Validation Preview for WebSphere Studio (J2EE Code Validation) is a tool that automatically detects common error patterns and coding violations of best practices in Web applications. IBM has identified hundreds of error patterns and coding violations from field experience and from best practices papers, and has categorized these violations into several, broad, and rule categories. J2EE Code Validation uses specialized analysis code for each rule category, and in this technology preview, detects over four hundred violations.

## AIX/SUN/LINUX Standards

This section of the standards document OS and hardware standards as determined by Bureau of Network Services, Bureau of Information Systems Support, and the Department of Administrative Services as well as best documented vendor best practices.

The server specified should be rack mountable and the racks used should be equipped with locks in the front and back. IBM racks are the standard for IBM AIX servers. Racks specified for Sun servers should have the Industry-standard dimensions: 900 mm or 1000 mm deep, 59.7 cm wide and 188 cm tall.

Adequate power for new systems should be provided and confirmed before rack installation. Redundant power supplies are to be used for all servers in the data center.

The servers name should adhere to the ODJFS naming conventions.

<OS>-<PROJECT>-<SERVER TYPE, Number>

I.E AX -(For aix) OHP-(For Ohio Health Plans)-DB01 (First Database Server)

The volume groups, filesystems, directories, and files should adhere to the ODJFS naming conventions (Dependant on Server Type).

The UNIX Operating System should be at the latest vendor supported release or latest GA version available with the latest critical fixes applied.

The solution should be compatible with Tivoli Storage Manager backup archive (BA) agent or latest vendor support backup product.

System users will be given a user ID on the system with staff group rights and restricted from the use of any administrative tools or root authority access.

Telnet will be disabled and access will only be available through secure shell (SSH).

Specific OS filesets not in the default install need to be documented. Any protocol specific or communication specific settings need to be documented. (I.E open or closed ports outside of default, NIC settings, etc).

Application start and stop scripts need to be provided and will be placed into start up and shutdown scripts.

Kernel settings need to be documented if they are not standard, and will be placed into start up procedures dependent on Operating System.

### **Request Standards**

A formalized process exists to request technical services by opening a request ticket. A requester should allow turnaround time for the request to be completed.

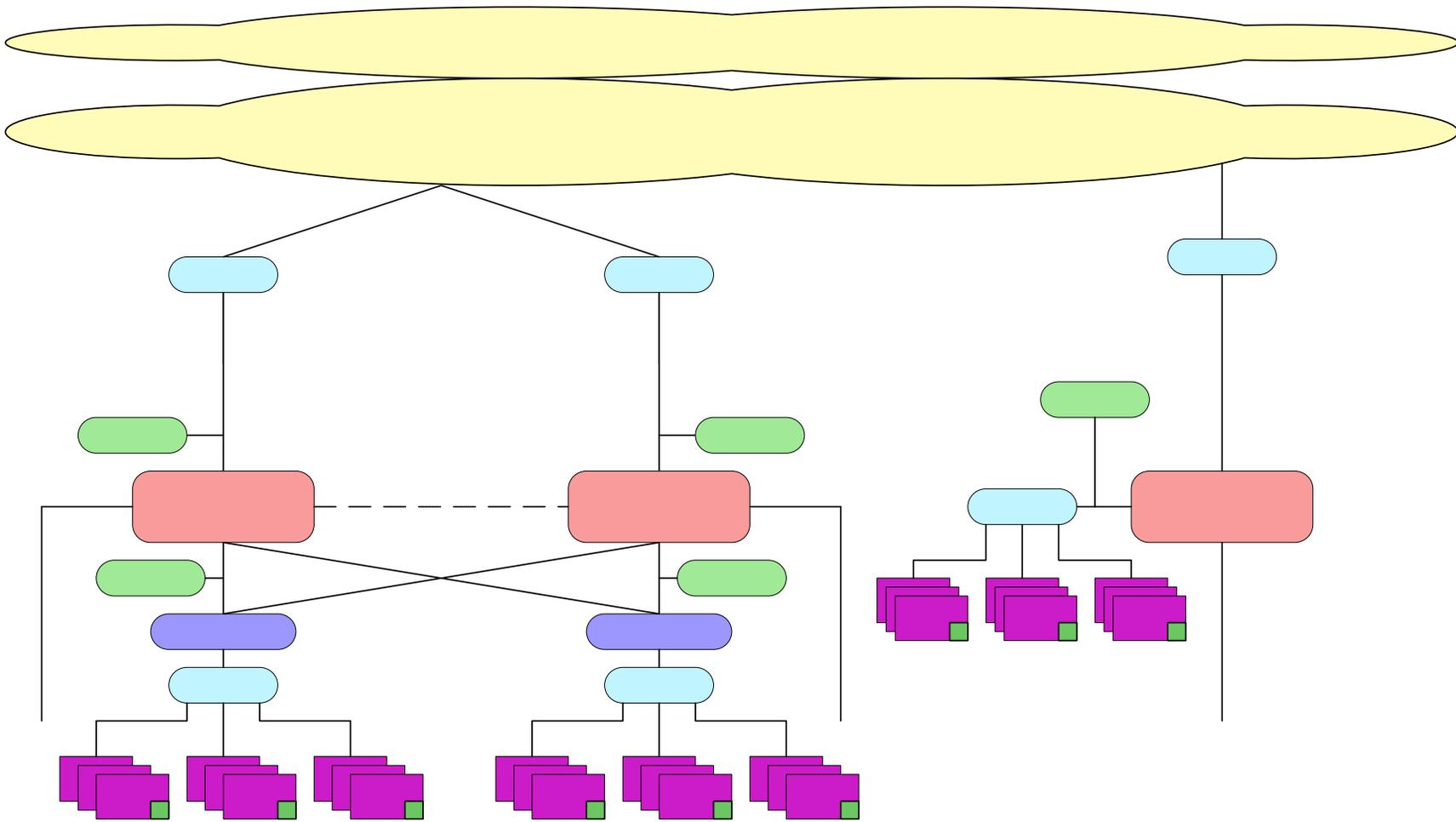
### **High Availability**

All solutions provided should have failover capability. Any single points of failure should be eliminated. IE production servers, power supplies, disk, and network services.

	Preferred Standard	Supportable Standard
Operating System	AIX (latest GA version)	Linux, Solaris, Windows (latest GA version)
Hardware	IBM POWER 5 R/S6000 (or current supported vendor hardware)	Sun EdgeServer 2000, 4000 series, IBM J20 Blade Server (or current supported vendor hardware)

**Secured Hosting Services includes the following:**

- High Availability Firewall Services using Check Point Firewalls utilizing either the Inter-Agency VPN or the standard ohio.gov networks.
- IDS devices on the inside and outside of the firewalls using ISS RealSecure to monitor traffic and possible attacks.
- Host and network based IDS using ISS Real Secure for deeper monitoring of servers and attack attempts.
- Load Balancing & High Availability servers using f5 BigIP load balancers to ensure that web traffic is being load balanced appropriately within the web server farms.
- VPN connectivity using Cisco's VPN 3000 series concentrator and a Cisco client for secure access from outside of the State of Ohio networks.
- Internal segregation from any other Secured Hosting Services customer or application using VLANs provided by Cisco Layer 3 Switches.
- Monthly vulnerability testing using ISS Internet Scanner software and NMAP software.
- Secured Authentication to resources using RSA SecurID Authentication which provides a one time only password with two-factor authentication.
- Highly trained professional services by dedicated professional Network Security Engineers to help build, maintain, and troubleshoot server environment.
- 24x7 availability and technical support with active log monitoring and alert notification using our paging and email systems.







# SERVICE DELIVERY DIVISION

<b>SDD</b> <b>Unix Systems Services Customer Guide:</b> <b>Policies, Standards, and Procedures</b>	
<b>Effective Date:</b> 3/11/05	<b>Revision Number:</b> SDD CG 2.1.0
<b>Issued by:</b> Walter F. Callahan, Deputy State CIO, OIT Service Delivery Division  <b>Published by:</b> SDD Program Management Office	

**State of Ohio**  
**Office of Information Technology**  
**Service Delivery Division**



# SERVICE DELIVERY DIVISION

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# SERVICE DELIVERY DIVISION

## 1.0 Purpose

The purpose of this Customer Guide is to provide our customers with policies, standards and procedures for Unix Systems Services. The policies, standards, and procedures are set forth to provide information regarding the following:

- Application/database shutdown and startup scripts
- Customer contact list
- Emergency and after hours support
- File systems
- Security
- Sendmail server definitions
- Server backups, maintenance, and network
- System definitions
- User identification numbers/groups
- User requests

## 2.0 Scope

These policies, standards, and procedures are specifically for customers of the Office of Information Technology Service Delivery Division's Unix Systems Services. They are to be reviewed and practiced by all OIT SDD Unix Systems Services customers. Issues not referenced in this guide will be addressed individually by the Unix Systems Services staff or may be covered under an SDD Service Level Agreement. Questions concerning these policies, standards and procedures should be referred to either your immediate supervisor or the OIT Service Delivery Unix Systems Services staff.



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## 3.0 Policies, Standards, and Procedures

### 3.1 Customer Contact List

Unix Systems Services will email our customers and request that they validate the current contact list information on a quarterly basis. This list is used to contact customers concerning server issues, scheduling notifications, etc.

### 3.2 Data Restore Requests

The following will need to be provided, when requesting Unix Systems Services to restore data:

- server name
- file(s) or filesystem(s) to restore
- location of the restore, i.e. the original location or some other filesystem
- whether the existing data is to be purged prior to restore or whether data is to be replaced
- exact point in time from which the file(s) or filesystem(s) are to be restored.

### 3.3 Emergency and After Hours Support

After hours support is maintained through the Unix Systems Services support line at 614-995-HELP.

After hours is defined as 5:00 PM to 7:00 AM Monday through Friday, and all weekends and holidays.

Emergencies are for server down situation, or problem with the Operating System that critically impacts the customer's business.

After hours support for non-emergency needs, should be coordinated with the manager of Unix Systems Services at least 5 business days prior to the needed date, and an additional charge may be assessed.



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## 3.4 File Systems

The customer will have input to the file system name. However, Unix Systems Services reserves the right to require these names to be descriptive of its purpose.

## 3.5 Password Administration

All user passwords will expire every 4 weeks.

All product administrative accounts will be set to expire and all ftp account passwords will be changed on the first working day of July. An email reminder of the expiration and the password changes will begin 60 days prior to the effective date in July. The password changes for all ftp accounts will be completed and the customer designee will be contacted by Unix Systems Services with the new ftp account passwords.

New default passwords will be set on the first working day in January and July for all customers or when Unix Systems Services has determined that the default password has been compromised. Unix Systems Services will contact the customer designee with the new default password.

## 3.6 System Security

Root Authority will not be given to any customer for any reason.

Any software that requires any type of root authority must be prior approved by the Unix Systems Services manager and must be installed and managed by the Unix Systems Services group.

A user id will be locked after three or more attempts to login as root within a one hour time period. In addition, the security and other appropriate manager(s) will be notified.

The user id will be locked for five business days or until the customer's management contacts the Unix Systems Services group, whichever is sooner. If the customer's management does not contact the Unix Systems Services group within five business days, the user will be removed. At the request of the customer's management, the user will either be removed immediately or reinstated. If the same user has the same security violation, the user will be



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locked for five business days, management will be notified, then the user will be removed.

NFS mounts are not supported by Unix Systems Services, as this is not a recommended method of file sharing, due to security and instability concerns. NFS will be considered, within the Unix Systems Services environment, given adequate justification and no other secured file sharing solution. This request must be made to the Unix Systems Services group 14 days in advance.

## 3.7 System Parameters

Prior justification is required if a customer is requesting a system parameter be changed, i.e. ulimit, snmpd.conf, inetd.conf, etc.

We will work with the customer on problem determination, as it relates to the system; however, we will not distribute the system parameter files.

## 3.8 Server

### 3.8.1 Server Maintenance

Unix Systems Services will provide 30 days notice on all major server maintenance, when possible.

Unix Systems Services will work with the customer's schedule when scheduling maintenance, with the exception of an emergency or if the maintenance is necessary to keep the Unix environment operational.

### 3.8.2 Server Network

All Unix servers will be registered OIT's Domain Name Server.

Unix Systems Services is responsible for any adds/removes/changes to hostnames, IP Addresses, and alias names for any Unix server in OIT's DNS.

Unix Systems Services strongly recommends that the customer use a DNS alias. This will eliminate the impact if the server hostname name or IP Address changes.

All servers will be on the OIT network, with the exception of ODJFS.



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Unix Systems Services will provide and manage the hostname and IP Address. Any server that needs to be accessed or accessible by another device outside of the OIT network needs to be approved by the Unix Systems Services manager. A request needs to be sent to the Unix Systems Services manager at least 30 days in advance.

## **3.8.3 Secure Servers**

Ten user ids per customer are defined to these servers.

SSH and a secured token are required to sign in to these servers.

No ftp is available to or from these servers. Only sftp can be used.

Secured Hosting Services and Secure Authentication Services tokens are required services.

## **3.8.4 Sendmail Server Definitions**

The server name to be added to the authorized sendmail server lists must be in DNS.

## **3.8.5 Server Backups and Application/Database Shutdown and Startup Scripts**

Server backups are performed nightly.

The Customer has the option to shutdown their application and/or database prior to starting the nightly backups.

Unix Systems Services highly recommends that customers provide shutdown and startup scripts for their application and/or database for nightly backups and server reboots. Without shutdown scripts, the application and/or database will be killed during shutdown of the server, and without startup scripts, the application and/or database will need to be started manually by the customer.

The customer must supply the necessary startup and shutdown scripts for their application and/or database and the userid to execute the scripts, if the customer



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requires their application and/or database to be shutdown prior to backups. Unix Systems Services strongly recommends that the customer also supply an output filename for messages output of the startup and shutdown scripts.

The customer will be notified if their script fails and causes the backup to be missed, Monday through Friday.

Unix Systems Services uses the IBM Tivoli Storage Manager software for tape management and provides backup and recovery due to data loss or corruption of all open systems platforms owned or managed by SDD.

Recovery of customer data excluded from backup at the customer's request becomes the responsibility of the customer.

It is the responsibility of Unix Systems Services to ensure that the data has been accurately restored; however, it is the responsibility of the customer to ensure the restore of the application and/or database's functionality.

The customer can request the ability to perform additional backups, restores and archives of their data.

## 3.9 Printer Definitions

The printer name must be in DNS to be defined to Unix.

## 3.10 User Ids/Groups

Each unique user must be defined in the State of Ohio directory. The unique uid in the Ohio Directory is used to identify the user to Unix.

Any user request that is not defined in the State of Ohio directory and is not an ftp only or product administrative account is classified as a generic account. Generic accounts are not created due to security concerns.

Any user request that is not defined in the State of Ohio directory will be defined with a maximum 4-character customer chosen prefix.

Any user id that is not defined in the State of Ohio directory will be su or ftp only accounts, without direct login access.



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Ftp only accounts will be without su or direct login access.

Product Administrator id's will be defined with a maximum 4-character customer chosen prefix.

Product Administrator id's will be su-only accounts, without direct login access.

Product Administrator id's will be defined to a group with the same 4-character customer chosen prefix.

Ftp only accounts will be named with a maximum 4-character customer chosen prefix.

If a group account is needed for the ftp only account, a group will be defined for all related ftp only accounts on the server.

Group accounts not related to an ftp only or administrator id will be defined with a maximum 4-character customer chosen prefix.

When users have left the employ of the customer, Unix Systems Services should be notified to lock such accounts. Users are locked for 30 days and then removed from the server, with the exception of the Secure Servers where users are removed immediately.

## 3.11 User Requested CD Mounts

When CD mounts are requested, Unix Systems Services will mount the CD's to the specified server. After 5 business days they will automatically be unmounted unless the customer requests an extension.

A report of the customer supplied CD's in Unix Systems Services possession will be provided for review on the first working day of April. Any CD's that are identified by the customer as no longer current will be returned to the customer.

## 4.0 References and Related Resources

None



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## 5.0 Definitions

None

## 6.0 Inquiries

Direct inquiries about this Customer Guide to:

SDD Program Management Office  
1320 Arthur E. Adams Drive, 1<sup>st</sup> Floor  
Columbus, Ohio 43221

614.752.9937

For information about SDD Unix Systems Services contact:

Nani Carroll  
1320 Arthur E. Adams Drive, 2<sup>nd</sup> Floor  
Columbus, Ohio 43221

614.644.9802

## 7.0 Revision History

Date	Description
11/08/2004	New customer guide SDD CG 2.0.0
3/11/2005	SDD CG 2.1.0 replaces SDD CG 2.0.0 due to changes to sections: 3.5 Password Administration 3.8.5 Server Backups and Application/Database Shutdown and Startup Scripts 3.10 User Ids/Groups 3.11 User Requested CD Mounts



# SERVICE DELIVERY DIVISION

## **State of Ohio**

Bob Taft, Governor

## **Office of Information Technology**

Mary F. Carroll, Interim State Chief Information Officer

## **Service Delivery Division**

Walter F. Callahan, Deputy State Chief Information Officer

# **Windows Systems Services Policies & Procedures Manual**

## **Introduction**

### **General**

This Windows Systems Services Policy & Procedures manual has been developed by the Office of Information Technology (OIT), Service Delivery Division (SDD). It contains policies and procedures pertaining to Windows Server management.

### **Objective**

The objective of this manual is to provide our customers with the policies and procedures that will be employed for this service. It is not a service level agreement.

### **Service Overview**

SDD provides Windows server management that promotes robust hardware, scalability, reliability and proactive management. SDD furnishes the server specifications and management of the customer's Windows servers. This enables customers to develop applications without incurring the costs of setting up and maintaining an operating system environment. Customers are responsible for managing their applications. Servers are housed at the State of Ohio Computer Center, which provides a high degree of physical security and environmental stability. The service includes server installation, configuration, network connectivity and ongoing management of operating system upgrades and patches, system monitoring, operational support and second level help desk support. For a complete description of the service, go to:

<http://www.das.ohio.gov/ITSD/SDDServicesDescriptions.htm#WindowsSystems>

### **Roles & Responsibilities**

#### **Hardware & Software Procurement**

The customer is responsible for purchasing the server, Operating System, Application software and hardware/software maintenance. The SDD Windows Group will assist in providing specifications and a quote from an authorized vendor. Contact The SDD Windows Group Manager, George Padavick (614.466.1090), to schedule a meeting to discuss server needs or requirements.

#### **Servers**

Servers must be rack mounted and do not require console monitors, keyboards, or mouse. These will be provided as part of the service.

The server hardware must include:

- Memory ( 2 Gb minimum)
- Drives (2 x 72 Gb 15K RPM Ultra320 Universal SCSI drives (1”), mirrored)
- Smart Array 6i controller
- Embedded Dual Gigabit NIC
- Hot Plug Redundant Power Supply Module
- Redundant Fan Option Kit
- Proliant Essentials Integrated Lights-Out Advanced Pack
- Rack Mount Kit
- 24x7, 4 hour response, on-site coverage – 3 years

## **Disks**

A minimum of two 72 Gb 15K RPM Ultra320 Universal SCSI drives (1”), are required for system disks. All database servers are required to utilize the SDD enterprise storage solution. This solution also requires the purchase of a Host Bus Adapter (HBA).

This storage is available in 10gb increments and is billed on a monthly basis, in addition to the server management charge. More information on the Enterprise storage service is available at:

<http://www.das.ohio.gov/ITSD/Services/EnterpriseDiskServ.htm>

## **Software**

The customer is responsible for purchasing the operating system license and all necessary application software. The SDD Windows Group will supply several software products used for server management.

### **Operating System Software/license**

The SDD Windows Group will supply the specifications regarding the Windows operating systems currently supported. At the current time, these include Standard, Web, and Enterprise editions of Windows 2003 and Windows 2000.

### **Application software**

The customer is responsible for the purchase and support of all application and database software, design work and development needed for the server. The customer is also responsible for providing maintenance and support for all products.

## **SDD Supplied software**

SDD provides several software products that are used for system management and monitoring. These products are:

### **NETiq Application Manager**

Application Manager is a product that provides extensive pro-active monitoring capabilities. This is used by Windows support staff to monitor various server components. Standard monitoring includes:

- CPU utilization
- Disk utilization
- Memory utilization
- Uptime – measured by availability of the server service
- NIC Utilization
- Web Response time
- SQL Response time

The NetIQ Application Manager software can be set up to monitor additional application related metrics that are not included in the standard service. The Windows Group can configure and implement additional monitoring capabilities based on an hourly fee for personnel services.

### **Symantec Anti-virus**

Anti-virus software is installed on all servers and kept up to date by the SDD Windows staff.

### **Tivoli Storage Manager (TSM)**

TSM is used for disk backup & recovery as part of the SDD Enterprise tape management solution for open systems. There is an additional monthly charge for backups. More information regarding backups is provided under the “Backup” section of this document.

## **Maintenance**

The customer is responsible for purchasing hardware and software maintenance and technical support from the appropriate vendors. SDD provides maintenance for TSM, Symantec anti-virus and NetIQ.

## **Server installation**

All servers are housed in the State of Ohio Computer Center (SOCC) located at 1320 Arthur E. Adams Drive. The SOCC is a highly secure facility that provides a high degree of environmental stability.

Equipment should be shipped to the SOCC, attention of George Padavick, the SDD Windows Group Manager.

The servers are rack mounted in SDD supplied racks and connected to a Keyboard/Video/Mouse (KVM) switch. The racks have redundant power supplies.

The servers are configured following Microsoft recommended practices for security. Information pertaining to this can be found at: [www.microsoft.com/security](http://www.microsoft.com/security).

SDD policies & standards regarding server security and configuration include:

- Each user must have a unique userid/password.
- Passwords must be 7 characters and expire after 60 days
- Only SDD Windows staff are granted administrative access rights on production servers. Customers are responsible for designing applications that do not require administrative privileges to run.
- Temporary administrative access can be granted on test/development servers to authorized customer users. Access will be revoked after 24 hours. The SDD Windows Group is not responsible for data corruption, data destruction, or the improper use or dissemination of data when administrative access is granted to customer personnel.
- The customer is responsible for informing SDD Windows staff of the TCP/IP ports utilized for communication by the application.
- IIS servers will be configured per Microsoft's recommendations at [www.microsoft.com/security](http://www.microsoft.com/security)

### **Network Connectivity**

A connection to the SDD network is included as part of the Windows management service. This connection provides access to the internet and basic firewall services. The SDD network is managed by the Network Services Group. Maintenance and outages on the network can impact the availability of Windows services.

### **Secured Hosting Service**

Security is a high priority and all servers are configured following Microsoft security recommendations. However, some applications may require additional security features. The SDD Network Services Group provides a Secured Hosting service that consists of a highly secure DMZ environment for Web servers that

are accessed via the Internet. More information regarding this service is available at: <http://www.das.ohio.gov/ITSD/Services/SecureHostingSvices.htm>.

### **Timeframes**

The initial server installation and configuration requires two weeks once all hardware and software is received. This includes time for installation, configuration, burn-in, and testing.

### **Application Software**

Once the operating system and base software has been configured, the server will be made available to the customer for installation and configuration of the application software.

### **Database Administration**

Database administration is the responsibility of the customer. SDD provides Database Administration services for SQL and Oracle for an hourly fee. The SDD Database Group has additional support requirements regarding test and development environments, database server configuration, disk configuration and support. More information regarding this service is available at:

<http://www.das.ohio.gov/ITSD/Services/DBServ.htm>

### **Security**

Maintaining appropriate security is the joint responsibility of the SDD Windows Group and the Customer. The Windows Group will work cooperatively with the Customer regarding network, host, and database security and will make recommendations about security to the Customer.

The Customer is responsible for knowing how their applications access the operating system and for identifying what security rights are required. The Customer is also responsible for creating and supporting applications that do not require administrative access in order to function correctly.

Standard Microsoft server security practices are followed.

Staff members of the SDD Windows Group will be granted administrative access on customer servers in order to properly monitor and administer them. All staff members have completed a security background check.

### **Billing**

Windows Systems Services are provided for a fixed, monthly fee. The current rate is \$525/server/month. The customer is responsible for providing a valid job for billing. Billing will start once the hardware is received by the Windows Group.

The rate for Windows Group personnel time for providing additional monitoring/reporting services not included in the base management fee is \$86/hour.

Job numbers can be established by contacting Dave Stephens of the SDD Business Office at 728-1289.

The SDD Business Office reviews and sets rates annually.

### **Contacts/Communication**

Each customer will be assigned a primary system administrator from the SDD Windows Group. This is the person who will be the main contact from the Windows Group and will provide notification of outages, maintenance, security issues, problems, etc. If the primary administrator is not available, other members of the Windows Group serve as backups.

The customer must supply a list of staff authorized to request changes in server, file, or database access or privileges. A contact person (or persons) must be specified for the following areas. The same individual may be the contact for more than one area.

- Administrative Contact – This person is responsible for the overall decision making related to the server.
- Security Contact(s) – Security contacts can request account creations/modifications, password resets, privilege/rights modifications. The security contacts will be consulted regarding all security related issues.
- Service Update Contact(s) – persons to be notified of any server outages, maintenance, or problems. It is the responsibility of the service update contacts to notify their users of outages or problems.

Modifications to the contact list can be requested by the Administrative Contact and/or the security contacts by sending a written or electronic mail request to the SDD Help Desk.

Contact information must include name, work phone number, e-mail address, and after hours contact information (home phone number, cell phone, pager, etc.).

### **Requests for Support**

Although a specific administrator from the Windows Group is assigned to each server, all requests for support or questions should be directed to the SDD Help desk. This will ensure requests are responded to should the primary support person be away from the office. It also ensures that requests are logged and tracked.

Helpdesk support is offered by phone and email to authorized Customer contacts. The SDD Customer Service Center is staffed Monday through Friday from 7:30 a.m. to 5:00 p.m. excluding state holidays. During off-hours, support can be obtained by leaving a message on the Helpdesk voice-mail. On-call technical staff will be paged automatically when a message is left on the voice-mail.

The SDD Customer Service Center can be reached at 1-888-322-1212 or 614-752-2222 (select option 3) or dialed directly at 644-5746. The Customer contacts can send electronic mail requests to [ODN\\_HOTLINE@EXCHANGE.STATE.OH.US](mailto:ODN_HOTLINE@EXCHANGE.STATE.OH.US). Electronic mail to the help desk is not monitored during off-hours.

All support requests should be directed to the help desk. The Customer should not contact individual members of the Provider's staff unless directed to do so by the help desk or SDD management.

### **Escalation Procedures**

Escalation procedures are outlined in Appendix A.

### **Maintenance/Patching**

In order to maintain security and proper functionality, it may be necessary to take systems down for system maintenance or for applying patches released by Microsoft.

The SDD Windows Group normally performs maintenance on Wednesday evening from 6:00-8:00pm.

Normal system maintenance/patching is scheduled at least 7 days in advance with the approval of the customer.

In some cases, emergency maintenance may be required (release of a critical security patch or failing system component). In these cases, the SDD Windows Group reserves the right to perform maintenance as needed prior to the next regularly scheduled maintenance window.

The customer is responsible for purchasing hardware maintenance. In the event of a hardware failure, SDD will contact the support vendor and work with the vendor to resolve the failure. If a support engineer must come in to replace a component, SDD staff will escort the engineer to the server and monitor his/her activities.

The customer is responsible for application testing after all system maintenance or patching.

### **Backups**

The SDD Windows Group will provide disk backup and recovery services for Customer's data based on a mutually agreed to schedule. Nightly backups can be scheduled from 6:00 pm to 6:00 am.

The Customer will be billed separately for backup and recovery services on the Windows platform. SDD will furnish the necessary backup hardware, software and tapes.

IBM's Tivoli Storage Manager (TSM) is used for backups. There will be an initial "full" backup of the entire system and incremental backups from that day forward. All backups are stored with the ability to go back seven changes of a particular file. Special backup or archival procedures can be arranged if necessary.

The Customer is responsible for implementing procedures to ensure database and application files are available for backups.

For database server backups, the Windows Group will run pre- and post- backup scripts provided by the Customer. The Customer must provide information concerning the location of the scripts and how they should be called. The Customer is responsible for checking the success or failure of the backups and the execution of pre- and post-exits

## **Change Control**

### **Monitoring**

The NetIQ Application Manager product is used by the Windows Group for pro-active monitoring (see NetIQ Application Manager description). Windows personnel are notified via pager or e-mail when critical system thresholds are reached or if the server become unavailable.

### **Reporting**

Standard reporting provided by Windows Systems Services includes monthly server availability, CPU utilization, and disk utilization. The NetIQ monitoring software can produce other reports that can be requested but are not part of the standard service. The Windows Group can setup/produce additional reports for an additional hourly fee.

### **Upgrades/Obsolescence**

In order to provide a high level of service, it is essential that customers maintain current software and hardware.

### **Operating System**

Microsoft publishes the support life cycle for its operating systems. The SDD Windows Group will not manage servers running an operating system that is no longer actively supported by Microsoft. The customer is responsible for

purchasing operating system upgrades. The Windows Group will perform operating system upgrades as part of the service. It is the responsibility of the customer to ensure the application works properly under the new OS version.

### **Hardware**

It is the responsibility of the customer to purchase hardware maintenance for the server and all related hardware. The standard server life cycle is usually three years.

### **Viruses/Hacking**

The security of customer servers and data is a top priority and precautions are taken to set up servers as securely as possible and to maintain current anti-virus definitions.

If a server is determined to have been hacked or contaminated with a virus, the Windows Group reserves the right to immediately remove the server from the network until the problem can be corrected.

Customer's are highly encouraged to ensure that all users keep their desktop security and anti-virus definitions up to date.

### **Disaster Recovery**

Disaster Recovery services are not included as part of the stand Windows System Services offering.

Disk backups are kept at two locations (SOCC and State Office Tower), but any disaster recovery/business continuity requires beyond this are the responsibility of the customer.

### **Availability**

The Windows Group strives to maintain a high level of availability for all servers. However, availability requirements are different for each customer and are directly related to configuration, testing, complexity, etc.

If specific levels of availability are required, they will be addressed in a Service Level Agreement that is established between SDD and the customer.

Uptime is a function of hardware and software configuration and by default will only be monitored. Expected uptime needs to be clearly stated in an SLA.

### **VIRTUAL Servers**

Many SDD Windows customers need to have development environments in order to develop new code and application enhancements. Customers utilizing the SDD Database Administration Services are required to have development, test and production environments. Development servers are a critical component to ensure applications can be maintained and updated effectively and safely, yet the need and usage may vary depending on how frequently the application is updated.

Development servers typically have much lower availability and capacity requirements than corresponding production servers and do not usually require 24X7 support or a high degree of redundancy and support.

In order to address this issue, the WSS Group provides a “Virtual Server” Service for development environments. Features and policies regarding this service include:

- The hardware is purchased by SDD. The hardware consists of a large, multi-processor system that may be shared by multiple customers. The standard Virtual Server platform is a server with 4 processors and 10GB of memory.
- The monthly rate for the Virtual Server service is lower than the standard SDD Windows server management rate and also includes the hardware and hardware maintenance costs.
- One physical server is partitioned into 20 virtual servers. Each virtual server runs its own copy or “image” of the Operating system and appears as a stand-alone server. Each Virtual server emulates a single processor system with 512gb of memory.
- Servers are created from a standard image file. If the virtual server becomes corrupted or non-operational, WSS will recreate the server from the image file (the image that was corrupted will not be restored).
- Customers access the virtual server via Terminal Services.
- Virtual servers can be part of the WSS Windows 2003 Active Directory environment, but must follow the same standards as other WSS servers.
- If a customer requires permanent Administrative access/privileges on a virtual server, WSS will not make that server part of the WSS Active Directory infrastructure.
- The Virtual Server service is offered **for development servers only**, NOT test or production.
- No standard backups – if backups are required, they can be done via TSM but the customer is responsible for the backup costs.
  
- Support will be provided from 7:30am-5:00pm Monday-Friday on state work days.
- No uptime reports or monitoring will be provided.
- Availability is best effort – no guarantees or Service Level Agreements.
- Servers will be limited to 20gb of disk space.
- Non-internet routable IP address will be assigned (all IP addresses will be in the 10. address space)

- Virtual servers will be created and configured in 5 business days from the receipt of a request/order.

### **Requesting a Virtual Server**

All Virtual Server requests need to be sent to the hotline in an email stating the following:

- 1) Intent of the server(s)
- 2) Number of servers
- 3) Date servers are needed by
- 4) Job Number for billing
- 5) Administrative access needs
- 6) Backup requirements if any (no backups are performed by default)

# **Supplement 9**

## **BUSINESS REQUIREMENT MATRIX**

## Instructions for Completing the Function Self-Scoring Worksheets

1. The Contractor must self-score each MITS Business Requirement in the "Response Code" column using Only the values that appear in the drop-down list.
2. The "Response Code" values are:
  - F** - Requirement will be fully met in the delivered transfer system software (without configuration, code extensions, or modification)
  - P** - Requirement will be partially met with the delivered transfer system (without configuration, code extensions, or modification)
  - C** - Requirement will be via configurable parameters (e.g., tables, rules)
  - E** - Requirement will be met via code extensions (without changing base application code)
  - M** - Requirement will be met via significant modification of the software solution (e.g., via new functional modules)
  - N** - Requirement will not be met
3. All requirements must contain one of the scoring values identified in Item #2 above. Any requirement without a scoring value will be considered to be "Not Met" ("N").
4. Comments **must** be included in the required narrative section of the Contractor's RFP response and the applicable narrative reference page number **must** be inserted in the Page Reference ("Page Ref") column for all requirements that are coded "P" (Requirement will be partially met in the delivered transfer system without configuration, code extensions, or modification). These narrative comments must explain how the requirement will be partially met and which areas will not be met.
5. Comments **must** be included in the required narrative section of the Contractor's RFP response and the applicable narrative reference page number **must** be inserted in the Page Reference ("Page Ref") column for all requirements that are coded "N" (Requirement will not be met) These narrative comments must explain why the requirement will not or cannot be met.

**MITS Business Requirement "Functional Fit" Survey**

**Business Infrastructure**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
<b>1.1</b>	<b>Medicaid Portal</b>			
1.1.1	General Requirements			
1.1.1.1	Provide the information and content currently available on the ODJFS website.			
1.1.1.2	Ensure Medicaid Portal design, development, implementation and operations are in accordance with State and Federal regulations and guidelines related to security, confidentiality, and auditing.			
1.1.1.3	Provide a single gateway to general and specific information and defined links for internal and external entities such as Medicaid consumers and providers and sub-recipient State agencies.			
1.1.1.4	Include secure and non-secure tabs.			
1.1.1.5	Provide public information without requiring authentication.			
1.1.1.6	Provide links to secure and non-secure ODJFS applications such as: <ul style="list-style-type: none"> <li>• ODJFS website</li> <li>• Provider Locator</li> <li>• Net Effect</li> <li>• Evaluate</li> <li>• Advanced Case Tracking System (ACTS)</li> <li>• Cognos</li> <li>• Quality Information.</li> </ul>			
1.1.1.7	Provide online, real time access to MITS provider, claims, prior authorization, and reference file information.			
1.1.1.8	Include static and easily updated web pages.			
1.1.1.9	Provide the ability to handle lockouts, timeouts.			
1.1.1.10	Support multiple communication lines and provide fail-over capability.			
1.1.1.11	Provide growth capacity for high volumes of activity.			
1.1.1.12	Develop and create specific search and drill-down capability for pages and applications.			
1.1.1.13	Ability to interface, receive, send, and download specified content and reporting information directly to entities such as provider associations, Ohio Council for Home Care, county agencies and sub-recipient State agencies.			
1.1.1.14	Provide users with the flexibility to select the frequency, format, source, and destination of secure transmissions.			
1.1.1.15	Provide flexible web based reporting that meets external reporting needs and requirements defined by ODJFS.			
1.1.1.16	Allow ODJFS staff to generate customized messages.			
1.1.1.17	Provide the capability to display confirmation messages for requestor transactions.			
1.1.1.18	Provide help screens and tutorials for Medicaid Portal application.			
1.1.1.19	Include a desktop windows environment with browser capability for easy navigation.			
1.1.1.20	Provide a Graphical User Interface (GUI) that allows all users to move easily throughout the system.			
1.1.1.21	Support a graphical menu and control system with highly flexible, mouse-driven tab-like navigation.			
1.1.1.22	Provide GUI features and capabilities including:			

**MTS Business Requirement "Functional Fit" Survey**

**Business Infrastructure**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Transfer of information from one screen to all related screens to reduce re-entry</li> <li>• Drag and drop, “point and click”, and “copy, cut, and paste” functionality</li> <li>• Pull down menus and window tabs</li> <li>• Scalable true type screen and printing fonts</li> <li>• Upper and lower case alphabetic characters</li> <li>• Multi-tasking and multi-windowing including split screen capability</li> <li>• Simultaneous closing of all windows relating to a single inquiry</li> <li>• Sophisticated form-based queries</li> <li>• Ability to tab and mouse-click through data fields and screens</li> <li>• Full use of mnemonics to aid keyboard navigation</li> <li>• Extensive file search and save capabilities, including ability for users to search by file name, date, and other characteristics.</li> </ul>			
1.1.1.23	Provide a user-friendly menu system that is easily navigable by the non-technical user while not restricting direct access to any screen to experienced users.			
1.1.1.24	<p>Use the following standards for all screens, windows, and reports:</p> <ul style="list-style-type: none"> <li>• Maintain a consistent theme throughout the site and standardize all headings and footers with index tabs as identified by ODJFS</li> <li>• Display current date and time in a system-wide consistent format</li> <li>• Utilize data labels and definitions in a system-wide consistent manner and as defined in user manuals and data element dictionaries</li> <li>• Generated messages must be available in both mixed font and mixed case formats</li> <li>• Screens should distinguish between production and test environments</li> <li>• Comply with the American Disabilities Act (ADA) development standards for user screens</li> <li>• Comply with the Older Americans Act development standards for user screens</li> </ul> <p>• All generated messages must be clear and sufficiently descriptive to provide enough information for problem correction and be written in full English text.</p>			
1.1.1.25	Ability to display and accept web site terms of agreement when entering the Medicaid Portal.			
1.1.1.26	Provide a site map that includes all areas of the Medicaid Portal.			
1.1.1.27	<p>The site must allow authorized users to perform Electronic Data Interchange (EDI) transactions such as, but not limited:</p> <ul style="list-style-type: none"> <li>• Interactive Eligibility Verification (270/271 – Direct Data Entry (DDE) compliant with an option for additional non-HIPAA-required information)</li> <li>• Interactive Claims Inquiry (276/277 – DDE compliant with an option for additional non-HIPAA-required information)</li> <li>• Interactive Claim Submission (DDE compliant) to allow a provider to submit a claim, including HIPAA/EDI compliant responses</li> <li>• Remittance Advice (RA) (835).</li> </ul>			
1.1.1.28	Utilize software that can automatically and proactively discover, report, and fix broken links.			

**MITS Business Requirement "Functional Fit" Survey**

**Business Infrastructure**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
1.1.1.29	Provide on-line option for end users to report any technical problems with the web application and web pages.			
1.1.1.30	Provide multiple access points for main topics.			
1.1.1.31	Allow for provider and consumer web survey submissions.			
1.1.1.32	Allow for Email submission by user initiated from a link on the website.			
1.1.1.33	Allow for direct mail services bulk outgoing email to registered users.			
1.1.1.34	Ensure that information taken into the Medicaid Portal is in a format that can be processed by MITS.			
1.1.1.35	Require qualifying information such as provider number, prior authorization number, consumer number, date of service, or claim number to access various information via the Medicaid Portal.			
1.1.1.36	Provide inquiry capabilities for categories including: <ul style="list-style-type: none"> <li>• Consumer eligibility</li> <li>• Claim status</li> <li>• Payment status</li> <li>• PA</li> <li>• Reference information</li> <li>• RA</li> <li>• Provider tax program information.</li> </ul>			
1.1.1.37	Implement audit trails to provide reporting and audit information regarding web usage. Audit trail functionality must include listings, transactions reports, update reports, transaction logs, and error logs.			
<b>1.1.2</b>	<b>Security/Authentication</b>			
1.1.2.1	Provide a secure web site with authentication standards to handle PHI as identified in State and Federal privacy and security standards.			
1.1.2.2	Utilize an authentication process to handle multiple layers of security levels as defined by ODJFS.			
1.1.2.3	Include email address in the authorization table. The confidentiality of email addresses must be protected and only used for official State business.			
1.1.2.4	Provide Internet security functionality to include firewalls, intrusion detection, and encrypted network/secure socket layer.			
1.1.2.5	Handle PHI through authentication, along with encryption methods to secure PHI.			
1.1.2.6	Establish user access to predefined ODJFS levels such as page level, field and data element level.			
1.1.2.7	Develop a protected web site with secure passwords and log-ons to include: <ul style="list-style-type: none"> <li>• Instructions on how to use the secure site</li> <li>• Site map</li> <li>• Contact information.</li> </ul>			
1.1.2.8	Provide a secure web site for MCPs, and the Selection Services Contractor that is customizable by ODJFS and includes functions for the interchange of data, both submission and receipt of reports, such as: <ul style="list-style-type: none"> <li>• Encounter data, grievance and complaint, and case management submissions</li> <li>• Membership and premium payment inquiries and reports</li> </ul>			

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**Business Infrastructure**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Hospital deferment and just cause requests</li> <li>• Newborn verification.</li> </ul>			
1.1.2.9	Send users their initial password via email and require that they change their password at next sign-on.			
1.1.2.10	Provide password protection.			
1.1.2.11	Provide the ability to expire a password in a given number of days according to ODJFS standards.			
1.1.2.12	Provide self-service password resets.			
1.1.2.13	Prohibit the display of passwords at the sign-on screen when entered by the user.			
1.1.2.14	Allow providers to be authorized to access only their own claim information.			
1.1.2.15	Allow providers to establish access for billing entities for which they have a contractual agreement. An “Agree” button with a disclaimer stating the provider’s responsibility for granting billing entity access will be added to the site’s design.			
1.1.2.16	Notify providers at regular intervals defined by ODJFS that security access tables will be cleared unless otherwise directed.			
1.1.2.17	Delete account profiles after a period of inactivity as defined by ODJFS.			
1.1.2.18	Do not delete an inactive user from history.			
1.1.2.19	Delete accounts with initial passwords that are not changed within a specified amount of time as defined by ODJFS.			
1.1.2.20	Provide ODJFS/county staff with secured access to information such as: <ul style="list-style-type: none"> <li>• County reports</li> <li>• Managed care programs monthly enrollment reports</li> <li>• Performance measures by county</li> <li>• Administrative information</li> <li>• Email mailing list</li> <li>• Quality Information.</li> </ul>			
1.1.2.21	Provide the capability to receive and send on-line, near real-time confidential information, as directed and managed by the State and Federal government.			
<b>1.1.3</b>	<b>Medicaid Program</b>			
1.1.3.1	Provide the ability for stakeholders such as providers and billing entities (as per direction of the provider) to access information about program policies and processes and be able to communicate readily with ODJFS.			
1.1.3.2	Provide general and program specific information and links to other programs, related agencies, and resources.			
1.1.3.3	Contain information such as: <ul style="list-style-type: none"> <li>• Frequently Asked Questions (FAQs)</li> <li>• Provider workshop information</li> <li>• Managed care plan information</li> <li>• Program information for both the Medicaid consumer and provider.</li> <li>• Provide access to the following documents and files:                             <ul style="list-style-type: none"> <li>o Bulletins (in formats including Portable Document Format (PDF))</li> <li>o Banners (in formats including PDF)</li> <li>o Provider manuals (in formats including PDF)</li> </ul> </li> </ul>			

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**Business Infrastructure**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>o Forms (in formats including PDF, Word, and Excel)</li> <li>o State Plan (in digitized format as appropriate).</li> </ul>			
1.1.3.4	Allow access to program reference information such as procedure, drug, and diagnosis code information to be viewed without requiring authentication.			
1.1.3.5	Provide access to non-claim related program information such as transportation and pregnancy services.			
1.1.3.6	Provide non-claim related program reports to county staff as identified by ODJFS.			
1.1.3.7	Allow for easy upload and update of Medicaid program/general website content.			
1.1.3.8	Allow for the ability to search various program reports by options such as name, number, and/or date.			
1.1.3.9	Display program training information.			
<b>1.1.4</b>	<b>Claim Submission</b>			
1.1.4.1	Accept claim data that is compliant with EDI transactions 837P, 837I, and 837D and also supports claim information submitted on the following claim forms: <ul style="list-style-type: none"> <li>• UB92</li> <li>• Center for Medicare and Medicaid Services (CMS)1500</li> <li>• 6780</li> <li>• ADA forms</li> <li>• NCPDP (Durable Medical Equipment) claim.</li> </ul>			
1.1.4.2	Accept attachments and supporting documentation in EDI formats such as: <ul style="list-style-type: none"> <li>• Remittance advice for an adjustment</li> <li>• County letters supporting eligibility</li> <li>• Inquiry forms</li> <li>• Operative reports</li> <li>• Adjustment forms 6766, 6767</li> <li>• Medical review form 6653</li> <li>• Phase 2 - Digital X-rays.</li> </ul>			
1.1.4.3	Reject those attachments that require an original signature, based on Federal regulations.			
1.1.4.4	Provide downloadable formats of forms to include: <ul style="list-style-type: none"> <li>• Medical review form 6653</li> <li>• UB92 form</li> <li>• CMS1500 form</li> <li>• ADA form</li> <li>• 6780 form</li> <li>• NCPDP (Durable Medical Equipment) claim</li> <li>• 3197 Abortion form</li> <li>• 3198 Sterilization form</li> <li>• 3199 Hysterectomy form</li> <li>• Adjustment forms 6766, 6767, 6768.</li> </ul>			
1.1.4.5	Assign reference/transaction control number to submitted claim and/or attachment claims that can be used in the translator process and through adjudication.			

**MITS Business Requirement "Functional Fit" Survey**

**Business Infrastructure**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
1.1.4.6	Capture fields on current claims submission forms on-line in a HIPAA compliant manner and in a format that allows them to be processed by a translator.			
1.1.4.7	Allow for growth, capacity, and scalability to respond to high volumes of claim submissions.			
1.1.4.8	Track and report web submission errors.			
1.1.4.9	Provide on-line access to claims/adjustments status for a rolling 24-month period.			
1.1.4.10	Accept third party submitted control numbers (e.g., Medicare Internal Control Number (ICN)) for crossover claims.			
1.1.4.11	Provide field level and relationship edit capability such as: <ul style="list-style-type: none"> <li>• Length of fields</li> <li>• Character type</li> <li>• Presence of data.</li> </ul>			
1.1.4.12	Validate fields such as: <ul style="list-style-type: none"> <li>• Provider number</li> <li>• Consumer billing number</li> <li>• Procedure code/modifier</li> <li>• Prior authorization</li> <li>• Consumer eligibility</li> <li>• Third party coverage</li> <li>• Date of service.</li> </ul>			
1.1.4.13	Accept 999 lines on an institutional claim.			
1.1.4.14	Provide the capability to limit the number of submissions per day per submitter.			
1.1.4.15	Track and report submissions per submitter per day.			
1.1.4.16	Ensure that claims and attachments submitted via the Medicaid Portal are in a format that can be processed by MITS.			
1.1.4.17	Provide the capability for providers to correct and resubmit claims immediately.			
1.1.4.18	Retrieve claims information directly from MITS.			
1.1.4.19	Provide the ability to display information from multiple sources such as paper, tape, and EDI transactions 837 I, 837 P, and 837 D.			
1.1.4.20	Provide quick links to related claim information including eligibility, status, payment status, prior authorization, and remittance advice.			
1.1.5	<b>Claim Inquiry</b>			
1.1.5.1	Provide search option fields (required unless otherwise noted) for claim status inquiries to include: <ul style="list-style-type: none"> <li>• Ohio Medicaid provider number</li> <li>• Consumer billing number</li> <li>• Claim status</li> <li>• Claim type</li> <li>• Date of service (optional field)</li> <li>• Total claim charge submitted (optional field)</li> <li>• Prescription number (optional field)</li> <li>• Claim transaction control number</li> <li>• Provider information</li> <li>• Consumer information</li> </ul>			

**MIT'S Business Requirement "Functional Fit" Survey**

**Business Infrastructure**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Billing code information</li> <li>• Claim/service information</li> <li>• Medicare information</li> <li>• Payment information</li> <li>• Third party information</li> <li>• Third party coordination of benefits.</li> </ul>			
1.1.5.2	Run a set of edits upon submission of an inquiry to include: <ul style="list-style-type: none"> <li>• Relationship edits</li> <li>• Field length</li> <li>• Character type</li> <li>• Presence of data.</li> </ul>			
1.1.5.3	Display multiple claims if search results in more than one claim.			
1.1.5.4	Provide claim status for all claim input media.			
1.1.5.5	Display high level information for multiple claims match to include: <ul style="list-style-type: none"> <li>• Remittance advice date</li> <li>• Claim type</li> <li>• Claim status</li> <li>• Claim line information.</li> </ul>			
1.1.5.6	Provide capability to select and drill down to line level information.			
1.1.5.7	Provide search capability for payment status by Medicaid provider number.			
1.1.5.8	Display information for a claim payment match to include: <ul style="list-style-type: none"> <li>• Medicaid provider name</li> <li>• Number of claims paid in current month</li> <li>• Amount paid in current month</li> <li>• Number of claims paid in past 12 months</li> <li>• Amount paid in past 12 months</li> <li>• Number of claims denied in current month</li> <li>• Number of claims denied in past 12 months</li> <li>• Number of claims in final disposition</li> <li>• Date, amount, and type of most recent payments</li> <li>• Number of suspended claims.</li> </ul>			
1.1.5.9	Provide search options for Remittance Advice claim information to include: <ul style="list-style-type: none"> <li>• Medicaid provider number</li> <li>• Provider name</li> <li>• Payment date</li> <li>• RA number</li> <li>• Transaction Control Number (TCN)</li> <li>• Check or Electronic Funds Transfer (EFT) Trace number.</li> </ul>			
1.1.6	Consumer Eligibility Inquiry			
1.1.6.1	Ability to search for consumer eligibility with options such as: <ul style="list-style-type: none"> <li>• Consumer billing number AND date of service OR month/year of service OR range of service</li> <li>• Consumer Social Security Number (SSN) AND date of birth AND date of service OR month/year of service OR range of service.</li> </ul>			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
1.1.6.2	Ability to search for consumer eligibility for a range of up to six months of service.			
1.1.6.3	Display information for a consumer eligibility match such as: <ul style="list-style-type: none"> <li>• Eligibility for those services that have limits during specific time frames, e.g., vision exams and glasses, physical therapy, chiropractic</li> <li>• Consumer Information                             <ul style="list-style-type: none"> <li>o Billing number</li> <li>o Name</li> <li>o Gender</li> <li>o Date of birth</li> <li>o Patient liability (full and partial month)</li> <li>o Level of care information with date spans</li> </ul> </li> <li>• Case worker Information                             <ul style="list-style-type: none"> <li>o Name/identifier</li> <li>o Number</li> <li>o County name</li> </ul> </li> <li>• Medicare Part A, Part B, Part C, and Part D information                             <ul style="list-style-type: none"> <li>o Health care ID numbers</li> <li>o Coverage spans</li> <li>o Prescription Drug Plan</li> <li>o Medicare Advantage Plan</li> </ul> </li> <li>• Managed care Information                             <ul style="list-style-type: none"> <li>o Coverage spans</li> <li>o MCP name and address</li> </ul> </li> <li>• Primary Alternative Care and Treatment Program information                             <ul style="list-style-type: none"> <li>o Primary care provider</li> <li>o Pharmacy coverage spans</li> <li>o Pharmacy name and address</li> </ul> </li> <li>• Waivers and Special Programs Information                             <ul style="list-style-type: none"> <li>o Coverage spans</li> <li>o Provider name and address</li> </ul> </li> <li>• Covered/Non-covered LTC leave days</li> <li>• Third party information                             <ul style="list-style-type: none"> <li>o National Association of Insurance Carriers (NAIC) numbers</li> <li>o Carrier names</li> <li>o Third party coverage periods</li> <li>o Policy number</li> <li>o Policy holder</li> <li>o Group number</li> <li>o Benefit package.</li> </ul> </li> </ul>			
1.1.7	<b>Prior Authorization (PA) Submission</b>			
1.1.7.1	Accept on-line, real-time entry and update of PA requests through the Medicaid Portal, including initial entry of PA requests pending determination.			
1.1.7.2	Allow prior authorization request entries through the Medicaid Portal to be limited to those provider types and services which are covered by Medicaid policy.			
1.1.7.3	Send alert to ODJFS staff for PA submissions.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
1.1.7.4	Provide role-based authorization/access of identified ODJFS staff to the PA module of the Medicaid Portal.			
1.1.7.5	Generate a tracking number for Medicaid Portal PA requests.			
1.1.7.6	Use tracking number to link attachments submitted by mail to electronic PA request.			
1.1.7.7	Notify submitter of successful submission and display the tracking number.			
1.1.7.8	Assign a PA number as soon as the submitted request passes edits.			
1.1.7.9	Reject PA request if it does not pass all edits.			
1.1.7.10	Notify the submitter of invalid web PA entries and which field(s) caused the edit to fail.			
1.1.7.11	Run edits such as the following on all submitted PA requests: <ul style="list-style-type: none"> <li>• Relationship edits</li> <li>• Field length</li> <li>• Character type</li> <li>• Presence of data.</li> </ul>			
1.1.7.12	Accept electronic attachments and link to PA request with tracking number.			
1.1.7.13	Allow users to submit PA's for multiple providers, but only for those providers that have authorized the user.			
1.1.7.14	Allow users to submit a PA request on the provider's behalf.			
1.1.7.15	Screen for duplicate PA requests for exact service and for related or similar type service requests (e.g., services bundled into other prior authorized service codes).			
1.1.7.16	Ensure that attachments submitted electronically meet PHI security policy.			
1.1.7.17	Interface with MITS to identify procedure codes that require PA (medical utilization requirements).			
1.1.7.18	Provide an on-line Medicaid Portal Tutorial for PA application to guide users through the screens they must complete to request a PA.			
1.1.7.19	Interface with MITS and populate PA sub-system screens with PA information to be determined during design.			
1.1.7.20	Phase 2 - Accept PA submissions using the 278, 275, eXtensive Markup Language (XML), Health Level 7 (HL7) Health Care Services Review standard and the National Council for Prescription Drug Programs (NCPDP) standard for retail pharmacy.			
1.1.7.21	Include data fields such as the following to be used for submission of web PA requests: <ul style="list-style-type: none"> <li>• Consumer billing number</li> <li>• Service</li> <li>• Provider name and ID</li> <li>• Dates of service</li> <li>• Authorized services (units, effective dates)</li> <li>• Miscellaneous codes with notes field (for contractors)</li> <li>• Rates</li> <li>• Dollar cap</li> <li>• Local provider information</li> <li>• Provider demographic and rate data</li> </ul>			

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Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Limits</li> <li>• Certification information</li> <li>• Room and board</li> <li>• Health costs</li> <li>• Waiver start date</li> <li>• Waiver program (benefit package)</li> <li>• Waiver wait list data</li> <li>• Cost share data</li> <li>• For miscellaneous codes, descriptions must be available on the PA request form.</li> </ul>			
1.1.7.22	Allow for expansion and addition of fields to the on-line PA request form.			
1.1.7.23	Allow providers the ability to view alerts and notifications generated by ODJFS staff via MITS to include: <ul style="list-style-type: none"> <li>• The need for additional information on an already submitted PA request</li> <li>• Reminders of missing information</li> <li>• Approval or denial of the PA</li> <li>• System updates/policy changes</li> <li>• Duplicate or possible duplicate requests.</li> </ul>			
1.1.7.24	Generate approval or denial notices as soon as the determination has been made.			
1.1.7.25	Provide the ability to automatically approve certain PA requests based on information entered as identified by ODJFS.			
1.1.7.26	Retain incomplete PA request submissions for a minimum number of days, to be defined by ODJFS, before deleting the record.			
1.1.7.27	Maintain a rolling thirteen-month period of on-line PA history.			
1.1.7.28	Allow PA request forms to be available on the Medicaid Portal for download by users.			
1.1.7.29	Link to Ohio administrative rules/program information.			
1.1.7.30	Provide an on-line PA submission tutorial.			
1.1.7.31	Reflect updates to MITS (e.g., when procedure codes and/or modifiers which require prior authorization have been deleted and/or replaced with new or revised HIPAA-compliant codes) without interruption to service.			
1.1.7.32	Support PA entries for medical services such as: <ul style="list-style-type: none"> <li>• Vision</li> <li>• Dental</li> <li>• Durable Medical Equipment (DME)</li> <li>• Surgical procedures.</li> </ul>			
1.1.7.33	Report and maintain Medicaid Portal PA activity statistics such as: <ul style="list-style-type: none"> <li>• Number of PA submissions</li> <li>• Number of times application was selected</li> <li>• Number of PA requests pending for review.</li> </ul>			
1.1.8	PA Inquiry			
1.1.8.1	Provide PA search options such as: <ul style="list-style-type: none"> <li>• Consumer billing number AND Medicaid provider number, OR</li> <li>• PA number.</li> </ul>			
1.1.8.2	Display PA status information for the previous 12 month period.			
1.1.8.3	Return multiple PAs if more than one match is found.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
1.1.8.4	Display information for a PA match to include: <ul style="list-style-type: none"> <li>• PA numbers</li> <li>• PA status</li> <li>• Procedure codes</li> <li>• Line item status</li> <li>• Reasons</li> <li>• Process dates</li> <li>• Service dates</li> <li>• Coverage types</li> <li>• Amounts approved</li> <li>• Amounts used.</li> </ul>			
1.1.9	Provider Enrollment/Maintenance			
1.1.9.1	Allow providers on-line entry, update, and access to screens that are designed to capture the enrollment and change information as defined by ODJFS requirements.			
1.1.9.2	Allow providers to complete and submit applications and update provider demographic data via the Medicaid Portal.			
1.1.9.3	Allow Medicaid Portal to accept electronic attachments and match them with enrollment application in the system.			
1.1.9.4	Require applicants to state whether they are a current or new provider before starting the enrollment application.			
1.1.9.5	Require applicants to state that they meet the State-defined provider eligibility rules.			
1.1.9.6	Provide help screens and tutorial to guide provider through the necessary steps to complete application.			
1.1.9.7	Identify provider applications and updates by provider types that are assigned by ODJFS.			
1.1.9.8	Generate tracking numbers for Medicaid Portal submitted provider enrollment applications and updates.			
1.1.9.9	Provide role-based access to ODJFS staff to provider application, supporting documentation, and other enrollment updates submitted through the Medicaid Portal.			
1.1.9.10	Send notification to ODJFS staff regarding new enrollment entries.			
1.1.9.11	Route applications and updates to the appropriate ODJFS staff to work.			
1.1.9.12	Incorporate relationship editing, as defined by ODJFS, into the interactive application process.			
1.1.9.13	Edit to ensure that all required fields, as defined by ODJFS, must be completed before the application is accepted.			
1.1.9.14	Provide web links to entities such as: <ul style="list-style-type: none"> <li>• Drug Enforcement Agency (DEA)</li> <li>• On-line Survey Certification and Reporting (OSCAR)</li> <li>• Clinical Laboratory Improvement Act (CLIA)</li> <li>• Automated Survey Process Environment (ASPEN)</li> <li>• Office of Inspector General (OIG) sanction list</li> <li>• National Provider System (NPS)</li> <li>• National practitioner</li> <li>• Board of nursing</li> <li>• Databank.</li> </ul>			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
1.1.9.15	Incorporate electronic signatures that comply with Ohio Administrative Rule 123:3-1-0, with provider enrollment applications and updates.			
1.1.9.16	Use a single provider enrollment application with required fields being driven by provider and program type as identified by ODJFS.			
1.1.9.17	Assign provider number prior to the completion of the credentialing process, but provider numbers must remain inactive until all the verification, accreditation, and credentialing are complete.			
1.1.9.18	Generate to the submitter a receipt notification with an inactive provider number when the application and/or update are submitted for review.			
1.1.9.19	Allow access, with appropriate level of security, to providers to retrieve the status of applications assigned to them.			
1.1.9.20	Make provider demographic information as defined by ODJFS available through the Medicaid Portal.			
1.1.9.21	Give providers the ability to view alerts and notifications generated by ODJFS staff.			
1.1.9.22	Provide the ability to terminate providers.			
1.1.9.23	Allow providers to request termination of their provider agreement on-line.			
1.1.9.24	Provide structured on-line templates and documents regarding enrollment and maintenance to providers.			
1.1.9.25	Maintain history and audit trails for all changes and updates made on-line.			
1.1.9.26	Restrict data elements that providers can change on-line to those permitted by ODJFS. Other changes will require approval by ODJFS staff.			
1.1.9.27	Include in the enrollment process and in notification to the provider links for accessing provider manuals and other important documentation, as defined by ODJFS.			
1.1.9.28	Check for duplicate providers when accepting an enrollment application and/or update via the Medicaid Portal.			
1.1.9.29	Provide help screens to define enrollment data requirements for providers and users.			
1.1.9.30	Alert appropriate ODJFS staff that an enrollment application has pended on for a certain amount of days as defined by ODJFS.			
1.1.9.31	Notify applicants of partially submitted applications.			
1.1.9.32	Save partially completed provider enrollments for a given number of days to be defined by ODJFS.			
1.1.9.33	Automatically notify providers via the Medicaid Portal of acceptance/rejection as a Medicaid provider and send enrolled providers an electronic notice for web site locations regarding policy and billing information.			
1.1.9.34	Update provider enrollments via the Medicaid Portal in the provider subsystem in near real-time, except when prevented by batch or other activities. If updates cannot be made immediately, they should be made at the next available time.			
1.1.9.35	Accommodate the 10 digit National Provider Identifier.			
1.1.9.36	Provide notes functionality for web applications.			

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Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
1.1.9.37	Provide on-line statistics of provider enrollments/updates and audit trail reports to include the number of enrollments submitted per day by provider type and the number that are approved, denied, or pending.			
1.1.9.38	Provide links from the Medicaid Portal to trading partner websites.			
1.1.9.39	Allow the Medicaid Portal to interface with contractors for waiver provider enrollment.			
1.1.9.40	Send email notification to appropriate agency when an application is submitted or ready for their review.			
1.1.9.41	Hold application in pending status until pre-approving entity gives authorization to proceed.			
1.1.9.42	Allow certain changes to provider demographic data, as defined by ODJFS, must be pre-approved depending on provider type.			
1.1.9.43	Provide on-line applications, addendums, and provider agreements. <ul style="list-style-type: none"> <li>• Provider agreement</li> <li>• Provider enrollment application (individual, group, organization).</li> </ul>			
1.1.9.44	Provide a link to downloadable W-9 form.			
1.1.9.45	Ensure that Medicaid Portal field definitions comply with system field definitions.			
1.1.9.46	Allow provider enrollment and update transaction information including status to be viewed for a rolling 13-month period.			
1.1.9.47	Allow providers to access to their own information and group owners to access information for all providers in the group.			
1.1.9.48	Provide ODJFS staff the ability to view on-line the details enrollment and update activities for the past seven (7) years.			
1.1.9.49	Report and maintain Medicaid Portal provider enrollment and update activity statistics such as the number of enrollment applications/updates received hourly, daily, etc, number of applications/updates pending.			
1.1.9.50	Provide forms on-line and in downloadable format to include: <ul style="list-style-type: none"> <li>• EFT</li> <li>• Change of address forms</li> <li>• Medicare information</li> <li>• CLIA</li> <li>• Adding individuals to a group practice</li> <li>• Change of ownership.</li> </ul>			
1.1.10	<b>Long Term Care (LTC) Rate Submission and Inquiry</b>			
1.1.10.1	Provide an interface between Perseus and MITS.			
1.1.10.2	Restrict LTC provider enrollment information from public viewing.			
1.1.10.3	Allow authenticated providers/users access to only their own information.			
1.1.10.4	Allow providers/users to submit/upload information in formats to include PDF and text files.			
1.1.10.5	Provide the capability for near real-time file transfers from providers to Medicaid Portal to Perseus and visa versa (for 1500 LTC providers and 65,000 consumers).			
1.1.10.6	Send cost report verification to user if no errors are found during edits and supply providers with a method to agree to the verification.			
1.1.10.7	Send automated notifications/alerts from LTC site to provider.			

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1.1.10.8	Provide non-secured access via links to public information to include: <ul style="list-style-type: none"> <li>• Provider specific information</li> <li>• Rate setting information</li> <li>• Statistical Analysis Software (SAS)/ Pregnancy Related Services (PRS) datasets</li> <li>• Cost report datasets</li> <li>• Rate setting ceiling data</li> <li>• Inflation data</li> <li>• Trend reporting information</li> <li>• Average monthly rates</li> <li>• Rule filing process</li> <li>• Public notices</li> <li>• Proposed rules</li> <li>• Public comments</li> <li>• Transmittal letters</li> <li>• Listing of providers.</li> </ul>			
1.1.10.9	Provide inquiry capabilities for public information with search options to include: <ul style="list-style-type: none"> <li>• County</li> <li>• Peer group</li> <li>• Date or date ranges</li> <li>• Keyword in provider name field.</li> </ul>			
1.1.10.10	Link to documents to include: <ul style="list-style-type: none"> <li>• Procedure code for LTC facility therapy</li> <li>• Bureau of LTC Facility (BLTCF) newsletters/bulletins</li> <li>• Center for Medicare and Medicaid Services (CMS) website</li> <li>• Resident’s rights document</li> <li>• Definition of cost report</li> <li>• Companion guide</li> <li>• Automated Cost Report (ACR) website</li> <li>• Ohio Revised Code (ORC) administrative code</li> <li>• Multiple links containing LTC data</li> <li>• Form 9402 &amp; Form 9405.</li> </ul>			
1.1.10.11	Provide link to Bureau of Long Term Care.			
1.1.10.12	Provide a private document page that will display a list of the available documents for each logged-in provider.			
1.1.10.13	Provide the ability to search for corporate facilities by provider-specific user ID and password.			
1.1.10.14	Provide the ability to upload rate information in batch or in bulk.			
1.1.10.15	Provide the ability to archive various documents after a specified period of time.			
1.1.10.16	Provide the ability to submit, inquiry, update, and publish information.			
1.1.10.17	Support file transfer on an hourly, daily, weekly, monthly, and yearly basis.			
1.1.10.18	Provide inquiry provider-specific access to secured information such as: <ul style="list-style-type: none"> <li>• Provider correspondence</li> <li>• Automated Cost Report (ACR) (data and reports)</li> <li>• Error reports as part of the cost verification process</li> </ul>			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Rate setting package report</li> <li>• Cost verification report</li> <li>• Provider acceptance of the Verification report</li> <li>• Minimum Data Set (MDS) scores</li> <li>• MDS error reports</li> <li>• Individual Assessment Form (IAF) scores</li> <li>• IAF error reports</li> <li>• Rate reconsideration requests</li> <li>• Non-extensive renovations request</li> <li>• Civil Monetary Penalties (CMP) notice</li> <li>• Provider acceptance of civil monetary penalties</li> <li>• Status of fiscal year adjudication by provider</li> <li>• Paid monthly MITS days report</li> <li>• Franchise fee assessment notices.</li> </ul>			
1.1.10.19	Allow providers to submit and upload via the Medicaid Portal to BLTCF the following: <ul style="list-style-type: none"> <li>• Cost reports</li> <li>• Provider acceptance of the verification report</li> <li>• MDS scores</li> <li>• Rate reconsideration requests</li> <li>• Provider correspondence</li> <li>• Non-extensive renovations request</li> <li>• Provider acceptance of civil monetary penalties.</li> </ul>			
1.1.11	<b>Disability Determination (DD)</b>			
1.1.11.1	Provide a gateway for ODJFS and county staff to: <ul style="list-style-type: none"> <li>• Review DD cases</li> <li>• Perform processing functions on DD case information.</li> </ul>			
1.1.11.2	Provide role-based access for both ODJFS and county staff to query, view, and update DD case information.			
1.1.11.3	Support web application by ODJFS and county database servers that will house DD case information.			
<b>1.2</b>	<b>Electronic Document Management System (EDMS)</b>			
1.2.1	<b>General EDMS Requirements</b>			
1.2.1.1	Integrate an EDMS sub-system into MITS that supports, at a minimum, the following capabilities: <ul style="list-style-type: none"> <li>• Document management</li> <li>• Content management</li> <li>• Records management</li> <li>• Document capture and imaging</li> <li>• Document-centric collaboration</li> <li>• Workflow management including document workflow.</li> </ul>			
1.2.1.2	Utilize open architecture standards and scalability to promote integration throughout all MITS business processes and sub-processes.			
1.2.1.3	Align with MITA standards.			
1.2.1.4	Employ a security approach that integrates with other MITS components to provide role-based access with a single log-on.			
1.2.1.5	Integrate with and provide support to various MITS components such as:			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Customer Relationship Management (CRM)</li> <li>• Medicaid Portal</li> <li>• Security system.</li> </ul>			
1.2.1.6	Accept documents through various input methods such as: <ul style="list-style-type: none"> <li>• Medicaid Portal</li> <li>• E-mail</li> <li>• Facsimile</li> <li>• Internal creation from Personal Computers (PCs)</li> <li>• Imaging</li> <li>• Mailroom.</li> </ul>			
1.2.1.7	Store both electronic and imaged paper documents and make them available on-line through a single user interface to promote a total view of current and historical information.			
1.2.1.8	Provide for on-line retrieval and access to documents and files for up to seven (7) years rolling.			
1.2.1.9	Provide backup and storage of documents as defined by ODJFS.			
<b>1.2.2</b>	<b>Document Management</b>			
1.2.2.1	Associate with all documents parameters such as: <ul style="list-style-type: none"> <li>• Document type</li> <li>• Document format</li> <li>• Storage location</li> <li>• Barcode formats</li> <li>• Security levels</li> <li>• Size</li> <li>• Field validation.</li> </ul>			
1.2.2.2	Provide multiple search options (e.g., Structured Query Language (SQL), various index search options, content-based searches, etc.) to view contents.			
1.2.2.3	Track all versions of each document.			
1.2.2.4	Phase 2 - Present users with the latest revision of a document with the option to view previous versions.			
1.2.2.5	Phase 2 - Manage document content and configuration across the ODJFS enterprise and, with suitable role-based permissions.			
1.2.2.6	Support the management of documents created in the following applications. <ul style="list-style-type: none"> <li>• Microsoft Word</li> <li>• Microsoft Excel</li> <li>• Microsoft PowerPoint</li> <li>• Microsoft Publisher</li> <li>• Microsoft Project.</li> </ul>			
1.2.2.7	Allow drag-and-drop functionality to be used when creating or editing a document.			
1.2.2.8	Include at a minimum the following document management capabilities: <ul style="list-style-type: none"> <li>• Access letter templates and forms</li> <li>• Concurrent retrieval functions to publications and other stored documents</li> <li>• On-line, updateable letter templates with the ability to add free-form text</li> </ul>			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>Automated inventory control for all forms, letter templates, publications and other ODJFS-designated documents</li> <li>Store documents and files</li> <li>Generate materials in both hard copy and electronic format including forms and letters.</li> </ul>			
1.2.2.9	<p>Create letter templates, and forms, for the following areas such as:</p> <ul style="list-style-type: none"> <li>Provider certification materials</li> <li>General correspondence/notices for providers and consumers</li> <li>Financial letters</li> <li>Coordination Of Benefits (COB) letters</li> <li>Managed Care Plan/Care Management Plan (MCP) letters</li> <li>PA letters</li> <li>Temporary ID cards</li> <li>Premium coupons</li> <li>State (Social Security Income) SSI benefit checks.</li> </ul>			
1.2.2.10	<p>Letter templates and forms should be stored within the document management system and contain the following attributes assigned to each letter template to include:</p> <ul style="list-style-type: none"> <li>Letter template/form name</li> <li>ODJFS letter template/form number</li> <li>Letter template/form unit owner (e.g., provider services)</li> <li>Contact name for updates</li> <li>Last revision date</li> <li>Letterhead type used (not applicable to forms)</li> <li>Whether ODJFS administrator signature is contained on the letter template (not applicable to forms).</li> </ul>			
1.2.2.11	<p>Allow for specific information on the letter templates such as:</p> <ul style="list-style-type: none"> <li>Signature block</li> <li>Electronic signature capability</li> <li>Revision date</li> <li>Phone number</li> <li>Department letterhead.</li> </ul>			
1.2.2.12	Print letter templates to networked and individual printers.			
1.2.2.13	Convert letters to PDF format.			
1.2.2.14	Update letter templates and forms as requested by ODJFS.			
1.2.2.15	Retain letter templates and forms for a time period defined by State and Federal guidelines.			
1.2.2.16	Generate pre-populated forms.			
1.2.2.17	Utilize document management capabilities, standard for all counties, for scanning and routing documents between County Department of Job and Family Services (CDJFS) offices and the Disability Determination Unit.			
1.2.2.18	Provide the ability to easily match up related documents such as claims and supporting attachments in a many to one relationship.			
1.2.2.19	Allow for storage and retrieval of all documents (e.g., fax, letters, reports, and claims).			
1.2.3	<b>Document Imaging</b>			
1.2.3.1	Support cataloging/indexing of all imaged documents.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
1.2.3.2	Include Optical Character Recognition (OCR) technology that minimizes manual indexing and automates the retrieval of scanned documents.			
1.2.3.3	Utilize bar code technology that minimizes manual indexing and automates the retrieval of scanned documents.			
1.2.3.4	Provide backup capability for manually indexed scanned documents.			
1.2.3.5	Provide the capability to adjust scan preferences for each document type to include: <ul style="list-style-type: none"> <li>• Resolution</li> <li>• File numbering</li> <li>• Storage location.</li> </ul>			
1.2.3.6	Include at a minimum the following imaging and document management capabilities: <ul style="list-style-type: none"> <li>• Scan both single and dual sided documents</li> <li>• Scan complete or scrapped documents</li> <li>• Scan color, black and white, and grayscale images</li> <li>• Provide capability to handle special characters</li> <li>• Support a wide range of compression methods</li> <li>• Retrieve images through the use of key word searches.</li> </ul>			
1.2.3.7	Provide the capability to manipulate images to include: <ul style="list-style-type: none"> <li>• Rotation</li> <li>• Inversion</li> <li>• Zoom</li> <li>• Brightness/contrast.</li> </ul>			
1.2.3.8	Use imaging/document management technology that handles multiple types of letters, forms, publications, and other State designated documents, files and automates workflow processing to include: <ul style="list-style-type: none"> <li>• Provider certification materials</li> <li>• Claim forms and attachments</li> <li>• PA forms and attachments</li> <li>• COB (including casualty)</li> <li>• Estate recovery</li> <li>• Employer verification of earnings and health insurance</li> <li>• Provider correspondence</li> <li>• Consumer correspondence</li> <li>• Medicaid Portal correspondence</li> <li>• Consumer enrollment materials</li> <li>• Notices</li> <li>• Letters</li> <li>• Audit materials.</li> </ul>			
1.2.3.9	Automate batch scanning with user-defined document separators to expedite the imaging and validation process.			
1.2.3.10	Provide the capability for documents to be scanned and batched based on date of receipt.			
1.2.3.11	Allow manual data entry from scanned documents if they cannot be read and transmitted electronically from an image to MITS.			
1.2.3.12	Transmit scanned document data to MITS.			
1.2.4	Workflow Management (Phase 2)			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
1.2.4.1	Include in the EDMS a comprehensive workflow management system that supports: <ul style="list-style-type: none"> <li>• Definition, and possibly modeling, of workflow processes and their constituent activities</li> <li>• Run-time control functions concerned with managing the workflow process in the MITS operational environment and sequencing the various activities to be handled as part of each process</li> <li>• Run-time interactions with users and Information Technology (IT) application tools for processing the various activity steps.</li> </ul>			
1.2.4.2	Provide a user-friendly GUI for process definition, execution, monitoring, and management.			
1.2.4.3	Support a role-based interface for process definition that leads the user through the steps of defining the workflow associated with a business process, and that captures all the information needed by the workflow engine to execute that process to include: <ul style="list-style-type: none"> <li>• Start and completion conditions</li> <li>• Activities and rules for navigation between them</li> <li>• Tasks to be undertaken by ODJFS staff involved in the process</li> <li>• Authorized approvers</li> <li>• References to applications which may need to be invoked</li> <li>• Definition of other workflow-relevant data.</li> </ul>			
1.2.4.4	Allow the process definition to be specified in terms of organizations and roles with later linkage to specific participants.			
1.2.4.5	Provide a rules-based workflow engine that supports workflow access, assignments, and execution.			
1.2.4.6	Coordinate interactions between the workflow engine and participating ODJFS staff to manage the work required to execute a process including: <ul style="list-style-type: none"> <li>• Work queues for each participating staff member</li> <li>• Alerts to the presence of work</li> <li>• Other triggers, timers, and alerts to support workflow</li> <li>• Status indicators to mark work in progress or completed.</li> </ul>			
1.2.4.7	Support workflow management for multiple simultaneous processes, each with multiple simultaneous instances of execution.			
1.2.4.8	Provide the ability to incorporate simple low-level workflow processes into more complex higher-level workflow processes.			
1.2.4.9	Log all instances of workflows that are executed throughout the ODJFS enterprise.			
1.2.4.10	Expose key interfaces to support integration with a variety of best-in-class applications to support process execution.			
1.2.4.11	Support supervisory operations for the management of workflow including: <ul style="list-style-type: none"> <li>• Assignments/re-assignments and priorities</li> <li>• Status querying and monitoring of individual documents and other work steps or products</li> <li>• Work allocation and load balancing</li> <li>• Approval for work assignments and work deliverables via a tiered approach</li> </ul>			

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Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Ability to take necessary action or provide notification when corrective action is needed, including the ability to modify or abort a workflow process</li> <li>• Monitoring of key information regarding a process in execution, including:                             <ul style="list-style-type: none"> <li>o Estimated time to completion</li> <li>o Staff assigned to various process activities</li> <li>o Any error conditions</li> </ul> </li> <li>• Overall monitoring of workflow indicators and statistics by sub-process, organization, or individual staff members including:                             <ul style="list-style-type: none"> <li>o Work in queue by priority</li> <li>o Throughput</li> <li>o Individual and organizational productivity</li> <li>o Current activity by individual staff member.</li> </ul> </li> </ul>			
1.2.4.12	Support ODJFS in mapping all business processes and sub-processes to the workflow application and in transitioning from manual to automated process execution.			
1.2.4.13	Utilize automated workflow to transfer documents to ODJFS for review, editing, and approval, and back to external stakeholders for re-writes and production.			
1.2.4.14	Use workflow management functionality to route and assign cases to the appropriate State and county staff and offices.			
<b>1.3</b>	<b>MIT S User Screens</b>			
1.3.1	Overall Requirements			
1.3.1.1	Incorporate systems navigation technology and a graphical user interface (GUI) that allows all users to move freely throughout the system.			
1.3.1.2	Provide a graphical menu and control system with highly flexible, mouse-driven, and tab navigation.			
1.3.1.3	Emphasize plain English commands, controls, menus, and files.			
1.3.1.4	Include at minimum the following GUI features and capabilities: <ul style="list-style-type: none"> <li>• Ability to transfer information from one screen to all related screens to reduce re-entry of information</li> <li>• Drag and drop, "point and click", and "copy, cut, and paste" functionality</li> <li>• Pull down menus and window tabs</li> <li>• Scalable true type screen and printing fonts</li> <li>• Use both upper and lower case alphabetic characters</li> <li>• Multi-tasking and multiple window capability including split screens</li> <li>• Ability to simultaneously close all windows relating to a single inquiry</li> <li>• Sophisticated form-based queries</li> <li>• Full use of mnemonics to aid keyboard navigation</li> <li>• Extensive file search and save capabilities, including ability for users to search by file name, date, and other characteristics</li> <li>• Ability to tab and mouse through data fields and screens.</li> </ul>			
1.3.1.5	Include a menu system, understandable by non-technical users, that provides access to all functional areas. This menu system must be hierarchical and provide submenus for all functional area.			

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Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
1.3.1.6	Incorporates a non-restrictive environment for experienced users to directly access a screen or to move from one screen to another without reverting to the menu structure.			
1.3.1.7	Utilize standard log-in; display and navigation requirements must be standard for all authorized users.			
1.3.1.8	Include "Help" screens with context-sensitive in order to provide for ease of use.			
1.3.1.9	Require help facility to be available from any screen and any screen field, must provide a description of and the processing performed by a screen or window, data entry format and restrictions, explanation of error messages and other information helpful to the user.			
1.3.1.10	Generate drop-down lists to identify options available, valid values, and code descriptions, by screen field.			
1.3.1.11	Omit screen scrape function from the GUI of the transferred system.			
1.3.1.12	Utilize the following standards for all screens, windows, and reports: <ul style="list-style-type: none"> <li>• All headings and footers must be standardized</li> <li>• Current date and time must be displayed</li> <li>• All references to dates must be displayed consistently throughout the system</li>   <li>• All data labels and definitions used must be consistent throughout the system and clearly defined in user manuals and data element dictionaries</li> <li>• All MITS generated messages must be clear and sufficiently descriptive to provide enough information for problem correction and be written in full English text</li> <li>• Generated messages must be available in both mixed font and mixed case formats</li> <li>• All screens must display the generating program identification name and/or number.</li> </ul>			
1.3.1.13	Display of data will be consistent from screen to screen.			
1.3.1.14	Require screens to distinguish between production and test environments.			
1.3.1.15	Comply with the American Disabilities Act (ADA) development standards for user screens.			
1.3.1.16	Comply with the Older Americans Act development standards for user screens.			
1.3.1.17	Provide an indicator on any summary window if additional information is available and provide drill-down capability from that summary window. Support role-based remote wireless access and data transmission to MITS via the Internet as indicated by ODJFS.			
<b>1.4</b>	<b>MITS Report Access &amp; Delivery</b>			
<b>1.4.1</b>	<b>General Reporting Capabilities</b>			
1.4.1.1	Generate reports for State for printing in the following formats: <ul style="list-style-type: none"> <li>• Letter or legal size paper</li> <li>• Landscape or portrait orientation</li> <li>• Laser print with scalable screen and print fonts</li> <li>• Single-sided or double-sided print</li> <li>• On-line (e.g., PDF)</li> <li>• Customization of report templates</li> </ul>			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	• Standard format that includes header, footer, etc.			
1.4.1.2	Support automatic Windows-based report production and distribution to the State via the State Local Area Network (LAN).			
1.4.1.3	Phase 2 Provide workflow tracking, version control, and near real-time reporting functionality from legislation to law, to administrative rule, contract, business rule and audit activity and resolution repository. (This may involve interfacing with sub-systems such as the Legislative Information System (LIS) and LawTrac.)			
1.4.1.4	Provide the ability to display a graphical representation that identifies the near real-time status of critical MITS system and processing functions (e.g., “vital signs” such as claim volume, pending claims, calls on hold, exceptions posted, etc.) This feature must run in near real-time or near near real-time with very little delay.			
1.4.1.5	Provide a flexible reporting system that meets ODJFS business requirements.			
1.4.1.6	Download reports in various formats.			
1.4.1.7	Allow information via various presentation methods with the preferred format web based (e.g., PDF).			
1.4.1.8	Allow users to run a series of standard reports on a scheduled basis.			
1.4.1.9	Provide the ability to export reports for enhanced manipulation and analysis.			
1.4.1.10	Provide the capability and flexibility for multiple simultaneous users to create and run in near real-time, ad hoc and canned reports without going through a formal change control process.			
1.4.1.11	Produce operational reports.			
1.4.1.12	Create reports that provide supervisory and management with detailed or summary reports by staff person or unit.			
1.4.1.13	Allow users the ability, with help screens, to extract data from management reports, manipulate the extracted data, and specify the desired format and media of the output.			
1.4.1.14	Support near real-time on-line notification to the case manager of a consumer hospitalization, nursing home admission, Intermediate Care Facility for Mentally Retarded (ICF-MR) admissions and emergency room use.			
1.4.1.15	Provide flexible query tools allow staff to customize information retrieved and analyze data to answer specific program questions and support management decisions.			
1.4.1.16	Provide query tools that are easy to learn, with the flexibility to support data changes.			
1.4.1.17	Provide on-line access to metadata.			
1.4.1.18	Provide the following on-line metadata information including: <ul style="list-style-type: none"> <li>• Describe the report</li> <li>• Provide the definitions of fields</li> <li>• Define any calculations</li> <li>• Built-in statistical measure objects.</li> </ul>			
1.4.1.19	Provides for the electronic delivery of reports to identified destinations.			
1.4.1.20	Interface to the Legislative Information System (LIS) to track the status of rules filed			

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Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
1.4.1.21	<p>Provide the capability to produce multi-dimensional, flexible, ad hoc reports across business functions using which meet the following reporting needs such as:</p> <ul style="list-style-type: none"> <li>• Financial reporting</li> <li>• Budget forecasting</li> <li>• Fiscal planning and control</li> <li>• Claims payment accuracy</li> <li>• Cash flow</li> <li>• Timely reimbursement analysis</li> <li>• Recipient cost and user of services</li> <li>• Cost/benefit analysis</li> <li>• Third party recovery</li> <li>• Estate recovery</li> <li>• Prescription drug policy</li> <li>• Cost and user of prescription drugs</li> <li>• Recipient participation</li> <li>• Eligibility and benefit design</li> <li>• Geographical analysis</li> <li>• Program planning</li> <li>• Policy analysis</li> <li>• Federal waiver program evaluation</li> <li>• Program performance monitoring</li> <li>• Provider reimbursement policy</li> <li>• Institutional rate-setting</li> <li>• Medical assistance policy development</li> <li>• Provider participation</li> <li>• Service delivery patterns</li> <li>• Adequacy of and access to care</li> <li>• Quality of care</li> <li>• Outcomes assessment</li> <li>• Disease management</li> <li>• External reporting</li> <li>• Public information</li> <li>• MCP planning and analysis.</li> </ul>			
1.4.1.22	Generate listings of any/all system maintained files, databases, or data as requested by the State.			
1.4.1.23	Generate a listing of all standard on-line reports available, the description of each report, and provide a hot link to the most recent report.			
1.4.1.24	Provide file search and save capabilities for reports, including searching by a variety of parameters, (e.g., file name, date, and other characteristics).			
1.4.1.25	Provide a process to import reports/data/information, which may be transferred by the State's email system.			
1.4.1.26	Segment reports based on functional area and further, by reports that contain PHI as defined by the State.			
1.4.1.27	Archival storage of reports shall comply with State records retention standards.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
1.4.1.28	Store reports on Compact Disk-Read Only Memory (CD-ROM) and shall be able to be rapidly and efficiently retrieved using Windows-based menu- driven selection criteria.			
1.4.1.29	Allow users the ability, with help screens, to extract data, manipulate the extracted data, and specify the desired format and media of the output.			
1.4.1.30	Generate all reports in a format, media, and time frame acceptable to the State and/or CMS, without manual intervention or manipulation of data.			
1.4.1.31	Display consistent ODJFS-approved headers and footers.			
1.4.1.32	Identify and use consistent report fields.			
1.4.1.33	Display the generating program identification name and /or number on production reports. This display must be consistent from report to report.			
1.4.1.34	Provide a user-friendly way to schedule when, with what frequency, or on what regular days within a month (e.g., the first Wednesday after the last Sunday of a calendar month) various reports are generated and disbursed.			
1.4.1.35	Allow staff to create customized reports, using State-defined parameters, on an ad hoc basis.			
1.4.1.36	Provide for the electronic delivery of reports to identified destinations.			
<b>1.4.2</b>	<b>Data Retention, Archival, Retrieval and Purge</b>			
1.4.2.1	Ability to maintain an unlimited number of historical records of each consumer eligibility change.			
1.4.2.2	Provide the capability for ODJFS to specify/modify auto archive rules.			
1.4.2.3	Provide the ability to retain and access historical reference file data according to ODJFS retention requirements.			
1.4.2.4	Provide the capability to retain historical reference file data on-line for up to seven years.			
1.4.2.5	Provide the ability to retain up to seven years of claims history on-line, to include adjustments and all supporting financial transactions.			
1.4.2.6	Provide the capability to retain PA determinations on-line for up to ten years.			
1.4.2.7	Provide the capability to restore archived data for reviewing, copying and printing.			
1.4.2.8	Provide the capability to purge archived data in accordance with ODJFS archival and purge schedules.			
<b>1.4.3</b>	<b>E-Library (General Report Repository and Management)</b>			
1.4.3.1	Track and store detailed information regarding all reporting requests including, but not limited to: <ul style="list-style-type: none"> <li>• Who requested the information</li> <li>• Date</li> <li>• Time</li> <li>• What the report included</li> <li>• Report storage upon completion</li> <li>• Route the entire history on-line.</li> </ul>			
1.4.3.2	Provide the ability to categorize and organize reports by source system, data content, purpose, frequency and other staff selected options.			
1.4.3.3	Provide the ability to print to compatible networked printers.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
1.4.3.4	Provide the ability to access all operations, administrative, financial, Surveillance Utilization and Review (SUR), external, Decision Support System reports through a web- based reports repository.			
1.4.3.5	Provide the ability to establish and maintain a master reports list that staff will browse and select reports from.			
1.4.3.6	Provide the ability to add change, delete report categories in the masters reports list.			
1.4.3.7	Provide the ability to add change, or delete report titles that will appear in the master reports lists.			
1.4.3.8	Provide the ability to select and access a report from a pre-determined master reports list.			
1.4.3.9	Provide the ability to search the reports repository by date, time, report title, report ID, run date, key words, and other characters within the report.			
1.4.3.10	Provide the ability to highlight, cut, paste, and print any selection of the report.			
1.4.3.11	Provide the ability to sort the reports list by date, time report title, run date, and other criteria.			
1.4.3.12	Provide the ability to establish and apply archival and purge parameters to reports.			
1.4.3.13	Provide the ability to access all reports history through the same reports master list.			
1.4.3.14	Provide the ability to download report content formats to Microsoft Office Products.			
1.4.3.15	Provide the ability to easily and flexibly create new reports through an automated and user-friendly report writer tool.			
1.4.3.16	Provide the ability to aggregate data from multiple data files with the MITS data structures.			
1.4.3.17	Provide the ability to use identifier mathematical functions format and manipulate data within reports.			
1.4.3.18	Provide the ability to direct all report output to the report management and repository system.			
<b>1.5</b>	<b>Rule-Based Engine</b>			
<b>1.5.1</b>	<b>General Requirements</b>			
1.5.1.1	Provide a rule-based engine with the capacity to support ODJFS policy needs.			
1.5.1.2	Provide the ability add, modify, or obsolete ODJFS business rules on-line.			
1.5.1.3	Maintain a rules repository for on-line viewing.			
1.5.1.4	Provide on-line user configuration to create and/or maintain rules such as: <ul style="list-style-type: none"> <li>• Procedure code</li> <li>• Claim edits and audit disposition</li> <li>• Benefit plan creation and maintenance.</li> </ul>			
1.5.1.5	Use rule-based logic for MITS business functions such as claims and PA processing, document and work flow management, eligibility determination, and benefit package definition.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
1.5.1.6	Match data attributes of the claim to the rule repository that include rules regarding ODJFS policy/benefit package and edit disposition.			
1.5.1.7	Provide role-based on-line, real-time modifications of rule-based tables and configuration of benefit packages.			
1.5.1.8	Provide on-line capability to easily add, end date, or modify health plan(s) and/or its related components.			
1.5.1.9	Use Windows interface to configure policy by relating attributes available in drop-down menus.			
1.5.1.10	Provide on-line help features.			
1.5.1.11	Retain an audit trail for all rule-based user actions (e.g., add, change, or end date).			
1.5.1.12	Limit or eliminate the need for programming /technical support.			
1.5.1.13	Provide the capability to instantly view the effect of changes.			
1.5.1.14	Provide the capability to view on-line rules used to process a claim, claim adjustment, or prior authorization.			
1.5.1.15	Utilize plain language business rules and processes to define program logic.			
<b>1.5.2</b>	<b>Rule Representation/Administration/Scalability</b>			
1.5.2.1	Provide the rule representation such as: <ul style="list-style-type: none"> <li>• Jump start vocabularies</li> <li>• Multiple rule representation (e.g., decision tables, pseudo-linguistic with context)</li> <li>• Rule sequencing</li> <li>• Definition of macros and cascading meanings</li> <li>• Rule inheritance</li> <li>• Rule consistency checks</li> <li>• Rule collision checks</li> <li>• Rule overlap and “under-lap” checks</li> <li>• Lexicon support</li> <li>• Upon rule entry, link rule test to the rule.</li> </ul>			
1.5.2.2	Provide easy administration such as: <ul style="list-style-type: none"> <li>• Easy to change rules</li> <li>• Easy to test rules</li> <li>• Easy to visualize rule-firing sequencing</li> <li>• Expert help</li> <li>• Ruling-firing audit report capabilities</li> <li>• Ability to used in a wizard/plugin for multiple development environments</li>   <li>• Dynamic rule change support</li> <li>• Rules separate from engine</li> <li>• Supports rule extensibility</li> <li>• Integration/Coordination of distributed rules engine with a corporate master</li>   <li>• Ability to re-run the engine for a point that has passed (e.g., after 1 January, able to rerun year end jobs with 31 December rules)</li> <li>• Constraints are naturally supported.</li> </ul>			
1.5.2.3	Provide scalability for future business needs such as: <ul style="list-style-type: none"> <li>• Must handle more than 20,000 rules</li> </ul>			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Ability to share rule sets across multiple engines</li> <li>• Dynamic and static execution of versions</li> <li>• Multiple, cross-platform support</li> <li>• Pre-built in rule paths</li> <li>• Rule pre-fetch memory</li> <li>• Parallel rule search.</li> </ul>			
1.5.2.4	Provide the capability to compile rule sequences in basic languages.			
1.5.2.5	Link with business activity monitoring and optimization.			
1.5.2.6	Support multiple rule methodologies.			
1.5.2.7	Provide links to accomplish MITS enterprise-wide solution.			
<b>1.5.3</b>	<b>Rule Maintenance</b>			
1.5.3.1	Provide a strong rule management environment.			
1.5.3.2	Provide maintenance to support parallel rule execution.			
1.5.3.3	Support rule aggregation.			
1.5.3.4	Provide rule change impact analysis.			
1.5.3.5	Provide a master listing of rule integration/coordination.			
1.5.3.6	Provide the capability to enter new rules or changes to become effective on a future date.			
1.5.3.7	Provide rule consistency/collision checks.			
1.5.3.8	Provide rule versioning and release versioning and rollback.			
1.5.3.9	Provide role-based access.			
1.5.3.10	Provide rule security.			
1.5.3.11	Provide triggers and outputs.			
<b>1.6</b>	<b>Medicaid Management Information System (MMIS) Compliance</b>			
1.6.1	Overall Requirements			
1.6.1.1	Implement and maintain a certifiable MMIS.			
1.6.1.2	Meet all CMS certification requirements at implementation and throughout operations.			
1.6.1.3	Assure MMIS certification is valid throughout the term of the contract.			
<b>1.7</b>	<b>Disaster Recovery and Contingency Planning</b>			
1.7.1	Overall Requirements			
1.7.1.1	Compliance with State and Federal disaster recovery regulations and standards as defined by the State. Regulations and guidelines include: <ul style="list-style-type: none"> <li>• HIPAA Security: Security Standards; Final Rule at 45 Code of Federal Regulations (CFR) Parts 150, 162, and 164</li> <li>• Automatic Data Processing Physical Security and Risk Management (Federal Information Processing Standard (FIPS) Publication (PUB) 31)</li> <li>• Computer Security Guidelines for Implementing the Privacy Act of 1974 (FIPS PUB 41)</li> <li>• Guidelines for Security of Computer Applications (FIPS PUB 73), and Federal Regulations at 45 CFR 95.621.</li> </ul>			
1.7.1.2	Provide a Disaster Recovery/Business Continuity Plan that complies with Federal and State rules and regulations, including at a minimum: <ul style="list-style-type: none"> <li>• Daily back-up which is adequate and secure for all computer software and operating programs; databases; files; and system, operation, and user documentation (in electronic and non-electronic form)</li> <li>• Full and complete back-up copies of all data and software on tape and/or optical disk</li> </ul>			

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**Business Infrastructure**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Storage of all back-up copies in a secure off-site location</li> <li>• Routine testing to verify the completeness, integrity, and availability of back-up information</li> <li>• Support for immediate restoration and recovery of lost or corrupted data or software from a disaster event</li> <li>• Provide for back-up processing capability at a remote site(s) from the primary site(s) such that normal payment processing, as well as other State defined systems and services can continue in the event of a disaster or major hardware problem at the primary site(s).</li> </ul>			
1.7.1.3	Provide sufficient transaction logging and database back-up to allow it to be restored. If multiple databases are used for work item routing and program data, restoration must ensure that databases are synchronized to prevent data corruption.			
1.7.1.4	<p>Address, at a minimum, the following areas in the Disaster Recovery/Business Continuity Plan:</p> <ul style="list-style-type: none"> <li>• Business functions and other dependent functions that must be maintained</li> <li>• Business function priority</li> <li>• Business impact analysis including potential impact of loss of critical business functions</li> <li>• Recovery time for each major business function, based on priority</li> <li>• Level of services that must be restored</li> <li>• Role and responsibilities for the System Risk Management team</li> <li>• Legal/regulatory/contractual issues</li> <li>• Critical systems dependencies</li> <li>• Business workflow and workaround procedures</li> <li>• Criteria for executing the Business Continuity Plan</li> <li>• Alternate processing methods</li> <li>• Performance metrics</li> <li>• Recording and updating business events information, files, data updates, etc., once business processes have been restored</li> <li>• Key business information that would be required within 24/48 hours of a declared disaster/event.</li> <li>• Key stakeholders and business partners communication</li> <li>• Escalation procedures</li> <li>• Critical personnel (Vendor and ODJFS) to be contacted</li> <li>• Security procedures for protection of data.</li> </ul>			
1.7.1.5	Provide back-up and disaster recovery plan for information submitted to Medicaid Portal, but not yet entered into MITS.			
<b>1.8</b>	<b>Notifications/Alerts</b>			
1.8.1	Overall Requirements			
1.8.1.1	Provide the ability to generate alerts.			
1.8.1.2	Provide the ability to generate individual system generated alerts with user-defined criteria (e.g., time intervals, events).			
1.8.1.3	Provide the ability to generate alerts when changes are made to policies and procedures and system tables or functionality.			
1.8.1.4	Provide the ability to generate alerts when the anticipated return time on a query or report job exceeds a defined time limit.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
1.8.1.5	Provide the ability to generate alerts that assist in monitoring time-sensitive activities.			
1.8.1.6	Provide the ability to generate alerts to a user-defined group or individual.			
1.8.1.7	Provide the ability to generate alerts to staff based on the status or prior authorizations.			
1.8.1.8	Provide the ability to generate alerts to notify staff when they need to take action in connection with workflow events.			
<b>1.9</b>	<b>General System Performance Expectations</b>			
<b>1.9.1</b>	<b>Overall Capacity and Throughput</b>			
1.9.1.1	Provide, without any degradation in performance, concurrent access, through the State Wide Area Network (WAN), for at least five thousand (5,000) users. This includes eighty-eight (88) counties, sub-recipient State agencies, stakeholders and other State contractors.			
1.9.1.2	<p>Provide sufficient capacity to handle the following processing volumes during times of peak operation while also meeting system response time requirements:</p> <ul style="list-style-type: none"> <li>• Adjudicate at a minimum 875,000 claims per day</li> <li>• Adjudicate at a minimum 200,000 encounters per day</li> <li>• Capacity to accept at a minimum 3.375 million pharmacy claims into payment on a monthly basis</li> <li>• Process at a minimum 1,750 claim adjustments per month</li> <li>• Process at a minimum 20,000 Prior Authorization (PA) requests per month</li> <li>• Support at a minimum 11,250 refunds per month</li> <li>• Support at a minimum 12,500 various types of per month</li> <li>• Support at a minimum 25,000 LTC adjustments per month</li> <li>• Support at a minimum 6,250 claim reversals per month</li> <li>• Support at a minimum 500,000 adjustments per month when mass/gross adjustments are executed</li> <li>• Image, index, and store at a minimum 50,000 pages per day</li> <li>• Handle workflow management for simultaneous processes (e.g., contracts, benefit package definition, etc.)</li> <li>• Support up to 50 reports running concurrently</li> <li>• Receive, log, and address at a minimum 55,000 customer calls through CRM per month.</li> </ul>			
1.9.1.3	<p>Provide sufficient data communication and processing capacity during times of peak operation to receive and process:</p> <ul style="list-style-type: none"> <li>• EDI transactions                             <ul style="list-style-type: none"> <li>o Process at a minimum 0.3 million Accredited Standards Committee (ASC) X12 270/271 eligibility inquiries and responses per month</li> <li>o Process at a minimum 3 million American National Standards Institute (ANSI) X.12 276/277 claim status inquiries and responses per month</li> <li>o Process at a minimum 6 million ANSI X.12 835 remittance transactions per month</li> <li>o Process at a minimum 3.7 million ANSI X.12 837 claim transactions per month</li> </ul> </li> </ul>			

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Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	o Process at a minimum 4.8 million responses or turnaround transactions (824, U277, 997, 999, TA1) per month.			
1.9.1.4	Build into the MITIS architecture sufficient scalability to handle a 5% annual increase from “day one” peak volumes for a minimum of ten years.			
1.9.2	<b>Response Times</b>			
1.9.2.1	<p>Meet system response time requirements. Response time shall be measured during normal working hours, which are 6:00 a.m. to 7:00 p.m., Eastern Time, Monday through Friday, and on Saturdays 8:00 a.m. to 12:00 p.m., Eastern Time except for State observed holidays. The Medicaid Portal response times will be measured 7 days a week, 24 hours a day, except during agreed upon downtime. The response time definitions do not apply to the data warehouse/DSS. The Vendor will only be responsible for that portion of the system and communication link for which the Vendor has responsibility and control. For example, the Vendor will not be responsible for the response times while a transmission is traveling over the State's LAN. The same logic will apply to transactions over the network controlled by the switch vendor, or individual providers, or their billing agents and services. The following definitions apply to networked workstations:</p> <ul style="list-style-type: none"> <li>• Record Search Time -- The time elapsed after the search command is entered until the list of matching records appears on the monitor</li> <li>• Record Retrieval Time -- The time elapsed after the retrieve command is entered until the record data appears on the monitor</li> <li>• Screen Edit Time -- The time elapsed after the last field is filled on the screen with an enter command until all field entries are edited with the errors highlighted</li> <li>• New Screen/Page Time -- The time elapsed from the time a new screen is requested until the data from the screen appears on the monitor</li> <li>• Print Initiation Time -- The elapsed time from the command to print a screen or report until it appears in the appropriate queue</li> <li>• Medicaid Portal Response Time -- The elapsed time from the command to view a response until the response begins to appear on the screen.</li> </ul>			
1.9.2.2	<p>Ensure that MITIS components' response times meet the following minimum standards. Times will be measured for adherence to the requirements at the ODJFS' discretion. The Vendor must provide a system to monitor and report on response times. The response time requirements do not apply to the data warehouse/DSS.</p> <ul style="list-style-type: none"> <li>• Record Search Time -- The response time must be within four (4) seconds for 95 percent of record searches</li> <li>• Record Retrieval Time -- The response time must be within four (4) seconds for 95 percent of records retrieved</li> <li>• Screen Edit Time -- The response time must be within two (2) seconds for 95 percent of the time</li> <li>• New Screen/Page Time -- The response time must be within two (2) seconds for 95 percent of the time</li> <li>• Print Initiation Time -- The response time must be within two (2) seconds for 95 percent of the time</li> </ul>			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Medicaid Portal Response Time -- The response time must be within four (4) seconds for 99 percent of the time.</li> </ul>			
1.9.2.3	Reports must be generated according to the following timelines: <ul style="list-style-type: none"> <li>• Daily reports delivered by noon of the next business day</li> <li>• Weekly reports and cycle processing report by noon of the next business day after the scheduled run</li> <li>• Monthly reports by noon within five (5) business days following the end of the month</li> <li>• Quarterly reports by noon within five (5) business days following the end of the quarter</li> <li>• Annual reports by noon within ten (10) business days following end of the year (Federal fiscal, State fiscal, or other annual cycle).</li> <li>• Ad-hoc and on-demand reports within the timeframes defined by ODJFS in the report request, but normally within five (5) seconds after the request is initiated ninety-five percent (95%) of the time.</li> </ul>			
1.9.3	<b>Availability</b>			
1.9.3.1	MTS access must be available at a minimum during ODJFS core working hours, which are 6:00 a.m. to 7:00 p.m., Eastern Standard Time, Monday through Friday, and on Saturdays 8:00 a.m. to 12:00 p.m., Eastern Standard Time, except for State observed holidays, and on an emergency basis if requested by the State.			
1.9.3.2	Data base system is available and accessible to multiple users 24X7 except for ODJFS-approved time for system maintenance.			
1.9.3.3	The Medicaid Portal, and other system components as required by ODJFS, must be available 7 days a week, 24 hours a day, except agreed upon downtime.			
1.9.4	<b>Error Handling and Trouble Reports</b>			
1.9.4.1	Submit system trouble reports to ODJFS-designated staff no later than close of business on the day the problems are identified.			
1.9.4.2	Notify ODJFS-designated staff of any system problem within one (1) hour of problem discovery.			
1.9.5	<b>Protection Against Unauthorized Access</b>			
1.9.5.1	The system shall provide security from anticipated threats or hazards to its data and shall restrict the availability of data to appropriate State staff and to other designated individuals and organizations through standardized system applications and data security capabilities.			
1.9.5.2	Ensure that all applications are protected against unauthorized access according to State and Federal guidelines. Additionally, all transmission lines and communications services and linkages between the data and each information system, and between each system and the LAN, must be secure from unauthorized access at all times.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
<b>2.1</b>	<b>Consumer Eligibility &amp; Enrollment</b>			
2.1.1	Requirements			
2.1.1.1	Maintain a principal repository for Medicaid eligibility data. In the event that data is stored in multiple systems, those systems must support near real-time synchronization and update capabilities.			
2.1.1.2	Maintain near real-time updates on all eligibility files from the eligibility systems.			
2.1.1.3	<p>Maintain and display current and historical consumer eligibility data required to support ID card production, claims and premium processing, Social Security payment status, prior authorization processing, inquiry, eligibility verification and reporting to include, at a minimum:</p> <ul style="list-style-type: none"> <li>• Unique and/or universal consumer identifiers from the eligibility systems</li> <li>• Time-dependant eligibility data, including consumer eligibility group and program codes</li> <li>• Demographics, including race/ethnicity and preferred language</li> <li>• Third party coverage including benefit package information (private insurance, Medicare)</li> <li>• Premium assistance eligibility and activity (Medicare, employer-sponsored insurance)</li> <li>• Cost share amounts (spend-down/deduction, client liability, premiums, deductibles)</li> <li>• Managed care program membership status</li> <li>• LTC level of care authorization</li> <li>• Hospice enrollment</li> <li>• Waiver program enrollment</li> <li>• ID card status, to include replacement reasons</li> <li>• Service restriction (lock-in, limited benefit eligibility)</li> <li>• Healthchek status</li> <li>• Claims history</li> <li>• Percent of Federal poverty level of family</li> <li>• Residence and mailing address(es)</li> <li>• Phone numbers (home, cell, etc.)</li> <li>• Email address</li> <li>• Family income earned by source</li> <li>• Individual income earned by source</li> <li>• Family size (not assistance group size)</li> <li>• Application date</li> <li>• Signature date</li> <li>• Approval date</li> <li>• Retro and back dated eligibility flags</li> <li>• Geo-coded information, including X, Y census tracking information.</li> </ul>			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
2.1.1.4	Provide authorized users limited role-based access to all current and historical consumer data by consumer ID number, name or partial name, Social Security number and the ability to use other factors such as gender and date of birth and/or county to limit the search. Partial name search must be provided through use of a proven mnemonic/phonetic algorithm.			
2.1.1.5	Maintain a unique universal consumer ID number provided by the eligibility systems for each consumer with capability to store ID numbers that are up to twelve (12) characters in history as directed by ODJFS.			
2.1.1.6	Utilize the following consumer identifiers as keys to the consumer eligibility files: <ul style="list-style-type: none"> <li>• Unique consumer ID number from the eligibility systems</li> <li>• The ODJFS electronic eligibility determination systems case number (currently Client Registry Information System-Enhanced (CRIS-E) and SACWIS)</li> <li>• Names (current and historical)</li> <li>• Date of birth</li> <li>• Gender</li> <li>• Social Security Number (SSN).</li> </ul>			
2.1.1.7	Provide an automated link to claims for the consumer under current and historical names and ID numbers.			
2.1.1.8	Provide an automated link to secondary demographic information such as: <ul style="list-style-type: none"> <li>• Actual county of residence for consumers certified by a specialized agency that doesn't have the county identified by the agency code</li> <li>• Specific office locations within a county.</li> </ul>			
2.1.1.9	Link all members of a Medicaid assistance group together and easily identify all members of that group, whether currently eligible or not.			
2.1.1.10	Link to demographic information in the eligibility system for Medicaid assistance group information to be used for other MITS processes (e.g., coordination of benefits, managed care, data warehouse interface, and mailings).			
2.1.1.11	Incorporate audit trails to allow information on all consumer update source transactions to be traced through the processing stages to the point where the information is finally recorded, regardless of the method used to update.			
2.1.1.12	Trace data from the final place of recording back to its source.			
2.1.1.13	Provide, at a minimum, audit trails to verify that update transactions are processed, to include an update source identifier, original date received, date processed, all data as sent from the update source, and if edits are set, the edit identifier and date the edit was resolved.			
2.1.1.14	Maintain an audit trail of changes to consumer data at the field or line level rather than at a higher tracking level of last change to screen or file.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
2.1.1.15	Provide role-based access to authorized users to manually add/change MITS data via batch and/or on-line updates.			
2.1.1.16	Ensure that updates to consumer eligibility accurately track to the correct benefit package.			
2.1.1.17	Edit all systematic consumer update transactions for data presence, format, validity, and consistency with other data in the update transaction.			
2.1.1.18	Perform on-line data presence, validity, format, and relationship edits for manually entered updates.			
2.1.1.19	Produce consumer error reports for each eligibility transaction from the eligibility system that fails one (1) or more edits.			
2.1.1.20	Provide the capability to correct eligibility information on-line using day-specific start and termination dates, including the ability to reverse eligibility status before the eligibility start date and link back to the eligibility system of record.			
2.1.1.21	Link to the reason eligibility was terminated from the eligibility systems.			
2.1.1.22	Maintain an audit trail of the eligibility status code and benefit package assigned by the administrative agency that will be utilized for claims processing and Federal reporting categories.			
2.1.1.23	Provide a system to track premium amount(s) owed and received to include: <ul style="list-style-type: none"> <li>• Consumer</li> <li>• Period for which payment owed</li> <li>• Amount owed</li> <li>• Date payment received</li> <li>• Payment method</li> <li>• Primary payer</li> <li>• Outstanding payments</li> <li>• Payment discrepancy reports</li> <li>• Program for which premium is owed.</li> </ul>			
2.1.1.24	Allow for providers to electronically submit invoice(s) information for spend-down calculation.			
2.1.1.25	Use flexible, rule-based logic to support all processes that access and use eligibility data, including in the rules, data such as medical status codes, medical eligibility coverage groups and, program identifiers that include multiple program eligibility.			
2.1.1.26	Identify and prevent, to the extent possible, potential duplicate consumer records from updating and systematically combine the files of definite duplicate consumer records during initial update and ongoing.			
2.1.1.27	Allow benefit package to be changed by authorized individuals.			
2.1.1.28	Prevent, or recoup, claims payment for services rendered after date of death.			
2.1.1.29	Transmit all updates and add consumer subsystem data to the data warehouse.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
2.1.1.30	Process updates to cost share amounts received daily from certifying agencies or ODJFS for consumers that have spend-down, deductible, patient liability, waiver cost share enrollment fees, or premium obligations.			
2.1.1.31	Update Medicaid eligibility for Section 1619a&b eligibles, as directed by ODJFS and as received from the State eligibility system(s).			
2.1.1.32	Provide the capability to create and distribute annual surveys to eligible groups.			
2.1.1.33	Process consumer hospice election and program withdrawal forms received from providers, updating the consumer's file for use in claims processing.			
2.1.1.34	Monitor and coordinate file information upon initial enrollment of hospice consumers that are residing in a nursing facility.			
2.1.1.35	Maintain information on presumptive eligibility, family planning waivers, and other programs as directed by ODJFS, assigning a unique ID number, if necessary, and produce consumer notification letters.			
2.1.1.36	Query Social Security Administration (SSA) on-line for Medicare information using State On-line Query to Social Security (SOLQ) as directed by ODJFS.			
2.1.1.37	Receive, process, and maintain consumer restriction data to support the claims processing functions, including restricted benefit packages, service types/codes, consumer lock-in enrollment, and effective start and end dates.			
2.1.1.38	Ensure that consumer data is routinely purged, archived as historical information, and protected from destruction, according to State and Federal requirements and on a schedule approved by ODJFS.			
2.1.1.39	Notify certifying agency workers when MITS is updated with newborn eligibility from reports received from providers.			
2.1.1.40	Provide role-based access to the consumer eligibility information using a variety of secure methods, including the Medicaid Portal, on-line direct connection through dial-up lines, switch vendor products, Eligibility Verification Systems (EVSs), and telephone to an Interactive Voice Response (IVR) line and/or eligibility staff person. Data provided for the eligibility verification includes: <ul style="list-style-type: none"> <li>• Waiver enrollment</li> <li>• Dates of program eligibility</li> <li>• Managed care programs enrollment</li> <li>• Commercial health insurance coverage</li> <li>• Medicare coverage</li> <li>• Provider lock-in</li> <li>• Hospice enrollment</li> <li>• Limited benefit information</li> <li>• Medicaid, spend-down, consumer liability and deductible balances</li> <li>• Long term care liability and cost share amounts</li> <li>• Demographic information such as county of residence</li> </ul>			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Health Personnel Shortage Area (HPSA)</li> <li>• Medical benefit package</li> </ul>			
2.1.1.41	Maintain role-based secure access to all current and historical (consumer lifetime) date-specific consumer eligibility information (7 years on-line and archived and retrievable in electronic form beyond that), per ODJFS guidelines.			
2.1.1.42	Phase 2 - Integrate State-provided standard card reader systems with MITS that provide labor saving efficiencies to the provider and consumer, for example, conducting eligibility and spend-down inquiries. There is a potential of 875,000 transactions per day from 36,000 providers.			
2.1.1.43	Phase 2 Include multiple card reader methods (There is a potential of 875,000 transactions per day from 36,000 providers.) such as: <ul style="list-style-type: none"> <li>• Readers connected to personal computers that conduct eligibility and spend-down inquiries over the Internet</li> <li>• Readers compatible with point of sale systems from other industries such as credit card and debit card readers</li> <li>• Stand alone readers that provide eligibility inquiry and spend-down functionality via a connection to a phone line.</li> </ul>			
2.1.1.44	Display and/or print all of the eligibility data that can be returned on a HIPAA 271 Eligibility Response transaction.			
2.1.1.45	Display and/or print consumers current spend-down information.			
2.1.1.46	Transmit monthly consumer premium no pay and late pay records to the Statewide eligibility determination system according to the ODJFS-defined schedule.			
2.1.1.47	Store and utilize consumer specific information to link benefit packages that identify specific services available to the consumer.			
2.1.1.48	Provide role-based access to individual eligibility data for budget forecasting to staff designated by ODJFS.			
2.1.1.49	Build in data quality assurance measures such as identification of error prone profiles.			
2.1.1.50	Provide the capability to receive date of death information from various sources (e.g., county board of health, hospitals, etc.), validate data against an external vital statistics database, and update consumer eligibility records.			
2.1.1.51	Provide the capability to generate a report that provides specified information for all recipients served by an identified provider or providers for a specific date span.			
2.1.1.52	Provide the capability to receive, store, and report on information related to the operation of a Long Term Care Insurance Partnership program.			
<b>2.2</b>	<b>Coordination of Benefits (COB)/Third Party Liability (TPL)</b>			
2.2.1	Requirements			
2.2.1.1	Support the management of TPL information as defined by the State per Federal guidelines.			
2.2.1.2	Receive, store, and process TPL information from various eligibility system sources (currently CRIS-E, Support Enforcement Tracking System (SETS), and SACWIS).			

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2.2.1.3	Query an ODJFS-defined list of insurance carriers (including at least the top ten) within one business day of eligibility to determine whether new or re-determined Medicaid consumers have other healthcare benefits.			
2.2.1.4	Query Federal Beneficiary and Earnings Data Exchange (BENDEX) information within one business day of eligibility to determine whether new or re-determined consumers have other healthcare benefits.			
2.2.1.5	Maintain all third party coverage information and benefit package information, including multiple TPL sources, for Medicaid consumers for all periods of eligibility.			
2.2.1.6	Maintain all third party resource information at the consumer specific level, consistent with ASC X12N 270/271 transactions, including: <ul style="list-style-type: none"> <li>• Insurance Carrier name and ODJFS-defined identifier (NAIC and/or National Plan Identifier (NPI))</li> <li>• Policy number and group number</li> <li>• Effective date and end date of coverage, if applicable</li> <li>• Add date, change date and verification date of insurance</li> <li>• Type of Insurance (e.g., MCP, Preferred Provider Organizations (PPO), Indemnity plan, etc.)</li> <li>• Source and type of insurance information identifier</li> <li>• Policy holder name, address, SSN, date of birth, relationship to insured, employer name and address</li> <li>• Coverage types (e.g., hospital, surgical, vision/dental plan, pharmacy, etc.) included in a TPL matrix to be used in claims adjudication</li>   <li>• Medicare Parts A, B, C, D</li> <li>• Supplemental (Medi-Gap policy).</li> </ul>			
2.2.1.7	Maintain a file of all insurance carriers that includes: <ul style="list-style-type: none"> <li>• Carrier name and identifier (NAIC and/or NPI)</li> <li>• Technical entity contact information, including phone number</li> <li>• Corporate contact name, address, and telephone number</li> <li>• Claims submission address and phone number</li> <li>• Indicators of participation in insurance disclosure, billing media (e.g., clearinghouses, trading partners, etc.) effective and end dates of activity</li>   <li>• Active/inactive status</li> <li>• Group and policy numbers and benefit packages supported by individual insurance carriers.</li> </ul>			
2.2.1.8	Provide a flexible interface that receives and stores TPL coverage information from a variety of external systems and sources, including Medicare, Managed Care Organizations, absent parent information from counties, and providers, and that accepts EDI 270/271 transactions.			
2.2.1.9	Maintain audit trails for all changes/updates to consumer insurance data including those that were unable to be applied.			

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2.2.1.10	Provide ODJFS staff with inquiry access to TPL case tracking information and TPL accounts receivable based on ODJFS-defined roles.			
2.2.1.11	Generate annual extract to Defense Enrollment Eligibility Reporting System (DEERS) and process response records according to Department of Defense (DOD) schedule.			
2.2.1.12	Provide the capability, using business rules, to specify and change the order of ODJFS payment with respect to TPL as required. (For instance, Medicaid is usually the payer of last resort, but for children with medical handicaps and victims of crime, those programs are the payer of last resort.)			
2.2.1.13	Provide download of consumer files to TPL post pay recovery vendor as per TPL post pay contract.			
2.2.1.14	Provide monthly verified TPL data, including Medicare, to the ODJFS contracting Medicaid MCPs.			
2.2.1.15	Provide a daily file of verified TPL data, including Medicare, to the Selection Services Contractor (SSC).			
2.2.1.16	Provide the ability to update TPL data on-line based upon authorized role-based access and with appropriate audit trails.			
2.2.1.17	Generate verification at ODJFS-defined intervals, of TPL information for Medicaid consumers using TPL clearinghouses utilizing EDI 270/271.			
2.2.1.18	Provide for on-line letter creation, generation, maintenance, modification, tracking, storage, and historical viewing of standard and ad hoc letters.			
2.2.1.19	Provide for mass change or archiving of TPL records affected by dissolved insurance companies or employers.			
2.2.1.20	Integrate functions within an existing TPL contract, an EDI exchange contract, and a child support contract, as needed.			
2.2.1.21	Provide statistical reports from the TPL interface tracking file, the TPL Master File, and the 270/271 exchange.			
2.2.1.22	Provide near real-time access of the TPL database to contributing source systems using role-based access defined by the ODJFS.			
<b>2.3</b>	<b>Managed Care Programs Membership</b>			
2.3.1	Requirements			
2.3.1.1	Implement secure on-line communications with MCPs and other medical professionals facilitate the transfer of information in compliance with HIPAA security and privacy standards.			
2.3.1.2	Accommodate near real-time program modifications and maintenance for care management programs, including: policy and process changes, edit and audit implementation, MCP participation changes, benefit coverage, service areas, program indicators, premium payment/procedure code and reporting requirements.			
2.3.1.3	Maintain, display on-line and utilize for the membership process, the following care management programs data: <ul style="list-style-type: none"> <li>• Maximum number of members allowed for each MCP</li> </ul>			

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**Member Services**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Current number (aggregate) of members for each MCP on a monthly basis</li> <li>• Open/closed indicator to display whether MCP is eligible for new members</li> <li>• Primary and extended service areas.</li> </ul>			
2.3.1.4	Track MCP availability to accept membership by assignment, reenrollment or choice, based on the current number of MCP members.			
2.3.1.5	Increment and/or decrement the number of eligible individuals assigned to the MCP, as members are added or terminated on a near real-time basis.			
2.3.1.6	Provide ODJFS staff with role-based near real-time access to activate or deactivate assignment, auto-reenrollment and choice, by MCP or by service area.			
2.3.1.7	Track MCP service areas and optional benefit coverage.			
2.3.1.8	Determine whether individuals are eligible for voluntary or mandatory MCP membership based on service area and/or program type following ODJFS-defined criteria.			
2.3.1.9	Select and assign, or reassign, all assistance group members eligible for membership in the same MCP based on ODJFS-defined criteria.			
2.3.1.10	Allow all Assistance Group (AG) members to be enrolled in an MCP even if the plan's maximum membership is reached after one (1+) or more case members are enrolled.			
2.3.1.11	Allow AG members to be enrolled in different MCP plans based on ODJFS policy as captured in business rules.			
2.3.1.12	Allow individuals to be enrolled in more than one MCP plan based on ODJFS policy as captured in business rules.			
2.3.1.13	Allow membership lock-in of a member to an MCP for a specific amount of time, according to ODJFS policy.			
2.3.1.14	Calculate the begin and end dates for membership lock-in based on ODJFS-defined criteria.			
2.3.1.15	Provide for day-specific MCP membership begin dates.			
2.3.1.16	Retroactively add/terminate newborns and others based on ODJFS-defined managed care criteria.			
2.3.1.17	Provide an audit trail of all MCP membership transactions and changes to enrollment including at a minimum: changes made, date of change, reason for change, and user ID of the individual making the change.			
2.3.1.18	Identify dual-eligibles (Medicaid and Medicare) and prevent them from being placed in an MCP according to ODJFS-defined criteria.			
2.3.1.19	Allow for "carve-outs" of premium payments or split premium payment according to ODJFS-defined criteria.			
2.3.1.20	Provide ODJFS with a role-based capability to maintain the provider charge file for Comprehensive Managed Care (CMC) program and CM rates.			

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**Member Services**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
2.3.1.21	Assure Bureau of Managed Health Care (BMHC) ability to hold and divert funds from the monthly premium check of those MCPs that have been fined.			
2.3.1.22	Retain at least seven years of premium payment data on-line.			
2.3.1.23	Provide a capability for authorized role-based users to enter case notes via the CRM, using access channels including the Medicaid Portal and secure wireless hand-held devices.			
2.3.1.24	Ensure continuity of eligibility and CMC/CM membership data across all repositories.			
2.3.1.25	Enable SSC to transmit CMC and CM membership data to the ODJFS eligibility file in a secure electronic format.			
2.3.1.26	Assign eligible consumers to MCPs based on MCP service area and/or program type according to ODJFS-defined criteria.			
2.3.1.27	Exempt certain terminated members from the auto-reenrollment process, based on ODJFS-defined criteria.			
2.3.1.28	Provide the capability for the SSC to enter membership additions/changes/deletions on-line or in batch mode, per ODJFS policy.			
2.3.1.29	Provide the capability to the SSC or other enrollment entity to enter MCP and other capitated programs membership data using on-line screens per ODJFS-defined criteria.			
2.3.1.30	Limit MCP membership changes to periods of time based on ODJFS-defined criteria.			
2.3.1.31	Generate and send via the CRM ODJFS-approved MCP membership materials to eligible individuals, at a minimum, on a weekly basis.			
2.3.1.32	Generate and electronically transmit eligibility and demographic information for all MCP eligible consumers to the SSC on a daily basis.			
2.3.1.33	Generate and send letters via the CRM to MCP new members and terminating members per ODJFS policy.			
2.3.1.34	Maintain and display on-line MCP member data including the following: <ul style="list-style-type: none"> <li>• The MCP for each effective data span</li> <li>• Effective date of membership</li> <li>• Effective date of termination of membership</li> <li>• MCP lock-in dates and assignment indicator</li> <li>• Reason codes for membership or termination of</li> <li>• Membership exemption codes</li> <li>• MCP morbidity codes</li> <li>• County or region-specific codes.</li> </ul>			
2.3.1.35	Provide for the automatic re-enrollment in the same MCP for members who lose Medicaid eligibility but regain eligibility within a specified period of time without the members having to go through the initial enrollment process.			
2.3.1.36	Accept and process MCP membership data received electronically from ODJFS' eligibility system(s), and manually from other sources.			

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**Member Services**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
2.3.1.37	Allow authorized, role-based access to users to override MCP membership, as defined by ODJFS.			
2.3.1.38	Generate electronic and/or hard copy reports of members for distribution to MCPs. Electronic transmissions (e.g., 834 transactions) must comply with State and Federal requirements.			
2.3.1.39	Send member status information to MCPs on a daily, weekly or other schedule, as defined by ODJFS.			
2.3.1.40	Identify and generate letters to MCP members impacted by a global change in MCP service areas, ownership or participation in the Medicaid program.			
2.3.1.41	Generate and send letters to MCP members at least sixty days prior to the annual open selection month for their county/region of residence to notify them of their option to change plans.			
2.3.1.42	Support on-line change to assignment, reenrollment and choice options, by managed care organizations or by service area as directed by the ODJFS.			
2.3.1.43	Base termination of MCP membership on ODJFS-defined criteria.			
2.3.1.44	Terminate or change MCP membership and/or exempt eligible individuals from MCP membership on-line or via batch processing.			
2.3.1.45	Provide the capability to move multiple members from one MCP to another MCP or to fee-for-service, based on ODJFS-defined criteria.			
2.3.1.46	Provide the capability for date-specific termination of membership (e.g., death) or MCP membership changes.			
2.3.1.47	Provide the capability to retroactively change MCP membership enrollment or termination-of-membership and adjust premium payments accordingly.			
2.3.1.48	Track the membership status for each assistance group (AG) member.			
2.3.1.49	Enable SSC to submit membership exception requests (e.g., just cause) to ODJFS via a secure electronic format.			
2.3.1.50	Enable MCPs to retrieve reconciliation templates and submit completed reconciliation files via the Medicaid Portal.			
2.3.1.51	Automatically route all incoming reconciliation files to appropriate ODJFS staff and notify them of their arrival.			
2.3.1.52	Identify all potential duplicate member files for analysis and resolution prior to membership effective date to avoid paying duplicate premium payments to the MCP(s).			
2.3.1.53	Calculate premium payments based on current or retroactive membership dates.			
2.3.1.54	Generate HIPAA 820 transactions to all MCPs including those MCPs that have a negative premium payment balance for the month. (The transactions must contain data about every premium owed for the current month, any retroactive months (adjustments), and any claim credit reversals (take back of premium payments) owed to the State.)			

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**Member Services**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
2.3.1.55	Provide the capability to define reports that will be run on a regular schedule as well as produce ad hoc reports based on ODJFS-defined criteria.			
2.3.1.56	Allow for staff to receive, access, query, and generate reports on: <ul style="list-style-type: none"> <li>• Grievance data reports submitted by the MCP</li> <li>• Consumer contact records provided by the SSC</li> <li>• Just Cause requests for termination or change of membership</li> <li>• Continuity of care membership deferment requests</li> <li>• Inpatient hospital membership deferment requests</li> <li>• Exclusion request actions, statistics, and correspondence</li> <li>• Newborn notification records.</li> </ul>			
2.3.1.57	Provide the capability to ODJFS-designated staff to perform on-line queries of premium payments by member and by month.			
2.3.1.58	Provide status reports that detail the accuracy and timeliness of MCP membership processing by the SSC.			
2.3.1.59	Identify errors or exceptions prior to the next membership and premium payment cycle after entry of new or changed data to prevent inaccurate membership reporting and/or premium payments to the MCPs.			
2.3.1.60	Periodically reconcile membership data across repositories (eligibility systems and MITS) on a ODJFS-defined time schedule.			
2.3.1.61	Allow ad hoc queries for premium reports by age, gender, county, or cap code for MCP.			
<b>2.4</b>	<b>Special Enrollment</b>			
2.4.1	Requirements			
2.4.1.1	Phase 2 Utilize EDMS workflow technology to manage and track all LTC facility and waiver programs including: <ul style="list-style-type: none"> <li>• Aging</li> <li>• ODJFS programs</li> <li>• LTC facilities</li> <li>• Mental Retardation/Developmental Disabilities (MR/DD) programs</li> <li>• Hospice.</li> </ul>			
2.4.1.2	Accept and store into MITS in support of claims adjudication: <ul style="list-style-type: none"> <li>• Prior authorized services, hours, and limits</li> <li>• Provider demographic and rate data including room and board versus health care costs</li> <li>• Cost share data.</li> </ul>			
2.4.1.3	Retain the following eligibility information transferred from the State eligibility system for the purposes of claims adjudication: <ul style="list-style-type: none"> <li>• Application dates (ELIG)</li> <li>• Request for enrollment/dis-enrollment including dates (ELIG)</li> <li>• Level Of Care (LOC) determination (ELIG)</li> <li>• Assessment date (ELIG)</li> <li>• Approval dates (ELIG)</li> <li>• Letter generation (consumer notice or other type of notification) (ELIG)</li> <li>• Track level of care changes (ELIG)</li> </ul>			

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### Member Services

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Effective date or the date of change for level of care determination (ELIG)</li> <li>• PASRR review (ELIG)</li> <li>• Reason codes for any component denial (ELIG)</li> <li>• Denial dates (ELIG).</li> </ul>			
2.4.1.4	Provide an automated eligibility determination recommendation process that will be presented to a State-identified individual for service authorization approval (ELIG).			
2.4.1.5	Provide role-based access via the Medicaid Portal to State-authorized sub-recipient State agencies to include: MR/DD, Passport Administrative Agencies, ODA, ODH, and ODMH. Web access would be limited to State-defined functions including inquiry and form completion.			
2.4.1.6	Provide an automated alert process to notify responsible agency of adverse PASRR, LOC, or financial eligibility determinations and alerts for changes in program and/or financial eligibility according to State-defined criteria (ELIG).			
2.4.1.7	Provide a presumptive eligibility process allowing for claim payments using State-defined financial and program eligibility criteria and circumstances. This process would use State-defined hierarchal relationships that would supersede overlapping eligibility spans, such as spend-down cases. This functionality would be program specific.			
2.4.1.8	Provide an automated process for suspension of waiver claims without affecting consumers' waiver eligibility. Must allow for concurrent eligibility spans but not allow for payments of claims for both institutions and waivers except as defined by ODJFS.			
2.4.1.9	Provide role-based access to all waiver data for tracking, oversight, research, and planning purposes.			
2.4.1.10	Provide and maintain a secure hearing tracking and reporting process based on program-specific criteria.			
2.4.1.11	Provide the capacity for the development, generation, and distribution of State-defined waiver program reports.			
2.4.1.12	Establish and track costs against a definitive person-specific cost cap for waivers.			
2.4.1.13	Verify cost cap, authorized provider, and authorized units of goods and services when adjudicating claims, including an option for plan of care.			
2.4.1.14	Authorize waiver and LTC facility services for a specific time period (e.g., six (6) months or one (1) year) as defined by the State.			
2.4.1.15	Notify waiver program staff if the specific dollar amount or units are reached and future claims will not be paid.			
2.4.1.16	Accept hospice enrollment information records/forms from a variety of sources (hospice providers, various data bases) and via a variety of formats and media (Medicaid Portal, EDI, fax, paper, etc).			

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**Member Services**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
2.4.1.17	Validate submitted information against health plan member records/files and incoming hospice enrollment information records/forms, and use business rules approved by ODJFS to resolve discrepancies (e.g., the rejection or the invocation of a decision scheme which would take health plan member record/file information over incoming/submitted information).			
2.4.1.18	Send notifications of the receipt and acceptance of hospice enrollment information or the receipt and rejection of the hospice enrollment information. Notification should include, at a minimum, the date and time of the receipt or rejection and key demographics (e.g., consumer Medicaid ID and provider Medicaid ID/NPI).			
2.4.1.19	Image and archive copies of the submitted hospice enrollment information records/forms.			
2.4.1.20	Create, develop and maintain hospice enrollment files/records which include:  Type of hospice action (e.g., election, revocation, discharge or death, change hospice organization, change individual demographics).  <ul style="list-style-type: none"> <li>• Submission date</li> <li>• Effective date</li> <li>• Begin/end date span of the hospice action period</li> <li>• Hospice agency name</li> <li>• Hospice Medicaid provider number</li> <li>• Hospice National Provider Identifier (NPI) when NPI is in effect</li> <li>• Medicaid consumer's name</li> <li>• Medicaid consumer's Medicaid billing number</li> <li>• Terminal diagnosis description</li> <li>• International Classification of Disease-9th revision (ICD-9) code that best coincides with terminal diagnosis</li> <li>• Place of residence</li> <li>• Medicaid waiver program</li> <li>• Other insurance (e.g., Medicare, private, other)</li> <li>• Patient liability.</li> </ul>			
2.4.1.21	Automatically populate ODJFS hospice enrollment files/records in near real-time upon the receipt of hospice enrollment information records/forms within not more than one business day of receipt.			
2.4.1.22	Relationally link the ODJFS hospice enrollment files/records to be an integrated part of the health plan member enrollment files to assure the appropriate benefit administration of the member's entitled benefits.			
2.4.1.23	Interface with or make information contained in hospice enrollment files/records accessible to claims adjudication, reference file, claims pricing, benefit package, and pharmacy benefit processes and available for any other associated business processes in accordance with established business rules.			
2.4.1.24	Provide the capability to send an alert to the waiver case manager if the consumer is also enrolled in a waiver or hospice program.			

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**Member Services**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
2.4.1.25	Provide the capability to send a notification to a LTC facility, specifying that the individual is enrolled in hospice and facility reimbursement must be obtained from the hospice organization.			
2.4.1.26	Provide the ability to interface with the State eligibility system to initiate changes to the Medicaid card issuance process to assure that the card identifies that the consumer is enrolled in a hospice.			
<b>2.5</b>	<b>County Department of Job and Family Services (CDJFS)</b>			
2.5.1	Requirements			
2.5.1.1	Provide the capability for county staff to have role-based access to Medicaid data (that is directly related to county work functions) including: <ul style="list-style-type: none"> <li>• Eligibility data</li> <li>• Provider locator system</li> <li>• SSI information</li> <li>• Buy-In data</li> <li>• TPL data</li> <li>• Healthchek data (Early Periodic Screening Diagnostic Testing (EPSDT) data)</li> <li>• Pregnancy Related Services (PRS) data.</li> </ul>			
2.5.1.2	Support edits for spend-down which prevent the provider from billing the full amount of the service if the consumer is on spend-down.			
2.5.1.3	Phase 2 – Provide an interface to the eligibility system for benefit package information to be used in the production of medical cards.			
2.5.1.4	Provide county staff the ability to have role-based access to produce ODJFS-defined reports, including: <ul style="list-style-type: none"> <li>• Healthchek reports</li> <li>• Types of services and benefits being received by population</li> </ul>			
2.5.1.5	Track the number of times an individual has used the Emergency Medical Transportation (EMT) service.			
2.5.1.6	Generate monthly reports to the State Emergency Medical Transportation (EMT) Unit on ODJFS-defined parameters.			

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**Benefits and Service Administration**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
<b>3.1</b>	<b>Benefit Packages</b>			
3.1.1	Requirements			
3.1.1.1	Build rule-based components for ODJFS benefit packages.			
3.1.1.2	<p>Maintain the following information for each health plan and/or health plan component offered by ODJFS in a manner which assures the information is accurate for each date of service and at the time &amp; date the transaction is processed (i.e., transactions could be a claim, an encounter claim, an inquiry, a prior authorization (PA) request, an adjustment, a premium payment, etc.):</p> <ul style="list-style-type: none"> <li>• The members enrolled in the health plan and their qualifying eligibility categories. Also see relationship to member enrollment process and associated file maintenance processes/sub-processes</li> <li>• The available benefit package(s) described, in general at each component level, and in detail at the procedure/service code level. Also see relationship to reference file sub-process and claim edits under the claims adjudication process</li> <li>• The list of participating providers by provider type, by service category, by specialty, by demographic area (e.g., county, etc.) and any other classification defined by the State. Also see relationship to provider network management process/sub-process. For certain provider types (e.g., professional group practices), the system must also maintain the list of individual providers associated with the provider entity.</li> </ul>			
3.1.1.3	Provide capability to easily add, delete, or modify health plan(s) and/or its related components.			
3.1.1.4	Generate expenditure, eligibility and utilization data by health plan(s) and/or any of its components to support budget forecasts, monitoring and health care program modeling.			
3.1.1.5	Provide standardized testing/modeling facilities or tools to determine impact of modifications to the health plan(s) and/or any of its components.			
3.1.1.6	Generate the reports needed to file fee schedule and other rules with the Joint Committee on Agency Rule Review (JCARR) once modifications to health plans and related components have been successfully tested in the testing/modeling facility.			
3.1.1.7	Provide capability for users to review, on-line or through extracted ad hoc or standard reports, all relevant data associated with the administration of a health plan, benefit package, health plan component, or program covered under ODJFS/OHP. Data would include information on MCP & county programs, covered medical benefits and services, coverage criteria and limitations, reimbursement, edits and audits compiled in a variety of classifications.			

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**Benefits and Service Administration**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
3.1.1.8	Provide capability to maintain and/or redesign health plans and/or any related components on a date-specific basis to meet business needs.			
3.1.1.9	Maintain identifiers for individual providers, provider types and specialties participating in the different health plans and/or any related components.			
3.1.1.10	Provide staff the ability to determine the health plans benefits packages and/or related components for which providers are participating and/or are eligible.			
3.1.1.11	Provide multiple benefit plan capabilities and maintain each covered waiver program (administered directly by ODJFS or by a sub-recipient State agency) as a separate health plan, benefit package and/or health plan component that has a distinct and separate provider participation list, covered services and limitation structure and consumer eligibility criteria and enrollment spans. While the waiver eligibility will be mutually exclusive for each waiver program participating providers and some services may or may not be duplicative across all waiver programs.			
3.1.1.12	Maintain an audit trail of all modifications made to health plans and/or related components with beginning and end dates in accordance with general specifications. Change management accountability documents must be maintained on-line for the greater of 7 years or 11 date spans.			
3.1.1.13	Maintain an audit trail/change record with dates, who requested the change, who authorized the change, and who implemented the change, and the description of the change.			
3.1.1.14	Provide staff with access to reports on changes and modifications made to health plans and/or related components by beginning and end dates.			
3.1.1.15	Provide on-line role-based lookup capability to ODJFS staff, providers, and other stakeholders identified by ODJFS for all files and parameters necessary to complete and document Benefits and Service Administration business processes.			
3.1.1.16	Maintain and update information in accordance with ODJFS policy, including limitations on services authorized under each benefit package and service included or excluded for each benefit package.			
3.1.1.17	Maintain and track service and/or dollar utilization on processed claims. Edit submitted claims not to exceed the individual consumer-specific limitation information (i.e., limits on units or dollars by the benefit package level, the procedure code level or some other component level within a specified time period). For example, reimbursement for waiver services for an individual is limited to \$1500 per month.			

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**Benefits and Service Administration**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
3.1.1.18	Provide on-line role-based lookup capability that will enable ODJFS and providers to identify, within a benefit package or a health care component (e.g., physical therapy, chiropractic, or psychological services), whether a consumer has reached a benefit limit/maximum (units or dollars) and/or identify how much of the benefit limit/maximum remains. Identify the number of units used and/or the dollar amount paid to date at any given point.			
3.1.1.19	Provide the capability to quickly and easily accommodate new or updated service limits or exclusions within each benefit package.			
3.1.1.20	Maintain a historical record of services where the procedures are limited over a specific time period, e.g., annual limit, lifetime limit, and make that available to ODJFS staff.			
3.1.1.21	Notify automatically staff designated by ODJFS of changes to health plans and/or related components (e.g., databases, modules, rules, etc.) and their effective dates to help assure the accurate implementation of policies relating to coverage of health care services, premium payments, and/or invoices.			
3.1.1.22	Generate reports on service limitations and exclusions for each health plan and/or related component.			
3.1.1.23	Maintain for each health plan, benefit package and/or component a customized set of coverage and service limitations on a variety of specific parameters (e.g., provider type limits, place of service limits, unit of service limits, claim submission limits, dollar limits, clinical coverage criteria, pre-approval criteria, rate limits). Also see key parameters specified in the reference file maintenance sub-process and edit requirements in the claims adjudication process.			
3.1.1.24	Tie certain categories of health care services (i.e., health care components) to alternative delivery system spans within the benefit package and including all the key parameters listed in reference file requirements.			
3.1.1.25	Link to & assure that service benefits are limited to the rules associated with these programs from the perspective of covered services, eligible providers, eligible consumers, and component specific limitations for each component associated with special enrollment/eligibility spans.			
3.1.1.26	Provide the capability to handle all sub-recipient State agency-administered programs as distinct and separate health plans, benefit packages or other health care components based on a set of rules or rule-driven parameters as determined by ODJFS and the sub-recipient State agency. Some sub-recipient State agency programs are linked to an enrollment span and the associated business requirements would apply (e.g., Pre-Admission Screening System Providing Options and Resources Today (PASSPORT)) and some are not (e.g., community mental health services).			

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**Benefits and Service Administration**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
<b>3.2</b>	<b>Claims Pricing</b>			
3.2.1	Requirements			
3.2.1.1	Support on-line updates / revisions to pricing logic.			
3.2.1.2	Provide on-line role-based pricing formula creation and update capabilities to designated staff.			
3.2.1.3	Allow for consistent calculation of payment amounts according to all reimbursement methodologies approved by ODJFS, including provider specific and universal fee schedules, per diems, LTC facility room and board charges, Diagnosis Related Groups (DRGs), Medicare coinsurance / deductible, formulas, percentages and other prospective payment methods.			
3.2.1.4	Support ODJFS-approved pricing activities during claims processing for all approved claim types and reimbursement methodologies and maintain a minimum of the greater of seven (7) years or eleven date spans of pricing history. Obtain and compile inputs as identified by ODJFS, including: <ul style="list-style-type: none"> <li>• Rates</li> <li>• Cost reports</li> <li>• Consumer specific MDS/IAF data</li> <li>• Hospital information</li> <li>• Facility specific Case Mix Score</li> <li>• Formulas</li> <li>• Peer group</li> <li>• Other health industry market and fiscal resources as determined by ODJFS.</li> <li>• Provider quality information</li> <li>• Resident and Family Satisfaction Survey results.</li> </ul>			
3.2.1.5	Maintain information that allows procedures to be automatically priced according to ODJFS-defined business rules, rates and effective dates.			
3.2.1.6	Provide on-line role-based access to pricing formulas and their associated parameters/variables, including the ability to view and modify pricing formulas. Parameters should include anesthesia conversion factors, anesthesia base rates, Vaccine for Children (VFC) rates and Ambulatory Surgery Center (ASC) groups (no black boxes).			
3.2.1.7	Provide the ability to conduct testing in a region for modeling and estimating/evaluating the fiscal impact prior to promotion of pricing changes to production. This test area must be available for all health plans or benefit packages and reporting. The system should be flexible to accept new parameters such as line level Central Accounting System (CAS) codes, that are not currently used in claims adjudication and other future parameters as defined by ODJFS or through HIPAA.			

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3.2.1.8	Generate pricing data for all provider programs on ODJFS-specified media using selection parameters specified by the State.			
3.2.1.9	Provide an automated process, approved by ODJFS, to acquire Medicare Rates and Pricing Profiles, and ensure conformance with Federal requirements regarding Medicare pricing.			
3.2.1.10	Establish edits for production or test region adjudication and notify ODJFS staff of exceptions.			
3.2.1.11	Maintain a DRG file as determined by Alert/notify ODJFS staff to exceptions to use in pricing inpatient hospital claims. The greater of seven (7) years or 11 date spans of data must be maintained. The DRG file will contain, at a minimum, elements such as: <ul style="list-style-type: none"> <li>• DRG code</li> <li>• English translation of code (DRG description)</li> <li>• Add date</li> <li>• Begin date</li> <li>• End date</li> <li>• DRG weight (relative value)</li> <li>• Outlier days (low and high days)</li> <li>• Outlier charges (low and high charges)</li> <li>• Audit trail</li> <li>• Average length of stay.</li> </ul>			
3.2.1.12	Maintain the following hospital-specific inpatient and outpatient rate data, by effective date(s) including: <ul style="list-style-type: none"> <li>• Inpatient DRG rate components</li> <li>• Inpatient and outpatient cost to charge ratios</li> <li>• Retroactive adjustment indicator and date</li> <li>• Other hospital specific payment components such as per diems, percentages.</li> </ul>			
3.2.1.13	Accommodate multiple outpatient hospital reimbursement methodologies based on business rules provided by ODJFS, including outpatient prospective payment, per discharge/visit, percent of charge, Fee-For-Service (FFS) procedure code prices for outpatient hospital care, line level and revenue center code pricing.			
3.2.1.14	Accommodate multiple inpatient hospital reimbursement methodologies based on business rules provided by ODJFS, including DRG, per discharge/visit, per diem, percent of charge, peer group level of care for inpatient hospital care, line level and revenue center code pricing.			
3.2.1.15	Maintain an outpatient hospital pricing file based upon bundled rates for services per visit by provider urban/suburban/rural classification. Rules would be based on provider location, classification, etc.			

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3.2.1.16	Perform mass updates, from multiple sources determined by ODJFS, on the test region and upon approval migrate to production on a schedule defined by ODJFS.			
3.2.1.17	Maintain multiple rates for all providers and provider types as identified by ODJFS.			
3.2.1.18	Provide the capability to flag and reprocess previously paid claims within the designated service date span if a rate change happened to be a retroactive rate change. Implement into production the reprocessed claims only after authorized staff review the outcome and approved implementation. Provide the capability to report on those claims.			
3.2.1.19	Distinguish and identify interim and final rates, per provider.			
3.2.1.20	Transmit and/or provide on-line inquiry access to pricing files for outside vendors and entities determined by the State.			
3.2.1.21	Provide capability to determine and adjust pricing based on package size (e.g., DME).			
3.2.1.22	<p>Adjust and maintain pricing data for all health plans and/or benefit packages and identify and calculate payment amounts according to rates and rules established by ODJFS for various categories of pricing methods, for claim types other than retail pharmacy claims, including:</p> <ul style="list-style-type: none"> <li>• Fee schedule</li> <li>• Per diem rates, assigned to each LTC provider with a corresponding date span for pricing</li> <li>• Negotiated rates</li> <li>• Premium rates for MCPs and case management services</li> <li>• Multiple-level dispensing fee for drugs (e.g., compound, enhanced, repackaged allowances, etc.)</li> <li>• Maximum allowable fee per service (note: some situations require paying Federal portion of fees)</li> <li>• Percent of charge (billed amount) pricing</li> <li>• Provider-specific percent pricing</li> <li>• Enhanced or adjusted incentive payments as determined by State-defined pricing rules (e.g., dental pediatric incentive, HPSA pricing)</li> <li>• Sub-recipient State agency pricing</li> <li>• Anesthesia pricing</li> <li>• Consumer specific pricing based on consumer location (i.e.,; hospice), monthly cost caps per consumer (i.e.,; for waiver programs)</li> </ul> <ul style="list-style-type: none"> <li>• Medicare pricing or payment rates</li> <li>• Provider specific rates</li> <li>• Provider specialty (pricing locality specific rate)</li> <li>• Contracted rate per service or provider</li> <li>• Procedure code modifier pricing</li> <li>• Manual pricing (medical consultant-determined rate per service)</li> </ul>			

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Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Drug cost plus dispensing fee per prescription</li> <li>• LTC facility daily rate, room and board charges</li> <li>• LTC Prospective Payment System (PPS) rates</li> <li>• Payment rates and effective dates for each rate, per facility</li> <li>• Inpatient hospital diagnosis-related group (DRG) rate per stay discharge</li>   <li>• Different rates to hospitals that qualify as: acute care and rehabilitation, drug and alcohol, psychiatric units of acute care hospitals, or mental health institutes</li> <li>• Different rates for transplants and organ acquisition costs</li> <li>• Different rates for acute care hospitals that qualify for special payments for Acquired Immune Deficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV), ventilator and brain injury payment adjustments</li>   <li>• Inpatient rate per diem</li> <li>• Inpatient capital and medical education pass through payments</li> <li>• Inpatient hospital managed care out-of-plan stays (DRG rate per stay/discharge, plus capital and medical education add-ons)</li> <li>• Outpatient hospital-specific rate per visit (day)</li> <li>• Outpatient PPS rates</li> <li>• Multiple claim pricing methodologies specific to Medicare Part A, B, C, and D, and/or Plan coverage. Examples include limiting to co-insurance/co-payment and deductible rates or other amounts defined by ODJFS.</li>   <li>• Aggregate co-pays and co-insurance on the family level with a trigger to insure co-pays or co-insurance charge would not be levied on family members whose family had reached the annual maximum co-pay/co-insurance of 5% of household income.</li> <li>• Assistant-at-Surgery pricing</li> <li>• Incentive payment pricing (e.g., performance payments, location)</li> <li>• Maximum Allowable Cost (MAC), Estimated Acquisition Cost (EAC), Average Wholesale Price (AWP), AWP Minus, Wholesale Acquisition Cost (WAC), WAC Plus, Federal Upper Limit (FUL), and direct pricing for drugs, plus a dispensing fee per prescription</li> <li>• Package size pricing</li> <li>• Individual consideration pricing (e.g., hospital outliers)</li> <li>• Geographic location of provider or consumer</li> <li>• Adjust prices based on consumer location (hospice and waiver)</li> <li>• Multiple surgery logic using national standards approved by the State</li>   <li>• ASC group pricing as determined by ODJFS</li> <li>• Provider specific rate at the modifier level.</li> <li>• VFC pricing and rates by procedure code</li> <li>• Ability to accept National Drug Code (NDC) on hospital claims and use for pricing</li> </ul>			

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	<ul style="list-style-type: none"> <li>• Ability to edit across provider types for services provided to a consumer.</li> <li>• Resident specific rates for long term care facilities</li> <li>• Long term care facility rates that would support alternative purchasing solutions</li> <li>• Ability to freeze a cost base for nursing facility and/or intermediate care facility for the mentally retarded rate-setting while still maintaining a record of subsequent audit adjustments to those costs.</li> </ul>			
3.2.1.23	Override established pricing calculations if the claim or the provider billing the claim meets the requirements defined by ODJFS for pricing exceptions.			
3.2.1.24	Provide the capability to determine how Medicare would adjudicate the submitted claims and compare rates and pricing policies. This should include the ability to plug in purchased pricing software.			
3.2.1.25	Provide ODJFS with on-line role-based access for updating MCP premium rates, including retroactive adjustments.			
3.2.1.26	Maintain various capitation/premium rate periods (e.g., fiscal year, calendar year, or other period) for specific rates for each MCP.			
3.2.1.27	Store daily or monthly premium rates to generate daily or monthly premium payments.			
3.2.1.28	Process mass adjustments to MCP-specific premium rates as required by ODJFS.			
3.2.1.29	Use consumer-specific information to process and evaluate monthly cost caps by individual and by waiver type.			
3.2.1.30	Support supplemental payments program calculations/pricing e.g., determination of distribution formula for Hospital Care Assurance Program (HCAP).			
3.2.1.31	Maintain the ability to utilize multiple rate-setting methodologies for long term care facilities (i.e., NF and ICF-MR, short term and long term stay, traditional Medicaid and selective contracting).			
3.2.1.32	Calculate long term care facility rates, and provide the capability to establish them at the provider or consumer level, using factors that may include, but are not limited to <ul style="list-style-type: none"> <li>• Provider cost experience</li> <li>• Provider location</li> <li>• Provider size</li> <li>• Quality and performance indicators</li> <li>• Resident acuity</li> <li>• Inflation factors</li> <li>• Provider tax rates</li> <li>• Occupancy</li> <li>• Medicaid utilization.</li> </ul>			
<b>3.3</b>	<b>Pharmacy</b>			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
3.3.1	Requirements			
3.3.1.1	Integrate with a Pharmacy Benefit Management System (PBM) that is accountable to ODJFS.			
3.3.1.2	Develop daily interfaces to the PBM to assure the availability of accurate information regarding client eligibility, drug pricing information, provider eligibility, other insurance resources (including Medicare), client benefit limitations, managed care enrollment status and other data necessary for the PBM to process pharmacy claims.			
3.3.1.3	Process non-retail pharmacy claims that are not billable under HIPAA in the NCPDP format (e.g., any valid pharmacy provider that does not fit the HIPAA definition of a retail pharmacy may be considered a non-retail pharmacy).			
3.3.1.4	Implement an on-line edit/audit process that is parameter or table driven to meet the dynamic needs of the non-retail pharmacy program.			
3.3.1.5	Develop interfaces as needed to accommodate the receipt of crossover, encounter or other outside claims and/or non-retail pharmacy information.			
3.3.1.6	Provide for batch updating of the drug file with information received on the First Data Bank Pharmacy Blue Book file and/or other pricing service.			
<b>3.4</b>	<b>Early Periodic Screening Diagnostic Testing (EPSDT)</b>			
3.4.1	Requirements			
3.4.1.1	Maintain all Healthchek (HC) /EPSDT program eligibility records, periodicity schedules, consumer notification and notification response dates, screening dates, and client notices, as directed by ODJFS.			
3.4.1.2	Maintain, for each Healthchek (HC) /EPSDT eligible consumer, the screening date and immunization and blood lead level testing status, including results for blood lead level testing. System interface with the Statewide Immunization Information System (SIIS) will include up-to-date immunizations, and lead test results from Statewide Tracking of Elevated Lead Levels and Remediation (STELLAR) at age-applicable moments. When claim is submitted the system should be able to identify applicable information from the SIIS/STELLAR interface.			
3.4.1.3	Identify EPSDT screening services and EPSDT referrals regardless of how the claim was submitted (CMS1500 or EDI electronic claim).			
3.4.1.4	Identify EPSDT data elements that trading partners are submitting via the EDI EPSDT loops and check the claim record to verify that the necessary EPSDT data elements are populated into the appropriate fields on the claim record.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
3.4.1.5	Retain indicators that denote that it is an EPSDT claim or EPSDT referral on historical claim records.			
3.4.1.6	Retain EPSDT and EPSDT referral indicators in the on-line version of the claim record.			
3.4.1.7	Identify whether services require Healthchek/EPSDT referral.			
3.4.1.8	Link EPSDT services claims that contain referrals to the referral claim. This would also filter back to the physician and HC coordinator for identification of received services and/or referrals.			
3.4.1.9	Provide ODJFS staff with on-line access to Healthchek/EPSDT and claims data.			
3.4.1.10	Provide on-line capability to query consumer Healthchek/EPSDT data to allow providers to check whether a consumer is due for a Healthchek screening.			
3.4.1.11	Limit coverage for EPSDT services to AAP (American Academy of Pediatrics) Guidelines and benefit packages as defined by ODJFS. Child Day Care (CDC) and House Bill (HB) 248 guidelines applicable where needed for lead and immunizations.			
3.4.1.12	Compare periodicity schedule to actual number of visits in a certain time period and by age.			
3.4.1.13	Provide an electronic on-line method that tracks outreach activities performed by staff.			
3.4.1.14	Provide capability to determine EPSDT consumers who have not received their scheduled screenings over varying periods of time.			
3.4.1.15	Determine the last time a consumer received an EPSDT service.			
3.4.1.16	Provide near real-time access to the State immunization database for staff, enrolled providers, and consumers.			
3.4.1.17	Provide role-based access to the State blood lead level registry			
3.4.1.18	Alert Healthchek County Coordinators and physicians when children's blood lead level exceeds State thresholds. Physician notifications as well as staff notification are applied every 30 days once a lead test is ordered. Claim adjudication for a lead test comes in from another source and should filter back to ordering physician and staff to indicate either level of lead test (from Ohio Department of Health (ODH) interface) and/or that no test has been documented (ODH) or a claim has occurred. Notification includes automatic generation of letter to physician, county staff, ODH, LPP and parent.			
3.4.1.19	Generate EPSDT screening notification reminders within timelines specified by ODJFS and county staff and incorporated into business rules.			
3.4.1.20	Provide automatic notifications for scheduled milestones as defined by ODJFS. This includes notification on lead tests needed and immunizations needed within timelines specified by business rules.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
3.4.1.21	Generate automatic follow-up notifications (to ODJFS, county and consumer) based upon EPSDT claim history detail and specific EPSDT criteria as defined by ODJFS for EPSDT consumers when an appointment is missed following EPSDT health criteria.			
3.4.1.22	Produce a monthly report that identifies eligible consumers who have not had their blood lead level test, EPSDT screenings, immunizations (according to the periodicity schedule) and any other diagnostic defined by ODJFS at age-applicable timeframes.			
3.4.1.23	Support near real-time data exchange updates with the State Immunization Registry (ODJFS claims to ODH and ODH to ODJFS).			
3.4.1.24	Produce summary level reports on a quarterly basis to Medicaid MCPs on providers enrolled and using the State Immunization Registry.			
3.4.1.25	Generate quarterly summary level blood lead level reports for EPSDT consumers.			
3.4.1.26	Generate on-line Healthchek/EPSDT or other children's primary care outreach reports to MCPs and other State-approved entities.			
3.4.1.27	Generate Healthchek/EPSDT or other children's primary care utilization reports to MCPs and other ODJFS-approved entities by frequency and demographics identified by ODJFS.			
3.4.1.28	Provide ad hoc reporting to ODJFS and county approved staff utilizing EPSDT data. Examples of ad hoc reports include: <ul style="list-style-type: none"> <li>• A list of all EPSDT consumers who have not received their scheduled screening</li> <li>• A list of all EPSDT consumers and the date of their latest screening</li> <li>• Blood lead levels for all EPSDT consumers and date last tested</li> <li>• Immunizations given in a timely manner</li> <li>• Missing immunizations</li> <li>• Listing of VFC/Medicaid providers enrolled and using the registry</li> <li>• Providers who provided EPSDT exams.</li> </ul>			
3.4.1.29	Compile and issue Federally required reports pertaining to EPSDT information in accordance with the Federal specifications and ODJFS specifications. <ul style="list-style-type: none"> <li>• Identify the number of consumers receiving EPSDT services</li> <li>• Identify the number of referrals from the screening by age group</li> <li>• Generate the data needed to produce the CMS-416 Annual EPSDT Participation Report (combination of claims and eligibility data).</li> </ul>			

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3.4.1.30	Provide a methodology to un-duplicate the claims to obtain an accurate count of EPSDT screening services, immunization services, blood lead tests, and EPSDT referral services for situations when ODJFS business rules allow multiple types of claims (e.g., both a professional and institutional claim) to be submitted for the EPSDT service.			
3.4.1.31	Maintain all Healthcek/EPSTDT program eligibility records, periodicity schedules, consumer notification and notification response dates, screening dates, and client notices, as directed by ODJFS.			
3.4.1.32	Maintain, for each Healthcek/EPSTDT eligible consumer, the screening date, immunization and blood lead level testing status, including results for blood lead level testing.			
3.4.1.33	Send lead test results back to the ordering provider by consumer ID. If there are no results or claim, notify provider that no claim was filed or no results were received.			
3.4.1.34	Notify ODH of lead test claims submitted to Medicaid; however it is not necessary to create a record in STELLAR at that point.			
3.4.1.35	Allow for VFC or SIIS provider indicator in applicable provider or reference file indicator.			
3.4.1.36	Allow consumers should be able to print off their own immunization, lead testing and well child examination records in accordance with privacy and security processes.			
<b>3.5</b>	<b>Reference File</b>			
3.5.1	Requirements			
3.5.1.1	Provide ODJFS-defined on-line role-based access for approval/update/edit of reference file data.			
3.5.1.2	Provide user-friendly navigation among the various reference files.			
3.5.1.3	Allow on-line input from ODJFS-approved sources.			
3.5.1.4	Allow ODJFS to test and approve any update to reference file data prior to moving data to production.			
3.5.1.5	Provide current revenue codes on-line.			
3.5.1.6	Provide data that supports claims edits, audits, and pricing logic in accordance with ODJFS policy. The application of these policies is subject to change; therefore, the edits, audits, and pricing methodologies described in this Request for Proposal shall not be considered an exhaustive list.			
3.5.1.7	Operate and support all reference data maintenance functions, files, and data elements as specified by ODJFS.			
3.5.1.8	Assure updates do not overlay or otherwise make historical information inaccessible. Must maintain back-up features to assure changes in parameters are maintained.			
3.5.1.9	Provide on-line inquiry capability to all current and the greater of seven (7) years of history or at least eleven date spans.			

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3.5.1.10	Link covered procedures to specific authorized provider types and to authorized service categories corresponding to those assigned by ODJFS to providers. Must be able to link historical policies to covered date spans or bill spans.			
3.5.1.11	Provide the ability to maintain and update: <ul style="list-style-type: none"> <li>• Reference file data</li> <li>• HIPAA mandated code sets, <ul style="list-style-type: none"> <li>▪ HL 7 LOINC code sets</li> </ul> </li> <li>• Approved versions of Health Common Procedure Coding System (HCPCS) procedure codes,</li> <li>• International Classification of Disease (ICD)-9-CM diagnosis and procedure codes,</li> <li>• Current Dental Terminology (CDT) procedure codes,</li> <li>• Revenue codes,</li> <li>• Managed care program payment codes</li> <li>• Relative value units</li> <li>• Diagnostic and Statistical Manual (DSM) diagnosis codes, including DSM age 0-3,</li> <li>• Diagnostic Related Groups (DRG), and</li> <li>• NDC drug codes</li> <li>• Edit/Audit criteria and disposition tables</li> <li>• Business rules</li> <li>• Exception code file.</li> </ul>			
3.5.1.12	Accept local level codes used by sub-recipient State agencies and provide a cross walk to National/State codes.			
3.5.1.13	Accept on-line and automated updates, additions, and deletions by tape or electronic transmission to all reference files, with the ability to make changes to individual records or mass changes to groups or classes of records (e.g., across provider type and specialty).			
3.5.1.14	Allow on-line role-based inquiry and update to the edit/audit criteria and disposition tables related to benefit package criteria.			
3.5.1.15	Generate on-line audit-trail reports that detail reference file updates and the directives that initiated them in a format and media approved by ODJFS.			
3.5.1.16	Provide the ability to alert designated ODJFS staff upon completion of updates of reference file data. This alert must identify all changes and revisions, deletions, and replacements and provide a cross-reference.			
3.5.1.17	Support ODJFS-approved pricing activities during claims processing for all approved claim types and reimbursement methodologies and maintain a minimum of seven (7) years of pricing history (e.g., viewing and on-line updating of activities). Provide additional electronic historical data off line that captures all changes to reference file data going forward.			

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3.5.1.18	Configure the reference file to allow the same procedure code to be priced differently (e.g., based on age of consumer for the same date span).			
3.5.1.19	Allow the tracking of changes to the reference file using on-line notes capability.			
3.5.1.20	Generate audit trail reports for all data sets showing before and after images of changed data, the ID of the person making the change, ODJFS-defined reason code, and the change date and time. The system should support multiple spans of identification for auditing purposes.			
3.5.1.21	Maintain an on-line cross-reference between HCPCS and International Classification of Diseases-9 (9th revision)-Clinical Modification (ICD-9-CM) procedure codes.			
3.5.1.22	Maintain an on-line cross-reference between ICD-9-CM and DSM diagnosis codes and DSM diagnosis, including DSM age 0-3 diagnosis.			
3.5.1.23	<p>Display on-line for each billing procedure code the following information/elements that must be maintained on the reference file including:</p> <ul style="list-style-type: none"> <li>• Procedure code (CDT, HCPCS, Current Procedure Terminology (CPT), Revenue Center Codes (RCC), NDC, ICD-9 procedure)</li> <li>• Modifiers</li> <li>• Denotation of the authorized provider types</li>   <li>• Denotation of the authorized category of service (service category type)</li> <li>• Denotation of the authorized specialty and taxonomy</li> <li>• Denotation of the authorized sub-specialty and taxonomy</li> <li>• Denotation of the required CLIA certification type</li> <li>• Denotation of the required CMS lab code classification assignment (micro, chemistry, hematology, etc)</li> <li>• Denotation of any consumer age limits</li> <li>• Denotation of any consumer gender limits</li> <li>• Denotation of the PA requirements (e.g., always required, sometimes required, never required)</li> <li>• Denotation of valid/invalid Place Of Service (POS) limitations</li> <li>• Denotation that the service qualifies as an EPSDT service (child well health service)</li>   <li>• Denotation specifying if there is a co-payment for the service and associated data including the co-payment amount/per service unit and/or aggregate out-of-pocket co-payment thresholds for the service</li> </ul>			

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	<ul style="list-style-type: none"> <li>• Denotation that the service always qualifies; never qualifies as or conditionally qualifies as a family planning service or must have a documented alternative methodology for identifying the procedures eligible for enhanced Federal Financial Participation (FFP)</li> <li>• Denotation of diagnosis code requirements including the list of valid/invalid diagnosis codes and if diagnosis is required (header/line) for claims adjudication</li> <li>• Maximum quantity units per a designated time period(s). The time period specified by pre-set time period values and the specified units. In addition need to know the lifetime limits</li> <li>• Denote if multiple units may be submitted for the procedure code at the line level</li>   <li>• Pertaining to other duplicate edit parameters, denote all duplicate claim/line level limits on same or different claims; same or different rendering providers; same or different group/pay to providers; unit level or code level either through a series of duplicate check indicators (see example, below) or through some other documented methodology which specify all the duplicate edits associated with this procedure code:             <ul style="list-style-type: none"> <li>o Limit procedure code to a single line per date of service</li> <li>o Limit code by same or different rendering provider</li> <li>o Limit by same or different group/pay to provider</li>   <li>o Allow procedure code on multiple line on same claim for same date of service (by same provider and/or different providers, all three)</li> <li>o Allow proc code multiple lines on different claims same date of service (by same and/or different providers, all three)</li> </ul> </li>   <li>• Identify procedure code as requiring sterilization form (always or conditionally, ability to embed conditions in rules link to indicator)</li>   <li>• Identify procedure code as requiring hysterectomy form (always or conditionally, ability to embed conditions in rules lined to the indicator)</li>   <li>• Identify procedure code as requiring abortion form (always or conditionally, ability to embed conditions in rules linked to the indicator)</li> <li>• Provide complete narrative descriptions of the code</li>   <li>• Provide short descriptions of the code that are specific enough to determine uniqueness of the code from other procedure codes in a series</li> </ul>			

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	<ul style="list-style-type: none"> <li>• Medicare coverage indicators: (e.g., always covered, conditionally covered (sometimes), never covered or some other documented methodology which would enable the use to know how Medicare cost avoidance edits are to work for the procedure code</li>   <li>• LTC facilities coverage indicators (values) and living arrangement indicator values. Coverage indicators must include at a minimum values to denote: if service is bundled into facility payment corresponding to the living arrangement; values to denote the service is covered as an add-on service (i.e., in addition or independent to the facility payment) by living arrangement; and values to denote the service is not covered as either (i.e., separately or as a bundled service). Living arrangement indicators must include, but would not be limited to Skilled Nursing Facility (SNF), Nursing Facility (NF), ICF-MR, assisted living facility, group home, other qualifying setting</li>   <li>• For dental procedure codes, must have an indicator (or some other method) to denote if a tooth number or tooth surfaces information is required when the procedure code is billed. Must denote the valid tooth numbers or tooth surfaces that may be billed</li>   <li>• For anesthesia services, maintain anesthesia base values. Directly related to this, must also maintain the anesthesia pricing conversion factor tables for an applicable date span within the reference file or in some other on-line file which can be updated in the test region and/or production). Must have a way to indicate if procedure code is paid only base value only; base value + time values; other possible applications</li>   <li>• Denote if the procedure code consists of both professional and technical components, is only a professional service or is only a technical service. Marking these as such could be accomplished through some rule-based applications using information from the RVUs, but the reference file should make allow the user to know if the code fits these categories. Corresponding to this must have a methodology to denote the variations in payment for the professional technical splits. For many of the codes, modifiers are required so this can be handled through the modifier pricing impact requirements. The remainder of the codes has specific code numbers splitting them into the professional/technical/complete procedure category</li>   <li>• Denote if the code has special payment incentives (in-office surgical incentive); site differential/incentive payments. Must be able to denote the resulting pricing impact these parameters have on the pricing of the code</li> </ul>			

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Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Denote the general pricing status of the code for each relevant pricing segment. At a minimum we would require values for the following payment categories:                             <ul style="list-style-type: none"> <li>o Fee schedule</li> <li>o Bundled into capitation payment</li> <li>o Add on payment to capitation</li> <li>o Provider charge file (perhaps a variety)</li> <li>o Anesthesia formula pricing</li> <li>o Transportation formula pricing</li>   <li>o Sub-recipient State agency pricing (pass through agency to agency)</li> <li>o Sub-recipient State agency pricing (direct provider payment)</li> <li>o Case-by-case pricing (by report, manually priced, etc.)</li> <li>o PA pricing fee schedule</li> <li>o PA pricing case-by-case</li> <li>o Non-specified formula pricing.</li> </ul> </li> <li>• Denote the post operative day(s) parameter used for determining bundling policy for surgical claims/visits</li>   <li>• Denote if referring provider number is required for the procedure code</li>   <li>• Denote if multiple surgery pricing applies to the procedure code and the extent to which Multiple Surgery (MS) pricing is applicable (the MS rule followed by business rules, canned or customized to meet ODJFS needs)</li> <li>• Revenue Center Codes (RCC) must denote if itemizations of HCPCS codes are required claims processing and identify the list of valid/invalid HCPCS codes.</li> </ul>			
3.5.1.24	<p>Maintain a drug file using the NDC, which can accommodate weekly updates from a contracted drug pricing service and the CMS Drug Rebate file and State rebate program updates. The drug data set must contain all of the data for the contracted drug pricing service including:</p> <ul style="list-style-type: none"> <li>• Eleven (11) digit NDC</li> <li>• Brand, generic, and label drug name</li> <li>• Add date</li> <li>• Begin date</li> <li>• Effective date</li> <li>• CMS termination date</li> <li>• Obsolete date</li> <li>• Specific therapeutic class and description</li> <li>• Route of administration (two (2) alpha characters)</li> <li>• Previous NDC (for three (3) years)</li> <li>• Minimum and maximum dosage units and days</li> <li>• Minimum quantity size field of five (5) positions</li> <li>• Allow for decimal units</li> </ul>			

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	<ul style="list-style-type: none"> <li>• Generic Code Number (GCN), Generic Sequence Number (GSN), Hierarchical Ingredient Code List (HICL) sequence number, HIC3 (Hierarchical Specific Therapeutic Class Code) number, American Hospital Formulary Service (AHFS) code</li> <li>• Unlimited date-specific pricing segments which include all prices needed to adjudicate drug claim records in accordance with State policy</li> <li>• Indicators for multiple dispensing fees</li> <li>• Indicators for multiple prices</li> <li>• Pricing indicators to accommodate at least the following seven (7) reimbursement methodologies: FUL, MAC, EAC, and AWP, WAC, AWP-minus, WAC-plus, ASP and other pricing methodologies as they become available.</li> <li>• Name of manufacturer and labeler codes</li> <li>• State-specified restrictions on conditions for a claim to be paid to include minimum/maximum days supply, quantities, refill restrictions, consumer age/gender restrictions, medical review requirements, PA requirements, place of service, and special indicators.</li> <li>• Indicator of preferred drug list status</li> <li>• Identification of CMS rebate, State rebate program status and corresponding dates</li> <li>• Generic product indicator</li> <li>• Identification of strength, units, and quantity (package size) on which price is based</li> <li>• CMS unit of measure</li> <li>• Yes/no indicators for DESI drugs, EPSDT, co-pay, manual review, long term care, unit-dose packaging and family planning</li> <li>• Pricing amount</li> <li>• Indicators of prescription required (or Over the Counter (OTC)) status</li> <li>• Indicators for schedule assigned to controlled drugs</li> <li>• Indicator for dispensing fee</li> <li>• Indicators for prior authorization requirements, including the reason PA is required</li> <li>• Indicators to identify drugs covered under Medicare Part D</li> <li>• Pricing field size should be 11-bytes (7,decimal,3)</li> <li>• Indicators for multiples programs (FFS, Disability, etc)</li> <li>• Multiple-level dispensing fee for drugs (e.g., compound, enhanced, repackaging allowance, etc.)</li> <li>• Other indicators as necessary (e.g., to denote behavior service, or control disposition of claims processing).</li> </ul>			
3.5.1.25	Flag procedure codes if technical/professional component exists by procedure code and link to percentage split and alternative pricing methodology.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
3.5.1.26	Define and enforce the use of appropriate procedure coding scheme (e.g., HCPCS, ICD-9-CM, CDT) and/or diagnosis coding scheme (e.g., ICD-9-CM, DSM) based on parameters as referenced above.			
3.5.1.27	Identify procedure codes that invoke incentive/disincentive payments.			
3.5.1.28	Identify Revenue Center Codes that designate whether procedure codes are to be itemized and additions to revenue codes.			
3.5.1.29	Provide a crosswalk from HCPCS injection codes (e.g., J-codes) to the 11-digit NDC, when applicable.			
3.5.1.30	Associate a minimum of 160 valid two-character/digit modifiers for each procedure code. The list must be associated with date spans for a valid date of service period or valid billed date period.			
3.5.1.31	Allow role-based users to have on-line view and/or update capabilities.			
3.5.1.32	Perform electronically mass modifier updates for a group of code sets. For example, new anesthesia modifiers were issued could replace the old with the new as valid modifiers to the anesthesia codes).			
3.5.1.33	Link associated valid modifiers by procedure code with the pricing impact/payment adjustment impact as it compares to the unmodified procedure code pricing (i.e., the fee schedule rate, provider charge file rate, etc.). Must denote if the impact reduces payment, increases payment or is informational only. Must denote if the impact (+/-) is a lump sum or a percentage change.			
3.5.1.34	Allow the modifier validity, definitions (HIPAA-compliant) and the pricing impact of the modifier specific to each code within the same and/or different health plan/benefit packages (i.e., the same modifier can have different pricing impact).			
3.5.1.35	Denote if the procedure code must be submitted with a modifier for pricing (e.g., anesthesia codes, certain professional services, etc.).			
3.5.1.36	Identify the immunization codes by the following categories: (1) exclusively covered under the Vaccine for Children (VFC) program; (2) not covered under the VFC; (3) combination coverage, VFC for children, non-VFC for adults. Must have the capacity to add other categories.			
3.5.1.37	Invoke category specific pricing and provide on-line view of the VFC administration rates for periods not spanning less than 7 years. For combination category there is a fee schedule rate or a VFC administration rate paid so must have both available to user. Must have the capacity to update VFC administration rate on-line.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
3.5.1.38	Indicate covered Revenue Center Codes (RCC) by institutional claim type (inpatient hospital, outpatient hospital, NF, ICF-MR, dialysis center, free-standing clinic, ambulatory surgical center, and others as needed).			
3.5.1.39	Link deleted procedure codes to (cross-walked) replacement codes and vice versa, whether there is a one to one, many-to-one or one-to-many relationship for at least one previous pricing span.			
3.5.1.40	Associate service code coverage to a specified health plan, benefit package and/or service category.			
3.5.1.41	Specify if the code is valid for a claim type (e.g., professional, dental, etc.) as defined by ODJFS or claim input media type (e.g., paper, EDI, other) as defined by ODJFS.			
3.5.1.42	Sub-categorize services into a minimum of two levels of service within the CPT (e.g., surgery/gastroenterology), HCPCS (e.g., Durable Medical Equipment (DME)/wheelchairs), CDT, RCC. Must have the capacity to add other levels.			
3.5.1.43	Maintain reference file documentation specifying the functionality of each parameter, the edits associated with each parameter/field, valid/invalid values for each field, and the definition of each value used in any of the fields. Must be maintained in a manner that can be viewed on-line, or printed out hard-copy.			
3.5.1.44	Provide a testing area or "sandbox" to determine impact of changes to reference files.			
<b>3.6</b>	<b>Drug Rebate</b>			
3.6.1	Requirements			
3.6.1.1	Provide the capability to send a monthly file of paid claims for drug products adjudicated for non-retail pharmacies.			
3.6.1.2	Provide the capability to send a monthly file of paid Medicare and COB claims for drug products.			
3.6.1.3	Provide the capability to send a monthly file of paid Medicaid outpatient hospital and professional claims for drug products (J-codes).			
<b>3.7</b>	<b>Benefit/Coverage Pre-Determination</b>			
3.7.1	Requirements			
3.7.1.1	Edit PAs on-line for the presence of required data to include the following: <ul style="list-style-type: none"> <li>• Valid provider ID and eligibility</li> <li>• Valid consumer ID and eligibility</li> <li>• Valid procedure and diagnosis codes</li> <li>• Presence of required claim type-specific data on the PA</li> <li>• Covered service</li> </ul> <ul style="list-style-type: none"> <li>• Duplicate authorization check to previously authorized or previously adjudicated code-specific services or groups of code-specific services (including denials) and duplicate requests in process</li> </ul>			

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	<ul style="list-style-type: none"> <li>Valid referring or prescribing provider, if required.</li> </ul>			
3.7.1.2	Identify errors on PA requests and/or on claims billing for prior authorized services with edits/audits that specify the field in error and would assist submitters in correcting problems.			
3.7.1.3	Execute a subset of claims adjudication edits (e.g., eligibility, provider type, etc.) on submitted PA requests, as defined by ODJFS, as well as edits for completing a PA request against the submitted PA request.			
3.7.1.4	Provide staff with on-line role-based access in order to force override edits on incoming PAs. System must have a feature that allows edit overrides only if valid reason is documented based on approved business rules. The final disposition of edits that posted during the PA review must then feed into or be accessible during the claims adjudication process.			
3.7.1.5	Alert/notify specified staff when a PA request pends indicating the edit and a brief edit description which caused the PA request to pend/suspend.			
3.7.1.6	Notify provider of invalid web-based and EDI PA entries.			
3.7.1.7	Create PA edit system so some edits, as defined by ODJFS, will return the PA request to the provider prior to initiating the PA approval process, while other edits will allow receipt of the PA request and will be used to determine or assist in the determination of the final disposition status of the PA request (i.e., PA edits can result in the following outcomes; deny, defer, approve with amendments/adjustments, approve, etc.).			
3.7.1.8	Identify and report duplicate PA requests for exact service requests and for related or similar type service requests (e.g., services bundled into other prior authorized service codes).			
3.7.1.9	Automatically notify users of duplicate or possible duplicate requests.			
3.7.1.10	Allow users to accept or reject duplicates, but must have a mechanism which allows acceptance or rejection exceptions to occur only if valid reasons are documented based on approved business rules.			
3.7.1.11	Assign a PA number as soon as the PA gets into the system and has passed the initial set of edits.			
3.7.1.12	Assign unique PA numbers that will not be used again.			
3.7.1.13	Notify the providers immediately after the PA number is assigned.			
3.7.1.14	Route PA requests into queues as defined by ODJFS based on types of PA requests.			
3.7.1.15	Utilize workflow management capabilities to manage the PA process (routing, reviewing, adjudicating, tracking, and updating PA requests and amendments) as determined by ODJFS-defined business rules, including: <ul style="list-style-type: none"> <li>Flexible workflow assignment of PAs to reviewers</li> </ul>			

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	<ul style="list-style-type: none"> <li>o Normally automated on a First-In-First-Out (FIFO) basis</li> <li>o Manual by selecting a given PA from the work queue</li> <li>o As determined by business rule changes.</li> <li>• Work prioritization</li> <li>• Alerting</li> <li>• Flexible staff assignment.</li> </ul>			
3.7.1.16	Allow for manual entry of PAs, although automated entry is preferred.			
3.7.1.17	Keep statistics and report on the number and types of PA requests (as well as other criteria defined by ODJFS) entered into the system, reviewed, and pending on a periodic basis.			
3.7.1.18	Create PA Reports that are viewable on-line and available in any other format and media (e.g., hard-copy) defined by ODJFS.			
3.7.1.19	Allow for electronic submission of PA request attachments (e.g., EDI 275, HL7).			
3.7.1.20	Store digital photos or electronic imaging of PA attachments and link them to the PA request, regardless of mode of submission.			
3.7.1.21	Capture and display on-line, PA data which includes, at minimum, the following: <ul style="list-style-type: none"> <li>• PA number</li> <li>• Billing, rendering, and referring provider information, including name and address, telephone number, and provider ID</li> <li>• PA type</li> <li>• Consumer information, including Consumer ID, date of birth, address, name, and gender</li> <li>• Diagnosis Information, including:               <ul style="list-style-type: none"> <li>o Primary diagnosis code and description</li> <li>o Start date – Spell of Illness (SOI)</li> <li>o First date of treatment – SOI</li> <li>o Secondary diagnosis code and description</li> </ul> </li> <li>• Service Information, including:               <ul style="list-style-type: none"> <li>o Status of service (e.g., approved, modified, denied, pending)</li> <li>o Requested start date</li> <li>o Rendering provider number</li> <li>o Procedure/NDC code</li> <li>o Modifiers</li> <li>o Place of service</li> <li>o Description of service</li> <li>o Manufacturer description</li> <li>o Manufacturer product number</li> <li>o Manufacturer price list</li> <li>o Manufacturer</li> <li>o Quantity requested by days, number of services, dollars</li> <li>o Quantity authorized</li> <li>o Quantity used</li> </ul> </li> </ul>			

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	<ul style="list-style-type: none"> <li>o Dollar amount charged</li> <li>o Begin (grant) and expiration date</li>   <li>• Status of the PA request, including pending, denied, approved, or modified</li> <li>• Receive date</li> <li>• Date approved</li> <li>• Expiration date</li>   <li>• History of all actions taken on PA request, including amendments</li> <li>• Date of last change, ID of person changing, and information changed for each PA record</li> <li>• Date of request for additional information</li> <li>• Amend date</li> <li>• Adjudication date</li> <li>• Review date</li> <li>• Date adjudication notice sent to provider and consumer</li> <li>• ID of authorizing person</li>   <li>• Free-form text area for special considerations, along with a flag to allow the system to identify authorizations with special considerations</li>   <li>• A text area which will be printed on the PA notice, using predefined messages as well as unique messages (e.g., informing providers of cases where the original code requested was changed to reflect the diagnosis on the PA) or special considerations, along with a flag to allow the system to identify authorizations with special considerations.</li> </ul>			
3.7.1.22	<p>Provide on-line search capability for PA data using the following search criteria (alone or in combination) at a minimum:</p> <ul style="list-style-type: none"> <li>• Consumer ID</li> <li>• Consumer name</li> <li>• Provider ID</li> <li>• Provider name</li> <li>• Date range</li> <li>• PA status</li> <li>• Rendering/billing/referring/prescribing provider ID</li> <li>• Provider (ID or name) and service type</li> <li>• PA number</li> <li>• Up to four (4) modifiers</li> <li>• Detail status (procedure)</li> <li>• Date approved</li> <li>• Begin (grant) and expiration date</li> <li>• Add date</li> <li>• Service code</li> <li>• Description field</li> <li>• HCPCS/CPT definition</li> </ul>			

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	• Miscellaneous actual service.			
3.7.1.23	Alert/notify PA reviewers of PA requests automatically, awaiting provider feedback if the provider has not responded within a timeframe defined by ODJFS.			
3.7.1.24	Automatically alert providers of the need for additional information (e.g., HIPAA 278 transaction).			
3.7.1.25	Provide multiple staff with simultaneous on-line role-based access to a PA request at the same time, but build in features that would preclude the actions of one staff member not to be unintentionally overlaid by the actions of another staff member.			
3.7.1.26	Allow staff to amend a PA record multiple times and display the history on-line.			
3.7.1.27	Maintain detailed audit trails for all changes to PA records (when, what, who, why, etc.).			
3.7.1.28	Develop business rules which dictate whether the rate established under the PA approval takes precedence over other payment rules (e.g., lesser of billed charges cannot exceed the maximum fee scheduled) or vice versa. Assure that, if non-PA pricing rules take precedence, pre-determined override procedures and business rules are followed to make special pricing exceptions requiring that special documentation be completed for the override to work.			
3.7.1.29	Assure that the system can limit the payment at the time of adjudication to the billed charges submitted by the provider (instead of maximum allowable or the authorized price) if the provider's submitted billed charges are less than the maximum allowable if ODJFS' business rules dictate this applies.			
3.7.1.30	Alert staff with the responsibility of reviewing and approving overrides to traditional pricing and give these role-based staff the ability to accept or reject the override when requested amounts exceed maximum allowable/or the established pricing rules.			
3.7.1.31	Provide the ability to automatically assign appropriate override codes when staff makes a pricing override exception notification.			
3.7.1.32	Allow reviewers to select equipment from a price list and automatically calculate the approved price based on those selections. (The claims pricing request should be supported by a database which contains manufacturer list prices for services, Medicare fee schedules, and other resources to assist in setting rates for services.)			
3.7.1.33	Notify the provider following the approval or denial of a PA.			
3.7.1.34	Notify other entities (e.g., MCPs) following the approval or denial of a PA.			

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3.7.1.35	Display on the notification to providers and/or consumers a reason description as an explanation to the disposition/outcome of the PA request, based on the reason codes selected automatically or by staff, on the notification to providers and clients.			
3.7.1.36	Generate a "Right to a Hearing" form with notification to the consumer when a PA denies.			
3.7.1.37	Allow staff to select the reason codes explaining the disposition of the request when a PA denies/approves.			
3.7.1.38	Provide the ability to enter notes on the PA.			
3.7.1.39	Include descriptions of miscellaneous codes with the PA request.			
3.7.1.40	Track items that were originally requested as well as what was actually approved.			
3.7.1.41	Allow staff to review PA history on-line and filter results based on criteria defined by ODJFS.			
3.7.1.42	Check PA history and automatically pull claims for similar types of services.			
3.7.1.43	Create on-line PA request/service utilization history to contain data elements specified and defined by ODJFS. Link the paid claim record used to decrement the PA record (including units and/or dollars used) to PA history.			
3.7.1.44	Provide access to eligibility data when reviewing the PA request.			
3.7.1.45	Retain PA records for varying periods of time for each type of PA as defined by ODJFS.			
3.7.1.46	Allow staff to authorize payment after a service has been administered. System should have an indicator that will enable the tracking of prospective and retrospective PA requests at the service level, provider level and/or provider type level.			
3.7.1.47	Accept notification of inpatient admission by all hospitals, LTC facilities, ICF-MRs and all other Residential Treatment facilities within twenty four (24) hours of admission, including the date of admission and primary diagnosis of admission.			
3.7.1.48	Make authorization data available to ODJFS staff, if other vendors perform authorizations (e.g., hospital), to the same extent the information would be available if ODJFS performed the PA function.			
3.7.1.49	Accommodate two levels of authorization (outside vendor authorization and in-house authorization).			
3.7.1.50	Provide flexibility to allow waiver PAs to be capped at a dollar amount at the consumer level, at the service level, at the provider level or any combination that can be controlled and/or measured through available claim/PA file data as determined by business rules approved by ODJFS.			
3.7.1.51	Alert staff that letters/notifications have been generated.			

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3.7.1.52	Enable staff to customize for issuance the standard letter/notification content as needed on a case-by-case basis or for a mass issuance for a special short-term situation. Maintain a data base of all the customized letters/notifications issued by ODJFS assuring that the data base tracks individual providers/consumers or provider type groups/ consumer eligibility group who received the customized letters and the date of issuance. Enable reports by data base demographics to be created.			
3.7.1.53	Allow staff to track requests through the entire PA process.			
3.7.1.54	Accept and respond to PA requests/amendments by paper, fax, telephone, Medicaid Portal or electronic transmission. Accept and respond to Medicaid Portal and electronic transmission using the 278, 275, XML, HL7D Health Care Services Review standard and the National Council for Prescription Drug Programs (NCPDP) standard for retail pharmacy.			
3.7.1.55	Accept on-line, real-time entry and update of PA requests through the Medicaid Portal, including initial entry of PA requests pending determination.			
3.7.1.56	Image PA requests and attachments and make them available for on-line retrieval, regardless of the mode of submission.			
3.7.1.57	Implement and maintain an automated process to link PA attachments (no matter what format), such as X-rays and virtual dental models, with the corresponding PAs that have been submitted electronically.			
3.7.1.58	Track, identify, and display on-line the location of the PA, the individual assigned to review the PA, and the length of time at that review location (including both ODJFS and contractor consultants).			
3.7.1.59	Process PA requests/amendments according to ODJFS-approved guidelines and provide automated, near real-time responses to providers on the outcome (approved, pending, or denied), including the ability to override or bypass PA edits/audits.			
3.7.1.60	Generate and distribute ODJFS-approved PA request forms and attachments to providers.			
3.7.1.61	Identify and review PA requests for which an appeal has been submitted, indicate the outcome of such reviews, and identify PAs for which an appeal has been filed.			
3.7.1.62	Update PA records based on claims processing to indicate that the authorized service has been used or partially used, including units and/or dollars, during each PA request period.			
3.7.1.63	Identify service categories that are subject to the same limitation and accumulate the same combination of services. Use combined services to compare to service authorization limit.			

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3.7.1.64	Allow for modification to the scope of services authorized and extend or limit the effective dates of authorization.			
3.7.1.65	Process PAs for non-covered services per ODJFS guidelines.			
3.7.1.66	Close unused PA records automatically after an ODJFS -defined time period. Issue a log sheet of the PAs that were closed. Archive records of closed PAs and keep the standard history period specified in the general requirement period.			
3.7.1.67	Purge records from on-line system and archive them on approved media as specified by ODJFS.			
3.7.1.68	Maintain provider-specific PA history and consumer-specific PA history.			
3.7.1.69	Allow staff to suspend PA requests, based on ODJFS rules, and identify the PA suspense status. Notify provider electronically or in a written format (e.g., mail) with results of PA clerical and/or clinical reviews and request additional information that is required from the provider.			
3.7.1.70	Allow providers access to pended PA's for near real-time corrections, but only have access to certain data fields (those fields that need to be corrected).			
3.7.1.71	Maintain and display on-line the following data for amended PAs: <ul style="list-style-type: none"> <li>• Amendment number</li> <li>• Amended services codes and descriptions</li> <li>• Amended authorized amounts (units, dollars)</li> <li>• Amended date</li> <li>• Amended reason code and message</li> <li>• Amended reason message</li> <li>• Reviewer ID and authorizer ID.</li> </ul>			
3.7.1.72	Provide on-line capability for ODJFS and contractor staff to analyze and report, at minimum, the following: <ul style="list-style-type: none"> <li>• Claims applied against a PA</li> <li>• PA records/amendments meeting specified criteria</li>   <li>• Up to at least seven years of on-line PA history except for dental and/or other services whose approval period exceeds that period</li> <li>• PA submission, expenditure, and service patterns of billing and rendering providers</li>   <li>• PA submission and adjudication characteristics and results, by provider type, by consumer type, by place of service, type of service, by named provider or consumer, by diagnosis, by quantity of service, by frequency of service, and by individual authorizer</li>   <li>• Total service amounts billed in certain categories or sub-categories of service (such as home health) compared with the total number of services authorized for a combination of categories and sub-categories</li> </ul>			

**MIT S Business Requirement "Functional Fit" Survey**

**Benefits and Service Administration**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• The number of authorized services provided and how many authorized services remain.</li> </ul>			
3.7.1.73	<p>Generate on-line reports at times specified by ODJFS, including:</p> <ul style="list-style-type: none"> <li>• Dollar value of services authorized</li> <li>• Suspended PAs</li> <li>• Duplicate PAs</li> <li>• Frequency of service codes requested and authorized</li> <li>• Quantity requested versus quantity approved</li> <li>• Utilization reports (including the number of times particular services were approved), by provider, provider type, consumer, individual types of services, and combinations of services</li> </ul> <ul style="list-style-type: none"> <li>• Denials (including denial reason), approvals, modifications, amendments, pends (including pend reason), with Year-to-Date (YTD) totals</li> <li>• PA reports to identify status of PA, type of PA and in which location (e.g., contractor, State) the PA is.</li> </ul> <ul style="list-style-type: none"> <li>• Provider's PA history showing which peer group the provider belongs to and giving a statistical analysis of where the provider stands in relation to peers in terms of number and type of PA requests</li> <li>• Outstanding approved PAs that have not been used within a specific time period</li> </ul> <ul style="list-style-type: none"> <li>• Summary and detail report by provider/agency on how many PAs were requested, approved, modified, or denied; outstanding PAs (authorized but unused services) and who authorized the services</li> <li>• Summary and detail reports showing type of PA, location, number of days in process, and adjudication decision</li> <li>• Summary and detail reports to track and summarize PAs processed by adjudication mode (e.g., automated or manual)</li> <li>• Summary reports that include consultant hours worked and projects worked on</li> </ul>			
3.7.1.74	Accept level of care data electronically from ODJFS and its contractors.			
3.7.1.75	Provide ODJFS with on-line access to waiver services data.			
3.7.1.76	<p>Allow for on-line entry, registration, and submission of PA data to the MITS via the Medicaid Portal. Data fields include:</p> <ul style="list-style-type: none"> <li>• Individual ID</li> <li>• Service</li> <li>• Provider name and ID</li> <li>• Dates of service</li> <li>• Authorized services (units, effective dates)</li> <li>• Miscellaneous codes w/ notes field (for contractors)</li> <li>• Rates</li> <li>• Dollar cap</li> </ul>			

**MIT S Business Requirement "Functional Fit" Survey**

**Benefits and Service Administration**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Local provider information</li> <li>• Provider demographic and rate data</li> <li>• Limits</li> <li>• Certification information</li> <li>• Room and board</li> <li>• Health costs</li> <li>• Waiver start date</li> <li>• Waiver program (benefit package)</li> <li>• Waiver wait list data</li> <li>• Cost share data.</li> </ul>			
3.7.1.77	Authorize waiver services for a specific time period (e.g., six (6) months or one (1) year).			
3.7.1.78	Approve service authorization requests for waiver services up to a specific dollar amount.			
3.7.1.79	Generate on-line reports at times specified by ODJFS for the following including: <ul style="list-style-type: none"> <li>• Waiver functional eligibility</li> <li>• Outstanding liability from claims and PA</li> <li>• Outstanding consumer liability</li> <li>• Open Prior authorizations at any give time</li> <li>• Obligation based on authorization data.</li> <li>• Prior authorizations versus claims.</li> </ul>			
3.7.1.80	Perform mass updates/revisions/ amendments to opened and impacted PA s or provide an alternative methodology to handle impacted PA s, when procedure codes and/or modifiers which require PA have been deleted as HIPAA-compliant codes and procedure codes have been replaced with other (new or revised ) HIPAA-compliant codes. The alternative methodology must be one which minimizes the need to require re-submission and re-processing of PA requests and the need to accept and process claims with non-HIPAA-compliant codes.			
3.7.1.81	Require PA and process PA requests on a variety of covered services excluded from the long term care facility service/payment for residents of long term care facilities or LTC facility-inpatients (i.e., not residents but admitted to LTC facilities) or other settings (assisted living, group homes, etc.) when PA is not required individuals living in private residences.			
3.7.1.82	Provide information automatically about the living arrangement of the consumer to the PA staff during the PA process. If the consumer is a resident of an LTC facility or is an LTC facility inpatient, pertinent LTC facility demographics should be made available to PA staff. Information would include level of care (LOC) & LOC effective dates, name of the facility and Medicaid provider number, LTC facility date spans, spend-down amount, Patient Liability Amount (PLA), and PLA effective dates.			

**MTS Business Requirement "Functional Fit" Survey**

**Benefits and Service Administration**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
3.7.1.83	Prohibit PA approval from occurring if ODJFS business rules prohibit coverage of the service in an LTC facility setting and does not allow PA to ever override this business rule.			
3.7.1.84	Assure that even with an approved PA that the claim will not pay if ODJFS LTC facility living arrangements indicate that the individual lives in an LTC facility setting on the date of service if an LTC facility prohibition applies.			
3.7.1.85	Provide information automatically about the consumer's participation or enrollment in other programs that would affect the disposition of the PA to PA staff during the PA process. For example, enrollment in hospice, TPL, Medicare coverage, enrollment in enhanced care management or some case management program, enrollment in a waiver program, etc. The system should provide detailed demographics of the program as determined by the ODJFS.			
3.7.1.86	Prohibit PA approval from occurring if ODJFS business rules prohibit coverage of the service if the individual's enrollment or eligibility in the aforementioned programs precludes coverage of the service by Medicaid and the business rules do not allow PA to override this business rule.			
3.7.1.87	Assure that, even with an approved PA, the claim at the time of adjudication will not pay if ODJFS records indicate the individual is enrolled or covered by one of the aforementioned programs on the date of service if the prohibition applies.			
3.7.1.88	Assure that, when an overall service requiring PA will result in the submission of multiple claim types from a variety of provider types, the disposition of all PA requests (if the methodology requires a separate PA request for each claim that will be submitted) are consistent with one another. Link all related PA s either by the numbering mechanism to cross-reference documentation. (For example, if gastric-bypass surgery requires PA, the disposition for the hospital facility payment, the surgeon's payment, and the anesthesiologist's payment should have the same disposition (approved, denied, deferred, etc.) and we should be able to pull up the related PA requests as a complete service package.)			
3.7.1.89	Handle HCPCS codes with a minimum of up to four modifiers. When processing prior authorized claims, the system must match the PA-required procedure codes submitted on the claim against the approved PA request at the modifier, or if applicable, at the multiple modifier level.			
3.7.1.90	Consider any PA overrides and/or the final edit dispositions before a claim is adjudicated. Based on business rules, match edit dispositions/overrides or allow edit dispositions/overrides to vary between the two processes.			

**MITS Business Requirement "Functional Fit" Survey**

**Benefits and Service Administration**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
3.7.1.91	Accept information/files/communications from any other ODJFS vendor whose contracts/agreements require the entity to perform utilization management and/or prior/post authorization functions and/or enhanced care management and/or sub-recipient State agency/ODJFS program case management services (e.g., hospital utilization review vendor).			

**MITS Business Requirement "Functional Fit" Survey**

**Customer Relationship Management (CRM)**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
<b>4.1</b>	<b>General MITS CRM System</b>			
4.1.1	Requirements			
4.1.1.1	Implement a CRM solution to integrate with MITS, existing consumer and provider ACD systems, existing IVR application and other office applications as identified.			
4.1.1.2	Manage contacts with providers, consumers, legislators, attorneys, stakeholders and others entities as identified by ODJFS across multimedia communications such as: email, phone, fax, Medicaid Portal, cell phone, Automatic Call Distribution (ACD) systems, Interactive Voice Response (IVR) application and other communication devices.			
4.1.1.3	Ability to track and manage inquiries, complaints, and/or grievances from customers and stakeholders (e.g., legislators, consumers, providers, managed care plans, provider associations, billing entities, trading partners, sub-recipient State agencies, medical associations and boards, and the general public) regarding State funded health care and other available health care programs provided through the Department.			
4.1.1.4	Integrate the CRM functionality with multimedia communications such as email, fax, Medicaid Portal, and phone to integrate electronic channels with existing call center functions and provide a single process to handle stakeholder interactions with computer telephony integrated with the ACD systems, IVR, centrex phone and desktop computer.			
4.1.1.5	Phase 2 Improve collaboration and workflow-driven processes among ODJFS staff and stakeholders by integrating CRM in MITS workflow, document management, and document imaging technology.			
4.1.1.6	Ability to communicate to consumers, stakeholders, and providers, information such as program benefits and payment and performance information.			
4.1.1.7	Track and report on those business functions identified by ODJFS.			
4.1.1.8	Provide an automated process to alert the responsible agency when a hearing is filed regarding special Medicaid enrollment.			
4.1.1.9	Track all contacts such as calls, correspondence, grievances and complaints from date of receipt through resolution process.			
4.1.1.10	Ability to generate alerts, reports and notifications via multiple medias such as the Medicaid Portal, wireless technology or other mechanisms as identified by ODJFS to consumers, internal staff, case managers, county coordinators, providers and other entities as identified by ODJFS.			
4.1.1.11	Enter, update, store, and retrieve on-line customer service notes related to service information.			

**MITIS Business Requirement "Functional Fit" Survey**

**Customer Relationship Management (CRM)**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
4.1.1.12	Provide customer and transaction analysis that leverages all existing data across ODJFS.			
4.1.1.13	Provide near real-time reporting capability regarding customer service and delivery to include performance metrics diagnostic metrics and participation metrics.			
4.1.1.14	Integrate all other customer functions to provide information on customer behavior, preferences, and trends.			
4.1.1.15	Receive, track and store direct referrals from outside sources (e.g., providers, etc.) on consumers that are possible over-users of Medicaid services.			
4.1.1.16	Ability to send alerts directly to medical care providers, care managers, Medicaid consumers, Medicaid Managed Care Plans and/or OHP staff, as authorized. Alerts will be generated based upon considerations of the types of medical services (e.g., diabetes exams, hospitalization), the timeliness of specific medical services (e.g., Healthchek exams, lead screening test), or the sequence of specific medical services (e.g., immunizations, pap smears).			
4.1.1.17	Interface with external public and private health care data sources (e.g., State Immunization Registry, Census information, lead poisoning database, and sub-recipient State agencies) to allow access to data that can be used to improve the quality or coordination of care provided to Medicaid consumers.			
4.1.1.18	Assign a unique tracking number for each contact (e.g., phone, correspondence) logged.			
4.1.1.19	Link tracking numbers to previous contacts.			
4.1.1.20	Track call/contacts with basic identifying information such as time and date of contact, provider number, consumer number, caller name, contact name, nature of inquiry, length of call, caller's county, customer representative ID, response provided by ODJFS staff, status of inquiry, and if status was elevated or referred and to whom.			
4.1.1.21	Track all correspondence, inquiries, grievances, complaints and subsequent responses coming into OHP through the following channels including: <ul style="list-style-type: none"> <li>• Consumer ACD Hotline</li> <li>• Provider Services IVR</li> <li>• Provider Services ACD</li> <li>• Governor's office</li> <li>• State and Federal legislative offices</li> <li>• ODJFS Director</li> <li>• Counties</li> <li>• Consumer</li> <li>• Provider</li> <li>• OHP</li> </ul>			

**MITS Business Requirement "Functional Fit" Survey**

**Customer Relationship Management (CRM)**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Sub-recipient State agencies</li> <li>• Office of Inspector General (OIG)</li> <li>• State Auditor</li> <li>• General correspondence.</li> </ul>			
4.1.1.22	Identify the type and priority of the grievance, complaint and/or inquiry.			
4.1.1.23	Grant role-based staff access to CRM information to include Medicaid-related correspondence data, even if it is stored in separate databases.			
4.1.1.24	Link correspondence data to appropriate MITS business process(e.g., provider, eligibility, data warehouse/DSS, and claims data).			
4.1.1.25	Receive and track correspondence that comes through multiple communication channels (e.g., fax, email, Medicaid Portal).			
4.1.1.26	Incorporate State, Federal and HIPAA security procedures and protocols into CRM correspondence tracking to support role-based access.			
4.1.1.27	Index all correspondence using parameters as defined by ODJFS (e.g., provider number, consumer number).			
4.1.1.28	Query correspondence records and reports using ODJFS-defined criteria.			
4.1.1.29	Ability to scan all inbound and outbound OHP correspondence to CRM system.			
4.1.1.30	Link scanned images to correspondence and records to provide one view of all related material (e.g., images, letters, interactions, and tracking number).			
4.1.1.31	Provide on-line role-based access to correspondence history for a period up to seven (7) years.			
4.1.1.32	Auto-archive correspondence records for a time period as defined by ODJFS and maintain the ability to purge those records to the ODJFS archiving system.			
4.1.1.33	Incorporate work item routing and queuing to send on-line alerts to identified ODJFS staff and escalate correspondence and phone contacts which have not been responded to within ODJFS defined timeframes to appropriate supervisory staff.			
4.1.1.34	Generate and distribute standardized templates used to respond to correspondence as directed by ODJFS.			
4.1.1.35	Generate ad hoc and standard reports for incoming and outgoing correspondence as defined by ODJFS.			
4.1.1.36	Track all correspondence sent to the counties or any follow-up activities communicated to the county or county agencies. Note: County follow-up activities do not need to be tracked unless they will be incorporated into the CRM system.			
4.1.1.37	Generate notices to requestors automatically or on demand.			

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**Customer Relationship Management (CRM)**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
4.1.1.38	Capture the following metrics and make available in report format and frequency as defined by ODJFS: <ul style="list-style-type: none"> <li>• Time from entry of correspondence to response</li> <li>• Time through the process.</li> </ul>			
4.1.1.39	Provide access to publications such as EDI companion documents, policy, training guides, consumer pamphlets thru multiple communication channels, (e.g., email, Medicaid Portal and fax).			
4.1.1.40	Provide the capability to support a desktop publishing application.			
4.1.1.41	Track correspondence with basic identifying information such as time and date, provider name/number, consumer name/number, contact name, nature of contact, county of residence, status of inquiry, if status was elevated and to whom.			
4.1.1.42	Provide standard letter templates and the ability to add supplemental free form text specific to the inquiry in order to develop individualized responses for unique or more complex issues.			
4.1.1.43	Capture contact information when calls are routed through the Automatic Call Distribution System (ACD) as defined by ODJFS.			
4.1.1.44	Populate call/contact management tracking system screens with relevant consumer and provider information including: <ul style="list-style-type: none"> <li>• Consumer eligibility and demographics</li> <li>• Provider certification and demographics</li> <li>• Claims information</li> <li>• Other related calls/contacts.</li> </ul>			
4.1.1.45	Ability to transfer, refer and track call/contacts to and from contractor or ODJFS staff for follow-up.			
4.1.1.46	Provide the ability to include the following information for referrals: <ul style="list-style-type: none"> <li>• Call/contact priority</li> <li>• Referral date</li> <li>• Resolution due date (ability to calculate date as defined by the State)</li> <li>• Resolution date</li> <li>• Referral unit/person ID</li> <li>• Name and ID of person resolving the call</li> <li>• Track resolution/disposition of calls.</li> </ul>			
4.1.1.47	Ability to archive and purge calls/contacts/correspondence from the CRM as directed by ODJFS.			
4.1.1.48	Allow inquiry and on-line display of call/contact/correspondence records by type, original call/contact date, consumer or provider name or number, caller name (if different than consumer), customer service correspondent name or ID, or any combination of these data elements.			

**MIT'S Business Requirement "Functional Fit" Survey**

**Customer Relationship Management (CRM)**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
4.1.1.49	Support easy navigation from call/contact/correspondence logging screens to other data relevant screens or other relevant system screens.			
4.1.1.50	Allow multiple screens to be displayed at one time.			
4.1.1.51	Provide inquiry routing and escalation capabilities based on priority and length of time as defined by ODJFS for inquiries that are outstanding.			
4.1.1.52	Generate a system notification to alert a customer service correspondent or other ODJFS staff that a call/contact/correspondence has been assigned to them.			
4.1.1.53	Include analytic functionality to collect customer (e.g., consumer, provider, county) information and the ability to classify customers into segments and by educational information.			
4.1.1.54	Provide on-line tutorial CRM user training for State staff.			
4.1.1.55	Interface and exchange data with other State-identified CRM systems.			
4.1.1.56	Verify that consumers and/or their representatives are verified/authenticated prior to releasing information in accordance with the State and Federal PHI requirements.			
4.1.1.57	Interface with the Patient Disease Registry, or other such databases, and send alerts regarding clinical information such as flu shots, Healthchek/EPSDT screening, and pharmaceutical use to the health service provider, consumer, prescribing provider, and the managed care plan responsible for the care management of the patient.			
4.1.1.58	Create ODJFS defined extract files from the CRM application that contain summary information on all calls/contacts/correspondence received during a specified timeframe.			
4.1.1.59	Refer and track call/contact to other contractor or ODJFS staff for follow-up. When the call/contact/correspondence is referred, in addition to the basic call/contact/correspondence identifying information, the referral shall include: <ul style="list-style-type: none"> <li>• Call/contact priority</li> <li>• Referral date</li> <li>• Resolution due date</li> <li>• Actual resolution date</li> <li>• Referral unit/person</li> <li>• Name and/or ID of person resolving the call/contact</li> <li>• Description of the resolution.</li> </ul>			
4.1.1.60	Ability to track calls that do not go through the ACD system to the CRM application.			
4.1.1.61	Interface CRM with the ACD applications to track and respond to telephone inquiries and also provide the capability to enter face-to-face contacts.			

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**Customer Relationship Management (CRM)**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
4.1.1.62	Track and store detailed information regarding all reporting requests, including: <ul style="list-style-type: none"> <li>• Who requested the information</li> <li>• Date</li> <li>• Time</li> <li>• What the report included</li> <li>• Report storage upon completion</li> <li>• Route the entire history on-line.</li> </ul>			
4.1.1.63	Support near real-time notification to the case manager and/or other ODJFS identified personnel of the following consumer events including: <ul style="list-style-type: none"> <li>• Hospitalization</li> <li>• LTC facility admission</li> <li>• ICF-MR admission</li> <li>• Emergency room admission.</li> </ul>			
4.1.1.64	Provide the flexibility to update the system without interruption to service, to meet future business needs.			
4.1.1.65	Provide a response to the most commonly asked questions regarding program and benefit information.			
4.1.1.66	Provide interface with MITS that allows staff on-line role-based access to program and benefit information to include benefit packages with service limitation and usage.			
4.1.1.67	Generate alerts/advisory notices via multi-media channels to selected groups regarding updates to program and benefit information.			
4.1.1.68	Support the ODJFS strategic plan to provide clinical outcome measurements, performance measurements, and disease information.			
4.1.1.69	Link to the provider locator application .			
4.1.1.70	Provide a computer telephony integration system that automatically populates CRM screens with relevant provider information including: <ul style="list-style-type: none"> <li>• Provider certification and demographics, including enrollment status, provider number, etc.</li> <li>• Claims information</li> <li>• Payment information</li> <li>• Other related calls/contacts.</li> </ul>			
4.1.1.71	Provide templates regarding membership and premium information via web access to managed care plans.			
4.1.1.72	Provide the ability to electronically exchange several types of reports with the LTC provider community, for example, the MDS exception report.			
4.1.1.73	Interface multi-media systems with the Medicaid Portal, ACD systems and IVR to capture, maintain, and report on the following performance, diagnostic, and participation metrics such as:			

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**Customer Relationship Management (CRM)**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Customer service levels</li> <li>• Web activity</li> <li>• Service levels</li> <li>• Compliances</li> <li>• Bottlenecks</li> <li>• Number of escalations</li> <li>• Number of alerts</li> <li>• Number of referrals (all weekly, monthly, yearly)</li> <li>• Number of customer contacts</li> <li>• Specific functions used</li> <li>• Timelines of updates</li> <li>• Accuracy abandonment rates</li> <li>• Inappropriate use of system defaults.</li> </ul>			
4.1.1.74	Generate alerts and notifications to the waiver program when specific dollar amounts or units are reached.			
4.1.1.75	Generate alerts to Healthchek county coordinators and physicians when blood lead levels exceed State thresholds and follow up notifications for EPSDT appointments.			
<b>4.2</b>	<b>Consumer Interface</b>			
4.2.1	Requirements			
4.2.1.1	<p>Implement an automated customer relationship management system to interface with the existing Consumer Hotline Call Center ACD system used to manage consumer inquiries regarding health care programs including:</p> <ul style="list-style-type: none"> <li>• Eligibility enrollment spans for special programs (e.g., Hospice, Primary Alternative Care and Treatment (PACT), Waiver and PACE)</li> <li>• Benefit packages</li> <li>• Immunization (vaccine information)</li> <li>• Health education</li> <li>• Prior authorization status</li> <li>• Claim info and status</li> <li>• General complaints</li> <li>• Language translation</li> <li>• Access to providers</li> <li>• Appeals process &amp; State hearings (reimbursement)</li> <li>• Policy</li> <li>• Delivery system</li> <li>• MCP information</li> <li>• Applications</li> <li>• Medicare Buy-In</li> <li>• Healthchek</li> <li>• Pregnancy related services</li> <li>• Disease registry</li> <li>• Blood testing.</li> </ul>			

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**Customer Relationship Management (CRM)**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
4.2.1.2	<p>Capture and track consumer calls/contacts with basic identifying information. The information shall include the following:</p> <ul style="list-style-type: none"> <li>• Time and date of call/contact</li> <li>• Unique call/contact ID number</li> <li>• Consumer name</li> <li>• Consumer ID number or representative ID number</li>   <li>• “How-heard-of” (how the consumer got the contact information)</li> <li>• Caller name (if not the consumer) and relationship to consumer</li> <li>• Consumer SSN</li> <li>• Nature of call/contact</li> <li>• Details of call/contact</li>   <li>• Type of inquiry (e.g., phone, written, face to face, Medicaid Portal, email)</li> <li>• Capacity for free form text of at least three thousand (3,000) characters for description purposes</li> <li>• Status of inquiry (e.g., finalized, follow up needed, etc.)</li> <li>• Date of resolution</li> <li>• Who responded</li> <li>• Response given by customer service correspondent and format response give (e.g., mail, phone)</li> <li>• Length of call when a phone contact</li> <li>• Caller's county</li>   <li>• If translation assistance was required and the requested language</li> <li>• Customer service correspondent name and ID</li> <li>• Current mailing address</li> <li>• Priority of call/contact (e.g., urgent, emergency, routine, etc.)</li> <li>• Business information</li> <li>• Service type</li> <li>• Service date</li> <li>• Provider information</li> <li>• If inquiry was elevated</li> <li>• To whom it was elevated</li> <li>• Provider information (if applicable).</li> </ul>			
4.2.1.3	Allow consumers to select and store a preferred method of communication.			
4.2.1.4	Support an email directory of consumers.			
4.2.1.5	Support managed care “grievances and appeals” which will continue to be handled by the managed care plans as mandated and monitored by ODJFS.			
4.2.1.6	Provide CRM ability to log and track managed care issues such as “just cause”. Currently a stand alone system supports this function.			

**MIT S Business Requirement "Functional Fit" Survey**

**Customer Relationship Management (CRM)**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
4.2.1.7	Generate and distribute ODJFS approved automated messages to selected consumers via phone, fax, and/or Medicaid Portal.			
4.2.1.8	Provide consumers with a secure message center where messages can be sent and received by ODJFS.			
4.2.1.9	<p>Interface CRM with the Consumer Hotline ACD system to capture performance metrics for service delivery reporting such as:</p> <ul style="list-style-type: none"> <li>• Number of daily calls/contacts answered</li> <li>• After hours calls/contacts</li> <li>• Total calls abandoned</li> <li>• Abandoned/lost rate percent</li> <li>• Call/contact customer service correspondent hours logged</li> </ul> <p>• Daily totals of calls/contacts for each customer service correspondent</p> <ul style="list-style-type: none"> <li>• Average calls/contacts (inbound) per Full Time Equivalent (FTE)</li> <li>• Average calls/contacts (inbound) per hour</li> <li>• Average wait time/minute</li> <li>• Average hold time in queue</li> <li>• Average talk time (minutes)</li> <li>• Agent active/available percent</li> <li>• Average idle time per customer service correspondent</li> <li>• Total outbound calls</li> </ul> <p>• Calls/contacts routed to a number outside of the customer service lines</p> <p>• Totals of caller/contacts by type including consumers, county or SSA agencies, advocates and others</p> <p>• Call topics regarding specific categories including FFS, managed care, finding a dental provider, benefit coverage, food stamps and others</p> <p>• Calls/contacts by hour (Busy Hour Report) to include calls received during business hours including average calls by day of week report</p> <p>• Calls/contacts assigned to an individual customer service correspondent or group</p> <ul style="list-style-type: none"> <li>• Number of messages left on voice mail</li> <li>• Number of returned responses categorized by phone, mail, fax or Medicaid Portal (email and portal)</li> <li>• Referrals to other units, including local income maintenance agencies, and other State specified units</li> <li>• Customer Service Correspondent active/available percent</li> </ul> <p>• Daily totals of calls/contacts for each customer service correspondent</p> <ul style="list-style-type: none"> <li>• Call topic.</li> <li>• Total number of calls per day and month,</li> </ul>			

**MIT S Business Requirement "Functional Fit" Survey**

**Customer Relationship Management (CRM)**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Number of solved inquiries,</li> <li>• Number of inquiries referred, and</li> <li>• Tracking agent specific performance.</li> </ul>			
<b>4.3</b>	<b>Provider Interface</b>			
4.3.1	Requirements			
4.3.1.1	Interface the CRM with the existing Provider Call Center’s Automatic Call Distribution (ACD) and the Provider Interactive Voice Response (IVR) systems that handles provider calls to capture service delivery performance metrics for incidents such as total number of calls per day and month, number of solved inquiries, number of inquiries referred, and with the capability to track agent specific performance.			
4.3.1.2	<p>Capture and track provider calls/contact data with basic identifying information. The information shall include the following:</p> <ul style="list-style-type: none"> <li>• Time and date of call/contact</li> <li>• Provider name and ID number</li> <li>• Type of provider</li> <li>• Caller or contact name (if not the provider)</li> <li>• Contact phone number and email</li> <li>• Nature and details of the call/contact</li>   <li>• Type of inquiry (e.g., phone, written, face to face, Medicaid Portal, email)</li> <li>• Length of call when a phone contact</li> <li>• Caller's county</li> <li>• Customer service correspondent name and ID</li>   <li>• Response given by customer service correspondent and the format in which the response was given (e.g., written, telephone, email)</li> <li>• Status of inquiry (e.g., closed, follow-up needed, etc.)</li> <li>• Capacity for free form text of at least five hundred (500) characters to describe problems and resolutions.</li> <li>• Authentication</li> <li>• Number of times called.</li> </ul>			
4.3.1.3	<p>Interface CRM with the provider ACD and IVR systems to capture performance metrics for service delivery reporting such as:</p> <ul style="list-style-type: none"> <li>• Incoming calls/contacts answered</li> <li>• After hours calls/contacts</li> <li>• Cumulative calls/contacts answered</li> <li>• Total calls abandoned</li> <li>• Abandoned/lost rate percent</li> <li>• Call/contact customer service correspondent hours logged on</li>   <li>• Daily totals of calls/contacts for each customer service correspondent</li> </ul>			

**MITS Business Requirement "Functional Fit" Survey**

**Customer Relationship Management (CRM)**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Average calls/contacts (inbound) per FTE</li> <li>• Average calls/contacts (inbound) per hour</li> <li>• Average wait time/minute</li> <li>• Average hold time in queue</li> <li>• Average talk time (minutes)</li> <li>• Agent active/available percent</li> <li>• Average idle time per customer service correspondent</li> <li>• Total outbound calls</li>   <li>• Calls/contacts routed to a number outside of the customer service lines</li> <li>• Totals of caller/contacts by type including provider, billing entity, agencies, advocates and others</li> <li>• Call topics regarding specific categories to include managed care, claim status, provider payment, provider and consumer eligibility and prior authorization</li>   <li>• Calls/contacts by hour (Busy Hour Report) to include calls received during business hours including average calls by day of week report</li> <li>• Calls/contacts assigned to an individual customer service correspondent or group</li> <li>• Number of messages left on voice mail</li> <li>• Number of returned responses categorized by phone, mail, fax or Medicaid Portal (email and portal)</li> <li>• Referrals to other units, including local income maintenance agencies, and other ODJFS specified units</li> <li>• Customer service representative active/available percent</li>   <li>• Daily totals of calls/contacts for each customer service correspondent</li> <li>• Call topic</li> <li>• Number of call contacts</li> <li>• Cumulative year-to-date statistics</li> <li>• Year-to-year comparisons and trend</li> </ul>			
4.3.1.4	Provide CRM capability to manage provider (customer) relationships by capturing claim data to anticipate/forecast the provider's needs, incorporating learned information about the provider and generating individualized responses.			
4.3.1.5	Provide CRM capability to identify, log, route, track, and archive all provider correspondence such as letters, inquiry forms, and corresponding attachments such as claims, x-rays, and prior authorization.			
4.3.1.6	Allow inquiry and on-line display of CRM call/contact records by type (letter, fax, phone, etc.), original call/contact date, consumer or provider number, caller's name (if different than provider), customer service correspondent name or ID, inquiry status, or any combination of these data elements.			

**MITS Business Requirement "Functional Fit" Survey**

**Customer Relationship Management (CRM)**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
4.3.1.7	Interface CRM with the Decision Support System to identify providers that may require additional educational support and to provide provider pay for performance information as defined by ODJFS.			
4.3.1.8	Interface CRM with the provider enrollment application to identify and notify both the newly enrolled providers and training unit of the need to schedule training.			
4.3.1.9	Provide the capability through the CRM to compile and generate a summary of responses from provider training questionnaires from all sessions, select field representative encounters, and meetings.			
4.3.1.10	Provide the capability to track all written provider inquiries from date of receipt to final resolution using an automated system.			
4.3.1.11	Provide a listserv capability which will enable providers to subscribe to OHP/ODJFS email notifications.			
4.3.1.12	Provide on-line access and/or links to the following such as OHP/ODJFS publications, EDI companion documents, provider handbooks, training guides, and managed care plans through multiple medias (e.g., Medicaid Portal, CDs, other) to designated providers, consumers or other groups.			
4.3.1.13	Generate on a monthly basis, a summary report to identify all publications issued during the month.			
4.3.1.14	Generate training reports (by provider type) to include: <ul style="list-style-type: none"> <li>• Training schedules</li> <li>• Training registration forms</li> <li>• Number of attendees</li> <li>• Provider survey results</li> <li>• Number of provider training sessions and workshops</li> <li>• Number of meetings</li> <li>• Number of publications</li> <li>• Calls handled by field representatives</li> <li>• Provider visits.</li> <li>• Association and group Meetings.</li> </ul>			
4.3.1.15	Interface CRM with MITS for access to remittance advice information, credit balances, and payment information through the Medicaid Portal.			
4.3.1.16	Provide on-line access training schedules and meeting information through the Medicaid Portal.			
4.3.1.17	Provide the capability for providers to query LTC databases to include cost reports, rate setting, and case mix data through the Medicaid Portal.			
<b>4.4</b>	<b>Provider Enrollment/Maintenance</b>			
4.4.1	Requirements			

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**Customer Relationship Management (CRM)**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
4.4.1.1	Provide a Medicaid Portal application to support OHP business processes such as provider enrollment, provider credentialing, and provider maintenance to be used by providers, trading partners, sub-recipient State agencies and managed health care organizations.			
4.4.1.2	<p>Allow on-line and/or batch entry and storage of provider data. Effective begin and end dates for appropriate elements must be provided for each update. Provider data includes:</p> <ul style="list-style-type: none"> <li>• Provider number</li> <li>• Disclosure /ownership information</li> <li>• Office hours</li> <li>• New patient information</li> <li>• Language</li> <li>• Provider name – store names in a standard format as specified by ODJFS; (both legal name and DBA name)</li> <li>• Provider type, specialty, and/or taxonomy</li> <li>• Enrollment and certification dates</li> <li>• Enrollment status</li> <li>• Certification status</li> <li>• Certified providers accepting new patients</li> <li>• Degree information</li> <li>• Multiple addresses including mailing address, payment address, multiple practice location and prior authorization notice or other notice addresses. Address format should conform to postal regulations and allow a zip plus 4 digit code.</li> <li>• County and locality information</li> <li>• Phone number(s)</li> <li>• Contact person(s)</li> <li>• Multiple fax number(s)</li> <li>• Multiple E-mail address(s)</li> <li>• National Provider Identifier (NPI) per HIPAA requirements, when implemented</li> <li>• Uniform Provider Identification Number (UPIN)</li> <li>• Drug Enforcement Agency (DEA) number</li> <li>• Social Security Number (SSN)</li> <li>• Federal Employer Identification Number (FEIN)</li> <li>• Clinical Laboratory Improvement Act (CLIA) number</li> <li>• Medicare numbers</li> <li>• License/certification/registration number</li> <li>• Categories of services for which a provider is allowed to bill</li> <li>• Approved transactions under the Trading Partner Agreement</li> </ul> <p>• Provider billing, rendering, or non-billing provider number and/or NPI</p> <p>• Identify pre-scriber only providers who are allowed to prescribe medication but are not enrolled or certified under other services.</p>			

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**Customer Relationship Management (CRM)**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Identify providers that receive publications and the type of service specific publications (e.g., physician, chiropractic, dental, other)</li> <li>• Any data elements required for proper program administration</li> <li>• Approved HIPAA transactions</li> <li>• Other provider related data required for EFT processing.</li> </ul>			
4.4.1.3	Store in provider subsystem, provider demographic information included in ASC X12, EDI transactions 274 such as: <ul style="list-style-type: none"> <li>• Health Care Provider Inquiry and Information Response Guide</li> <li>• Health Care Provider Credentialing Implementation Guide</li> <li>• Health Care Provider Directory Implementation Guide</li> <li>• Health Care Provider Information Implementation Guide.</li> </ul>			
4.4.1.4	Allow providers to complete, submit, resubmit, modify, or cancel applications and updates via the Medicaid Portal.			
4.4.1.5	Incorporate into the provider subsystem all information collected on the current types of provider enrollment applications.			
4.4.1.6	Incorporate relationship editing, as defined by ODJFS, into interactive Medicaid Portal application.			
4.4.1.7	Use a single enrollment application with required fields being driven by provider type as identified by ODJFS. Active provider numbers will not be assigned until all the verification, accreditation, and credentialing is complete. Note: There will be differences in required data for MCPs, and the system must be able to distinguish by provider types which fields must be completed.			
4.4.1.8	Edit to ensure the Medicaid Portal application and MITS requires completion of all required fields, as defined by ODJFS, before the application is accepted.			
4.4.1.9	Check for duplicate providers and owners when processing an enrollment application and/or update.			
4.4.1.10	Link providers/facilities to parent organizations.			
4.4.1.11	Incorporate electronic signatures that comply with Ohio Administrative Rule 123:3-1-0, with provider enrollment applications and updates.			
4.4.1.12	Use a zip code application to automatically populate on-line screen fields such as county and city.			
4.4.1.13	Edit and verify accuracy of all entered data for presence, format, validity and consistency with other data in the update transaction and on the provider subsystem (e.g., prevent duplicate provider enrollment).			
4.4.1.14	Provide the capability to update the provider subsystem in near real-time.			

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**Customer Relationship Management (CRM)**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
4.4.1.15	Provide the capability to update the provider files with service restrictions requested by ODJFS. Allow authorized users to add, change or delete all provider data on-line, near real-time contingent on role-based criteria defined by ODJFS with a tiered approval and management approach.			
4.4.1.16	Allow authorized users to add, change or delete all provider data on-line, near real-time contingent on role-based criteria defined by ODJFS with a tiered approval and management approach.			
4.4.1.17	Identify applications and updates by provider types that are assigned by ODJFS.			
4.4.1.18	Retain all open and closed segments along with information such as user identification, date and time for both the before and after image.			
4.4.1.19	Identify providers with a unique provider number using the ten (10) digit National Provider Identifier. Unique identifier information should include all locations, provider types, specialties, provider taxonomy, authorization/certifications/licensing for services, and all other appropriate information for that provider as a logical record linked to the one provider number.			
4.4.1.20	Provide the ability to assign provider identification numbers to non-medical providers.			
4.4.1.21	Crosswalk from legacy provider number to NPI.			
4.4.1.22	Store multiple provider addresses including: physical, contact and pay to.			
4.4.1.23	Use industry standards for provider specialty information.			
4.4.1.24	Provide on-line, near real-time creation and modification of provider types, program specialties and associated information.			
4.4.1.25	Provide on-line ability to identify, add and update transfer of funds to providers.			
4.4.1.26	Input supporting documentation included in the enrollment process, such as paperwork related to verification of the license, into a document imaging application and then match that input with the enrollment application in the system.			
4.4.1.27	Provide staff on-line inquiry to supporting documentation related to an enrollment application in the system.			
4.4.1.28	Provide role-based on-line query and sort function for all provider enrollment application and update activities as defined by ODJFS.			
4.4.1.29	Notify on-line ODJFS staff that a new provider has been enrolled or re-enrolled.			
4.4.1.30	Provide help screens to define enrollment data requirements for providers and users.			
4.4.1.31	Alert appropriate staff that an enrollment application and/or update has pending for a certain amount of days as defined by ODJFS.			

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**Customer Relationship Management (CRM)**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
4.4.1.32	Automate the process used to perform review/verification and re-verification activities to include, but not limited, to all provider types, including enrollment, sanctions and appeal processing.			
4.4.1.33	Provide functions for ODJFS staff to review and track all applications throughout the review/certification process to final disposition of the application to include applications and/or updates submitted through the Medicaid Portal.			
4.4.1.34	Notify providers of acceptance/rejection as a Medicaid provider and send enrolled providers an electronic notice for web site locations regarding policy and billing information.			
4.4.1.35	Generate in an automated manner tracking numbers, for all provider types, for all applications and updates. In the case of MCPs, the testing tracking number must be compatible with the current eligibility system.			
4.4.1.36	Generate to the submitter a receipt notification with a tracking number when the application or update is submitted for review.			
4.4.1.37	Utilize a system generated tracking number for trading partner and managed care testing prior to certification in lieu of a provider number.			
4.4.1.38	Route applications and updates to the appropriate ODJFS staff to process.			
4.4.1.39	Allow access, with appropriate level of security, to providers to retrieve the status of their application.			
4.4.1.40	Provide on-line training application and help screens for the provider subsystem.			
4.4.1.41	Provide the ability to easily share certification and/or license information between sub-recipient State agencies.			
4.4.1.42	Provide automated data exchange with such entities as CMS, DEA, OSCAR, CLIA, Automated Survey Process Environment (ASPEN), OIG sanction list, National Plan and Provider Enumeration System (NPPES), and the National Practitioner Databank when verifying or credentialing the provider and for ongoing maintenance to support provider integrity.			
4.4.1.43	Maintain a cross-reference to identify prescribing physicians using the 10-digit numbering scheme developed by HCIda (a national prescribing number being promoted by NCPDP).			
4.4.1.44	Automatically cross reference license and sanction information as defined by ODJFS such as other sub-recipient State agencies, other licensing or accreditation agencies, and the Federal Office of Inspector General sanction list to prevent enrollment and certification of any provider with outstanding sanctions.			
4.4.1.45	Send electronic notification to the provider based on the communication method chosen by the provider, which should be specified on the application.			

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**Customer Relationship Management (CRM)**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
4.4.1.46	Allow providers to request termination of their provider agreement, enroll and/or update their provider information on-line using the Medicaid Portal.			
4.4.1.47	Terminate providers that meet specific criteria (e.g., sanctioned by the Medicare Program).			
4.4.1.48	Automatically generate and send termination notices to providers based on ODJFS-approved criteria.			
4.4.1.49	Provide structured on-line templates regarding enrollment and maintenance to providers.			
4.4.1.50	Maintain history and audit trails for all changes and updates to the provider subsystem.			
4.4.1.51	Restrict data elements that providers can change on-line, as defined by ODJFS. Other changes will require approval by ODJFS staff.			
4.4.1.52	Communicate changes of provider numbers to the current eligibility system.			
4.4.1.53	Include provider agreements with the enrollment application except for LTC and MCP-subcontracted providers. The LTC provider agreement must be completed by the provider after ODJFS staff have reviewed the application and performed verification. For providers that are contracted with an MCP and with FFS, the FFS provider agreement should be included with the enrollment application and the MCP subcontract should be included in the MCP provider verification system.			
4.4.1.54	<p>Store and provide on-line access to provider data for the certification, review and approval functions. Track information required for provider applications through final disposition, as well as the re-certification, change of ownership, and /or related update processes. Information should include:</p> <ul style="list-style-type: none"> <li>• Certification request date</li> <li>• Date certification materials sent</li> <li>• Date returned certification materials received</li> <li>• Application status (e.g., certified, pending, rejected)</li> <li>• Number of approved applications</li> <li>• Number of pending applications and length of time pending</li> <li>• Number of rejected applications and reasons</li> <li>• Provider name</li> <li>• Provider number</li> <li>• Provider type</li> <li>• Demographics</li> <li>• Missing data</li> <li>• Re-certification dates</li> <li>• Re-certification materials sent/dates</li> <li>• Narrative field</li> <li>• Tracking number.</li> </ul>			

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**Customer Relationship Management (CRM)**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
4.4.1.55	Generate all required provider material based on ODJFS policy for new, re-enrolled, and certified providers.			
4.4.1.56	Identify and generate notices to providers due for re-certification/re-enrollment and include appropriate re-certification/re-enrollment materials based on ODJFS specified re-certification and re-enrollment schedules.			
4.4.1.57	Maintain and store electronic copies of provider materials for all approved and denied providers. The file for approved providers contains the application, provider agreements, copy of provider license, and all correspondence relating to certification or re-certification resulting in a provider file update. Files for denied providers will include applications and/or profile information and documentation regarding the reason for the denial.			
4.4.1.58	Provide the capability to download provider information from the National Plan and Provider Enumeration System (NPPES) that contains NPI information.			
4.4.1.59	Accept and perform mass data updates such as NPI, telephone information, licensing and credentialing.			
4.4.1.60	Track, maintain, and report provider enrollment status codes with their associated date spans. The enrollment status codes must include: <ul style="list-style-type: none"> <li>• Closed or out of business</li> <li>• Approved</li> <li>• Change of ownership</li> <li>• Limited time-span enrollment</li> <li>• Enrollment pending</li> <li>• Terminated – voluntary/involuntary</li> <li>• Provider deceased</li> <li>• Provider retired.</li> </ul>			
4.4.1.61	Allow tracking of provider activities/movements into and out of group practices.			
4.4.1.62	Use ODJFS defined standardized abbreviations for data fields in the provider file.			
4.4.1.63	Use a zip code application to automatically populate on-line screen fields such as county and city.			
4.4.1.64	Support possible policy changes in the future to enforce such higher-order provider qualifications for the purpose of improving quality of care, coordination of care, and health outcomes for Medicaid consumers.			
4.4.1.65	Ability to identify those providers who provide immunizations in the office.			
4.4.1.66	Ability to identify those providers who draw blood for tests in the office.			
4.4.1.67	Ability to identify those providers who perform lab tests.			

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**Customer Relationship Management (CRM)**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
4.4.1.68	Ability to identify those providers who perform X-ray services in the office.			
4.4.1.69	Ability to identify Durable Medical Equipment providers who offers delivery services.			
4.4.1.70	Maintain an audit trail on all updated transactions applied to the provider subsystem.			
4.4.1.71	Allow the trading partner subsystem to display, track, report, and archive all additions, deletions, and updates with corresponding date span of activity with user identification.			
4.4.1.72	Track provider IDs across organizations with which they are affiliated.			
4.4.1.73	Track different types of certification, (e.g., board certification).			
4.4.1.74	Generate reports on any occurrences of duplicate provider numbers and ownership.			
4.4.1.75	Provide on-line, and/or on-demand statistics and reports of provider enrollments/updates and audit trail reports to include the number of enrollments per day, week, month and year by provider type, and specialty, inventory management, data operator statistics, web site submissions, and returned applications.			
4.4.1.76	Allow provider data in the provider subsystem to be available to other appropriate subsystems in a near real-time manner.			
4.4.1.77	Purge, transfer, and archive provider records to storage for those providers who have been inactive for a period of three years or as identified by ODJFS.			
4.4.1.78	Support on-line certification and reporting of the Federal OSCAR file.			
4.4.1.79	Automatically update inpatient and outpatient rate information.			
4.4.1.80	Assign trading partner vendor numbers and maintain a subsystem for trading partner information such as linkage of trading partner and provider numbers, transaction testing status, corresponding dates, and what transactions are approved for the EDI vendor/provider relationship and corresponding dates.			
4.4.1.81	Integrate or interface with the MCP provider verification system as defined by ODJFS.			
4.4.1.82	Automatically reconcile provider Medicaid data with Medicare provider information from Carriers and Intermediaries.			
4.4.1.83	Provide on-line capability to establish provider hold and review information.			
4.4.1.84	Provide the ability to include bankruptcy information proceeding for a provider to include the date of filing with ability to identify those claims pre-petition and post-petition.			
4.4.1.85	Track, report and provide on-line capability for all information generated on the annual 1099 report and for previous years as defined by ODJFS.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
4.4.1.86	Access information such as fines, Internal Revenue Service (IRS) levies/liens, and child support.			
4.4.1.87	Provide on-line capability to establish installment plans for providers based on ODJFS defined criteria.			
4.4.1.88	Utilize on-line display and query for provider payment history as defined by ODJFS.			
4.4.1.89	Utilize tools and technologies to support provider enrollment activities across multiple channels to include the ACD, IVR, Medicaid Portal, telephone, email, fax and other communication devices.			
4.4.1.90	Integrate electronic channels with existing call center operations handling provider enrollment inquiries.			
4.4.1.91	Integrate with CRM to systematically manage provider relationships by capturing claim data to anticipate/forecast the provider enrollment and training needs, incorporating learned information about the provider and generating individualized responses.			
4.4.1.92	Track and capture call/contact information to manage provider enrollment inquiries from FFS and managed care providers, legislators, and other stakeholders (e.g., managed care plans, provider associations, billing entities, trading partners, sub-recipient State agencies/providers, medical associations and boards, and general inquirers) regarding State funded health care and other available health care programs provided through the Department.			
4.4.1.93	Provide the ability to identify and notify both the newly enrolled providers and training staff of the need to schedule training.			
4.4.1.94	Generates alerts/advisory notices via multi media channels to selected enrolled providers or provider groups regarding updates to program and benefit information.			
4.4.1.95	Maintain home/applicant information currently housed in Perseus, including: <ul style="list-style-type: none"> <li>• Standard name</li> <li>• Phone</li> <li>• Fax</li> <li>• Mail to addresses</li> <li>• Pay to addresses</li> <li>• Licensure type (specific for NF and ICF-MR)</li> <li>• Number of licensed beds by category, including ICF-MR waiver of license beds and out of service beds</li> <li>• License numbers</li> <li>• ODMR/DD numbers</li> <li>• ODH numbers</li> <li>• Certification type (NF, SNF/NF, ICF-MR)</li> <li>• Number of certified beds by category</li> </ul>			

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**Customer Relationship Management (CRM)**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Provider name history</li> <li>• Provider agreement history (dates for re-certification)</li> <li>• Ownership data</li> <li>• Franchise fees</li> <li>• Maintenance issues (e.g., change of operators, Re-certifications, Bed changes, etc.)</li> <li>• Owner of the real estate (landlords)</li> <li>• Lessees and subleases</li> <li>• Management agreements of operators</li> <li>• Buyers and sellers for Change of Provider (CHOP) transactions</li> <li>• Non-Medicaid facilities (for future Franchise Fee (FF) purposes)</li> <li>• Medicaid status (active and inactive, with sub codes)</li> <li>• Separate business status (open for business, closed/out of business).</li> </ul>			
4.4.1.96	Ability to enter a variety of risk status categories and corresponding effective date when enrolling LTC providers types.			
4.4.1.97	Ability to link provider names, Medicaid provider numbers, and NPIs of affiliated general/acute/rehabilitation hospital or assisted care living provider to that of the LTCF.			
4.4.1.98	Trigger a notice for certain changes, as will be defined by ODJFS, in the provider enrollment subsystem to the claims pricing subsystem to ensure that the appropriate NF or ICF-MR rate is assigned to the applicable service date span as a result of a change in the provider enrollment subsystem.			
4.4.1.99	<p>Make available the following functionality currently exists in Perseus and must be available in the new system if Perseus will no longer be used:</p> <ul style="list-style-type: none"> <li>• Ability to produce bed count reports by licensure and certification types</li> <li>• Ability to produce lists of new and CHOP homes by time periods</li> <li>• Ability to produce lists of labels of facilities by types</li> <li>• Ability to record some providers that have rates set elsewhere (development centers, Veterans Homes)</li> <li>• Ability to distinguish outliers from regular facilities</li> <li>• Risk/alert status with effective date spans (e.g., homes whose licensures are proposed for revocation, homes under a ban on admission, homes found to be in immediate jeopardy, homes proposed for termination, homes under bankruptcy)</li> <li>• Ability to obtain ODH transfer application data and get certif. survey results</li> <li>• Ability to track sanctions by provider and effective dates (fines, denial of payment for new admission (i.e., bans) and send alerts to payment unit and counties</li> </ul>			

**MITS Business Requirement "Functional Fit" Survey**

**Customer Relationship Management (CRM)**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Ability to compare bed counts to other agencies' bed counts (e.g., Inter-agency agreement with ODMR/DD to invoice for beds above a certain count)</li> <li>• Ability to identify facilities by county (pull up a list of all facilities in a given county)</li> <li>• Ability to track information about the actual physical facility to link with all operators of that facility</li> <li>• Ability to insert comments about events and data, by data element type with effective dates and audit trail of users/authors</li> <li>• Ability to record cost of a change of operator (sale price, lease price, sublease price) and scan/import lengthy lease/sale agreements into provider files</li> <li>• Ability to record transaction type of change of operator (sale, lease, partnership, sale-leaseback, etc.)</li>   <li>• Ability to scan business structural analyses into provider files (e.g., depicting corp. reorganizations and parent companies, related entities)</li> <li>• Ability to produce securities documents (escrow documents, promissory notes, etc.) automatically in cases of closure and change of operator notice receipts (using data from provider information and recent monthly vendor totals)</li> <li>• Ability to process re-certifications, with separate procedures for ICF-MR and NF</li> <li>• Ability to process two-month extensions for ICF-MR for provider agreement terms</li> <li>• Ability to identify facilities whose terms are ready to expire</li>   <li>• Ability to process bed changes for initial Medicare approvals, for ICF-MRs and development centers, for waiver of licensure requests and for expiration of waiver of licensure requests for ICF-MR and dev. centers, and for taking beds out of service for renovations--all with effective date spans</li> <li>• Ability to process cancellation clauses for ICF-MR</li> <li>• Ability to produce standard letters responding to transaction notices (notice to change operator, to close, to change beds, to get licensure waivers, to add Medicare, etc.)</li>   <li>• Ability to produce standard letters calculating penalties for failure to provide adequate notices for closure and change of operator</li>   <li>• Ability to produce reports about penalties proposed and imposed</li> <li>• Ability to capture licensure data from ODMR/DD and ODH and Cincinnati Health Department</li> <li>• Ability to record provider records sent to off-site storage if all records aren't scanned into MITS</li> </ul>			

**MIT S Business Requirement "Functional Fit" Survey**

**Customer Relationship Management (CRM)**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Ability to produce descriptive reports summarizing info about LTCF enrollment data and changes over time</li> <li>• Ability to track bed movement (transfers) from facility to facility (Certificate of Need (CON) rules, affects rate-setting)</li> <li>• Ability to incorporate separate enrollment protocols for new facilities with transferred beds, new facilities without transferred beds, and change of operators</li> <li>• Ability to link all operators of same facility ownership</li> <li>• Ability to compute assessments (based on bed counts), prepare assessments and track collections</li>   <li>• Ability to compare owners, leasees, and subleases across providers</li>   <li>• Ability to track 5% and greater owners within the operating company.</li> <li>• Ability to link to ODH survey data.</li> </ul>			
4.4.1.100	Provide a test environment to assure MCP competency with EDI transactions governing membership, premium payment and encounter data, including EDI 820, 834, 835, 837I, 837P, and 837D in versions specified by ODJFS.			
4.4.1.101	<p>Assign an internal test number prior to actual provider number assignment to the Managed Care Plan/Care Management provider. The signing of the provider agreement is contingent upon successful testing. The test number must be compatible with the eligibility system. The eligibility system must be able to validate this number in the MITS provider enrollment module.</p> <p>Note: The current eligibility system will only accept a seven (7) digit provider number. The CRIS-E number is cross-referenced to the Medicaid provider billing number and cannot be changed after it is added to the CRIS-E table. This number is also shared with the Selection Services Contractor (SSC) and the Health Care Transactions Processor (HTP) Contractor to use in the set-up of their data systems testing phase with the Plans as well.</p>			
4.4.1.102	Provide the ability to capture and maintain data elements contained in the National Plan and Provider Enumeration System (NPPES).			

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**Contract Management**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
<b>5.1</b>	<b>Managed Health Care Plan Provider Agreements</b>			
5.1.1	Requirements			
5.1.1.1	Maintain provider agreements for each MCP including imaged signature pages and personalized attachments.			
5.1.1.2	Develop standard HIPAA-compliant encryption methodology to communicate electronically with MCPs, contractors and other medical professionals.			
5.1.1.3	Accept and maintain MCP contracted rates for seven years at a minimum.			
5.1.1.4	Phase 1 Accept electronically rates from actuarial contractors and update the provider charge file with new rate data.			
5.1.1.5	Accept changes and updates to rate schedule and rate cohorts entered on-line by role-based ODJFS-identified staff.			
5.1.1.6	Link the geographic area for each MCP within CMC/CM programs to premium payment generation and payment, down to the zip code level.			
5.1.1.7	Phase 1 Accept electronically and maintain managed care membership data files from the Selection Services Contractor (SSC).			
5.1.1.8	Accept electronic inquiries on newborns from MCPs and verify newborn eligibility as defined by ODJFS.			
5.1.1.9	Forward newborn inquiries and verification status to role-based users as defined by ODJFS.			
5.1.1.10	Phase 1 Generate a notice to the local CDJFS for each newborn who has not been added to the eligibility system for medical benefits as defined by ODJFS.			
5.1.1.11	Interface with the SSC system for the purpose of data sharing, inquiry and audit capabilities.			
5.1.1.12	Provide to role-based ODJFS staff the capability to make on-line changes and updates to MCP membership data as defined by ODJFS.			
5.1.1.13	Provide the capability to monitor, track, maintain, and access compliance performance with CMC/CM program requirements including: <ul style="list-style-type: none"> <li>• Tracking all compliance assessment activity per MCP and in aggregate from time of assessment to time of resolution</li> <li>• Maintain compliance assessment logs per type of activity for both current and historical activities</li> <li>• Generate reports on compliance assessment activities as defined by ODJFS</li> <li>• Generate alerts for both ODJFS and the MCPs for submission deadlines and other events as defined ODJFS.</li> <li>• Utilize imaging and Optical Character Recognition (OCR) capabilities to store information and documentation received from MCPs including corrective action plans</li> </ul>			

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**Contract Management**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Calculate fines or other compliance assessments based on the type of penalty assessed as defined by ODJFS</li> <li>• Maintain a log of penalties assessed for ad hoc calculations and reports of MCP compliance status including the accumulation and penalty assessed against MCPs</li> <li>• Automate performance and measurement calculations as defined by ODJFS and integrate with penalty calculations where applicable.</li> </ul>			
5.1.1.14	Accept, download, and generate reports on MCP required submissions, as defined by ODJFS.			
5.1.1.15	Track and generate reports on MCP performance as reported by outside sources (e.g., provider/consumer complaints), as defined by ODJFS.			
5.1.1.16	Maintain on-line forms for regular compliance activity and regular MCP correspondence including letters on particular types of compliance actions, forms for the submission of fines, and notices of late submissions.			
<b>5.2</b>	<b>Sub-Recipient State Agency Contracts</b>			
5.2.1	Requirements			
5.2.1.1	Phase 1 Automate the disability determination data file transfer from sub-recipient State agencies to MITS.			
5.2.1.2	Store and provide access to back-up documentation in support of inter-agency transfer payments.			
5.2.1.3	Store supporting data for Medicaid Administrative Claiming (MAC) from sub-recipient State agencies.			
5.2.1.4	Identify primary and secondary provider information on claim files, including both sub-recipient State agency and specific provider information.			
5.2.1.5	Allow sub-recipient State agencies to enter administrative information for eligibility into MITS.			
5.2.1.6	Generate reports including: <ul style="list-style-type: none"> <li>• Outlier reviews (client and provider)</li> <li>• Service utilization reviews by providers, consumer, geographic region, etc.</li> <li>• Services received by consumer</li> <li>• Types of services billed by provider</li> <li>• Cross State billing.</li> </ul>			
5.2.1.7	Generate reports for performance monitoring of sub-recipient State agency agreements.			
5.2.1.8	Track pre-established thresholds/performance measures of sub-recipient State agencies.			
5.2.1.9	Generate alerts to notify OHP if pre-established thresholds/performance measures of sub-recipient State agencies are not being met.			
5.2.1.10	Track and report on expenditures against purchase order amount.			

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**Contract Management**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
5.2.1.11	Phase 1 Automate file transfer of PASSPORT functional assessments, Nursing Facility (NF) Screens, PASRR Screens, Mental Retardation Waiver Functional Assessments and Minimum Data Sets (MDS) Assessments.			
<b>5.3</b>	<b>ODJFS Administered Home and Community Based Services (HCBS) Waiver Case Management Contracts</b>			
5.3.1	Requirements			
5.3.1.1	Provide the case management vendor with role-based access to MITS.			
5.3.1.2	Provide the flexibility to add “other” types of new case management contracts that may be required and / or applicable in the future.			
5.3.1.3	Accept electronically and maintain case management vendor contract deliverables including: <ul style="list-style-type: none"> <li>• Quality management plan</li> <li>• Quarterly management report</li> <li>• Monthly performance report</li> <li>• Monthly initial assessment report</li> <li>• Monthly caseload report.</li> </ul>			
5.3.1.4	Utilize workflow capability for review of case management contract deliverables.			
5.3.1.5	Receive and store case management vendor contract data including: <ul style="list-style-type: none"> <li>• Contract amount</li> <li>• Performance expectations</li> <li>• Contract.</li> </ul>			
5.3.1.6	Track deliverable status for case management vendor deliverables including: <ul style="list-style-type: none"> <li>• Date submitted by vendor</li> <li>• Date reviewed by ODJFS</li> <li>• Accept or reject deliverable</li> <li>• Comments for rejection of deliverable</li> <li>• Date revised deliverable received</li> <li>• Approval date of deliverable.</li> </ul>			
5.3.1.7	Alert ODJFS if deliverable from case management vendor is past due date.			
5.3.1.8	Link status of invoice receipt to deliverable acceptance.			
5.3.1.9	Accept electronically and store invoices from case management vendors.			
5.3.1.10	Interface with OAKS to send invoice for payment.			
5.3.1.11	Provide electronic notification to ODJFS of payment to case management vendor.			
5.3.1.12	Track actual versus planned case management vendor performance.			

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**Contract Management**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
5.3.1.13	Generate customizable reports for monitoring case management vendor performance.			
5.3.1.14	Provide for electronic submission of corrective action plan from case management vendor.			
5.3.1.15	Edit claims against authorized service level and authorized plan level.			
5.3.1.16	Electronically store All Services Plans (Plans of Care) data and provide the ability to establish and identify rules based thresholds for each All Services Plan to be used for adjudication, analysis and reporting purposes.			
5.3.1.17	Provide electronic storage and retrieval for historical All Services Plans (Plans of Care).			

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**Financial Management**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
<b>6.1</b>	<b>Ohio Administrative Knowledge System (OAKS) Integration</b>			
6.1.1	Requirements			
6.1.1.1	Integrate MITS with OAKS, which will utilize PeopleSoft Release 8 (or later) financial management software.			
6.1.1.2	Interface with OAKS and support seamless transfers of data between the two systems as required to support Claims Processing and other financial functions; other financial functions may include modules or functionality associated with Accounts Receivable, Budget Management and Analysis, Contract Management, Administrative Claiming, and inter-agency transfers payments.			
6.1.1.3	Provide control and reconciliation reports to track and balance financial information between MITS and OAKS.			
6.1.1.4	Provide an identification and tracking mechanism that allows aggregate information in OAKS to be associated with supporting detailed information in MITS and vice versa.			
6.1.1.5	Accept warrant numbers, EFT numbers, other payment information and invoice information from OAKS, including information associated with claim payments, stop payments, reissued warrants, voided warrants, encumbrances, accounts receivables, inter-agency transfers, MAC administrative claiming, contract management, etc.			
6.1.1.6	Identify, support on-line review, and generate reports of claims payment detail for claims paid or denied (rejected) through warrants or EFT's issued by the State.			
6.1.1.7	Generate detailed claims payment data reports on-line by warrant numbers, EFT numbers, provider numbers, Medicaid consumer identification, chart fields, fund, and other criteria.			
6.1.1.8	Send claims payment information at a level of detail defined by the State, to OAKS in order to facilitate actual payments to providers.			
<b>6.2</b>	<b>Budget Management and Analysis/ Revenue Management</b>			
6.2.1	Requirements			
6.2.1.1	Create each month a monthly summary of selected claims data fields and forward it to the data warehouse/DSS for use in financial forecasting. Such fields may include the following: <ul style="list-style-type: none"> <li>• State agency (i.e., the agency that has or will make the payment)</li> <li>• Date of service</li> <li>• Date of payment</li> <li>• Expenditure</li> <li>• Provider type</li> <li>• Category of service</li> <li>• DRG code</li>   <li>• Non-DRG code (e.g., to capture hospital claims that are paid as outliers)</li> <li>• Geographical location</li> </ul>			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Eligibility groups (including waiver programs)</li> <li>• Age (according to cohorts defined by the State).</li> </ul>			
6.2.1.2	Allow flexibility to change the fields included in the summary data.			
6.2.1.3	Support the retrospective re-creation of monthly data upon the change of the fields included in the budget data mart.			
6.2.1.4	Support on-line inquiries, made from desktops, of the data in the budget data mart.			
6.2.1.5	Generate ad hoc reports based on information in the budget data mart.			
6.2.1.6	Ability to access the summary data in the data mart.			
6.2.1.7	Provide on-line access to summarized caseload totals that are current to the previous day to support Federal approval of waivers including information related to: <ul style="list-style-type: none"> <li>• Number of enrolled consumers</li> <li>• Number of case closures</li> <li>• Category of eligibility (including by waiver programs)</li> <li>• Age</li> <li>• County</li> <li>• Income</li> <li>• Gender.</li> </ul>			
6.2.1.8	Ability to delay payment of claims on a targeted basis by the following categories including: <ul style="list-style-type: none"> <li>• Category of eligibility</li> <li>• Provider type</li> <li>• State agency</li> <li>• Date of service</li> <li>• Initial receipt or processing date</li> <li>• Vendor</li> <li>• Relative to pre-determined limit on an aggregate or categorical amount to be paid.</li> </ul>			
6.2.1.9	Provide the ability for designated staff to view, on-line in near real-time, information about claims in queue for payment, including information related to: <ul style="list-style-type: none"> <li>• Category of eligibility</li> <li>• Provider type</li> <li>• State agency</li> <li>• Date of service</li> <li>• Initial receipt or processing date</li> <li>• Vendor</li> <li>• Amount of payment.</li> </ul>			
6.2.1.10	Generate ad hoc reports in regard to claims in the queue for payment including information related to: <ul style="list-style-type: none"> <li>• Category of eligibility</li> <li>• Provider type</li> </ul>			

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**Financial Management**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• State agency</li> <li>• Date of service</li> <li>• Initial receipt or processing date</li> <li>• Vendor</li> <li>• Amount of payment.</li> </ul>			
<b>6.3</b>	<b>Accounts Receivable (AR)</b>			
6.3.1	Requirements			
6.3.1.1	Provide the capability to associate receivables in OAKS with claims detail information in MITS and provide the capability to track the status of receivables captured in chart fields in OAKS.			
6.3.1.2	<p>Provide on-line access and an ability to generate ad hoc reports that integrate information queried from OAKS with the following MITS information:</p> <ul style="list-style-type: none"> <li>• Payer type (“payer” here is the entity from which money is owed to the State or from whom the State otherwise receives payments associated with a receivable)</li> <li>• Payer tax ID</li> <li>• Reason code</li> <li>• Authorizing party</li> <li>• Service date (for claims-related)</li> <li>• Adjustment history by receivable</li> <li>• Denial codes from carriers to allow for identification of possible modifications to post payment recovery extraction and cost avoidance criteria and to update consumer-specific insurance information in the claims processing system.</li> </ul>			
6.3.1.3	Track overpayments, adjustments, penalties and interest associated with receivable funds.			
6.3.1.4	Maintain a complete record for audit trail purposes of all relevant documents and records associated with receivables.			
6.3.1.5	Provide the ability to identify, review, and obtain in reports complete data from the paid claims associated with the original payments that have since been recovered, in full or in part, or that have otherwise been identified as recoverable funds.			
6.3.1.6	<p>Provide flexible, rule-driven reporting and analytical capacity that can generate reports and perform calculations on the basis of multiple sources of claims-related and non-claim related data in order to determine, or support the determination of, accurate amounts of receivable funds associated with:</p> <ul style="list-style-type: none"> <li>• SURS recoveries</li> <li>• Drug rebates</li> <li>• Supplemental drug rebates</li> <li>• Hospital Care Assurance Program (HCAP) assessments</li> <li>▪ Nursing home franchise fees</li> <li>▪ ICF-MR franchise fees</li> <li>▪ Managed care plan assessments</li> </ul>			

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**Financial Management**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Funds paid for participation in Upper Payment Limit programs (UPL)</li> <li>• Hospital cost settlements</li>   <li>• Overpayments corrections associated with Nursing Homes and ICF-MR</li> <li>• Estate recoveries</li> <li>• Other provider fees and assessments</li>   <li>• Premiums paid by Medicaid consumers to establish or maintain coverage</li>   <li>• Administrative fees and other portions of receivables associated with HCAP, UPL, SURS, Medicaid Administrative Claiming (MAC), audits, and any other funds that are statutorily required to be deposited into the Health Care Services Administration fund.</li> </ul>			
6.3.1.7	Generate reports related to estate recoveries that accurately identify amounts paid for services provided to now deceased consumers.			
6.3.1.8	Interface with Department of Health and the Attorney General’s office to receive vital statistics information essential to the determination of estate recoveries or other claims adjudication in MITS.			
6.3.1.9	Automatically provide information to OAKS so that AR records can be updated whenever providers owe an outstanding balance.			
6.3.1.10	Support internal auditing procedures and cycles in accordance with Generally Accepted Accounting Principles (GAAP).			
6.3.1.11	Maintain account detail (e.g., claims payment detail) and summary information for each accounts receivable transaction including the following data: <ul style="list-style-type: none"> <li>• Beginning and ending balances</li> <li>• Activity for the period</li> <li>• Pending credit</li> <li>• Recoupment schedule</li> <li>• Adjustments</li> <li>• Interest</li> <li>• Penalties</li> <li>• Summary totals.</li> </ul>			
6.3.1.12	Maintain accurate and timely information (e.g., insurance information from the claims processing system claims history) to allow for precise selection of paid claims for post payment recovery.			
6.3.1.13	Generate bills for collections from Medicare, insurance companies, and other third parties who are liable for payments of claims-related receivables in formats as specified by ODJFS or the Federal government. This includes HIPAA-approved formats (including NCPDP) as well as formats such as the CMS1500 and UB92 claim forms.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
6.3.1.14	Send information to the claims processing system so that claims history can accurately reflect that receivables have been initiated and/or recovered in association with particular claims.			
<b>6.4</b>	<b>Accounts Payable (AP)</b>			
6.4.1	Requirements			
6.4.1.1	Transmit and maintain the necessary financial information into Accounts Payable in OAKS.			
6.4.1.2	Provide the capability to aggregate, retain, and transmit to OAKS the information needed to support its accounts payable function.			
6.4.1.3	Provide the capability to associate accounts payable in OAKS with claims detail information in MITS and provide the capability to track the status of accounts payable as captured in chart fields in OAKS.			
6.4.1.4	Generate financial trending reports by provider, provider type, provider category of service and contractor.			
6.4.1.5	Support the State's ability to issue payments or EFTs associated with Medicaid claims by transmitting necessary information to OAKS such as: <ul style="list-style-type: none"> <li>• Payment period</li> <li>• Provider information, including tax ID, name, address, and amount to be paid.</li> </ul>			
6.4.1.6	Provide checks and balances to verify that all necessary payments are submitted to OAKS, and accepted.			
6.4.1.7	Track payments down to the claim line level.			
6.4.1.8	Generate an audit trail for accounts payables that accommodates all claims submission types.			
6.4.1.9	Archive claim payments history for at least seven (7) years.			
6.4.1.10	Calculate payments directly for Medicaid consumers, according to protocol defined by the State.			
6.4.1.11	Calculate payments to Financial Management Service providers according to protocol defined by the State (e.g., for a Cash and Counseling Waiver).			
6.4.1.12	Support the ability to schedule or restrict payments according to any criteria associated with any element of the funding code.			
6.4.1.13	Electronically interface with or otherwise accept payment information from OAKS regarding: <ul style="list-style-type: none"> <li>• Notification of payments of claims</li> <li>• Updates on the status of payment of claims</li> <li>• Warrant numbers associated with the actual payment of particular claims</li> <li>• Information about stop payments, re-issues and voids.</li> </ul>			
6.4.1.14	Supply data to the data warehouse/DSS that can be used to establish a complete audit trail to provide information in response to queries from desktops and to support the creation of standard and ad hoc reports regarding Medicaid claims payment data including:			

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Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• A history of all transactions, including dates, associated with the payment</li> <li>• Warrant numbers associated with the actual payments</li> <li>• Warrant dates associated with the actual payments</li> <li>• Information about stop payments, re-issues, voids, etc.</li> <li>• Medicaid claim numbers</li> <li>• Medicaid claim types</li> <li>• Dates of service</li> <li>• Provider information</li> <li>• Category of service</li> <li>• Medicaid consumer.</li> </ul>			
6.4.1.15	Recognize and provide OAKS with the information as needed to reissue payments when appropriate after an initial payment is stopped, voided, or cancelled.			
6.4.1.16	Accommodate automatic electronic feeds from the Federal Social Security Administration for information associated with SSI Benefits.			
6.4.1.17	<p>Provide flexible, rule-driven reporting and analytical capacity that can generate reports and perform calculations (MITS) on the basis of multiple sources of data in order to determine, or support the determination of, accurate amounts of payable funds associated with:</p> <ul style="list-style-type: none"> <li>• Medicaid claims</li> <li>• Claims adjustments</li> <li>• Nursing Home reimbursements</li>   <li>• Intermediate Care Facility for the Mentally Retarded reimbursements</li> <li>• Hospital Care Assurance Program</li> <li>• Upper Payment Limit programs</li> <li>• Cost settlements</li>   <li>• Other provider payments/adjustments/settlements/incentives/refunds</li> <li>• Medicare Buy-In payments /adjustments</li> <li>• Premium payments and adjustments</li> <li>• Other supplemental provider payment programs</li> <li>• County Cost Reimbursement payments</li> <li>• Drug Rebate refunds/interest</li> <li>• Insurer refunds/premium payments</li> <li>• Dispute resolution settlements</li> <li>• SSI payments</li> <li>• Withholds for child support and IRS liens.</li> </ul>			
<b>6.5</b>	<b>Federal Reporting</b>			
6.5.1	Requirements			

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Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
6.5.1.1	Synchronize paid claims data generated and stored by MITS with warrant and other payment information generated and stored in OAKS (or in a data warehouse) weekly in a way that supports the ability to generate reports that align paid claim detail with warrant and other payment information by specific accounting element and relative to all categories of service and spending that must be reported in the CMS 64, 372 cost neutrality reports, and other Federal reports. (OAKS data to include cost allocation and county administrative reporting. Claims specific information will reside in MITS with a tracking number related to OAKS.)			
6.5.1.2	Provide the capability to easily “drill-down” and generate paid claim and other detailed information that supports summary figures presented in Federal reports.			
6.5.1.3	Generate reports that compare OAKS data to MITS data to analyze and reconcile Payment Appropriation Report “out of balance” information, including specific accounting elements in OAKS.			
6.5.1.4	Support the generation of information for all Federal reports and supporting data required by CMS, including: <ul style="list-style-type: none"> <li>• CMS 21 report (Administrative Claims for State Children’s Health Insurance Program (SCHIP))</li> <li>• CMS 64 report (Medicaid claims)</li> <li>• CMS 372 (Cost Neutrality Assessment for Waivers)</li> <li>• CMS 416 (Healthchek Report)</li> <li>• Medicaid Statistical Information System Data Reports (formerly CMS-2082)</li> <li>• Uncollectible Overpayments Report</li> <li>• Public provider payouts by State category of service</li> <li>• Non-collection write-off transactions applied to cash accounts receivable during the reporting period and not previously refunded to CMS as overpayments; report of checks that were voided and applied to overpayment accounts receivable records.</li> </ul>			
6.5.1.5	Recover overpayments through accounts receivable including: (OAKS, OAKS Interface to MITS) <ul style="list-style-type: none"> <li>• Tort-related recoveries</li> <li>• Cost-settlements</li> <li>• Credit balances</li>   <li>• Estate recoveries; have the ability to account for data reporting requirements related to a long term care insurance partnership program.</li> <li>• SURS recoveries</li> <li>• Drug rebates</li> <li>• Franchise fees</li> <li>• Fraud recoveries.</li> </ul>			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
6.5.1.6	Calculate offsets netted in MITS in support of Federal Reports. including: (MITS, Interface to OAKS) <ul style="list-style-type: none"> <li>• Claims adjustments</li> <li>• Third-party liability and/or payments</li>   <li>• Adjudication and final settlements of nursing home and ICF-MR payments</li> <li>• HCAP assessments</li> <li>• Funds paid for participation in UPL programs</li> <li>• Audit findings.</li> </ul>			
6.5.1.7	Provide on-line analytical capacity for completing calculations that are necessary in Federal reports that can be accessed from desktops.			
6.5.1.8	Support the generation of FFP reports and supporting documentation according to Federal and State requirements.			
6.5.1.9	Report on cash recoupment transactions, not previously refunded to CMS as overpayments, that occurred during the Federal reporting quarter by State category of service within Federal category of service.			
<b>6.6</b>	<b>Cost Reports/Settlements</b>			
6.6.1	Nursing Homes and Intermediate Care Facility for Mentally Retarded (ICF-MR)			
6.6.1.1	Provide for rate recalculation based on ODJFS defined inputs and criteria.			
6.6.1.2	Reprocess rates using audited versus un-audited information.			
6.6.1.3	Perform calculations defined by ODJFS and used in the overpayment correction process.			
6.6.1.4	Provide flexibility to calculate numbers of “days paid” as defined by ODJFS.			
6.6.1.5	Generate reports for all claims by fiscal year, by provider, or other criteria as defined by ODJFS.			
6.6.1.6	Match/run consumer ID against other room and board claims.			
6.6.1.7	Identify dates of service overlaps and to make adjustments to days paid due to overlaps.			
6.6.1.8	Generate reports to reconcile patient liability to the eligibility system.			
6.6.1.9	Adjust original patient liability based on the most current data on the eligibility system.			
6.6.1.10	Calculate rates times days minus patient liability, by consumer, by service month.			
6.6.1.11	Roll up all receivables by providers.			
6.6.1.12	Reconcile the amount paid to providers and calculate overpayment amounts by criteria including service month, per person, and fiscal year.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
6.6.1.13	Report fiscal year overpayments reflected in proposed adjudication orders to the Office of Fiscal Services' Bureau of Federal Reporting as identified and adjudicated on a quarterly basis.			
6.6.1.14	Track the status of recoupment by provider through all stages of the collection and appeals processes.			
6.6.1.15	Maintain an audit trail of all calculations used in the overpayment correction process, including payment amounts, the dates and times of key processing events, and warrant numbers for any outgoing payments.			
6.6.1.16	Generate proposed and final adjudication orders associated with the overpayment correction process for nursing homes and ICF-MR to those providers. Adjudication Order includes the following information: <ul style="list-style-type: none"> <li>• Adjudication Order template/cover letter</li> <li>• Dollar amount</li> <li>• Reports of examination</li> <li>• Hearing and appeal information</li> <li>• Waiver form by which the provider can agree to accept a particular amount to be paid and waive their right to a hearing</li> <li>• Fiscal forms to assure that payments are credited to proper accounts.</li> </ul>			
6.6.1.17	Store, track, and provide ODJFS staff with easy access to electronic storage of all waiver forms and/or other documentation received from providers and other sources that pertain to the overpayment correction actions.			
6.6.1.18	Automatically update the status of particular overpayment correction actions when waiver forms and other documents are received and logged on to the tracking system.			
6.6.1.19	Automatically initiate the assembly and mailing of final adjudication orders associated with the overpayment correction process (CPAO) when waiver forms are received.			
6.6.1.20	Generate data and reports as defined by the State or Federal Government and associated with adjudication orders and overpayment corrections as needed by the Office of Fiscal Services, Bureau of Federal Reporting, for preparation of relevant sections of the CMS 64 report.			
6.6.1.21	Generate cost settlement information for the CMS 64 report on a timescale specified by ODJFS to meet Federal regulations.			
6.6.1.22	Interface, or at least support a common data identifier, with OAKS.			
6.6.2	Hospitals			
6.6.2.1	Generate "clean" paid claims within each provider's reporting period.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
6.6.2.2	Generate reports, on an ad hoc basis, of hospital summary data based on specific revenue centers, as defined in the cost report including the following criteria: <ul style="list-style-type: none"> <li>• Paid days</li> <li>• Paid charges</li> <li>• Total third party payments</li> <li>• Total Medicaid payments</li> <li>• Number of discharges</li> <li>• Cost Outliers</li> <li>• DRG.</li> </ul>			
6.6.2.3	Provide the capability to generate and view ad hoc reports on-line of claims adjustment information including the dollar amount of all adjustments, the dollar amount of the related charges, and if applicable, the days adjusted.			
6.6.2.4	Generate proposed and final adjudication orders associated with the cost settlement of hospital payments to providers. Adjudication orders includes the following information: <ul style="list-style-type: none"> <li>• Adjudication Order template/cover letter</li> <li>• Dollar amount</li> <li>• Hearing and appeal information</li> <li>• Waiver Form by which the provider can agree to accept a particular amount to be paid and waive their right to a hearing</li> <li>• Fiscal Forms to assure that payments are credited to proper accounts.</li> </ul>			
6.6.2.5	Store, track, and provide ODJFS staff with on-line access to electronic images of all waiver forms and or other documentation received from providers and other sources that pertain to the cost settlements of hospital payments.			
6.6.2.6	Automatically update the status of particular hospital cost settlement initiatives when waiver forms and other documents are received and logged on to the tracking system.			
6.6.2.7	Automatically initiate the assembly and mailing of final adjudication orders associated with hospital cost settlement initiatives when waiver forms are received.			
6.6.2.8	Generate data and reports as defined by the State or Federal Government and associated with the cost settlement of hospital payments as needed by to the Office of Fiscal Services' Bureau of Federal Reporting for preparation of relevant sections of the CMS 64 report.			
6.6.2.9	Track adjustments that result when collections of overpayments are realized through offsets to other vendor payments, and support the ability to verify that those offsets have occurred relative to specific overpayment collection initiatives.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
6.6.2.10	Interface with, or at least support a common data identifier with, OAKS and/or other stand-alone systems as necessary to support effective tracking of hospital payment cost settlements as accounts receivable or accounts payable.			
<b>6.7</b>	<b>Inter-agency Transactions</b>			
<b>6.7.1</b>	<b>General Requirements</b>			
6.7.1.1	Produce information used to generate transactions such as reports that summarize the costs associated with successfully processed claims for Medicaid services provided through programs managed by State agencies other than ODJFS.			
6.7.1.2	Accept , process , reimburse (OAKS), and pay claims (OAKS) from sub-recipient State agencies (e.g., State agencies other than ODJFS) that manage programs that provide Medicaid benefits and services.			
6.7.1.3	Maintain fee schedules established by sub-recipient State agencies and be able to reference rates in those fees schedule for each particular procedure code covered under programs managed by sub-recipient State agencies.			
6.7.1.4	Utilize rates in the fee schedule in order to price and initiate payment of claims in cases that require ODJFS to make direct payments to providers for services rendered under a program managed by a sub-recipient State agency.			
6.7.1.5	Generate reports to support the creation of inter-agency transactions when arrangements between ODJFS and sub-recipient State agencies require a local contracting entity to make direct payments to direct care providers and under which post-payment claims are submitted to ODJFS or an ODJFS vendor for the calculation of Federal match.			
6.7.1.6	Issue alerts when there are errors in the claims submitted by other agencies relative to fee schedules and based on other pre-defined business rules.			
6.7.1.7	Create custom ODJFS oversight edits for each sub-recipient State agency program based on pre-defined business rules determined by ODJFS and the sub-recipient State agency; the type of editing may include eligibility validation, limits on rates per procedure, units of service per procedure code, expenditures over an established time period, valid providers, date of service and a number of parameters documented in reference data bases.			
6.7.1.8	Recognize claims from sub-recipient State agencies and link the claim to the correct sub-recipient State agency program/benefit package/health care component and associated processing rules.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
6.7.1.9	Process sub-recipient State agency claims: 1) on a direct payment basis when claims are submitted directly to ODJFS & paid directly by ODJFS; 2) on an encounter basis for reporting information used to generating inter-agency transfer payments by which ODJFS reimburses the sub-recipient State agencies for Federal match associated with the cost of the claims; or 3) some alternative method which is a hybrid of the two.			
6.7.1.10	Provide information to support reports for accurate claiming of Federal match associated with payments and expenditures for services provided and reimbursed as part of the sub-recipient State agency benefit package and/or health care component, regardless of the payment arrangement or money exchange methodology.			
6.7.1.11	Accept in an electronic format, lists of valid participating providers for the sub-recipient State agency programs.			
6.7.1.12	Update from appropriate sources the consumer eligibility/enrollment spans which are associated with the sub-recipient State agency programs.			
6.7.1.13	Provide role-based access to reports of complete Medicaid claims payment information that reflects all of claims paid on behalf of individual or groups of Medicaid consumers, including information associated with claims paid by or on behalf of sub-recipient State agencies, and with an ability to select information by date of service.			
6.7.1.14	Generate standard and ad hoc reports that show claims-level detail behind summary cost reports associated with claims paid by or on behalf of other State agencies for Medicaid services; information about rejected claims should also be available in this way.			
6.7.1.15	Generate standard and ad hoc reports that show information about claims paid to particular providers, including the individual providers in the other agency systems.			
6.7.1.16	Provide the role-based access by sub-recipient State agencies to claims information at a preliminary stage in the processing of those claims, including information about claims that are initially scheduled for rejection, and support the ability of sub-recipient State agencies to make on-line adjustments to those claims in regard to errors, issues of validation, and benefits management.			
6.7.1.17	Accommodate changes in payment methodologies associated with claims for services provided through programs managed by State agencies other than ODJFS in order to accommodate possible changes in future Federal requirements from CMS in regard to claims processing and payment (e.g., if CMS requires that ODJFS pays all Medicaid claims directly).			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
6.7.1.18	Accept information associated with Medicare “crossover,” or portions of the cost of services provided through sub-recipient State agencies that was paid or is eligible for payment by Medicare, and to calculate appropriate payment amounts after that information is taken into account.			
6.7.1.19	Accept information back from OAKS in regard to the disposition of inter-agency transactions and that supports an ability to tie particular transfers to particular Medicaid claims. (Interface from OAKS to MITS)			

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**Transactions, Claims, and Encounters**

Req Number	Requirement	MITS Phase (1 or 2)	Response Code	Page Ref
<b>7.1</b>	<b>Healthcare and Business Transactions</b>			
7.1.1	Requirements			
7.1.1.1	Anticipate and provide a flexible solution that is positioned to effectively meet the requirements of current and future HIPAA regulations.			
7.1.1.2	Accommodate changes with global impacts for all transactions currently supported or adopted by ODJFS in the future (e.g., implementation of International Classification of Diseases-10 (10th revision)-Clinical Modification (ICD-10-CM) diagnosis and procedure codes) at no additional cost to the State.			
7.1.1.3	Accommodate healthcare and business transactions when these transactions enhance ODJFS' ability to process health care information, (e.g., ASC X12N 275 Additional Information to Support a Health Care Claim or Encounter).			
7.1.1.4	Provide a system that meets all requirements of the HIPAA mandated National Provider Identifier (NPI) rule.			
7.1.1.5	Phase 2 - Provide a HIPAA compliant MITS system capable of processing all existing healthcare and business transactions and future transactions developed by any of the data standards maintenance organizations that support HIPAA (current and future). This includes ASC X 12, HL 7, NCPDP, Logical Observation Identifiers Names and Codes (LOINC), and XML formats Clinical Document Architecture (CDA) and Context Inspired Component Architecture (CICA.).			
7.1.1.6	Interface with the ODJFS EDI translator process and systems for the processing of all EDI transactions.			
7.1.1.7	Accept and process or generate the following HIPAA mandated batch and near real-time transactions, other versions or standards that may be mandated, and other transactions including: <ul style="list-style-type: none"> <li>• Health Care Claims: <ul style="list-style-type: none"> <li>o ASC X12N 837 Health Care Claim: Professional</li> <li>o ASC X12N 837 Health Care Claim: Institutional</li> <li>o ASC X12N 837 Health Care Claim: Dental</li> </ul> </li> <li>o National Council for Prescription Drug Programs (NCPDP) Version 5, Release 1, and equivalent NCPDP Batch Standard Version 1, Release 0</li> <li>• Eligibility for a Health Plan: <ul style="list-style-type: none"> <li>o ASC X12N 270/271 Health Care Eligibility Benefit Inquiry and Response</li> </ul> </li> <li>• Health Care Claim Status: <ul style="list-style-type: none"> <li>o ASC X12N 276/277 Health Care Claim Status Request and Response</li> </ul> </li> <li>• Referral Certification and Authorization:</li> </ul>			

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Req Number	Requirement	MITS Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>o ASC X12N 278 Health Care Services Review - Request for Review and Response</li> <li>• Health Plan Premium Payments:               <ul style="list-style-type: none"> <li>o ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products</li> </ul> </li> <li>• Enrollment and Dis-enrollment in a Health Plan:               <ul style="list-style-type: none"> <li>o ASC X12N 834 Benefit Enrollment and Maintenance</li> </ul> </li> <li>• Health Care Payment and Remittance Advice:               <ul style="list-style-type: none"> <li>o ASC X12N 835 Health Care Claim Payment/Advice</li> </ul> </li> <li>• Coordination of Benefits:               <ul style="list-style-type: none"> <li>o ASC X12N 837 Health Care Claim: Professional</li> <li>o ASC X12N 837 Health Care Claim: Institutional</li> <li>o ASC X12N 837 Health Care Claim: Dental</li> </ul> </li> <li>• National Council for Prescription Drug Programs:               <ul style="list-style-type: none"> <li>o (NCPDP) Version 5, Release 1, and equivalent NCPDP Batch Standard Version 1</li> </ul> </li> <li>• Acknowledgements:               <ul style="list-style-type: none"> <li>o ASC X12 824: Application Reporting Version 4010</li> <li>o ASC X12 277: Health Care Payer Unsolicited Claim Status</li> </ul> </li> <li>• New transaction content to include:               <ul style="list-style-type: none"> <li>o ASC X12N 269: Health Care Coordination of Benefits Request and Response</li> <li>o ASC X12N 270/271: Health Care Eligibility/Benefit Inquiry and Response (with commercial insurance carriers)</li> <li>o ASC X12N 274: Health Care Provider Inquiry and Information Response Guide</li> </ul> </li> <li>- ASC X12N Health Care Provider Credentialing Implementation Guide</li> <li>- ASC X12N Health Care Provider Directory Implementation Guide</li> <li>- ASC X12N Health Care Provider Information Implementation Guide</li> <li>- ASC X12N Additional Information to Support a Health Care Services Review               <ul style="list-style-type: none"> <li>o ASC X12N 275: Additional Information to Support a Health Care Claim or Encounter</li> <li>o ASC X12N 841: Specifications/Technical Information</li> </ul> </li> </ul>			
7.1.1.8	Comply with all ODJFS companion guides related to EDI transactions.			
7.1.1.9	Track EDI transactions/versions submitted by trading partners for test and/or production.			
7.1.1.10	Provide the capability to crosswalk codes on input and output.			
7.1.1.11	Display rules or codes applied at the field or loop level.			
7.1.1.12	Point and click access to stored documents.			

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<b>Req Number</b>	<b>Requirement</b>	<b>MITS Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
7.1.1.13	Apply appropriate security for production, certification, and test environments.			
7.1.1.14	Allow user to set up each transaction set as both test and production by the trading partner.			
7.1.1.15	Maintain control number for transaction set by the trading partner.			
7.1.1.16	Consolidate and associate multiple healthcare providers and claims with a single or multiple trading partner destinations.			
7.1.1.17	Provide the ability to calculate the value of certain fields.			
7.1.1.18	Define precision for numeric or monetary "R" type fields.			
7.1.1.19	Perform concatenation/un-concatenation of composite data elements.			
7.1.1.20	Provide ability to build tables to test HIPAA standards still in the trial stage.			
7.1.1.21	Provide recovery and back up mechanisms in the event of system failure, file corruption, or any unexpected event that makes it necessary to reprocess data.			
7.1.1.22	Provide ability to recover (resend) by date.			
7.1.1.23	Provide ability to recover (resend) by transaction.			
7.1.1.24	Provide ability to recover (resend) by document type.			
7.1.1.25	Provide ability to recover (resend) by trading partner.			
7.1.1.26	Provide detailed auditing capabilities that can assist the support team, provide for non-repudiation of file, and comply with Medicaid and HIPAA standards for privacy and security.			
7.1.1.27	Create audit trail of system and table changes by user ID.			
7.1.1.28	Report number of documents translated.			
7.1.1.29	Report by document type the number of documents processed for each business partner.			
7.1.1.30	Date and timestamp all data content flowing through the system.			
7.1.1.31	Provide a test environment to assure MCP competency with HIPAA transactions governing membership, premium payment and encounter data, including ANSI X12 820, 834, 835, 837 I, P, and D in versions specified by ODJFS.			
7.1.1.32	Generate and distribute 835 health care payment advice companion documents that provide information on how to interpret data on the 835.			
<b>7.2</b>	<b>Claims Submission</b>			
7.2.1	Requirements			
7.2.1.1	Support claims submission via: <ul style="list-style-type: none"> <li>• EDI</li> <li>• Medicaid Portal</li> <li>• Other electronic devices such as hand held devices</li> <li>• Application programming interface</li> <li>• Paper.</li> </ul>			

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**Transactions, Claims, and Encounters**

Req Number	Requirement	MITS Phase (1 or 2)	Response Code	Page Ref
7.2.1.2	Accept, process and prepare for transmission the content of any electronic transactions developed by any of the data standards maintenance organizations that support HIPAA (current and future) -- including: ASC X 12, HL 7, NCPDP and XML formats CDA and CICA. Support claims/encounters submitted in an ODJFS approved proprietary format.			
7.2.1.3	Develop interfaces as needed to accommodate the receipt of cross-over claims, encounter claims, and claims from commercial insurance carriers and other information (such as attachments) to support claims processing.			
7.2.1.4	Accept other claim, encounter and/or attachment inputs to MITS, including: <ul style="list-style-type: none"> <li>• Claims for Medicare coinsurance and deductible (cross-over claims), in both paper and electronic formats</li> <li>• Adjustment forms 6766, 6768, 6767</li> <li>• Medical review form 6653</li> <li>• Ability to accept cost reports</li> <li>• Paper claim types UB92, CMS1500, 6780, and ADA claim form, or current HIPAA compliant paper claim forms in use at the time of implementation</li> <li>• Attachments required for claims adjudication, including: <ul style="list-style-type: none"> <li>o Coordination of benefits and Medicare explanation of medical benefits</li> <li>o Sterilization, abortion, and hysterectomy consent forms</li> <li>o X-rays</li> <li>o Surgical reports</li> <li>o Digitized photos</li> <li>o Manual or automated medical expenditure transactions which have been processed outside of MITS (e.g., spend-down and premiums for Medicaid Buy-In)</li> <li>o Non-claim specific financial transactions such as fraud and abuse settlements, insurance recoveries, and cash receipts.</li> </ul> </li> </ul>			
7.2.1.5	Track claims/encounters that are rejected back to a provider, including: <ul style="list-style-type: none"> <li>• Provider</li> <li>• Date returned</li> <li>• Reason for the return.</li> </ul>			
7.2.1.6	Track and report submission errors to the submitter.			
7.2.1.7	Alert appropriate ODJFS business unit of claim submission errors.			
7.2.1.8	Image paper claims/encounters and attachments and store electronically for on-line retrieval through the document management and imaging system.			
7.2.1.9	Assign TCNs (Transaction Control Numbers) to all claims, encounters, items in pending status, and attachments.			

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7.2.1.10	Provide on-line data entry to MITS for claims, encounters and attachments.			
7.2.1.11	Provide on-line access to three years of prior claims processing data on date of implementation.			
7.2.1.12	Accept claims/encounters and attachments and be able to match attachments to the appropriate claims, regardless of order received.			
7.2.1.13	Utilize appropriate validity edits for external claims submission using the Medicaid Portal.			
7.2.1.14	Claims, transactions, encounters and attachments submitted via the Medicaid Portal or other electronic access channels, are required to be in EDI format and HIPAA compliant.			
7.2.1.15	Convert the most recent 7 calendar years (including month to date) at time of implementation..			
7.2.1.16	Notify provider of pended status and TCN assigned to claim/encounter or attachments so that missing component(s) can be submitted and matched to existing component(s).			
7.2.1.17	Re-notify submitter of pending status after 30 days.			
7.2.1.18	Deny claim/encounter if status is pending more than 60 days. If the item is an attachment, delete the attachment.			
7.2.1.19	Accommodate and retain electronic signatures in accordance with CMS/State guidelines.			
7.2.1.20	Identify and reconcile TCNs that fail to balance control counts.			
7.2.1.21	Flag ODJFS specified documents to be routed automatically to appropriate destination for multistage manual review (e.g., Provider Network Management, Medicaid Operations Section (MOS), etc).			
7.2.1.22	Provide the ability to test end-to-end: new releases, transactions, or business rules, including what-if scenarios for analysis, testing, and modeling.			
<b>7.3</b>	<b>Claims/Encounters Adjudication</b>			
7.3.1	Requirements			
7.3.1.1	Process and adjudicate FFS and encounter claims on-line.			
7.3.1.2	Adjudicate FFS, waiver , sub-recipient State agency, alternate delivery system, and care management claims.			
7.3.1.3	Support claims payment on a daily basis, or at other time intervals as defined by ODJFS.			
7.3.1.4	Provide a flexible rule-based engine to support the adjudication process.			
7.3.1.5	Prevent payment for duplicate services(s) except for those situations identified by ODJFS.			
7.3.1.6	Ensure that all claims received are processed to the point of payment, denial, or suspense.			
7.3.1.7	Interface with data warehouse/DSS, EDMS, IVR, ACD, and CRM.			

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7.3.1.8	Provide the ability to calculate and pay interest.			
7.3.1.9	Provide the capability to purge claims based on ODJFS criteria.			
7.3.1.10	Provide the capability to query claims with flexible search criteria as identified by ODJFS.			
7.3.1.11	Track and display eligibility for those services that have limits (time and dollar) for specific time frames.			
7.3.1.12	Pay, pay and report, deny or suspend FFS claims as defined by ODJFS.			
7.3.1.13	Accept all encounter claims, including those paid, partially paid, or denied, so that they can be adjudicated and accepted, partially accepted, or rejected by ODJFS.			
7.3.1.14	Utilize HIPAA compliant claim adjustment reason and remittance advice remark codes for processing and display on-line without the need to crosswalk to legacy codes.			
7.3.1.15	Automatically route and process claims based on eligibility type (e.g., waiver, LTC, and other programs) through the adjudication process.			
7.3.1.16	Automatically route suspended claims to designated units for review according to ODJFS defined criteria using the EDMS workflow system.			
7.3.1.17	Generate alerts to appropriate work units notifying them of suspended claims requiring review.			
7.3.1.18	Generate alert to work unit management, at timeframe defined by ODJFS, if suspended claim has not been worked.			
7.3.1.19	Suspend claims that require pre-payment review.			
7.3.1.20	Send adjudicated (paid and denied) claims and encounter data to data warehouse/DSS, the financial reporting system, or other systems as appropriate, and to claims history, as defined by the ODJFS.			
7.3.1.21	Provide the capability to distinguish between encounter data payments, premium payments, and FFS claims.			
7.3.1.22	<p>Provide role-based on-line inquiry access, for internal use only by ODJFS staff, to all claims using the following selection (search) criteria:</p> <ul style="list-style-type: none"> <li>• Consumer ID (Currently “Medicaid Billing Number”)</li> <li>• Provider ID</li> <li>• TCN</li> <li>• Claim adjustment reason codes</li> <li>• RA Remark codes</li> <li>• Procedure and diagnostic codes</li> <li>• All UB code sets</li> <li>• Information submitted on COB claims</li> </ul> <p>• Inquiry by specific parameters (e.g., date range) defined by ODJFS</p>			

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**Transactions, Claims, and Encounters**

<b>Req Number</b>	<b>Requirement</b>	<b>MIT S Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Claim type</li> <li>• Note: For excessive volume requests, provide the capability to run in batch mode.</li> </ul>			
7.3.1.23	Support on-line viewing of all data used to process a claim with navigation from the claim record to the reference files that support adjudication.			
7.3.1.24	Allow on-line modification to edits/audits as dictated by policy.			
7.3.1.25	Maintain an on-line audit trail for all edit/audit changes.			
7.3.1.26	Maintain an on-line audit trail for each claim record that shows each stage of processing, the date the claim entered each stage, and any edit/audit codes posted to the claim at each step in processing.			
7.3.1.27	Process all modifiers submitted on a claim.			
7.3.1.28	Designate, change, and maintain history of begin and end dates for each edit/audit per ODJFS guidelines.			
7.3.1.29	Incorporate software for edits and audits per ODJFS policy to detect fraud and abuse, including bundling/unbundling, multiple surgery, medically unnecessary services, and overuse of services for all claims, and for criteria, provider types, and consumer categories, and program eligibility.			
7.3.1.30	Adjudicate professional surgery claims in a manner which supports the CPT surgical concept. Services that should be bundled based on the surgical package concept and in accordance with CPT and ODJFS policy must be cost avoided (e.g., visits for pre and post visits, local anesthesia).			
7.3.1.31	Provide a methodology for identifying “add-on codes”, multiple surgery exempt codes, diagnostic codes and therapeutic surgical codes for which the package concept may not be applicable and process them as exceptions (e.g., CPT appendix D and E codes).			
7.3.1.32	Adjudicate professional surgery claims to cost avoid surgical and other procedures which are a component procedure of another procedure billed on the same date of service.			
7.3.1.33	Adjudicate multiple surgical procedures that are performed at the same operative session, process professional surgery claims to adjust (reduce) the maximum reimbursement of all procedures (e.g., secondary, tertiary, etc.) with the exception of the primary procedure and those procedures that are typically exempted from multiple surgery payment reductions in accordance with the CPT and/or ODJFS policy (e.g., CPT appendix D and E codes).			

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<b>Req Number</b>	<b>Requirement</b>	<b>MITS Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
7.3.1.34	When bilateral surgical codes are performed at the same operative session, process professional surgery claims to adjust reimbursement to reflect bilateral pricing. Must have a methodology to determine when bilateral pricing concepts apply and when left and right side procedures should not invoke bilateral pricing logic.			
7.3.1.35	Adjudicate assistant-at-surgery claims in the same manner as professional surgery claims, except apply assistant-at-surgery pricing.			
7.3.1.36	Adjudicate and process anesthesia claims containing allowable surgical codes (e.g., surgical codes recognized as allowable in addition to the anesthesia procedures codes).			
7.3.1.37	Provide for distinct edits by program type, benefit package, and benefit package component category.			
7.3.1.38	Identify and track EPSDT screening services and referrals made to other providers, regardless of how the claim was submitted Health Care Financing Administration (HCFA) 1500 or EDI electronic claim).			
7.3.1.39	Track a visit made to another provider resulting from an EPSDT referral.			
7.3.1.40	Perform exceptional adjudication of claims edits and audits in accordance with ODJFS approved guidelines (e.g., deny, override) including special claims (e.g., multi transfer or transplant claim and LTC claims).			
7.3.1.41	<p>Include functionality in claims and encounter processing that properly handles payments in situations where there are annual dollar limits (or annual number-of-visit limits) that need to be considered when adjudicating the claim and/or determining payment amounts. Needed functionality includes the capability to:</p> <ul style="list-style-type: none"> <li>• Adjudicate claims to pay up to, but not more than the amount remaining in the annual dollar limit</li> <li>• View on-line how much of an annual dollar limit remains prior to adjudication of a new claim</li> <li>• Perform on-line edits or set parameters that limit the dollar or unit reimbursement amount for specific providers for specific procedure codes for specific periods of time for designated benefit packages</li> <li>• Generate alerts that would warn providers that a consumer is nearing their annual dollar limit or their annual visit limit for various services (e.g. Physical Therapy (PT), Speech Therapy (ST), chiropractic, psychological counseling, or others as defined by ODJFS.).</li> </ul>			

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<b>Req Number</b>	<b>Requirement</b>	<b>MIT S Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
7.3.1.42	Provide flexible, on-line edit/audit disposition codes in accordance with ODJFS health care plan and waiver program policies and procedures. MIT S must have the capability to post an unlimited number of edits/audits to a claim.			
7.3.1.43	Define claim edit/audit dispositions and exceptions (pay, pay and report, deny, suspend) including bill type, submission media, provider type, or individual provider number.			
7.3.1.44	Define encounter claim edit/audit dispositions and exceptions (reject, accept, partially accept), including bill type, submission media, provider type, or individual provider number.			
7.3.1.45	MIT S must be easily expandable to add new entries to rule-based tables in accordance with ODJFS health plan and waiver program policies and procedures.			
7.3.1.46	Allow for specific procedure codes for encounter claims to be processed for payment as defined by ODJFS (e.g., delivery codes).			
7.3.1.47	Allow the disposition of edits to be easily changed to pay, pay and report, suspend to a specific location, suspend to the provider for correction, deny and report on the RA the claim disposition or the 835 with reason and remark codes.			
7.3.1.48	Maintain at least three (3) years of on-line adjudicated (paid and denied) claims history including all other claims for procedures exempt from regular claims history purge criteria as defined by ODJFS. The on-line history file shall be used in audit processing, on-line inquiry and update, and generate printed responses to claims inquiries. Adjudicated claims history data includes: <ul style="list-style-type: none"> <li>• 837 transaction data</li> <li>• NCPDP data</li> <li>• 834 transaction data</li> <li>• 820 transaction data</li> <li>• 835 transaction data</li> <li>• 275 transaction data</li> <li>• 277 transaction data</li> <li>• 278 transaction data.</li> </ul>			
7.3.1.49	Group or assemble like suspended claims and make changes (mass changes) as appropriate.			
7.3.1.50	Deny, suspend, release groups of like claims as defined by ODJFS.			
7.3.1.51	Systematically accept global changes to suspended claims based on ODJFS defined criteria. Process and mass release suspended claims according to parameters defined by ODJFS and capture and retain adequate audit trail documentation.			
7.3.1.52	Identify edit number(s) for which the claim was suspended.			

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Req Number	Requirement	MITS Phase (1 or 2)	Response Code	Page Ref
7.3.1.53	Maintain claim correction screens that display all claims data as entered or subsequently corrected by either the provider or ODJFS staff.			
7.3.1.54	Maintain inquiry and update capability to claim correction screens with access by TCN, provider ID, consumer ID, and/or claim location or other criteria as defined by ODJFS.			
7.3.1.55	Generate unsolicited 277 content for translation back to provider.			
7.3.1.56	Allow on-line near real-time resolution of any claims that suspend for edits/audits.			
7.3.1.57	Adjudicate claims with up to 999 lines or other claims size standard as mandated by Federal or State regulations.			
7.3.1.58	Adjudicate claims according to the rules defined in the reference files.			
7.3.1.59	Utilize National Provider Identifier (NPI) in the adjudication process.			
7.3.1.60	Utilize National Association of Insurance Commissions (NAIC) number in the cost avoidance process.			
7.3.1.61	Provide the capability to withhold payments or partial payments based on IRS liens, child support payments, or other reasons as defined by the State.			
7.3.1.62	Utilize 269 COB EDI transactions to verify previous payers' payments.			
7.3.1.63	Process COB claims at the line level including Medicare cross-over claims.			
7.3.1.64	Process all header and line level claim adjustment reason codes on COB claims (including Medicare cross-over claims).			
7.3.1.65	Using ODJFS business rules and audit policies, edit against the following, including: <ul style="list-style-type: none"> <li>• TPL information specific to coverage type/benefit package</li> <li>• Valid program service</li> <li>• Valid program eligibility for both provider and consumer</li> <li>• Level of care</li> <li>• Required attachments are present</li> <li>• Consumer's age when appropriate</li> <li>• Cost-sharing requirements on applicable claims or benefit plans</li> <li>• Provider participation as a member of a billing group</li>   <li>• Valid billing, attending, and/or prescribing provider number and/or NPI</li> <li>• Age of claim (based on date of service)</li> <li>• State defined filing deadlines</li> <li>• Diagnosis and procedure codes that are present on Medicare cross-over claims and other applicable claim types</li> <li>• Valid consumer ID number</li> <li>• Valid consumer date of birth</li> </ul>			

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**Transactions, Claims, and Encounters**

Req Number	Requirement	MIT S Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Valid consumer name and cross-checking against previous consumer names</li> <li>• Valid insurance or Medicare indicator as it exists on the eligibility file if insurance or Medicare is indicated on the claim</li> <li>• Consumer eligibility on date(s) of service and retroactive eligibility with audit trail</li> <li>• Pre-payment review required</li> <li>• Prior authorization (PA) met as appropriate</li> <li>• Valid procedure, drug, diagnosis, and revenue codes</li> <li>• Identified history related services (e.g., dental)</li> <li>• Limit on the maximum dollars and/or units</li> <li>• Other data specified by ODJFS.</li> </ul>			
7.3.1.66	Verify carrier on claim versus carrier identification on TPL master file.			
7.3.1.67	Establish unverified TPL master record and generate 270 eligibility inquiry transactions to carriers.			
7.3.1.68	Edit to ensure that claims submitted for consumers assigned to a specific provider under the consumer lock-in program are either billed by the assigned provider or performed by the assigned provider, or that the assigned provider is present on the claim as the referring physician.			
7.3.1.69	Edit for lock-in program specific (CM, hospice, etc.) procedure codes.			
7.3.1.70	Allow exceptions to edits (e.g., county determination) for special circumstances as defined by the ODJFS.			
7.3.1.71	Edit/audit against PASRR requirements as specified in ODJFS rules.			
7.3.1.72	Provide the capability to edit LTC and waiver claims against consumer level of care, consumer Medicaid eligibility and PASRR determinations according to State and Federal requirements.			
7.3.1.73	Provide the capability to edit provider eligibility to ensure that the provider is eligible to perform the type of service rendered on the date of service including: <ul style="list-style-type: none"> <li>• Category of service</li> <li>• Provider type</li> <li>• Provider's CLIA identification number.</li> </ul>			
7.3.1.74	Account for lifetime reserve days according to Federal requirements.			
7.3.1.75	Using a rules-based engine, provide the capability to notify select ODJFS staff when a specified edit/audit posts to a claim.			
7.3.1.76	As applicable to ODJFS business rules and audit policies, edit LTC facility claims against the following including: <ul style="list-style-type: none"> <li>• Admit and discharge</li> <li>• Timely submission requirements</li> </ul>			

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Req Number	Requirement	MIT S Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• One claim per month, per provider, per consumer</li> <li>• Duplicate claim submissions</li> <li>• Payment to other providers for services rendered to a consumer with the claim span</li> <li>• Bans on admissions</li> <li>• Date of death and/or date of birth</li> <li>• Improper consumer transfer or resources</li> <li>• Several eligibility categories (e.g., QMB coinsurance and deductibles, dually eligible consumers)</li> <li>• Patient liability</li> <li>• NF bill type</li> <li>• Leave days</li> <li>• Provider enrollment status</li> <li>• Provider eligible to provide NF services</li> <li>• Base Medicaid eligibility</li> <li>• Dates of service with the claims span fall within hospice, hospital, or waiver service span</li> <li>• Overlapping SNF or Medicare Part C or ICF-MR claim</li> <li>• Total number of days on the claim</li> <li>• Overlap of the total number of days</li> <li>• PASRR requirements met</li> <li>• Level of care requirements met</li> <li>• Dates of service do not coincide with dates of PACE enrollment</li> <li>• Date of admission on the claim matched to the last digit of the bill type.</li> </ul>			
7.3.1.77	Provide for exceptions to the one claim per month per provider per consumer according to ODJFS requirements for LTC facility claims.			
7.3.1.78	Track and account for the number of leave days for each consumer in a LTC facility, according to ODJFS requirements.			
7.3.1.79	Pay for leave days according to ODJFS requirements for PASSR, LTC facility and hospice claims.			
7.3.1.80	Account for the number of covered days in a claim span according to ODJFS requirements for LTC facility claims.			
7.3.1.81	Adjudicate Medicare cross-over claims for co-insurance and deductibles versus LTC facility room and board claims.			
7.3.1.82	Provide for exceptions to timely submission for claims awaiting prior payment from third party payers, including LTC facility claims.			
7.3.1.83	Identify prior payment from third party payers including LTC facility claims.			
7.3.1.84	Provide on-line automated functionality for claims status checks throughout the claims lifecycle.			

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<b>Req Number</b>	<b>Requirement</b>	<b>MITS Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
7.3.1.85	Accept and process all HIPAA compliant (current and future) code sets and other code sets as defined by ODJFS			
7.3.1.86	Accept HIPAA compliant ANSI X12 276, batch or near real-time content for claims status inquiry.			
7.3.1.87	Adjudicate claims from sub-recipient State agencies or from their providers.			
7.3.1.88	Respond to electronic claim status inquiries with a HIPAA compliant ANSI X12 277 transaction content both batch and near real-time.			
7.3.1.89	Provide the ability to view at least seven (7) years of remittance advice (835) on-line. Load history beginning with 01/01/2004.			
7.3.1.90	Send RA's back to providers, billing agents, or sub-recipient State agencies via electronic media (including CD, Medicaid Portal, and 835) or via paper or both.			
7.3.1.91	Generate paper RAs if required by ODJFS to including: <ul style="list-style-type: none"> <li>• No limits of wording length on provider notices</li> <li>• An itemization of submitted claims that were paid, denied or adjusted and any financial transactions that were processed for that provider, including sub totals and totals</li> <li>• Adjusted claim information showing both the original claims information and the adjusted claim information with an explanation of the adjustment reason code</li> <li>• OAKS description relating to the claim payment reduction, denial, or payment</li> <li>• Summary section containing earnings information regarding the number of claims paid, denied, suspended, and adjusted and financial transactions for the current payment period, month to date, and year (calendar, State fiscal, provider fiscal) to date.</li> </ul>			
7.3.1.92	Provide capability to generate targeted newsletters to providers by provider type, provider category-of-service, procedure codes, claim-adjustment-and-remittance-advice-remark codes, etc.			
7.1.1.93	Transmit information regarding sub-recipient State agencies claim payment to OAKS.			
7.3.1.94	Provide on-line capability to change adjudication cycles based on budget, cash, and fiscal management as directed by the State.			
7.3.1.95	Provide a mechanism to generate a communication via the web or paper to providers that are in credit balance.			
7.3.1.96	Generate content so that the 835 transaction can be used to communicate credit balance information on the 835 remittance advice.			
7.3.1.97	Adjudicate claims to process Federal Qualified Health Center (FQHC), rural health clinic, and outpatient health facility supplemental payments as TPL claims and other supplemental payments.			

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7.3.1.98	Provide the capability for payment of vaccine code to differ based on whether claim is for child Vaccine for Children (VFC) or adult (non VFC). Must be date specific.			
7.3.1.99	Provide an ad hoc capability to define and generate claims adjudication reports.			
7.3.1.100	View and report on EPSDT claims as defined by ODJFS.			
7.3.1.101	Identify duplicate cross-over claims and edit processing or deny based on ODJFS defined criteria.			
7.3.1.102	Calculate and verify the amount of co-insurance on Medicare cross-over claims.			
7.3.1.103	Accept fully adjudicated pharmacy claims, including NCPDP reject/payment codes, directly into the payment cycle.			
7.3.1.104	Provide the capability to make payments directly to a Medicaid consumer (or authorized representative) or a fiscal agent using warrants, EFT, or other payment methods. (An example would be when retroactive Medicaid eligibility has been determined for a consumer who has already paid the bill).			
7.3.1.105	Maintain at the claim header and line level all accounting codes for payment distribution.			
7.3.1.106	Support edits based on tooth number.			
7.3.1.107	For Long Term Care, maintain and display data that reflects an entire calendar month's worth of services.			
<b>7.4</b>	<b>Claims Adjustments</b>			
7.4.1	Requirements			
7.4.1.1	Maintain three years of on-line claim history to be used for adjustment processing upon implementation (e.g., 3 years available on day one of implementation), including encounter data.			
7.4.1.2	Accept and process 837 adjustments and NCPDP transactions.			
7.4.1.3	Link adjustments or replacement claims to immediate predecessor or original claims.			
7.4.1.4	Associate all supporting documentation for gross adjustments to TCN assigned to the gross adjustment.			
7.4.1.5	Suspend and review eligibility changes for consumers enrolled in MCPs.			
7.4.1.6	Provide capability to easily turn suspend function off and on at a specific edit level.			
7.4.1.7	Crosswalk and store third party submitted control numbers (e.g., Medicare ICN) for cross-over claims.			
7.4.1.8	Copy a claim, manually enter data into the copied claims, and submit claims as an adjustment. This capability must be available for State staff and providers.			

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7.4.1.9	Track all incoming adjustment requests and claims regardless of input media and assign a unique tracking number and an adjustment type identifier.			
7.4.1.10	Image claim adjustments requests from providers (including faxes).			
7.4.1.11	Provide flexible reporting capability for analysis purposes (e.g., by provider, by reason, etc).			
7.4.1.12	Provide customizable workflow routing for adjustments.			
7.4.1.13	Provide management adjustments reporting capability for all adjustments requests, (e.g., aging, media type, provider).			
7.4.1.14	Process returned warrants or EFTs. Functionality should include: <ul style="list-style-type: none"> <li>• Reestablishment of all claims into a to-be paid status</li> <li>• Be able to redistribute the funds to appropriate accounts</li> <li>• Reinstate units and dollars for prior authorized services.</li> </ul>			
7.4.1.15	Automatically recognize if an adjustment is a prior-authorized claim and adjust units and dollars related to the PA record.			
7.4.1.16	Generate an alert to provider enrollment based on returned warrants (e.g., linked to auto payment stoppage) to reinstate the claims and adjust financial records.			
7.4.1.17	Receive and maintain all managed care retroactive and current eligibility enrollment spans and trigger retroactive adjustment claims.			
7.4.1.18	Pull paid claims history into adjustments record by multiple identifiers and assign a unique tracking number to each claim, as defined by the ODJFS (mass adjustments).			
7.4.1.19	Trigger take backs or payments and generate the content of 820 remittance advice for premium payments to providers, at ODJFS-defined intervals.			
7.4.1.20	Check for duplicate Medicare cross-over claims.			
7.4.1.21	Utilize workflow capability to route gross adjustments requests to optional customizable approval criteria.			
7.4.1.22	Provide on-line, role-based, approval for gross adjustments, as defined by ODJFS.			
7.4.1.23	Adjust claims both retroactively and prospectively (e.g., take back or not pay) based in consumer resource information.			
7.4.1.24	Allow adjustments for retroactive eligibility.			
7.4.1.25	Allow adjustments due to third party prior payment and alert the cost avoidance unit.			
7.4.1.26	Display both contracted agreement amount and actual payment amount.			
7.4.1.27	Provide the capability to easily modify the adjustment process to support one-time adjustments, such as Combined Proposed Adjudication Order (CPAO), or recurring adjustments to recoup Civil Monetary Penalties (CMP), other types of fines and liens.			

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<b>Req Number</b>	<b>Requirement</b>	<b>MIT S Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
7.4.1.28	Establish weekly payment reductions or increases based on the following including: IRS levy/lien, child support, as defined by ODJFS.			
7.4.1.29	Adjust a claim within a current month, (including re-billing).			
7.4.1.30	Accommodate adjustments across multiple providers.			
7.4.1.31	Provide for near real-time, on-line, mass adjustments, based on ODJFS-defined criteria			
7.4.1.32	Designate the release of payments related to adjustments.			
7.4.1.33	Access to the internal or external rate adjustment tables used in adjustment calculations.			
7.4.1.34	Find and replace claims by provider numbers.			
7.4.1.35	Provide easily customizable / parameter driven mass adjustment selection and review process.			
7.4.1.36	Establish and provide a sandbox environment that provides the functionality to create, test, modify and store fiscal impact scenarios.			
7.4.1.37	Provide internal communication capabilities (notification/explanation) tied to mass adjustments when necessary (e.g., policy initiated mass adjustments).			
7.4.1.38	Provide offline claim history back seven years. (This does not include claims requiring lifetime history.)			
7.4.1.39	Provide on-line reports for internal purposes such as credit balance.			
7.4.1.40	Deny or hold payments for review or release for immediate payment.			
7.4.1.41	Interface with Fiscal to accommodate warrant replacement, process liens and recoupments with MIT S.			
<b>7.5</b>	<b>Premium Payment</b>			
7.5.1	Requirements			
7.5.1.1	Establish and maintain a flexible premium payment and adjustment system that incorporates to the following rate components: <ul style="list-style-type: none"> <li>• Type of program</li> <li>• Geographic rate (region or other unit)</li> <li>• Type of Medicaid and /or Non-Medicaid eligibility within a specific care management program</li> <li>• Age and gender cohort</li> <li>• Disease and/or condition cohort, when applicable</li> <li>• Provision of optional services (e.g., dental, chiropractic, etc.)</li> <li>• Effective dates for rates including 7 year history</li> <li>• Premium production and payment on a program-specific frequency schedule as specified by ODJFS</li> <li>• Functional Level of Care or Nursing Home level of care</li> <li>• Medicare Status (including Parts A,B,C,D)</li> <li>• Specific premium rates per case management program</li> </ul>			

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	• PACE (Medicaid only, dually eligible, Medicare only).			
7.5.1.2	Update consumer records to reflect premium payments made on his/her behalf.			
7.5.1.3	Process incentive/special payments to MCPs or other care management programs.			
7.5.1.4	Assess penalties including premium reductions, refundable fines and rate adjustments to MCPs or other care management programs.			
7.5.1.5	Calculate and remit monthly and daily, or as otherwise specified, premium payments to providers based on such criteria as monthly membership, benefit plan, and provider specific rate information.			
7.5.1.6	Provide a test environment to change rate structures for payments. Then provide ability to export rate structure into a file that can be imported to production by change management.			
7.5.1.7	Allow for on-line near real-time payment adjustments.			
7.5.1.8	Generate, and transmit to providers on a frequency specified by ODJFS, the content of HIPAA compliant automated premium payment reports (ASC-X12N 820) for members who are prospectively or retroactively enrolled in a care management plan.			
7.5.1.9	Maintain the capability to pay MCP premium payments directly or to reimburse a sub-recipient State agency.			
7.5.1.10	Adjust and track premium payments at the member level based on changing eligibility and membership status or other changes that affect the premium payment.			
7.5.1.11	Generate on-line and hard-copy balancing and control reports for specific programs as defined by ODJFS.			
7.5.1.12	Create and update rates on-line for effective dates as specified by program area.			
7.5.1.13	Case mix adjust based on claims data (both FFS and encounter data).			
7.5.1.14	Accept payments (EFT, inter-agency transfer payments, Warrants) from other entities.			
7.5.1.15	Generate additional care management program payments (e.g., delivery payments) from encounter data.			
7.5.1.16	Allow simultaneous membership in more than one care management program.			
7.5.1.17	Provide for review and oversight of mass rate changes after implementation.			
7.5.1.18	Generate a report identifying when retroactive rates changes have been initiated.			
7.5.1.19	Calculate and remit or recoup premium payments due to membership changes.			
<b>7.6</b>	<b>Encounter Data</b>			
7.6.1	Requirements			

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7.6.1.1	Accept encounter data, on-line or in batch form, in ANSI X 12 837 format or other ODJFS-defined format			
7.6.1.2	Accept encounter data daily.			
7.6.1.3	Edit encounter data against specific encounter edits using ODJFS-defined edit policies.			
7.6.1.4	Process encounter data and produce EDI 835 or unsolicited 277 or ODJFS defined error report per ODJFS specifications.			
7.6.1.5	Identify encounters by type of benefit package (e.g., waivers, care management programs, etc).			
7.6.1.6	Accept on a daily basis encounter data from Medicare Pharmacy benefit managers for eligible Medicaid consumers whose pharmacy coverage is through Medicare.			
7.6.1.7	Identify encounters by program (e.g., EPSDT).			
7.6.1.8	Assign category of service like FFS claims.			
7.6.1.9	Provide encounter data submission testing capabilities for care management plans as requested by ODJFS.			
7.6.1.10	Allow on-line modification to edits/audits as dictated by policy with a detailed audit trail.			
7.6.1.11	Provide the capability to update edits/audits in reference file.			
7.6.1.12	Utilize national code sets and update when changes are made to national code sets such as HCPCS, ICD-9 diagnosis and revenue service codes per benefit package.			
7.6.1.13	Identify encounter data versus FFS claims and maintain data for reporting purposes.			
7.6.1.14	Identify and store denied encounter data.			
7.6.1.15	Automate encounter data to SAS file formats.			
7.6.1.16	Trigger payments or recoupments for carved-out services (e.g., delivery payments) based on codes in the encounter or adjustment data, as designated by ODJFS.			
7.6.1.17	Generate an audit trail that identifies the specific encounter that triggered payment.			
7.6.1.18	Identify and generate an alert to specified State personnel for on-line encounter claims with TPL indicator requiring review.			
7.6.1.19	Generate a summary report that identifies changes being made to adjusted premium payments including codes for rejected encounter data.			
7.6.1.20	Produce and forward to specified ODJFS personnel a daily summary of encounter data mass revision submissions identifying data element changes.			
7.6.1.21	Maintain a complete history of encounter data and subsequent revisions thereto.			
7.6.1.22	Price encounter data based on FFS rates.			
7.6.1.23	Capture care management payments and denials by encounter and line item.			

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**Transactions, Claims, and Encounters**

<b>Req Number</b>	<b>Requirement</b>	<b>MITS Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
<b>7.7</b>	<b>Alternative Delivery System Model</b>			
7.7.1	Requirements			
7.7.1.1	Input and process PROGRAM specific financial and program eligibility information for PROGRAM program participation including the capability for different budgets for community and institutional living arrangements.			
7.7.1.2	Track the status of PROGRAM program applications from initial referral through approval/denial, including hearings and decisions, if applicable.			
7.7.1.3	Generate alerts to appropriate parties at each PROGRAM application decision point.			
7.7.1.4	Provide PROGRAM sites and other users approved by the State the ability to access PROGRAM financial and program eligibility data in accordance with ODJFS security rules.			
7.7.1.5	Provide on-line capability to capture and track data required for the determination of PROGRAM program eligibility.			
7.7.1.6	Provide the system capability to recommend level of care based on ODJFS-defined criteria and comparison to data regarding the individual diagnoses, functional ability to perform Activities of Daily Living (ADLs), IADLS, medication administration, treatments, etc. on assessment/level of care forms.			
7.7.1.7	Allow State specified staff to override the automated level of care recommendation.			
7.7.1.8	Capture and store data from PROGRAM sites including assessment data, level of care form, level of care plan, referral form, withdrawal form, enrollment agreement, and other forms as identified by the State.			
7.7.1.9	Generate alerts to staff that identifies case/applicant ready for program eligibility review.			
7.7.1.10	Provide on-line approval/denial of program eligibility.			
7.7.1.11	Generate alert if applicant is enrolled in other Medicaid programs.			
7.7.1.12	Generate alerts to appropriate staff identifying PROGRAM program participants that are due for annual review.			
7.7.1.13	Provide an on-line capability to modify re-determination dates and eligibility spans including initial and follow-up.			
7.7.1.14	Easily accommodate changes to re-determination period as defined by ODJFS.			
7.7.1.15	Capture both effective and begin dates for PROGRAM program.			
7.7.1.16	Provide the capability to accommodate partial month enrollment.			
7.7.1.17	Provide automated interfaces with Department of Aging and/or other sub-recipient State agencies as determined by ODJFS.			
7.7.1.18	Provide on-line role-based access to county and other users as determined by ODJFS.			
7.7.1.19	Provide on-line role-based access to enrollment agreement.			

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**Transactions, Claims, and Encounters**

<b>Req Number</b>	<b>Requirement</b>	<b>MITS Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
7.7.1.20	Maintain seven years of on-line history of PROGRAM program data as defined by ODJFS.			
7.7.1.21	Provide on-line notifications to PROGRAM site of approved enrollment agreement.			
7.7.1.22	Generate and distribute enrollment agreement and/or notification letters to participants and/or their guardians and/or authorized representatives.			
7.7.1.23	Generate and distribute ODJFS-defined denial of PROGRAM eligibility letters, including rights to fair hearings, to applicants and/or their guardians and/or authorized representatives.			
7.7.1.24	Generate notices to State defined staff of any PROGRAM eligibility denials.			
7.7.1.25	Provide the capability to request on-line dis-enrollment functionality.			
7.7.1.26	Provide on-line capability to complete and track PROGRAM financial eligibility data.			
7.7.1.27	Automatically close the PROGRAM referral and notify appropriate parties if the applicant chooses not to enroll.			
7.7.1.28	Track hearings, date of hearing, issues and outcomes, and linkage to hearing documents for PROGRAM program.			
7.7.1.29	Provide the capability to defer enrollment to a future date as determined by the State when participant is hospitalized in the effective date of the enrollment.			
7.7.1.30	Provide capability to re-establish eligibility spans using ODJFS defined criteria and automatically notify appropriate parties.			
7.7.1.31	Provide capability to pend an application for the consumer based on ODJFS defined-rules.			
7.7.1.32	Capture data through the use of a Programmable Digital Assistant (PDA) and the capability to upload that data to the system.			
7.7.1.33	Support acceptance of electronically submitted physical signatures.			
7.7.1.34	Generate and distribute PROGRAM program related reports including: <ul style="list-style-type: none"> <li>• Length of stay</li> <li>• Enrollment/dis-enrollment</li> <li>• Census data by PROGRAM site</li> <li>• In home versus institutional care</li> <li>• Processing times</li> <li>• Reasons for dis-enrollment.</li> </ul>			
7.7.1.35	Capture and track individual participant decisions regarding PROGRAM program enrollment and/or dis-enrollment.			
7.7.1.36	Capture and track individual PROGRAM participant enrollment in Medicare Part A and Part B and all necessary capitation fees and co-pays.			

**MITS Business Requirement "Functional Fit" Survey**

**Transactions, Claims, and Encounters**

<b>Req Number</b>	<b>Requirement</b>	<b>MITS Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
7.7.1.37	Identify and track PROGRAM participants by program (e.g., Medicaid, Medicare, Dual Eligible, or Private Pay).			
7.7.1.38	Provide for on-line completion of PROGRAM referral form 2398 by the CDJFS, the PROGRAM site, and other entities as specified by the State.			
7.7.1.39	Generate/send the referral to CDJFS and/or the PROGRAM site and notify the State Administering Agency (SAA) that the referral was made.			
7.7.1.40	Provide on-line access to referral form containing data elements specified by the ODJFS and form completion capability for State staff and other entities as specified by ODJFS.			
7.7.1.41	Identify PROGRAM participants and the date spans during which they are enrolled in PROGRAM to allow payment of claims only to the PROGRAM site and to prevent Medicaid payment to any other Medicaid providers during such periods of PROGRAM enrollment.			
7.7.1.42	Prevent payment of PROGRAM capitation payments (under either FFS claims or managed care monthly lump sum payment mechanism) to providers that are not approved PROGRAM sites or are not the specific PROGRAM site at which the individual is enrolled as a participant.			
7.7.1.43	Recognize attempts at enrollment to/from mutually exclusive benefit packages (e.g., HCBS waiver, accessing card services from providers other than PROGRAM site, NF vendor payments, etc) to prevent simultaneous enrollment/participations in mutually exclusive benefit packages, and alert the affected entities or program areas as identified by ODJFS.			
7.7.1.44	Recognize when a PROGRAM participant change of address is to an out-of-service location and alert the SAA, PROGRAM site, CDJFS caseworker, and/or other entity as specified by ODJFS.			
7.7.1.45	Provide capability to pay more than one rate per PROGRAM site/provider number when specified by ODJFS (e.g., Medicaid only and Medicaid/Medicare dual eligible PROGRAM rates based on the participant's eligibility status).			
7.7.1.46	Capture and record PROGRAM program eligibility for both Medicaid and non-Medicaid participants and only allow payment for those participants who are Medicaid eligible.			

**MTS Business Requirement "Functional Fit" Survey**

**Transactions, Claims, and Encounters**

Req Number	Requirement	MTS Phase (1 or 2)	Response Code	Page Ref
7.7.1.47	Ensure that PROGRAM sites are paid the appropriate rate based on both the Medicare and Medicaid eligibility status of the individual during the dates the participant is enrolled in PROGRAM (e.g., if a PROGRAM site bills the Medicaid-only rate for someone who is dually eligible for Medicare/Medicaid it would not pay but would notify the PROGRAM site that the wrong rate was billed and direct the site to either provide evidence that the person did not have Medicare coverage or resubmit a corrected claim in which the dually eligible rate was billed for the participant).			
7.7.1.48	Adjudicate claims to pay the appropriate PROGRAM capitation rate for the individual's eligibility status (e.g., Medicaid-only or Medicare/Medicaid dually eligible) minus the individual's patient liability amount, if applicable, to prevent overpayments to PROGRAM sites.			
7.7.1.49	Accept the PROGRAM site name/address as the participants mailing address for purposes of receiving the individual's Medicaid card in addition to the participant's actual residence address.			
7.7.1.50	Track outcomes of referrals, including voluntary withdrawals from the PROGRAM application process following completion of a 2398 form.			
7.7.1.51	Provide on-line access to PROGRAM site's staff/applications for completion of forms (e.g., voluntary withdrawal of PROGRAM application form) with electronic signature capability.			
7.7.1.52	Provide for on-line submission, routing, processing and provision of notice to parties as specified by ODJFS (e.g., CDJF caseworker/PROGRAM coordinator, SAA, PROGRAM site, when applicants voluntarily withdraw their applications).			
7.7.1.53	Provide the capability to receive on-line submission of PROGRAM applications including sufficient notes and comments space for explanations.			
7.7.1.54	Provide the capability to direct submitted application forms to appropriate worker at appropriate agency pursuant to criteria determined by ODJFS.			

**MIT S Business Requirement "Functional Fit" Survey**

**Quality Management**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
<b>8.1</b>	<b>Provider Performance Management</b>			
8.1.1	Requirements			
8.1.1.1	Provide near real-time role-based HIPAA compliant access (updated in accordance with other business requirements) to electronic files via the Medicaid Portal or other access channels. This access should be made available to medical service providers, other care manager professionals, and OHP staff, as permitted under State and Federal law using security protocols. Only information that is determined necessary to support informed, high-quality care management and best clinical practice in regard to the care provided to Medicaid consumers will be available. The system may need to provide access to service information at a stage in claims processing that precedes the claim's final adjudication and payment of the claim.			
8.1.1.2	Develop a Quality Management application for OHP to access and display the following information: <ul style="list-style-type: none"> <li>• Service information</li> <li>• Pharmacy benefit system (if separate)</li> <li>• Encounter data</li> <li>• Eligibility data</li> <li>• Demographic data</li> <li>• Census data</li> <li>• Provider information</li> <li>• Geographic location information</li> <li>• Benefits packages associated with various programs</li> <li>• Electronic medical records</li> <li>• Individualized waiver service plans</li> <li>• Reports of major unusual incidents</li> <li>• State Immunization Registry</li> <li>• Clinical studies and recommendations</li> <li>• Lead poisoning database</li> <li>• Quality reviews</li> <li>• Information from other stand alone systems including:                             <ul style="list-style-type: none"> <li>o data warehouse/DSS</li> <li>o Pegasus</li> <li>o Perseus</li> <li>o Consumer satisfaction survey data, etc.</li> </ul> </li> </ul>			

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**Quality Management**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
8.1.1.3	<p>8.1.1.3 Phase 2 - Monitor, measure, and compare the performance of individual medical service providers and care manager professionals, and comparisons of managed health care plans to variable pre-established standards of care for Medicaid consumers with particular diagnostic or demographic characteristics. This monitoring/comparison should be able to be aggregated according to specified reporting dimensions (e.g. county, MCPs, etc.). Standards of care should include:</p> <ul style="list-style-type: none"> <li>• Considerations of the types of medical services</li> <li>• Health Plan Employer Data and Information Set (HEDIS), HEDIS-like, or other performance measures as defined by the state</li> <li>• Timeliness of specific medical services</li> <li>• Sequence of specific medical services</li> <li>• Venues through which particular medical services are provided</li> <li>• Other patterns of patient care and medical treatment or modalities, or outcomes.</li> </ul>			
8.1.1.4	<p>Phase 2 - Produce monthly (at a minimum) a provider scorecard or report card, as defined by ODJFS, that calculates and presents provider information associated with specific performance measures, including:</p> <ul style="list-style-type: none"> <li>• Utilization measures</li> <li>• Quality of care measures</li> <li>• Comparisons across peer groups and relative to norms</li> <li>• Comparisons of performance over time</li> <li>• Outlier identification</li> <li>• Comparisons to strategic targets</li> <li>• Information examples include lead testing rates, immunization rates, emergency department visits, and inpatient length of stay analysis.</li> </ul>			
8.1.1.5	<p>Phase 2 - Allow role-based access to information that includes clinical, utilization, financial and outcome based information in clear formats, with user-friendly query development, with flexible reporting capabilities, including fields and categories that can be selected on an ad hoc basis.</p>			
8.1.1.6	<p>Automate an alert system to be sent directly to medical care providers, care managers, Medicaid consumers, Medicaid Managed Care Plans and/or OHP staff, as authorized. Alerts will be generated based upon considerations of the types of medical services (e.g., diabetes exams, hospitalization), the timeliness of specific medical services (e.g., Healthchek exams, lead screening test), or the sequence of specific medical services (e.g., immunizations, pap smears).</p>			

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**Quality Management**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
8.1.1.7	Include in the alert information the medical care that has been provided, medical care that may need to be provided, or in regard to other medical events, as defined by ODJFS, that are determined to be relevant to the quality or coordination of care provided to particular Medicaid consumers.			
8.1.1.8	<p>Ability for the system to generate timely alerts based upon the following criteria:</p> <ul style="list-style-type: none"> <li>• Through the Medicaid Portal, automated telephone calls, and/or automatically generated and mailed hardcopy correspondence or delivery mechanisms as defined by ODJFS</li> <li>• Directly to medical care providers, care managers, Medicaid consumers, and/or OHP staff, as authorized</li> <li>• Relative to pre-established variable standards of medical care for consumers with particular diagnostic or demographic characteristics</li> <li>• To warn medical care providers, care manager professionals, Medicaid consumers, or OHP staff, as authorized, when the medical care that has been provided is determined by studies of clinical outcomes or the input provided to OHP by medical professionals, to potentially create adverse medical conditions or to otherwise increase the health risks of Medicaid consumers</li> <li>• In which “timely” is defined by ODJFS in terms of the timeframes within which particular alerts need to be issued in order to have a probable positive impact on the quality or coordination of care provided to Medicaid consumers</li> <li>• In which “automated” infers devices that trigger alerts, on a variable rule defined basis, when information indicating that a particular service has been rendered or that a medical event as defined by ODJFS has occurred, or when other pre-defined situations are determined to exist or to have occurred by an algorithmic analytical capacity that exists in data warehouse/DSS, in an enhanced Medicaid claims processing system, or elsewhere.</li> </ul>			
8.1.1.9	Phase 2 - Provide flexibility in MITS components to support pay for performance.			
8.1.1.10	<p>Phase 2 - Interface with claims pricing to prompt payment adjustment (increase/decrease) for specific services paid to individual providers and care manager professionals based on their performance relative to variable pre-established standards of care for Medicaid consumers with particular diagnostic or demographic characteristics. Standards of care should include:</p> <ul style="list-style-type: none"> <li>• Considerations of the types of medical services</li> <li>• Timeliness of specific medical services, the sequence of specific medical services</li> <li>• Venues through which particular medical services are provided</li> </ul>			

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**Quality Management**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>Other patterns of patient care and medical treatment or modalities.</li> </ul>			
8.1.1.11	Phase 2 - Support the benefits and service administration business process to allow the potential of “rule-based” flexibility to manage incentive programs within provider groups (e.g., allow staff to view the top ten percent of providers within a certain category) and automatically assign or remove an incentive payment bonus to the reimbursement rate for a set period of time.			
8.1.1.12	<p>Phase 2 - Generate and display, through Medicaid Portal and other media, provider scorecards and/or other particular provider performance information based on criteria as defined by ODJFS. This report/scorecard will provide a complete picture of individual providers including:</p> <ul style="list-style-type: none"> <li>Information that clarifies their participation in various provider groups and practices</li> <li>Services they provide or are qualified to provide</li> <li>Their occurrence in various Medicaid groupings of provider types, specialization, or other qualifications</li> <li>All tax ID, provider numbers, and provider names under which they bill for Medicaid services, etc.</li> </ul>			
8.1.1.13	Automate interfaces with external public and private health care data sources (e.g., State Immunization Registry, Census information, lead poisoning database, and sub-recipient State agencies) to allow access to data that can be used to improve the quality or coordination of care provided to Medicaid consumers.			
8.1.1.14	<p>Interface with MITS, data warehouse/DSS component to perform algorithmic and other analytical capability to analyze claims and/or multiple data sources in order to identify; A) individual or classes of Medicaid consumers or B) individual or classes of Medicaid providers to include the following:</p> <ul style="list-style-type: none"> <li>Patterns of treatment and diagnosis</li> <li>Relationships among peer providers or providers and consumers correlations</li> <li>Consumers’ age or gender</li> <li>Types or costs of services delivered.</li> </ul>			
8.1.1.15	Phase 2 - Through mechanisms as defined by ODJFS define, initiate, and track surveys of consumers and others in order to gather and generate performance information on individual or groupings of providers.			
8.1.1.16	Phase 2 - Interface with MITS data warehouse/DSS component to generate provider profile reports using on-line selection of providers from an exception report and have the ability to do monthly aggregations of the data on units of service by provider type and category of service.			

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**Quality Management**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
8.1.1.17	Provide consolidation of health care information and services across all providers.			
<b>8.2</b>	<b>Quality Assurance</b>			
8.2.1	Requirements			
8.2.1.1	Phase 2 - Analyze multiple data sources to include eligibility files and encounter/claims data to identify clinical and non-clinical areas of health care that need improvement. Examples of these areas are: <ul style="list-style-type: none"> <li>• Asthma</li> <li>• Diabetes</li> <li>• Acute Myocardial Infarction (AMI)</li> <li>• Childhood immunization</li> <li>• Blood lead screening</li> <li>• Mental health services</li> <li>• Pap tests.</li> </ul>			
8.2.1.2	Phase 2 - Produce quality and outcome review data, such as Health Plan Employer Data and Information Set (HEDIS) and other clinical performance measures as specified by ODJFS.			
8.2.1.3	Phase 2 - Through mechanisms as defined by ODJFS initiate and track surveys of Medicaid consumers and others in order to gather and generate performance information on individual or groupings of providers.			
8.2.1.4	Phase 2 - Provide the flexibility to easily change the parameters that drive the performance measurement process.			
8.2.1.5	Phase 2 - Provide on-line role-based access to encounter/claims and eligibility data for vendors identified by ODJFS to generate samples for studies/surveys.			
8.2.1.6	Phase 2 - Perform a data import function to integrate and analyze data in various types of file formats such as Access, Excel, Text, Paradox, and Dbase external sources that are transmitted from external sources such as vendors and sub-recipient State agencies to ODJFS.			
8.2.1.7	Phase 2 - Link to Medicaid consumer level data from quality studies to service providers.			
8.2.1.8	Phase 2 - Capture data extracted from medical record reviews to evaluate services provided to Medicaid consumers.			
8.2.1.9	Phase 2 - Generate reports and analytical finds for ODJFS staff on managed care plans, providers, county programs and other external stakeholders by addressing the following areas, at a minimum: <ul style="list-style-type: none"> <li>• Complex analysis and reporting of health care utilization and expenditure patterns and trends primarily using health care claims data</li> <li>• Performance of specialized studies of access, quality, use and/or cost of health care</li> </ul>			

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**Quality Management**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Comparative analysis and profiling of health care providers, including the profiling of the clinical and financial performance of health care providers</li> <li>• Complex clinically oriented analysis and reporting of access to and quality of health care</li> <li>• Detection, analysis, and reporting of patterns and trends in access, quality, use and cost of health care</li> <li>• Analysis of merged or multiple data sources (e.g. public health, lead data, immunization registration data).</li> </ul>			
<b>8.3</b>	<b>Consumer Health and Safety</b>			
8.3.1	Requirements			
8.3.1.1	Provide the capability to interface, accept, retain, track, analyze and report on incidents and provider occurrences that occur within ODJFS-administered Medicaid programs (e.g. Ohio Home Care Waiver), using Consumer and Provider Occurrence Report Tracking System (C-PORTS) as the functional model.			
8.3.1.2	Convert data from C-PORTS to the applicable MITS component.			
8.3.1.3	Interface MITS components with any other ODJFS or external incident reporting systems (e.g. ODMR/DD's Major Unusual Incidence (MUI) database) as identified by ODJFS.			
8.3.1.4	Allow provider and/or care manager to complete on-line incident report.			
8.3.1.5	Generate notice of deficiencies or correction action plans to the provider.			
8.3.1.6	Issue timely alerts to medical care providers, care managers or OHP staff in regard to reports of health and safety related to incidents (e.g. e-mail, hardcopy letter).			
8.3.1.7	Accept and track information associated with health and safety related incidents reported by providers, field review staff, consumers, and/or other entities identified by ODJFS.			
8.3.1.8	Generate reports on health and safety incidents and related information by data such as provider or by Medicaid consumers.			
8.3.1.9	Perform waiver (or other) program field (i.e., remote) data gathering / transmission functions via hand held wireless technology, systems or other mechanisms as identified by ODJFS.			
<b>8.4</b>	<b>Consumer Satisfaction</b>			
8.4.1	Requirements			
8.4.1.1	Phase 2 - Generate a sampling frame or other types of a random sample, related to the eligible population and benefit package for the consumer satisfaction survey as specified by ODJFS. Provide flexibility to change the sampling frame used in analysis such as the eligible population and benefit package for the consumer satisfaction survey.			

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**Quality Management**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
8.4.1.2	Phase 2 - Import and accept survey data from multiple sources (e.g., External Quality Review Organization (EQRO) vendor, sub-recipient State agencies) via multiple media types such as CDs, Medicaid Portal, wireless technology, systems, or other mechanisms as identified by ODJFS.			
8.4.1.3	Phase 2 - Link survey data to the consumer and provider for use by OHP staff.			
8.4.1.4	Phase 2 - Send and store survey response data in data warehouse/DSS.			
8.4.1.5	Phase 2 - Interface with external data sources as defined by ODJFS, such as National Committee for Quality Assurance (NCQA) database.			
8.4.1.6	Phase 2 - Produce quality management reporting related to the interaction and timely response to consumer contact (as defined by ODJFS).			
8.4.1.7	Phase 2 - Perform waiver (or other) program field (i.e., remote) data gathering / transmission functions via hand held wireless technology, systems or other mechanisms as identified by ODJFS.			
8.4.1.8	Phase 2 - Trigger, at a minimum, customer satisfaction surveys automatically based on ODJFS specified criteria within 6 months of waiver program enrollment.			
8.4.1.9	Phase 2 - Provide flexible parameter setting functionality to determine the frequency of various activities including: <ul style="list-style-type: none"> <li>• Surveys</li> <li>• Reports.</li> </ul>			
<b>8.5</b>	<b>Provider Satisfaction</b>			
8.5.1	Requirements			
8.5.1.1	Phase 2- Generate a “sample frame”, or random sample, related to the specified provider population for the provider satisfaction survey, as specified by ODJFS every six months.			
8.5.1.2	Phase 2 - Import and accept survey data from multiple sources (e.g., External Quality Review Organization (EQRO) vendor and sub-recipient State agencies) via multiple media types such as CDs, Medicaid web portal, and wireless technology.			
8.5.1.3	Phase 2 - Link survey data to consumer and provider for use by OHP staff.			
8.5.1.4	Phase 2 - Send and store survey response data in the Decision Support System.			
8.5.1.5	Phase 2 - Interface with external data sources as identified by ODJFS (e.g. NCQA database, sub-recipient State agencies).			
8.5.1.6	Phase 2 - Produce quality management reporting related to the interaction and timely response to provide contact as defined by ODJFS.			

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**Quality Management**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
8.5.1.7	Phase 2 - Perform waiver (or other) program field (i.e., remote) data gathering / transmission functions via hand held wireless technology, systems or other mechanisms as identified by ODJFS.			
8.5.1.8	Phase 2 - Trigger, at a minimum, provider satisfaction surveys automatically based on ODJFS specified criteria within six months of waiver program enrollment.			
8.5.1.9	Phase 2 - Provide flexible parameter setting functionality to determine the frequency of various activities including: <ul style="list-style-type: none"> <li>• Surveys</li> <li>• Reports.</li> </ul>			
<b>8.6</b>	<b>Case Management</b>			
8.6.1	Requirements			
8.6.1.1	Provide the capability to accept, retain, track, analyze, and report on case management related quality of care and quality performance data in the aggregate, as well as at the individual case level.			
8.6.1.2	Accommodate varying needs of case management initiatives and programs and other ODJFS-administered community-based and institutional case management initiatives. Criteria and types of data will include: <ul style="list-style-type: none"> <li>• Identification/screening results</li> <li>• Assessment results</li> <li>• Treatment/service plan development status</li> <li>• Level of intensity of services</li> <li>• CMS quality standards and initiatives Accept case management data and interface with internal (e.g. CRIS-E, MITS) and external sources and in a variety of mediums, including data acceptance via the Medicaid Portal.</li> </ul>			
8.6.1.3	Link case management performance data to the claims processing system (and/or other external interfaces, as defined by ODJFS) for purposes of monitoring and enforcing established case management contract expectations or performance standards including expectations, standards, or measures related to: <ul style="list-style-type: none"> <li>• Return on Investment</li> <li>• Cost effectiveness of care</li> <li>• Other performance expectations.</li> </ul>			
8.6.1.4	Generate case management reports by program, service, or provider in pre-established formats and on a flexible ad hoc basis.			
8.6.1.5	Provide variable role-based access to case management data for case managers. Information should include the following: claims data, historical case, claims, and enrollment data, eligibility information, benefit packages, case notes, case activity codes, and incident and provider occurrence reports. Case Managers can be defined as any of the following: <ul style="list-style-type: none"> <li>• ODJFS staff</li> </ul>			

**MITS Business Requirement "Functional Fit" Survey**

**Quality Management**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Nurses</li> <li>• Sub-recipient State agencies</li> <li>• Contractors</li> <li>• Social workers</li> <li>• Primacy care providers</li> <li>• Other entities as defined by ODJFS.</li> </ul>			
8.6.1.6	Accept, retain and maintain financial information associated with variable, pre-established budget caps or spending limits associated with individual cases that are being case managed. This should include the capability to allow ongoing and immediate entry of and adjustments to this financial information by designated ODJFS staff.			
8.6.1.7	Automatically flag and send alerts to designated case managers or OHP staff, as designated, when the actual or expected cost of claims for services provided to individual Medicaid consumers exceed interim limits or caps, as defined by ODJFS.			
8.6.1.8	Generate pre-defined data extracts and send the selected case management information (e.g., claims data and demographic information) to authorized entities at established intervals and/or upon request.			
8.6.1.9	Provide variable role-based capability to view electronic files of case management reports and other case management information from computer desktops in pre-established formats and on an ad hoc basis.			

**MTS Business Requirement "Functional Fit" Survey**

**Business Intelligence**

Req Number	Requirement	MTS Phase (1 or 2)	Response Code	Page Ref
<b>9.1</b>	<b>External Reporting (Operational)</b>			
9.1.1	Clinical Reporting Requirements			
	Blood Testing Reporting			
9.1.1.1	Interface with other systems to generate Blood Testing Reporting results as specified by ODJFS.			
	Clinical Based Outcome Data Reporting			
9.1.1.2	Report on data/information including preventive health indicators and screenings of waiver consumers.			
9.1.1.3	Report on information including deaths & causes, vital statistics, and have the ability to identify cases of suspicious deaths.			
9.1.1.4	Report on waiver outcomes on County Medical Systems participant			
9.1.1.5	Track EPSDT referrals.			
	Disease Patient Registry			
9.1.1.6	Include a Disease Patient Registry where the end user can easily extract consumer information with specific condition for targeted case management activities as specified by ODJFS in a secure role-based access environment.			
	Immunization Reporting			
9.1.1.7	Provide the flexibility to interface (including receiving, storing and sending information) with immunization statistics and information/data regarding waiver consumers.			
9.1.1.8	Interface (including receiving, storing, and sending information/data) directly related to Minimum Data Sets (MDS). Information and data needed includes: <ul style="list-style-type: none"> <li>• MDS summary data</li> <li>• Case mix calculations and reports</li> <li>• Policy updates</li> <li>• MDS reporting information by providers and reports.</li> </ul>			
9.1.2	Federal/State/Other Agencies Reporting			
	Federal Reporting			
9.1.2.1	Provide information to support Federal reporting requirements including: <ul style="list-style-type: none"> <li>• CMS 64 report to identify recovery efforts</li> <li>• CMS 372 Cost Neutrality Assessment for Waivers</li> <li>• CMS 416 (Healthchek Report)</li> <li>• Medicaid Statistical Information System data reports.</li> </ul>			
9.1.2.2	Compile and aggregate the necessary data for ODJFS and Federal Healthchek and EPSDT reporting including the CMS 416 report that uses both fee-for-service and encounter data.			
9.1.2.3	Generate the Medicaid Statistical Information System (MSIS) Data (formerly CMS-2082) according to CMS media requirements and timeframes and submit a copy to ODJFS on specified media for review and filing.			
	County Department of Job and Family Services Reporting (CDJFS)			

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**Business Intelligence**

<b>Req Number</b>	<b>Requirement</b>	<b>MTS Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
9.1.2.4	Support the reporting needs of the counties and county boards including direct reporting interfaces with other sub-recipient State agencies including Mental Retardation and Developmental Disabilities (MR/DD), Department of Aging, etc.			
9.1.2.5	Provide a method to track and report on incident tracking, Medicaid services and quality assurance processes.			
9.1.2.6	Provide enhanced on-line, web-based reporting capabilities to CDJFS based upon a role-based security system.			
9.1.2.7	Provide the capability for CDJFS to generate external reports through the Medicaid Portal.			
<b>Other State Agencies Reporting</b>				
9.1.2.8	Provide a direct secure interface to other survey information as identified by ODJFS such as Quality Assurance (QA) survey data (e.g., authorized & provider-reported services) and to other agencies (e.g., Ohio Department of Health Outcome and Assessment Information Set (OASIS) data).			
9.1.3	<b>Medicaid Reporting</b>			
<b>External Contractors/Partners Reporting</b>				
9.1.3.1	Provide flexible reporting tools via the Medicaid Portal that interface directly to individual single providers, including: <ul style="list-style-type: none"> <li>• Reports to home care agencies for benchmarking across Agencies</li> <li>• Reports to waiver case managers of independent providers</li> <li>• Agency provider caseloads, services &amp; reimbursements.</li> </ul>			
<b>Contractors/Partners Reporting</b>				
9.1.3.2	Provide business contractors/partners on-line access through the Medicaid Portal to reports as specified by ODJFS including: <ul style="list-style-type: none"> <li>• Non-Claim business provider process information reporting</li> <li>• Cost report trends</li> <li>• Contract monitoring for waiver consumers.</li> </ul>			
<b>Managed Care Plans (MCPs)</b>				
9.1.3.3	Interface directly with all MCPs and be able to provide on-line, web-based reporting information and data that includes: <ul style="list-style-type: none"> <li>• Care management membership and premium payment reports</li> <li>• Performance measurement reports</li> <li>• MCP progress reports</li> <li>• Ad hoc reports as developed by ODJFS</li> <li>• Capability to convert MCP files to specified formats.</li> </ul>			
9.1.3.4	Provide to MCPs the capability to access fee-for-service claims data utilization reports for their members as defined by ODJFS.			
9.1.3.5	Capability to report on-line aggregate and summary data and store information on benefit packages.			
<b>9.2</b>	<b>Operational/Administrative – Cost/Benefit Reporting</b>			
9.2.1	Business Intelligence Support For Financial Reporting			

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**Business Intelligence**

<b>Req Number</b>	<b>Requirement</b>	<b>MTS Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
<b>Financial and Budget Reporting</b>				
9.2.1.1	Provide a tool for use in financial and budget reporting, including: <ul style="list-style-type: none"> <li>• Cost report trends</li> <li>• Rate to cost analyses</li> <li>• near real-time checking of budgets by Case Management</li> <li>• Budget development for waiver applications and renewals</li> <li>• Premium payment reports by Managed Care plans.</li> </ul>			
9.2.1.2	Interface with authorized services to coordinate claims payment.			
9.2.1.3	Provide automatic alerts that are easily programmed by end users, to case managers if cost limit approached/exceeded.			
9.2.1.4	Provide trend reports of types and quantities of services authorized, such as: <ul style="list-style-type: none"> <li>• Detailed financial transaction registers</li> <li>• Disbursement account control reports</li> <li>• Recoupment by amount and time period for providers</li> <li>• Aged accounts receivable, with flags on those that have no activity within a State-specified period of time.</li> </ul>			
9.2.1.5	Report on costing information for LTC facilities, MCPs, and all other institutional providers.			
9.2.1.6	Generate 20 reports to identify various types of recoupment and collections, for example including fraud and abuse recoupment, account receivable collections, estate and casualty recovery cases, TPL, insurance collections, or other categories, as defined by ODJFS.			
9.2.1.7	Report COB activities that impact management reporting including cost avoidance amounts, insurance post payment billing and collection, copays and insurance premiums. This coordination includes history-only adjustments, gross adjustments, and mass adjustments.			
<b>Claims Monitoring Reporting</b>				
9.2.1.8	Provide data, including reports, on a real-time basis to include: <ul style="list-style-type: none"> <li>• Claims paid for State-funded programs</li> <li>• Claims &amp; payments after each payment cycle</li> <li>• Finalized input into weekly claims payment cycle</li> <li>• Claims withheld from payment processing</li> <li>• Specially-handled or manually-processed claims</li> <li>• Monthly adjudicated claims file</li> <li>• Paid &amp; denied claims</li> <li>• Summary report by adjustment and/or reason code</li> <li>• Direct bill reporting</li> <li>• Combined Provider Adjudication Order (CPAO)</li> <li>• Trends &amp; analyses of expenditure patterns</li> </ul>			

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**Business Intelligence**

<b>Req Number</b>	<b>Requirement</b>	<b>MITS Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
	<ul style="list-style-type: none"> <li>• Analyses of budget variances</li> <li>• Generation of Federal cost neutrality reports for waivers.</li> <li>▪ Lag factors between date of service and date of payment based on expenditures to determine cash flow trends.</li> </ul>			
<b>Contract Monitoring Reporting</b>				
9.2.1.9	Receive, store and provide reporting capabilities for Ohio Department of Health (and other sub-recipient State agencies) survey and certification data.			
9.2.1.10	Provide information on cumulative data sets requiring periodic reports from waiver contractors for example, benefit plans.			
<b>Provider Measurement Reporting</b>				
9.2.1.11	Generate report of billing lags and processing time statistics by provider categories.			
9.2.1.12	Generate claims processing summary reports that report expenditures by claim type, edit failures, percent of denials, and "input media".			
<b>Consumer Measurement Reporting</b>				
9.2.1.13	Generate reports identifying claims paid under both Medicaid and State-funded programs when a client has switched program eligibility to monitor payment under the proper program.			
9.2.2	<b>Business Intelligence Support for Clinical Reporting</b>			
<b>Case Management Reporting</b>				
9.2.2.1	Electronically provide community resource manuals in an on-line format that is easily accessible to case managers and consumers.			
9.2.2.2	Generate clinical paths for tracking treatments versus clinical guidelines based upon claim data.			
<b>Breast &amp; Cervical Cancer Program (BCCP) Reporting</b>				
9.2.2.3	Provide reporting to track and report on BCCP hearings and BCCP hearing results.			
<b>Clinical Based Outcome Reporting</b>				
9.2.2.4	Provide Identification and notification to case managers of multi-pharmacy abuse by consumers or providers.			
9.2.2.5	Report on death certificates to consumers for identification of suspicious deaths.			
<b>Disease / Patient Registry (including Well Care)</b>				
9.2.2.6	Provide reports to allow case managers to review preventative assessments for consumers, managed care plans and their providers regarding care needed by members.			
<b>Incident Tracking Reporting</b>				
9.2.2.7	Ability to report on data relating to ocmplaints and incidents.			
9.2.2.8	Summarize and provide trend analyses regarding incident tracking and resolution outcomes.			
9.2.2.9	Report on provider incident profiles, including termination of providers.			

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**Business Intelligence**

Req Number	Requirement	MTS Phase (1 or 2)	Response Code	Page Ref
9.2.2.10	Generate Notification of Death and Cease and Desist letters.			
9.2.2.11	Provide report cards and reports of provider sanctions, including automatic alerts to end-users.			
<b>Provider Measurement Reporting</b>				
9.2.2.12	Provide reporting feedback to providers and ODJFS including: <ul style="list-style-type: none"> <li>• LTC Beds Reporting</li> <li>• MDS based audit risk analysis</li> <li>• Maintenance of approved agency/provider type lists for waiver consumers</li>   <li>• Checking of provider licensures and Bureau of Criminal Investigation (BCI) status</li> <li>• Identification of high reimbursement providers and those with “surges” in reimbursements</li> <li>• Tracking of investigation/audit of outliers</li> <li>• Linkage of provider investigative work to that by AG and provider licensure boards</li> <li>• Monitoring of provider turnover for consumers.</li> </ul>			
<b>Waiver Monitoring Reporting</b>				
9.2.2.13	Provide reporting for quality assurance administration.			
9.2.2.14	Report movement of consumers in and out of waiver programs and to report on waiver trends.			
9.2.2.15	Provide performance measure reporting capability.			
<b>9.3</b>	<b>Program Analysis and Development</b>			
9.3.1	<b>MTS Support of General DSS Capabilities</b>			
9.3.1.1	Integrate with the warehouse/DSS, which is based on a singular database and technical platform, which supports waiver program planning and evaluation, financial reporting, medical policy development, utilization management, eligibility analysis, actuarial rate setting, managerial-level program performance measurement, fraud and abuse detection and investigation, and a variety of other Medicaid healthcare reporting as defined by ODJFS.			
9.3.1.2	Interoperate with the warehouse/DSS data model which is based on a Medicaid-proven and expandable design concept that is specialized for on-line analytical processing.			
9.3.1.3	Supply data to the warehouse/DSS which integrates data from the following sources into a single analytically-ready database that supports rapid and efficient population-based reporting across all systems and programs including: <ul style="list-style-type: none"> <li>• Multiple eligibility systems</li> <li>• Capitation systems</li> <li>• Claims systems (paid and denied claims, as well as claim adjustments in bulk and in detail)</li> <li>• Managed care encounter data</li> </ul>			

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**Business Intelligence**

Req Number	Requirement	MITS Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Carve-out contractors, such as pharmacy benefit managers, behavioral health plans, chip contractors</li> <li>• Prior-authorization data</li> </ul>			
9.3.1.4	Supply data to the warehouse/DSS to support features such as the Medstat Episode Grouper (MEG) or other Episode Grouper, CMS DRG, Diagnostic Cost Grouper (DxCG).			
9.3.1.5	Supply data to the warehouse/DSS to support its true drill-down capabilities that enable a user to drill-down to the lowest level of detail.			

**MIT S Business Requirement "Functional Fit" Survey**

**Program Integrity**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
<b>10.1</b>	<b>Provider Utilization Management/Fraud Waste and Abuse Prevention (FWAP)</b>			
10.1.1	Profiling and Claims Analysis			
10.1.1.1	Interface and interoperate with the data warehouse/DSS.			
10.1.1.2	Maintain up-to-date clinical summaries for consumers including diagnosis and services information. (Interface with the data warehouse/DSS)			
10.1.1.3	Analyze, identify, report, and alert on hit-and-run provider schemes and spike billings as defined by ODJFS. For example, these schemes involve a significant or sudden high volume of submitted claims by an individual or group of providers compared to their previous claim activity or to their peers for a given time period. (Interface with the data warehouse/DSS)			
10.1.1.4	Associate individual providers with their practice affiliation, such as a group practice or MCP. (Interface with the data warehouse/DSS)			
10.1.1.5	Cross-reference all provider ID numbers, including NPIs as identified by CMS, to a single ID number (e.g., individual provider numbers for their group practice affiliation(s)), track a single provider ID across various sub-recipient State agencies, and report selectively and collectively on provider utilization.			
10.1.1.6	Associate services furnished in a clinic setting to both the clinic and servicing provider.			
10.1.1.7	Where appropriate, integrate near real-time algorithms into MITS to detect aberrant billing patterns and/or other anomalies while claims are being processed.			
10.1.2	Communication, Tracking, and Alerts			
10.1.2.1	Track report and information request deadlines and generate alerts to appropriate staff when deadlines are past due.			
10.1.2.2	Provide role-based access to enter complaints and referrals from outside parties and agencies about consumers or providers into the on-line tracking system for fraud and abuse investigations, and track dispute resolutions and referrals.			
10.1.2.3	Link provider enrollment with the payment system to automatically generate a message when an amount is due because of an audit or review finding.			
10.1.2.4	Generate an alert to the appropriate staff/business area when it is required to place a provider's claims payment on "hold and review" status.			
10.1.2.5	Provide the capability to track and document compliance with the applicable Federal regulations for specific time periods to be defined by ODJFS and produce compliance reports, both summary and detailed, to include the number and percentage of: <ul style="list-style-type: none"> <li>• Cases referred and to which agency the referral</li> <li>• Full scope reviews conducted</li> <li>• Cases on "hold and review" status</li> </ul>			

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**Program Integrity**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Other parameters as defined by ODJFS.</li> </ul>			
10.1.2.6	<p>Develop and maintain an automated case tracking and alert system as defined by ODJFS to accommodate internal and external program integrity audit-related data and activities including:</p> <ul style="list-style-type: none"> <li>• Audit time period</li> <li>• Initiating agency</li> <li>• Reason for audit</li> <li>• Providers placed on a hold and review status, the reason for hold and review status, and dates of hold and review.</li> <li>• Outcomes including monetary recoveries</li> <li>• Required actions and alerts, such as to re-review alerts, education activities</li> <li>• Tracking of the repayment activities including the date of overpayment discovery, amount of overpayment, and amount of recovered overpayment.</li> <li>• Chronology of significant case activity, such as date of opening letter sent to the provider; dates of phone calls to providers; dates of records/information received by the provider</li> <li>• Significant case documentation, such as case findings and recommendations; exception code key; summary of exceptions; and phone memos</li> <li>• Listing of case contacts</li> <li>• Electronic storage of the supporting documents for the case review including significant case documentation as defined by the ODJFS and records received from the providers.</li> </ul>			
10.1.3	<b>Support for Payment Error Rate Measurement (PERM) System</b>			
10.1.3.1	Comply with Federal (CMS) requirements in support of PERM.			
10.1.3.2	<p>In compliance with CMS quarterly claims sample frequency requirements, send the required data to the Statistical Contractor (SC) according to the claims extract approach using CMS-approved formats, media, and security procedures. Only claims that have not been adjusted during the quarter are to be included. The required fields are:</p> <ul style="list-style-type: none"> <li>• Unique claim identifier</li> <li>• Date of payment</li> <li>• Paid amount (\$0 for denied claims)</li> <li>• Provider type or similar variable</li> <li>• Strata assignment (1 through 8) or MSIS category.</li> </ul>			
10.1.3.3	<p>Receive the file of sample claims selected by the SC (including the fields submitted in the claims extract) and send to the SC for each claim (or claim line) in the list of samples, the claim history and all other supporting information including the sample claim itself and any adjustments made within 60 days of the original paid date. For each claim or adjustment, the following information is required:</p>			

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**Program Integrity**

Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Unique claim identifier (Identification Claim Number or other State-assigned number)</li> <li>• Strata assignment (1 through 8) or MSIS category</li> <li>• Dates for original payment, adjustments, and for denials, adjudication</li> <li>• Provider type or similar variable</li>   <li>• Patient information (e.g., name, date of birth, gender, program enrollment indicators impacting claim processing rules, eligibility information including spend-down indicator, if applicable)</li> <li>• Provider number and name for both billing provider and servicing provider</li>   <li>• Provider specialty of both billing provider and servicing provider</li> <li>• Servicing provider address</li> <li>• Servicing provider phone number</li> <li>• Claim type</li> <li>• All diagnosis codes</li> <li>• DRG code, if applicable</li> <li>• Service from date</li> <li>• Service to date</li> <li>• Prior authorization</li> <li>• Place of service</li> <li>• Number of line items</li> <li>• Procedure codes (CPT, HCPCS, etc.) and units of service for all line items associated with the claim</li> <li>• ype of service</li> <li>• Include at both the line item and claim levels, if applicable:                             <ul style="list-style-type: none"> <li>o Submitted charge</li> <li>o Allowed charge</li> <li>o Third party liability information</li> <li>o Patient co-payment responsibility</li> <li>o Paid amount (\$0 for denied claims).</li> </ul> </li> </ul>			
<b>10.2</b>	<b>Consumer Utilization Management/FWAP</b>			
10.2.1	Requirements			
10.2.1.1	Identify the specific PACT exception criteria for each Medicaid consumer that has been identified for potential PACT participation.			
10.2.1.2	Implement and maintain an automated tracking system to accommodate PACT data and activities including: <ul style="list-style-type: none"> <li>• PACT category (e.g., physician, drug, etc.)</li> <li>• Medicaid provider number</li>   <li>• PACT primary care physician name, address and telephone number</li> <li>• Pact pharmacy, address, and telephone number</li> <li>• PACT starting and end dates</li> </ul>			

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Req Number	Requirement	Phase (1 or 2)	Response Code	Page Ref
	<ul style="list-style-type: none"> <li>• Appeals and status</li> <li>• Hearings, date of hearing, issues and outcomes, and linkage to hearing documents for the PACT program.</li> <li>• Letters to providers</li> <li>• Letters to PACT Medicaid consumers</li> <li>• Note taking functionality.</li> </ul>			
10.2.1.3	Generate the following PACT related letters to consumers and providers including: <ul style="list-style-type: none"> <li>• Notice of enrollment to consumers</li> <li>• Welcome letter and designated provider form to provider</li> <li>• State hearing and appeals information to consumer</li> <li>• Primary care physician name, address, selected pharmacy name and address</li> <li>• Additional brochures, newsletters, fact sheets, and other PACT related materials.</li> </ul>			
10.2.1.4	Automate correspondence to the provider and/or consumer via the CRM and EDMS systems.			
10.2.1.5	Image documentation and correspondence from consumers and providers regarding the PACT program.			
10.2.1.6	Provide on-line role-based access to information including: <ul style="list-style-type: none"> <li>• PACT data and imaged documentation</li> <li>• Consumer information, such as hospitalizations, LTC facility, pharmacy, PA information, State Plan services</li> <li>• Provider information, such as outpatient services, waiver services by type, waiver services by provider and by consumer</li> <li>• Waiver services by procedure code</li> <li>• Waiver services by day.</li> </ul>			
10.2.1.7	Generate automatic alerts to appropriate PACT staff. Alerts are identified by ODJFS and include: <ul style="list-style-type: none"> <li>• Notification of pending review</li> <li>• State hearings</li> <li>• 9- and 18-month report due dates for consumer reviews.</li> </ul>			
10.2.1.8	Identify and view on-line all Medicaid consumers currently restricted to PACT for the month, and new PACT consumers, applying all changes to reflect updates made during the month as directed by ODJFS.			
10.2.1.9	Send PACT consumer enrollment information to the eligibility system to drive PACT card issuance.			
10.2.1.10	Generate an automatic notification to the appropriate staff when the Medicaid card is issued for consumers identified as PACT consumers. Include in this notification, the name of the consumer and the type of card that was generated.			
10.2.1.11	Pay case management fees on a monthly basis to primary care physicians who serve PACT consumers. See the claims adjudication sub-process for managed care payments.			

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<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
10.2.1.12	Identify conflicting and complementary services by consumer during the same time period (i.e., nursing facility stays and waiver services billed simultaneously).			
10.2.1.13	Maintain a history of actions, edits, and changes made to a PACT consumer profile and the staff person who made the changes. Actions, edits, and changes including: re-opening a PACT case; release of a PACT consumer; change in PACT primary care provider or pharmacy.			
<b>10.3</b>	<b>Retrospective Drug Utilization Review (DUR)</b>			
10.3.1	Requirements			
10.3.1.1	Generate, track, acknowledge, and archive letters, including responses from providers. Letters should include provider name, date mailed, and findings.			
10.3.1.2	Track and notify providers of: <ul style="list-style-type: none"> <li>• The need to respond to letters sent according to a time period defined by ODJFS</li> <li>• Review dates</li> <li>• Re-review dates.</li> </ul>			
10.3.1.3	Image, access, archive and maintain incoming correspondence utilizing electronic document management system technology.			
10.3.1.4	Refer providers to appropriate licensing board using criteria to be defined by ODJFS.			
10.3.1.5	Develop a tickler file with all DUR reviews and alert ODJFS staff when reviews are due. Tickler file criteria and time intervals of re-views will be defined by ODJFS.			
<b>10.4</b>	<b>Sub-recipient State Agency Reviews</b>			
10.4.1	Requirements			
10.4.1.1	Identify the following information for contracts including: <ul style="list-style-type: none"> <li>• Catalog of Federal Domestic Assistance (CFDA) Number</li> <li>• Vendor vs. sub-recipient State agency</li> <li>• Fiscal year for vendor and sub-recipient State agency.</li> </ul>			
10.4.1.2	Match period expenditures to inter-agency agreement amounts.			
10.4.1.3	Generate a report identifying vendor vs. sub-recipient State agency and a report of all sub-recipient State agencies.			
10.4.1.4	Generate accounts payable information to track status of sanctions.			
10.4.1.5	Track original amount owed, settled amounts and recouped funds, and once paid.			
10.4.1.6	Generate reports on expenditures by sub-recipient State agency, by program.			
10.4.1.7	Generate and create letters to sub-recipient State agencies.			
10.4.1.8	Identify whether an A-133 audit report was required (based upon expenditure information received from MITS, \$500,000 or more in known expenditures) and if the report was received.			

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**Program Integrity**

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10.4.1.9	Generate a report that identifies exceptions on single audits and notifies designated staff as defined by ODJFS.			
10.4.1.10	Track the status of issues/exceptions (Cost Allocation Plan (CAP), Sanctions) and report to designated ODJFS staff including: <ul style="list-style-type: none"> <li>• Audited entity</li> <li>• Time period audited</li> <li>• Status of issues/exceptions</li> <li>• Disposition of issues/exceptions</li> <li>• Date of and amounts remitted to the State of: <ul style="list-style-type: none"> <li>o Initial finding</li> <li>o Adjudicated amount</li> <li>o Actual amount collected.</li> </ul> </li> </ul>			
10.4.1.11	Generate a report on services authorized vs. services received.			
10.4.1.12	Generate reports based upon ODJFS specified date parameters (e.g., dates needed for audit rather than set time periods).			
10.4.1.13	Report on claims that were not paid to utilize in completing a risk assessment for the providers to determine who to audit in a given time period			
10.4.1.14	Capture proposed cost adjustments and alert program staff of proposed cost adjustments.			
10.4.1.15	Notify ODJFS of final settlement amount.			
10.4.1.16	Generate an A-133 report with Medicaid funding listed by sub-recipient State agencies and potentially by county, by CFDA number, and by discrete entity.			
<b>10.5</b>	<b>Provider State Hearing Rights</b>			
10.5.1	Requirements			
10.5.1.1	Provide case management tracking capabilities / functionality that tracks case activity related audits and reviews completed by internal and external entities on behalf of Medicaid.			
10.5.1.2	Provide complaint identification tracking.			
10.5.1.3	Generate Report of Examination (ROE) documentation.			
10.5.1.4	Distribute case and ROE documentation in a format that cannot be altered by the notification recipient.			
10.5.1.5	Provide flexible status and activity reporting, as defined by ODJFS including: <ul style="list-style-type: none"> <li>• Process status</li> <li>• Adjudication results/amounts</li> <li>• Date ROE is issued</li> <li>• Universe dollar amount</li> <li>• Finding amounts</li> <li>• Dollars set for recoveries</li> <li>• Actual recoveries.</li> </ul>			
10.5.1.6	Generate alerts to ODJFS from the Office of Fiscal Services when a provider defaults on repayment.			

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10.5.1.7	Update provider history and provider profiles with audit/review findings as defined by ODJFS.			
10.5.1.8	Track the collection of repayments by providers, either timed payments or lump sum payments.			
10.5.1.9	Accept, retain and track report findings from: <ul style="list-style-type: none"> <li>• Auditor of State</li> <li>• Hospital reviews</li> <li>• SURS.</li> </ul>			
10.5.1.10	Track and report on reviews performed by ODJFS and provide results to outside entities as defined by ODJFS.			
10.5.1.11	Track cases referred to law enforcement (e.g., Medicaid Fraud Control Unit from the Attorney General, local / State law enforcement, etc.).			
10.5.1.12	Accept, retain and track Hospital Submissions for Appeals.			
10.5.1.13	Alert ODJFS when appeals are received from peer review organizations.			
10.5.1.14	Produce on-line performance reports related to pre-admission review based on ODJFS defined criteria.			
10.5.1.15	Track outside legal proceedings and decisions in a format as defined by ODJFS.			

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**Privacy and Security**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
<b>11.1</b>	<b>Privacy Requests Management</b>			
11.1.1	Requirements			
11.1.1.1	Provide functionality to receive, log, track and report on individual requests related to PHI.			
11.1.1.2	<p>Track the following data pertaining to the management of PHI requests:</p> <ul style="list-style-type: none"> <li>• Consumer identification numbers, including: Medicaid Billing Number, Social Security Number, and CRIS-E/BEN Number</li> <li>• Consumer demographic data</li> <li>• Accounting for disclosures of PHI – including when released, for what purpose, and to whom</li> <li>• Restrictions requested by the consumer and what actions ODJFS has taken</li> <li>• Individual or personal representative (what was used as proof – legal needs a scanned copy if they are making the call; caseworkers sometimes make call w/o documentation and load into eligibility systems) requesting the data</li> <li>• Consumer requests for corrections to PHI data and the action taken</li> <li>• Consumer objections to PHI data if changes were not made</li> <li>• Authorizations for releases of data other than payment, treatment or healthcare operations</li> <li>• Complaints and dispositions</li> <li>• A record of the PHI that was requested</li> <li>• The date the request was received</li> <li>• The date the response was generated</li> <li>• The detailed information that was provided</li> <li>• How the request came in (e.g., Consumer Hotline, Legislature, or P.O. Box).</li> </ul>			
11.1.1.3	Automatically populate PHI screen or window with demographic data and previous disclosure requests and the request dispositions.			
11.1.1.4	Pull personal representative data from the eligibility system (currently CRIS-E and FACSIS).			
11.1.1.5	<p>Provide ability to perform ad hoc queries to obtain PHI data. Example search fields include:</p> <ul style="list-style-type: none"> <li>• Dates of service</li> <li>• Provider name</li> <li>• HCPCS codes</li> </ul> <p>• Search results would populate the PHI data fields in the PHI screen.</p>			
11.1.1.6	Automatically generate response letters to the requestor.			
11.1.1.7	Provide the capability for the user to choose from multiple form letters and customize them as needed.			
11.1.1.8	Retain an archived copy of letters that are sent out.			

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**Privacy and Security**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
11.1.1.9	Generate on-line canned and ad hoc reports on privacy related activity. Examples include: • Number of complaints filed • Disposition of complaints.			
11.1.1.10	Allow the use of alternate mailing address to send PHI, upon individual request, as approved and directed by the State.			
11.1.1.11	Continue to interface with the eligibility systems (currently CRIS-E and SACWIS) to obtain privacy-related consumer eligibility data.			
11.1.1.12	Track and process written correspondence from individuals exercising their right to access information under the privacy rule.			
11.1.1.13	Respond to an individual's request for a copy of their PHI, as directed by ODJFS.			
11.1.1.14	Maintain a record of restrictions, per individual request, on certain uses and disclosures of PHI, as approved and directed by ODJFS.			
11.1.1.15	Track and provide an accounting of anyone who sent and/or received PHI relating to an individual. .			
11.1.1.16	Interface electronically with other systems which contain PHI.			
11.1.1.17	Log and track PHI requests and responses wherever they occur in MITS or other Medicaid processes.			
<b>11.2</b>	<b>Security Management</b>			
11.2.1	Requirements			
11.2.1.1	MIT'S must interface with an Identity Management System - An enterprise wide security system designed to help entities to simplify, strengthen, and track access to information across an organization's digital assets and physical infrastructure.			
11.2.1.2	MIT'S must seamlessly integrate with the Single Sign On (SSO) solution within ODJFS.			
11.2.1.3	Ensure that all applications operate in accordance with all State and Federal security rules including the final and amended rules adopted under HIPAA for security and privacy incorporating appropriate National Institute of Standards and Technology (NIST) and International Standards Organization (ISO) standards.			
11.2.1.4	Access roles should be defined at the individual data element.			
11.2.1.5	Utilize the primary security tool (Identity Management System) implemented with Novell's eDirectory as a single identity vault for security protocols and access control.			
11.2.1.6	Requests for access must come from an authoritative source(s) as defined by ODJFS.			
11.2.1.7	Support on-line, near real-time updating of security information if this functionality is not included in the Identity Management System.			

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**Privacy and Security**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
11.2.1.8	Provide ad hoc reporting capabilities that can correlate security metrics such as profile e.g. user id/number), privileges (e.g. role based), environment (e.g. test/development), last successful login, failed logins. and password resets.			
11.2.1.9	Protect all systems from anticipated threats or hazards to data and restrict the availability of data to appropriate State staff or other designated individuals and organizations through standardized system applications and data security capabilities.			
11.2.1.10	Implement and maintain a secure environment for both on-line and batch access to State data through the use of a fully functional and documented security software package.			
11.2.1.11	Provide three types of controls to maintain the integrity, availability, and confidentiality of PHI data contained within the system: These controls shall be in place at all appropriate points of processing.  <ul style="list-style-type: none"> <li>• Preventive Controls: Controls designed to prevent errors and unauthorized events from occurring</li> <li>• Detective Controls: Controls designed to identify errors and unauthorized transactions which have occurred in the system</li> <li>• Corrective Controls: Controls to ensure that the problems identified by the detective controls are corrected.</li> </ul>			
11.2.1.12	Ensure various levels of security within MITS on-line applications including the following features: <ul style="list-style-type: none"> <li>• Unique log-on for each user</li> <li>• Required passwords that will expire on a staggered schedule and that can be reset at any time by appropriate personnel and/or automated system reset</li> <li>• Restriction of application and/or function within an application through role-based security. Role assignments are used to determine which user categories have permission to access which application and/or function within an application.</li> <li>• Audit trails of all updates to the security system (add/change/delete) by log-on ID (or batch update identifier), date and time of the change, and source of entry (workstation ID), including all attempted updates.</li> </ul>			
11.2.1.13	Access control to all data and to the applications software; the system shall employ a security system that restricts access to varying hierarchical levels of data, including functions, screens and individual data fields; the security system must restrict access to data on a “minimum necessary” basis and restrict functions based on an individual user profile, including inquiry only capabilities; global access to all functions must be restricted to specified staff.			

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**Privacy and Security**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
11.2.1.14	Maintain a list of users and their security profiles, if this functionality is not included in the State’s Identity Management System, including updating security files with State approved additions of new staff, changes to existing security profiles and be able to support audits of security profiles against currently approved roles as required by the State.			
11.2.1.15	Automatically remove individual security profile upon notification of termination, but save profile for archival purposes.			
11.2.1.16	Ensure that all applications comply and are compatible with existing State and Federal guidelines preventing unauthorized access.			
11.2.1.17	Prohibit display of passwords on the sign-on screen when entered by the user.			
11.2.1.18	Log and report all unauthorized access attempts by terminal ID, user ID, date, and time.			
11.2.1.19	Log a user off a system if there is no activity within a 30 minute period of time.			
11.2.1.20	Terminate access if there is no activity on a user account within ninety (90) days, or other period designated by ODJFS.			
11.2.1.21	Immediately disable access to any user or user group after a predetermined number of attempts to log-on.			
11.2.1.22	Follow ODJFS guidelines for the restriction of override capabilities of the Identity Management System.			
11.2.1.23	Implement audit trails to allow information on source documents to be traced through the processing stages to the point where the information is finally recorded.			
11.2.1.24	Trace data from the final place of recording back to its source of entry. Audit trail functionality must include Medicaid Portal, IVR system, CRM system, listings, transactions reports, update reports, transaction logs, error logs, downloads, and file transfers.			
11.2.1.25	Ensure that the integrity and confidentiality of consumer and all other data is protected by safeguards to assure that information is not released without proper consent.			
11.2.1.26	Comply with the HIPAA-mandated Accounting for Disclosures requirements.			
11.2.1.27	Identify the source of any request to add, change, or delete data on the system.			
11.2.1.28	Amend the data and associate a note with that amendment as required by the HIPAA Privacy Amendment requirement.			
11.2.1.29	Ensure all application design, development, and implementation and operations are in accordance with State and Federal regulations and guidelines related to security, confidentiality, and auditing.			

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**Privacy and Security**

<b>Req Number</b>	<b>Requirement</b>	<b>Phase (1 or 2)</b>	<b>Response Code</b>	<b>Page Ref</b>
11.2.1.30	Provide for the same hierarchical password protection, as well as a system-inherent mechanism for recording any change to a software module or subsystem. The contractor shall propose procedures for safeguarding ODJFS from unauthorized modifications to the MITS.			
11.2.1.31	Generate and distribute all ODJFS-defined security reports.			
11.2.1.32	Anticipate and provide a flexible solution that is positioned to effectively meet the requirements of current and future HIPAA security regulations.			
11.2.1.33	Include a notification matrix that will escalate notification of security issues, including breaches and attempted breaches, to the ODJFS chief security official and others as designated.			