

Solution Requirements Deliverable

For

Reverse Extract Reporting Requirements



February 2015

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Introduction

The Solution Requirements Deliverable document outlines the required elements for reporting claims and client eligibility information from external Board Level Claims Adjudication systems for non-Medicaid claims data, which includes (1) Non-Medicaid payable services for Medicaid eligible clients and (2) Medicaid and non-Medicaid payable services for non-Medicaid eligible clients.

This deliverable consolidates the following work products, which are listed in order of completion:

- Solution Overview
- Functional Requirements
- Non-Functional Requirements
- Out of Scope

The Solution Overview

High-Level Description

Board Level Claims Adjudication systems are being adopted by varying Boards as they replace their business process dependency upon MACSIS with proprietary systems. However, the reporting requirement to the federal government and other grant entities is still mandated in the Ohio Revised Code, requiring these proprietary systems to provide data for reporting. The State of Ohio will continue to coordinate, organize and submit reporting in order to maintain and promote grant funding for mental health and drug addiction treatment programs in the State of Ohio through a reverse extract process. Now instead of MHAS distributing claims data files to the Boards adopting the new systems, the data will be sent by the board, in a similar format, described below, to MHAS.

Feature List

ID	Feature Text
Feat 1	A Reverse Extract Member Eligibility file will be sent to MHAS
Feat 2	A Reverse Extract Claims file will be sent to MHAS
Feat 3	MHAS reporting will be maintained
Feat 4	Records with required fields that are missing or in error will be rejected
Feat 5	Control files will be sent to MHAS for all file submissions
Feat 6	With the implementation of ICD-10, there likely will be more specific pairing between diagnosis codes and procedure codes, i.e., certain procedure codes go with certain diagnosis codes.

Definitions

Term	Definition
BAA	Business Associate Agreement – An agreement that is negotiated with terms as to how data sharing and integrity will be practiced
MHAS	Ohio Mental Health and Addiction Services

Assumptions and Dependencies

Assumptions are future situations, beyond the control of the project, whose outcomes influence the success of a project. An example would be the availability of a hardware/software platform, developments in technology, or pending legislation. Dependencies are relationships between the Application for which these Business Requirements are written and the other existing applications/systems.

Requirement Assumptions

ID	Requirement Assumptions	Comments
RA1	Ohio Mental Health and Addiction Services Boards will continue to have access to state SFTP servers	
RA2	Reverse extract data will be submitted directly by each Board to MHAS, not a third party	
RA3	Boards will continue to submit data through MACSIS, as it is currently done, until a full conversion by a board to their new Board Level Adjudication system	
RA4	New file feeds will reflect cleanly adjudicated, final pay claims, only. This data will exclude reversals.	The intent of this assumption is that boards will send data only on claims that are finalized.
RA5	Data will be for non-Medicaid data only, including (1) non-Medicaid payable services for Medicaid eligible clients and (2) Medicaid and non-Medicaid payable services for non-Medicaid eligible clients.	
RA6	All data submissions are covered by a BAA	
RA7	All data submissions will occur by SFTP	
RA8	For the current usage of the Reverse Extract, the payment taxonomy for the system will be to use (existing) MACSIS codes.	<p>Future near term will use agreed upon (Agency, Boards and OMHAS) expanded Taxonomy.</p> <p>It is intended that future discussions, with all stakeholders, will be undertaken to determine the desirability/feasibility of Board Level Claims Adjudication systems generating a pre-approved set of billable service codes that boards will use to make payments.</p>
RA9	OMHAS will verify claim and member data vs. internal data warehouse/database	

Requirement Dependencies

ID	Requirement Dependencies	Comments
RD1		
RD2		

Functional Requirements

Reverse Member Eligibility Extract File Requirements

ID	Functional Requirements for Phase 1 Electronic Report	Comments
FR1.0	A Reverse Extract Member Eligibility file will be sent to MHAS	
FR1.1	File will be sent through existing SFTP process. The specific directory is to be established for each board's feed.	
FR1.2	Race Codes (Field 16 in Appendix B)	See Appendix G for translation
FR1.3	Gender Codes (Field 11 in Appendix B)	See Appendix H for translation
FR1.4	Ethnicity Codes (Field 17 in Appendix B)	See Appendix F for translation
FR1.5	Marital Status Codes (Field 13 in Appendix B)	See Appendix E for translation
FR1.6	Language Codes (Field 15 in Appendix B)	See Appendix D for translation
FR1.7	This requirement left blank	
FR1.8		Requirement intentionally blank
FR1.9	Data contained in the file will reflect all data through Midnight of each Friday	Data after the cutoff will be reported on a subsequent file submission. It is understood that the data may not be sent to OMHAS until the following Monday morning, although it can be accepted over the weekend.
FR1.10	Each weekly data file will be a complete reload of all data accumulated by the Board	
FR1.11	A Reverse Claims Extract file must be sent with each Reverse Member Eligibility Extract file	
FR1.12	The file will be a tilde delimited format, with carriage return and line feed as line delimiter listed in Appendix B	
FR1.13	Those fields highlighted in orange are required to be submitted to the State of Ohio.	

ID	Functional Requirements for Phase 1 Electronic Report	Comments
FR1.14	Green highlighted fields are required, but dependent upon other fields in the extract or dependent upon data available for only certain clients.	
FR1.15	All data will be non-Medicaid data except as noted.	Data will be for non-Medicaid data only, including (1) non-Medicaid payable services for Medicaid eligible clients and (2) Medicaid and non-Medicaid payable services for non-Medicaid eligible clients.

Reverse Claims Extract File Requirements

ID	Functional Requirements for Phase 1 Electronic Report	Comments
FR2.0	A Reverse Claims Extract file will be sent to MHAS	
FR2.1	File will be sent through existing SFTP process, the specific directory to be established for each board feed set up	
FR2.2	Race Code (Field 87 in Appendix A)	See Appendix G for translation
FR2.3	Gender Codes (Field 98 in Appendix A)	See Appendix H for translation
FR2.4	Ethnicity Codes (Field 88 in Appendix A)	See Appendix F for translation
FR2.5		Requirement intentionally blank
FR2.6		Requirement intentionally blank
FR2.7	<p>Procedure Codes that Require Diagnosis 1 code to be populated (See Field 26 (procedure) in Appendix A ; Field 13 (Diagnosis) in Appendix A)</p> <p>If there is a different procedure code than listed in Appendix C, a diagnostic code must be still provided if available.</p>	<p>See Appendix C for translation</p> <p>Note: The procedure codes requiring at least one diagnosis code (in the diagnosis 1 position). This is the list currently effective in MACSIS that requires diagnosis 1.</p>
FR2.8	Data contained in the file will reflect all data through Midnight of each Friday	Data after the cutoff will be reported on a subsequent file submission. It is understood that the data may not be sent to OMHAS until the following Monday morning, although it can be accepted over the weekend.
FR2.9	Each weekly data file will be a complete reload of all data accumulated by the Board	
FR2.10		Requirement intentionally blank
FR2.11	A matching Reverse Member Eligibility Extract file must be sent with the Reverse Claims Extract file	
FR2.12	The file will be a tilde delimited format, with carriage return and line feed as line delimiter listed in Appendix A	

ID	Functional Requirements for Phase 1 Electronic Report	Comments
FR2.13	Those fields highlighted in orange are required to be submitted to the State of Ohio.	
FR2.14	Those fields highlighted in green are required fields that have additional information that should be reviewed prior to submission to the State of Ohio.	
FR2.15	All data will be non-Medicaid data	Data will be for non-Medicaid data only, including (1) non-Medicaid payable services for Medicaid eligible clients and (2) Medicaid and non-Medicaid payable services for non-Medicaid eligible clients.

Reporting

ID	Requirement Dependencies	Comments
FR3.0	MHAS will test and ensure that all existing reporting will function as expected	
FR3.1	MHAS will consider data warehouse design concepts to anticipate potential future reporting needs	This may be considered in a future enhancement
FR3.2	MHAS will consider reporting that will enhance board metric comparisons, where desired by the board, for reported data	This may be considered in a future enhancement
FR3.3	MHAS will confirm that data files sent by MHAS to other governmental agencies, match/balance with data transmitted to MHAS from the boards	
FR3.4		

Error Processing

ID	Requirement Dependencies	Comments
FR4.0	Records with required fields that are missing or in error will be rejected	
FR4.1	A reject error file of error'ed records will be sent back to the submitting board for correction and resubmission on the next file submission date	
FR4.2	Reject error messages will be clear about the fields in error and what is needed to correct them	All errors detected for the record will be returned to the Board
FR4.3	Rejected records will not be entered to the data warehouse.	
FR4.4	Notification of errors will be provided by an email to the Board. The Board can then log into their directory to pick up the error file. A link to the file will be contained in the email for ease of use. The email will list total records processed, and total rejected records.	A List Serve from the Board must be submitted by the board and updates sent to OMHAS for OMHAS to maintain this functionality.
FR4.5	Notification of file acceptance will also be emailed to the Board. The email will list total records processed.	A List Serve from the Board must be submitted by the board and updates sent to OMHAS for OMHAS to maintain this functionality.
FR4.6	The reject file format will be the entire record submitted to MHAS, followed by the character "F", With 30 character error messages for each reject reason. Each message will follow the next until all errors are reported. The file will be in tilde delimited format.	
FR4.7	MHAS will retain each weekly error reject file	
FR4.8	The reject file naming convention is Board Identification (3 characters), A 2 character system ID – (01 = Gosh, 02 = Shares), a file type (98 = Reject) , and a one character identifier for split boards (1=ADA, 2 = MH, 3= for Dual boards)	
FR4.9	MHAS will create an error file each week with the same file name, replacing the previous week's error file, and then distribute it to the submitting board. MHAS will keep a running log of the errors and statistics.	

File Processing

ID	Requirement Dependencies	Comments
FR5.0	Control files will be sent to MHAS for all file submissions	
FR5.1	Each submission of Reverse Extract Claims file will also require a separate control file indicating Total Number of Records, Total Billed Amount, Total Allowed Amount, and Total Net Amount for verification purposes	
FR5.2	Each submission of Reverse Extract Member Eligibility file will also require a separate control file indicating Total number of Records	
FR5.3	The file naming convention is Board Identification (3 characters), A 2 character system ID – (01 = Gosh, 02 = Shares), a file type (01=Claim, 02 = Member, 99 = Control), and a one character identifier for split boards (1=ADA, 2 = MH, 3=for Dual boards)	Some Boards are split, but report under the same board id. i.e.: 09A/09M reports under 09B
FR5.4	Notification of file acceptance will also be emailed to the Board. The email will list total records processed.	A List Serve from the Board must be submitted by the board and updates sent to OMHAS for OMHAS to maintain this functionality.
FR5.5		

Diagnostic Codes

ID	Requirement Dependencies	Comments
FR6.0	With the implementation of ICD-10, there likely will be more specific pairing between diagnosis codes and procedure codes, i.e., certain procedure codes go with certain diagnosis codes.	
FR6.1	The MHAS system and Board systems will be designed to seamlessly process diagnostic codes with the final implementation of ICD10 by the federal government.	
FR6.2	All captured diagnosis codes are required to be submitted to OMHAS. Additionally, code 999.996 for ICD-9 and 999.9996 for ICD-10 must be coded when a diagnosis is not available or not applicable.	This is an ICD 9 and ICD 10 requirement
FR6.3		
FR6.4		
FR6.5		

Non Functional Requirements

ID	Non-Functional Requirements	Comments
NF01	OIS will retain all weekly files for up to 18 months after a state fiscal year ends	
NF02	All final files will be archived and retained for a period of 10 years	
NF03	MHAS will ensure that all reporting functions are fully recoverable, in the event of a disaster scenario or business interruption, within a 30 day window.	
NF04	MHAS will take steps to ensure data security and integrity for all transmissions, archives, reporting, and database interactions	
NF05	MHAS will require that Board data interactions comply with transmission standards	
NF06	MHAS will send a return email message to the Board describing the number of records received and the dollar amount of all transactions from a transmitted file	The email message will ask the board to contact us immediately if the record count or dollar total varies from their understanding
NF07	MHAS will accept replacement files for error'ed transmission files upon written request	Email is sufficient
NF08		

Out of Scope for This Initiative

ID	Out of Scope	Notes
OOS01	Medicaid Data will not be accepted except as noted.	Data will be for non-Medicaid data only, including (1) non-Medicaid payable services for Medicaid eligible clients and (2) Medicaid and non-Medicaid payable services for non-Medicaid eligible clients.
OOS02	Only adjudicated, paid, non-reversal claims transaction data will be accepted	
OOS03	MACSIS changes and updates	

Appendix A: Claims Extract File Layout

updated 4/10/2014

Fld #	Expanded Field Name / Description	Field Type	Extract (SAS) Field Name	Diamond Source File	Field Length	Additional Information
1	Name of the Provider	Text	N_PROV	Created	15	
k2	Name of the Vendor	Text	N_VEND	Created	15	
3					05	Filler
4	Claim Primary Date	Date/Time	CPDATE	Header	08	Formatted - YYYYMMDD
5	Claim Number	Text	CLAIMNO	Header & Detail	16	
6	Subscriber Number (UCI)	Text	SUBNO	Header	12	If do not have UCI, then use the source system Client ID (Field #16) in this field.
						Note: Item 6 will enable us to identify clients more easily if there is no UCI available, by using provider's assigned client id.
7	Group on the Claim Header	Text	CGROUP	Header	10	
8	Plan on the Claim Header	Text	CPLAN	Header	10	
9					03	Filler
10	Panel	Text	PANEL	Header	03	
11	Provider Number, UPID	Number	PROVNO	Header	12	Please use official UPI, if not available, use Medicaid NPI, if not available, use LACTS License
12	Vendor Number	Number	VENDOR	Header	15	
13	Diagnosis 1	Text	DIAG1	Header	08	Required when service requires Diagnosis.
14	Diagnosis 2	Text	DIAG2	Header	08	
15	Diagnosis 3	Text	DIAG3	Header	08	
16					15	Filler
17					09	Filler
18					01	Filler
19	Creation Time Stamp	Date/Time	CACDT	Header	8	Formatted - YYYYMMDD
20					03	Filler
21					12	Filler
22					03	Filler
23	Line Number	Text	LINENO	Detail	03	
24				Detail	01	Filler
25	Service Date	Date/Time	SERVDATE	Detail	08	Formatted - YYYYMMDD
26	Procedure Code	Text	PROCCODE	Detail	08	See Appendix C

27	Procedure Modifier	Text	PROCMOD	Detail	02	
28	Quantity (6.1 field size)	Number	QUANTITY	Detail	06	
29	Billed Amount (11.2)	Currency	BILLAMT	Detail	11	
30	Allowed Amount (11.2)	Currency	ALLOWED	Detail	11	
31	Not Covered Amount (11.2)	Currency	NOTCOV	Detail	11	
32	Co-Pay Amount (11.2)	Currency	COPAY	Detail	11	
33	Deductible Amount (11.2)	Currency	DEDUCT	Detail	11	
34	Other Carrier Amount (11.2)	Currency	OTHCAMT	Detail	11	
35	Withhold Amount (11.2)	Currency	WITHHOLD	Detail	11	
36	Net Amount (11.2)	Currency	NETAMT	Detail	11	
37	Not Covered Reason Code	Text	NOTCOVR	Detail	05	
38	Co-Pay Reason Code	Text	COPAYR	Detail	05	
39	Deductible Code	Text	DEDUCTR	Detail	05	
40	Adjustment Reason Code	Text	ADJUSTR	Detail	05	
41	Allowed Reason Code	Text	ALLOWR	Detail	05	
42	Other Carrier Code	Text	OTHCR	Detail	05	
43					05	Filler
44					05	Filler
45					05	Filler
46	Claim Status	Text	CLMSTAT	Detail	01	
47	Processing Status	Text	PROCSTAT	Detail	01	
48					04	Filler
49					08	Filler
50					08	Filler
51	Company Code	Text	COMPANY	Detail	05	
52					03	Filler
53					02	Filler
54					09	Filler
55	Created Date and Time	Date/Time	CBCDT	Detail	8	Formatted - YYYYMMDD
56					03	Filler
57	Update Date and Time	Date/Time	CBUDT	Detail	8	Formatted - YYYYMMDD
58					03	Filler
59	Place of Service on Detail	Text	POS	Detail	05	
60					28	Filler
61					01	Filler
62					08	Filler
63					08	Filler

64					09	Filler
65					09	Filler
66					05	Filler
67					03	Filler
68					03	Filler
69					03	Filler
70					05	Filler
71					15	Filler
72					12	Filler
73					15	Filler
74					02	Filler
75					01	Filler
76					08	Filler
77					01	Filler
78					08	Filler
79					08	Filler
80					08	Filler
81					08	Filler
82					10	Filler
83	Subscriber Last Name	Text	LNAME	Member	35	
84	Subscriber First Name	Text	FNAME	Member	15	
85	Middle Initial	Text	MI	Member	01	
86	Date of Birth	Date/Time	CDOB	Member	08	Formatted - YYYYMMDD
87	User Defined 1 on Member: Race	Text	RACE	Member	15	Specific codes available in requirements document – See Appendix G for Translation
88	User Defined 2 on Member: Ethnicity	Text	ETHNIC	Member	15	Specific codes available in requirements document - See appendix F
89	Effective Date of Eligibility Span of Claim	Date/Time	CEFFDATE	Eligibility	08	Formatted - YYYYMMDD
90	Termination Date of Span of Claims	Date/Time	CTDATE	Eligibility	08	Formatted - YYYYMMDD
91	Group on Eligibility Record	Text	EGROUP	Eligibility	10	
92					10	Filler
93	Rider Code	Text	RIDER	Eligibility	06	
94					11	Filler
95	Panel from matching Eligibility Span	Text	EPANEL	Eligibility	03	
96					15	Filler
97	County of Residence on Eligibility	Text	SREP	Eligibility	08	
98	Sex	Text	ESEX	Member	01	Specific codes available in requirements document – see Appendix H

99					27	Filler
100	Label or expansion / Not Covered Reason	Text	C_NOTCO	Created	44	
101	Diagnosis 4	Text	DIAG4	Header	08	
102	Diagnosis 5	Text	DIAG5	Header	08	
103	Diagnosis 6	Text	DIAG6	Header	08	
104	Diagnosis 7	Text	DIAG7	Header	08	
105	Diagnosis 8	Text	DIAG8	Header	08	
106					38	Filler
107	Procedure Modifier 2	Text	PROCMOD2	Detail	02	Submit data when claims uses additional modifier
108	Procedure Modifier 3	Text	PROCMOD3	Detail	02	Submit data when claims uses additional modifier
109	Diagnosis Pointer	Text	DIAGP	Detail	01	Used to indicate primary condition for the services billed
110					25	Filler
111					05	Filler
112	Procedure Modifier 4	Text	PROCMOD4	Detail	02	Submit data when claims uses additional modifier
113					01	Filler
114					25	Filler
115					01	Filler
116					12	Filler
117					02	Filler
118					03	Filler
119					04	Filler
120					02	Filler
121					03	Filler
122					04	Filler
123					02	Filler
124					03	Filler
125					04	Filler
126					02	Filler
127					03	Filler
128					04	Filler
129					02	Filler
130					03	Filler
131					04	Filler
132					02	Filler
133					03	Filler
134					04	Filler
135	Place of Service	Text	PLACE	Header	05	
136					12	Filler
137	Provider NPI value from PROV file	Text	NPI_PROV	Jp	10	

138	Vendor NPI value from VENDR file	Text	NPI_VEND	Jp	10	
139	Claim Line Control Number	Text	LINE_CNTRL_NO	Aoclm	50	
140					08	Filler
141					01	Filler
142	Diagnosis 9	Text	DIAG9	Header	08	
143	Diagnosis 10	Text	DIAG10	Header	08	
144	Diagnosis 11	Text	DIAG11	Header	08	
145	Diagnosis 12	Text	DIAG12	Header	08	

Those fields highlighted in orange are required to be submitted by the State of Ohio.

Those fields highlighted in green are required fields that have additional information that should be reviewed prior to submission to the State of Ohio.

Appendix B: Member Eligibility Extract File Layout

Last Update: 4/10/2014

Field #	Expanded Field Name / Description	Variable	File	Field Type	Length	Additional Information
1					10	Filler
2					50	Filler
3					1	Filler
4	Subscriber Number	SUBNO	M & E	Text	12	
5					2	Filler
6	Subscriber Last Name	LNAME	Member	Text	35	
7	Subscriber First name	FNAME	Member	Text	15	
8	Subscriber Middle Initial	MI	Member	Text	1	
9					4	Filler
10	Date of Birth	DOB	Member	Date/Time	8	Formatted - YYYYMMDD
11	Gender	SEX	Member	Text	1	Specific codes available in requirements document – See Appendix H for Translation
12					1	Filler
13	Marital Status	MARIT	Member	Text	1	Specific codes available in requirements document – see Appendix E
14					2	Filler
15	Language Code	LANG	Member	Text	5	Specific codes available in requirements document – See Appendix D
16	Race	MUDEF1	Member	Text	15	Specific codes available in requirements document – See Appendix G
17	Ethnicity	MUDEF2	Member	Text	15	Specific codes available in requirements document – See Appendix F for Translation
18	Medicare Number	MCARE	Member	Text	12	
19	Active Medicaid Number	MCAID	Member	Text	16	
20	Social Security Number	SSN	Member	Text	9	This should be populated with the actual SSN of the client. If a SSN is not available for the client, or unknown, populate the

						<p>field with 5555555555. It is expected that the all 5's option is a temporary placeholder until the client record is updated by the board on a subsequent file submission.</p> <p>Another possibility for entry to this field is 1111111111. An all 1's entry will be accepted for prevention/consultation/education services.</p> <p>OMHAS will develop reports to monitor the data for file submissions containing 1's and 5's beyond a reasonable expectation.</p>
21					12	Filler
22					12	Filler
23					10	Filler
24					10	Filler
25	Subscriber Address 1	ADDR1	Member	Text	60	
26	Subscriber Address 2	ADDR2	Member	Text	60	
27	Subscriber City	CITY	Member	Text	30	
28	Subscriber State	STATE	Member	Text	2	
29	Subscriber Zip Code	ZIP	Member	Text	15	
30					1	Filler
31					12	Filler
32					2	Filler
33					2	Filler
34					15	Filler
35					15	Filler
36					2	Filler
37					5	Filler
38					8	Filler
39					1	Filler
40					8	Filler
42	Subscriber Date of Birth	MUDEF3	Member	Text	15	
43					30	Filler
44					30	Filler
45	Upper Case Last	UCLNAME	Member	Text	20	

	Name					
46	Upper Case First Name	UCFNAME	Member	Text	15	
47	Upper Case Middle Initial	UCMI	Member	Text	1	
48					2	Filler
49					1	Filler
50					15	Filler
51					15	Filler
52					15	Filler
53					14	Filler
54					15	Filler
55					15	Filler
56					8	Filler
57					8	Filler
58					8	Filler
59					8	Filler
60					8	Filler
61	Person # for Elig Span	EPERNO	Eligibility	Text	2	
62					3	Filler
63					8	Filler
64					8	Filler
65					10	Filler
66					3	Filler
67					6	Filler
68					11	Filler
69					8	Filler
70					2	Filler
71					2	Filler
72					6	Filler
73					1	Filler
75					5	Filler
76					12	Filler
77					3	Filler
78					12	Filler
79	Creation Time Stamp	ECSTMP	Eligibility	Date/Time	15	Formatted - YYYYMMDD
80	Update Time Stamp	EUSTMP	Eligibility	Date/Time	15	Formatted - YYYYMMDD
81					3	Filler

82					8	Filler
83					11	Filler
84					15	Filler
85					8	Filler
86	County of Residence	SREP	Eligibility	Text	8	
87					2	Filler
88					5	Filler

Those fields highlighted in orange are required to be submitted to the State of Ohio.

Those fields highlighted in green are required fields that have additional information that should be reviewed prior to submission to the State of Ohio.

Appendix C: Procedure Codes Requiring a Diagnostic Code in Claims Extract Field #13

(Also Requires a Diagnostic Code in Diagnostic Field One)

90792	PSY DIAG EVAL WITH MEDICAL
90801	MH ASSMT-PHYSICIAN
90805	20 TO 30 MIN F2F W/PATIENT
90807	45 TO 50 MIN F2F W/PATIENT
90809	75 TO 80 MIN F2F W/PATIENT
90862	MH PHARM MGMT
90863	PHARMACOLOGIC MANAGEMENT
992xx	OFFICE/OPT E/M F2F
A023x	MCR:NON-HOSPITAL SETTING
A121x	MCR:NON-HOSPITAL SETTING
A122x	NMCR:NON-ACUTE RES SET
A999x	MARP
H0001	ASSESSMENT
H0003	LABORATORY URINALYSIS
H0004	BH COUNS/THERAPY
H0005	GROUP COUNSELING
H0006	CASE MANAGEMENT
H0007	CRISIS INTERVENTION
H0009	ACUTE HOSPITAL DETOX
H0012	SUB ACUTE DETOXIFICATION
H0014	AMBULATORY DETOXIFICATION
H0015	INTENSIVE OUTPATIENT
H0016	MEDICAL/SOMATIC
H0017	BHMCRT: HOSPITAL SETTING
H0018	BHMCRT: NON-HOSPITAL
H0019	BHNON-MEDICAL CRT
H0020	METHADONE ADMINISTRATION
H0031	MH ASSMT-NON PHYSICIAN
H0036	MH COMM PSYCH SUPP
H0040	ACT-CLINICAL
H2016	IHBT-CLINICAL
J1630	HALOPERIDOL INJECTION HALOPERIDOL DECANOATE
J1631	INJECT
J2060	LORAZEPAM INJECTION
J2315	NALTREXONE, DEPOT FORM
J2358	OLANZAPINE LONG ACT INJ 1MG

J2426	PALIPERIDONE PALMITATE INJ
J2680	FLUPHENAZINE DECANOATE 25MG
J2794	RISPERIDONE, LONG ACTING
J3360	VALIUM INJECTION
J8499	ORAL PRESCRIP DRUG NON CHEMO
M9999	MH RWJ CUYA WAIVER
S0201	MH PARTIAL HOSP
S9484	MH CRISIS INTERV

Appendix D: Language Code Table

Allowed Language Codes	
Language Code	Language Description
AFD	DARI (AFGHANISTAN)
AFP	PASHTU (AFGHANISTAN)
AFR	AFRIKAAN
ALB	ALBANIAN
AMH	AMHARIC (ETHIOPIA)
ARA	ARABIC (MIDDLE EAST)
ARM	ARMENIAN
ASL	AMERICAN SIGN LANGUAGE
BAS	BASQUE
BCH	CHIN (BURMA)
BEL	BELORUSSIAN (BELARUS)
BEN	BENGALI (BANGLADESH)
BHU	BHUTANESE (BHUTAN)
BKA	KAREN (BURMA)
BKI	KIRUNDI (BURUNDI)
BKN	KINYAWANDA (BURUNDI, RWANDA)
BUL	BULGARIAN
BUR	BURMESE
CAM	KHMER (CAMBODIAN)
CAN	CANTONESE (HONG KONG)
CHI	MANDARIN (CHINA-SIMPLIFIED)
CHT	MANDARIN (CHINA- TRADITIONAL)
CRO	CROATIAN
CUS	CUSHITE
CZE	CZECH
DAN	DANISH
DUT	DUTCH
ENG	ENGLISH
EST	ESTONIAN
FAR	FARSI (AFGANISTAN)
FIN	FINNISH
FLE	FLEMISH
FOR	FORMOSAN
FRC	FRENCH CREOLE
FRE	FRENCH (FRANCE)
FUL	FULANI

GER	GERMAN (GERMANY)
GRE	GREEK
GUJ	GUJARATHI
HAI	HAITIAN
HEB	HEBREW (ISRAEL)
HIN	HINDI
HMO	HMONG
HUN	HUNGARIAN
ICE	ICELANDIC
IND	INDIC
IRA	FARSI (IRAN)
ITA	ITALIAN (ITALY)
JAP	JAPANESE (JAPAN)
KOR	KOREAN (KOREA)
KUN	KUNAMA (ERITREA)
KUR	KURDISH (NORTHERN IRAQ)
KU1	KURDISH (SOUTHERN IRAQ)
LAO	LAOTIAN (LAOS)
LAT	LATVIAN
LIN	LINGALA
LIT	LITUANIAN
MAC	MACEDONIAN (MACEDONIA)
MON	MON-KHMER (BURMA, THAILAND)
NAV	NAVAJO
NEP	NEPALI/NEPALESE (NEPAL,BHUTAN)
NOR	NORWEGIAN
ORO	OROMO (ETHIOPIA)
OTH	OTHER
PAD	PENNSYLVANIA DUTCH
PAK	PAKISTAN
PER	PERSIAN
POC	PORTUGUESE CREOLE
POL	POLISH
POR	PORTUGUESE (BRAZIL, PORTUGAL)
PUN	PUNJABI
ROM	ROMANIAN
RUS	RUSSIAN (RUSSIA)
SEC	SERBO-CROATIAN
SER	SERBIAN
SLO	SLOVAK

SLV	SLOVENIAN
SMM	SOMALI/MAAY MAAY (SOMALIA)
SOM	SOMALI/SOMALI (SOMALIA)
SPA	SPANISH
SPE	SPANISH/ENGLISH BILINGUAL
SWA	SWAHILI (TANZANIA)
SWE	SWEDISH
TAG	TAGALOG
THA	THAI (THAILAND)
TIG	TIGRINYA (ERITREA)
TUR	TURKISH (TURKEY)
UKN	UNKNOWN
UKR	UKRANIAN (UKRANE)
URD	URDU
UZB	UZBEK (UZBEKISTAN)
VIE	VIETNAMESE (VIETNAM)
WOL	WOLOF (SENEGAL)
YDD	YIDDISH

Appendix E: Marital Status Code Table

Allowed Marital Status Codes	
Marital Status Code	Marital Status Description
B	Dom Part
D	Divorced
I	Single
M	Married
R	Unreported
S	Separated
U	Unmarried
W	Widowed
X	Legal Sep

Appendix F: Ethnicity Code Table

Allowed Ethnicity Codes	
Ethnicity Code	Ethnicity Description
A	Puerto Rican
B	Mexican
C	Cuban
O	Other Specific Hispanic
D	Hispanic – Specific Origin Not Specified
E	Not of Hispanic Origin
U	Unknown

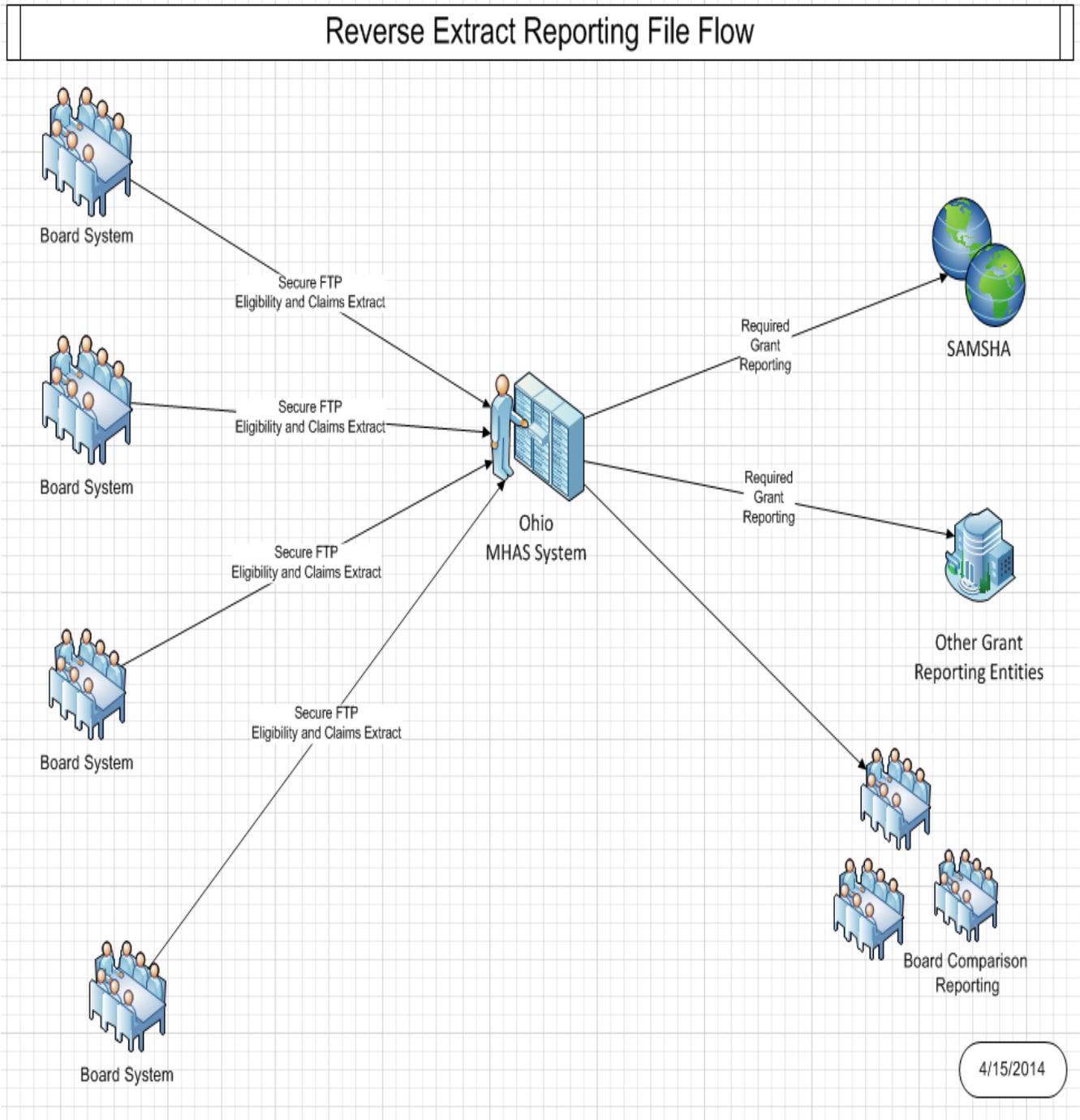
Appendix G: Race Code Table

Allowed Race Codes	
Race Code	Race Description
M	M – Alaskan Native
N	N – American Indian
A	A – Asian
B	B – Black or African American
P	P – Native Hawaiian or Other Pacific Islander
W	W – White
O	O – Other Single Race
R	R – Two or More Races
U	U – Unknown

Appendix H: Gender Code Table

Allowed Gender Codes	
Gender Code	Gender Description
F	Female
M	Male
U	Other

Appendix I: Overview Map



Document History

Version	Date	Author	Summary of Changes
1.0	4/15/14	Alan Rogers	Draft created
1.1	5/20/15	Alan Rogers	Developer discovered minor spacing changes that needed to align with latest version of MACSIS layout. They are highlighted in blue.
1.2	6/11/2015	Alan Rogers	Changes made in order to align with data warehouse direction on race and ethnicity