Executive Office of Health and Human Services

MCO 837 Provider Network Exchange Companion Guide

Rhode Island Medicaid

Version 2.0

Statement of Confidentiality

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Contents

OVERVIEW

Version	Last Update	Author	Change Description
	11/9/2012	Piyush Khandelwal	Initial Entry
	4/12/2013	Piyush Khandelwal	Updated the overview with the Claim Type, Specifiers and taxonomy references.
	1/27/2017	Deb Meiklejohn	Updated logo(HPE)
1.8	5/11/2017	Deb Meiklejohn	Updated logo (DXC) Removed language code 99- not in use
1.9	4/10/2018	Mary Jane Nardone	Added language to page 80 for Health plan provider enrollment special circumstances.
2.0	9/24/2018	Mary Jane Nardone	Updated Language Codes due UHIP
2.0	10/9/2018	Mary Jane Nardone	Updated the date in the footer through-out the document.

The following narrative provides a high level explanation of the new MCO Provider Network load processing, which will contain data for MCO Medicaid Providers (MCO Providers serving Medicaid clients) from each participating health plan detailing relevant enrollment information within the health plan's network. Claims utilization data reported on the X12 837 or NCPDP files will utilize data loaded as part of this exchange to edit data submitted specific Billing and Rendering Provider information.

The processes for MCO 837 Provider Network Exchange can be categorized into two categories: (A) Load MCO Medicaid Provider Network Information and (B) Reconciliation of MCO Medicaid Provider Information.

A. LOAD MCO PROVIDER NETWORK INFORMATION

One-time Initial Conversion Load (OICL) and Daily File

At the start of the MCO 837 Provider Network Exchange implementation, Submitting Health Plans (SHPs) will send a full file of all providers actively enrolled within the health plan's network for a One-time Initial Conversion Load (OICL). This file will contain two types of request records (apart from header and trailer record): Address and Provider Request records.

An Address Request record will contain the details about the physical addresses and the accessibility features available at that address. Every physical address will be identified using a unique Location Code (this location code will be used to associate an address with the provider in the Provider Request record). Address Request records will include the following:

- Unique Location Code
- Physical Address (First Address Line, Second Address Line, City, County, State, Zip)
- Accessibility Features (Accessibility Feature Code) - *Please note that there are no standard/universal codes available for Accessibility Features. The use of these codes is still under discussion.*

Provider Request Records, in the OICL file, will contain the information about all the active and participating providers (serving Medicaid clients). SHPs will be expected to submit all the applicable and required data elements (as defined in the Appendix 1 – Provider Exchange File Layout), any missing or invalid data element will set an error and the request record will be rejected. The following is the summary of information expected in a Provider Request record (Refer Appendix 1 for the complete list of data elements):

- Current Provider Identifiers (NPI, MCO Internal ID)
- All active Medicare IDs (if available)
- All active Licenses (if available)
- Current FEIN Information (EIN or SSN)
- Current Provider personal information (Gender and Languages)
- Claim Type, Specifier and Taxonomy records

- Current Group Affiliation Information (if applicable)
- Current Enrollment Status
- All the active contract locations (Address Type, Location Codes), with the associated contact information (Name, Phone and Email).

Once the OICL has been performed, the SHPs will be expected to send all new MCO provider network additions and updates through submission of a daily file. This Daily File will utilize the same layout and validation rules as the OICL File, with the exception that the Daily File will accommodate the Update

Request records as well (the OICL file will contain add request records only). The following information would be expected through the daily file submission:

- Update Request records (Action = 'U'). Update request records may consist of following two types:
    - Incremental Updates – These are defined as all changes made to an address or provider record by the SHPs. This type of request record will either update the most recent records, or add new information to the provider record. All these changes will effective from or after the date of file creation. Only the information to be updated or added to the provider record would be included in these types of records.
      For example, if a previously added MCO Medicaid Provider has started working with a new group, SHPs would only send us the Provider Identifiers (MCO Internal ID and NPI), Group NPI, Group Affiliation Status, a Start and an End Date of the Affiliation, Group Type (Group/Individual), Client Relationship Indicator (PCP/Specialist/Both/None), Reimbursement Indicator (Capitation/FFS/Both) and Location information (in case the provider has started working from a new location as well).
    - Retroactive Updates – SHPs would also send an update request record to correct data/human errors for a given provider record. Following the protocol for updates to the FFS Medicaid Providers, the retroactive changes would be accepted only for last one year from the date of file creation, and would be applicable to information that has a date associated. These changes would either update the records added prior to the most recent record or update the dates (and details) of the most recent record and end date them or make them effective from a date before the file creation date.
- Add Request records (Action = 'A'). The Add request records can be of the following two types:
    - New Enrollment (Add) Request record – This would include information about providers newly enrolled into the health plan's provider network. With new enrollments, no historical information would be expected for these request records. For these type of records the SHP would send the current Provider Identifiers (NPI, MCO Internal ID), all active Medicare IDs (if available), all active Licenses (if available), current FEIN Information (EIN or SSN), current Provider personal information (Gender and Languages), Claim Type, Specifier and Taxonomy records, current Group Affiliation and Client Relationship Information (if applicable), current Enrollment Status, and all the active contract locations (Address Type, Location Codes), with the associated contact information (Name, Phone and Email).
    - Re-activated Provider (Add) Request record – These request records would be identical to the New Enrollment (Add) Request records in nature, with an exception that they are not for a new provider enrollment. SHPs would send information about providers who were inactive during OICL and have subsequently become actively enrolled (or re-enrolled) within the MCO's Medicaid Provider network. This type of request record will contain the same information as that of a New Enrollment (Add) Request record – current Provider Identifiers (NPI, MCO Internal ID), all active Medicare IDs (if available), all active Licenses (if available), current FEIN Information (EIN or SSN), current Provider personal information (Gender and Languages), Claim Type, Specifier and Taxonomy records, current Group Affiliation and Client Relationship Information (if applicable), current Enrollment Status, and all the active contract locations (Address Type, Location Codes), with the associated contact information (Name, Phone and Email).

To help illustrate the types of data scenarios that will be received, the following examples are provided (these examples use only a subset of the provider fields; the actual request would contain lot more information):

1. Group Enrollment Records for Health Plan A - Health Plan A will send all the active groups, who have associated providers serving Medicaid clients. The information about these associated rendering/attending providers will be sent with the individual provider record.
   - Group A

     Name: ENT Associates
     NPI: 1000000001
     MCO Internal ID: GRP010021
     Organization Type: 1 (Group)

Enrollment Start Date	Enrollment End Date	Enrollment Status
01-01-2010	12-31-2014	03

   - Group B

     Name: ENT & ENT Associates
     NPI: 1000110001
     MCO Internal ID: GRP012001
     Organization Type: 1 (Group)

Enrollment Start Date	Enrollment End Date	Enrollment Status
01-01-2010	12-31-2014	03

   - Group C

     Name: ABC Associates
     NPI: 1001111001
     MCO Internal ID: GRP012201
     Organization Type: 1 (Group)

Enrollment Start Date	Enrollment End Date	Enrollment Status
01-01-2010	12-31-2014	03

2. Health Plan A's Individual Provider (affiliated with multiple groups) – Health Plan will send all the active group affiliation records for the provider.

   Name: MURPHY, JOHN J MD
   NPI: 9000110009
   MCO Internal ID: PR0022001
   Organization Type: 0 (Individual)

Enrollment Start Date	Enrollment End Date	Enrollment Status

Enrollment Start Date	Enrollment End Date	Enrollment Status
01-01-2012	12-31-2013	03

Group NPI	Grp. Affl. Status	Grp. Affl. Start Date	Grp. Affl. End Date	Grp. Type	Rmbrs. Indicator	Client Relationship	In Network
1000000001	A	01-01-2012	12-31-2382	G	C	B	Y
1000110001	A	01-03-2012	12-31-2012	G	B	P	Y
1001111001	A	01-04-2012	12-31-2382	G	F	N	N

3. Incremental Updates for Health Plan A's Individual Provider - Murphy, John J MD (example #2 and Group Row #2)

Name: MURPHY, JOHN J MD
NPI: 9000110009
MCO Internal ID: PR0022001
Organization Type: 0 (Individual)

Group NPI	Grp. Affl. Status	Grp. Affl. Start Date	Grp. Affl. End Date	Grp. Type	Rmbrs. Indicator	Client Relationship	In Network
1000110001	A	01-01-2012	12-31-2014	G	B	N	Y

4. Health Plan B's Individual Provider (billing himself)

Name: SMITH, JOHN DO
NPI: 9000990009
MCO Internal ID: HPBP023001
Organization Type: 0 (Individual)

Enrollment Start Date	Enrollment End Date	Enrollment Status
01-01-2012	12-31-2013	03

	Grp. Status	Grp. Affl. Start Date	Grp. Affl. End Date	Grp. Type	Rmbrs. Indicator	Client Relationship	In Network
9000990009	A	01-01-2012	12-31-2382	I	F	P	Y

5. Individual Provider registered with both Health Plan A and Heath Plan B

Health Plan A		**Health Plan B**	
Name:	**SMITH, JOHN DO**	Name:	**SMITH, JOHN M DO**
NPI:	9000990009	NPI:	9000990009

MCO Internal ID:	**HPAP023001**	MCO Internal ID:	**HPBP7657001**
Organization Type:	0 (Individual)	Organization Type:	0 (Individual)
Enrollment Start Date:	**01-01-2012**	Enrollment Start Date:	**01-03-2012**
Enrollment End Date:	**12-31-2013**	Enrollment End Date:	**12-31-2014**
Enrollment Status:	03	Enrollment Status:	03
Group NPI:	9000990009	Group NPI:	9000990009
Grp. Affl. Status:	A	Grp. Affl. Status:	A
Grp. Affl. Start Date:	**01-01-2012**	Grp. Affl. Start Date:	**01-03-2012**
Grp. Affl. End Date:	**12-31-2013**	Grp. Affl. End Date:	**12-31-2382**
Grp. Type:	I	Grp. Type:	I
Rmbrs. Indicator:	B	Rmbrs. Indicator:	C
Client Relationship:	P	Client Relationship:	P
In Network:	Y	In Network:	Y
Taxonomy:	207R00000X	Taxonomy:	207R00000X
Claim Type:	PR	Claim Type:	PR
Specifier:	[blank]	Specifier:	[blank]
Start Date:	1993-04-01	Start Date:	1993-04-01
End Date:	2382-12-31	End Date:	2382-12-31
Status:	A	Status:	A

XSD (XML Schema Document) Validation performed by SHPs

SHPs are also expected to perform a compliance check using the XML Schema Document (XSD) supplied by DXC, before submittal. This XML Schema Document contains rules for the minimum and maximum occurrences of all the tags, the presence of all required fields, and that all values are valid (for both required and optional fields). It will be the responsibility of the SHPs to build their own logic or use an existing XML engine to confirm that the file complies with all the rules. This validation does not check for any logical errors (for example, the start date is greater than the end date). Logical errors would be identified during the DXC file processing, and all errors will be reported back to the SHPs at the conclusion of the MMIS MCO Provider Network load processing.

DXC File Processing

Since both OICL and Daily File use the same file layout, the steps to process these files are same as well. These are:

1. Process 1 - Perform XSD Validations and load requests: The objective of this process is to perform the compliance check (using the XSD Validation), and stage the records in the file for processing (only if the compliance check was successful). In case the file fails the compliance check, this process would reject the whole file.
2. Process 2 - Process the request transactions: The objective of this process is to validate the staged records, make required additions/updates to the database and log errors (if any). It uses following processes for handling different types of requests:
   - Process 3 - Add Address Record – This process validates the address request record; to ensure that all the required fields are present, and confirms that an address with the same Location Code (for the SHP) doesn't already exist.
   - Process 4 - Update Address Record – This process updates an existing address record in the Address Master, Accessibility Master (if applicable), and all the provider address records using this address.
   - Process 5 - Add Provider Record - The purpose of this process is to validate the provider request record and add a new provider profile.

- Process 6 - Update Provider Record – The purpose of this process is to validate the provider request record to update an existing provider profile.
- Process 7 - Add an Atypical Provider - The purpose of this process is to validate the Atypical provider request (providers without access to an NPI), and add a new provider profile.
- Process 8 - Update an existing Atypical Provider - The purpose of this process is to validate the Atypical provider request (providers without access to an NPI), and update an existing provider profile.

These above mentioned processes perform business (or logical) validations. The resulting errors from these validations are divided into two categories: Type 'F' and Type 'I'. Errors of Type 'F' are fatal or critical errors, and no further validations will be performed for these records. Additions or Updates for the records with Error of Type 'F', will not be applied, rather the error information will be reported back to the submitting health plan with an expectation that the record will be corrected and resubmitted. Errors of Type 'I' are non-critical and are considered to be informational only. The requested record Adds/Updates will be applied to the MMIS, with the informational error being reported back to the submitting health plan. If a request record passes all the validations without an error or with Error Type 'I' only, the process would make the requested additions or updates.

Note: Only the tags/attributes that are required for both add and update request records are marked as required in the XSD validation. Tags/attributes that are not required for both update and add request record will require an explicit validation in this process.

3. Process 9 – Generate Provider Response File: The purpose of this process is to generate the response file for the request and reconciliation files. This response file would act as the acknowledgement for the request file, and would also contain the status of the request records and the errors encountered during the processing, saving the overhead of a separate report, just for the errors. This response file would be sent back to the SHP along with a XML Stylesheet (XSL), which would enable SHP employees to view the response file in any browser of their preference.

   If the request file is not compliant, it will report the value of the compliant tag as 'N' and populates the compliance error tag with the output of the XML Validation (from Process 1: Perform XSD Validations and load requests). Otherwise the value of the Compliance Tag is reported as 'Y'.

   If the request file was blank, the Blank Tag will be set to 'Y', otherwise 'N'. If the file is not blank the process will populate the summary of request records processed. If there were any records in error, the Errors Encountered will be set to 'Y'.

   The process then populates the detailed results of the records. Results for the address request records, if any, are included first, and results for the provider record request is populated after that. The following information will be reported back to the SHP in the Response File for every processed request record individually:
   - Result – The outcome of processing the request record.
   - PRRequest/ADRequest indicators
   - Transaction ID/SAK
   - Errors Encountered Indicator – Y/N (Value 'Y' will be reported if errors of type I/F were encountered during processing)
   - Errors – All the errors (error code, error type and description) will be reported back to the SHPs.

   The generated response file and a XML Stylesheet (for viewing the response file in browser), are then moved to the DXC's Secure FTP Server (SHP's will be expected to pick the files from this location).

B. RECONCILIATION OF MCO PROVIDER NETWORK INFORMATION

The objectives of this process are (1) to confirm that all the additions and updates made by the Submitting Health Plans (SHPs) to the MCO Medicaid Providers (MCO Providers serving Medicaid clients) have been applied to the RI MMIS (Encounter Data), (2) in case of any discrepancies attempt to update the record into RI MMIS (based on the information contained in the reconciliation record) and (3) report all the matches, updates made and discrepancies back to the SHPs.

For the reconciliation process the SHPs will be expected to send us a file with all the providers with active records and end dates greater than OICL Date or the last two years from the date of file creation (whichever is sooner). Comparing the records for last two years would ensure that the unresolved discrepancies (if any) are reported multiple times. The reconciliation process will check for instances where the changes made by the SHPs have not been applied to the RI MMIS (Encounter Data), by comparing the provider information in the RI MMIS with the information in the Reconciliation File. In case such instances are found, the process will perform all the edits and validations on the reconciliation records and if the reconciliation record passes all the validations, it will be used to update the RI MMIS Encounter records, otherwise all these instances will be reported back to the SHPs (along with the matches and updates made).

In case the process finds one or more discrepancies, the process will use the validations defined in the Daily/Weekly Provider Network Load Process to determine if the reconciliation record can be used for updating the RI MMIS Encounter Records. If the record in the reconciliation file passes all the validations successfully, the RI MMIS Encounter Data record will be updated.

Once all the applicable updates are applied to the RI MMIS Encounter records, a response file will be generated to report the following:

- Compliance Errors – In case the reconciliation file fails the compliance check.
- Records in error – For the records where discrepancies were found but the record in the reconciliation file could not be used for adding/updating the RI MMIS record due to errors.
- Records matched – For the records with no discrepancies.
- Records added – For the records that were not found in MMIS, and were added using the reconciliation record.
- Records updated– For the records where discrepancies were found, but were resolved by updating the records in RI MMIS. Discrepancies that could not be resolved by performing an update will be reported as informational errors.
- Records Not Found – Records that were selected for comparison in MMIS, but were not found in the Reconciliation File.

ASSUMPTIONS

- Health Plans are required to perform the XML Schema Document (XSD) Validation and make sure that the data file is error free, before sending it to the RIMMIS.
- RI MMIS would be performing the same XML Schema Document (XSD) Validation, as Health Plans have been asked to perform, before starting to process the Provider Exchange File. In case the Health Plans modify the XSD supplied to them, in order to bypass XSD validations, it would not affect the validations performed by the RI MMIS and the entire file would be rejected without processing.
- It is be the responsibility of the Health Plans to validate and verify the provider credentials with external agencies (for example NPESS, OIG, etc.) during their provider enrollment process.
- SHPs will send the following information on a schedule to be defined by EOHHS (likely to be either daily or weekly):
    - All the additions and/or updates for the MCO Medicaid Providers.
    - Corrections to previous request(s) that were not applied to the RI MMIS (due to errors) in the previously submitted Daily/Weekly Update file.
- It is the responsibility of the SHPs to send us all the additions/updates using the Daily/Weekly Provider Network Load Process, prior to submittal of the reconciliation file.
- DXC will apply all the Daily/Weekly Provider Network Load files received from the SHPs, to the RI MMIS before initiating the reconciliation process.
- SHPs will send us a full file for reconciliation purposes. It will contain information about all the active MCO Medicaid Providers (on that date) and all the provider records that were updated since the Initial Load/Last Reconciliation Process to the processing date.
- The records in the reconciliation file will be used for updating any Provider/Address information (provided they pass all the validations successfully), and all the matches found, discrepancies, updates made will be reported back to the SHPs.
- DXC will continue to accept claims/adjustments (with end of service date, prior to 6/1/2013) and the provider/client information (required for processing the claims) in the proprietary file layout, up till December 2014 (or as required).
- Requests for Atypical providers will not contain any standard identifier, like a NPI and/or License Number, thus it will not be possible to link these providers across the Health Plans.

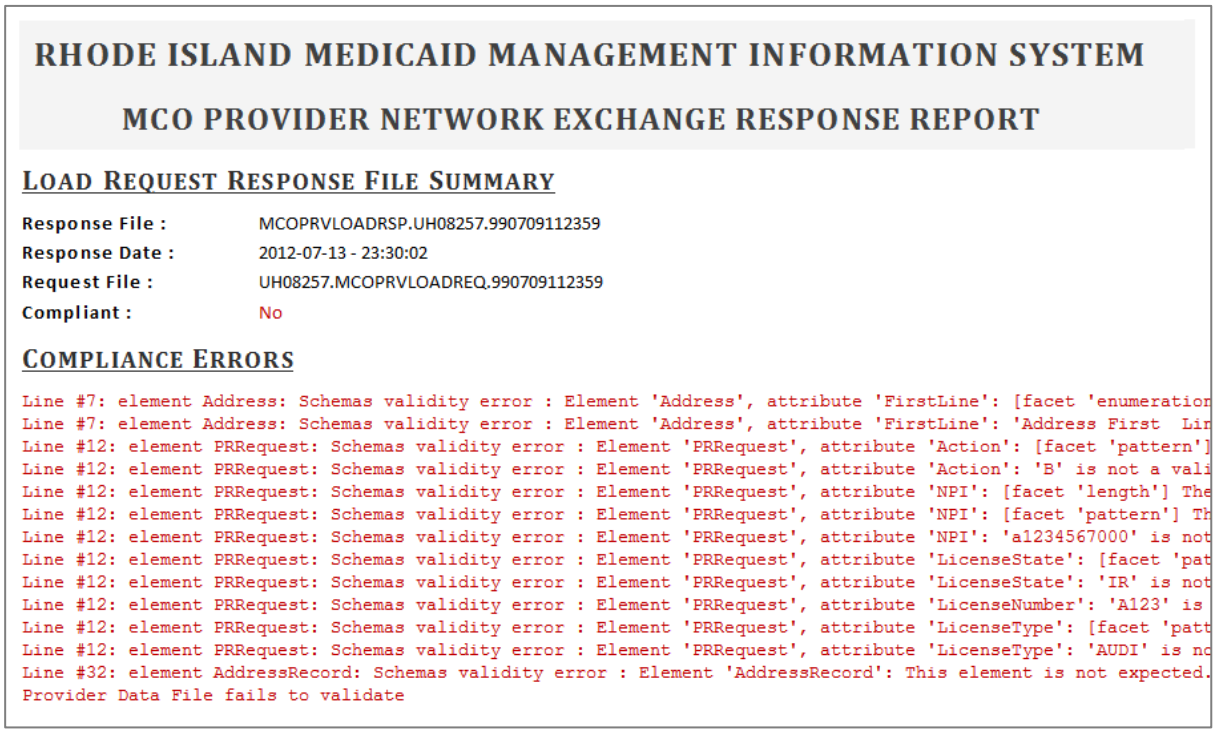
REPORT DEFINITION

Last Update	Author	Change Description
11/9/2012	Piyush Khandelwal	Initial Entry
12/21/2012	Piyush Khandelwal	Updated report mockups to reflect the updated filename format.

Encounter Data Reports	
Report#1	
Report Code	ENCPRRSPRPT
Report Title	MCO Provider Network Exchange Response Report
Report Function	This report contains the result of the MCO Provider Network Exchange Request file. It is an XML file that contains the information about file processing summary, compliance errors (if applicable), total number of records processed, and details of all the records processed along with the errors encountered while processing the requests. This report will be sent back to the Submitting Health Plans (SHPs). SHPs will use this report for identifying the requests in error and resolving the issues. The companion XML Stylesheet would allow the XML data to be rendered as a HTML page. This would allow the health plan's business and non-technical users to go through the response file in the browser of their choice. Note: For viewing the file in browser, an XML Stylesheet document would be sent along with the response report.
Number of Paper Copies	None
Sort Order	Order in which the requests were processed.
Totaling and Grouping	None.
Report Layout	Please refer Appendix 4 – Response File Layout for XML Layout of the Response File. Please see next page for viewable layouts.
Media Type	Electronic.
Distribution	Participating Health Plans and EOHHS (on demand).

Following are the layouts of the file when viewed in the browser. The file automatically switches the relevant sections on and off, depending on the indicators in the file summary.

1. File not compliant – If the request file was not compliant and failed the XSD Validations, compliance errors will be displayed to the user.



RHODE ISLAND MEDICAID MANAGEMENT INFORMATION SYSTEM

MCO PROVIDER NETWORK EXCHANGE RESPONSE REPORT

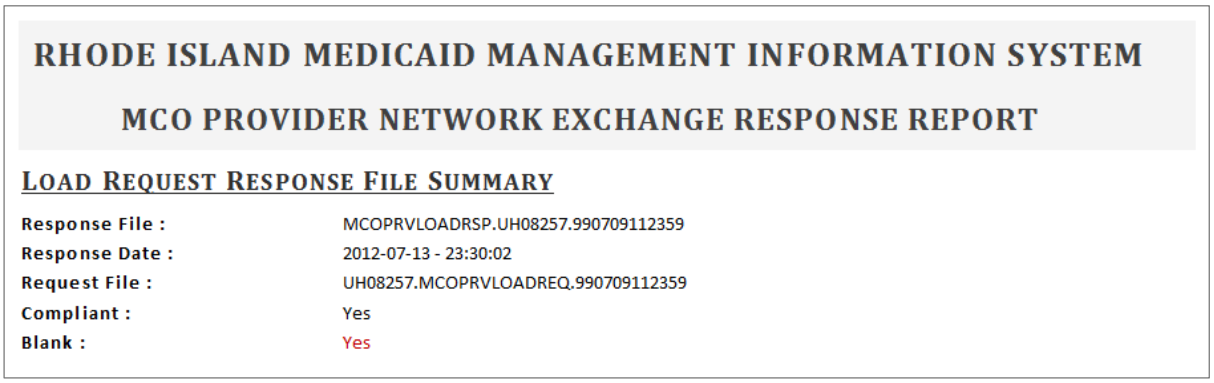
LOAD REQUEST RESPONSE FILE SUMMARY

Response File :	MCOPRVLOADRSP.UH08257.990709112359
Response Date :	2012-07-13 - 23:30:02
Request File :	UH08257.MCOPRVLOADREQ.990709112359
Compliant :	No

COMPLIANCE ERRORS

```
Line #7: element Address: Schemas validity error : Element 'Address', attribute 'FirstLine': [facet 'enumeration
Line #7: element Address: Schemas validity error : Element 'Address', attribute 'FirstLine': 'Address First  Lin
Line #12: element PRRequest: Schemas validity error : Element 'PRRequest', attribute 'Action': [facet 'pattern']
Line #12: element PRRequest: Schemas validity error : Element 'PRRequest', attribute 'Action': 'B' is not a vali
Line #12: element PRRequest: Schemas validity error : Element 'PRRequest', attribute 'NPI': [facet 'length'] The
Line #12: element PRRequest: Schemas validity error : Element 'PRRequest', attribute 'NPI': [facet 'pattern'] Th
Line #12: element PRRequest: Schemas validity error : Element 'PRRequest', attribute 'NPI': 'a1234567000' is not
Line #12: element PRRequest: Schemas validity error : Element 'PRRequest', attribute 'LicenseState': [facet 'pat
Line #12: element PRRequest: Schemas validity error : Element 'PRRequest', attribute 'LicenseState': 'IR' is not
Line #12: element PRRequest: Schemas validity error : Element 'PRRequest', attribute 'LicenseNumber': 'A123' is
Line #12: element PRRequest: Schemas validity error : Element 'PRRequest', attribute 'LicenseType': [facet 'patt
Line #12: element PRRequest: Schemas validity error : Element 'PRRequest', attribute 'LicenseType': 'AUDI' is no
Line #32: element AddressRecord: Schemas validity error : Element 'AddressRecord': This element is not expected.
Provider Data File fails to validate
```

2. Blank File – If the request file was found blank or no records were processed for the file, a blank indicator will be displayed.



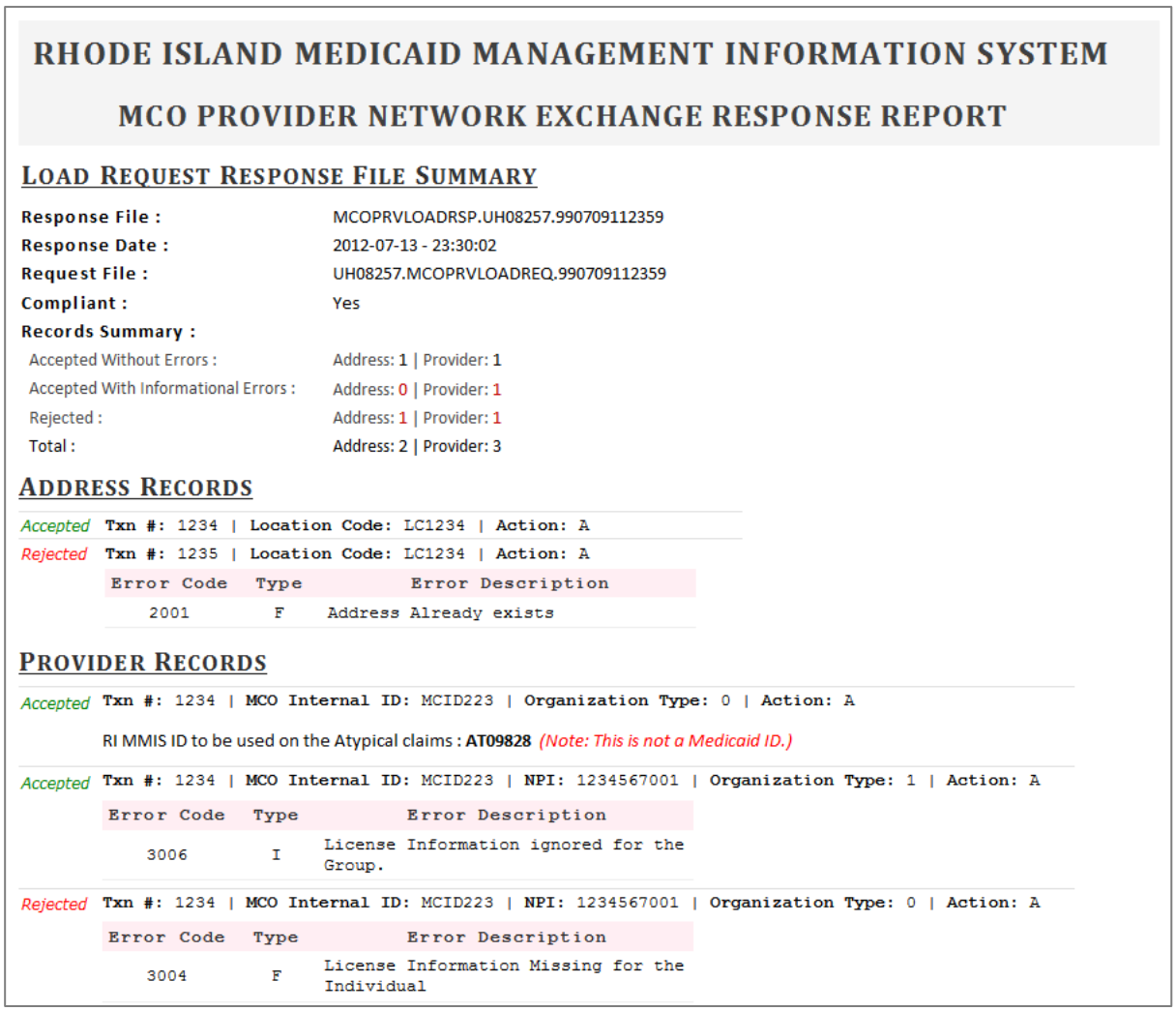
RHODE ISLAND MEDICAID MANAGEMENT INFORMATION SYSTEM

MCO PROVIDER NETWORK EXCHANGE RESPONSE REPORT

LOAD REQUEST RESPONSE FILE SUMMARY

Response File :	MCOPRVLOADRSP.UH08257.990709112359
Response Date :	2012-07-13 - 23:30:02
Request File :	UH08257.MCOPRVLOADREQ.990709112359
Compliant :	Yes
Blank :	Yes

3. File with response records (with or without errors) – If the request file had some requests, the results of the file will be displayed to the user.
    a. With both Address and Provider sections



RHODE ISLAND MEDICAID MANAGEMENT INFORMATION SYSTEM

MCO PROVIDER NETWORK EXCHANGE RESPONSE REPORT

LOAD REQUEST RESPONSE FILE SUMMARY

Response File :	MCOPRVLOADRSP.UH08257.990709112359
Response Date :	2012-07-13 - 23:30:02
Request File :	UH08257.MCOPRVLOADREQ.990709112359
Compliant :	Yes
Records Summary :	
Accepted Without Errors :	Address: 1 | Provider: 1
Accepted With Informational Errors :	Address: 0 | Provider: 1
Rejected :	Address: 1 | Provider: 1
Total :	Address: 2 | Provider: 3

ADDRESS RECORDS

Accepted **Txn #:** 1234 | **Location Code:** LC1234 | **Action:** A

Rejected **Txn #:** 1235 | **Location Code:** LC1234 | **Action:** A

Error Code	Type	Error Description
2001	F	Address Already exists

PROVIDER RECORDS

Accepted **Txn #:** 1234 | **MCO Internal ID:** MCID223 | **Organization Type:** 0 | **Action:** A

RI MMIS ID to be used on the Atypical claims : **AT09828** *(Note: This is not a Medicaid ID.)*

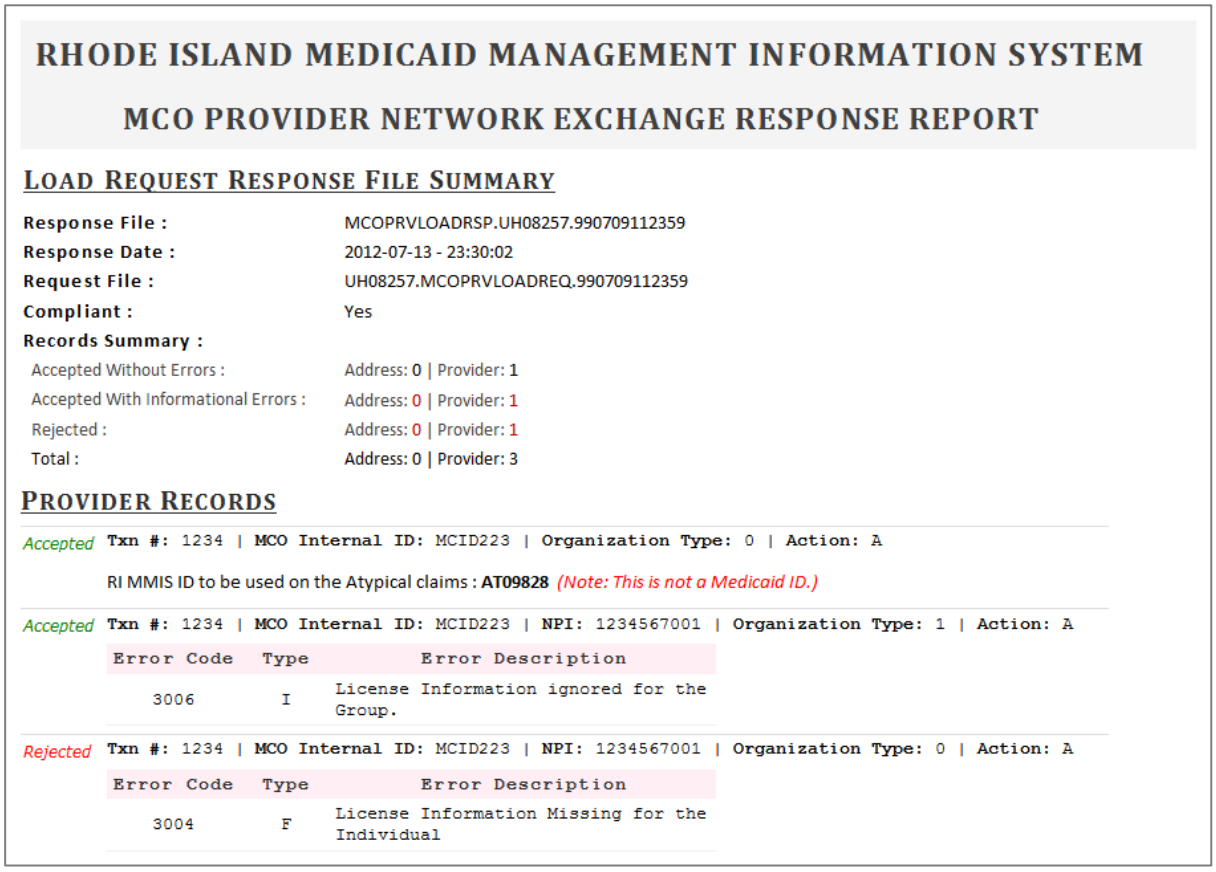
Accepted **Txn #:** 1234 | **MCO Internal ID:** MCID223 | **NPI:** 1234567001 | **Organization Type:** 1 | **Action:** A

Error Code	Type	Error Description
3006	I	License Information ignored for the Group.

Rejected **Txn #:** 1234 | **MCO Internal ID:** MCID223 | **NPI:** 1234567001 | **Organization Type:** 0 | **Action:** A

Error Code	Type	Error Description
3004	F	License Information Missing for the Individual

b. Response to request file with only provider records - In case, the number of address/provider requests processed are zero, the empty address/provider section will not be displayed to the user.



RHODE ISLAND MEDICAID MANAGEMENT INFORMATION SYSTEM

MCO PROVIDER NETWORK EXCHANGE RESPONSE REPORT

LOAD REQUEST RESPONSE FILE SUMMARY

Response File :	MCOPRVLOADRSP.UH08257.990709112359
Response Date :	2012-07-13 - 23:30:02
Request File :	UH08257.MCOPRVLOADREQ.990709112359
Compliant :	Yes
Records Summary :	
Accepted Without Errors :	Address: 0 | Provider: 1
Accepted With Informational Errors :	Address: 0 | Provider: 1
Rejected :	Address: 0 | Provider: 1
Total :	Address: 0 | Provider: 3

PROVIDER RECORDS

Accepted **Txn #:** 1234 | **MCO Internal ID:** MCID223 | **Organization Type:** 0 | **Action:** A

RI MMIS ID to be used on the Atypical claims : **AT09828** *(Note: This is not a Medicaid ID.)*

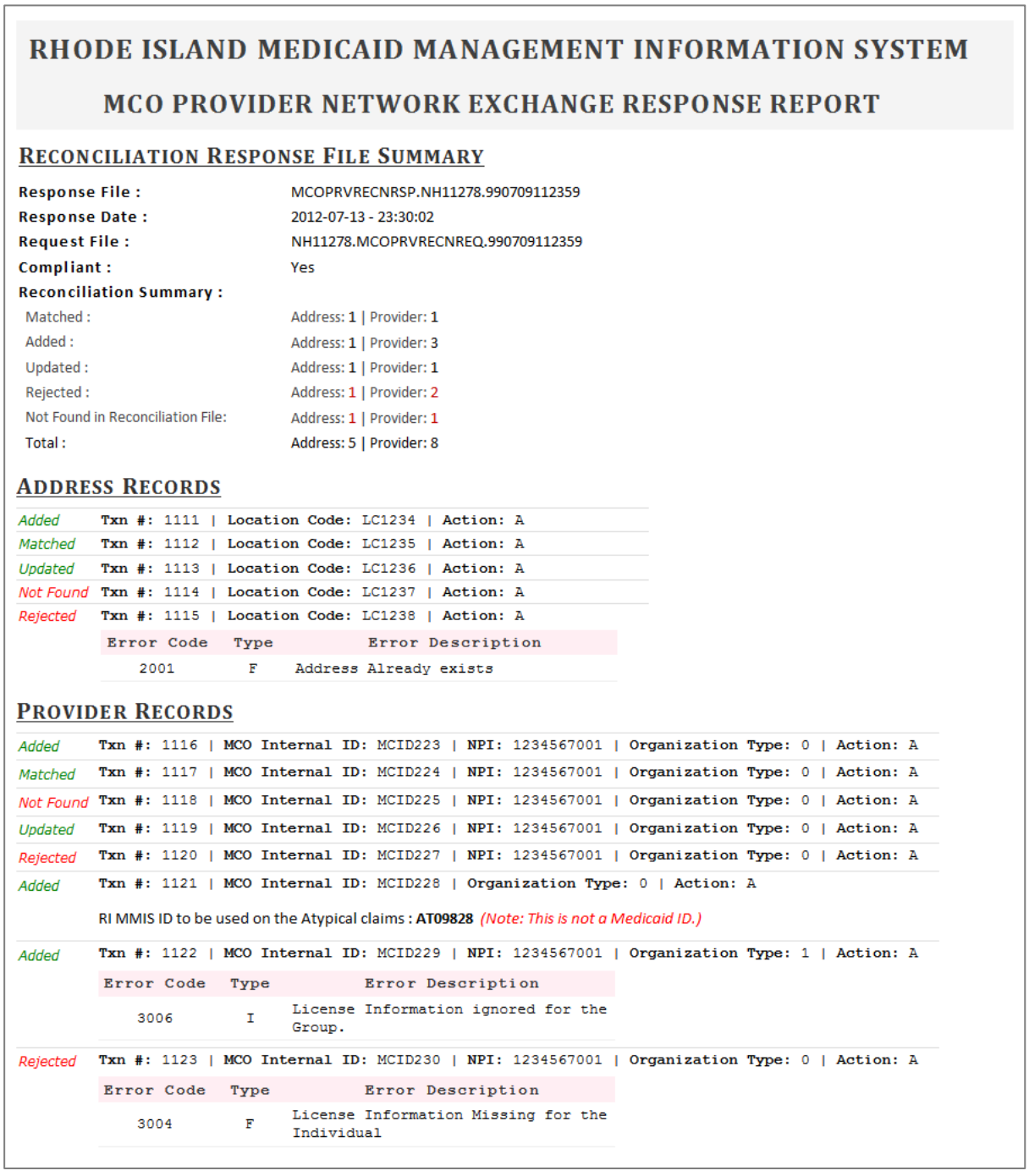
Accepted **Txn #:** 1234 | **MCO Internal ID:** MCID223 | **NPI:** 1234567001 | **Organization Type:** 1 | **Action:** A

Error Code	Type	Error Description
3006	I	License Information ignored for the Group.

Rejected **Txn #:** 1234 | **MCO Internal ID:** MCID223 | **NPI:** 1234567001 | **Organization Type:** 0 | **Action:** A

Error Code	Type	Error Description
3004	F	License Information Missing for the Individual

4. Reconciliation Response File



RHODE ISLAND MEDICAID MANAGEMENT INFORMATION SYSTEM

MCO PROVIDER NETWORK EXCHANGE RESPONSE REPORT

RECONCILIATION RESPONSE FILE SUMMARY

Response File : MCOPRVRECNRSP.NH11278.990709112359
Response Date : 2012-07-13 - 23:30:02
Request File : NH11278.MCOPRVRECNREQ.990709112359
Compliant : Yes
Reconciliation Summary :

Matched :	Address: 1 | Provider: 1
Added :	Address: 1 | Provider: 3
Updated :	Address: 1 | Provider: 1
Rejected :	Address: 1 | Provider: 2
Not Found in Reconciliation File:	Address: 1 | Provider: 1
Total :	Address: 5 | Provider: 8

ADDRESS RECORDS

Added **Txn #:** 1111 | **Location Code:** LC1234 | **Action:** A

Matched **Txn #:** 1112 | **Location Code:** LC1235 | **Action:** A

Updated **Txn #:** 1113 | **Location Code:** LC1236 | **Action:** A

Not Found **Txn #:** 1114 | **Location Code:** LC1237 | **Action:** A

Rejected **Txn #:** 1115 | **Location Code:** LC1238 | **Action:** A

Error Code	Type	Error Description
2001	F	Address Already exists

PROVIDER RECORDS

Added **Txn #:** 1116 | **MCO Internal ID:** MCID223 | **NPI:** 1234567001 | **Organization Type:** 0 | **Action:** A

Matched **Txn #:** 1117 | **MCO Internal ID:** MCID224 | **NPI:** 1234567001 | **Organization Type:** 0 | **Action:** A

Not Found **Txn #:** 1118 | **MCO Internal ID:** MCID225 | **NPI:** 1234567001 | **Organization Type:** 0 | **Action:** A

Updated **Txn #:** 1119 | **MCO Internal ID:** MCID226 | **NPI:** 1234567001 | **Organization Type:** 0 | **Action:** A

Rejected **Txn #:** 1120 | **MCO Internal ID:** MCID227 | **NPI:** 1234567001 | **Organization Type:** 0 | **Action:** A

Added **Txn #:** 1121 | **MCO Internal ID:** MCID228 | **Organization Type:** 0 | **Action:** A

RI MMIS ID to be used on the Atypical claims : **AT09828** *(Note: This is not a Medicaid ID.)*

Added **Txn #:** 1122 | **MCO Internal ID:** MCID229 | **NPI:** 1234567001 | **Organization Type:** 1 | **Action:** A

Error Code	Type	Error Description
3006	I	License Information ignored for the Group.

Rejected **Txn #:** 1123 | **MCO Internal ID:** MCID230 | **NPI:** 1234567001 | **Organization Type:** 0 | **Action:** A

Error Code	Type	Error Description
3004	F	License Information Missing for the Individual

PROCESS SPECIFICATION

Last Update	Author	Change Description
11/9/2012	Piyush Khandelwal	Initial Entry
2/6/2013	Piyush Khandelwal	• Updated the conditions for error code #3004 and #3005 in Process 5 - Add Provider • Removed error code #3004 and #3005 from the list, and added a new fatal error (#3070) in Process 6 - Update Provider
4/12/2013	Piyush Khandelwal	• Added Error# 3071 (Process #5) • Added Error# 3072 (Process #5) • Added Error# 3073 (Process #7 and #8) • Added Error# 3074 (Process #6) • Added Error# 3075 (Process #7 and #8) • Added Error# 3076 (Process #8) • Added Error# 3077 (Process #6) • Added Error# 3078 (Process #8) • Removed Specialty from Error# 3039 • Updated Error# 3036, 3049, 3033, 3048, 3070, 3013, 3001, 3004, 3005 • Updated BR# 301 • Removed Error# 3064 - In Network Provider cannot be an Atypical Provider • Removed Error# 3052 - Group Affiliation Records ignored
6/4/2013	Piyush Khandelwal	• Added Error# 3110 (Process #5 and #6)

PROCESS 1: PERFORM XSD VALIDATIONS AND LOAD REQUESTS

Provider (ENC) Subsystem	
Process #1	
Process Name	Perform XSD Validations and load requests
Process Description	The objective of this process is to perform the compliance check (using the XSD Validation), and stage the records in the file for processing (only if the compliance check was successful). In case the file fails the compliance check, this process would reject the whole file.
Non-Functional Requirements	• **Frequency:** Daily. The process will check for the file daily, but SHPs will send a file only if there are some updates to their provider/address records. • **Error Handling:** Unless otherwise stated in the process specifications, o If the process encounters database error, the process would terminate and operator on duty would be notified by an email notification o For all the Failure (Type 'F') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and exit. o For all the Informational (Type 'I') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and continue with the next step.
Process Specifications	
Specification Number	**Description**
1.	Validate File.

	Errors: ▪ 1001 - Duplicate File/File Already Processed ▪ 1002 - Non-Compliant File ▪ 1003 - Blank File Received
2.	Stage the transactions.

Error Codes			
Error Code	**Description/Message**	**Condition**	**Type**
1001	Duplicate File/File Already Processed	Check for the following to determine if the file already exists: • Filename • Submitting Health Plan ID (SHPID) • File Code • ERR_CDE is '1001', '1002' or '1003', or if Header & Trailer already exist in the staging tables. Note: 1. In case the filename, file code, and SHPID already exists and ERR_CDE is 1002 and Header and Trailer record doesn't exist. 2. This error will not be reported back to the health plans.	F
1002	Non-Compliant File	XSD Validation failed. Note: Only the tags/attributes that are required for both add and update requests are marked as required in the XSD validation. Tags/attributes that are not required for both update and add request, will require an explicit validation. Please refer Appendix 3 – Request XML Schema on page 64 for validation details.	F
1003	Blank File Received	No Provider or Address request records available for processing.	I

PROCESS 2: PROCESS THE REQUEST TRANSACTIONS

Provider (ENC) Subsystem	
Process #2	
Process Name	Process the requests transactions
Process Description	The objective of this process is to validate the staged records, make required additions/updates to the database and log errors (if any). It uses following processes for handling different types of requests: ▪ Process 3 - Add Address Record – This process validates the address request record; to ensure that all the required fields are present, and confirms that an address with the same Location Code (for the SHP) doesn't already exist. ▪ Process 4 - Update Address Record – This process updates an existing address record in the Address Master, Accessibility Master (if applicable), and all the provider address records using this address. ▪ Process 5 - Add Provider Record - The purpose of this process is to validate the provider request record and add a new provider profile. ▪ Process 6 - Update Provider Record – The purpose of this process is to validate the provider request record to update an existing provider profile. ▪ Process 7 - Add an Atypical Provider - The purpose of this process is to validate the Atypical provider request (providers without access to an NPI), and add a new provider profile.

	▪ Process 8 - Update an existing Atypical Provider - The purpose of this process is to validate the Atypical provider request (providers without access to an NPI), and update an existing provider profile. These above mentioned processes perform business (or logical) validations. The resulting errors from these validations are divided into two categories: Type 'F' and Type 'I'. Errors of Type 'F' are fatal or critical errors, and no further validations will be performed for these records. Additions or Updates for the records with Error of Type 'F', will not be applied, rather the error information will be reported back to the submitting health plan with an expectation that the record will be corrected and resubmitted. Errors of Type 'I' are non-critical and are considered to be informational only. The requested record Adds/Updates will be applied to the MMIS, with the informational error being reported back to the submitting health plan. If a request record passes all the validations without an error or with Error Type 'I' only, the process would make the requested additions or updates. Note: Only the tags/attributes that are required for both add and update request records are marked as required in the XSD validation. Tags/attributes that are not required for both update and add request record will require an explicit validation in this process.
Non-Functional Requirements	• **Frequency:** Daily • **Error Handling:** Unless otherwise stated in the process specifications, o If the process encounters database error, the process would terminate and operator on duty would be notified by an email notification o For all the Failure (Type 'F') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and exit. o For all the Informational (Type 'I') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and continue with the next step. • Every record will be committed to the database individually.

Process Specifications	
Specification Number	**Description**
1.	Select oldest staged file.
2.	Process Staged Address records. In case there are no Address records available for the selected file, go to Step 6.
3.	Determine the Action for the Address Request: Scenario 1 - Add Address Request (Action = A) – Call Process 3 - Add Address Record. Scenario 2 - Update Address Request (Action = U) – Call Process 4 - Update Address Record.
4.	Log Errors and commit the changes (only if the record passed the validations without errors or with Errors of Type 'I' only).
5.	Repeat Step 3 and 4, until all the selected address records are processed.
6.	Process staged provider records. Scenario 2 - Provider Records exist: Continue with the Step 7.
7.	Determine the Action for the Provider Request: Scenario 1 - Add Provider Request (Action = A) – Call Process 5 - Add Provider Record. Scenario 2 - Update Provider Request (Action = U) – Call Process 6 - Update Provider Record.
8.	Log Errors and commit the changes (only if the record passed the validations without

	errors or with Errors of Type 'I' only).
9.	Repeat Step 7 and 8, until all the selected provider records are processed.
10.	In case more staged files are available for processing, go to Step 1.

PROCESS 3: ADD ADDRESS

Provider (ENC) Subsystem			
Process #3			
Process Name	Add Address		
Process Description	This process validates the address request record; to ensure that all the required fields are present, and confirms that an address with the same Location Code (for the SHP) doesn't already exist.		
Parent Process	Process 2 - Process the request transactions		
Non-Functional Requirements	• **Error Handling:** Unless otherwise stated in the process specifications, ○ If the process encounters database error, the process would terminate and operator on duty would be notified by an email notification ○ For all the Failure (Type 'F') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and exit. ○ For all the Informational (Type 'I') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and continue with the next step.		
Process Specifications			
Specification Number	**Description**		
1.	Validate Address. Errors: ▪ 2001 - Address Already exists		
2.	Add the address record in the Address Master.		
Error Codes			
Error Code	**Description/Message**	**Condition**	**Type**
2001	Address Already exists	Check if the following exist: • LocationCode • Submitting Health Plan ID Note: We will not check the details for the physical address (i.e. Address First Line, Address Second Line, City, etc.) for determining a unique address.	F

PROCESS 4: UPDATE ADDRESS

Provider (ENC) Subsystem	
Process #4	
Process Name	Update Address
Process Description	This process updates an existing address record in the Address Master, Accessibility Master (if applicable), and all the provider address records using this address.
Parent Process	Process 2: Process the request transactions
Non-Functional Requirements	• **Error Handling:** Unless otherwise stated in the process specifications, ○ If the process encounters database error, the process would terminate and operator on duty would be notified by an email notification ○ For all the Failure (Type 'F') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and exit.

	○ For all the Informational (Type 'I') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and continue with the next step.

Process Specifications	
Specification Number	**Description**
1.	Validate address request. Errors: ▪ 2002 - Address doesn't exist.
2.	Update the address record in MMIS.

Error Codes			
Error Code	**Description/Message**	**Condition**	**Type**
2002	Address doesn't exist.	Check if the following exist: • LocationCode • Submitting Health Plan ID Note: We will not check the details for the physical address (i.e. Address First Line, Address Second Line, City, etc.) for determining a unique address.	F

PROCESS 5: ADD PROVIDER

Provider (ENC) Subsystem	
Process #5	
Process Name	Add Provider
Process Description	The purpose of this process is to validate the provider request record and add a new provider profile.
Parent Process	Process 2: Process the request transactions
Non-Functional Requirements	• **Error Handling:** Unless otherwise stated in the process specifications, ○ If the process encounters database error, the process would terminate and operator on duty would be notified by an email notification ○ For all the Failure (Type 'F') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and exit. ○ For all the Informational (Type 'I') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and continue with the next step.

Process Specifications	
Specification Number	**Description**
1.	If the Provider is an Atypical Provider, exit sub-process and go to Process 7 – Add an Atypical Provider. See Business Rules: - Check for Atypical Providers Errors: ▪ 3001 - Claim Type Taxonomy Records are missing ▪ 3013 - Invalid Claim Type, Specifier and Taxonomy combination ▪ 3071 - Both FQHC and Non-FQHC claim types available for the group record ▪ 3072 - Multiple Specifier combinations exist for the same Taxonomy and Claim Type combination ▪ 3073 - Individuals and Hospitals cannot use FQHC Claim Types

2.	Validate provider record. See Business Rules: - Validate NPI Check digit - Sequential Date Entry - Ensure Non Overlapping Date Segments - Check for duplicate provider. Errors: ▪ 3002 - NPI Missing ▪ 3003 - Invalid NPI ▪ 3004 - License Information Missing for the Individual ▪ 3005 - License Information Missing for the Hospitals ▪ 3006 - License Information ignored for the Group ▪ 3007 - NPI Change information ignored for Add request ▪ 3010 - Provider Info Missing ▪ 3011 - Gender is Missing ▪ 3012 - Language1 is Missing ▪ 3014 - FEIN is missing ▪ 3015 - MCO Enrollment Records are missing ▪ 3019 - Contract Location Records are missing for the Add request. ▪ 3020 - At least one Service Location is required. ▪ 3021 - At least one Mail-To Location is required. ▪ 3022 - At least one Pay-To Location is required. ▪ 3023 - Phone number Missing ▪ 3024 - Accepting New Patients Missing ▪ 3025 - Name Type Missing ▪ 3026 - First Name Missing ▪ 3027 - Last Name Missing ▪ 3028 - Organization Name Missing ▪ 3029 - First Name, Last Name, Middle Name and Title ignored ▪ 3030 - Organization Name Ignored ▪ 3036 - Multiple ClaimTypeTaxonomyRecords with same information found ▪ 3037 - Multiple GroupAffiliationRecords with same information found ▪ 3038 - Multiple MCOEnrollmentRecords with same information found ▪ 3039 - Multiple ContractLocationRecords with same information found ▪ 3047 - Group NPI Not found ▪ 3048 - Historical Records ignored ▪ 3051 - LocationType Missing for the following service record ▪ 3053 - Group NPI is not Individual Provider NPI for the Type ‘I’ Group Affiliation record ▪ 3054 - Group NPI is the Individual Provider NPI for the Type ‘G’ Group Affiliation record ▪ 3055 - Billing restrictions ignored ▪ 3056 - Billing restrictions applied to the Individual Provider record ▪ 3057 - Gender Information ignored ▪ 3066 - Multiple Addresses with same Address Type and Address Sequence are present ▪ 3067 - No Primary Service Address Present ▪ 3068 - No Primary Pay-To Address Present ▪ 3069 - No Primary Mail-To Address Present

	▪ 3031 - Location Code not found in the database ▪ 3033 - Invalid Dates for ClaimTypeTaxonomyRecords ▪ 3034 - Invalid Dates for GroupAffiliationRecords ▪ 3035 - Invalid Dates for MCOEnrollmentRecords ▪ 3032 - Provider already exists. ▪ 3074 - Groups/Hospitals cannot be attending providers ▪ 3075 - Individuals/Groups cannot submit a Group Affiliation record with Group Type 'H' ▪ 3076 - Groups/Hospitals are mentioned as PCP/Specialist/Both ▪ 3110 - Out-of-date License record.
3.	Add Provider in MMIS.

Error Codes

Error Code	Description/Message	Condition	Type
3001	Claim Type Taxonomy Records are missing	Provider Request doesn't have the ClaimTypeTaxonomyRecords tag.	F
3002	NPI Missing	Provider Request doesn't have the NPI	F
3003	Invalid NPI	NPI Check digit Validation failed.	F
3004	License Information Missing for the Individual	If either of the following conditions is true: • No GroupAffiliationRecords are present, Organization Type is '0' (individual), No Specifier value is present and the License Segment is missing (not reported). Or, • GroupAffiliationRecords are present, one or more InNetwork indicator is 'I', the Organization Type is '0' (individual), no Specifier value is present and the License Segment is missing (not reported). Note: If the Organization Type is '0' (individual) and valid license information is present, it will be stored.	F
3005	License Information Missing for the Hospitals	If either of the following conditions is true: • No GroupAffiliationRecords are present, Organization Type is '2' (Hospital), Claim Type is 'IN' and the License Segment is missing (not reported). Or, • GroupAffiliationRecords are present, one or more InNetwork indicator is 'I', Organization Type is '2' (hospital), Claim Type is 'IN' and the License Segment is missing (not reported). Note: If the Organization Type is '2' (hospital) and valid license information is present, it will be stored.	F
3006	License Information ignored for the Group.	If the Organization Type is '1' (Group) and the License information is present. Note: In this scenario license information will not be stored on the provider profile.	I
3007	NPI Change information ignored for Add request	If the NPIChange tag is present. Note: This tag cannot be used with an Add Provider Request.	I
3010	Provider Info Missing	Provider Info tag is missing.	F
3011	Gender is Missing	If the Organization Type is '0' (individual) and the Gender Field is missing in the tag ProviderInfo.	F

3012	Language1 is Missing	If the Language1 is missing in the tag ProviderInfo.	F
3013	Invalid Claim Type, Specifier and Taxonomy combination.	This will use the Encounter Claim Type, Specifier and Taxonomy combinations.	F
3014	FEIN is missing	If the FEIN Tag is missing.	F
3015	MCO Enrollment Records are missing	If the MCOEnrollmentRecords is missing.	F
3019	Contract Location Records are missing for the Add request.	If the ContractLocationRecords is missing. Note: Only the tags/attributes that are required for both add and update request are marked as required in the XSD validation. Since this is not a required tag/attribute for both update and add request, an explicit validation is required to confirm that this tag is present in the add request.	F
3020	At least one Service Location is required.	If there's no LocationRecord with Address Type '04' in the Provider Record.	F
3021	At least one Mail-To Location is required.	If there's no LocationRecord with Address Type '02' in the Provider Record.	F
3022	At least one Pay-To Location is required.	If there's no LocationRecord with Address Type '01' in the Provider Record.	F
3023	Phone number Missing	If the Phone is missing in the tag Location.	F
3024	Accepting New Patients Missing	If the Address Type is '04' and AcceptingNewPatient is missing in the tag Location.	F
3025	Name Type Missing	If the NameType is missing in the tag Location.	F
3026	First Name Missing	If the Name Type is '1' and the First Name is missing in the tag Location.	F
3027	Last Name Missing	If the Name Type is '1' and the Last Name is missing in the tag Location.	F
3028	Organization Name Missing	If the Name Type is '2' or '3', and the Organization Name is missing in the tag Location.	F
3029	First Name, Last Name, Middle Name and Title ignored	If the Name Type is '2' or '3', and one of the following fields is present - First Name, Last Name, Middle Name or Title.	I
3030	Organization Name Ignored	If the Name Type is '1' and the Organization Name is present.	I
3031	Location Code not found in the database	If the Location Code for the SHP ID doesn't exist in the Address Master.	F
3032	Provider already exists.	If the Provider record already exists in the database.	F
3033	Invalid Dates for ClaimTypeTaxonomyRecords	Check for non-overlapping dates, using the following business rules: • Sequential Date Entry • Ensure Non Overlapping Date Segments	F
3034	Invalid Dates for GroupAffiliationRecords	Check for non-overlapping dates, using the following business rules: • Sequential Date Entry • Ensure Non Overlapping Date Segments	F
3035	Invalid Dates for MCOEnrollmentRecords	Check for non-overlapping dates, using the following business rules: • Sequential Date Entry • Ensure Non Overlapping Date Segments	F
3036	Multiple ClaimTypeTaxonomyRecords with same information found	Multiple ClaimTypeTaxonomyRecords with same values in the following fields is available in the request: • Claim Type • Specifier • Taxonomy • Type Start Date	F

		• Type End Date • Type Status	
3037	Multiple GroupAffiliationRecords with same information found	Multiple GroupAffiliationRecords with same values in the following fields is available in the request: • Group NPI • Group Affiliation Status • Group Affiliation Start Date • Group Affiliation End Date • Group Type	F
3038	Multiple MCOEnrollmentRecords with same information found	Multiple MCOEnrollmentRecords with same values in the following fields is available in the request: • MCO Enrollment Status • MCO Enrollment Start Date • MCO Enrollment End Date	F
3039	Multiple ContractLocationRecords with same information found	Multiple ContractLocationRecords with same values in the following fields is available in the request: • Location Code • Address Type	F
3047	Group NPI Not found	If the Group Affiliation Type is 'G' and the Group NPI and a Group type record for the SHP Doesn't exist.	F
3048	Historical Records ignored	If the add requests contains Enrollment, Group Affiliation, Claim Type Taxonomy, License or Medicare ID Records that were not active on the date of file generation (to account for any delay in processing the file).	I
3050	Invalid FEIN	If the FEIN Value is all zeros.	F
3051	LocationType Missing for the following service record	If the Address Type is '04' and AcceptingNewPatient is missing in the tag Location.	F
3053	Group NPI is not Individual Provider NPI for the Type 'I' Group Affiliation record.	If the GroupAffiliation Type indicator is 'I' and NPI is not Provider's NPI.	F
3054	Group NPI is the Individual Provider NPI for the Type 'G' Group Affiliation record.	If the GroupAffiliation Type indicator is 'G' and NPI is Provider's NPI.	I
3055	Billing restrictions ignored	If the OrganizationType is '1' (Group) or '2' (Hospital), and the Restriction Code is '03'. Note: Groups and Hospitals are essentially Billing Providers.	I
3056	Billing restrictions applied to the Individual Provider record.	If the OrganizationType is '0' (Individual), and the Restriction Code '03' is present. Note: In this scenario the provider will not be able to submit the claims individually.	I
3057	Gender Information ignored	If the OrganizationType is '1' (Group) or '2' (Hospital)	I
3066	Multiple Addresses with same Address Type and Address Sequence are present	If multiple addresses with same Address Type and Address Sequence are present.	F
3067	No Primary Service Address Present	If the Address Type is '04' and no record with Address Sequence '1' is present.	F
3068	No Primary Pay-To Address Present	If the Address Type is '01' and no record with Address Sequence '1' is present.	F
3069	No Primary Mail-To Address Present	If the Address Type is '02' and no record with Address Sequence '1' is present.	F
3071	Both FQHC and Non-FQHC claim types available for the group record	If the OrganizationType is '1' (Group) and both FQHC claim types (FPR/FDN) and Non-FQHC claim types (DN/IN/PR/PH) are available in the provider request.	F

3072	Multiple Specifier combinations exist for the same Taxonomy and Claim Type combination	If multiple ClaimTypeTaxonomy records are present with the same Claim Type &Taxonomy and different Specifier Value.	F
3073	Individuals and Hospitals cannot use FQHC Claim Types	If the OrganizationType is '0' (individual) or '2' (Hospital) and one or more Claim Types are FPR/FDN.	F
3074	Groups/Hospitals cannot be attending providers	If the OrganizationType is '1' (Group) or '2' (Hospital), and one or more records with Group Type 'G' are present.	F
3075	Individuals/Groups cannot submit a Group Affiliation record with Group Type 'H'	If the OrganizationType is '1' (Group) or '0' (Individual), and one or more records with Group Type 'H' are present.	F
3076	Groups/Hospitals are mentioned as PCP/Specialist/Both	If the OrganizationType is '1' (Group) or '2' (Hospital), and one or more records with ClientRelationship P/S/B are present. Note: The recommended ClientRelationship value is 'N'. In case some other value is used, we would not reject the record, and the information would be stored.	I
3110	Out-of-date License record.	If the requests contains License Records that are not active within last one year from the date of file creation. Note: This license information will be stored in the system, in spite of the old dates.	I
Business Rules			
BR No.	**Rule**	**Description**	
301	Check for Atypical Providers	Check if the NPI is not present and if all the Claim Type Taxonomy records contain Specifier value 'A'. Note: In case the provider request contains one or more Claim Type Taxonomy records contain Specifier value other than 'A', the provider will not be considered as an Atypical provider.	
302	Check for duplicate provider.	Check if a Provider with same values for the following fields already exist: • SHP ID • MCO Internal ID • NPI	
303	Validate NPI Check digit	Following are the steps to validate the NPI Check digit: 1. Double the value of alternate digits beginning with the rightmost digit. 2. Add the individual digits of the products resulting from step 1 to the unaffected digits from the original number. 3. Subtract the total obtained in step 2 from the next higher number ending in zero. This is the check digit. If the total obtained in step 2 is a number ending in zero, the check digit is zero. Generate an error if the check digit, doesn't match the last digit of the NPI.	
304	Sequential Date Entry	All the records with the date segments should be validated and stored sequentially. Note: In case the health plans don't send the date information in sequential order, the program should sort the records by dates in the temporary space and then perform any other date based validations.	
305	Ensure Non Overlapping Date	Pre-Requisite: BR-Sequential Date Entry (validate the dates	

	Segments	coming on the request only. The dates existing in the database will be end dated if required.) - The Start Date of the new record should be greater than End Dates of 'all' the previous records. If the end date of the last available record is the end of time date it will be end dated with Start Date - 1. - The End Date of the new record should be greater than the Start Date (of the new record). Generate an error if this rule fails, proceed otherwise.

PROCESS 6: UPDATE PROVIDER

Provider (ENC) Subsystem	
Process #6	
Process Name	Update Provider
Process Description	The purpose of this process is to validate the provider request record to update an existing provider profile.
Parent Process	Process 2: Process the request transactions
Non-Functional Requirements	• **Error Handling:** Unless otherwise stated in the process specifications, o If the process encounters database error, the process would terminate and operator on duty would be notified by an email notification o For all the Failure (Type 'F') errors: As soon as an error with type 'F' is encountered, the process would log the error (for reporting back to the SHP in the Provider Response File) and in this scenario all updates in this request will be rejected, and exit the sub-process. o For all the Informational (Type 'I') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and continue with the next step.
Process Specifications	
Specification Number	**Description**
1.	If the Provider is an Atypical Provider, exit sub-process and go to Process 8 – Update an existing Atypical Provider. See Business Rules: - Check for Atypical Providers Errors: ▪ 3001 - Claim Type Taxonomy Records are missing ▪ 3013 - Invalid Claim Type, Specifier and Taxonomy combination ▪ 3073 - Individuals and Hospitals cannot use FQHC Claim Types ▪ 3077 - Conflicting Update – Group cannot have both FQHC and Non-FQHC claim types ▪ 3078 - Conflicting Update – A provider cannot have multiple Specifier values for the same Taxonomy and Claim Type combination
2.	Validate Provider Record. See Business Rules: - Check for an existing provider. - Validate NPI Check digit - Sequential Date Entry - Ensure Non Overlapping Date Segments

	Errors: ▪ 3040 - Previous NPI not found in the database ▪ 3042 - Provider Record not found in the database ▪ 3031 - Location Code not found in the database ▪ 3002 - NPI Missing ▪ 3003 - Invalid NPI ▪ 3006 - License Information ignored for the Group. ▪ 3023 - Phone number Missing ▪ 3024 - Accepting New Patients Missing ▪ 3025 - Name Type Missing ▪ 3026 - First Name Missing ▪ 3027 - Last Name Missing ▪ 3028 - Organization Name Missing ▪ 3029 - First Name, Last Name, Middle Name and Title ignored ▪ 3030 - Organization Name Ignored ▪ 3036 - Multiple ClaimTypeTaxonomyRecords with same information found ▪ 3037 - Multiple GroupAffiliationRecords with same information found ▪ 3038 - Multiple MCOEnrollmentRecords with same information found ▪ 3039 - Multiple ContractLocationRecords with same information found ▪ 3043 - Invalid NPI in NPIChange tag ▪ 3046 - Blank ProviderInfo Tag ▪ 3047 - Group NPI Not found ▪ 3066 - Multiple Addresses with same Address Type and Address Sequence are present ▪ 3050 - Invalid FEIN ▪ 3051 - LocationType Missing for the following service record ▪ 3053 - Group NPI is not Individual Provider NPI for the Type 'I' Group Affiliation record ▪ 3054 - Group NPI is the Individual Provider NPI for the Type 'G' Group Affiliation record ▪ 3055 - Billing restrictions ignored ▪ 3056 - Billing restrictions applied to the Individual Provider record ▪ 3057 - Gender Information ignored ▪ 3033 - Invalid Dates for ClaimTypeTaxonomyRecords ▪ 3034 - Invalid Dates for GroupAffiliationRecords ▪ 3035 - Invalid Dates for MCOEnrollmentRecords ▪ 3049 - Retroactive update request dated prior to last one year from the date of file creation ▪ 3070 - No license information available for the participating provider ▪ 3074 - Groups/Hospitals cannot be attending providers ▪ 3075 - Individuals/Groups cannot submit a Group Affiliation record with Group Type 'H' ▪ 3076 - Groups/Hospitals are mentioned as PCP/Specialist/Both ▪ 3110 - Out-of-date License record.
3.	Update the provider record in MMIS. See Business Rule - Updates to Existing Date Segments
Error Codes	

Error Code	Description/Message	Condition	Type
3001	Claim Type Taxonomy Records are missing	Provider Request doesn't have the ClaimTypeTaxonomyRecords tag.	F
3002	NPI Missing	Provider Request doesn't have the NPI	F
3003	Invalid NPI	NPI Check digit Validation failed.	F
3006	License Information ignored for the Group.	If the Organization Type is '1' (Group) and the License information is present. Note: In this scenario license information will not be stored on the provider profile.	I
3013	Invalid Claim Type, Specifier and Taxonomy combination.	This will use the Encounter Claim Type, Specifier and Taxonomy combinations.	F
3023	Phone number Missing	If the Location Code isn't associated with the Provider already, a Phone is required for the Location.	F
3024	Accepting New Patients Missing	If the Location Code isn't associated with the Provider already, an AcceptingNewPatient is required for the Location.	F
3025	Name Type Missing	If the Location Code isn't associated with the Provider already, a NameType is required for the Location.	F
3026	First Name Missing	If the Name Type is '1' and the First Name is missing in the tag Location.	F
3027	Last Name Missing	If the Name Type is '1' and the Last Name is missing in the tag Location.	F
3028	Organization Name Missing	If the Name Type is '2' or '3', and the Organization Name is missing in the tag Location.	F
3029	First Name, Last Name, Middle Name and Title ignored	If the Name Type is '2' or '3', and one of the following fields is present - First Name, Last Name, Middle Name or Title.	I
3030	Organization Name Ignored	If the Name Type is '1' and the Organization Name is present.	I
3031	Location Code not found in the database	If the Location Code for the SHP ID doesn't exist in the Address Master.	F
3033	Invalid Dates for ClaimTypeTaxonomyRecords	Check for non-overlapping dates, using the following business rules: • Sequential Date Entry • Ensure Non Overlapping Date Segments	F
3034	Invalid Dates for GroupAffiliationRecords	Check for non-overlapping dates, using the following business rules: • Sequential Date Entry • Ensure Non Overlapping Date Segments	F
3035	Invalid Dates for MCOEnrollmentRecords	Check for non-overlapping dates, using the following business rules: • Sequential Date Entry • Ensure Non Overlapping Date Segments	F
3036	Multiple ClaimTypeTaxonomyRecords with same information found	Multiple ClaimTypeTaxonomyRecords with same values in the following fields is available in the request: • Claim Type • Specifier • Taxonomy • Type Start Date • Type End Date • Type Status	F

3037	Multiple GroupAffiliationRecords with same information found	Multiple GroupAffiliationRecords with same values in the following fields is available in the request: • Group NPI • Group Affiliation Status • Group Affiliation Start Date • Group Affiliation End Date • Group Type	F
3038	Multiple MCOEnrollmentRecords with same information found	Multiple MCOEnrollmentRecords with same values in the following fields is available in the request: • MCO Enrollment Status • MCO Enrollment Start Date • MCO Enrollment End Date	F
3039	Multiple ContractLocationRecords with same information found	Multiple ContractLocationRecords with same values in the following fields is available in the request: • Location Code • Address Type	F
3040	Previous NPI not found in the database	If the NPI in the NPIChange tag doesn't exist in the database.	F
3042	Provider Record not found in the database	If no matching Provider Profile is available in the database.	F
3043	Invalid NPI in NPIChange tag	NPI Check digit Validation failed.	F
3046	Blank ProviderInfo Tag	ProviderInfo tag should have at least one of the following – Gender, Language1, Language2, Language3	I
3047	Group NPI Not found	If the Group Affiliation Type is 'G' and the Group NPI and a Group type record for the SHP Doesn't exist.	F
3049	Retroactive update request dated prior to last one year from the date of file creation.	Generate an error if any of the following conditions is true: 1. If the end date requested on the NPIChange, MedicareIDRecords is older than one year from the file creation date 2. If the update/add is requested on the records older than the most recent LicenseRecords, ClaimTypeTaxonomyRecords, MCOEnrollmentRecords or GroupAffiliationRecords and the start or end date is older than one year from the file creation date.	F
3050	Invalid FEIN	If the FEIN Value is all zeros.	F
3051	LocationType Missing for the following service record	If the Address Type is '04' and AcceptingNewPatient is missing in the tag Location.	F
3053	Group NPI is not Individual Provider NPI for the Type 'I' Group Affiliation record.	If the GroupAffiliation Type indicator is 'I' and NPI is not Provider's NPI.	F
3054	Group NPI is the Individual Provider NPI for the Type 'G' Group Affiliation record.	If the GroupAffiliation Type indicator is 'G' and NPI is Provider's NPI.	I
3055	Billing restrictions ignored	If the OrganizationType is '1' (Group) or '2' (Hospital), and the Restriction Code is '03'. Note: Groups and Hospitals are essentially Billing Providers.	I
3056	Billing restrictions applied to the Individual Provider record.	If the OrganizationType is '0' (Individual), and the Restriction Code '03' is present. Note: In this scenario the provider will not be able to submit the claims individually.	I
3057	Gender Information ignored	If the OrganizationType is '1' (Group) or '2' (Hospital).	I

3066	Multiple Addresses with same Address Type and Address Sequence are present	If multiple addresses with same Address Type and Address Sequence are present.	F
3070	No license information available for the participating provider	Check if the GroupAffiliationRecords are present and if one or more InNetwork indicator is 'I', a valid license segment is not reported on the request, and if any of the following conditions is true: • Organization Type is '0' (individual), one or more Claim Type Taxonomy records contain Specifier value other than 'E' (check for Claim Type Taxonomy records in the MMIS, if not reported on the request) and a valid License Segment is not available in the MMIS. • Organization Type is '2' (hospital), Claim Type is 'IN' (check for Claim Type Taxonomy records in the MMIS, if not reported on the request) and a valid License Segment is not available in the MMIS. Note: If the Organization Type is either '1' or '2', and a valid license segment is available, it will be stored.	F
3073	Individuals and Hospitals cannot use FQHC Claim Types	If the OrganizationType is '0' (individual) or '2' (Hospital) and one or more Claim Types are FPR/FDN.	F
3074	Groups/Hospitals cannot be attending providers	If the OrganizationType is '1' (Group) or '2' (Hospital), and one or more records with Group Type 'G' are present.	F
3075	Individuals/Groups cannot submit a Group Affiliation record with Group Type 'H'	If the OrganizationType is '1' (Group) or '0' (Individual), and one or more records with Group Type 'H' are present.	F
3076	Groups/Hospitals are mentioned as PCP/Specialist/Both	If the OrganizationType is '1' (Group) or '2' (Hospital), and one or more records with ClientRelationship P/S/B are present. Note: The recommended ClientRelationship value is 'N'. In case some other value is used, we would not reject the record, and the information would be stored.	I
3077	Conflicting Update – Group cannot have both FQHC and Non-FQHC claim types	If the Organization Type is '1' (Group) and ClaimTypeTaxonomy records are present on the request, check if accepting these changes would result in a group record with both FQHC claim types (FPR/FDN) and Non-FQHC claim types (DN/IN/PR/PH). Generate an error if it does.	F
3078	Conflicting Update – A provider cannot have multiple Specifier values for the same Taxonomy and Claim Type combination	If ClaimTypeTaxonomy records are present on the request, check if accepting this request would result in a provider record with same Claim Type & Taxonomy combination, with different Specifier Values. Generate an error if it does.	F
3110	Out-of-date License record	If the requests contains License Records that are not active within last one year from the date of file creation. Note: This license information will be stored in the system, in spite of the old dates.	I
Business Rules			
BR No.	**Rule**	**Description**	

301	Check for Atypical Providers	Check if the NPI is not present and if all the Claim Type Taxonomy records in the provider request contain Specifier value 'A'. Note: In case the provider request contains one or more Claim Type Taxonomy records with Specifier Value other than 'A', the provider will not be considered as an Atypical provider.
303	Validate NPI Check digit	Following are the steps to validate the NPI Check digit: 1. Double the value of alternate digits beginning with the rightmost digit. 2. Add the individual digits of the products resulting from step 1 to the unaffected digits from the original number. 3. Subtract the total obtained in step 2 from the next higher number ending in zero. This is the check digit. If the total obtained in step 2 is a number ending in zero, the check digit is zero. Generate an error if the check digit, doesn't match the last digit of the NPI.
304	Sequential Date Entry	All the records with the date segments should be validated and stored sequentially. Note: In case the health plans don't send the date information in sequential order, the program should sort the records by dates in the temporary space and then perform any other date based validations.
305	Ensure Non Overlapping Date Segments	Pre-Requisite: BR-Sequential Date Entry (validate the dates coming on the request only. The dates existing in the database will be end dated if required.) - The Start Date of the new record should be greater than End Dates of 'all' the previous records. If the end date of the last available record is the end of time date it will be end dated with Start Date - 1. - The End Date of the new record should be greater than the Start Date (of the new record). Generate an error if this rule fails, proceed otherwise.

306	Updates to Existing Date Segments	While processing the date segment updates ensure the following 1. We will adjust the date segments, with the new dates received in the Update Request. 2. In case a request comes with a retroactive change request, i.e. the changes affect the historical records, following steps have to be taken to update the records: a) The oldest start date on the request will be used to adjust any date segments that exist on that day in our database b) All the records (in our database) starting after that start date will set to cancelled status, Last change date will be set to the system date and Clerk Number will be updated. c) The cancelled records will be replaced by the new records in the request. Note: For Retroactive Updates 1. Following FFS protocol, the updates will be accepted for last one year from the date of file creation. 2. SHPs would be expected to send all the updates again, since the change took place to the most recent record.
308	Check for an existing provider.	Check if a Provider with same values for the following fields already exist: • SHP ID • MCO Internal ID • NPI

PROCESS 7: ADD AN ATYPICAL PROVIDER

Provider (ENC) Subsystem	
Process #7	
Process Name	Add an Atypical Provider
Process Description	The purpose of this process is to validate the Atypical provider request (providers without access to an NPI), and add a new provider profile.
Parent Process	Process 5: Add Provider
Non-Functional Requirements	• **Error Handling:** Unless otherwise stated in the process specifications, o If the process encounters database error, the process would terminate and operator on duty would be notified by an email notification o For all the Failure (Type 'F') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and exit. o For all the Informational (Type 'I') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and continue with the next step.
Process Specifications	
Specification Number	**Description**
1.	Validate Provider Record. See Business Rules: - Sequential Date Entry - Ensure Non Overlapping Date Segments - Check for duplicate atypical provider

	Errors: ▪ 3007 - NPI Change information ignored for Add request ▪ 3010 - Provider Info Missing ▪ 3011 - Gender is Missing ▪ 3012 - Language1 is Missing ▪ 3014 - FEIN is missing ▪ 3015 - MCO Enrollment Records are missing ▪ 3019 - Contract Location Records are missing for the Add request. ▪ 3020 - At least one Service Location is required. ▪ 3021 - At least one Mail-To Location is required. ▪ 3022 - At least one Pay-To Location is required. ▪ 3023 - Phone number Missing ▪ 3025 - Name Type Missing ▪ 3026 - First Name Missing ▪ 3027 - Last Name Missing ▪ 3028 - Organization Name Missing ▪ 3029 - First Name, Last Name, Middle Name and Title ignored ▪ 3030 - Organization Name Ignored ▪ 3036 - Multiple ClaimTypeTaxonomyRecords with same information found ▪ 3037 - Multiple GroupAffiliationRecords with same information found ▪ 3038 - Multiple MCOEnrollmentRecords with same information found ▪ 3039 - Multiple ContractLocationRecords with same information found ▪ 3048 - Historical Records ignored ▪ 3051 - LocationType Missing for the following service record ▪ 3058 - Group NPI is not Individual Provider NPI for the Type 'I' Group Affiliation ▪ 3059 - Group cannot be an Atypical Provider ▪ 3060 - Hospital cannot be an Atypical Provider ▪ 3061 - Providers affiliated to a group cannot be an Atypical Provider ▪ 3062 - Providers with Medicare ID cannot be Atypical Providers ▪ 3063 - Atypical Providers cannot be a PCP, a Specialist or Both ▪ 3064 - In Network Provider cannot be an Atypical Provider ▪ 3065 - Billing Restrictions cannot be applied to the Atypical Provider Record ▪ 3066 - Multiple Addresses with same Address Type and Address Sequence are present ▪ 3067 - No Primary Service Address Present ▪ 3068 - No Primary Pay-To Address Present ▪ 3069 - No Primary Mail-To Address Present ▪ 3031 - Location Code not found in the database ▪ 3033 - Invalid Dates for ClaimTypeTaxonomyRecords ▪ 3034 - Invalid Dates for GroupAffiliationRecords ▪ 3035 - Invalid Dates for MCOEnrollmentRecords ▪ 3032 - Provider already exists. ▪ 3073 - Individuals and Hospitals cannot use FQHC Claim Types ▪ 3075 - Individuals/Groups cannot submit a Group Affiliation record with Group Type 'H'
2.	Add the atypical provider record.

Error Codes			
Error Code	**Description/Message**	**Condition**	**Type**

3007	NPI Change information ignored for Add request	If the NPIChange tag is present. Note: This tag cannot be used with an Add Provider Request.	I
3010	Provider Info Missing	Provider Info tag is missing.	F
3011	Gender is Missing	If the Organization Type is '0' (individual) and the Gender Field is missing in the tag ProviderInfo.	F
3012	Language1 is Missing	If the Language1 is missing in the tag ProviderInfo.	F
3014	FEIN is missing	If the FEIN Tag is missing.	F
3015	MCO Enrollment Records are missing	If the MCOEnrollmentRecords is missing.	F
3019	Contract Location Records are missing for the Add request.	If the ContractLocationRecords is missing. Note: Only the tags/attributes that are required for both add and update request are marked as required in the XSD validation. Since this is not a required tag/attribute for both update and add request, an explicit validation is required to confirm that this tag is present in the add request.	F
3020	At least one Service Location is required.	If there's no LocationRecord with Address Type '04' in the Provider Record.	F
3021	At least one Mail-To Location is required.	If there's no LocationRecord with Address Type '02' in the Provider Record.	F
3022	At least one Pay-To Location is required.	If there's no LocationRecord with Address Type '01' in the Provider Record.	F
3023	Phone number Missing	If the Phone is missing in the tag Location.	F
3024	Accepting New Patients Missing	If the Address Type is '04' and AcceptingNewPatient is missing in the tag Location.	F
3025	Name Type Missing	If the NameType is missing in the tag Location.	F
3026	First Name Missing	If the Name Type is '1' and the First Name is missing in the tag Location.	F
3027	Last Name Missing	If the Name Type is '1' and the Last Name is missing in the tag Location.	F
3028	Organization Name Missing	If the Name Type is '2' or '3', and the Organization Name is missing in the tag Location.	F
3029	First Name, Last Name, Middle Name and Title ignored	If the Name Type is '2' or '3', and one of the following fields is present - First Name, Last Name, Middle Name or Title.	I
3030	Organization Name Ignored	If the Name Type is '1' and the Organization Name is present.	I
3031	Location Code not found in the database	If the Location Code for the SHP ID doesn't exist in the Address Master.	F
3032	Provider already exists.	If the Provider record already exists in the database.	F
3033	Invalid Dates for ClaimTypeTaxonomyRecords	Check for non-overlapping dates, using the following business rules: • Sequential Date Entry • Ensure Non Overlapping Date Segments	F
3034	Invalid Dates for GroupAffiliationRecords	Check for non-overlapping dates, using the following business rules: • Sequential Date Entry • Ensure Non Overlapping Date Segments	F
3035	Invalid Dates for MCOEnrollmentRecords	Check for non-overlapping dates, using the following business rules: • Sequential Date Entry • Ensure Non Overlapping Date Segments	F

3036	Multiple ClaimTypeTaxonomyRecords with same information found	Multiple ClaimTypeTaxonomyRecords with same values in the following fields is available in the request: • Claim Type • Specifier • Taxonomy • Type Start Date • Type End Date • Type Status	F
3037	Multiple GroupAffiliationRecords with same information found	Multiple GroupAffiliationRecords with same values in the following fields is available in the request: • Group NPI • Group Affiliation Status • Group Affiliation Start Date • Group Affiliation End Date • Group Type	F
3038	Multiple MCOEnrollmentRecords with same information found	Multiple MCOEnrollmentRecords with same values in the following fields is available in the request: • MCO Enrollment Status • MCO Enrollment Start Date • MCO Enrollment End Date	F
3039	Multiple ContractLocationRecords with same information found	Multiple ContractLocationRecords with same values in the following fields is available in the request: • Location Code • Address Type	F
3048	Historical Records ignored	If the add requests contains Enrollment, Group Affiliation, Claim Type Taxonomy, License or Medicare ID Records that were not active on the date of file generation (to account for any delay in processing the file).	I
3050	Invalid FEIN	If the FEIN Value is all zeros.	F
3051	LocationType Missing for the following service record	If the Address Type is '04' and AcceptingNewPatient is missing in the tag Location.	F
3058	Group NPI is not Individual Provider's NPI for the Type 'I' Group Affiliation	If the GroupAffiliation Type indicator is 'I' and NPI is not Provider's NPI. Note: An Atypical Provider cannot be a part of a group.	F
3059	Group cannot be an Atypical Provider	If the OrganizationType is '1' (Group).	F
3060	Hospital cannot be an Atypical Provider	If the OrganizationType is '2' (Hospital).	F
3061	Providers affiliated to a group cannot be an Atypical Provider	If Group Affiliation records with Type 'G' are present.	F
3062	Providers with Medicare ID cannot be Atypical Providers	If one or more Medicare ID records are present.	F
3063	Atypical Providers cannot be a PCP, a Specialist or Both	If the value of the Client Relationship Indicator (under any Group Affiliation Record) is P/S/B. Note: Only value 'N' is allowed for Atypical Providers.	F
3065	Billing Restrictions cannot be applied to the Atypical Provider Record	If Billing Restriction with Restriction Code 03 is present.	I
3066	Multiple Addresses with same Address Type and Address Sequence are present	If multiple addresses with same Address Type and Address Sequence are present.	F
3067	No Primary Service Address Present	If the Address Type is '04' and no record with Address Sequence '1' is present.	F

3068	No Primary Pay-To Address Present	If the Address Type is '01' and no record with Address Sequence '1' is present.	F
3069	No Primary Mail-To Address Present	If the Address Type is '02' and no record with Address Sequence '1' is present.	F
3073	Individuals and Hospitals cannot use FQHC Claim Types	If the OrganizationType is '0' (individual) or '2' (Hospital) and one or more Claim Types are FPR/FDN.	F
3075	Individuals/Groups cannot submit a Group Affiliation record with Group Type 'H'	If the OrganizationType is '1' (Group) or '0' (Individual), and one or more records with Group Type 'H' are present.	F
Business Rules			
BR No.	**Rule**	**Description**	
304	Sequential Date Entry	All the records with the date segments should be validated and stored sequentially. Note: In case the health plans don't send the date information in sequential order, the program should sort the records by dates in the temporary space and then perform any other date based validations.	
305	Ensure Non Overlapping Date Segments	Pre-Requisite: BR-Sequential Date Entry (validate the dates coming on the request only. The dates existing in the database will be end dated if required.) - The Start Date of the new record should be greater than End Dates of 'all' the previous records. If the end date of the last available record is the end of time date it will be end dated with Start Date - 1. - The End Date of the new record should be greater than the Start Date (of the new record). Generate an error if this rule fails, proceed otherwise.	
309	Check for duplicate atypical provider.	Check if an Atypical Provider with same values for the following fields already exist: • SHP ID • MCO Internal ID	

PROCESS 8: UPDATE AN EXISTING ATYPICAL PROVIDER

Provider (ENC) Subsystem	
Process #8	
Process Name	Update an existing Atypical Provider
Process Description	The purpose of this process is to validate the Atypical provider request (providers without access to an NPI), and update an existing provider profile.
Parent Process	Process 6: Update Provider
Non-Functional Requirements	• **Error Handling:** Unless otherwise stated in the process specifications, o If the process encounters database error, the process would terminate and operator on duty would be notified by an email notification o For all the Failure (Type 'F') errors: As soon as an error with type 'F' is encountered, the process would log the error (for reporting back to the SHP in the Provider Response File) and in this scenario all updates in this request will be rejected, and exit the sub-process. o For all the Informational (Type 'I') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and continue with the next step.

Process Specifications	
Specification Number	**Description**
1.	Validate provider record. See Business Rules: - Check for an existing atypical provider - Sequential Date Entry - Ensure Non Overlapping Date Segments Errors: ▪ 3042 - Provider Record not found in the database ▪ 3031 - Location Code not found in the database ▪ 3023 - Phone number Missing ▪ 3025 - Name Type Missing ▪ 3026 - First Name Missing ▪ 3027 - Last Name Missing ▪ 3028 - Organization Name Missing ▪ 3029 - First Name, Last Name, Middle Name and Title ignored ▪ 3030 - Organization Name Ignored ▪ 3036 - Multiple ClaimTypeTaxonomyRecords with same information found ▪ 3037 - Multiple GroupAffiliationRecords with same information found ▪ 3038 - Multiple MCOEnrollmentRecords with same information found ▪ 3039 - Multiple ContractLocationRecords with same information found ▪ 3046 - Blank ProviderInfo Tag ▪ 3050 - Invalid FEIN ▪ 3051 - LocationType Missing for the following service record ▪ 3058 - Group NPI is not Individual Provider's NPI for the Type 'I' Group Affiliation ▪ 3059 - Group cannot be an Atypical Provider ▪ 3060 - Hospital cannot be an Atypical Provider ▪ 3061 - Providers affiliated to a group cannot be an Atypical Provider ▪ 3062 - Providers with Medicare ID cannot be Atypical Providers ▪ 3063 - Atypical Providers cannot be a PCP, a Specialist or Both ▪ 3064 - In Network Provider cannot be an Atypical Provider ▪ 3065 - Billing Restrictions cannot be applied to the Atypical Provider Record ▪ 3066 - Multiple Addresses with same Address Type and Address Sequence are present ▪ 3033 - Invalid Dates for ClaimTypeTaxonomyRecords ▪ 3034 - Invalid Dates for GroupAffiliationRecords ▪ 3035 - Invalid Dates for MCOEnrollmentRecords ▪ 3049 - Retroactive update request dated prior to last one year from the date of file creation ▪ 3073 - Individuals and Hospitals cannot use FQHC Claim Types ▪ 3075 - Individuals/Groups cannot submit a Group Affiliation record with Group Type 'H' ▪ 3078 - Conflicting Update – A provider cannot have multiple Specifier values for the same Taxonomy and Claim Type combination
2.	Update Atypical Provider. See Business Rule - Updates to Existing Date Segments
Error Codes	

Error Code	Description/Message	Condition	Type
3023	Phone number Missing	If the Location Code isn't associated with the Provider already, a Phone is required for the Location.	F
3025	Name Type Missing	If the Location Code isn't associated with the Provider already, a NameType is required for the Location.	F
3026	First Name Missing	If the Name Type is '1' and the First Name is missing in the tag Location.	F
3027	Last Name Missing	If the Name Type is '1' and the Last Name is missing in the tag Location.	F
3028	Organization Name Missing	If the Name Type is '2' or '3', and the Organization Name is missing in the tag Location.	F
3029	First Name, Last Name, Middle Name and Title ignored	If the Name Type is '2' or '3', and one of the following fields is present - First Name, Last Name, Middle Name or Title.	I
3030	Organization Name Ignored	If the Name Type is '1' and the Organization Name is present.	I
3031	Location Code not found in the database	If the Location Code for the SHP ID doesn't exist in the Address Master.	F
3033	Invalid Dates for ClaimTypeTaxonomyRecords	Check for non-overlapping dates, using the following business rules: • Sequential Date Entry • Ensure Non Overlapping Date Segments	F
3034	Invalid Dates for GroupAffiliationRecords	Check for non-overlapping dates, using the following business rules: • Sequential Date Entry • Ensure Non Overlapping Date Segments	F
3035	Invalid Dates for MCOEnrollmentRecords	Check for non-overlapping dates, using the following business rules: • Sequential Date Entry • Ensure Non Overlapping Date Segments	F
3036	Multiple ClaimTypeTaxonomyRecords with same information found	Multiple ClaimTypeTaxonomyRecords with same values in the following fields is available in the request: • Claim Type • Specifier • Taxonomy • Type Start Date • Type End Date • Type Status	F
3037	Multiple GroupAffiliationRecords with same information found	Multiple GroupAffiliationRecords with same values in the following fields is available in the request: • Group NPI • Group Affiliation Status • Group Affiliation Start Date • Group Affiliation End Date • Group Type	F
3038	Multiple MCOEnrollmentRecords with same information found	Multiple MCOEnrollmentRecords with same values in the following fields is available in the request: • MCO Enrollment Status • MCO Enrollment Start Date • MCO Enrollment End Date	F
3039	Multiple ContractLocationRecords with same information found	Multiple ContractLocationRecords with same values in the following fields is available in the request: • Location Code • Address Type	F
3042	Provider Record not found in the database	If no matching Provider Profile is available in the database.	F

3046	Blank ProviderInfo Tag	ProviderInfo tag should have at least one of the following – Gender, Language1, Language2, Language3	I
3049	Retroactive update request dated prior to last one year from the date of file creation.	If the request contains retroactive updates to License, Enrollment, Claim Type Taxonomy and the dates on the record are more than a year old from the date of file generation.	F
3050	Invalid FEIN	If the FEIN Value is all zeros.	F
3051	LocationType Missing for the following service record	If the Address Type is '04' and AcceptingNewPatient is missing in the tag Location.	F
3058	Group NPI is not Individual Provider's NPI for the Type 'I' Group Affiliation	If the GroupAffiliation Type indicator is 'I' and NPI is not Provider's NPI. Note: An Atypical Provider cannot be a part of a group.	F
3059	Group cannot be an Atypical Provider	If the OrganizationType is '1' (Group).	F
3060	Hospital cannot be an Atypical Provider	If the OrganizationType is '2' (Hospital).	F
3061	Providers affiliated to a group cannot be an Atypical Provider	If Group Affiliation records with Type 'G' are present.	F
3062	Providers with Medicare ID cannot be Atypical Providers	If one or more Medicare ID records are present.	F
3063	Atypical Providers cannot be a PCP, a Specialist or Both	If the value of the Client Relationship Indicator (under any Group Affiliation Record) is P/S/B. Note: Only value 'N' is allowed for Atypical Providers.	F
3064	In Network Provider cannot be an Atypical Provider	If the value of the In Network Indicator (under any Group Affiliation Record) is 'Y'. Note: Only value 'N' is allowed for Atypical Providers.	F
3065	Billing Restrictions cannot be applied to the Atypical Provider Record	If Billing Restriction with Restriction Code 03 is present.	I
3066	Multiple Addresses with same Address Type and Address Sequence are present	If multiple addresses with same Address Type and Address Sequence are present.	F
3073	Individuals and Hospitals cannot use FQHC Claim Types	If the OrganizationType is '0' (individual) or '2' (Hospital) and one or more Claim Types are FPR/FDN.	F
3075	Individuals/Groups cannot submit a Group Affiliation record with Group Type 'H'	If the OrganizationType is '1' (Group) or '0' (Individual), and one or more records with Group Type 'H' are present.	F
3078	Conflicting Update – A provider cannot have multiple Specifier values for the same Taxonomy and Claim Type combination	If ClaimTypeTaxonomy records are present on the request, check if accepting this request would result in a provider record with same Claim Type & Taxonomy combination, with different Specifier Values. Generate an error if it does.	F
Business Rules			
BR No.	**Rule**	**Description**	
304	Sequential Date Entry	All the records with the date segments should be validated and stored sequentially. Note: In case the health plans don't send the date information in sequential order, the program should sort the records by dates in the temporary space and then perform any other date based validations.	
305	Ensure Non Overlapping Date Segments	Pre-Requisite: BR-Sequential Date Entry (validate the dates coming on the request only. The dates existing in the database	

		will be end dated if required.) - The Start Date of the new record should be greater than End Dates of 'all' the previous records. If the end date of the last available record is the end of time date it will be end dated with Start Date - 1. - The End Date of the new record should be greater than the Start Date (of the new record). Generate an error if this rule fails, proceed otherwise.
306	Updates to Existing Date Segments	While processing the date segment updates ensure the following 1. We will adjust the date segments, with the new dates received in the Update Request. 2. In case a request comes with a retroactive change request, i.e. the changes affect the historical records, following steps have to be taken to update the records: a) The oldest start date on the request will be used to adjust any date segments that exist on that day in our database b) All the records (in our database) starting after that start date will set to cancelled status, Last change date will be set to the system date and Clerk Number will be updated. c) The cancelled records will be replaced by the new records in the request. Note: For Retroactive Updates 1. Following FFS protocol, the updates will be accepted for last one year from the date of file creation. 2. SHPs would be expected to send all the updates again, since the change took place to the most recent record.
310	Check for an existing atypical provider.	Check if an atypical provider with same values for the following fields already exist: • SHP ID • MCO Internal ID

PROCESS 9: GENERATE PROVIDER RESPONSE FILE

Provider (ENC) Subsystem	
Process #9	
Process Name	Generate Provider Response File
Process Description	The purpose of this process is to generate the response file for the request and reconciliation files. This response file would act as the acknowledgement for the request file, and would also contain the status of the request records and the errors encountered during the processing, saving the overhead of a separate report, just for the errors. This response file would be sent back to the SHP along with a XML Stylesheet (XSL), which would enable SHP employees to view the response file in any browser of their preference. If the request file is not compliant, it will report the value of the compliant tag as 'N' and populates the compliance error tag with the output of the XML Validation (from Process 1: Perform XSD Validations and load requests). Otherwise the value of the Compliance Tag is reported as 'Y'. If the request file was blank, the Blank Tag will be set to 'Y', otherwise 'N'. If the file is

	not blank the process will populate the summary of request records processed. If there were any records in error, the Errors Encountered will be set to 'Y'. The process then populates the detailed results of the records. Results for the address request records, if any, are included first, and results for the provider record request is populated after that. The following information will be reported back to the SHP in the Response File for every processed request record individually: • Result – The outcome of processing the request record. • PRRequest/ADRequest indicators • Transaction ID/SAK • Errors Encountered Indicator – Y/N (Value 'Y' will be reported if errors of type I/F were encountered during processing) • Errors – All the errors (error code, error type and description) will be reported back to the SHPs. The generated response file and a XML Stylesheet (for viewing the response file in browser), are then moved to the DXC's Secure FTP Server (SHP's will be expected to pick the files from this location).
Non-Functional Requirements	• **Error Handling:** Unless otherwise stated in the process specifications, o If the process encounters database error, the process would terminate and operator on duty would be notified by an email notification o For all the Failure (Type 'F') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and exit. o For all the Informational (Type 'I') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and continue with the next step.
Process Specifications	
Specification Number	**Description**
1.	Check for the oldest processed (and not reported) file. In case no files exist, exit the process.
2.	Populate Request and Response file information.
3.	If the file was not compliant add the XSD Validation output under the ComplianceErrors tag.
4.	If the Request file was blank set the blank indicator to 'Y'
5.	For Load Response File - Populate following fields under RecordResults: • AddressRequestsTotal - Total number of address requests • ProviderRequestsTotal - Total number of provider requests • AddressRequestsAccepted – Total number of address requests accepted without errors. • ProviderRequestsAccepted – Total number of provider requests accepted without errors. • AddressRequestsAcceptedWithErrors – Total number of address requests accepted with errors of Type 'I' only. • ProviderRequestsAcceptedWithErrors – Total number of provider requests accepted with errors of Type 'I' only. • AddressRequestsRejected – Total number of address requests rejected due to errors. • ProviderRequestsRejected – Total number of provider requests rejected due to errors. For Reconciliation Response File - Populate following fields under

	ReconciliationResults: • AddressRequestsTotal - Total number of address requests processed. • ProviderRequestsTotal - Total number of provider requests processed. • AddressRequestsMatchedTotal - Total number of address requests matched. • ProviderRequestsMatchedTotal - Total number of provider requests matched. • AddressRequestsAddedTotal - Total number of address requests in MMIS added using the reconciliation records. • ProviderRequestsAddedTotal - Total number of provider requests in MMIS added using the reconciliation records. • AddressRequestsUpdatedTotal - Total number of address requests in MMIS updated using the reconciliation records. • ProviderRequestsUpdatedTotal - Total number of provider requests in MMIS updated using the reconciliation records. • AddressRequestsRejected - Total number of address requests that could not be matched or used for updating the MMIS records due to error. • ProviderRequestsRejected - Total number of provider requests that could not be matched or used for updating the MMIS records due to error. • AddressRequestsNotFound - Total number of address records that are available in the MMIS but not present in the reconciliation file. • ProviderRequestsNotFound - Total number of provider records that are available in the MMIS but not present in the reconciliation file.
6.	Check if Address requests were processed: Scenario 1 – No records found: go to step 8. Scenario 2 – Records found: continue with the next step.
7.	Populate following fields under AddressRecord.ADResponse for every request processed: • Action – Request Action value • LocationCode – Location code from the request • Result – Result code on the transaction. • TxnID – Transaction ID • ErrorsEncountered – Set to 'Y', if errors are available for this transaction, otherwise set to 'N'. In case errors are found for this transaction, populate the following fields for every error under AddressRecord.Errors: • ErrorDetail.ErrorCode – Error Code • ErrorDetail.ErrorDesc – Error Description • ErrorDetail.Type – Error Type
8.	Check if Provider requests were processed: Scenario 1 – No records found: go to step 10. Scenario 2 – Records found: continue with the next step.
9.	Populate following fields under ProviderRecord.PRResponse for every provider request processed: • Action – Request Action value • MCOInternalProviderIdentifier – MCOInternalProviderIdentifier from the Request • NPI – NPI from the request • OrganizationType - OrganizationType from the request • Result – Result code on the transaction. • TxnID – Transaction SAK • ErrorsEncountered – Set to 'Y', if errors are available for this transaction,

	otherwise set to 'N'. In case errors are found for this transaction, populate the following fields for every error under AddressRecord.Errors: • ErrorDetail.ErrorCode – Error Code • ErrorDetail.ErrorDesc – Error Description • ErrorDetail.Type – Error Type In case the provider is an Atypical Provider populate the following under AtypicalProvider • LegacyProviderID - Legacy Provider ID generated for the Atypical Provider
10.	Send the Response File to the SHP.

PROCESS 10: RECONCILE MCO PROVIDER INFORMATION

Provider (ENC) Subsystem	
Process #10	
Process Name	Reconcile MCO Provider Information
Process Description	The objectives of this process are (1) to confirm that all the additions and updates made by the Submitting Health Plans (SHPs) to the MCO Medicaid Providers (MCO Providers serving Medicaid clients) have been applied to the RI MMIS (Encounter Data), (2) in case of any discrepancies attempt to update the record into RI MMIS (based on the information contained in the reconciliation record) and (3) report all the matches, updates made and discrepancies back to the SHPs. For the reconciliation process the SHPs will be expected to send us a file with all the providers with active records and end dates greater than OICL Date or the last two years from the date of file creation (whichever is sooner). Comparing the records for last two years would ensure that the unresolved discrepancies (if any) are reported multiple times. The reconciliation process will check for instances where the changes made by the SHPs have not been applied to the RI MMIS (Encounter Data), by comparing the provider information in the RI MMIS with the information in the Reconciliation File. In case such instances are found, the process will perform all the edits and validations on the reconciliation records and if the reconciliation record passes all the validations, it will be used to update the RI MMIS Encounter records, otherwise all these instances will be reported back to the SHPs (along with the matches and updates made). In case the process finds one or more discrepancies, the process will use the validations defined in the Daily/Weekly Provider Network Load Process to determine if the reconciliation record can be used for updating the RI MMIS Encounter Records. If the record in the reconciliation file passes all the validations successfully, the RI MMIS Encounter Data record will be updated. Once all the applicable updates are applied to the RI MMIS Encounter records, a response file will be generated to report the following: • Compliance Errors – In case the reconciliation file fails the compliance check. • Records in error – For the records where discrepancies were found but the record in the reconciliation file could not be used for adding/updating the RI MMIS record due to errors. • Records matched – For the records with no discrepancies. • Records added – For the records that were not found in MMIS, and were added using the reconciliation record. • Records updated– For the records where discrepancies were found, but were resolved by updating the records in RI MMIS. Discrepancies that could not be

	resolved by performing an update will be reported as informational errors. • Records Not Found – Records that were selected for comparison in MMIS, but were not found in the Reconciliation File.
Non-Functional Requirements	• **Frequency:** Daily. The process will check for the file daily, but SHPs will send a file only if there are some updates to their provider/address records. • **Error Handling:** Unless otherwise stated in the process specifications, o If the process encounters database error, the process would terminate and operator on duty would be notified by an email notification o For all the Failure (Type 'F') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and exit. o For all the Informational (Type 'I') errors: The process would log the error (for reporting back to the SHP in the Provider Response File) and continue with the next step. • All the records will be committed to the database individually. In case the file is partially processed and the job encounters an error, the job would process the remaining transactions only.
Process Specifications	
Specification Number	**Description**
1.	Select the oldest reconciliation file available for processing. In case no files with FileCode 'MCOPRVRECNREQ' are available, exit the process.
2.	Store all the address and provider records to be compared in a Temporary Table. See Business Rule - Select Provider Records for Reconciliation
3.	Compare the records selected from MMIS with the records in the Reconciliation File. See Business Rule - Compare Address Records - Compare Provider Records
4.	In case discrepancies are found, resolve the discrepancies by calling following processes: • Call Process 3 - Add Address Record to add the address record in RI MMIS • Call Process 4 - Update Address Record to update the address record in RI MMIS • Call Process 5 - Add Provider Record to add the provider record in RI MMIS • Call Process 6 - Update Provider Record to update the provider record in RI MMIS Errors: • 4001 - Address didn't exist and was added in the RI MMIS. • 4002 - Address record in RI MMIS updated to resolve the discrepancies. • 4003 - Address record exist in RI MMIS, but not found in the Reconciliation File • 4004 - Provider record didn't exist and was added in the RI MMIS. • 4005 - Provider record in RI MMIS updated to resolve the discrepancies. • 4006 - An update was made to the Provider record in the RI MMIS. Provider record in RI MMIS contains more GroupAffiliation records as compared to the Reconciliation File. • 4007 - An update was made to the Provider record in the RI MMIS. Provider record in RI MMIS contains more FEIN records as compared to the Reconciliation File. • 4008 - An update was made to the Provider record in the RI MMIS. Provider record in RI MMIS contains more License records as compared to the Reconciliation File.

	• 4009 - An update was made to the Provider record in the RI MMIS. Provider record in RI MMIS contains more MedicareID records as compared to the Reconciliation File. • 4010 - An update was made to the Provider record in the RI MMIS. Provider record in RI MMIS contains more ClaimTypeTaxonomy records as compared to the Reconciliation File. • 4011 - An update was made to the Provider record in the RI MMIS. Provider record in RI MMIS contains more MCOEnrollment records as compared to the Reconciliation File. • 4012 - An update was made to the Provider record in the RI MMIS. Provider record in RI MMIS contains more ProviderRestriction records as compared to the Reconciliation File. • 4013 - An update was made to the Provider record in the RI MMIS. Provider record in RI MMIS contains more ContractLocation records as compared to the Reconciliation File. • 4014 - Provider record exist in RI MMIS, but not found in the Reconciliation File
5.	Log Errors and commit the changes (only if the record passed the validations without errors or with Errors of Type 'I' only).
6.	Report all the errors, discrepancies and any un-reconciled records in the Temporary Table

Error Codes

Error Code	Description/Message	Condition	Type
4001	Address didn't exist and was added in the RI MMIS.	If the Location Code (for the SHP ID) wasn't found in the MMIS.	I
4002	Address record in RI MMIS updated to resolve the discrepancies.	If the Location Code (for the SHP ID) is found in the MMIS, but the record details don't match.	I
4003	Address record exist in RI MMIS, but not found in the Reconciliation File	If the Location Code (for the SHP ID) exist in the MMIS but wasn't found in the Reconciliation File.	I
4004	Provider record didn't exist and was added in the RI MMIS.	If the MCO Internal ID (for the SHP ID) and NPI (if applicable) wasn't found in the MMIS.	I
4005	Provider record in RI MMIS updated to resolve the discrepancies.	If the MCO Internal ID (for the SHP ID) and NPI (if applicable) is found in the MMIS, but the record details don't match.	I
4006	An update was made to the Provider record in the RI MMIS. Provider record in RI MMIS contains more GroupAffiliation records as compared to the Reconciliation File.	If the provider record was updated using the reconciliation file, but the GroupAffiliation records still don't match.	I
4007	An update was made to the Provider record in the RI MMIS. Provider record in RI MMIS contains more FEIN records as compared to the Reconciliation File.	If the provider record was updated using the reconciliation file, but the FEIN records still don't match.	I
4008	An update was made to the Provider record in the RI MMIS. Provider record in RI MMIS contains more License records as compared to the	If the provider record was updated using the reconciliation file, but the License records still doesn't match.	I

	Reconciliation File.		
4009	An update was made to the Provider record in the RI MMIS. Provider record in RI MMIS contains more MedicareID records as compared to the Reconciliation File.	If the provider record was updated using the reconciliation file, but the MedicareID records still don't match.	I
4010	An update was made to the Provider record in the RI MMIS. Provider record in RI MMIS contains more ClaimTypeTaxonomy records as compared to the Reconciliation File.	If the provider record was updated using the reconciliation file, but the ClaimTypeTaxonomy records still don't match.	I
4011	An update was made to the Provider record in the RI MMIS. Provider record in RI MMIS contains more MCOEnrollment records as compared to the Reconciliation File.	If the provider record was updated using the reconciliation file, but the MCOEnrollment records still don't match.	I
4012	An update was made to the Provider record in the RI MMIS. Provider record in RI MMIS contains more ProviderRestriction records as compared to the Reconciliation File.	If the provider record was updated using the reconciliation file, but the ProviderRestriction records still don't match.	I
4013	An update was made to the Provider record in the RI MMIS. Provider record in RI MMIS contains more ContractLocation records as compared to the Reconciliation File.	If the provider record in the reconciliation file doesn't have at least one Mail-To, Pay-To and Service Location with Sequence number 1.	I
4014	Provider record exist in RI MMIS, but not found in the Reconciliation File	If the MCO Internal ID (for the SHP ID) and NPI (if applicable) matching the selection criteria was found in the MMIS, but a record for reconciliation was not found in the Reconciliation File.	I
Business Rules			
BR No.	**Rule**	**Description**	
401	Compare Address Records	Address information would be compared using an equality check. Spelling or abbreviation differences, etc. will not be tested. For example '123 Main Rd.' and '123 Main Road' will be considered as a mismatch.	
402	Select Provider Records for Reconciliation	Step 1 - Determine Reconciliation Criteria Start Date (RCSD): Out of the following two dates, the process will use the date that is greater (or most recent): • One-time Initial Conversion Load (OICL) Date • Processing Date – (365*2) Step 2 – Determine Reconciliation Criteria End Date (RCED): The process will use the End of Time date as the End Date.	

		Step 3 – Select Provider Records to Reconcile: Provider Records that match any of the following conditions will be selected for the Reconciliation:
		• If any of the following has the Status as Active (03/13 for Enrollment Records) and the End Date between RCSD and RCED:
		  ○ License Records
		  ○ Claim Type Taxonomies
		  ○ Group Affiliation Records
		  ○ MCO Enrollment Records
		• If any of the following has the End Date between RCSD and RCED:
		  ○ FEIN
		  ○ Medicare ID Records
		  ○ Provider Restriction Records

403	Compare Provider Records	Following comparison method will be used for comparing the provider records: • For License Records, Claim Type Taxonomies, Group Affiliation Records and MCO Enrollment Records – All the records in MMIS with an Active Status (03/13 for Enrollment Records) and End Date between RCSD and RCED will be used for comparison. • For MedicareID Records, FEIN and Provider Restriction Records – All the records in MMIS with End Date between RCSD and RCED will be used for comparison. • For Contract Location Records – The process will check the Address Type and Sequence Number for the Contract Location Records and will use only the corresponding Address Records in the MMIS for comparison.

APPENDIX

APPENDIX 1 – PROVIDER EXCHANGE FILE LAYOUT

Last Update	Author	Change Description
11/9/2012	Piyush Khandelwal	Initial Entry
12/21/2012	Piyush Khandelwal	Updated FileName format and Length.
1/18/2013	Piyush Khandelwal	• Updated RequestCount's length to 7 • Updated LicenseNumber's length to 12.
2/6/2013	Piyush Khandelwal	• Updated description for License Records (3) • Updated description for Group Affiliation Records (7) • Added new value for Group Type (7.1.6) • Updated description for Location Type (11.1.6)
2/12/2013	Piyush Khandelwal	• Added a note for default value to be used for License End Date (3.1.5).
4/12/2013	Piyush Khandelwal	• Updated Description of Organization Type field (for FQHC Providers) • Renamed Type Specialty Records to Claim Type Taxonomy Records • Renamed Type Specialty Record to Claim Type Taxonomy Record • Renamed Provider Type to Claim Type • Renamed Specialty to Specifier • Renamed Specialty Status to Type Status • Removed Specialty from Location Record

The file is categorized into following segments:

- Header
- Request Details
  - Provider (NPI Change, License, Medicare ID, Provider Info, Type Specialties, Group Association Info, FEIN, Enrollment Details, Restrictions, Contract Locations)
  - Address Record (Address, Accessibility)
- Trailer

Add/Update Column Value Legend

- R – Required
- C - Conditional – This field could be a required or an optional field depending on the type of provider.
- O - Optional

Following is the detailed overview of the fields listed in the file:

High-level summary of Provider and Address Record structure

S. No.	Record Name	Type	Len-gth	Required		Description
				Add	Update	
1.	Header Record	-	-	R	R	Header Record
2.	Request Details Record	-	-	R	R	Contains group of provider and/or address request records.
2.1.	Address Records	-	-	C	C	Contains address details. *At least one Provider or Address record is required.
2.2.	Provider Records	-	-	C	C	Contains provider details.

						*At least one Provider or Address record is required.
3.	Trailer Record	-	-	R	R	Trailer Record.

1. Header Record

S. No.	Record Name	Type	Length	Required		Description
				Add	Update	
1.	File Code	S	13	R	R	Constant Value – For Load Process – MCOPRVLOADREQ For Reconciliation Process - MCOPRVRECNREQ
2.	Submitting Health Plan ID	A/N	7	R	R	This is the existing seven byte MMIS Medicaid ID Number assigned to each participating Health Plan
3.	File Name	S	34	R	R	Name of the file. File naming convention should take the following form: For Load Process - <Health Plan Medicaid ID>.MCOPRVLOADREQ.<date of file creation><time of file creation> For Reconciliation Process - <Health Plan Medicaid ID>.MCOPRVRECNREQ.<date of file creation><time of file creation> For example: HP12345.MCOPRVLOADREQ.yymmddhhmmss Note: Files that don't follow the above mentioned file name format, will not be picked for processing.
4.	Date Time	S	19	R	R	File Creation Date and Time. Format: YYYY-MM-DDThh:mm:ss

2.1 Address Record

S. No.	Record Name	Type	Length	Required		Description
				Add	Update	
1.	AD Request	-	-	R	R	Address Request Identifiers.
1.1.	Action	S	1	R	R	For OICL - Action requested on the record. 'A' (Add) For Load Process - Action requested on the record. 'A' (Add), 'U' (Update) For Reconciliation Process - Action requested on the record. 'R' (Reconciliation)
1.2.	Location Code	A/N	12	R	R	Internal ID used by MCOs to uniquely identify an address. (For ex MB30, 3297, 0411, 0129, 2242, 1696, 6781, 0327, etc.)

						Note that this information is intended to be used to link a provider to a specific site of service.
2.	Address	-	-	R	R	Contains Address.
2.1.	First Line	S	20	R	R	Address First Line
2.2.	Second Line	S	25	O	O	Address Second Line
2.3.	City	S	20	R	R	City
2.4.	County	S	20	R	R	County
2.5.	State	S	2	R	R	State *Please refer to appendix on page 58 for the list of valid values
2.6.	Zip	S	10	R	R	9 Digit Zip Code (#####-####)
3.	Accessibility Features	-	-	O	O	This section reports accessibility features.
3.1.	Accessibility Feature	-	-	R	R	The information in this segment could be repeated to include all the accessibility features.
3.1.1.	Accessibility Code	S	2	R	R	Accessibility feature code indicates the accessibility options available for the physically challenged patients. *Please refer to appendix on page 62 for the list of valid values

2.2 Provider Record

S. No.	Record Name	Type	Len-gth	Required		Description
				Add	Update	
1.	PR Request	-	-	R	R	Provider Request Identifiers
1.1.	Action	S	1	R	R	For OICL - Action requested on the record. 'A' (Add) For Load Process - Action requested on the record. 'A' (Add), 'U' (Update) For Reconciliation Process - Action requested on the record. 'R' (Reconciliation)
1.2.	MCO Internal Provider Identifier	A/N	12	R	R	Internal provider ID assigned by MCOs to uniquely identify a provider.
1.3.	NPI	N	10	C	C	Provider NPI. *Required in all cases, with the exception of atypical providers of types to be agreed upon between participating Health Plans and EOHHS.
1.4.	Organization Type	S	1	R	R	Indicates the organization type of the provider – '0' (Individual), '1' (Group), '2' (Hospital). Note – For FQHC Providers (Groupsonly): • Claim Type - Health Plans are expected to send FQHC claim types

						(FDN/FPR) in the Claim Type Taxonomy records.Org Type - FHQC providers should be identified in this field as a '1' (Group).
2.	NPI Change	-	-	N/A	O	To be used with Update request.
2.1.	Previous NPI	N	10	N/A	R	Provider NPI
2.2.	NPI End Date	D	10	N/A	R	End date for the previous NPI.
3.	License Records			C	O	*Required field for Individuals and Hospitals. Optional for Atypical Providers, exempted providers and Non-Par Providers.
3.1.	License Record			R	R	The information in this segment could be repeated to include all the Licenses.
3.1.1.	License State	S	2	R	R	State issuing license *Please refer to appendix on page 58 for the list of valid values
3.1.2.	License Number	A/N	12	R	R	Provider's License number.
3.1.3.	License Type	S	3	R	R	License type code. * Please refer to appendix on page 60 for the list of license types presently used by the MMIS.
3.1.4.	License Start Date	D	10	R	R	License Start Date (CCYY-MM-DD). This should reflect the Start Date of the current active license. In case, original license date (date on which license was issued by the State) is not available, enrollment start date or implementation start date can be used.
3.1.5.	License End Date	D	10	R	R	License End Date (CCYY-MM-DD). This value should reflect the date on which the license expires. Note: EOHHS has relaxed the requirement of actual license end date, till the first reconciliation process run. Health plans can use the date/value 12/31/2382 in case the license end date is unknown. EOHHS expects the health plans to collect this information and send it in the first reconciliation file, and start sending the actual dates going forward in the daily file.
3.1.6.	License Status	S	1	R	R	License Status – 'A' (Active), 'I' (Inactive)
4.	Medicare ID Records			C	O	*Required for all the providers, who are eligible for a Medicare ID.
4.1.	Medicare ID Record			R	R	The information in this segment could be repeated to include all the Medicare IDs.
4.1.1.	Medicare ID	N	10	R	R	Medicare ID (or PTAN) - PTAN stands for Provider Transaction Access Number. A Medicare Provider is issued PTAN for each entity they work for. The PTAN identifies who rendered services to a Medicare Beneficiary in the Medicare claims processing system. Earlier they used to call it Medicare Billing Number, CMS Certification Number (CCN), OSCAR Number and Provider Legacy Number. The new official name of this ID is PTAN.
4.1.2.	Medicare ID End Date	D	10	O	O	End date for the Medicare ID. By default the end date of a Medicare ID would be the end of time date. Health Plans can use it to end date a Medicare ID.
5.	Provider Info			R	O	This section reports MCO Provider'

						Information.
5.1.	Gender	S	1	C	O	Provider's gender – M/F/U *Required field for Individuals only
5.2.	Language 1	A/N	2	R	O	Provider/Translator speaking this language is available. *Please refer to appendix on page 57 for the list of languages presently used by the MMIS.
5.3.	Language 2	A/N	2	O	O	Provider/Translator speaking this language is available. *Please refer to appendix on page 57 for the list of languages presently used by the MMIS.
5.4.	Language 3	A/N	2	O	O	Provider/Translator speaking this language is available. *Please refer to appendix on page 57 for the list of languages presently used by the MMIS.
6.	Claim Type Taxonomies			R	O	This section reports MCO Provider's Claim Type and Taxonomy Details.
6.1.	Claim Type Taxonomy			R	R	The information in this segment could be repeated to include all the applicable taxonomies and claim types.
6.1.1.	Claim Type	A/N	3	R	R	Claim Type. * Please refer to appendix on page 58 for the list of valid values
6.1.2.	Specifier	A/N	3	R	R	Specifier Code, used to indicate if the provider is exempted from getting a medical license or is an atypical provider * Please refer to appendix on page 58 for the list of valid values
6.1.3.	Taxonomy	A/N	10	R	R	Provider Taxonomy. * Please refer to appendix on page 61 for the list of taxonomies presently used by the MMIS.
6.1.4.	Type Start Date	D	10	R	R	Claim Type Taxonomy Start Date (CCYY-MM-DD)
6.1.5.	Type End Date	D	10	R	R	Claim Type Taxonomy End Date (CCYY-MM-DD)
6.1.6.	Type Status	S	1	R	R	Type Status – 'A' (Active), 'I' (Inactive)
7.	Group Affiliation Records			C	O	It is expected that the health plans will send this information if a group association exists, or if the provider uses his own NPI for billing, or to indicate the Hospital's participation status. Absence of this information would indicate that this provider is a participating provider. Status of the non-participating providers has to be explicitly specified. FQHC providers will be defined as a group. This section will be required for FQHC providers. Following is how we expect the health plans to report information in this segment: • Group Type 'I' (when provider has his own practice and is allowed to bill their personal NPI; provider may or may not associated with a group): SHPs are expected to use provider's NPI, MCO Internal ID, appropriate

						status value and enrollment dates, and ClientRelationship, InNetwork and ReimbursementIndicator, as assigned by the SHPs. • Group Type 'G' (When provider is associated with a group): SHPs are expected to use group's NPI, group's MCO Internal ID, status value and affiliation start/end dates, ClientRelationship, InNetwork and ReimbursementIndicator. This information could be found in group/provider contract. • Group Type 'H' (for Hospitals): We expect the SHPs to send us a record with Hospital's NPI, MCO Internal ID, appropriate status value and enrollment dates, and ClientRelationship, InNetwork and ReimbursementIndicator, as assigned by the SHP.
7.1.	Group Affiliation Record			R	R	The information in this segment could be repeated to include all the associated Groups.
7.1.1.	Group NPI	N	10	R	R	Group NPI or Individual Provider's NPI (in case the provider is billing himself). *SHPs are expected to send a separate record for the Group NPI before sending an individual provider (with a group affiliation) record. No extra records will be required if the Group Type ='I' and the NPI is Individual's NPI.
7.1.2.	Group MCO Internal Provider Identifier	A/N	12	R	R	Internal provider ID, assigned by MCOs, to uniquely identify a group provider profile.
7.1.3.	Group Affiliation Status	S	1	R	R	Association status of the provider – 'A' (Active), 'I' (Inactive).
7.1.4.	Group Affiliation Start Date	D	10	R	R	Association Start Date (CCYY-MM-DD)
7.1.5.	Group Affiliation End Date	D	10	R	R	Association End Date (CCYY-MM-DD)
7.1.6.	Group Type	S	1	R	R	Group Type Indicator – 'G' (Group), 'I' (Individual), 'H' (Hospital) Type 'G' will be used if the provider is associated with a group, and Type 'I' is used if the Provider uses his own NPI for billing. Type 'H' will be used for Hospitals, and this record will be used to track the participation status of the hospital.
7.1.7.	Reimbursement Indicator	S	1	R	R	Reimbursement Indicator – 'F' (FFS), 'C' (CAP), 'B' (BOTH)
7.1.8.	Client Relationship	S	1	R	R	Indicates Client Relationship. – 'P' (PCP), 'S' (SPC), 'B' (BOTH), 'N' (NONE)
7.1.9.	In Network	S	1	R	R	Indicates if the provider is an In network provider or an Out of Network Provider – 'I' (In Network),'O' (Out of Network)
8.	FEIN			R	O	This section reports MCO Provider's FEIN Details.
8.1.	FEIN Type	S	1	R	R	Indicates whether the FEIN is 'S' (SSN) or 'E' (EIN)
8.2.	FEIN Value	A/N	10	R	R	FEIN Number (Zero fill to the left)
8.3.	FEIN Start Date	D	10	R	R	FEIN Start Date (CCYY-MM-DD)

8.4.	FEIN End Date	D	10	R	R	FEIN End Date (CCYY-MM-DD)
9.	MCO Enrollment Records			R	O	This section reports MCO Provider's Enrollment details (with the SHP).
9.1.	Enrollment Record			R	R	The information in this segment could be repeated to include all the enrollment and renewal records.
9.1.1.	MCO Enrollment Status	S	2	R	R	Provider Enrollment Status Suggested Values * Please refer to appendix on page 57 for the list of valid values
9.1.2.	MCO Enrollment Start Date	D	10	R	R	Enrollment Start Date (CCYY-MM-DD)
9.1.3.	MCO Enrollment End Date	D	10	R	R	Enrollment End Date (CCYY-MM-DD)
10.	Provider Restrictions			O	O	This section reports Restrictions imposed on MCO Providers.
10.1.	Restrictions			R	R	The information in this segment could be repeated to include all the restrictions imposed on the providers. *Note: As of now HPE is going to accept Restriction Code '03' only. In future, this section could be used to accept other restrictions codes as well.*
10.1.1.	Restrictions Code	S	2	R	R	Restriction Codes imposed on the provider. * Please refer to appendix on page 62 for the list of valid values
10.1.2.	Restrictions Start Date	D	10	R	R	Restrictions Start Date (CCYY-MM-DD)
10.1.3.	Restrictions End Date	D	10	R	R	Restrictions End Date (CCYY-MM-DD)
11.	Contract Location Records			R	O	This section reports MCO Provider's contract locations.
11.1.	Location Record			R	R	The information in this segment could be repeated to include all the provider locations.
11.1.1.	Location Code	A/N	12	R	R	Location Code for the address. (For ex MB30, 3297, 0411, 0129, 2242, 1696, 6781, 0327, etc.). Note that this information is intended to be used to link a provider to a specific site of service. *Note - This code, assigned by health plans, represents a physical address only. Need more discussion with EOHHS and Health Plans, to determine how this data element is generated and used (by the health plan) and whether having this value on the MMIS would be a benefit.*
11.1.2.	Address Type	A/N	2	R	R	Address Type * Please refer to appendix on page 61 for the list of valid values
11.1.3.	Address Sequence	N	10	R	R	Address Sequence number is used to differentiate between primary and secondary addresses.
11.1.4.	Accepting New Patient	S	1	C	C	Indicates if the provider is accepting new Medicaid patients. – Y/N *Required for service locations only
11.1.5.	Location Type	S	1	R	R	Indicates whether the provider is situated - '1' (In-state), '2' (Border), or '3' (Out-of-state). Following is how the location type has to be determined: • All the RI addresses should have the value '1' (In-State).

						• All the service locations that fall under the Border Communities (page 62) should have the value '2' (Border). • All other addresses (Par or Non-Par) should have the value '3' (Out-of-state).
11.1.6.	Name Type	S	1	R	O	Provider Name Type –'1' - Individual, '2' - Institutional, '3' – Group
11.1.7.	First Name	S	19	C	C	First Name associated with the provider or location. *Required if the Name Type is Individual
11.1.8.	Middle Initial	S	1	C	C	Middle Initial associated with the provider or location. Leave blank if there is no Middle Initial. *Required if the Name Type is Individual
11.1.9.	Last Name	S	20	C	C	Last Name associated with the provider or location. *Required if the Name Type is Individual
11.1.10.	Title	S	5	C	C	Title associated with the provider or location. Leave blank if there is no associated Title. *Required if the Name Type is Individual
11.1.11.	Organization Name	S	70	C	C	Organization Name associated with the location. *Required if the Name Type is Group or Institutional.
11.1.12.	Phone	S	10	R	O	Phone number
11.1.13.	Email	E	60	O	O	Contains email address.

3. Trailer Record

S. No.	Record Name	Type	Len-gth	Required		Description
				Add	Update	
1.	Request Count	N	7	R	R	Total number of address and provider requests in the file.

Field Types

Type	Description
S	String
A/N	Alpha-numeric
N	Numeric
E	Email Address. Contains characters, numbers, and only following special symbols – '@', '.', '-', '_'
D	Date

APPENDIX 2 – LIST OF VALID VALUES

Last Update	Author	Change Description
11/9/2012	Piyush Khandelwal	Initial Entry
2/6/2013	Piyush Khandelwal	• Updated the list of Taxonomies • Updated the list of License Types • Added list of Border Communities
2/12/2013	Piyush Khandelwal	• Added three new taxonomies in the list of Taxonomies • Corrected the description for the List of Border Communities
4/12/2013	Piyush Khandelwal	• Added list of valid Claim Type Codes • Added list of valid Specifier Codes • List of Taxonomy Codes has been moved to a separate spreadsheet.
12/4/2013	Piyush Khandelwal	• Added License Types - ADC and ARL

Enrollment Status Codes

The following is a list of status codes used by the MMIS for Provider Enrollment purposes. The provider is considered active and is allowed to submit claims only if status code on his record is '03' or '13', all the other codes primarily mark the provider either as Inactive or Non-participating. It should be noted that any status codes submitted in the Provider File that are not on the MMIS will cause the record to be rejected.

Status Code	Description
01	Voluntary - Inactive
02	Retired - Inactive
03	Active - Participating
04	Deceased - Inactive
05	Moved - Inactive
06	License Not Renewed - Inactive
07	Medicare Suspension - Inactive
08	Conviction of Fraud - Inactive
09	Administration Active - Inactive
10	Terminated - Inactive
11	Decertified - Inactive
12	Active - Non-Participating
13	Requires Prior Authorization - Active
14	No PAF on file
15	Mail returned, no forwarding address listed
16	Voluntarily Inactive from PAF
17	Inactive per DHS request

Language Codes

The following is a list of languages used by the MMIS. Health Plans are requested to review and confirm that this list includes all the languages used by their providers, and to advise EOHHS of any gaps. It should be noted that any languages submitted in the Provider file that are not on the MMIS will cause the

record to be rejected. Additional languages (identified by health plan gap analysis) can be applied to the MMIS at the direction of EOHHS.

Code	Language
00	English
01	Spanish
02	Vietnamese
03	Mandarin
04	Cantonese
05	Arabic
06	Korean
07	Hindi
08	Farsi
09	Urdu
10	Russian
11	Bosnian
12	Albanian
13	Somali
14	French
15	German
16	Czech
17	Sign Language
18	Amharic
19	Armenian
20	Bengali
21	Croatian
22	Haitian Creole
23	Hebrew
24	Hungarian
25	Indonesian
26	Japanese
27	Kurdish
28	Laotian
29	Maltese
30	Polish
31	Portuguese
32	Punjabi
34	Serbian
35	Slovak
36	Slovenian
37	Swahili
38	Tagalog
39	Taiwanese
40	Thai
41	Tigrinya
42	Turkish

45	Khmer
46	Greek
47	Italian
48	Cambodian
49	Hmong
50	Other

Claim Types

The following is a list of claim type values to be used in the MCO Provider Network Exchange. It should be noted that any other claim type values submitted in the Provider file that are not in this list will cause the record to be rejected.

Claim Type	Description
DN	For Dental Claims (837D) [To be used with Non-FQHC providers only]
IN	For Institutional Claims (837I) [To be used with Non-FQHC providers only]
PH	For Pharmacy (NCPDP) [To be used with Non-FQHC providers only]
PR	For Professional Claims (837P) [To be used with Non-FQHC providers only]
FDN	For FQHC Dental Claims (837D) [To be used with FQHC Groups only]
FPR	For FQHC Professional Claims (837P) [To be used with FQHC Groups only]

Specifier Codes

The following is a list of specifier values to be used in the MCO Provider Network Exchange. It should be noted that any other specifier values submitted in the provider file that are not in this list will cause the provider file to be rejected.

Specifier Code	Description
[blank]	Blank Value for providers that do not fall in the exempted or atypical provider category
A	Atypical Provider
E	Exempted Providers. (These provider do not require a Medical License)

State Codes

The following is a list of states used by the MMIS. It should be noted that any states submitted in the Provider file that are not on the MMIS will cause the record to be rejected.

State Code	State Name
AK	Alaska
AL	Alabama
AR	Arkansas
AZ	Arizona
CA	California
CO	Colorado
CT	Connecticut
DC	Dist Columbia
DE	Delaware
FL	Florida
GA	Georgia
HI	Hawaii
IA	Iowa
ID	Idaho
IL	Illinois
IN	Indiana
KS	Kansas
KY	Kentucky
LA	Louisiana
MA	Massachusetts
MD	Maryland
ME	Maine
MI	Michigan
MN	Minnesota
MO	Missouri
MS	Mississippi
MT	Montana
NC	North Carolina
ND	North Dakota
NE	Nebraska
NH	New Hampshire
NJ	New Jersey
NM	New Mexico
NV	Nevada
NY	New York
OH	Ohio
OK	Oklahoma
OR	Oregon
PA	Pennsylvania
PR	Puerto Rico
RI	Rhode Island
SC	South Carolina
SD	South Dakota

TN	Tennessee
TX	Texas
UT	Utah
VA	Virginia
VI	US Virgin Island
VT	Vermont
WA	Washington
WI	Wisconsin
WV	West Virginia
WY	Wyoming

License Type Codes

The following is a list of license types used by the MMIS. Health Plans are requested to review and confirm that this list includes all the license types used by their providers, and to advise EOHHS of any gaps. It should be noted that any license types submitted in the Provider file that are not on the MMIS will cause the record to be rejected. Additional license types (identified by health plan gap analysis) can be applied to the MMIS at the direction of EOHHS.

License Type	Description
AC	ACUPUNCTURIST
ADC	ADULT DAY CARE
ARL	ASSISTED LIVING
AUD	AUDIOLOGIST
CAC	CERTIFIED ALCOHOLISM COUNSELOR
CDP	CHEM DEPENDANCY PROFESSIONAL
CP	CERTIFIED PROSTHETIST
CPH	PHARMACIES ALLOWED TO SELL CONTROLLED SUBSTANCES
CSW	CLINICAL SOCIAL WORKER
CYT	CYTOTECHNOLOGIST
DC	CHIROPRACTOR
DEN	DENTIST
DH	DENTAL HYGIENIST
DO	DOCTOR OF OSTEOPATHY
DPM	PODIATRIST
FE	FREESTANDING EMERGENCY CARE
FS	FREESTANDING AMBULATORY SURGER
GRP	GROUP
HH	HOME HEALTH
HO	HOSPITAL
HP	HOSPICE
ISW	INDEPENDENT CLINICAL SOCIAL WK
KD	KIDNEY DISEASE TREATMENT CNTR
LA	CLINICAL LABORATORIES
LDN	NUTRITIONIST
MD	DOCTOR OF MEDICINE

MFT	MARRIAGE AND FAMILY THERAPIST
MH	COMMUNITY MENTAL HEALTH CNTR
MHC	MENTAL HEALTH COUNSELOR
MT	MASSAGE THERAPIST
MW	MIDWIFE
NH	NURSING HOME
NP	NURSE PRACTITIONER
NPP	NURSE PRACTITIONER PRESCRIPTIV
NS	NURSING SERVICE AGENT
OA	ORGANIZED AMBULATORY CARE FACL
OD	OPTOMETRIST
ODT	OPTOMETRIST
ONP	OUT OF NETWORK PROVIDER
OR	OUTPATIENT REHABILITATION CNTR
OT	OCCUPATIONAL THERAPIST
PA	PHYSICIAN ASSISTANT
PH	OTHER PHARMACIES. To be used when the health plans are not able to determine which pharmacy license type to use. This value is anticipated for out of state pharmacies, which may not necessarily have the level of distinction used by RI.
PHA	RI Pharmacy-Retail
PHB	RI Pharmacy—Institutional
PHN	RI Pharmacy—Non-Resident
PS	PSYCHOLOGIST
PT	PHYSICAL THERAPIST
RCP	RESPIRATORY CARE PRACTITIONER
RE	REHABILITATION HOSPITAL CNTR
RN	REGISTERED NURSE
SA	SUBSTANCE ABUSE TREATMENT CNTR
SC	RESIDENTIAL CARE ASSISTED LIVE
SP	SPEECH PATHOLOGIST
ULP	UNLICENSED PROVIDER

Taxonomy Codes

The list of valid taxonomies has been removed from this document, as this is a dynamic list and would change over time. We would be using the companion spreadsheet (TAXxCLTYP Mapping.xlsx) to maintain the list of taxonomies being used for MCO Provider Network Exchange. This document and this sheet combined would form the Provider Companion Guide and both the documents would be shared as a package.

Address Type Codes

The following is a list of address types used by the MMIS. It should be noted that any address types submitted in the Provider file that are not on the MMIS will cause the record to be rejected.

Address Type	Description
01	Pay-To

02	Mail To
03	Billing Service
04	Service Location
05	Technical Address
06	Financial
07	Legal
08	Carrier Claims Submi
09	Carrier Corresponden
10	Premium
11	Employer

Accessibility Feature Codes

The following is a list of address types used by the MMIS. It should be noted that any address types submitted in the Provider file that are not on the MMIS will cause the record to be rejected.

Accessibility Feature Codes	Description
WC	Wheelchair
WF	Accessible Water Fountains
WL	Wheelchair Lifts
AT	Accessible Toilet Stalls
AP	Accessible Parking and Passenger Loading Space
CR	Accessible Curb ramps
AD	Accessible Automated Doors

Restriction Codes

The following is a list of Restriction Codes used by the MMIS. It should be noted that any Restriction Codes submitted in the Provider file that are not on the MMIS will cause the record to be rejected.

Restriction Codes	Description
01	Reserved for Potential Future Use
02	Reserved for Potential Future Use
03	All Claims Suspect (Used to indicate that the provider can bill as a part of the group only. If the provider bills a non-group NPI the claim would be flagged or denied)
04	Reserved for Potential Future Use
05	Reserved for Potential Future Use
07	Reserved for Potential Future Use
08	Reserved for Potential Future Use
H3	Reserved for Potential Future Use

Border Communities

The following is a list of cities/towns that are considered as border communities by the state of Rhode Island. This list should to be used for determining the value of the field Location Type (11.1.6):

Town/City	State

Danielson	Connecticut (CT)
Groton	Connecticut (CT)
Moosup	Connecticut (CT)
Mystic	Connecticut (CT)
New London	Connecticut (CT)
North Stonington	Connecticut (CT)
Pawcatuck	Connecticut (CT)
Putnam	Connecticut (CT)
Stonington	Connecticut (CT)
Thompson	Connecticut (CT)
Waterford	Connecticut (CT)
Attleboro	Massachusetts (MA)
Bellingham	Massachusetts (MA)
Blackstone	Massachusetts (MA)
Dartmouth	Massachusetts (MA)
Fall River	Massachusetts (MA)
Foxboro	Massachusetts (MA)
Milford	Massachusetts (MA)
New Bedford	Massachusetts (MA)
North Attleboro	Massachusetts (MA)
North Dartmouth	Massachusetts (MA)
Rehoboth	Massachusetts (MA)
Seekonk	Massachusetts (MA)
Somerset	Massachusetts (MA)
South Attleboro	Massachusetts (MA)
Swansea	Massachusetts (MA)
Taunton	Massachusetts (MA)
Uxbridge	Massachusetts (MA)
Webster	Massachusetts (MA)
Westport	Massachusetts (MA)
Whitinsville	Massachusetts (MA)

APPENDIX 3 – REQUEST XML SCHEMA

Last Update	Author	Change Description
11/9/2012	Piyush Khandelwal	Initial Entry
12/21/2012	Piyush Khandelwal	• Added validation to check for the valid SHP IDs • Updated XML Schema Validations to avoid fields with all zeroes/spaces.
1/18/2013	Piyush Khandelwal	• Relaxed validations for Organization Name, to allow all the characters/symbols/etc. (it still requires at least one character/digit) • Updated RequestRecords' minOccurs value to 1, to reflect the value mentioned in the Companion Guide. • Renamed SequenceNumber to AddressSequence, to reflect the value mentioned in the Companion Guide. • Specialty field under Location Code allows blank value now. • LicenseNumber is a variable length field now with a maximum length of 12 (requires at least 1 character) • Added MCOGroupIdentifier (under GroupAffiliationRecord). This field was mentioned in the Companion Guide, but was missing from the XML File and the Schema. • Relaxed validations for FirstLine and SecondLine, to allow all the characters/symbols/etc. (it still requires at least one character/digit) • SecondLine (still optional) requires at least one digit/character.
2/6/2013	Piyush Khandelwal	• Updated the taxonomy validation to check for taxonomy-like values • Added a new value for Group Type Field. • Updated License Type validation with new License Type values
4/12/2013	Piyush Khandelwal	• Renamed TypeSpecialtyRecords to ClaimTypeTaxonomyRecords • Renamed TypeSpecialtyRecord to ClaimTypeTaxonomyRecord • Renamed ProviderType to ClaimType • Renamed Specialty to Specifier • Renamed SpecialtyStatus to TypeStatus • Removed Specialty from LocationRecord • Updated Element IDs for rest of the attributes under LocationRecord

Elem-ent ID	Element Name	Type	Required/ Occurrence	Length	Details
1000	MCOProviderExchange	Tag	Min : 1 | Max : 1	-	-

2000	Header	Tag	Min : 1 | Max : 1	-	-
2001	FileCode	Attribute	R	13	● Values: MCOPRVLOADREQ, MCOPRVRECNREQ ● Example: MCOPRVLOADREQ
2002	SubmittingHealthPlanID	Attribute	R	7	● Values: UH08257, NH11278, DB60072 ● Example: UH08257
2003	FileName	Attribute	R	34	● Pattern: (UH08257|NH11278|DB60072)[.](MCOPRVLOADREQ|MCOPRVRECNREQ)[.]([0-9]*[1-9][0-9]*)([0][1-9]|[1][0-9])([0][1-9]|[1-2][0-9]|[3][0-1])([0-1][0-9]|[2][0-4])[0-5][0-9][0-5][0-9] ● Example: UH08257.MCOPRVLOADREQ.990709112359
2004	DateTime	Attribute	R	19	● Format: YYYY-MM-DDThh:mm:ss ● Example: 2012-10-12T13:20:50
3000	RequestRecords	Tag	Min : 1 | Max : 1	-	-
4000	AddressRecord	Tag	Min : 0 | Max : Unbounded	-	-
5000	ADRequest	Tag	Min : 1 | Max : 1	-	-
5001	Action	Attribute	R	1	● Values: A, U, R ● Example: A
5002	LocationCode	Attribute	R	Min : 1 | Max : 12	● Pattern: [a-zA-Z0-9]*[a-zA-Z1-9][a-zA-Z0-9]* ● Format: Only characters (A-Z) and digits (0-9) allowed. No spaces or all zero value allowed. ● Example: LC123, 1223
6000	Address	Tag	Min : 1 | Max : 1	-	-
6001	FirstLine	Attribute	R	Min : 1 | Max : 20	● Pattern: (.*)([a-zA-Z0-9])(.*) ● Format: Any characters, with at least one character (A-Z) or digit (0-9) required. ● Example: A/12
6002	SecondLine	Attribute	O	Min : 0 | Max : 25	● Pattern: (.*)([a-zA-Z0-9])(.*) ● Format: Any characters, with at least one character (A-Z) or digit (0-9) required. ● Example: 123 Main Road
6003	City	Attribute	R	Min : 1 | Max : 20	● Pattern: ([A-Za-z '\(\),\-\.])*([a-zA-Z])([A-Za-z '\(\),\-\.])* ● Format: Only characters (A-Z) with spaces (all spaces are not allowed) and following characters are allowed: '(),-. ● Example: Warwick
6004	County	Attribute	R	Min : 1 | Max : 20	● Pattern: ([A-Za-z '\(\),\-\.])*([a-zA-Z])([A-Za-z '\(\),\-\.])* ● Format: Only characters (A-Z) with spaces (all spaces are not allowed) and following characters are allowed: '(),-. ● Example: Kent
6005	State	Attribute	R	2	● Please refer Appendix 2 for allowed list of values. ● Example: RI

6006	Zip	Attribute	R	10	● Pattern: ([0-9]*[1-9][0-9]*)-[0-9]{4}● Format: #####-#### ● Example: 02886-0000
7000	AccessibilityFeatures	Tag	Min : 0 | Max : 1	-	-
8000	AccessibilityFeature	Tag	Min : 1 | Max : Unbounded	-	-
8001	Code	Attribute	R	2	● Values: WC, WF, WL, AT, AP, CR, AD ● Example: WC
9000	Provider	Tag	Min : 0 | Max : Unbounded	-	-
1000	PRRequest	Tag	Min : 1 | Max : 1	-	-
1001	Action	Attribute	R	1	● Values: A, U, R ● Example: A
1002	MCOInternalProviderIdentifier	Attribute	R	Min : 1 | Max : 12	● Pattern: [a-zA-Z0-9]*[a-zA-Z1-9][a-zA-Z0-9]* ● Format: Only characters (A-Z) and digits (0-9) allowed. No spaces or all zero value allowed. ● Example: 122341
1003	NPI	Attribute	O	10	● Pattern: [0-9]*[1-9][0-9]* ● Format: Digits (0-9) only. Padding with 0 is allowed. ● Example: 1111111112
1004	OrganizationType	Attribute	R	1	● Values: 0, 1, 2 ● Example: 1
1100	NPIChange	Tag	Min : 0 | Max : 1	-	-
1101	PreviousNPI	Attribute	R	10	● Pattern: [0-9]*[1-9][0-9]* ● Format: Digits (0-9) only. Padding with 0 is allowed. ● Example: 1111111104
1102	NPIEndDate	Attribute	R	10	● Format: YYYY-MM-DD ● Min: 1900-01-01 | Max: 2382-12-31 ● Example: 2011-12-31
1200	LicenseRecords	Tag	Min : 0 | Max : 1	-	-
1300	LicenseRecord	Tag	Min : 1 | Max : Unbounded	-	-
1301	LicenseState	Attribute	R	2	● Please refer Appendix 2 for allowed list of values. ● Example: RI
1302	LicenseNumber	Attribute	R	Min : 1 | Max : 12	● Pattern: [a-zA-Z0-9]*[a-zA-Z1-9][a-zA-Z0-9]* ● Format: Only characters (A-Z) and digits (0-9) allowed. No spaces or all zero value allowed. ● Example: G97679
1303	LicenseType	Attribute	R	Min : 2 | Max : 3	● Please refer Appendix 2 for allowed list of values. ● Example: MD
1304	LicenseStartDate	Attribute	R	10	● Format: YYYY-MM-DD ● Min: 1900-01-01 | Max: 2382-12-31 ● Example: 2001-01-01

1305	LicenseEndDate	Attribute	R	10	● Format: YYYY-MM-DD ● Min: 1900-01-01 | Max: 2382-12-31 ● Example: 2011-12-31
1306	LicenseStatus	Attribute	R	1	● Values: A, I ● Example: A
1400	MedicareIDRecords	Tag	Min : 0 | Max : 1	-	-
1500	MedicareIDRecord	Tag	Min : 1 | Max : Unbounded	-	-
1501	MedicareID	Attribute	R	10	● Pattern: [0-9]*[1-9][0-9]* ● Format: Digits (0-9) only. Padding with 0 is allowed. ● Example: 0000234567
1502	MedicareIDEndDate	Attribute	O	10	● Format: YYYY-MM-DD ● Min: 1900-01-01 | Max: 2382-12-31 ● Example: 2011-12-31
1600	ProviderInfo	Tag	Min : 0 | Max : 1	-	-
1601	Gender	Attribute	O	1	● Values: M, F, U ● Example: M
1602	Language1	Attribute	O	2	● Please refer Appendix 2 for allowed list of values. ● Example: 01
1603	Language2	Attribute	O	2	● Please refer Appendix 2 for allowed list of values. ● Example: 02
1604	Language3	Attribute	O	2	● Please refer Appendix 2 for allowed list of values. ● Example: 03
1700	ClaimTypeTaxonomyRecords	Tag	Min : 0 | Max : 1	-	-
1800	ClaimTypeTaxonomyRecord	Tag	Min : 1 | Max : Unbounded	-	-
1801	ClaimType	Attribute	R	3	● Please refer Appendix 2 for allowed list of values. ● Example: PR
1802	Specifier	Attribute	R	Min : 0 | Max : 3	● Please refer Appendix 2 for allowed list of values. ● Example: A
1803	Taxonomy	Attribute	R	Min : 0 | Max : 10	● Pattern: [1-9][0-9][0-9][0-9A-Z][0-9A-Z][0-9][0-9][0-9][X] ● Format: ###@@####X (#-Digits, @ - AlphaNumeric) ● Example: 2081H0002X
1804	TypeStartDate	Attribute	R	10	● Format: YYYY-MM-DD ● Min: 1900-01-01 | Max: 2382-12-31 ● Example: 2001-01-01
1805	TypeEndDate	Attribute	R	10	● Format: YYYY-MM-DD ● Min: 1900-01-01 | Max: 2382-12-31 ● Example: 2013-12-31
1806	TypeStatus	Attribute	R	1	● Values: A, I ● Example: I
1900	GroupAffiliationRecords	Tag	Min : 0 | Max : 1	-	-
2000	GroupAffiliationRecord	Tag	Min : 1 | Max : Unbounded	-	-

2001	GroupNPI	Attribute	R	10	● Pattern: [0-9]*[1-9][0-9]* ● Format: Digits (0-9) only. Padding with 0 is allowed. ● Example: 2222222228
2002	MCOGroupIdentifier	Attribute	R	Min : 1 | Max : 12	● Pattern: [a-zA-Z0-9]*[a-zA-Z1-9][a-zA-Z0-9]* ● Format: Only characters (A-Z) and digits (0-9) allowed. No spaces or all zero value allowed. ● Example: G123870
2003	GroupAffiliationStatus	Attribute	R	1	● Values: A, I ● Example: I
2004	GroupAffiliationStartDate	Attribute	R	10	● Format: YYYY-MM-DD ● Min: 1900-01-01 | Max: 2382-12-31 ● Example: 2001-01-01
2005	GroupAffiliationEndDate	Attribute	R	10	● Format: YYYY-MM-DD ● Min: 1900-01-01 | Max: 2382-12-31 ● Example: 2013-12-31
2006	GroupType	Attribute	R	1	● Values: G, I, H ● Example: I
2007	ReimbursementIndicator	Attribute	R	1	● Values: F, C, B ● Example: B
2008	InNetwork	Attribute	R	1	● Values: I, O ● Example: I
2009	ClientRelationship	Attribute	R	1	● Values: P, S, B, N ● Example: B
2100	FEIN	Tag	Min : 0 | Max : 1	-	-
2101	FEINType	Attribute	R	1	● Values: S, E ● Example: E
2102	FEINValue	Attribute	R	10	● Pattern: [0-9]*[1-9][0-9]* ● Format: Digits (0-9) only. Padding with 0 is allowed. ● Example: 0003424567
2103	FEINStartDate	Attribute	R	10	● Format: YYYY-MM-DD ● Min: 1900-01-01 | Max: 2382-12-31 ● Example: 2001-01-01
2104	FEINEndDate	Attribute	R	10	● Format: YYYY-MM-DD ● Min: 1900-01-01 | Max: 2382-12-31 ● Example: 2013-12-31
2200	MCOEnrollmentRecords	Tag	Min : 0 | Max : 1	-	-
2300	EnrollmentRecord	Tag	Min : 1 | Max : Unbounded	-	-
2301	MCOEnrollmentStatus	Attribute	R	2	● Please refer Appendix 2 for allowed list of values. ● Example: 03
2302	MCOEnrollmentStartDate	Attribute	R	10	● Format: YYYY-MM-DD ● Min: 1900-01-01 | Max: 2382-12-31 ● Example: 2001-01-01
2303	MCOEnrollmentEndDate	Attribute	R	10	● Format: YYYY-MM-DD ● Min: 1900-01-01 | Max: 2382-12-31 ● Example: 2013-12-31
2400	ProviderRestrictionRecords	Tag	Min : 0 | Max : 1	-	-
2500	Restriction	Tag	Min : 1 | Max : 1	-	-

2501	RestrictionCode	Attribute	R	2	● Pattern: [0-9]*[1-9][0-9]* ● 03 ● Example: 03
2502	RestrictionStartDate	Attribute	R	10	● Format: YYYY-MM-DD ● Min: 1900-01-01 | Max: 2382-12-31 ● Example: 2001-01-01
2503	RestrictionEndDate	Attribute	R	10	● Format: YYYY-MM-DD ● Min: 1900-01-01 | Max: 2382-12-31 ● Example: 2013-12-31
2600	ContractLocationRecords	Tag	Min : 0 | Max : 1	-	-
2700	LocationRecord	Tag	Min : 1 | Max : Unbounded	-	-
2701	LocationCode	Attribute	R	Min : 1 | Max : 12	● Pattern: [a-zA-Z0-9]*[a-zA-Z1-9][a-zA-Z0-9]* ● Format: Only characters (A-Z) and digits (0-9) allowed. No spaces or all zero value allowed. ● Example: LC123, 1223
2702	AddressType	Attribute	R	2	● Please refer Appendix 2 for allowed list of values. ● Example: 04
2703	AddressSequence	Attribute	R	Min : 1 | Max : 10	● Pattern: [0-9]*[1-9][0-9]* ● Format: Digits (0-9) only. Padding with 0 is allowed. ● Example: 1
2704	LocationType	Attribute	R	1	● Values: 1, 2, 3 ● Example: 1
2705	AcceptingNewPatient	Attribute	O	1	● Values: Y, N ● Example: Y
2706	NameType	Attribute	O	1	● Values: 1, 2, 3 ● Example: 1
2707	Title	Attribute	O	Min : 0 | Max : 5	● Pattern: ([a-zA-Z0-9\- ,.''\(\)])*([a-zA-Z])([a-zA-Z0-9\- ,.''\(\)]*)● Format: Characters (A-Z), Digits (0-9), spaces (all spaces are not allowed) and following characters are allowed: -,.''()● Example: Dr.
2708	First	Attribute	O	Min : 1 | Max : 19	● Pattern: ([a-zA-Z0-9\- ,.''\(\)])*([a-zA-Z])([a-zA-Z0-9\- ,.''\(\)]*) ● Format: Characters (A-Z), Digits (0-9), spaces (all spaces are not allowed) and following characters are allowed: -,.''() ● Example: John
2709	Middle	Attribute	O	Min : 0 | Max : 1	● Pattern: ([a-zA-Z0-9\- ,.''\(\)])*([a-zA-Z])([a-zA-Z0-9\- ,.''\(\)]*) ● Format: Characters (A-Z), Digits (0-9), spaces (all spaces are not allowed) and following characters are allowed: -,.''() ● Example: A
2710	Last	Attribute	O	Min : 1 | Max : 20	● Pattern: ([a-zA-Z0-9\- ,.''\(\)])*([a-zA-Z])([a-zA-Z0-9\- ,.''\(\)]*) ● Format: Characters (A-Z), Digits (0-9), spaces (all spaces are not allowed) and following characters are allowed: -,.''() ● Example: Doe

2711	OrganizationName	Attribute	O	Min : 1 | Max : 70	● Pattern: (.*)([a-zA-Z0-9])(.*) ● Format: Any characters, with at least one character (A-Z) or digit (0-9) required. ● Example: Some & Some Hospital
2712	Phone	Attribute	O	10	● Pattern: [2-9][0-9]* ● Format: Digits (0-9) only. Must start with a digit between 2-9. ● Example: 4019998888
2713	Email	Attribute	O	Min : 0 | Max : 60	● Pattern: ([a-zA-Z0-9_\-\.]*[a-zA-Z][a-zA-Z0-9_\-\.]*)@([A-Za-z0-9-]*[A-Za-z][A-Za-z0-9-]*)(\.[A-Za-z0-9-]+)*(\.[A-Za-z]{2,3}) ● Format: Valid Email Address with 2-3 characters top-level domain (e.g. .com, .me). ● Example: John.doe@someorg.com
2800	Trailer	Tag	Min : 1 | Max : 1	-	-
2801	RequestCount	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. Padding with 0 is not allowed. ● Example: 1

APPENDIX 4 – RESPONSE FILE LAYOUT

Last Update	Author	Change Description
11/9/2012	Piyush Khandelwal	Initial Entry
12/21/2012	Piyush Khandelwal	Updated Request FileName length
4/12/2013	Piyush Khandelwal	Added Duplicate Indicator

S. No.	Record Name	Type	Len-gth	Requ-ired	Description
1.	Header	-	-	R	Address Request Identifiers.
1.1.	FileCode	S	13	R	Constant Value For Load Response File -MCOPRVLOADRSP For Reconciliation File – MCOPRVRECNRSP
1.2.	FileName	S	34	R	Name of the file. Format for Load Response File: <MCOPRVLOADRSP>.<Submitting Health Plan Medicaid ID>.<date of file creation><time of file creation> Format for Reconciliation Response File: <MCOPRVRECNRSP>.<Submitting Health Plan Medicaid ID>.<date of file creation><time of file creation>
1.3.	DateTime	S	19	R	File Creation Date and Time. Format: YYYY-MM-DDThh:mm:ss
2.	FileProcessingSummary	-	-	-	
2.1.	FileResult				
2.1.1.	RequestFileName	S	34	R	Name of the request file.
2.1.2.	FileCompliant	S	1	R	Indicates if the file is compliant (Y/N)
2.1.3.	Blank	S	1	R	Indicates if the file is blank (Y/N)
2.1.4.	Duplicate	S	1	R	Indicates if the file has been processed already (Y/N)
2.1.5.	ErrorsEncountered	S	1	R	Indicates if the errors were encountered during processing. (Y/N)
2.2.	ComplianceErrors	S	Unbounded	C	Contains the output of the XML Validation. *Required if the FileCompliant='N'
2.3.	RecordResult	-	-	-	-
2.3.1.	AddressRequestsTotal	N	10	R	Total number of address requests processed.
2.3.2.	ProviderRequestsTotal	N	10	R	Total number of provider requests processed.
2.3.3.	AddressRequestsAccepted	N	10	R	Total number of address requests accepted without errors.
2.3.4.	ProviderRequestsAccepted	N	10	R	Total number of provider requests accepted without errors.
2.3.5.	AddressRequestsAcceptedWithErrors	N	10	R	Total number of address requests accepted with errors of type 'I'.
2.3.6.	ProviderRequestsAcceptedWithErrors	N	10	R	Total number of provider requests accepted with errors of type 'I'
2.3.7.	AddressRequestsRejected	N	10	R	Total number of rejected address requests
2.3.8.	ProviderRequestsRejected	N	10	R	Total number of rejected provider requests
2.4.	ReconciliationResults	-	-	-	
2.4.1.	AddressRequestsTotal	N	10	R	Total number of address requests processed.
2.4.2.	ProviderRequestsTotal	N	10	R	Total number of provider requests processed.

2.4.3.	AddressRequestsMatchedTotal	N	10	R	Total number of address requests matched.
2.4.4.	ProviderRequestsMatchedTotal	N	10	R	Total number of provider requests matched.
2.4.5.	AddressRequestsAddedTotal	N	10	R	Total number of address requests in MMIS added using the reconciliation records.
2.4.6.	ProviderRequestsAddedTotal	N	10	R	Total number of provider requests in MMIS added using the reconciliation records.
2.4.7.	AddressRequestsUpdatedTotal	N	10	R	Total number of address requests in MMIS updated using the reconciliation records.
2.4.8.	ProviderRequestsUpdatedTotal	N	10	R	Total number of provider requests in MMIS updated using the reconciliation records.
2.4.9.	AddressRequestsRejected	N	10	R	Total number of address requests that could not be matched or used for updating the MMIS records due to error.
2.4.10.	ProviderRequestsRejected	N	10	R	Total number of provider requests that could not be matched or used for updating the MMIS records due to error.
2.4.11.	AddressRequestsNotFound	N	10	R	Total number of address records that are available in the MMIS but not present in the reconciliation file.
2.4.12.	ProviderRequestsNotFound	N	10	R	Total number of provider records that are available in the MMIS but not present in the reconciliation file.
3.	RecordDetails	-	-	-	
3.1.	AddressRecord	-	-	-	This can be repeated to include responses to all the address requests.
3.1.1.	ADResponse	-	-	-	
3.1.1.1.	Action	S	1	R	Action value from the original request.
3.1.1.2.	Location Code	A/N	12	R	Location Code value from the original request.
3.1.1.3.	Result	S	1	R	For Load Process - Indicates if the request was (A)ccepted or (R)ejected For Reconciliation Process - Indicates if the request was (M)atched, (A)dded, (U)pdated, (R)ejected, or (N)ot found in Reconciliation File
3.1.1.4.	TxnID	N	10	R	MMIS Internal Transaction ID/SAK for the request.
3.1.1.5.	ErrorsEncountered	S	1	R	Indicates if errors were encountered while processing this request.
3.1.2.	Errors	-	-	C	*Included only if errors were encountered during processing this request.
3.1.2.1.	ErrorDetail	-	-	R	This can be repeated to include all the errors encountered during processing this request.
3.1.2.1.1.	ErrorCode	N	5	R	Error Code
3.1.2.1.2.	ErrorDesc	S	150	R	Error Description
3.1.2.1.3.	Type	S	1	R	Indicates if the Error is for type informational (I) or fatal (F)
3.2.	ProviderRecord				
3.2.1.	PRResponse				
3.2.1.1.	Action	S	1	R	Action value from the original request.
3.2.1.2.	MCOInternalProviderIdentifier	A/N	12	R	MCOInternalProviderIdentifier value from the original request.
3.2.1.3.	NPI	N	10	O	NPI value from the original request.
3.2.1.4.	OrganizationType	S	1	R	OrganizationType value from the original request.
3.2.1.5.	Result	S	1	R	For Load Process - Indicates if the request was (A)ccepted or (R)ejected For Reconciliation Process - Indicates if the request was (M)atched, (A)dded, (U)pdated,

					(R)ejected, or (N)ot found in Reconciliation File
3.2.1.6.	TxnID	N	10	R	MMIS Internal Transaction ID/SAK for the request.
3.2.1.7.	ErrorsEncountered	S	1	R	Indicates if errors were encountered while processing this request.
3.2.2.	Errors	-	-	C	*Included only if errors were encountered during processing this request.
3.2.2.1.	ErrorDetail	-	-	R	This can be repeated to include all the errors encountered during processing this request.
3.2.2.1.1.	ErrorCode	N	5	R	Error Code
3.2.2.1.2.	ErrorDesc	S	150	R	Error Description
3.2.2.1.3.	Type	S	1	R	Indicates if the Error is for type informational (I) or fatal (F)
3.2.3.	AtypicalProvider	-	-	C	*Included only if the provider is an Atypical Provider.
3.2.3.1.	LegacyProviderID	S	7	R	Legacy Provider ID generated for the Atypical Provider Note: This is not Medicaid Provider ID.

APPENDIX 5 – RESPONSE XML SCHEMA

Last Update	Author	Change Description
1/18/2013	Piyush Khandelwal	Initial Entry
4/12/2013	Piyush Khandelwal	Added Duplicate Indicator

Element ID	Element Name	Type	Required/ Occurrence	Length	Details
1000	MCOProviderExchangeResponse	Tag	Min : 1 | Max : 1	-	-
2000	Header	Tag	Min : 1 | Max : 1	-	-
2001	FileName	Attribute	R	34	● Pattern: (MCOPRVLOADRSP|MCOPRVRECNRSP)[.](UH08257|NH11278|DB60072)[.]([0-9]*[1-9][0-9]*)([0][1-9]|[1][0-9])([0][1-9]|[1-2][0-9]|[3][0-1])([0][1-9]|[1][0-9]|[2][0-4])[0-5][0-9][0-5][0-9] ● Example: MCOPRVRECNRSP.DB60072.101030200000
2002	FileCode	Attribute	R	13	● Values: MCOPRVLOADRSP, MCOPRVRECNRSP ● Example: MCOPRVRECNRSP
2003	DateTime	Attribute	R	19	● Format: YYYY-MM-DDThh:mm:ss ● Example: 2001-12-17T09:30:47Z
3000	FileProcessingSummary	Tag	Min : 1 | Max : 1	-	-
4000	FileResult	Tag	Min : 1 | Max : 1	-	-
4001	RequestFileName	Attribute	R	34	● Pattern: (UH08257|NH11278|DB60072)[.](MCOPRVLOADREQ|MCOPRVRECNREQ)[.]([0-9]*[1-9][0-9]*)([0][1-9]|[1][0-9])([0][1-9]|[1-2][0-9]|[3][0-1])([0][1-9]|[1][0-9]|[2][0-4])[0-5][0-9][0-5][0-9] ● Example: DB60072.MCOPRVRECNREQ.101030200000
4002	FileCompliant	Attribute	R	1	● Values: Y, N ● Example: N
4003	ErrorsEncountered	Attribute	R	1	● Values: Y, N ● Example: N
4004	Blank	Attribute	R	1	● Values: Y, N ● Example: N
4005	Duplicate	Attribute	R	1	● Values: Y, N ● Example: N
5000	ComplianceErrors	Tag	Min : 0 | Max : 1	Unbounded	● Format: CDATA
6000	RecordResult	Tag	Min : 0 | Max : 1	-	-
6001	ProviderRequestsTotal	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 3
6002	ProviderRequestsRejected	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 1

6003	ProviderRequestsAcceptedWithErrors	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 1
6004	ProviderRequestsAccepted	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 2
6005	AddressRequestsTotal	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 8
6006	AddressRequestsRejected	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 1
6007	AddressRequestsAcceptedWithErrors	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 1
6008	AddressRequestsAccepted	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 1
7000	ReconciliationResults	Tag	Min : 0 | Max : 1	-	-
7001	ProviderRequestsAddedTotal	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 3
7002	ProviderRequestsMatchedTotal	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 1
7003	ProviderRequestsNotFound	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 1
7004	ProviderRequestsRejected	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 1
7005	ProviderRequestsTotal	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 3
7006	ProviderRequestsUpdatedTotal	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 1
7007	AddressRequestsAddedTotal	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 1
7008	AddressRequestsMatchedTotal	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 1
7009	AddressRequestsNotFound	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 1

7010	AddressRequestsRejected	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 1
7011	AddressRequestsTotal	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 8
7012	AddressRequestsUpdatedTotal	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]{1,7} ● Format: Digits (0-9) only. ● Example: 1
8000	RecordDetails	Tag	Min : 0 | Max : 1	-	-
9000	AddressRecord	Tag	Min : 0 | Max : unbounded	-	-
1000	ADResponse	Tag	Min : 1 | Max : 1	-	-
1001	TxnID	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]*[1-9][0-9]* ● Format: Digits (0-9) only. A number greater than Zero is required. ● Example: 1
1002	Result	Attribute	R	1	● Values: A, M, N, R, U ● Example: U
1003	LocationCode	Attribute	R	Min : 1 | Max : 12	● Pattern: [a-zA-Z0-9]*[a-zA-Z1-9][a-zA-Z0-9]* ● Format: Only characters (A-Z) and digits (0-9) allowed. No spaces or all zero value allowed. ● Example: 1
1004	ErrorsEncountered	Attribute	R	1	● Values: Y, N ● Example: N
1005	Action	Attribute	R	1	● Values: A, U, R ● Example: R
1100	Errors	Tag	Min : 0 | Max : 1	-	-
1200	ErrorDetail	Tag	Min : 0 | Max : unbounded	-	-
1201	Type	Attribute	R	1	● Values: F, I ● Example: I
1202	ErrorDesc	Attribute	R	Min : 1 | Max : 250	● Pattern: (.*)([a-zA-Z0-9])(.*) ● Format: Any characters, with at least one character (A-Z) or digit (0-9) required. ● Example: 0
1203	ErrorCode	Attribute	R	4	● Pattern: [0-9]*[1-9][0-9]* ● Format: Digits (0-9) only. A number greater than Zero is required. ● Example: 1000
1300	ProviderRecord	Tag	Min : 0 | Max : unbounded	-	-
1400	PRResponse	Tag	Min : 1 | Max : 1	-	-
1401	TxnID	Attribute	R	Min : 1 | Max : 7	● Pattern: [0-9]*[1-9][0-9]* ● Format: Digits (0-9) only. A number greater than Zero is required. ● Example: 1

1402	Result	Attribute	R	1	● Values: A, M, N, R, U ● Example: U
1403	OrganizationType	Attribute	R	1	● Values: 0, 1, 2 ● Example: 2
1404	NPI	Attribute	O	10	● Pattern: [0-9]*[1-9][0-9]* ● Format: Digits (0-9) only. A number greater than Zero is required. ● Example: 1000000000
1405	MCOInternalProviderIdentifier	Attribute	R	Min : 1 | Max : 12	● Pattern: [a-zA-Z0-9]*[a-zA-Z1-9][a-zA-Z0-9]* ● Format: Only characters (A-Z) and digits (0-9) allowed. No spaces or all zero value allowed. ● Example: 1
1406	ErrorsEncountered	Attribute	R	1	● Values: Y, N ● Example: N
1407	Action	Attribute	R	1	● Values: A, U, R ● Example: R
1500	AtypicalProvider	Tag	Min : 0 | Max : 1	-	-
1501	LegacyProviderID	Attribute	R	7	● Pattern: [a-zA-Z0-9]*[a-zA-Z1-9][a-zA-Z0-9]* ● Format: Only characters (A-Z) and digits (0-9) allowed. No spaces or all zero value allowed. ● Example: 1000000
1600	Errors	Tag	Min : 0 | Max : 1	-	-
1700	ErrorDetail	Tag	Min : 0 | Max : unbounded	-	-
1701	Type	Attribute	R	1	● Values: F, I ● Example: I
1702	ErrorDesc	Attribute	R	Min : 1 | Max : 250	● Pattern: (.*)([a-zA-Z0-9])(.*) ● Format: Any characters, with at least one character (A-Z) or digit (0-9) required. ● Example: 0
1703	ErrorCode	Attribute	R	4	● Pattern: [0-9]*[1-9][0-9]* ● Format: Digits (0-9) only. A number greater than Zero is required. ● Example: 1000

APPENDIX 6 – FAQS FOR MCO PROVIDER NETWORK EXCHANGE

Last Update	Author	Change Description
4/12/2013	Piyush Khandelwal	Initial Entry

Claim Type Taxonomy Record Generation

Taxonomies are nationally recognized standards and are used to represent the provider's type, classification and area of specialization in a standardized manner, whereas provider type and specialty values are not standardized and every organization manages these values differently, which makes it difficult to use these values across different organizations.

In order to ensure that the understanding of the services provided by a provider is consistent between DXC and MCO Organizations, we are going to accept taxonomies associated to the provider and the type of claims a provider is allowed to submit in the provider file. Since some of the taxonomies can be used on multiple claim types, we are asking health plans to send us the type of claim that provider is allowed to submit. This combination of taxonomies and claim types would allow MMIS to determine what type of services this provider is allowed to render and bill, and would allow it to assign appropriate MMIS provider types to the provider records, and process the claims. This would resolve the Provider Type, Specialty and Taxonomy Mapping mismatch issue, as well as Inpatient/Outpatient Hospital Record Issue (as both are institutional claims).

For MCO Provider Network Exchange, we have defined the claim type values as per the formats used to submit these claims. Following are these claim type values (the last two values have to be used with FQHC groups only):

Claim Type	Description
PH	Pharmacy Claims (NCPDP format)
DN	Dental Claims (837D Transaction)
PR	Professional Claims (837P Transaction)
IN	Institutional Claims (837I Transaction)
FDN	FQHC Dental Claims (837D Transaction)
FPR	FQHC Professional Claims (837P Transaction)

FQHCs do not submit the claims using some special formats; they use the standard 837D/837P format as well. These additional values have been added with a sole purpose of tracking FQHC groups separately, thus these claim types should be used with the FQHC groups only.

The companion excel spreadsheet (TAXxCLTYP Mapping.xlsx) contains the taxonomy and claim type mapping. We have added one more column named Specifier in this sheet. We would be using this to indicate the taxonomies that are assigned to the providers who are exempt from having a medical license (E) or for atypical providers (A).

Some of the taxonomies in this sheet are listed more than once (for example 332B00000X), since they can be used by multiple type of providers and not all are exempted from license. Health plans would have to check the taxonomies associated with the provider, the type of claims that can be billed by the provider and if one of these Specifier values are applicable for the provider. The most appropriate Taxonomy, Claim Type and Specifier record(s) would be sent to the MMIS in the Provider Network Exchange File. Following are some sample records form this sheet:

Taxonomy	Claim Type	Specifier
283Q00000X	IN	
283Q00000X	PR	
332B00000X	*PR*	*E*
332B00000X	*PR*	
332BP3500X	PR	E
225700000X	PR	A
193200000X	DN	

Taxonomy	Claim Type	Specifier
193200000X	PR	
261Q00000X	DN	
261Q00000X	FDN	
261Q00000X	PR	
261Q00000X	FPR	
207R00000X	DN	
207R00000X	PR	
207R00000X	FPR	
283Q00000X	IN	
283Q00000X	PR	

Please note:

- In case two records exist, in this mapping, with the same taxonomy and claim type, but one of the records has a specifier and other record doesn't, we would be accepting only one of these records in the provider record.
- In order for a provider to be considered as Exempted/Atypical, all the Claim Type Taxonomy records should have the same specifier (i.e. E/A). In case the specifier value for one or more Claim Type Taxonomy records is blank or different, the provider would be considered as a normal (non-exempt/non-atypical) provider.
- A group can either be an FQHC group or a normal physician group, it cannot be both. Thus we would not accept both FQHC (FDN/FPR) and Non-FQHC (DN/IN/PH/PR) claim type values with a provider record. Also, these FQHC Claim Type values can be used with a group only (i.e. provider request with Org Type '1' (Group). These claim Type values would not be accepted with an individual (Org Type '0') or a hospital (Org Type '2') request.

Group Affiliation Records

Group Affiliation records are used to track following information:

- *Attending – Billing provider relationships (Individuals only)* - For professional claims where the Billing Provider and Attending Provider aren't same, MMIS looks for a valid association between the two providers. The Group Affiliation section in the provider file layout is used to capture this information, and it is very essential that we have correct information in order to adjudicate professional claims. This information can be sent using Group Type 'G'.
- *Individual providers billing themselves (Individuals only)* – Some individual providers incorporate themselves, which allows them to act as their own billing providers. Information about these providers can also be sent using Group Type 'G'.
- *Providers who can bill their own NPI (All providers)* – Information about providers who can bill their own NPI and receive claims payment, can be sent using Group Type 'I'.
- Client Relationship – PCP/Specialist/Both/None (Individuals only)
- Par/Non-Par Provider (All providers)
- Reimbursement Indicator (All providers)

Following is the usage information, categorized by provider's organization type:

- Individual Providers (Org Type – 0) – Allowed Group Type values 'I', 'G'
    - *Type 'I':* [WHEN TO USE] Provider is not associated with any other group, and provides services in his own practice. [HOW TO USE] Group NPI (Field# 7.1.1) and Group MCO Internal Provider Identifier (Field# 7.1.2) should be same as the NPI (Field# 1.3) and MCO Internal ID (Field# 1.2) in the PRRequest Tag (Field# 1).
    - *Type 'G':* [WHEN TO USE] Provider acts as an attending provider and provides service on the behalf of a group/billing provider, or has incorporated himself as a group. [HOW TO USE #1] If the provider is enrolled with a group, the Group NPI (Field# 7.1.1) and Group MCO Internal Provider Identifier (Field# 7.1.2) should be populated with Group/Billing Provider's details. [HOW TO USE #2] In case the provider has incorporated himself, Group NPI (Field# 7.1.1) and Group MCO Internal Provider Identifier (Field# 7.1.2) should be same as the NPI (Field# 1.3) and MCO Internal ID (Field# 1.2) in the PRRequest Tag (Field# 1).
- Hospital Providers (Org Type – 2) – Allowed Group Type value: 'H' (for out-of-network only)
    - *Type 'H':* [WHEN TO USE] Hospital is an out of network hospital. It is optional to send this record for in-network hospitals, as absence of Group Affiliation records indicate that the provider is an in-network provider. [HOW TO USE] Group NPI (Field# 7.1.1) and Group MCO Internal Provider Identifier (Field# 7.1.2) should be same as the NPI (Field# 1.3) and MCO Internal ID (Field# 1.2) in the PRRequest Tag (Field# 1).
- Groups (Org Type – 1) – Allowed Group Type Value: 'I' (for out-of-network only)
    - Type 'I': [WHEN TO USE] Group is an out of network group. In FFS, out-of-network groups have to go through our enrollment process, in order to receive the payments. [HOW TO USE] Group NPI (Field# 7.1.1) and Group MCO Internal Provider Identifier (Field# 7.1.2) should be same as the NPI (Field# 1.3) and MCO Internal ID (Field# 1.2) in the PRRequest Tag (Field# 1).

Note: We would expect Group Affiliation records for all Individual providers and for non-par hospitals/groups. However absence of Group Affiliation records would not result in rejection of the records. In case the group records are not available for the provider, we would consider that provider to be an in-network provider, and would require a license.

MCO Provider Enrollment – Special Circumstances

In cases where a provider is enrolled as a group within a group for the MCO, the MMIS does not recognize this scenario. In these cases, the MCO can add the provider as an individual on the specific claim. The provider must have active enrollment for the dates of service on the claim in MMIS.

- The provider would need an Org Type= "0" and a group type "G".

The group MCO and the associated NPI must be in MMIS for the provider to be accepted.

Example: If the MCO enrolls a lab as a group, but the MMIS expects the lab to be an individual, then the above rule applies to the provider enrollment.