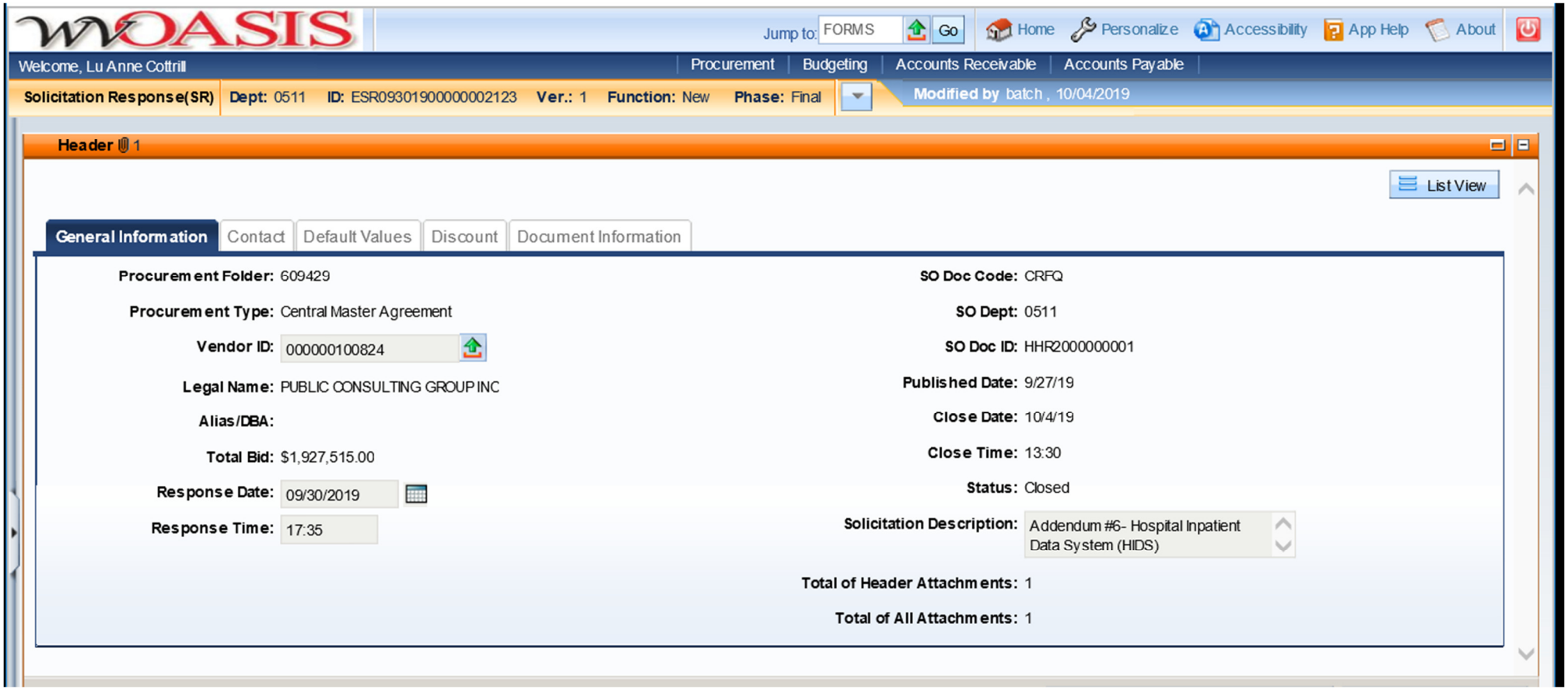
The following documentation is an electronically-submitted vendor response to an advertised solicitation from the *West Virginia Purchasing Bulletin* within the Vendor Self-Service portal at ***wvOASIS.gov***. As part of the State of West Virginia's procurement process, and to maintain the transparency of the bid-opening process, this documentation submitted online is publicly posted by the West Virginia Purchasing Division at ***WVPurchasing.gov*** with any other vendor responses to this solicitation submitted to the Purchasing Division in hard copy format.


wvOASIS
Jump to: FORMS Go
Home
Personalize
Accessibility
App Help
About
Welcome, Lu Anne Cottrill
Procurement
Budgeting
Accounts Receivable
Accounts Payable
Solicitation Response(SR) Dept: 0511 ID: ESR09301900000002123 Ver.: 1 Function: New Phase: Final
Modified by batch , 10/04/2019
Header 1
List View
General Information
Contact
Default Values
Discount
Document Information
Procurement Folder: 609429
Procurement Type: Central Master Agreement
Vendor ID: 000000100824
Legal Name: PUBLIC CONSULTING GROUP INC
Alias/DBA:
Total Bid: $1,927,515.00
Response Date: 09/30/2019
Response Time: 17:35
SO Doc Code: CRFQ
SO Dept: 0511
SO Doc ID: HHR2000000001
Published Date: 9/27/19
Close Date: 10/4/19
Close Time: 13:30
Status: Closed
Solicitation Description: Addendum #6- Hospital Inpatient Data System (HIDS)
Total of Header Attachments: 1
Total of All Attachments: 1

Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

State of West Virginia
Solicitation Response

Proc Folder : 609429

Solicitation Description : Addendum #6- Hospital Inpatient Data System (HIDS)

Proc Type : Central Master Agreement

Date issued	Solicitation Closes	Solicitation Response	Version
	2019-10-04 13:30:00	SR 0511 ESR09301900000002123	1

VENDOR

000000100824

PUBLIC CONSULTING GROUP INC

Solicitation Number: CRFQ 0511 HHR2000000001

Total Bid : $1,927,515.00 **Response Date:** 2019-09-30 **Response Time:** 17:35:22

Comments:

FOR INFORMATION CONTACT THE BUYER

April E Battle

(304) 558-0067
april.e.battle@wv.gov

Signature on File **FEIN #** **DATE**

All offers subject to all terms and conditions contained in this solicitation

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
1	Hospital In-Patient UB Data System and Emergency Department	4.00000	QTR	$82,500.000000	$330,000.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Hospital In-Patient UB Data System and Emergency Department

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
2	Outpatient Surgery	3.00000	QTR	$5,680.000000	$17,040.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Outpatient Surgery

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
3	Outpatient Observation stays	3.00000	QTR	$4,530.000000	$13,590.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Outpatient Observation stays

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
4	Outpatient Diagnostic and Therapeutic Hospital	3.00000	QTR	$5,680.000000	$17,040.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Outpatient Diagnostic and Therapeutic Hospital

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
5	Outpatient Physician Office visits	3.00000	QTR	$6,545.000000	$19,635.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Outpatient Physician Office visits

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
6	Other hospital outpatient services	3.00000	QTR	$4,530.000000	$13,590.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Other hospital outpatient services

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
7	Hourly rate for all optional services	500.00000	HOUR	$135.000000	$67,500.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Hourly rate for all optional services

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
8	Optional Renewal Year 1-Hospital In patient UB data system	4.00000	QTR	$82,500.000000	$330,000.00

Comm Code	Manufacturer	Specification	Model #
81112201			

Extended Description : Optional Renewal Year 1-Hospital In patient UB data system

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
9	Optional Renewal Year 1-Outpatient Surgery	4.00000	QTR	$5,680.000000	$22,720.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 1-Outpatient Surgery

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
10	Optional Renewal Year 1-Outpatient Observation stays	4.00000	QTR	$4,530.000000	$18,120.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 1-Outpatient Observation stays

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
11	Opt. Renewal Yr 1 Outpatient Diagnostic & Therapeutic Hospit	4.00000	QTR	$5,680.000000	$22,720.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 1-Outpatient Diagnostic and Therapeutic Hospital

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
12	Optional Renewal Year 1-Outpatient Physician Office visits	4.00000	QTR	$6,545.000000	$26,180.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 1-Outpatient Physician Office visits

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
13	Optional Renewal Year 1-Other hospital outpatient services	4.00000	QTR	$4,530.000000	$18,120.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 1-Other hospital outpatient services

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
14	Optional Renewal Year 1-Hourly rate for all optional service	500.00000	HOUR	$135.000000	$67,500.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 1-Hourly rate for all optional service

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
15	Optional Renewal Year 2-Outpatient Surgery	4.00000	QTR	$5,680.000000	$22,720.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 2-Outpatient Surgery

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
16	Optional Renewal Year 2-Outpatient Observation stays	4.00000	QTR	$4,530.000000	$18,120.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 2-Outpatient Observation stays

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
17	Opt. Renewal Yr 2 Outpatient Diagnostic & Therapeutic Hospit	4.00000	QTR	$5,680.000000	$22,720.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 2-Outpatient Diagnostic and Therapeutic Hospital

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
18	Optional Renewal Year 2-Outpatient Physician Office visits	4.00000	QTR	$6,545.000000	$26,180.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 2-Outpatient Physician Office visits

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
19	Optional Renewal Year 2-Other hospital outpatient services	4.00000	QTR	$4,530.000000	$18,120.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 2-Other hospital outpatient services

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
20	Optional Year 2-Hourly rate for all optional services	500.00000	HOUR	$135.000000	$67,500.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Year 2-Hourly rate for all optional services

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
21	Optional Renewal Year 3-Outpatient Surgery	4.00000	QTR	$5,680.000000	$22,720.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 3-Outpatient Surgery

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
22	Optional Renewal Year 3-Outpatient Observation stays	4.00000	QTR	$4,530.000000	$18,120.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 3-Outpatient Observation stays

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
23	Opt. Renewal Yr 3 Outpatient Diagnostic & Therapeutic Hospit	4.00000	QTR	$5,680.000000	$22,720.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 3-Outpatient Diagnostic and Therapeutic Hospital

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
24	Optional Renewal Year 3-Outpatient Physician Office visits	4.00000	QTR	$6,545.000000	$26,180.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 3-Outpatient Physician Office visits

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
25	Optional Renewal Year 3-Other hospital outpatient services	4.00000	QTR	$4,530.000000	$18,120.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 3-Other hospital outpatient services

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
26	Optional Renewal Year 3-Hourly rate for all optional service	4.00000	QTR	$135.000000	$540.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 3-Hourly rate for all optional service

Comments: PCG is submitting this as a price per hour as requested in the Description of Lot 1 Line 26.

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
27	Optional Renewal Year 2-Hospital Data System	4.00000	QTR	$82,500.000000	$330,000.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 2-Hospital Data System

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
28	Optional Renewal Year 3-Hospital Data System	4.00000	QTR	$82,500.000000	$330,000.00

Comm Code	Manufacturer	Specification	Model #
81111503			

Extended Description : Optional Renewal Year 3-Hospital Data System

PUBLIC CONSULTING GROUP

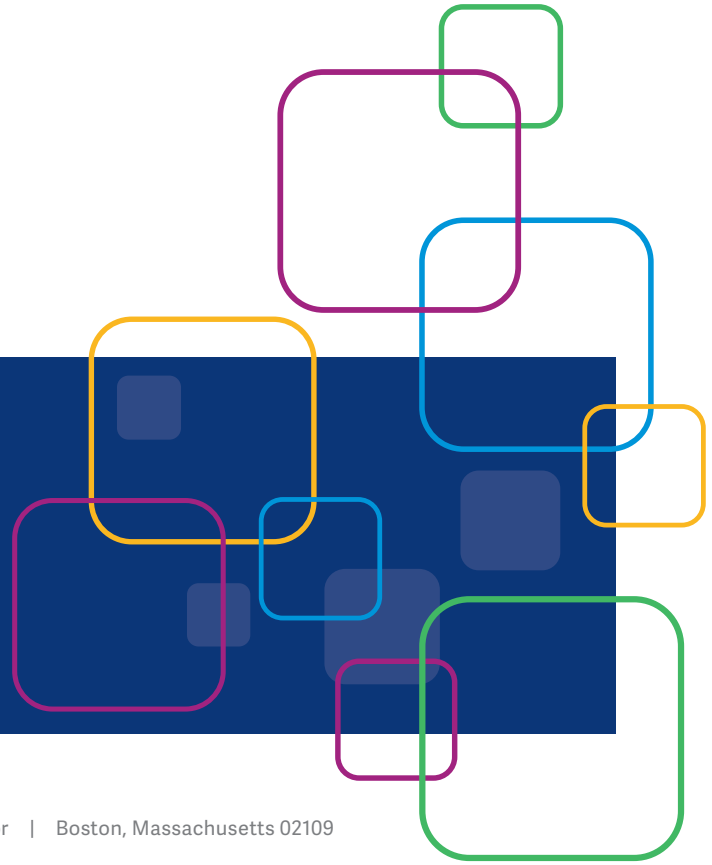
Solutions that Matter

TECHNICAL PROPOSAL

West Virginia Department of Health and Human Resources

Hospital Inpatient Data System (HIDS)

CRFQ 0511 HHR2000000001



September 26, 2019

April Battle
2019 Washington Street, East
Charleston, WV 25305

TABLE OF CONTENTS – PROPOSAL AND RESPONDENT INFORMATION

I. Required Forms

I.1 Designated Contact Form
I.2 Addendum Acknowledgement Form
I.3 HIPAA Business Associate Addendum
I.4 Purchasing Affidavit
I.5 Contract Manager

I.1 Designated Contact Form

DESIGNATED CONTACT: Vendor appoints the individual identified in this Section as the Contract Administrator and the initial point of contact for matters relating to this Contract.

Rick Dwyer, Manager
(Name, Title)

Rick Dwyer, Manager
(Printed Name and Title)

148 State Street, Boston, MA 02109
(Address)

617-717-1250 / 617-426-4632
(Phone Number) / (Fax Number)

rdwyer@pcgus.com
(email address)

CERTIFICATION AND SIGNATURE: By signing below, or submitting documentation through wvOASIS, I certify that I have reviewed this Solicitation in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that I am authorized by the vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

Public Consulting Group, Inc.
(Company)

Marc Staubley
(Authorized Signature) (Representative Name, Title)

Marc Staubley, Health Practice Area Director
(Printed Name and Title of Authorized Representative)

9/17/2019
(Date)

512-287-4662 / 512-407-9249
(Phone Number) (Fax Number)

I.2 Addendum Acknowledgement Form

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFQ 0511 HHR2000000001

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

- [x] Addendum No. 1
- [x] Addendum No. 2
- [x] Addendum No. 3
- [x] Addendum No. 4
- [x] Addendum No. 5
- [x] Addendum No. 6
- [ ] Addendum No. 7
- [ ] Addendum No. 8
- [ ] Addendum No. 9
- [ ] Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

Public Consulting Group, Inc.

Company

Marc Hawtley

Authorized Signature

9/30/2019

Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

I.3 HIPAA Business Associate Addendum

WV STATE GOVERNMENT

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Health Insurance Portability and Accountability Act of 1996 (hereafter, HIPAA) Business Associate Addendum ("Addendum") is made a part of the Agreement ("Agreement") by and between the State of West Virginia ("Agency"), and Business Associate ("Associate"), and is effective as of the date of execution of the Addendum.

The Associate performs certain services on behalf of or for the Agency pursuant to the underlying Agreement that requires the exchange of information including protected health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) (the "HITECH Act"), any associated regulations and the federal regulations published at 45 CFR parts 160 and 164 (sometimes collectively referred to as "HIPAA"). The Agency is a "Covered Entity" as that term is defined in HIPAA, and the parties to the underlying Agreement are entering into this Addendum to establish the responsibilities of both parties regarding HIPAA-covered information and to bring the underlying Agreement into compliance with HIPAA.

Whereas it is desirable, in order to further the continued efficient operations of Agency to disclose to its Associate certain information which may contain confidential individually identifiable health information (hereafter, Protected Health Information or PHI); and

Whereas, it is the desire of both parties that the confidentiality of the PHI disclosed hereunder be maintained and treated in accordance with all applicable laws relating to confidentiality, including the Privacy and Security Rules, the HITECH Act and its associated regulations, and the parties do agree to at all times treat the PHI and interpret this Addendum consistent with that desire.

NOW THEREFORE: the parties agree that in consideration of the mutual promises herein, in the Agreement, and of the exchange of PHI hereunder that:

1. **Definitions.** Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

    a. **Agency Procurement Officer** shall mean the appropriate Agency individual listed at: http://www.state.wv.us/admin/purchase/vrc/agencyli.html.

    b. **Agent** shall mean those person(s) who are agent(s) of the Business Associate, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c).

    c. **Breach** shall mean the acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except as excluded in the definition of Breach in 45 CFR § 164.402.

    d. **Business Associate** shall have the meaning given to such term in 45 CFR § 160.103.

    e. **HITECH Act** shall mean the Health Information Technology for Economic and Clinical Health Act. Public Law No. 111-05. 111th Congress (2009).

f. **Privacy Rule** means the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Parts 160 and 164.

g. **Protected Health Information or PHI** shall have the meaning given to such term in 45 CFR § 160.103, limited to the information created or received by Associate from or on behalf of Agency.

h. **Security Incident** means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information or interference with system operations in an information system.

i. **Security Rule** means the Security Standards for the Protection of Electronic Protected Health Information found at 45 CFR Parts 160 and 164.

j. **Subcontractor** means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

2. **Permitted Uses and Disclosures.**

a. **PHI Described.** This means PHI created, received, maintained or transmitted on behalf of the Agency by the Associate. This PHI is governed by this Addendum and is limited to the minimum necessary, to complete the tasks or to provide the services associated with the terms of the original Agreement, and is described in Appendix A.

b. **Purposes.** Except as otherwise limited in this Addendum, Associate may use or disclose the PHI on behalf of, or to provide services to, Agency for the purposes necessary to complete the tasks, or provide the services, associated with, and required by the terms of the original Agreement, or as required by law, if such use or disclosure of the PHI would not violate the Privacy or Security Rules or applicable state law if done by Agency or Associate, or violate the minimum necessary and related Privacy and Security policies and procedures of the Agency. The Associate is directly liable under HIPAA for impermissible uses and disclosures of the PHI it handles on behalf of Agency.

c. **Further Uses and Disclosures**. Except as otherwise limited in this Addendum, the Associate may disclose PHI to third parties for the purpose of its own proper management and administration, or as required by law, provided that (i) the disclosure is required by law, or (ii) the Associate has obtained from the third party reasonable assurances that the PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party by the Associate; and, (iii) an agreement to notify the Associate and Agency of any instances of which it (the third party) is aware in which the confidentiality of the information has been breached. To the extent practical, the information should be in a limited data set or the minimum necessary information pursuant to 45 CFR § 164.502, or take other measures as necessary to satisfy the Agency's obligations under 45 CFR § 164.502.

3. **Obligations of Associate.**

a. **Stated Purposes Only.** The PHI may not be used by the Associate for any purpose other than as stated in this Addendum or as required or permitted by law.

b. **Limited Disclosure.** The PHI is confidential and will not be disclosed by the Associate other than as stated in this Addendum or as required or permitted by law. Associate is prohibited from directly or indirectly receiving any remuneration in exchange for an individual's PHI unless Agency gives written approval and the individual provides a valid authorization. Associate will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Associate will report to Agency any use or disclosure of the PHI, including any Security Incident not provided for by this Agreement of which it becomes aware.

c. **Safeguards.** The Associate will use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the PHI, except as provided for in this Addendum. This shall include, but not be limited to:

i. Limitation of the groups of its workforce and agents, to whom the PHI is disclosed to those reasonably required to accomplish the purposes stated in this Addendum, and the use and disclosure of the minimum PHI necessary or a Limited Data Set;

ii. Appropriate notification and training of its workforce and agents in order to protect the PHI from unauthorized use and disclosure;

iii. Maintenance of a comprehensive, reasonable and appropriate written PHI privacy and security program that includes administrative, technical and physical safeguards appropriate to the size, nature, scope and complexity of the Associate's operations, in compliance with the Security Rule;

iv. In accordance with 45 CFR §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information.

d. **Compliance With Law.** The Associate will not use or disclose the PHI in a manner in violation of existing law and specifically not in violation of laws relating to confidentiality of PHI, including but not limited to, the Privacy and Security Rules.

e. **Mitigation.** Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Associate of a use or disclosure of the PHI by Associate in violation of the requirements of this Addendum, and report its mitigation activity back to the Agency.

f. **Support of Individual Rights.**

i. **Access to PHI.** Associate shall make the PHI maintained by Associate or its agents or subcontractors in Designated Record Sets available to Agency for inspection and copying, and in electronic format, if requested, within ten (10) days of a request by Agency to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524 and consistent with Section 13405 of the HITECH Act.

ii. **Amendment of PHI.** Within ten (10) days of receipt of a request from Agency for an amendment of the PHI or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such PHI available to Agency for amendment and incorporate any such amendment to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526.

iii. **Accounting Rights.** Within ten (10) days of notice of a request for an accounting of disclosures of the PHI, Associate and its agents or subcontractors shall make available to Agency the documentation required to provide an accounting of disclosures to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR §164.528 and consistent with Section 13405 of the HITECH Act. Associate agrees to document disclosures of the PHI and information related to such disclosures as would be required for Agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. This should include a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years from the date of disclosure, or longer if required by state law. At a minimum, such documentation shall include:

- the date of disclosure;
- the name of the entity or person who received the PHI, and if known, the address of the entity or person;
- a brief description of the PHI disclosed; and
- a brief statement of purposes of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure.

iv. **Request for Restriction**. Under the direction of the Agency, abide by any individual's request to restrict the disclosure of PHI, consistent with the requirements of Section 13405 of the HITECH Act and 45 CFR § 164.522, when the Agency determines to do so (except as required by law) and if the disclosure is to a health plan for payment or health care operations and it pertains to a health care item or service for which the health care provider was paid in full "out-of-pocket."

v. **Immediate Discontinuance of Use or Disclosure.** The Associate will immediately discontinue use or disclosure of Agency PHI pertaining to any individual when so requested by Agency. This includes, but is not limited to, cases in which an individual has withdrawn or modified an authorization to use or disclose PHI.

g. **Retention of PHI.** Notwithstanding section 4.a. of this Addendum, Associate and its subcontractors or agents shall retain all PHI pursuant to state and federal law and shall continue to maintain the PHI required under Section 3.f. of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.

h. **Agent's, Subcontractor's Compliance.** The Associate shall notify the Agency of all subcontracts and agreements relating to the Agreement, where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum. Such notification shall occur within 30 (thirty) calendar days of the execution of the subcontract and shall be delivered to the Agency Procurement Officer. The Associate will ensure that any of its subcontractors, to whom it provides any of the PHI it receives hereunder, or to whom it provides any PHI which the Associate creates or receives on behalf of the Agency, agree to the restrictions and conditions which apply to the Associate hereunder. The Agency may request copies of downstream subcontracts and agreements to determine whether all restrictions, terms and conditions have been flowed down. Failure to ensure that downstream contracts, subcontracts and agreements contain the required restrictions, terms and conditions may result in termination of the Agreement.

j. **Federal and Agency Access.** The Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI, as well as the PHI, received from, or created or received by the Associate on behalf of the Agency available to the U.S. Secretary of Health and Human Services consistent with 45 CFR § 164.504. The Associate shall also make these records available to Agency, or Agency's contractor, for periodic audit of Associate's compliance with the Privacy and Security Rules. Upon Agency's request, the Associate shall provide proof of compliance with HIPAA and HITECH data privacy/protection guidelines, certification of a secure network and other assurance relative to compliance with the Privacy and Security Rules. This section shall also apply to Associate's subcontractors, if any.

k. **Security.** The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI. In addition, compliance with 74 FR 19006 Guidance Specifying the Technologies and Methodologies That Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of Title XIII is required, to the extent practicable. If Associate chooses not to adopt such methodologies as defined in 74 FR 19006 to secure the PHI governed by this Addendum, it must submit such written rationale, including its Security Risk Analysis, to the Agency Procurement Officer for review prior to the execution of the Addendum. This review may take up to ten (10) days.

l. **Notification of Breach.** During the term of this Addendum, the Associate shall notify the Agency and, unless otherwise directed by the Agency in writing, the WV Office of Technology immediately by e-mail or web form upon the discovery of any Breach of unsecured PHI; or within 24 hours by e-mail or web form of any suspected Security Incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency Procurement Officer at www.state.wv.us/admin/purchase/vrc/agencyli.htm and,

unless otherwise directed by the Agency in writing, the Office of Technology at incident@wv.gov or https://apps.wv.gov/ot/ir/Default.aspx.

The Associate shall immediately investigate such Security Incident, Breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, the Associate shall notify the Agency Procurement Officer, and, unless otherwise directed by the Agency in writing, the Office of Technology of: (a) Date of discovery; (b) What data elements were involved and the extent of the data involved in the Breach; (c) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data; (d) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (e) A description of the probable causes of the improper use or disclosure; and (f) Whether any federal or state laws requiring individual notifications of Breaches are triggered.

Agency will coordinate with Associate to determine additional specific actions that will be required of the Associate for mitigation of the Breach, which may include notification to the individual or other authorities.

All associated costs shall be borne by the Associate. This may include, but not be limited to costs associated with notifying affected individuals.

If the Associate enters into a subcontract relating to the Agreement where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum, all such subcontracts or downstream agreements shall contain the same incident notification requirements as contained herein, with reporting directly to the Agency Procurement Officer. Failure to include such requirement in any subcontract or agreement may result in the Agency's termination of the Agreement.

m. **Assistance in Litigation or Administrative Proceedings.** The Associate shall make itself and any subcontractors, workforce or agents assisting Associate in the performance of its obligations under this Agreement, available to the Agency at no cost to the Agency to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Agency, its officers or employees based upon claimed violations of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inaction or actions by the Associate, except where Associate or its subcontractor, workforce or agent is a named as an adverse party.

4. Addendum Administration.

a. **Term.** This Addendum shall terminate on termination of the underlying Agreement or on the date the Agency terminates for cause as authorized in paragraph (c) of this Section, whichever is sooner.

b. **Duties at Termination.** Upon any termination of the underlying Agreement, the Associate shall return or destroy, at the Agency's option, all PHI received from, or created or received by the Associate on behalf of the Agency that the Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, the Associate shall extend the protections of this Addendum to the PHI and limit further uses and disclosures to the purposes that make the return or destruction of the PHI infeasible. This shall also apply to all agents and subcontractors of Associate. The duty of the Associate and its agents

and subcontractors to assist the Agency with any HIPAA required accounting of disclosures survives the termination of the underlying Agreement.

c. **Termination for Cause.** Associate authorizes termination of this Agreement by Agency, if Agency determines Associate has violated a material term of the Agreement. Agency may, at its sole discretion, allow Associate a reasonable period of time to cure the material breach before termination.

d. **Judicial or Administrative Proceedings.** The Agency may terminate this Agreement if the Associate is found guilty of a criminal violation of HIPAA. The Agency may terminate this Agreement if a finding or stipulation that the Associate has violated any standard or requirement of HIPAA/HITECH, or other security or privacy laws is made in any administrative or civil proceeding in which the Associate is a party or has been joined. Associate shall be subject to prosecution by the Department of Justice for violations of HIPAA/HITECH and shall be responsible for any and all costs associated with prosecution.

e. **Survival.** The respective rights and obligations of Associate under this Addendum shall survive the termination of the underlying Agreement.

5. **General Provisions/Ownership of PHI.**

a. **Retention of Ownership.** Ownership of the PHI resides with the Agency and is to be returned on demand or destroyed at the Agency's option, at any time, and subject to the restrictions found within section 4.b. above.

b. **Secondary PHI.** Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an individual must be held confidential and is also the property of Agency.

c. **Electronic Transmission.** Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an individual must not be transmitted to another party by electronic or other means for additional uses or disclosures not authorized by this Addendum or to another contractor, or allied agency, or affiliate without prior written approval of Agency.

d. **No Sales.** Reports or data containing the PHI may not be sold without Agency's or the affected individual's written consent.

e. **No Third-Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Agency, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

f. **Interpretation.** The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this Addendum. The interpretation of this Addendum shall be made under the laws of the state of West Virginia.

g. **Amendment.** The parties agree that to the extent necessary to comply with applicable law they will agree to further amend this Addendum.

h. **Additional Terms and Conditions.** Additional discretionary terms may be included in the release order or change order process.

AGREED:

Name of Agency:_____

Signature:_____

Title:_____

Date:_____

Name of Associate: Public Consulting Group, Inc.

Signature: Marc Hartley

Title: Health Practice Area Director

Date: 9/17/2019

Form - WVBAA-012004
Amended 06.26.2013

APPROVED AS TO FORM THIS 26th
DAY Of June 20 19
Patrick Morrisey
Attorney General
BY _____

Appendix A

(To be completed by the Agency's Procurement Officer prior to the execution of the Addendum, and shall be made a part of the Addendum. PHI not identified prior to execution of the Addendum may only be added by amending Appendix A and the Addendum, via Change Order.)

Name of Associate: _____

Name of Agency: _____

Describe the PHI (do not include any actual PHI). If not applicable, please indicate the same.

I.4 Purchasing Affidavit

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

CONSTRUCTION CONTRACTS: Under W. Va. Code § 5-22-1(i), the contracting public entity shall not award a construction contract to any bidder that is known to be in default on any monetary obligation owed to the state or a political subdivision of the state, including, but not limited to, obligations related to payroll taxes, property taxes, sales and use taxes, fire service fees, or other fines or fees.

ALL CONTRACTS: Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Employer default" means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceed five percent of the total contract amount.

AFFIRMATION: By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (*W. Va. Code* §61-5-3) that: (1) for construction contracts, the vendor is not in default on any monetary obligation owed to the state or a political subdivision of the state, and (2) for all other contracts, that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:

Vendor's Name: Public Consulting Group, Inc.

Authorized Signature: Marc Hawley Date: 9/17/2019

State of Massachusetts

County of Suffolk, to-wit:

Taken, subscribed, and sworn to before me this 17th day of September, 2019

My Commission expires August 22, 2025

AFFIX SEAL HERE

NOTARY PUBLIC Carrie P. Kaplowitz

CARRIE P. KAPLOWITZ
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires On
August 22, 2025

I.5 Contract Manager

4.5. Vendor shall inform all staff of Agency's security protocol and procedures.

5. VENDOR DEFAULT:

5.1. The following shall be considered a vendor default under this Contract.

5.1.1. Failure to perform Contract Services in accordance with the requirements contained herein.

5.1.2. Failure to comply with other specifications and requirements contained herein.

5.1.3. Failure to comply with any laws, rules, and ordinances applicable to the Contract Services provided under this Contract.

5.1.4. Failure to remedy deficient performance upon request.

5.2. The following remedies shall be available to Agency upon default.

5.2.1. Immediate cancellation of the Contract.

5.2.2. Immediate cancellation of one or more release orders issued under this Contract.

5.2.3. Any other remedies available in law or equity.

6. MISCELLANEOUS:

6.1. Contract Manager: During its performance of this Contract, Vendor must designate and maintain a primary contract manager responsible for overseeing Vendor's responsibilities under this Contract. The Contract manager must be available during normal business hours to address any customer service or other issues related to this Contract. Vendor should list its Contract manager and his or her contact information below.

Contract Manager: Rick Dwyer
Telephone Number: 617-717-1250
Fax Number: 617-426-4632
Email Address: rdwyer@pcgus.com

II. Transmittal Letter

PUBLIC CONSULTING GROUP

Solutions that Matter

September 26, 2019

April E. Battle
Purchaser
Department of Administration
2019 Washington Street East,
Charleston, WV 25305

Dear Ms. Battle:

Public Consulting Group, Inc. (PCG) is pleased to present a response to the West Virginia Department of Health and Human Resources' (the Department's) request for a vendor to provide a Hospital Inpatient Data System*, CRFQ-0511-HHR2000000001.* For more than 30 years, PCG has helped state health and human resources agencies operate more efficiently and effectively.

PCG has Extensive Hospital Billing and Data Experience

PCG combines strong fiscal agent operations acumen with significant subject matter expertise in inpatient and outpatient claims processing and auditing techniques. This includes experience in **providing Data intermediary Services for the Department of Health in the State of New Jersey**, whose scope of work is directly related to those required in this RFQ, as well as our work as a third party administrator, where we collect, process, and adjudicate healthcare payments that exceed $2 billion dollars each year. Due to this experience, **we not only meet but exceed the minimum of ten years of experience** in collecting hospital billing data, but **we also prove that we are the ideal fit**. These attributes position us well to provide The Department with a robust and fully supported data collection and reporting application that can maintain inpatient and outpatient discharge data for over 60 hospitals.

The plan and approach described below, and the detailed system functionality and business processes discussed further into the proposal are designed to provide DHHR with the necessary foundation to implement a more modern, intuitive, and efficient hospital inpatient data system. PCG has built a superior data collection and processing system which operates unobtrusively in the background and that efficiently supports both facilities and agency staff as they manage discharge data and is flexible enough to be customized to meet the technical requirements of DHHR and the provider community. Our system will provide a high level of confidence to its users such that they need not unduly worry about the integrity of the data or the application. With PCG as your next inpatient data system, you will be selecting a firm dedicated to improving upon what you currently have and maintaining excellence over time.

Our approach and plans also understand the need for stability, if you chose to transition from the current incumbent. We understand that switching from one vendor to another carries with it an element of risk. You need the transition to be seamless so that program participants – both facilities and providers – are not negatively impacted in any way and so that DHHR is able to receive all patient and claim discharge data as expected. **Our plan for mitigating that risk is to provide you a proven system, the components of which have been successfully implemented in other environments, and an implementation team that is highly experienced in building and maintaining electronic data interchanges.** And those personnel resources will focus initially on those items most critical to a successful transition from the incumbent. Our experience in New Jersey, where we replaced a long-term vendor, demonstrates our ability to plan and execute a smooth transition.

By minimizing transition disruptions, it will allow PCG and DHHR to focus on the appropriate set of priorities - working towards business process improvements that reduce administrative burdens, improve the utility of information gleaned from the data, and thus enhance DHHR's ability to address quality, access, and cost issues associated with inpatient and outpatient services.

PCG Knows West Virginia

PCG has had a proven track record working with DHHR as the vendor for the School Based Health Services (SBHS) program's administration for nearly a decade and demonstrated a strong presence in West Virginia through numerous other engagements with the State. As part of the SBHS program, PCG created and operates a claiming system that is utilized by over fifty counties and hundreds of users in West Virginia.

In addition, PCG Public Partnerships has been a longtime partner with the West Virginia Bureau for Medical Services providing full-service fiscal/employer agent financial management (F/EA FMS) and resource consulting services for Personal Options, the self-directed option within the WV Waiver programs since February 2007. Public Partnerships provides participant enrollment and ongoing support, provider enrollment and credentialing, budget management, payroll and accounts payable activity, Medicaid claims submission, and customer service.

Our additional state experience includes several revenue enhancement and cost savings engagements on behalf of DHHR, including a behavioral health system redesign, a comprehensive assessment and implementation plan maximizing federal recoveries for the State, as well as the current operation of the transformed SBHS program. **PCG also has a local office in Charleston and over 40 employees based in West Virginia**. We are confident that we can build on our past experiences working with the Department and the state of West Virginia to provide a Hospital Inpatient Data System that meets the needs of hospital providers and the State.

PCG's Project Goals

PCG has set **two goals** if we are fortunate to win this procurement:

1. First, PCG wants to improve the level of service currently experienced by DHHR and the provider community in capturing and maintaining discharge data. **We want to make it an easy, efficient, and accurate experience** in both directions.

2. But second, and more importantly, **PCG also wants to help DHHR and the provider community make that data useful** to the goals of improving care quality, increasing access, and controlling costs. This is the true added value PCG can bring to DHHR. PCG will not only provide the electronic data interchange system capabilities to collect data but will also provide the subject matter expertise in both report writing and the Optum Grouper to help DHHR decipher meaningful information.\

To meet these twin goals, PCG is proposing modern technologies, better workflow processes, and exceptionally skilled staff members. But we start with articulating **our objectives** as we understand the Scope of Work. They include:

- **Provide a user-friendly Web-Portal** for facilities and DHHR that is HIPAA compliant and allows the end-user to transmit, query and export patient and claim discharge data. Key functionality includes the ability for facilities to interface with the PCG system to upload HIPAA compliant 837 files, process 999 and 277 files, and make corrections to file and claim errors. This modern, scalable, and proven technology will have the capabilities for:
    - **Immediate intake of all claim types** listed in the RFP, including: Inpatient UB, Emergency Department, Outpatient Surgery, Outpatient Observation Stays, Outpatient Diagnostic and Therapeutic Hospital Services, Outpatient Physician Office Visits, and Other Hospital Outpatient Services.
    - A SQL database structure that is hosted in Amazon Web Services
    - SSRS reporting and other advanced analytical tools

- **Implement a data processing system** that utilizes the Optum Medicare Severity DRG Grouper to assign diagnosis related groups (DRGs) to claim discharge data for inpatient services.

- **Build a data warehouse** to store patient and claim discharge data in order to provide standard and ad-hoc reporting. This includes an ability for DHHR and facilities to run reports, query our system to retrieve claim data, and have immediate access to data at project go-live.

- **Ensure compliance** with all federal and state laws, rules and regulations.

- **Provide a highly secure system** that is HIPAA compliant, with appropriate controls in place

PCG Will Provide the Best Value for the Department

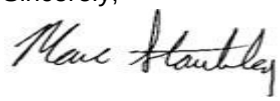
PCG is committed to working with the Department to provide a high-quality and cost-effective system. We have developed a high level of loyalty and trust amongst our existing clients. Our successful history demonstrates our understanding of the Department's needs, and our ability to successfully meet and exceed the expectations outlined in the RFQ.

Our corporate mission is dedicated to serving and improving public health and human resources programs and the operations that support them. If selected as the vendor to provide the Hospital Inpatient Data System, PCG will strive to provide the best possible service to the Department.

If you have any questions regarding our proposal, please feel free to reach out directly to PCG Manager and proposed Project Manager for this engagement, Rick Dwyer, who can be reached at rdwyer@pcgus.com or 617-717-1250.

PCG looks forward to working with you on this important engagement, and we hope that this proposal will be viewed favorably.

Sincerely,



Marc Staubley
Health Practice Area Director

III. Qualifications and Experience [3.1]

III.1 Qualifications and Experience [3.1]

III.1 Qualifications and Experience [3.1]

3. QUALIFICATIONS

III.1 Qualifications and Experience [3.1]

3.1.1 Vendor MUST have a minimum of 10 years of experience collecting Hospital Billing data in a then current standard format such as ANSI (American National Standards Institute, Accredited Standards Committee). ASC X12 8371 4010.

Public Consulting Group, Inc.'s (PCG) Experience

PCG has deep and broad experience in developing and operating information systems to support specific reporting and analytical health care claims initiatives on behalf of health and human services agencies. Throughout our firm's 30 plus year history, one consistent area of focus has been providing healthcare claims processing solutions that adhere to industry standard file formats with the goal of providing accurate data to our clients for analysis and evaluation purposes. **In fact, PCG performs data intermediary services nationally for child welfare, educational, and early intervention clients, in addition to Medicaid and public health agencies. We have processed and analyzed claims for an array of health care programs including behavioral health, public health services, ambulatory surgery clinics, and hospitals (acute care, critical access, and long term acute care)**. Furthermore, PCG has developed a proprietary, secure, web-based claims processing system to support the reporting of inpatient and outpatient hospital services required by state public health agencies. This system will be the foundation for this project, customized to meet your specific processing requirements outlined in your Administrative Code.

Our experience not only includes providing technological platforms, but customer and operational support in a number of capacities. In fact, in addition to serving as a data intermediary, PCG supports claims processing services as a third-party administrator, administrative service organization, and fiscal services agent. PCG processes over ***$2.2 billion in claims on an annual basis for payment purposes***.

This combination of experience and expertise (including experience with diverse providers and provider systems), documented throughout this proposal provides ample evidence of PCG's ability to perform the services outlined in the RFQ and configure our application that will meet the expectations and requirements.

Hospital Claims Expertise

Throughout PCG's thirty-year history providing consulting and technical services to governmental agencies across the nation, PCG Health has been intricately involved in almost every aspect of hospital and ambulatory surgical center claims processing, auditing, analysis, and reimbursement. PCG has developed technical applications and best practice process maps for collecting claims data through nationally standardized ANSI ASC X12N 837 implementation guides from both providers directly and clearinghouse vendors.

PCG has worked closely with our government agency clients to implement customized claims auditing policies and complex algorithms that ensure that all collected claims are complete and accurate. As part of PCG's hospital rate setting and reimbursement methodology development projects with state Medicaid agencies, PCG works closely with state Medicaid Management Information Systems (MMIS) vendors such as Xerox and HP to implement the claim editing requirement of groupers such as the MS-DRG, APR-DRG, EAPG, and APC groupers and reconcile the applicability of the individual claim edits with Medicaid reimbursement policies. Furthermore, PCG has also leveraged, accepted and grouped claims data from a multitude of payers to develop in-depth analyses of cost, payment, case mix index, and utilization trends to support payment and reporting efforts on behalf of our clients.

PCG's experiences with hospital and ambulatory surgery center claims across all aspects of the claims collection cycle uniquely positions PCG as a vendor that can meet the experience requirements of DHHR. In fact, PCG has successfully launched our tool on behalf of the State of New Jersey, assuming services

from an incumbent vendor. PCG's comprehensive hospital claims data experience allows us to integrate every aspect of the claim lifecycle into an effective and efficient solution.

Inpatient and Outpatient Hospital Claim Groupers

In addition to PCG's extensive experience providing fiscal agent and data intermediary services to a variety of government agencies, PCG also possesses significant experience implementing various groupers, for state Medicaid agencies across the country. In fact, PCG assisted the state of Texas in analyzing and performing an in-depth assessment of a potential transition to the 3M EAPG grouper for reimbursing Medicaid outpatient hospital claims. Our experience does not stop there; we have an in depth understanding of 3M's clinical risk group (CRG) software.

As part of PCG's approach to adopt our current application to DHHR's requirements, PCG will leverage our national experience implementing inpatient and outpatient claims groupers and utilize this experience to ensure that the claims data being submitted by the providers meet the accuracy and consistency expectations of DHHR, which will allow for impactful analysis of population health in West Virginia using the claims data, but with an improved provider experience.

3.1.2 Vendor MUST have verifiable experience exchanging clinical data in HL7 (American National Standards Institute, Accredited Standards Committee) v2.x and v3.x and experience collecting, editing and using data coded, ICD-10-CM.

Contracts of Similar Size and Scope

As you will see below, PCG and our proposed team have extensive experience with successfully completing similar projects in other states, including large data management projects, among others. The following six (6) contracts are of similar size and scope to what is being requested in this RFQ. These contracts are described in further detail in this section.

Large Data Management Projects

01

Department of Health (DOH), State of New Jersey: Data Intermediary Services

PCG has contracted with the New Jersey Department of Health to build, develop, and maintain a web-based application on a hosted database environment that maintains inpatient and outpatient discharge data submitted from 72 hospitals, 11 long term acute care facilities and approximately 400 ambulatory care facilities, totaling more than 6 million claims per year. The system's database contains sufficient capacity to maintain nine (9) years of data. In addition, PCG provides customer support to submitting entities through provider training, a toll-free hotline, as well as email support. More importantly, PCG seamlessly transitioned these functions from a long-standing incumbent. PCG brought a fresh and innovative approach to this program. While successfully assume the responsibilities of the prior vendor, we made a number of operational and reporting improvements by streamlining prior processes. These improvements were welcomed by both the State and the provider community.

02

Health and Human Services Commission (HHSC), State of Texas: Data Broker Services

PCG is contracted with Texas Health and Human Services Commission (HHSC) through June 2021 to provide comprehensive data broker services. The PCG Team has worked HHSC since 2016 to develop and deploy the **country's most sophisticated benefits eligibility verification system in operation today. It is used by 15,000+ workers across the State to process more than 1 million daily real-time Medicaid, SNAP, CHIP, and TANF eligibility verification transactions.** The PCG web-based application incorporates data from nearly 40 federal, state, and commercial sources into an automated workflow, which allows workers to verify eligibility, flag potential ineligibility and/or fraud, and quantify the level of risk associated with each eligibility review area (e.g. income, assets, and residency) using PCG's proprietary predictive analytics. Thus far, PCG has processed more than 600 million eligibility verification transactions on the State's behalf. Each one results in its own custom, beneficiary-level data pulls, analytics, on-screen results, and reports and each one averages less than 1 second to complete.

Through this comprehensive “data broker service”, PCG assumed this effort from a longstanding vendor and not only replicated existing or legacy processes, but significantly enhanced the capabilities of agency staff. Our proprietary application helps the state ensure benefits are determined appropriately, while significantly reducing the amount of time required of eligibility workers to retrieve paperwork from the applying beneficiary.

03

Department of Health, Bureau of Early Intervention (EI), State of New York: State Fiscal Agent

PCG has contracted with the New York State Department of Health, Bureau of Early Intervention to serve as the EI State Fiscal Agent. As the Fiscal Agent, PCG is responsible for the collection and processing of provider and insurance claims. PCG has developed a proprietary web-based health care claim collection tool, which is the platform used to facilitate claim collection. In addition, PCG is responsible for maintaining a help desk to support healthcare submitters throughout the adjudication process

04

Department of Health Care Finance (DHCF), District of Columbia: Administrative Service Organization

PCG serves as the District of Columbia Administrative Services Organization (ASO) to support the Medicaid billing of community-based programs and services. PCG has developed a comprehensive and standardized approach to Partner Agency Medicaid billing that produces compliant claims that meet the District of Columbia and federal standards for our client, while accounting for the differences that exist in the service delivery and business processes of the partner agencies. PCG collects claims electronically through a web-based portal in a variety of HIPAA compliant claim formats and standards. PCG is also responsible for assisting providers in the claim submission process, which we support through the establishment of a call center help desk, as well as email support.

05

Commonwealth Care Alliance (CCA), Commonwealth of Massachusetts: Third Party Administrator

Based in Massachusetts, Commonwealth Care Alliance (CCA) is a not-for-profit, community-based healthcare organization dedicated to improving care for individuals who are dually eligible for MassHealth (Medicaid) and Medicare with complex medical, behavioral health and social needs, including persons with disabilities. CCA offers two health plans: Senior Care Options (HMO SNP), for individuals ages 65 and over who have Medicare and MassHealth Standard or only MassHealth Standard; and One Care, a Massachusetts demonstration program for dual eligible individuals ages 21 to 64. PCG serves as the third-party administrator (TPA) responsible for claims adjudication and provider support pertaining to payment and reimbursement issues. PCG has extensive experience with all HIPAA standard claim submissions, including 837 file submissions and 999/277 processes. PCG designed and implemented all operational requirements to enable effective management of our TPA work for CCA. PCG claims and processes claims through a number of methods, including batch submission, as well as direct data entry into our claims portal. PCG has implemented various reimbursement methods, including APR-DRG, Capitation and Fee-For-Service, to support associated complex contract payment policies. PCG support hundreds of providers for the CCA program through the seamless collection of health care claims and processes these claims, which results in over $600 million in healthcare payments per year. This work includes transitioning new providers onto PCG systems. This transition work includes moving providers from our test environment to production, training staff, and troubleshooting day-to-day activities. Finally, it includes the operation of a help desk and call center to help providers with claim submission and payment processing.

06

Arizona Health Care Cost Containment System (AHCCCS) Administrative Service Organization, State of Arizona: Administrative Service Organization

PCG pre-adjudicates submitted claims for a variety of validations, including student eligibility, provider eligibility, third-party liability, and specific Medicaid requirements. PCG accepts approximately 2.4 million claims in 837 format per year for processing and works with the providers to handle day-to-day 837 processes.

These are just some of our projects which are similar to the requirements of this RFQ. We are confident

that PCG has the demonstrated experience, tools, and applications to be considered the State's vendor to provide not only the Hospital Inpatient Data System, but the outpatient as well.

3.1.3 Vendor MUST have a minimum of 10 years of experience operating a secure web-based system for standards based on-line data submission.

PCG has been providing claims administration services for both public and private entities for more than 30 years. The firm's national experience consulting with each Medicaid agency in the country combined with its operational expertise of the claims management process places PCG in a league with few other firms possessing the same level of hands-on experience. Often, PCG becomes involved on every level necessary to facilitate the greatest outcome from a client engagement.

Project Qualifications

In *Figure IV.1.2* on the next page, PCG has provided DHHR with some of our current and historical projects that describe PCG's experiences across a variety of different services with web-based systems that are identified per the requirements in the RFQ.

Project	Application Development & Management	Data File Transactions	Data Auditing	Claims Grouping	Data Reporting
AZ AHCCCS: Administrative Service Organization	✓	✓	✓		✓
CO Department of Regulatory Agencies: Network Adequacy Study	✓				
CO HCPF: Hospital Rate Methodology Implementation			✓	✓	✓
DC DHCF: Administrative Service Organization	✓	✓	✓		✓
MA CCA: Third Party Administration Services	✓	✓	✓	✓	✓
MA EOHHS: EAPG Implementation for Outpatient Claims			✓	✓	✓
NJ DOH: Data Intermediary Services	✓	✓	✓	✓	✓
NY Medical Indemnity Fund: Third Party Administration Services	✓	✓	✓		✓
NY Independence Care System: Third Party Administration Services	✓	✓	✓	✓	✓
NY DOH: EI State Fiscal Agent	✓	✓	✓		✓
OR DHS: Financial Management	✓	✓			✓
PA Office of Long Term Living: Fiscal/Employer Agent	✓	✓			✓
TX HHSC: Assessment of EAPG Payment Method Implementation			✓	✓	✓
TX HHSC: Data Broker Services	✓	✓	✓		✓
VA MCO: Fiscal/Employer Agent	✓	✓			✓
WI DHS: Medicaid Provider Assessment Consulting, Rate Setting, and DRG Recalibration Consulting Services			✓	✓	✓

Figure III.1.1: PCG's current and past projects pertaining to the different services that are identified in the RFQ's statement of work.

On the following pages, PCG has included detailed project qualifications for each of the engagements outlined in the above table.

CONNECTION TO RFO

- ✓ *Application Development & Management*
- ✓ *Data File Transactions*
- ✓ *Data Auditing*
- ✓ *Data Reporting*

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCSS)
STATE OF ARIZONA

ADMINISTRATIVE SERVICE ORGANIZATION

FEBRUARY 2009 - PRESENT

SCOPE

Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid agency. AHCCCS offers health care programs to serve Arizona residents. Arizona participates in two Medicaid reimbursement programs for school-based services, the Direct Service Claiming (DSC) program and the Medicaid Administrative Claiming (MAC) program. These two school-based programs assist participating school districts, referred to as Local Education Agencies (LEAs), including charter schools and the Arizona School for the Deaf and Blind (ASDB), by reimbursing them for Medicaid covered services that they provide to eligible and qualified students. The purpose of the DSC Program is to allow LEAs to receive reimbursement for Medicaid covered medical services provided to Title XIX eligible students. The purpose of the MAC program is to allow LEAs to receive reimbursement for Medicaid administrative outreach activities that are done routinely within the school setting. Under our agreement with AHCCCS, PCG pre-adjudicates submitted claims for a variety of validations including student eligibility, provider eligibility, third party liability and specific Medicaid requirements. PCG is processing approximately 2,400,000 claims per year. PCG has invested in a proven and virtually turnkey solution to facilitate the processing of claims for its existing clients, with a modular solution that is capable of supporting the requirements listed in the Request for Proposal.

KEY ACHIEVEMENTS

PCG has performed the contract with AHCCCS as a fiscal agent for the DSC and MAC programs since February 2009. PCG provides a full spectrum of services under this contract including:

- Accept of claims from providers, processing claims and submitting them through the AZ MMIS system.
- Providing the Information Services (IS) system required to administer the Programs.
- The PCG data processing system houses the Program membership, contracted providers and needed reference materials.
- The system receives claims, edits and processes them and forwards them to AHCCCS for final approval. Some edits are as follows: Member eligibility; Provider eligibility; Third Party Liability; Coordination of benefits; Validation of covered services
- The system assists with distributing payments to each LEA or their Biller, providing a remittance advice that identifies the claims and the amount paid, as well as a list of any denied claims, pended claims and the reason codes.

- Conducting periodic compliance reviews of participating LEA's.
- Performing adjustments voids or recoupment as a part of compliance review for each LEA

REFERENCE

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CONNECTION TO RFQ

✓ *Application Development & Management*

DEPARTMENT OF REGULATORY AGENCIES, STATE OF COLORADO

NETWORK ADEQUACY STUDY

MAY 2014 – SEPTEMBER 2015

SCOPE

PCG was contracted to research and evaluate the strength of provider networks for the Colorado Division of Insurance, Department of Regulatory Agencies. Within this scope of work, PCG has completed a Network Adequacy analysis for Plan Year 2014, and is in the process for completing an analysis for Plan Year 2015. This work focuses on both federally qualified health plans that are available on Connect for Health Colorado (the Exchange) as well as those plans not offered on the Exchange.

PCG's work included the creation of over 1,300 maps using a Geographic Information Systems (GIS) software. In order to create these maps for evaluation, PCG was supplied with healthcare provider data for each carrier and network. Subsequently, PCG cleaned, classified, and then geocoded hundreds of thousands of data entries which were filtered onto the correct maps to show the statewide coverage of an individual network. These maps were used to demonstrate the composition of provider networks in rural and urban areas, and an analysis of the similarities and differences between networks offered inside Connect for Health Colorado (the State-based Exchange) and networks offered in the marketplace outside the Exchange.

The final report created from the study is used by the Division of Insurance to help establish a set of appropriate standards to measure and evaluate the adequacy, accessibility, and quality of health care services offered under managed care plans. The Division feels the incorporation of consumer protections in the creation and maintenance of provider networks is essential to ensure that all state residents have adequate access to quality services: this study provides the basis for incorporating consumer protections into the process of creating, maintaining, and possibly enhancing carrier networks within the state. This work will serve as a critical first step towards uniformity in the process the DOI will use to conduct review of Network Adequacy in the state of Colorado.

KEY ACHIEVEMENTS

- PCG initiated analysis of network strength in Colorado, and laid groundwork for evaluation of Network Adequacy in future years.
- PCG was required to clean and classify hundreds of thousands of lines of data in order to correctly geocode all data provided.
- PCG filtered this geocoded data in order to create over 1,300 maps using a GIS software. These maps represented health insurance plans sold both on and off of the Connect for Health Colorado Exchange.

REFERENCE

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CONNECTION TO RFQ

✓ *Data Auditing*

✓ *Claims Grouping*

✓ *Data Reporting*

DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, STATE OF COLORADO

HOSPITAL PROVIDER FEE MODELING AND BENEFITS DESIGN AND IMPLEMENTATION

NOVEMBER 2010 – JUNE 2015

SCOPE

In April 2009, the State of Colorado initialed a health care reform effort with the passage of the Colorado Health Care Affordability Act (CHCAA). The state proactively decided to provide health coverage to more than 100,000 uninsured Colorado citizens and families. The legislation also aimed at stemming rising health insurance costs for businesses and families. PCG assisted the Department of Health Care Policy and Financing ("the Department") with the development and implementation of six separate, but interrelated, projects that will fulfill the provisions of the CHCAA.

KEY ACHIEVEMENTS

1. **Hospital Provider Fee Modeling:** develop a fee and payment strategies to increase funding to Colorado's hospital providers and provide a funding source for eligibility population expansions for health care to low-income populations
2. **Hospital Rate Reform:** to review, conduct analysis and provide recommendations to modernize rate setting methodology for inpatient and outpatient hospital services
3. **Buy-In Programs for People with Disabilities:** program design and assistance with implementation
4. **Adults without Dependent Children Eligibility Population Expansion:** health care benefits design and assistance with implementation
5. **Budget Neutrality and Expenditure Forecast:** calculate budget neutrality and expenditures forecasted for the proposed Section 1115 of the Social Security Act waivers (commonly referred to as a Section 1115 waiver) and to write the budget neutrality section of the waiver, calculate the expected expenditures for any SPA and forecast the expenditures for the expansion populations
6. **Integrated Programs for Dual Eligibles:** develop a program that will offer a coordinated benefit package, including care coordination and care management, that evidence based, promotes value, and contributes to the overall improved health for Dual Eligibles.

PCG provided numerous reports, Provider Fee calculations, Upper Payment Limit calculations, waiver budget neutrality calculations, Dual Eligible Demonstration proposals, and Hospital Pay for Performance methodologies to HCFP. Ultimately, HCPF successfully enrolled and ensured health insurance for over 100,000 Colorado citizens.

REFERENCES

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CONNECTION TO RFQ

- ✓ *Application Development & Management*
- ✓ *Data File Transactions*
- ✓ *Data Auditing*
- ✓ *Data Reporting*

DEPARTMENT OF HEALTH CARE FINANCE (DHCF), DISTRICT OF COLUMBIA

ADMINISTRATIVE SERVICE ORGANIZATION

SEPTEMBER 2010 – PRESENT

SCOPE

The Department of Health Care Finance (DHCF), formerly the Medical Assistance Administration under the Department of Health, is the District of Columbia's state Medicaid agency. The mission of the Department of Health Care Finance is to improve health outcomes by providing access to comprehensive, cost-effective and quality healthcare services for residents of the District of Columbia.

Under the agreement with DHCF, PCG has developed a comprehensive and standardized approach to Partner Agency Medicaid billing that produce compliant claims meeting the District of Columbia and federal standards for our client, while accounting for the differences that exist in the service delivery and business processes of the Partner Agencies.

KEY ACHIEVEMENTS

- PCG's claiming solution has reduced agency overhead and process duplication between the Department of Health Care Finance (DHCF) and its Partner Agencies by designing one overall claiming application that optimizes the use of multiple and diverse existing systems to collect claim data from the Partner Agencies. This includes but is not limited to standardization of procedures within the Medicaid claims management through the creation, documentation, procession, resolution and payment validation of Medicaid claims for DHCF and the Partner Agencies. Additionally, PCG enabled smaller agencies that primarily claimed through a paper platform and enabled them to produce electronic claim files thus improving payment response time.
- PCG has worked with the district to standardize provider rates and business processes for services to reduce the rate of federal recoupment from Medicaid paid claims due to insufficient or erroneous documentation, provider errors and avoidable mistakes; and to ensure that all claims billed to Medicaid and other funding sources available to the District of Columbia are billed and paid in a timely manner to comply with federal prompt payment requirements.
- PCG with the Department of Health Care Finance (DHCF) and its Partner Agencies created unique and specific validation routines that were outside and above the scope of the fiscal intermediary. These validation routines quantitatively reviewed claim data through proprietary data extraction that denied or provided claim errors based on claim information outside that standard demographic and HIPAA code sets, this included but was not limited to: Signed Consent to Bill Medicaid Forms, Individual Education Plan dates of service and service line items, individual providers and schools

PCG created a proprietary audit application that uses specific questions as it relates to a Partner Agencies documentation processes. The Qualitative Review Questionnaires were created through an assessment and documentation improvement process that improved and in several cases standardized documentation. This process created through implementation improved outcomes in audit results, with a byproduct of improved processes and documentation for the Partner Agency. The audit application allows for

results and a detailed review of the documentation provided for each form or template used by a specific agency. PCG presents these results to the agency through a monthly Compliance Meeting.

On average, PCG processes 16K claims per month across four (4) agencies. All operational services under this contract are rendered at our Washington DC office at 1025 Connecticut Avenue, NW, Suite 917, Washington DC 20036. System support is provided out of our Boston office location at 40 Broad Street, Boson, MA 02109.

REFERENCE

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CONNECTION TO RFQ

- ✓ *Application Development & Management*
- ✓ *Data File Transactions*
- ✓ *Data Auditing*
- ✓ *Claims Grouping*
- ✓ *Data Reporting*

COMMONWEALTH CARE ALLIANCE (CCA), COMMONWEALTH OF MASSACHUSETTS

THIRD PARTY ADMINISTRATION (TPA) SERVICES

JUNE 2004 – PRESENT

CLIENT

CCA in partnership with Medicare and Medicaid manages two coordinated health plans called Senior Care Options (SCO) and One Care. The SCO plan has been successfully transforming healthcare delivery for individuals aged 65 and over since 2004. By providing a comprehensive health plan utilizing a fully integrated Geriatric Model of Care, members are afforded access to medical care and support services 24/7. The One Care plan brings high-quality, personalized care to individuals with complex medical and behavioral health needs to improve their health and the quality of their lives.

SCOPE OF WORK

PCG provides CCA with claims administration including data entry, claims processing, and payment services for medical, behavioral health, and non-clinical support claims. PCG manages member eligibility and enrollment as well as vendor and provider network data. The claims adjudication system maintained by PCG facilitates proper processing of payments by implementing benefit rules that pend claims that require prior authorizations. The system also adheres to validation routines that process claims according to plan limitations. To provide customer service and assist with claims processing, PCG staffs a call center which handles over 3,000 calls per month. PCG has worked with CCA since its inception in 2004, and in that time CCA has grown to more than 17,000 members with over $400MM in disbursements in 2015.

Applicable statistics:

- Average days for claim turnaround: 21 days
- Claims Turnaround: 95% of claims processed within 30 business days
- EDI Claim Submission Rate: 86% of all claims submitted

KEY ACHIEVEMENTS

PCG established necessary processes to support the implementation of the new OneCare product line. These activities included:

- Automating a 278 process for authorizations required to approve claims for payment
- Customizing a benefit matrix which supports CCA's clinical treatment model
- Developing various operational reports in collaboration with CCA

In addition, by signing up providers for direct submission of claims, PCG reduced paper claims submission by 50% promoting a more efficient intake process.PCG designed and implemented all operational requirements to enable effective management of several aspects of the SCO plan. These activities include:

- Enrollee data management
- Provider contracts administration
- Claims processing
- Pre-authorization and referral management associated with clinical case management

As part of CCA's infrastructure design, PCG implemented:

- DRG/APC grouper pricing mechanism,
- Electronic claims payments system
- Claims editing software
- Web-based EDI submissions and batch monitoring system

In addition, PCG implemented various reimbursement methods including Capitation and Fee-For-Service to support associated complex contract payment policies. Operational workflows, compliance procedures, and policies/procedures relating to Medicare and Medicaid have also been adopted to further reinforce CCA's infrastructure.

PCG has been instrumental in assisting CCA in establishing their network of providers. PCG performs and maintains the ongoing management responsibilities associated with all providers. This network continues to grow and as of March 2016, PCG has processed for CCA the enrollment of:

- Over 17,500 members
- Approximately 42,000 providers
- Over 8,600 vendors including hospitals, SNFs and Ancillary providers

PCG's supported the efforts to secure the participation of some prestigious hospital facilities across Massachusetts which include among other noteworthy facilities:

- Baystate Medical Center in Springfield, MA
- Boston Medical Center in Boston, MA
- Beth Israel Deaconess Medical Center in Boston, MA
- Salem Union Hospital in Lynn, MA (member of Partners Health Care System)

PCG's ongoing business support to CCA includes:

- Data mining and analysis
- Payment reconciliations
- Business process redesign (e.g. authorizations tracking and data transfers)

REFERENCE

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CONNECTION TO RFQ

✓ *Data Auditing*

✓ *Claims Grouping*

✓ *Data Reporting*

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES, COMMONWEALTH OF MASSACHUSETTS

ASSESSMENT OF ENHANCED AMBULATORY PATIENT GROUP (EAPG) PAYMENT METHOD FOR OUTPATIENT SERVICES PROVIDED IN MA'S ACUTE CARE HOSPITALS

JANUARY 2014 – DECEMBER 2016

SCOPE

The Executive Office of Health and Human Services (EOHHS) contracted with PCG to facilitate the transition to a prospective outpatient rate-setting methodology. The implementation date of EAPG Payment method is December 31, 2016.

KEY ACHIEVEMENTS

To accomplish this, PCG conducted the following work:

- Analyzed existing Outpatient Methodology (Payment Amount Per Episode, PAPE);
- Performed Analyses and Provided Recommendations Regarding the Parameters and Implementation of EAPG Payment Model;
- Engaged the Provider community in policy decision making and trained on EAPG concepts and billing parameters
- Recommended Transitional Strategies from PAPE to EAPG with Analytical Support;
- Performed Analyses to Identify Unintended Consequences and Recommend Approach to Minimize Impacts;
- Completed an Assessment of Changes to Billing and Remittance Processes;
- Highlighted Technical Specifications for MMIS implementation;
- Developed Payment Rates and Payment Weights for Individual EAPGs;
- Calculated Overall and Hospital-Specific Fiscal Impacts of EAPGs;
- Calculated of Hospital Specific Case Mix Index under EAPG Reimbursement System; and
- Provided ongoing Technical support during implementation and testing

REFERENCE

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CONNECTION TO RFQ

- ✓ *Application Development & Management*
- ✓ *Data File Transactions*
- ✓ *Data Auditing*
- ✓ *Claims Grouping*
- ✓ *Data Reporting*

DEPARTMENT OF HEALTH, STATE OF NEW JERSEY

DATA INTERMEDIARY SERVICES

FEBRUARY 2017 – PRESENT

SCOPE

PCG contract with the New Jersey Department of Health to build and develop a web interface to a hosted database environment that maintains inpatient and outpatient discharge data submitted from 72 hospitals and 11 long term acute care facilities.

The application processes all-payer inpatient claims in the form of daily provider 837Rs through the latest available versions of the Medicare MS-DRG grouper and 3M's proprietary APR-DRG grouper. The application processes all-payer outpatient claims, also in the form of daily provider 837Rs, through the latest available versions of the Medicare APC grouper. All submitted claims are processed and accepted/rejected according to industry standard claim edits (e.g. MCE, OCE, NCCI, MUE).

The application contains an interactive claims editor for providers to view all detail level information for designated claims and make appropriate edits. The system produces standard 999 acknowledgements and 277 notifications to inform providers of file and claim statuses, per industry standard.

In addition to claim processing and editing functionalities, the application also possesses comprehensive file load statistic reports, data warehouse extract of accepted claims, and dynamic billing and invoicing details. The application's reporting function produces 837s from accepted claims for providers to submit to external quality vendors for reporting purposes.

REFERENCES

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CONNECTION TO RFQ

- ✓ *Application Development & Management*
- ✓ *Data File Transactions*
- ✓ *Data Auditing*
- ✓ *Data Reporting*

DEPARTMENT OF FINANCIAL SERVICES, STATE OF NEW YORK

MEDICAL INDEMNITY FUND (MIF) THIRD PARTY ADMINISTRATOR

JULY 2017 – PRESENT

SCOPE

PCG serves as the Third Party Administrator (TPA) for the Medical Indemnity Fund. The Medical Indemnity Fund was established by the State of New York to cover the cost of medical services provided to approximately 550 enrollees who obtained neurological impairments during birth. PCG processes MIF payments in accordance with a fee schedule set forth by state regulations and provides case managements services to all MIF enrollees.

As Claims Administrator, PCG is responsible for claims administration including data entry, claims processing, and payment services for medical and non-clinical support claims. PCG manages member and provider questions relating to claims processing. The claims adjudication system maintained by PCG facilitates proper processing of payments by implementing benefit rules that pend claims that require prior authorizations. The system also adheres to validation routines that process claims according to plan limitations. To provide customer service and assist with claims processing, PCG staffs a call center which handles approximately 750 calls per month.

As Fund Administrator, PCG oversees the enrollment process, provides technical and case management support to enrollees and families, and adjudicates requests for services requiring prior authorization. PCG has a team of Case Managers (registered nurses, social workers, and other licensed healthcare providers) who assist in coordinating care for the MIF enrollees. Case Managers develop initial assessments, annual reassessments, and individualized care plans using a case management system maintained by PCG.

PCG has worked with DFS on MIF TPA services since July 2017 and went live as the Claims Administrator effective September 1, 2017. In that time, PCG has gained a comprehensive understanding of the unique structure of the MIF program. PCG started the Fund Administrator engagement in August 2018.

KEY ACHIEVEMENTS

- Transitioned into a claims processing role on an expedited timeline to meet the departments need for a Third Party Administrator go-live of September 1, 2017.
- Paid $34,855,176.77 in total claims to MIF enrollees and providers from October 4, 2017 to September 19, 2018.

- Developed a process for paying claims in accordance with the requirements of the MIF as well as national claiming best practices. Included the review of Fair Health, Medicaid and Medicare rates as well as partnering with the department to establish contingency rates for services not covered by Fair Health, Medicare or Medicaid.
- Conducted extensive outreach to:
- MIF providers including mail, phone calls and an ongoing W-9 collection effort.
- MIF members to assign PCG case managers and schedule and complete assessments.
- Collaborated with the Department to:

- Develop detailed claims submission guidance for providers serving the MIF and MIF enrollees
- Establish legal and medical criteria for determining applicants' eligibility. Enrolled new MIF members using the established processes.
- Sent member ID cards, welcome packets and case manager assignment letters to all MIF enrollees.
- Maintained a member and provider support customer service line and email address staffed by PCG's team of MIF case managers and claims processing experts.
- Established detailed weekly reporting to the department as well as weekly check-in meetings to ensure key stakeholders at DFS are aware of progress and issues relating to MIF administration and claims processing.

CLIENT REFERENCE

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CONNECTION TO RFQ

- ✓ *Application Development & Management*
- ✓ *Data File Transactions*
- ✓ *Data Auditing*
- ✓ *Claims Grouping*
- ✓ *Data Reporting*

INDEPENDENCE CARE SYSTEM (ICS), STATE OF NEW YORK

THIRD PARTY ADMINISTRATOR AND MANAGEMENT SERVICES

JANUARY 2015 – DECEMBER 2017

CLIENT

ICS manages a care system that blends health care services with social supports. ICS offers its members two health plans: ICS Community Care MLTC, a traditional Medicaid managed long-term care plan, and ICS Community Care Plus FIDA-MMP, a new plan for those eligible for both Medicare and Medicaid. Through the coordination of a wide range of home care, health care, and social services, ICS enables senior adults and people with disabilities or chronic conditions to live as independently as possible. Since its creation in 2000, ICS has grown to support over 5,000 members.

SCOPE OF WORK

PCG provided administrative and management services for the ICS Community Care Plus FIDA-MMP product line, including claims adjudication and payment services. By maintaining an automated claims processing system, PCG ensured proper claims payment through edits for eligibility, correct coding, service agreements, and any applicable payment rules. PCG also managed vendor and provider network data and member eligibility information. To assist ICS members and providers, PCG staffed a call center with claims representatives ready to answer questions and assist with claims processing.

KEY ACHIEVEMENTS

- PCG assisted in launching the new FIDA-MMP product line for implementation on 1/1/2015 which included such activities as member enrollment data management and provider contracts administration.
- PCG created customized HIPAA 837 file formats to deliver unique data fields to stakeholders.

REFERENCE

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CONNECTION TO RFQ

- ✓ *Application Development & Management*
- ✓ *Data File Transactions*
- ✓ *Data Auditing*
- ✓ *Data Reporting*

DEPARTMENT OF HEALTH, BUREAU OF EARLY INTERVENTION, STATE OF NEW YORK

STATE FISCAL AGENT

APRIL 1, 2013 – PRESENT

SCOPE

By delivering and managing a unified platform to facilitate Early Intervention health care claiming for providers throughout the state, PCG has helped New York increase compliance, reimbursement, and efficiency for the Early Intervention program.

PCG has contracted with the New York State Department of Health, Bureau of Early Intervention to manage the EI State Fiscal Agent in a five-year contract. This included the development and maintenance of a web-based claiming application for EI providers. The NY BEI program is the largest in the country, with over 70,000 children in the program. The State Fiscal Agent processes all provider and insurance claims for the State when families make use of the State's early intervention services and see the related providers. PCG's role in the SFA is to oversee the fiscal management and payment of claims for the State's EI program. The total value of claims processed in the program exceeds $550 million.

In its management of the billing processes for the SFA, PCG is expected to increase recoveries from commercial insurers from previous levels (less than 3%) to national standards that average between 10 and 12%, which would incrementally increase revenues for EI services between $45M and $57M annually.

In addition to managing the billing and claiming processes for the SFA, PCG manages a technical assistance call center for the program. The call center helps to facilitate proper transactions between early intervention providers and insurance companies, while also providing services for family clients as needed. PCG also provides training staff for the SFA that have the capacity to provide up to 300 training session a year. Full-time training staff, dedicated field-based trainings, and subject matter experts are all provided to assist in the knowledge transfer efforts that are related to this project.

KEY ACHIEVEMENTS

PCG designed and implemented all operational requirements to enable effective management of several aspects of the operations plan. These activities include:

Ongoing Operations:

- Developed data import routines to validate and upload over 12 million service records per year into our Billing System
- Process approximately 8 million claims exceeding $550 million for over 1,000 Early Intervention Providers

CONNECTION TO RFQ

- ✓ *Application Development & Management*
- ✓ *Data File Transactions*
- ✓ *Data Reporting*

DEPARTMENT OF HUMAN SERVICES, STATE OF OREGON

FINANCIAL MANAGEMENT AGENT SERVICES

AUGUST 2016 - PRESENT

SCOPE

The State of Oregon engaged PCG Public Partnerships LLC to provide Financial Management Agent Services (FMAS) to Common Law Employers with respect to Personal Support Workers (PSWs) providing In Home Support services to the Common Law Employer or to the Individual on whose behalf the Common Law Employer is acting. Public Partnerships is also responsible for providing FMAS to DHS as a Statutory Employer, with respect to amounts paid to PSWs that are not attributable to a Common Law Employer. Public Partnerships makes the payments with funds provided by DHS and based on data provided by DHS and, in certain circumstances, CDDPs or Brokerages.

KEY ACHIEVEMENTS

1. Transitioned 11,000 individuals and 22,000 PSWs from prior vendor.
2. Established data transfers to communicate:
    a. Approved employer-employee associations
    b. Payroll files
    c. Tax Withholdings
    d. Union Membership Data
    e. Voluntary Withholdings
3. Trained Case Management Entities on referral process through our web based system.
4. Offered portal access to individuals, representatives and PSWs.
5. Implemented payroll processing.

CONNECTION TO RFQ

- ✓ *Application Development & Management*
- ✓ *Data File Transactions*
- ✓ *Data Reporting*

DEPARTMENT OF HUMAN SERVICES, STATE OF PENNSYLVANIA

FINANCIAL MANAGEMENT SERVICES

OCTOBER 2012 - PRESENT

SCOPE

Under contract with the Pennsylvania Department of Human Service's Office of Long-Term Living (PA DHS OLTL), PCG Public Partnerships LLC provides state-wide Vendor Fiscal/Employer Agent (VF/EA) Financial Management Services (FMS) to Home and Community- Based Services waiver and state program participants opting to self-direct their direct-care services. Specifically, Public Partnerships provides VF/EA FMS to waiver/program-eligible common-law employers who want to select, hire, and manage their own direct-care workers. Currently, 17,427 enrolled individuals-- eligible under the provisions of either the state-funded ACT 150 program or 1 of 6 funded waivers—receive Public Partnerships VF/EA FMS in PA DHS OLTL. Public Partnerships pays 18,500 direct care workers for services provided to program participants.

Public Partnerships supports participants and their workers, and service coordinators with superior customer service infrastructure that handles more than 24,000 inbound calls per month via live agents and 18,000 inbound calls per month via an interactive voice response (IVR) system.

KEY ACHIEVEMENTS

- Reduced Customer Service call volumes from 243,234 in January 2013 to 37,000 in December 2018.
- Transitioned 22,800 participants and approximately 25,000 workers from 23 separate vendors.
- Implemented in-home and phone visitations for employer training and program orientation to newly referred program participants.
- Offer multiple program enrollment options for participants and their workers.
- Implemented a Social Forum for participants, workers and other stakeholders.
- Offer MyChoice4Care™ provider directory that connects care-giver applicants with participants who need workers.
- Implemented the Time4Care™ Mobile Timesheet Application.
- Our BetterOnline™ Web portal allows administrators, participants, workers, and service coordinators 24/7 access to up-to-date case file information.
- Timely payment of over 98% of all accurately submitted timesheets.
- Enhanced services while maintaining cost savings and efficiencies.

CONNECTION TO RFQ

✓ *Data Auditing*

✓ *Claims Grouping*

✓ *Data Reporting*

HEALTH & HUMAN SERVICES COMMISSION (HHSC)
STATE OF TEXAS

ASSESSMENT AND IMPLEMENTATION OF ENHANCED AMBULATORY PATIENT GROUP (EAPG) PAYMENT METHOD FOR OUTPATIENT SERVICES

MARCH 2014 – JUNE 2016

SCOPE

The Texas Health and Human Services Commission (HHSC) contracted with PCG to facilitate the transition to a prospective outpatient rate-setting methodology. To accomplish this, PCG is providing the following services:

- Analyzing existing outpatient methodology (prospective percentage of charge reimbursement);
- Performing analyses and providing recommendations regarding the parameters and implementation of EAPG payment model;
- Recommending transitional strategies from prospective percentage of charge to EAPG with analytical support;
- Performing analyses to identify unintended consequences and recommend approach to minimize impact;
- Developing payment rates and payment weights for individual EAPGs;
- Calculating overall and hospital-specific fiscal impacts of EAPGs;
- Calculating hospital-specific Case Mix Index under the EAPG Reimbursement System; and,
- Providing ongoing technical support during implementation and testing.

KEY ACHIEVEMENTS

- PCG produced a comprehensive report that addressed each of the reimbursement components (base rate, relative weights, outlier payment policy, EAPG software pricing options, transitional corridor mechanism, etc.) that should be carefully evaluated for implementation.
- PCG completed an assessment of the current state of the relevant outpatient hospital claims processing, reviewed all business processes impacted as a result of EAPG implementation, and provided HHSC an overview of the EAPG software. Our team offered recommendations to overcome challenges and obstacles identified in the implementation process.
- PCG accessed current audited cost report data via Healthcare Cost Report Information System (HCRIS) and Medicaid Management Information System data to calculate outpatient provider specific costs.
- PCG established state-specific EAPG weights using historical claims data and calculated cost information.
- PCG developed budget neutral provider type specific EAPG base rates according to historical utilization and expected utilization trends

PCG created financial models to project provider specific outcomes based on various assumptions.

- PCG documented, in detail, all rate setting calculations and provided HHSC with a comprehensive binder and electronic version of work papers to support future rate setting efforts.
- PCG developed a comprehensive implementation work plan and timeline including implementation planning documents in support for the launching of EAPG implementation. This includes all of the necessary operational tasks in order to implement EAPGs.

- PCG conducted formal weekly status meetings which will include detailed status reports that outline tasks that have been completed during the week and to date through the presentation of the work plan.

REFERENCE

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CONNECTION TO RFQ

- ✓ *Application Development & Management*
- ✓ *Data File Transactions*
- ✓ *Data Auditing*
- ✓ *Data Reporting*

HEALTH AND HUMAN SERVICES COMMISSION, STATE OF TEXAS

DATA BROKER SERVICES

JUNE 2016 – PRESENT

SCOPE

PCG is contracted with Texas Health and Human Services Commission through June 2021. In our role, PCG is responsible for building a first-of-its-kind automated eligibility resource hub that will allow eligibility workers to access valuable dozens of third party data sources to make accurate and efficient eligibility determinations. Through this comprehensive "data broker service", PCG will help the state ensure benefits are determined appropriately, while significantly reducing the amount of time required of eligibility workers to retrieve paperwork from the applying beneficiary. PCG's system successfully went live in March of 2017.

KEY ACHIEVEMENTS

- Established interfaces with more than 25 state, federal and commercial data sources, connecting the state's eligibility system with data critical to the eligibility determination process
- Implemented dozens of processes and reports allowing thousands of state workers to request data on demand through the state's eligibility system
- Established cloud-based data storage infrastructure with Amazon Web Services
- Designed, developed and deployed stand-alone web application allowing external stakeholders to access PCG's data broker service outside of the state's eligibility system
- Successfully processing more than 2 million data exchange transactions for 17,000+ users per day

REFERENCE

David L. Lumpkins
Texas Health and Human Services Commission
Access and Eligibility Services
Data Broker Product Owner
Office: (512) 310-4678
Cell: (512) 466-8637
David.Lumpkins@hhsc.state.tx.us

CONNECTION TO RFQ

- ✓ *Application Development & Management*
- ✓ *Data File Transactions*
- ✓ *Data Reporting*

MANAGED CARE ORGANIZATIONS, COMMONWEALTH OF VIRGINIA

FISCAL/EMPLOYER AGENT SERVICES

APRIL 2014 - PRESENT

SCOPE

PCG Public Partnerships LLC has contracted with multiple Managed Care Organizations to provide Fiscal/Employer Agent (F/EA) services for qualified dual eligible members that elect to participate in the Participant Directed program through their Medicaid-funded Home and Community based waivers. This service allows Medicaid-Medicare recipients to serve as common-law employers, responsible for directly hiring, training, supervising and firing their attendants.

Public Partnerships services for the MCOs include, but are not limited to, managing recipient enrollment packets, maintaining current recipient authorization information, approving attendant employment and tax-related documentation, processing payroll, calculating and depositing State and Federal tax withholdings and unemployment taxes (FICA, FUTA, SUTA). As the F/EA, Public Partnerships acts as the agent to the common-law employer (Medicaid-Medicare recipient) or his/her representative in accordance with Section 3504 of the IRS Code and Revenue Procedure 70-6. Public Partnerships acts as the front line for Medicaid-Medicare Fraud and mandated reporters for Adult Protection Services (APS). Public Partnerships also provides customer service to the managed care member, their representative and worker as well as their Case Managers

KEY ACHIEVEMENTS

- As the MCO Participant Directed program membership continues to increase, Public Partnerships assists MCO Case Managers through training on our paperwork processes and system navigation.

Provide payroll processing, fiscal intermediary operations, for individuals receiving services under home

CONNECTION TO RFQ

✓ *Data Auditing*

✓ *Claims Grouping*

✓ *Data Reporting*

DEPARTMENT OF HEALTH SERVICES
STATE OF WISCONSIN

MEDICAID PROVIDER ASSESSMENT CONSULTING, RATE SETTING, AND DRG RECALIBRATION CONSULTING SERVICES

JANUARY 2007 – DECEMBER 2015

SCOPE

The Department of Health Services (DHS) contracted PCG to provide consulting services on a variety of hospital reimbursement related issues. Our work included obtaining approval from the Centers of Medicare and Medicaid Services (CMS) to implement a provider assessment on in state acute care, rehabilitation, and critical access hospitals. This provider assessment allowed the state Medicaid agency to implement an 1115 Medicaid transformation waiver to expand Medicaid eligibility to childless adults, as well as increase Medicaid payments to hospitals for inpatient and outpatient services. In addition, PCG at the direction of DHS helped to transform the payment methodology by implementing a Diagnosis Related Group (DRG) per discharge rate methodology for inpatient hospital services, performed Disproportionate Share Hospital eligibility determinations and calculations, and performed outpatient hospital rate setting calculations for rate years 2008 through 2015.

KEY ACHIEVEMENTS

Provider Assessment Services

- Developed financial survey data to determine tax amounts by provider and system of providers.
- Modeled provider specific outcomes under assessment model and analyzed results to ensure the model passed hold harmless provisions.
- Performed P1P2 statistical analysis to obtain approval to waive the broad based provider assessment requirements.
- Meet with hospital stakeholders and representatives to present provider assessment models and analysis.
- Supported DHS throughout the CMS review and approval process.
- Developed payment methodology to increase revenues to the hospital community, both through the Medicaid fee for service program, as well as the Medicaid managed care organizations (MCOs).

Upper Payment Limit Services

- Presented alternative UPL methodologies to maximize UPL room in order to
- optimize payments to providers as a result of implementing provider assessment
- Participated in meetings with CMS to review UPL calculations.
- Responded to CMS inquiries until approval was obtained.

Inpatient and Outpatient Rate Setting Services

- Drafted and submitted public notices and Medicaid State Plan Amendment (SPA).
- Completed Upper Payment Limit calculations to support rate increases to providers.
- Assisted DHS to receive CMS approval of the SPA within 90 days of submission.

- Accessed current audited cost report data via Healthcare Cost Report Information System (HCRIS) and Medicaid Management Information System data to calculate inpatient provider specific cost-based rates.
- Calculated capital costs by provider.
- Calculated Graduate Medical Education costs by provider.
- Revised Outlier payment criteria to account for updated rate methodology.
- Developed prospective per diem cost-based rate for psychiatric and rehabilitation hospitals and distinct part units.
- Calculated cost per visit for outpatient hospital services.
- Developed financial models to project provider specific outcomes.
- Completed analyses to determine budgetary impact to implement rate setting changes.
- Drafted responses to provider inquiries surrounding rate calculations.
- Effective for rate year 2013, transformed outpatient reimbursement system to an acuity-based reimbursement system under 3M Enhanced Ambulatory Patient Groupings (EAPGs). Utilizing 3M Core Grouping Software (CGS) to discuss grouper options available to produce a line item specific reimbursement methodology. EAPG uses procedure and diagnosis codes to determine the intensity of a line item in order to reimburse according to the service provided. PCG reviews claims data to ensure that data is sufficient for input into the grouper. Also reviewing and determining which outputs and edits should be received and displayed/saved in MMIS. PCG uses a cost-based method to determine the intensity of each EAPG and assign a relative weight accordingly.

Diagnosis Related Groupings Recalibration of Weights

- Updated MS-DRG assignments to version 24, version 25, version 26, version 27, version 28, version 30 and version 31 of the Medicare grouper.
- Calculated cost of claims to establish weights.
- Removed outlier claims to normalize data.
- Developed specific MS-DRG enhancements for Medicaid specific services, specifically for neonatal and psychiatric services.

Disproportionate Share Hospital (DSH) Consulting Services

- Determined DSH eligibility for in state hospitals.
- Calculated DSH payments for qualifying providers.
- Identified opportunity to expand DSH funding to public hospitals
    - Drafted and submitted state plan documents for CMS review and approval.
    - Calculated uninsured and Medicaid deficit costs for public hospitals.
    -

For more information on PCG's web-based system, similar to the one outlined in this RFQ, please refer to section IV.1 Data Collection Processing and Editing [4.2].

3.1.4 Within 15 working days of contract award the vendor MUST provide DHHR with a representative staffing plan that covers, at a minimum, a project manager, a functional/operational lead, a programmer, a trainer, and a data analyst. A single staff member may fill multiple roles but must satisfy the qualifications for each role. Provide resumes, including degrees and certificates applicable to this project for proposed staff. If you are proposing the same staff member to fill multiple roles include an estimate of the percent of time the member will spend in each role. Resumes must demonstrate at least:

3.1.4.1 PROJECT MANAGER - Minimum of 5 years of experience managing projects similar in size and scope to this project.

3.1.4.2 FUNCTIONAL/OPERATIONAL LEAD - Minimum of 3 years of experience in a lead role on projects similar in scope and size to this project including experience trouble-shooting NW/Communications problems from submitters to the on-line system.

3.1.4.3 PROGRAMMER - Minimum of 3 years of experience programming with modern programming languages and interacting with data stored in Oracle and SQL Server databases.

3.1.4.4 TRAINER - Minimum of 2 years of experience training end users on the use of the proposed on-line data submission tool.

3.1.4.5 DATA ANALYST - Minimum of 2 years of experience analyzing data and producing reports utilizing data analytics tools such as IBM Cognos, Microsoft Power BI, or other commercially available data analytics tools.

Key Staffing

PCG utilizes six key success factors that guide toward the building and maintaining of a successful organizational structure and staffing model for our engagements. These six key success factors are listed below:

1. Develop an organizational structure that is efficient, effective and communicates across all organizational units;

2. Assign only current and experienced PCG employees to key staff positions;

3. Rapidly and aggressively recruit staff for any remaining positions within the project staffing structure, ensuring that new hires reflect PCG's values and are proficient in PCG's core competencies;

4. Create physical workspace environments to promotes efficiency, collegiality, and a positive workplace experience for staff;

5. Constantly monitor performance; and,

6. Maintain strong participation from Senior Level executives representing the leadership of PCG.

Over the last decade in particular, we have successfully staffed small and large scale projects using key members of our existing organization while hiring additional qualified management and operational staff to fill out the staffing requirements for the rest of the project.

PCG is pleased that we can leverage experienced staff for both the implementation and on-going operations. We will not need to hire any new staff to fill any of the required key personnel proposed for this engagement. Our organization is at the point where strong leadership, sufficient size, and a deep bench of skilled and experienced staff make it possible to provide DHHR with prior experience in hospital claims data and data intermediary system implementation.

As a firm of over 3,000 professionals, PCG is able to call upon additional resources with a wide range of expertise and skills as needed to ensure the success of this engagement. This includes ample call center support, technical and application development support, as well as project management support.

Please see *Figure III.1.2* on the following page for a depiction of PCG's contract-specific organizational chart. This figure identifies the key organization units and personnel responsibilities for this project.

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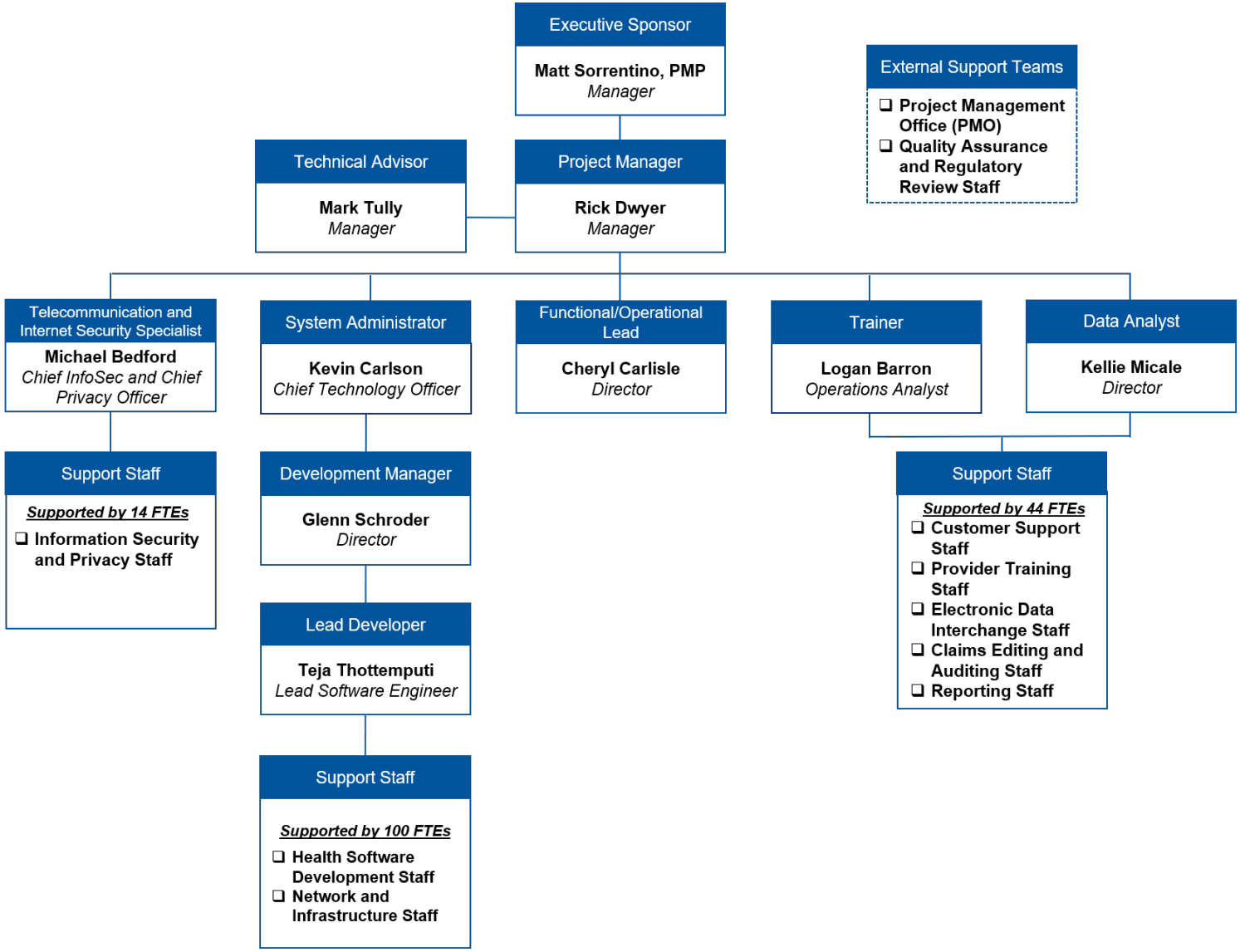


Figure III.1.2: PCG Project Organizational Chart.

Matt Sorrentino, PMP, a Manager at PCG, will serve as the Executive Sponsor. Mr. Sorrentino has over 16 years of experience leading healthcare payment and reimbursement engagements. He will be responsible for overall contract compliance, working with the HCA Project Manager in risk identification, mitigation, and resolution activities. He will be heavily involved in the development and implementation phases, and will be the point of contact for escalations and crisis management during the operations phase.

Rick Dwyer, a Manager at PCG, will serve as the Project Manager. Mr. Dwyer has over 30 years of experience in healthcare claims processing and reporting. Recently he has been actively involved in improving business processes and the use of automation to gain operational efficiencies for our Data intermediary Services, Third Party Administration, and Administrative Services Organization projects. Mr. Dwyer will be responsible for the overall delivery, execution, and performance of the statement of work as described in the RFQ. The program manager will be ensuring that all PCG key personnel and support teams are clearly focused on the goals and objectives of this implementation to develop a customized application that meets the RFQ requirements and performs in an efficient manner. Furthermore, Mr. Dwyer will quickly establish a collaborative and productive working relationship with the HCA project manager. Mr. Dwyer will be supported by an experience team that has significant healthcare claims and collection experience.

Mr. Dwyer, will be supported by Mark Tully, a Manager at PCG, who will serve as a Technical Advisor. As director for PCG Heath's Data Analytics Management team, Mr. Tully has over twenty years of experience working with very large datasets, including all Payer Claims Databases and State Medicaid Claims Databases. He is a subject matter expert on measuring and analyzing payment methodologies utilizing the 3M Suite of healthcare analytics products. Mr. Tully will leverage his extensive experience with the 3M and Optum rate groupers to provide guidance regarding the grouper applications and processes for West Virginia's Hospital Inpatient Data System.

Cheryl Carlisle, a Director at PCG will be the Functional/Operational Lead for this engagement. Ms. Carlisle has 28 years of experience directing large-scale healthcare revenue cycle projects, which has provided her with substantial experience working with and analyzing hospital claims data. Assisting clients and users with navigating claims systems is a core component of this work. Ms. Carlisle will be responsible for gathering core business requirements, understanding current business processes, and determining appropriate process and required changes. In addition, she will be collaborating with business end users to identify needs and opportunities for improved data management and delivery

Kevin Carlson, Chief Technology Officer at PCG, will serve as the System Administrator. Mr. Carlson has over 20 years in the Healthcare Technology space in capacity of an Entrepreneur and a C-Level Executive. Mr. Carlson has overseen the development and implementation of several large scale Electronic Health Record and Revenue Cycle Management systems that continue to lead the industry today. He will be responsible for overseeing and managing the customization and implementation of the data collection system, including coding the business rules, establishing the central database, developing interfaces and web-portals, testing the application, and building reports. To handle these tasks, the PCG system administrator utilizes the PCG system design development staff to customize the application and database, and he is supported by sub-teams addressing system integration and data processing functionality.

Mr. Carlson oversees 100 staff members that can be used as resources for this engagement. The breadth of his team is shown below:

Roles	# of FTEs
Data Base Administrators	4
Developers	48
Infrastructure Managers	5
Management	13
Project Management Office	5

Quality Assurance Analysts	14
Release Managers	4
Scrum Managers	3
System Analysts	4
Grand Total	**100**

Glenn Schroder, Director of Software Development at PCG, will serve as the Development Manager. Since joining PCG in 2012, Mr. Schroder's primary responsibilities are as a system architect, preparing project proposals and estimates in response to user requirements, leading 'white board' architecture sessions, technology research, prototyping, managing development and teams of development engineers in PCG offices in Massachusetts, North Carolina, and New Hampshire. Most recently, Mr. Schroder oversaw development on the NJ Data Intermediary System.

The health software development staff, directly led by Mr. Schroder, are charged with developing and configuring the functionality of the system. The team is comprised of the following staff:

- Technical Leader/Lead Developer;
- Report Builder;
- Software Testers;
- Designer/Architect; and,
- Software Developers.

For this engagement, Mr. Schroder will have access to the 100 staff members that Mr. Carlson oversees.

Additionally, Mr. Schroder will be supported by Teja Thottemputi, who will serve as the Lead Developer. Mr. Thottemputi has 14 years of experience in designing, development, testing and integrating of Client / Server and Web Technology based Projects using Microsoft Technology stack. Mr. Thottemputi was a key staff member for the development of PCG Health Cap, the claims analysis and reporting application built by PCG for use in New Jersey.

Logan Barron, an Operations Analyst at PCG, will serve as the Trainer and Helpdesk Support. Ms. Barron has over three years providing support and training for PCG's New Jersey Data Intermediary Services project. In this role, she has acquired very relevant experience assisting providers with navigating PCG's claims collection, processing, auditing, and warehousing application in New Jersey. Ms. Barron will also be heavily involved during the system implementation phase of this project to support the requirement definition and user acceptance testing to the technical team during development.

In addition to the responsibilities described above, Ms. Barron is also responsible for providing technical support, internal staff training, and external facility and provider training. Areas of focus will include use of the web-portal for the submission of 837 institutional and professional claim files, correcting claim errors using appropriate public resources, running data reports, and understanding the application work flow.

Alongside Ms. Barron will be Kellie Micale, a Director at PCG, who will serve as the Data Analyst. Ms. Micale is Director of Reporting and Analysis and brings 14 years of healthcare experience specializing in accounting and financial reporting. Ms. Micale leads a team of full-time business analysts, report developers, application developers, and database developers to create reports using tools such as SSRS, Excel, Crystal Reports, Tableau, SAS Visual Analytics, and the .NET framework.

Both Ms. Barron and Ms. Micale, along with the applicable support staff, are responsible for the day-to-day operations and covers multiple functions, including but limited to the following:

- Customer Support Staff
- Provider Training Staff
- Electronic Data Interchange (EDI) Staff.

- The Claims Editing and Auditing Staff
- The Information Technology Maintenance Staff
- Reporting Staff

Further information regarding these above roles can be found in Section 4.2 Documentation and Technical Support [4.3].

Michael Bedford, Chief InfoSec Officer and Chief Privacy Officer at PCG will serve as the Telecommunication and Internet Security Specialist. Mr. Bedford has 20+ years of enterprise technology management experience, specializing in cyber security, information privacy, and risk management. Mr. Bedford oversees 15 staff members that can be used as resources for this engagement.

Resumes

We have provided detailed resumes as Appendix A: Resumes, including brief biographies and relevant project experience –for the proposed key staff for this project.

3.1.5 Over the life of the contract, Vendor may substitute other staff for those named in 3.1.4.1 as long as the substitute meets the minimum requirements listed therein.

PCG understands and acknowledges that we may substitute other staff as long as the substitute meets the minimum requirements listed.

3.1.6 If any portions of the program will be subcontracted, vendor MUST identify in the bid those subcontractors that it intends to use and the portions of the program to be assigned to each. Vendor must notify DHHR 15 days in advance. If no subcontractor is identified in the submitted bid subcontracting will not be permitted.

PCG does not intend to subcontract any portion of this contract.

IV. Mandatory Contract Services Requirements and Deliverables [4.1]

IV.1 Data Collection Processing and Editing [4.2]
IV.2 Documentation and Technical Support [4.3]
IV.3 Analytic Files [4.4]
IV.4 Data Security and Privacy [4.5]
IV.5 Project Management [4.6]
IV.6 Optional Services [4.7]
IV.7 Data Ownership and Use [4.8]
IV.8 Milestones, Deliverables, and Service Level Agreements [4.9]
IV.9 Invoices and Payments [4.10]

IV.1 Data Collection Processing and Editing [4.2]

4. MANDATORY REQUIREMENTS

IV.1 Data Collection Processing and Editing [4.2]

4.2.1 Vendor SHALL collect, process, maintain, and assure the quality of inpatient hospital discharge electronic billing from all 63 non-federal hospitals in West Virginia in accordance with the West Virginia Hospital Data Submission System, Data Collection Policies and Procedures.

The Public Consulting Group, Inc. (PCG) Data Intermediary and Collection System encompasses an interrelated Claims processing solution comprising software components and processes to handle ingestion of claims data, Electronic Data Interchange (EDI), Extract, Transfer, and Load (ETL), file formatting, validation, and error logging, notifications, inpatient and outpatient claims groupers, address verification, output claims files, transactional database and data warehouse catalogs, a web application interface for real-time claim review, correction and certification, data extracts, and reporting.

Receiving Claims Data

The PCG Data Intermediary and Collection system will ingest claims by batch via the website User Interface (UI). There is also an option for secure submission through a secure FTP.

Claims Data Validation

Parsing and Validating 837 Files

PCG Health Software Development (HSD) has several options available for electronic data interchange (EDI) to parse the 837 claims file data. The PCG Data Intermediary and Collection system is currently utilizing an open source EDI framework solution in .NET code to parse, translate, and validate EDI X12 files. This component utilizes a Standard Exchange Format (SEF) to obtain the EDI implementation guidelines and reports on errors. Validation at this stage of the process is on the EDI file segments to ensure a proper, complete, and compliant claim file has been received.

Generation of 999 Files

Errors found in the EDI 837 file validation process will be noted in a generated 999 acknowledgement file to the provider. The PCG Data Intermediary and Collection system stores the 999 files on the file system where it is available to the Provider for download via the website User Interface.

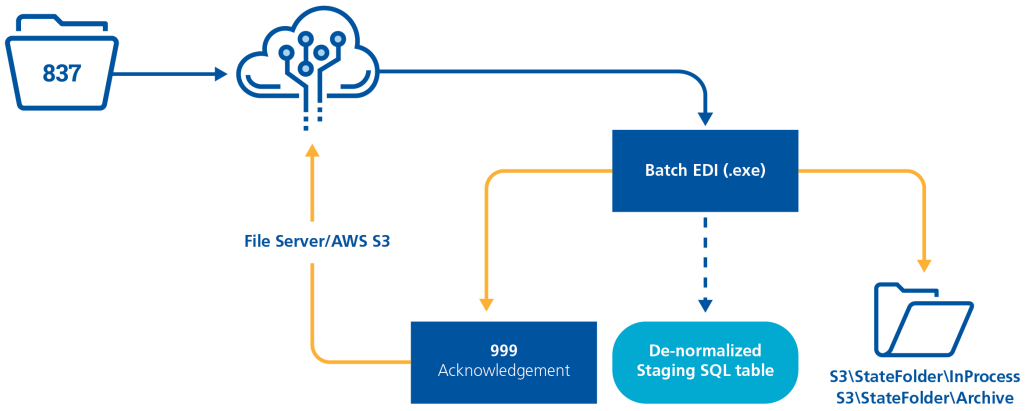


Figure IV.1.1: For files that have successfully passed validation, data is parsed into a de-normalized staging SQL database for another level of validation.

Additional Validation on Accepted Files

The 999 Acknowledgement is stored on the PCG file server or AWS S3 bucket for one (1) year. For files that have successfully passed validation, data is parsed into a de-normalized staging SQL database (see *Figure III.2.2* **above**) for another level of validation.

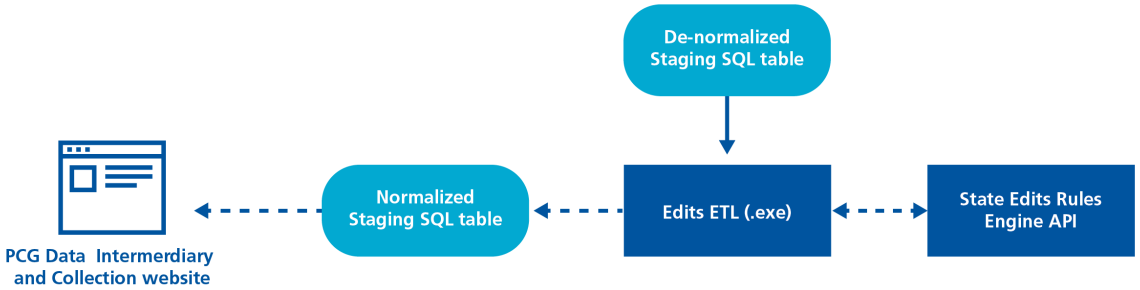


Figure IV.1.2: Ingesting and Validating Claims Data from Approved 837 Files

Database System

Each client implementation of the PCG Data Intermediary and Collection system connects to several MS 2016 R2 SQL catalogs on dedicated Relational Data Storage servers. The database system includes transaction tables for web application processing and real-time reporting, and a data warehouse catalog for data extracts. PCG conforms to HIPAA compliance guidelines for the storage of sensitive data including PI and PHI. Data is backed up nightly.

4.2.2 Vendor SHALL collect the hospital inpatient uniform billing (UB) data elements outlined in the Data Element Specifications Guide and implement annual additions and/or modifications to reported data elements based on changes in state, federal, or industry standards or policies, including but not limited to ICD-10-CM, in a manner and timeline approved by the Health Care Authority.

PCG acknowledges these requirements and agrees to comply.

4.2.2.1 Vendor SHALL agree to process in accordance to federal regulations or guidance the collection of expected sources of payment, revising the payer codes and updating user documentation. Source of payment is currently reported in accordance with the West Virginia Hospital Inpatient Data System Payer Coding Specifications.

Expected sources of payment along with payer codes are fields that are being collected in PCG's current system. There are edits in place that ensure the payer codes are correct, and any claims that are submitted with an incorrect payer code is rejected and revision is required. The payer codes are kept in the database in a table that can be updated as needed. When codes are changed, added, or removed PCG can update the payer codes in a quick and efficient manner. As mentioned in section 4.3 of this RFQ, PCG will update documentation as needed.

4.2.2.2 Vendor SHALL accept inpatient data files in the current West Virginia UB-04 Extended Data Layout and ANSI ASC X12 837i 5010.

The system accepts and is configurable to accept several variations of the ASC X12 837 format, including 837R, 837I, and 837P that conform to HIPAA 5010 compliance. The system will be able to accept data files in the current West Virginia UB-04 Extended Data Layout and ANSI ASC X12 837I 5010 format.

4.2.2.3 Vendor SHALL assess and confirm the accuracy, completeness, quality, appropriateness, and reasonability of the submitted data to identify and eliminate common errors. Implement current edit checks, as outlined in the Edit Check Definitions guide. Identify data submission and processing errors. Implement additional or revised edits over the course of the contract based upon identified data quality issues; revised reporting requirements; or changes to coding, billing, and reimbursement standards, as requested, required, and/or approved by DHHR.

For data that passed the first round of 999 validation, a processed developed by the PCG HSD group performs ETL on the de-normalized staging data and utilizes a customizable “Rules Engine” API to perform checks on the actual data against companion guide specifications. This process also performs processing for removing duplicate claims and collating, aggregating, and consolidating interim claims (per specification) to look like a single episode of care.

Errors on the data found in this round of edits are flagged and displayed in Claim Error summary and detail screens on the PCG Data Intermediary and Collection website where they can be viewed and corrected – in real time via the UI. This ETL and validation process also puts the claim data onto a transaction SQL catalog in a normalized format to optimize transaction processing on the website.

The edits are customizable, so PCG can certainly use the edit checks that are outlined in the Edit Check Definitions Guide and can be revised based on reporting requirements, and changes in coding, billing, and reimbursement standards as needed. Alongside the customizable edits, the groupers will apply more in-depth edits that align with billing, coding and reimbursement standards. Users will have the chance to correct these edits as well to ensure the claim is accurate and complete. Updates can and will be made as needed or required. The figure below shows the cycle a claim goes through in the system.

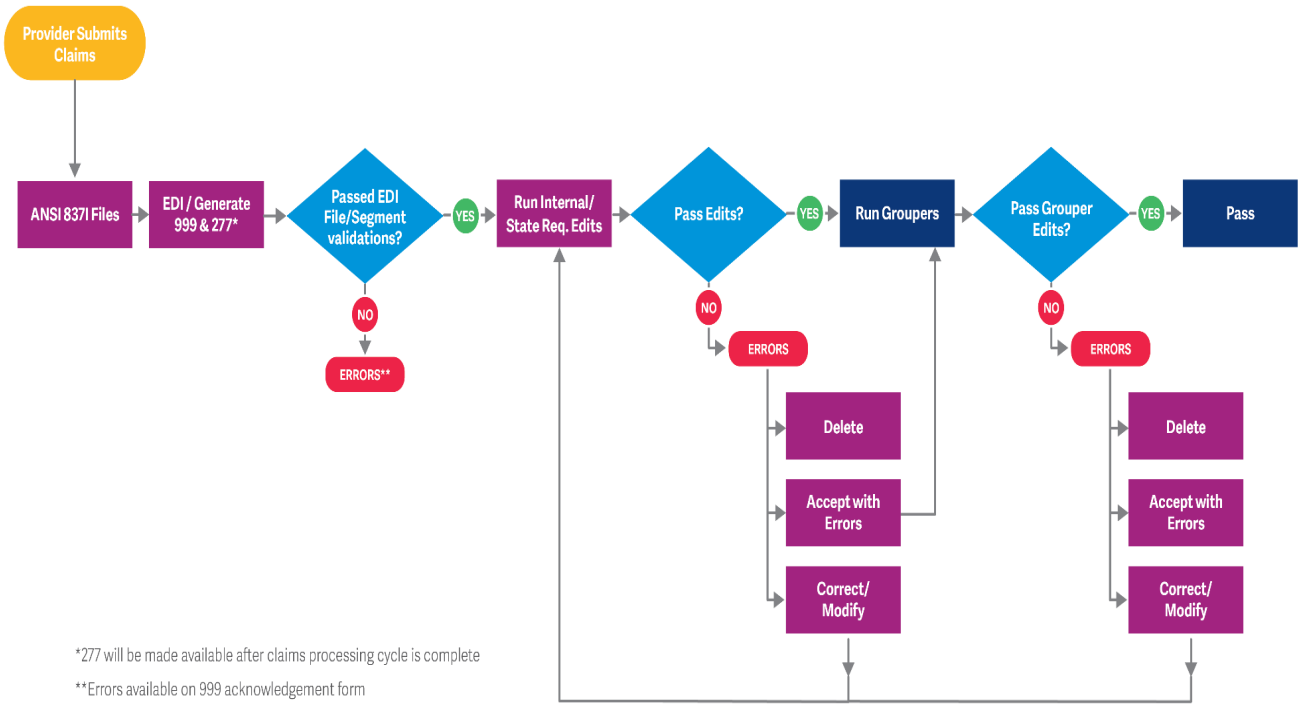


Figure IV.1.3: Claims Processing Cycle

4.2.3 Vendor SHALL collect, process, maintain, and assure the quality of Hospital Emergency Department data from all non-federal hospitals in West Virginia and assist DHHR in the development of West Virginia Emergency Department Data System Policies and Procedures and Emergency Department Data Element Specifications Guide similar in content and appearance to the policies, procedures, and guides referenced in 4.2.1 above.

Please refer to section 4.2.1 above. All items mentioned in that section are applicable for hospital emergency department data collection as well. PCG agrees to provide any additional assistance to DHHR to ensure that the policies, procedures, and guides are developed to fully meet your needs.

4.2.3.1 Vendor SHALL accept emergency department data files in a current Industry Standard data format and assist DHHR in modifying the Data Element Specification Guide to include those standards. Implement additions and/or modifications to the file format over the course of the contract in accordance with state, federal, and/or industry requirements, as required and/or approved by DHHR.

As mentioned above in section 4.2.2.2, PCG's system accepts and is configurable to accept several variations of the ASC X12 837 format. At the award of this contract PCG will already have the ability to accept emergency department claims in an industry standard data format. The Data Element Specification Guide will be updated to include those standards, and any additions and/or modifications to the file format will be updated accordingly to the file intake process and documentation.

4.2.4 Vendor SHALL continually evaluate the data collection, processing, and editing procedures for performance and compliance; routinely implement quality improvements, based on these reviews, to enhance system processes, efficiencies, and speed, as requested and/or approved by the HCA.

PCG Utilizes Rigorous, State-of-the-Art Performance Management Tools

Public Consulting Group, Inc. (PCG) has adopted Amazon's CloudWatch monitoring and management service to ensure that our systems are always configured properly, that they are working up to specifications and that any performance changes are attended to immediately. We currently use CloudWatch for our Texas HHSC Data Broker engagement, and it has allowed us to exceed the extensive performance requirements of our contract.

PCG builds in performance testing for all areas of our system, using either a continuous or on-demand testing using CloudWatch. By doing so, **we can monitor our current performance and understand where any additional testing can be brought to bear to assure top performance by our system for our client.** PCG understands the importance of rigorous testing.

PCG utilizes CloudWatch for our TX HHSC Data Broker Project, for which we have developed a robust **system that has processed over 600 million eligibility verification transactions**, and we process over two million of these transactions daily for 17,000 + users. And PCG could not have maintained its excellence in exceeding contract standards without a bullet-proof system for monitoring and intervening in all important areas of system performance.

How CloudWatch Works

CloudWatch shows data and actionable insights to monitor applications, understand and respond to system-wide performance changes, optimize resource utilization, and get a unified view of operational health. CloudWatch collects monitoring and operational data in the form of logs, metrics, and events, providing a unified view of system resources, applications and services that run on AWS. We use CloudWatch to set high resolution alarms, visualize logs and metrics side by side, take automated actions, troubleshoot issues, and discover insights to optimize applications, and ensure they are running smoothly.

CloudWatch allows us to collect and access all performance monitoring on a single platform, allowing excellent visibility of all parts of the system's architecture. We can monitor the complete stack (applications, infrastructure, and services) and leverage alarms, logs, and events data to take automated actions to maximize performance. PCG will perform stress and load testing as needed, using the AWS tools to balance loads and meet stress tests' objectives.

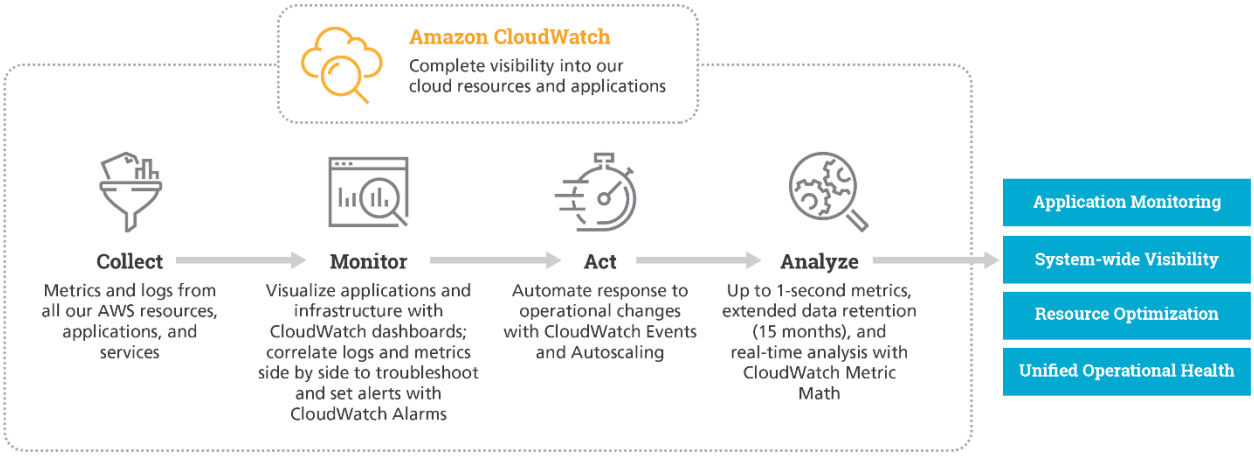


Figure IV.1.4: Amazon CloudWatch Functionality

CloudWatch Provides Automated Solutions

CloudWatch becomes aware of operational changes, such as increased demand from users, as they occur and responds to these operational changes and takes corrective action as necessary through pre-programmed change instructions, activating functions, making changes, and capturing state information. CloudWatch also sends messages to our systems team alerting them to responses to the environment.

While many minor corrections can and will be made on the fly, areas where system changes are needed, PCG will confer with DHHR and gain approval of significant system changes.

Performance and Monitoring Specific to WV HIDS Processes

During the course of this engagement, PCG will monitor the performance of specific requirements of this RFO. This will include up-to date monitoring of the following:

1. **Files/batches and claims/transaction sets** received from the submitters, identifying their chief characteristics and counts of accepted and rejected claims, to determine if extra training or working with submitters is necessary, or if system modifications are necessary.
2. **Any changes to the system**, including monitoring of logic changes, programming changes, reporting changes or any change due to maintenance.
3. Any changes to the PC**/web-based tool for claim submission**, again including monitoring of logic changes, programming changes, reporting changes or any change due to maintenance.

PCG manages all of its projects using Team Foundation Server (TFS) and uses an Agile approach to development. This process includes tracking all changes – logic, reference tables etc. – and reporting on any problems with changes, and the ability to roll back changes from production if there is an issue. Our QA process includes automated testing, and User Acceptance Testing (UAT) which will confirm the effectiveness of any of the above changes – logic, report or system changes.

4. MANDATORY REQUIREMENTS

IV.1 Data Collection Processing and Editing [4.2]

4.2.5 Vendor MUST maintain a secure web-based system for the online submission and editing of hospital inpatient LIB data and emergency department data with the capacity for expansion to accept data related to any of the Additional Optional Systems Modules required in 4.1.11. Implement updates or revisions to the system based on changes adopted per 4.2.1, 4.2.2, and 4.2.3 and 4.2.4 above.

Public Consulting Group, Inc. (PCG) Data Intermediary and Collection System encompasses an interrelated Claims processing solution comprising software components and processes to handle ingestion of claims data, Electronic Data Interchange (EDI), Extract, Transfer, and Load (ETL), file formatting, validation, and error logging, notifications, inpatient and outpatient claims groupers, address verification, output claims files, transactional database and data warehouse catalogs, a web application interface for real-time claim review, correction and certification, data extracts, and reporting. As such, the system will be able to efficiently handle the estimated annual claim volume of 2 million with additional claims processing capacity available as required for use with the required claim formats.

PCG Data Intermediary and Collection Web Application

The PCG Data Intermediary and Collection website is an n-tier application built on the Microsoft technology stack utilizing .NET 4.5 framework and the MVC 5.2 design pattern with modular APIs. Web controls are a mix of MVC Kendo UI components that are built in jQuery. The front-end User Interface (UI) utilizes Razor and HTML5. The site employs CSS which is designed to display an adaptable layout to appropriately resize for standard contemporary web browsers, varying screen resolutions and tablets. The bulk of the code is written in C# and conforms to W3C best- practice standards. JavaScript and Lambda functions are also employed. Business layer transaction processing resides in the compiled code, and in stored procedures on the SQL server. The site utilizes entity framework core for I/O processing An uses SQL Server Reporting Services for Reporting.

Web Application Features

Since WV HIDS requires specific application requirements that will require PCG to modify our current system to meet, for your reference, we have provided select examples of features within our existing Web Application, branded for use by the New Jersey Department of Health.

PCG includes the following screens which illustrate the look, feel and functionality of these features within an existing deployment:

- **Log-in Screen**
- **Dashboard Screen**
- **File and Claim Submission Status Screen**
- **Administrative Screens**
- **Claim Error Summary Screen**
- **Claim Error Drill-Down Detail Screen**
- **Batch File Upload Screen**

Each of the categories mentioned above contain many specific features that function similarly to the current **HIDS** application, along with other features that are currently not present in the DHHR data collection application.

Web Application: Log-in Screen

The User Access Login Page is the first page that users will be presented with when they first enter the URL into their browsers. The purpose of this page is to allow users to login to the application and reset their credentials in the event that the credentials are lost and/or forgotten. In addition, this page will be the first page that will contain the contact information for both HIDS and PCG customer support in case that users cannot login to the application.

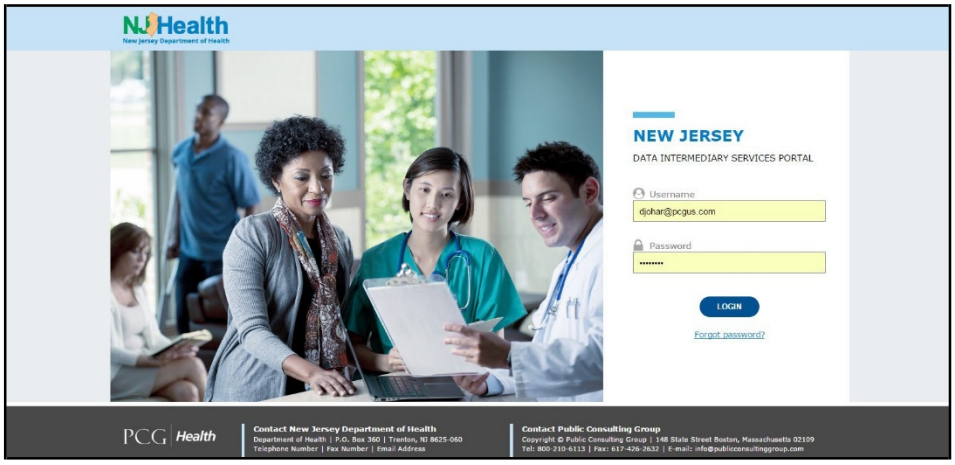


Figure IV.1.5: Web Application Log-in Screen.

Web Application: HIPAA Compliant Password Screen

Currently, the PCG application is set to allow users to only change their password, as the current application does not intend to allow a user to change his/her personal information in order to ensure that user actions are clearly logged in the application and is not subject to constant revisions. However, the PCG platform can enable more flexible personal account management features without the need for significant coding due to how the user management system is currently set up for admin users. PCG ensures the password functionality on the application is HIPAA compliant. Passwords expire every 90 days, so users are forced to change their passwords. When creating a password, users must follow the HIPAA password rules pictured below.

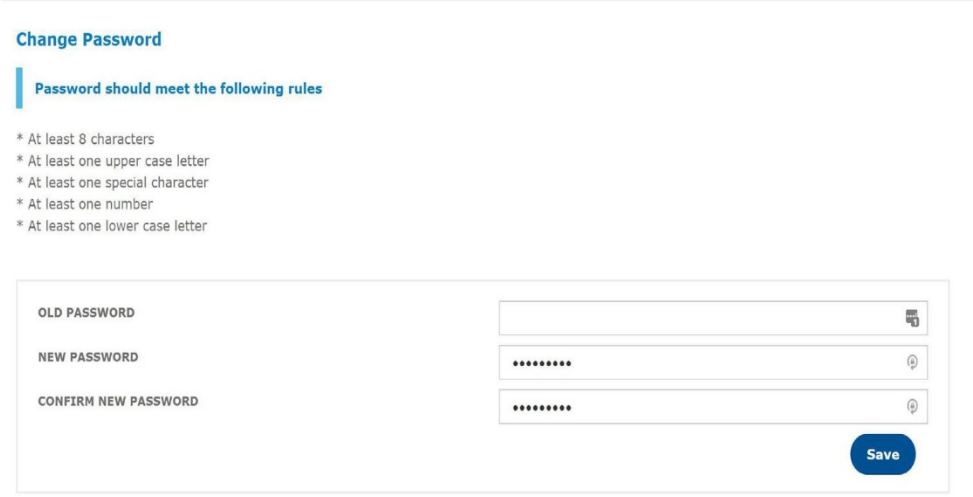


Figure IV.1.6: HIPAA Compliant Password Screen.

Role-Based Application Dashboard

The dashboard of the application is the landing page for the user upon a successful login to the application. The application board is designed as a role-based dashboard user interface, meaning that each user role created for the application will have its own version of the application dashboard, in order to ensure that only information relevant and appropriate to that user role is displayed.

In addition to the role-based nature of the application dashboard, the dashboard also contains various widgets that provide useful information to the user. Current widgets in the PCG application include:

- Public Announcement Banner
- Announcements and Bulletin Panel
- Application Resources Panel
- Useful Links Panel
- Grouper Batch Processing Statistics (Vendor Admin Only)
- All Provider Claim Errors Queue (Vendor Admin Only)
- Data Extract Request Log (Vendor Admin Only)
- Statewide Batch Upload Volume Statistics Chart (State Admin Only)
- Enrolled Providers List (State Admin Only)
- Provider-Specific Batch Upload Statistics Chart (Volume, Acceptance Rate, Error Rate by Day, Bi-Weekly, or Monthly)
- Count of Claims by Days in Error Queue

Depending on the specific requirements identified by **HIDS**, PCG can customize and modify the dashboard widgets to display the information that is relevant to the providers under the DHHR data collection application. All PCG's responses to the Statement of Work requirements can be found in the second subsection of this section.

Web Application: Provider Application Dashboard Screen

The dashboard provides users with claim submission statistics, claim error statistics, important announcements, useful resources and links upon login. The claim submission graphic can be filtered to view different claim volumes based on daily, bi-weekly, or monthly submissions. A second filter can be used to see the volume for submitted claims, acceptance rate, or error rate. Both inpatient and outpatient claims are displayed on this graph.

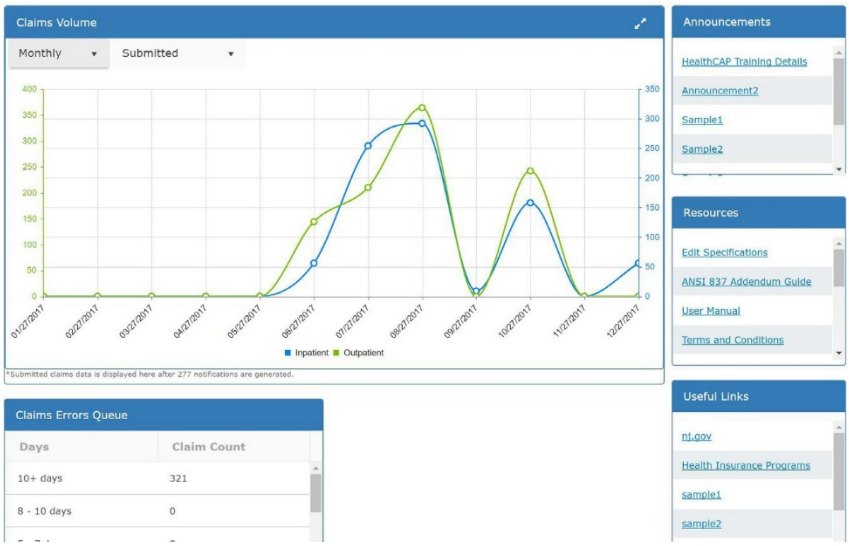


Figure IV.1.7: Provider Application Dashboard Screen.

Web Application: Admin Role Application Dashboard Screen

The Administrative user account dashboard provides the ability to review the status of claim grouper batches, view stats on Claim Errors by Provider Number, and Review status of Data Extract requests by Provider. It also provides a central source for resource links and announcements. Announcements are customizable and can easily be added or removed at any time. The resources tab contains useful documents such as the user manual and ANSI 837 Companion Guide.

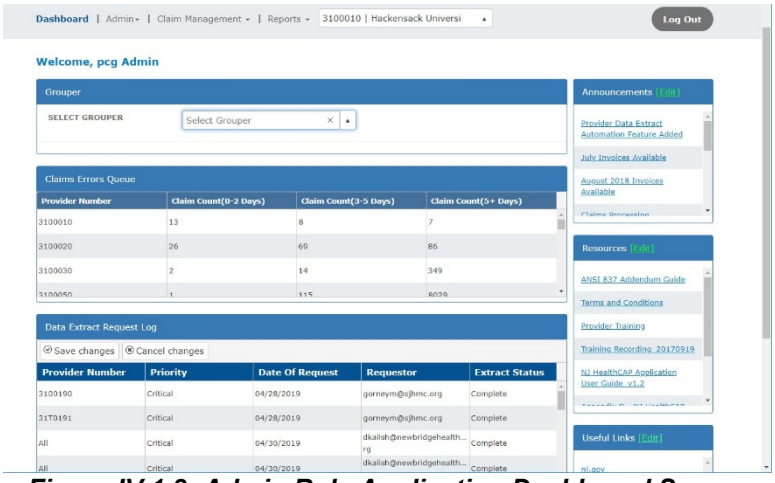


Figure IV.1.8: Admin Role Application Dashboard Screen.

Web Application: Batch File and Claim Submission Status Overview Screen

Provides online access to system-generated 999 (837 format errors) and 277 (claim status) data associated with batch files. The PCG application's batch file submission status overview page will allow users to easily review their batch file submissions and identify important statuses and statistics relevant to their claim files. While PCG's current system displays a specific set of fields/information categories, PCG has the flexibility to add and modify this page to meet HIDS requirements per the Statement of Work. PCG's current batch file submission status page already includes a good majority of the information that HIDS is requiring the application to contain.

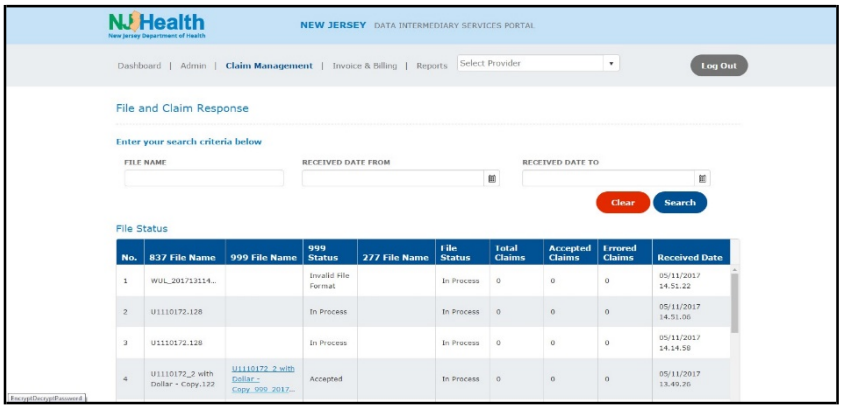


Figure IV.1.9: Batch File and Claim Submission Status Overview Screen.

Web Application: 837 Batch File Upload Screen

Online interface for uploading and then viewing uploaded batch claim files.

The PCG application allows for a simple, efficient, and minimalistic approach to uploading 837 files into the PCG EDI processing engine. Providers are able to select and upload multiple files at a time, with the ability to review the upload status immediately after the upload button has been engaged. On the same page, PCG's application will provide the name of the files that were uploaded, the internal unique trace number that PCG's system has generated for each file, and the date and time the files were uploaded on.

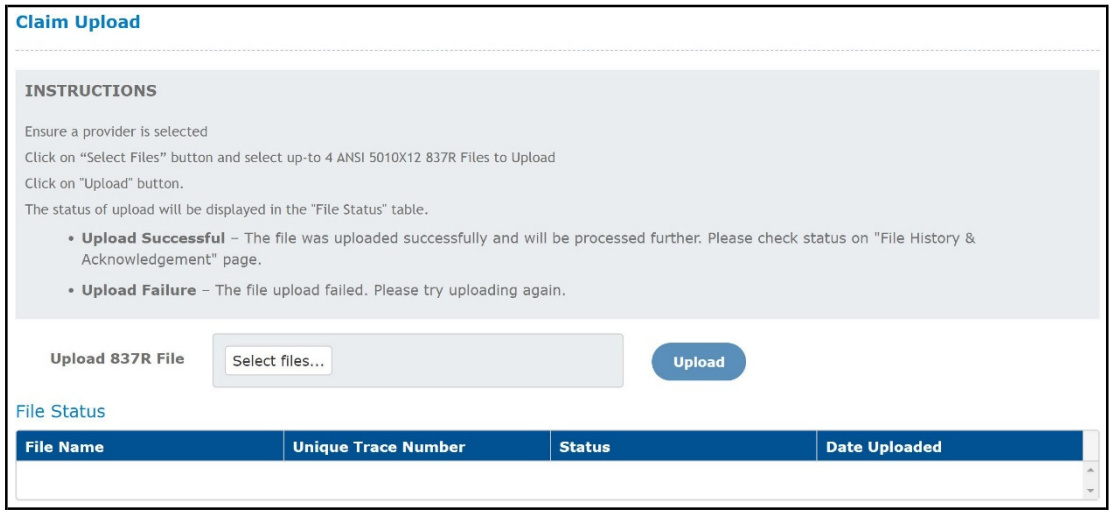
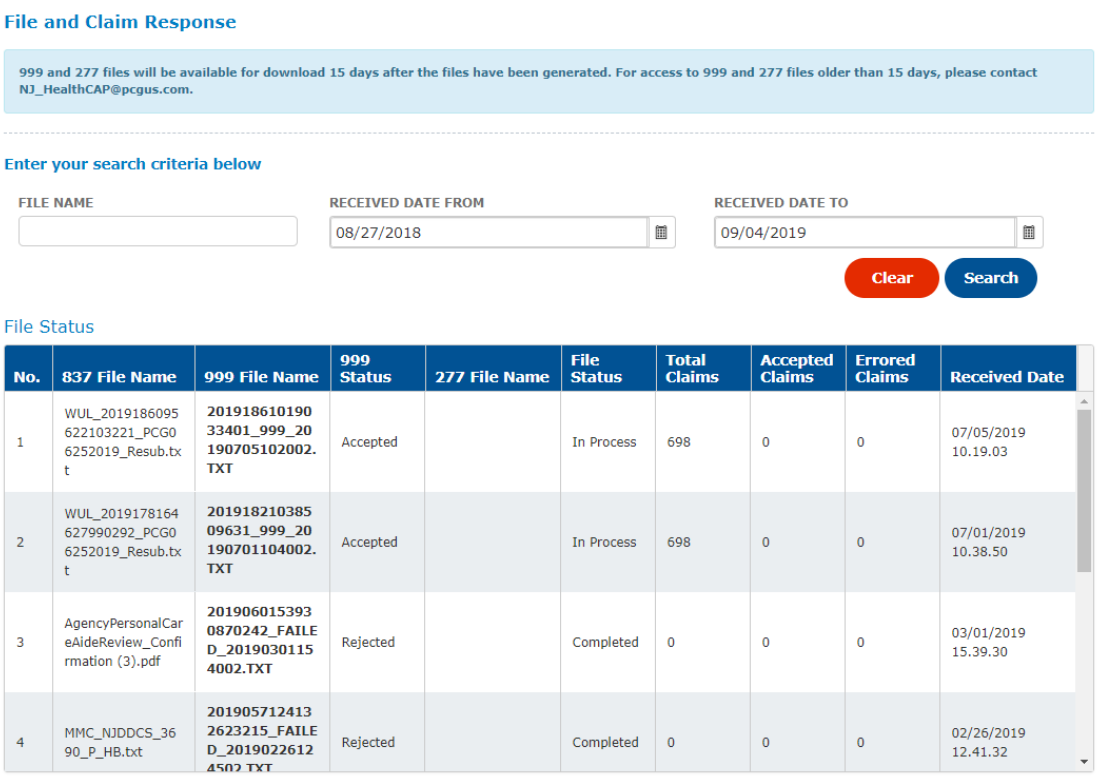


Figure IV.1.10: 837 Batch File Upload Screen I.



File and Claim Response

999 and 277 files will be available for download 15 days after the files have been generated. For access to 999 and 277 files older than 15 days, please contact NJ_HealthCAP@pcgus.com.

Enter your search criteria below

FILE NAME | RECEIVED DATE FROM 08/27/2018 | RECEIVED DATE TO 09/04/2019

Clear Search

File Status

No.	837 File Name	999 File Name	999 Status	277 File Name	File Status	Total Claims	Accepted Claims	Errored Claims	Received Date
1	WUL_2019186095622103221_PCG06252019_Resub.txt	201918610190 33401_999_20 190705102002. TXT	Accepted		In Process	698	0	0	07/05/2019 10.19.03
2	WUL_2019178164627990292_PCG06252019_Resub.txt	201918210385 09631_999_20 190701104002. TXT	Accepted		In Process	698	0	0	07/01/2019 10.38.50
3	AgencyPersonalCareAideReview_Confirmation (3).pdf	201906015393 0870242_FAILED_2019030115 4002.TXT	Rejected		Completed	0	0	0	03/01/2019 15.39.30
4	MMC_NJDDCS_3690_P_HB.txt	201905712413 2623215_FAILED_2019022612 4502.TXT	Rejected		Completed	0	0	0	02/26/2019 12.41.32

Figure IV.1.11: 837 Batch File Upload Screen II.

Batch File Processing

In addition to providing an online interface for uploading claims into the system, the PCG Data Intermediary system can accept and process bulk batches of claims throughout the day, if DHHR would like. PCG utilizes individual Provider and Client accounts on a secure file transfer (SFTP) server to provide a repository for sending claim file batches into the system. All claim files utilizing the PCG SFTP server are encrypted in transit and at rest. The PCG Data Intermediary and Collection system utilizes Move IT software by Ipswitch to deliver posted batch files to secure file repositories in the AWS hosted environment where they are then ingested by scheduled EDI and ETL processes for verification, validation, data parsing and archive storage. Both 999 and 277 records are generated for each batch of claims via the batch file processing. Processes are continuously monitored via automated tools and generate success and error notifications as applicable for every batch of claims processed.

As illustrated in *Figure IV.1.12* below, each Provider has several folders on the SFTP server for exchanging (bi-directional) files. SSH is a protocol that provides a secure connection, and encryption on files during transfer and at rest. From there, PCG utilizes “MOVEit,” a Managed File Transfer (MFT) tool from Ipswitch to securely transfer files from the Provider’s folder on SFTP over to folders on the PCG file server (if hosted on-prem) or an S3 Bucket (if hosted on AWS) for processing. This process also generates error and other types of notices that relate specifically to the existence of a file that is being moved between locations. Claim files that are received into the system via either batch of uploaded via the UI follow the same process and reside in the same folders.

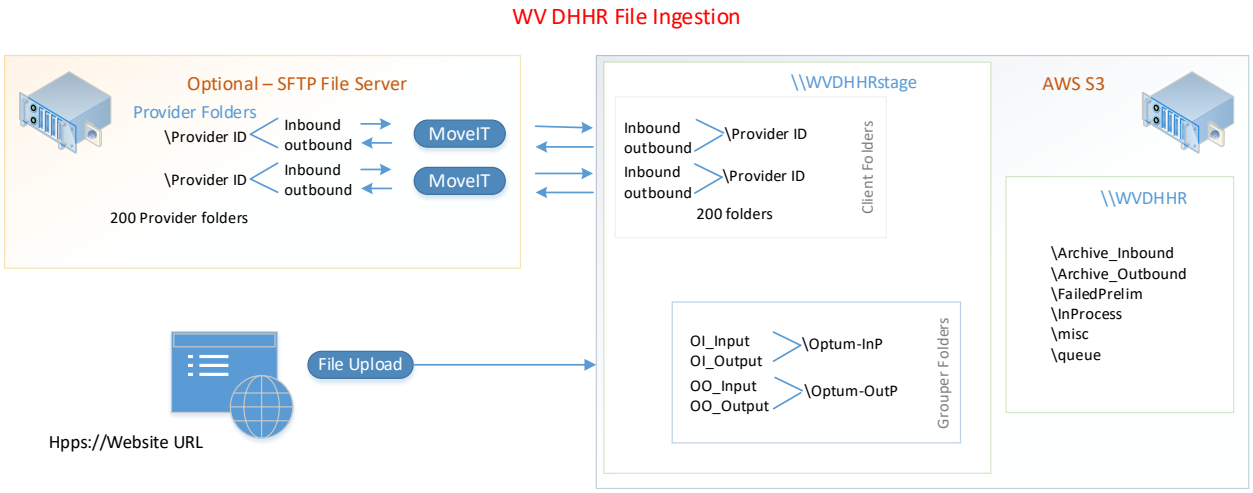


Figure IV.1.12: PCG SSH File Transfer Protocol (SFTP) Server.

Web Application: Claim Error Summary Screen

To access the individual claims and review the UB-level information to correct the errors, users can click on the hyperlinked Claim Numbers located in the second column of the table. To delete claims from the Claim Error queue, users can select as many claims as necessary by clicking the checkboxes and clicking the “Delete” button located at the bottom of the summary page.

Once a hyperlinked claim number has been clicked, the application will display the claim detail information in a streamlined format based on the fields that can be found in the UB04 (and the CMS-1500 if necessary, per HIDS requirements). Given the significant amount of claim detail fields that can be present in a UB, PCG has developed accordions to ease the navigation process and improve the speed at which the user can navigate to different sections of the claim detail. All fields that were identified in error are highlighted in red to ensure that users will not need to click through each category to find the errors. Furthermore, all the claim detail fields that require providers to use codes and values from a specific data dictionary table will incorporate predictive dropdown menus that not only easy the process for correcting the errors, but also ensures that the users are entering the correct values. Once a claim has been corrected and the user presses the submit button, the application will automatically move onto the next claim in error.

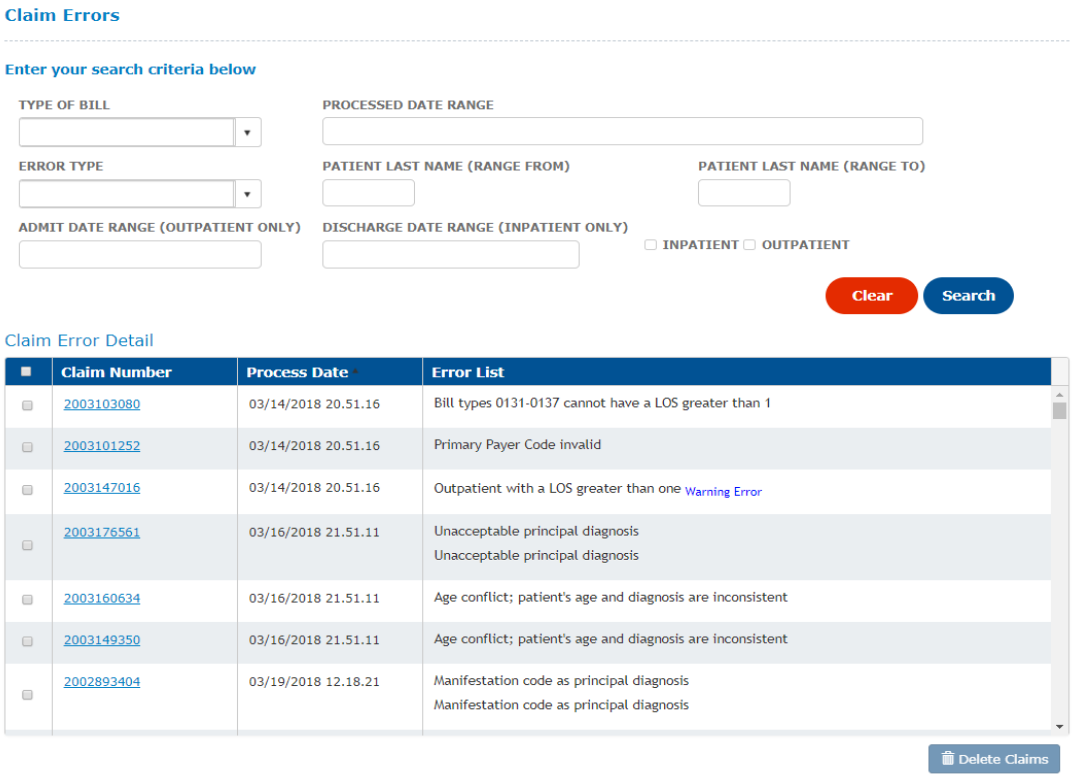


Figure IV.1.13: Claim Error Summary Screen.

Web Application: Predictive Completion Dropdown Selection

The predictive completion dropdown selection is available on all screens that have fields with a specific table of accepted options attached. PCG can customize the specific data fields that have predictive completion dropdown selections based on HIDS preferences.

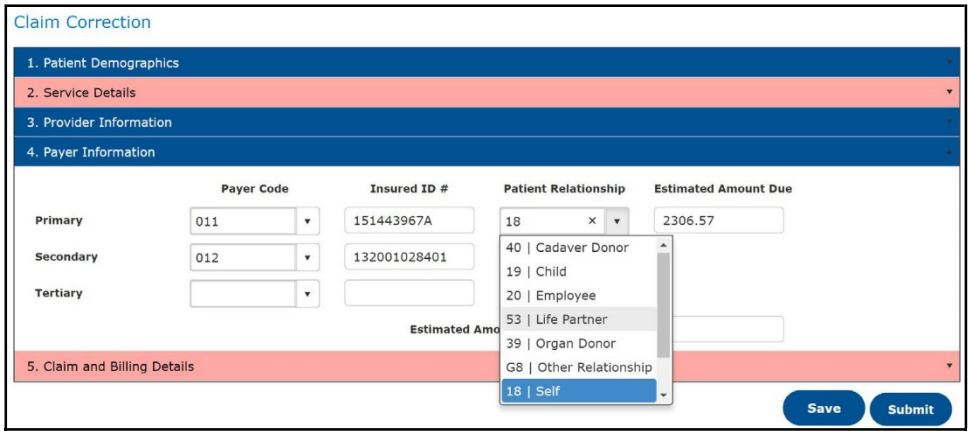


Figure IV.1.14: Predictive Completion Dropdown Selection.

Web Application: Claim Error Detail Page, Patient Demographics Screen

The data field that's in error will be highlighted on this page when the error is in the patient demographics section of the claim These errors are based on the State specific edits. Examples of types of errors under

patient demographics are invalid gender, invalid zip code, invalid residence code, missing occupation, etc.

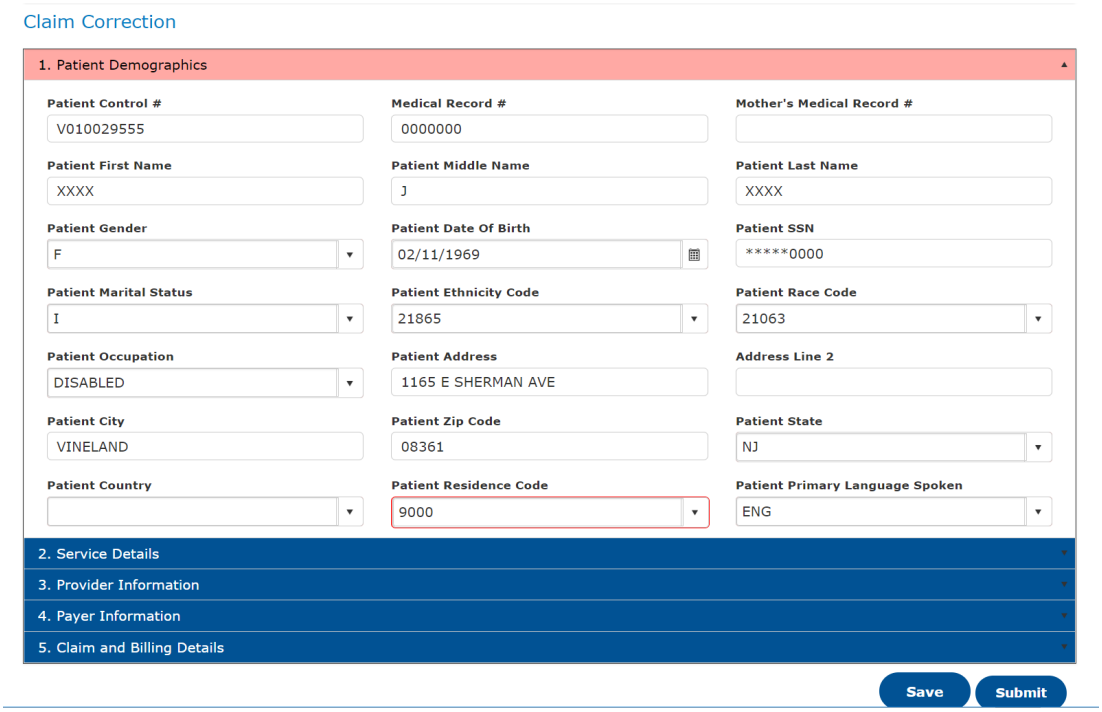


Figure IV.1.15: Claim Error Detail Page. Patient Demographics Screen.

Web Application: Claim Error Detail Page, Service Details Screen

The data field that's in error will be highlighted on this page when the error is in the service details section of the claim

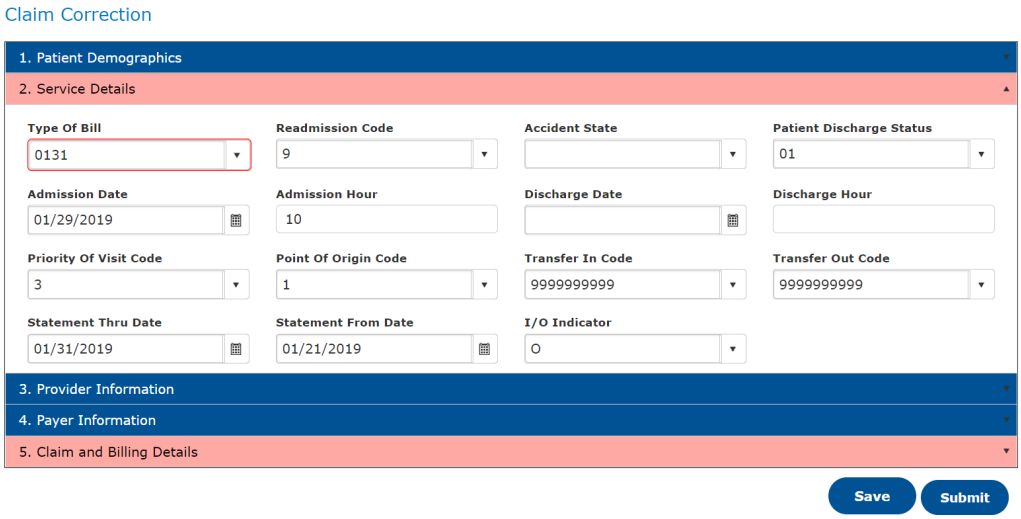


Figure IV.1.16: Claim Error Detail Page. Service Details Screen.

Web Application: Claim Error Detail Page, Provider Information Screen

The data field that's in error will be highlighted on this page when the error is for invalid provider NPI or state license number. The error can be fixed directly on this screen, and the data element in error will be highlighted along with the corresponding message up top.

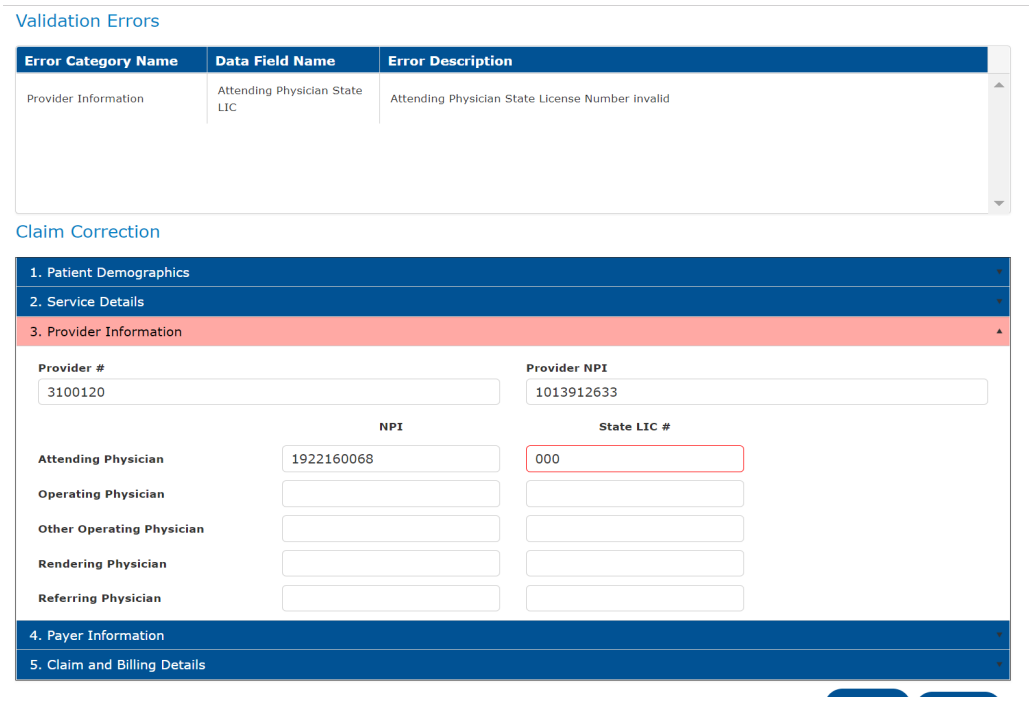


Figure IV.1.17: Claim Error Detail Page. Provider Information Screen.

Web Application: Claim Error Detail Page, Payer Information Screen

The data field that's in error will be highlighted on this page when the error is in the payer information section.

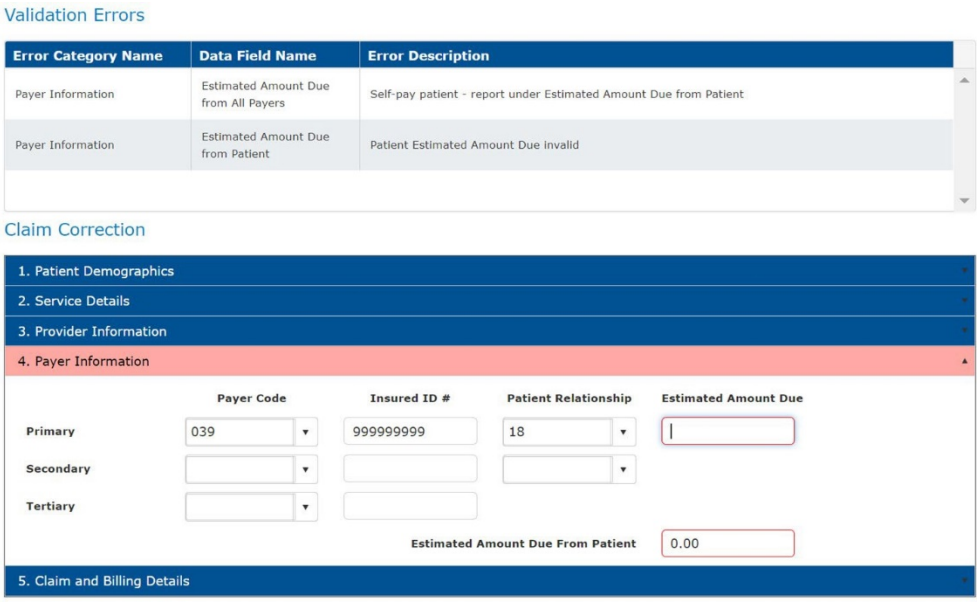


Figure IV.1.18: Claim Error Detail Page. Payer Information Screen.

Web Application: Claim Error Detail Page, Claim & Billing Details Screen

The claim data field that's in error will be highlighted on this page when the error is in the claim and/or billing details of the claim. The error is highlighted in the red box as shown below.

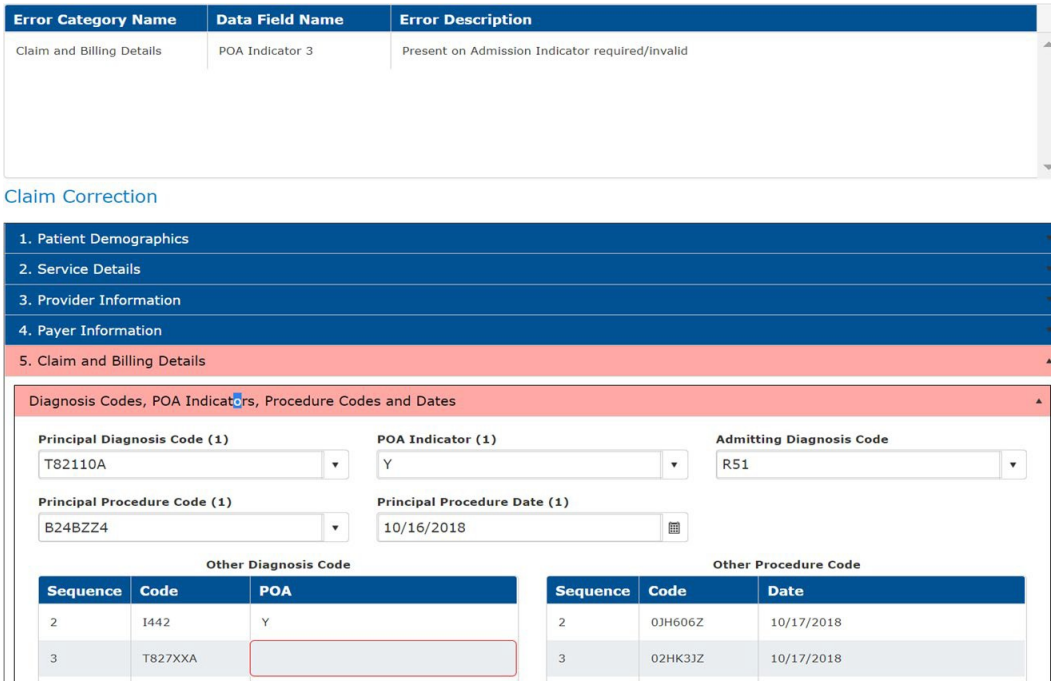


Figure IV.1.19: Claim Error Detail Page. Claim & Billing Details Screen.

Web Application: General Claim Search and Review Screen

The general claim search function allows users to search for claims that meet specific criteria chosen through the variables at the top of the page. Once claims that meet the search criteria are identified, the user can review the claim details (but not edit) if the claim has been accepted by the system and passes through the various system audit engines. PCG understands that HIDS requirements for this feature will require modifications to PCG's current claim inquiry feature and is prepared to customize this feature according to those requirements. Given that the platform has already been developed, PCG can quickly adapt our application meet the specific needs of the WV Hospital Inpatient Data System.

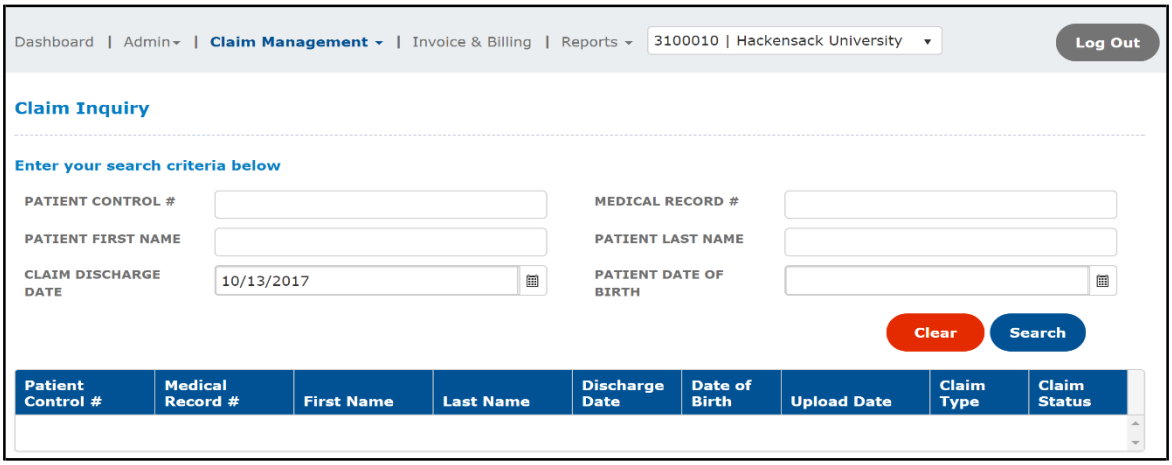


Figure IV.1.20: General Claim Search and Review Screen

Web Application: Canned Reports Screen

While PCG's current system only includes a limited amount of canned reports due to existing requirements, PCG can easily leverage our team of talented database architects and data analysis staff to develop complex summary and detail reports per the Statement of Work. PCG has the ability to leverage both **MS SQL SSRS, Tableau, and AWS Quick sight** Analytics platforms to develop extensive reports and queries that will be able to not only produce the results that **WV HIDS** is looking for, but also place them in intuitive visual displays that will be able to quickly inform discoveries and decision making processes. The report platform is already developed in PCG's application and the only modifications would be to add additional reports to the platform based on the requirements identified through the requirement gathering process.

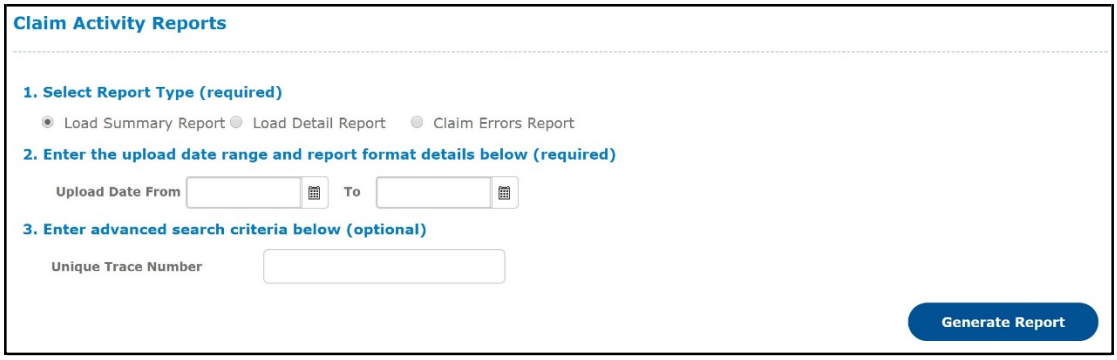


Figure IV.1.21: Canned Reports Screen

Web Application: Data Extract Request and Automation Screen

PCG's application currently allows providers to make data extract requests directly through the application and will process the requests in real time for users to download. This feature can be customized to meet the various reporting and data extract requirements identified by DHHR through the Statement of Work, and is certainly something that PCG will work with DHHR closely on to ensure that the data being extracted by users are appropriate.

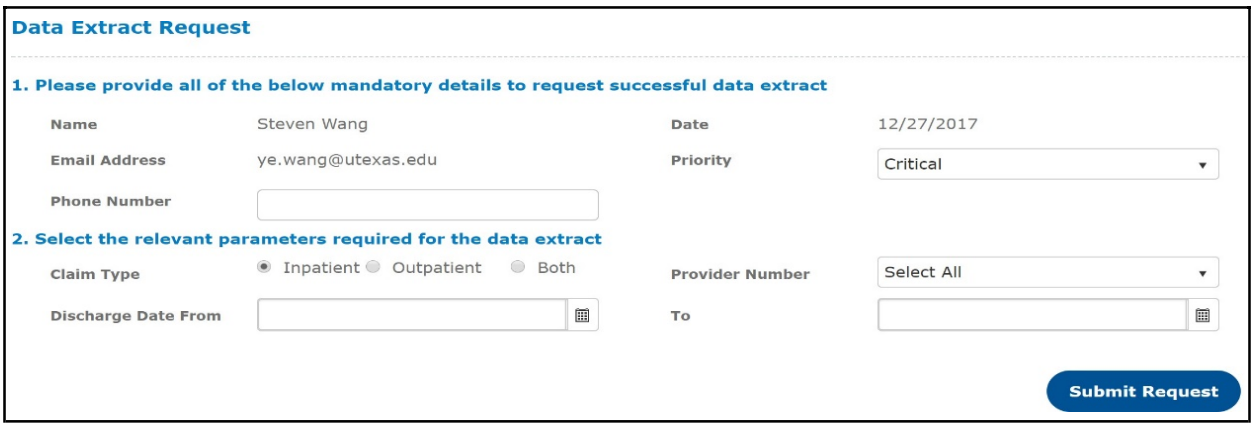


Figure IV.1.22: Data Extract Request and Automation Screen

Web Application: User Management Screen

The User Management page is the PCG application's current page where designated admin users can access user information and control the degree of access for users, they have access to. The specific set of user access capabilities and roles can be customized based on client requirements, as PCG understands that each state agency have varying standards regarding access capabilities and hierarchies. Using the user roles and management

requirements in the Statement of Work, PCG will work closely with WV HIDS to document the specific structure of the user access hierarchy for implementation into the User Management once awarded the contract.

The User Management page not only allows an admin user to specifically designate the type of role each user is assigned to; the admin users can also specifically identify the individual facilities that the user has access to through the “Provider Access” functionality. This feature is extremely important for provider organizations that are consolidated but have individual facility’s staff performing the claims submission and claims correction processes and want to restrict their access to only their direct facilities.

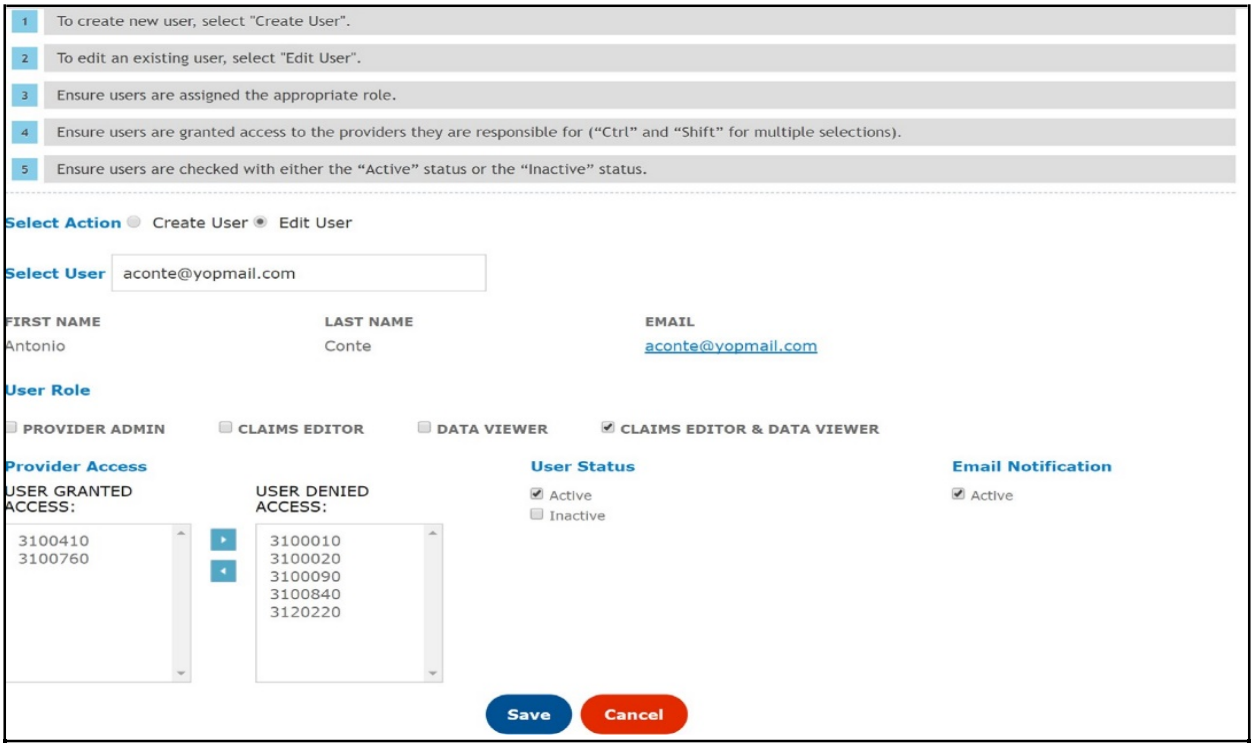


Figure IV.1.23: User Management Screen

Web Application: Provider Management Screen

In addition to User Management, PCG’s current application also contains a comprehensive Provider Management feature that will allow admin users to update and revise specific fields without the need to contact WV HIDS or PCG support. PCG understands that WV HIDS wants to be able to control how much providers can edit their information, as there are typically rules and standards for providers to notify the state whenever they make a significant change to their business name, primary contact, parent organization, provider IDs, etc. The PCG Provider Management page allows our developers to quickly customize individual fields for admin users to access, and to set up specific validation rules for each field to ensure that the data being entered is in the expected format.

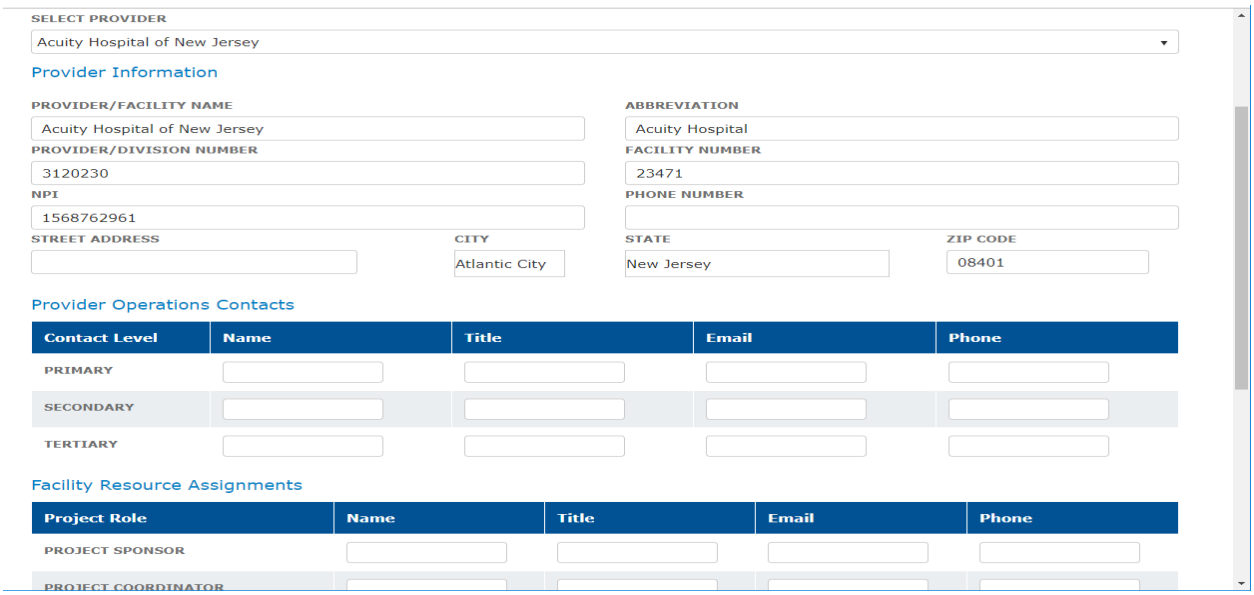


Figure IV.1.24: Provider Management Screen

Web Application: Claim Grouping Batch File Management Screen

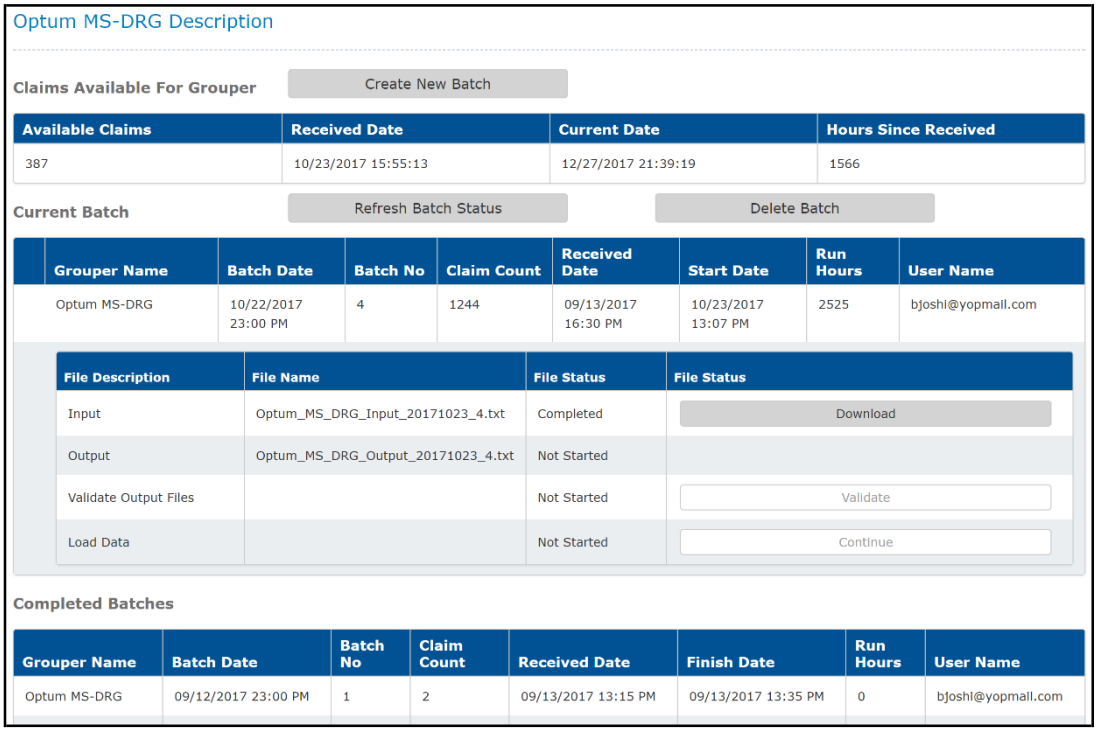


Figure IV.1.25: Claim Grouping Batch File Management Screen

Database System

Each client implementation of the PCG Data Intermediary and Collection system connects to several latest SQL Server Database on dedicated Relational Data Storage servers. The database system includes transaction tables for web application processing and real-time reporting, and a data warehouse catalog for data extracts. PCG conforms to HIPAA compliance guidelines for the storage of sensitive data including PI and PHI. Data is backed up nightly.

Operational Reporting

PCG has the capability to leverage several powerful reporting tools so that we can tailor our response by bringing the correct tool to bear on the reporting problem to be solved. These tools include, but are not necessarily limited to, **SQL Server Reporting Services (SSRS), Tableau,** and **AWS Quick Sight,** so that PCG can design any operational report that the System Agency requires.

Claims Groupers

PCG will utilize the CMS Medicare Severity Diagnosis Related Group (MS-DRG) grouper, where we will process for claim weights and Major Diagnostic Category (MDC).

PCG has extensive experience with claims groupers. PCG will always use the same version of grouper software for claims which fall in the same reporting quarter.

Enhancements/Modules

PCG Architecture is designed in a way to easily expand and add new functionality with minimal changes.

PCG Applications are based on Provider inputs and every claim related operation is connected to the Provider/User. For this engagement, we can expand the EDI component to accept EDI files such as **837P** with minimal changes.

4.2.6 Vendor SHALL maintain a master database of all data collected during the contract period and develop and implement processes that allow for an audit trail of all submissions, additions, changes, and deletions to the master database.

PCG collects every data element from the **837** files uploaded to the system and is maintained using relational Database and we can easily Query/Report to get required log Reports.

Every user related change is logged and maintained in log tables. We use below Techniques for Audit Trail.

Custom Logging

We collect all the information from the user and are logged in diff tables for Audit purposes. Here are some examples:

- File submission.
- Claim Changes (Update/Delete).
- Change log for specific Data elements.
- User Management changes.
- Log In/Log out log.
- Change log Report for Claim related changes

SQL Server Triggers

They can be set up easily and track a variety of information. Triggers lend themselves to full customization allowing users to build their own auditing information repositories.

SQL Server transaction logs

The transaction log in SQL Server records everything that occurs, which lends itself well to purposes like auditing. There is no additional overhead as this is already a built-in process in SQL Server.

4.2.7 Vendor SHALL implement methods to link all records submitted for a single discharge (including interim, replacement, and late charges bills) and create and/or identify a single complete (analytic) record representing each encounter, based on HCA adjudication requirements, generally accepted industry standards, and record characteristics, such as patient control number, bill type, and discharge date.

PCG has also developed a data warehouse for end users to extract and use claim data for statistical and financial analysis to improve management decision making. The data warehouse is flexible in its architecture, in order to allow for quick configurations for variety of functions including DRG coding and Geocoding.

Existing PCG application has logic to identify **Replacement/Interim/Void/Late charge** claims and ties them to the original claim using the below criteria and we can easily change these criteria to match the WV HIDS requirements.

- Provider ID
- Type of Bill
- Date of Birth
- Patient Control Number
- Admission Date
- Discharge Date
- Statement from Date

When a new claim is submitted to the system though Web/SFTP, the first thing we do is identify the Frequency code and check that claim against the existing claims in the System. When we find a match using the above criteria, we tie this to the existing claim.

Here is the list of Frequency codes which are handled by our existing system.

Claim type/frequency (Fourth digit)
• XXX1 – New claim
• XXX2 – Interim, first claim
• XXX3 – Interim, continuing claim
• XXX4 – Interim, last claim
• XXX5 – Late charge
• XXX7 – Replacement of prior claim
• XXX8 – Void of prior claim

We can get all the claims related to a single individual using the reporting tools like **SQL Server Reporting Services (SSRS), Tableau,** and **AWS QuickSight** for further Analysis.

4.2.8 Vendor SHALL develop and make available to data submitters and DHHR, reports that promote the assessment of the quality and completeness of data submitted to the master database. The data quality reports should be updated on a reasonable and routine basis to summarize recently submitted data and be available in common formats (e.g., PDF, Excel, etc.).

Public Consulting Group, Inc. (PCG) has the capability to leverage SQL Server Reporting Services (SSRS), Tableau, and AWS QuickSight to design any operational report that DHHR requires.

PCG will work with DHHR to provide DHHR and data submitters with reports that help analyze and promote the assessment of quality and completeness of data submitted to the HIDS system. As expected, the claim and grouper edits will help to ensure the quality and completeness of data, and we will work with DHHR to develop such reports as frequency counts for values in key fields, timeliness of submission/correction of data by submitters, and other desired reports.

PCG employs full-time Business Analysts, report developers, application developers, and database developers to create reports using tools such as Excel, SSRS, Crystal Reports, Tableau, QuickSight and the .NET framework. PCG will deploy a web-based reporting tool that is secure, robust, and flexible, and is only accessible by authorized users. This will ensure the protection of HIPAA-sensitive data. The reporting module will allow users to run standardized reports on an as-needed basis and run ad-hoc reports based upon specific state defined data fields, which are restricted based on state-defined roles. All reports will have a variety of data points related to facilities, clients, claims, and services. PCG's system will allow the user to build/modify, review/print, save/delete, recall/reuse, and restrict/share data for any WV DHHR and/or Facility user generated Ad Hoc report, based on State-defined data fields and user roles. All data exports will be done in a secure environment.

PCG uses COTS reporting products and frameworks, such as Microsoft SSRS, Tableau, and AWS QuickSight, because they allow PCG developers to develop highly interactive reports that can contain a wide set of display characteristics, including, but not limited to, presentations that are sortable, tabulated, and contain graphics (histograms, pie charts, etc.) with varying color and fonts. PCG develops standard reports in SSRS that are seamlessly hosted and integrated into the Web-Based Portal for secure, end-user access. These reports will be provided in SSRS and will be available to export in standard SSRS formats – PDF, Excel, CSV etc.

4.2.9 Vendor SHALL provide a web-based, user self-service reporting tool for 200 submitters and DHHR Staff to perform data analytics and produce simple ad hoc reports. The self-service reporting tool MUST restrict submitter access to only the data they have submitted. The self-service reporting tool MUST allow users to store an unlimited number of queries and standard reports.

Self-service ad hoc reporting will be provided through AWS QuickSight for data analytics and simple ad-hoc reports. Submitter users will be able to use their login credentials to only access data that they have submitted to HIDS (or are otherwise authorized to view). Users will be able to drill down on some fields for greater visibility into their data and use a limited dataset to produce simple ad hoc reports.

PCG will work closely with DHHR to identify the fields designated for drill down and to define the limited dataset to be used for ad hoc reporting in QuickSight. Users will be able to store as many queries/reports as they need.

PCG currently supports over 1,000 active public sector consulting and operations contracts, many of which utilize PCG-provided application software to process, analyze, and review information. **PCG has been developing reports using a proven development process and a strong suite of software technologies for more than 20 years**. Over the years and through the course of many project deliverables, we have developed a reliable and repeatable process to create reports based on an exhaustive business analysis, implementation, and testing process. For example: **20 states use a PCG-developed personal services claims web portal that hosts hundreds of millions of dollars' worth of services**. This portal supports thousands of users and thousands of daily transactions per day. The report server has been fine-tuned and optimized to ensure Service Level Agreements (SLAs), quick response time, and report viewing using Excel, a web browser, or PDFs.

Individual states draw upon PCG's reporting capabilities to manage their programs. For example:

- In **New York,** PCG built a data warehouse, along with the design and development of 25 Standard reports for NY's Department of Health, Early Intervention program.
- In **North Carolina,** PCG analyzes terabytes of Medicaid data and renders sophisticated data reports for the State's Medicaid program.
- In **Washington, D.C.** and **Michigan,** our clients rely on our commercial off-the-shelf software to view the status of their operations, using a suite of standard reports generated dynamically in real time.

These clients have direct access to our report module and can generate a multitude of on-demand reports, including claims processing status, processing errors, claim details, and claim summaries. Users require authorization to access reports, and access can be limited based on a user's role within the organization.

4.2.10 Vendor SHALL provide resources or tools to assist the HCA (Health Care Authority) with the quarterly reconciliation of the master database. Currently, the hospitals submit to the HCA a quarterly reconciliation report summarizing the number of discharges by provider number (CMS Certification Number), month, and HCA payer classification (available for download on the HCA website). This report is manually compared to a report of the data contained in the master database. Hospitals are notified by the HCA of discrepancies and must revise the submitted data, as requested by the HCA.

PCG is uniquely qualified to help HCA with the quarterly reconciliation of the master database. Assuming each quarter is reconciled successfully; each subsequent quarter is able to stand on its own in terms of reconciliation. We would suggest that the hospitals submit their quarterly discharge summaries in electronic format (Excel or CSV) so that these reports can be consolidated and used as a reference in comparing the reconciliation data in the database. Having access to the HIDS Master Database, can test the reconciliation directly, and PCG can consolidate the reconciliation data for HCA and provide a text file that can be imported into a database to ease in reconciliation if HCA desires.

4.2.11 Vendor MUST propose a system that may expand (at DHHR's option) to accept data related to Outpatient Surgery, Outpatient Observation Stays, Outpatient Diagnostic and Therapeutic Hospital Services, and Outpatient Physician Office Visits or other types of hospital outpatient services. Optional System Modules will be priced separately and based on a cost per calendar quarter. No optional services will be requested during the first calendar quarter of the contract.

Public Consulting Group, Inc. (PCG) system as designed is ready to accept all 837 Institutional (837I) claims which is the designated claim type required of all hospital submissions. This is anticipated to cover all claim service areas listed above except for Outpatient Physician Office Visits. These physician office claims will require the expansion of our claim intake process and data base structure to accept the 837 Professional (837P) data files required for use with these claims. PCG will work with DHHR to determine what, if any, groupers are to be used for these optional services. The cost of these groupers are not included in our cost, but the staff hours for configuration of the groupers are included in our price.

PCG will work closely with DHHR to determine how reporting of each service area (e.g. Outpatient Surgery) will be appropriate for the analysis and tracking of provider claim submission volume and status (accepted or rejected claims) as part of our report development.

IV.2 Documentation and Technical Support [4.3]

4. MANDATORY REQUIREMENTS

IV.2 Documentation and Technical Support [4.3]

4.3.1 Vendor SHALL develop and provide documentation, training, and technical support regarding data collection, editing, and reconciliation.

Public Consulting Group, Inc. (PCG)'s training approach and strategy is based on years of experience spent training tens of thousands of stakeholders in thousands of sessions, forums, and one-on-one calls. For this project, the primary training will focus on four core areas:

1. How to navigate our Web-Portal and Application;
2. How to upload and manage the 837-claim file submission process;
3. How to fix claim edits and ensure the billing and coding standards are understood and followed; and
4. How to perform data queries and run reports from our system for claim reconciliation.

PCG will develop all the necessary training and reference materials, including 837 Companion Guides and 837 submission training documents. PCG will maintain version control and make updates to the latest versions of training materials. PCG will also post all training materials to our web portal for real-time and efficient access as well as provide DHHR with a copy to put on their website.

In addition to preparing the necessary technical training and training materials, PCG will address the individual needs of West Virginia's 70 data submitters and their representatives with a dedicated outreach and training professional to support these facilities.

PCG's outreach plan includes provisions for:

- Training workshops for the staff
- An initial training workshop will be held via webinar for providers and on-site for DHHR staff. per RFQ requirements.
- Single-day workshops on system updates, edit rule changes, data quality, and other important data submission issues.
    - These workshops will be conducted via webinar and performed on an annual basis. It will also be done when system updates are implemented.

Training workshops on ICD-10-CM for facility representatives and supporting facility staff

PCG will provide a Technical Support Customer Service Center, which will be staffed Monday-Friday during normal business hours, EST, to assist facilities with 837 file upload issues, data and reporting issues, etc. The Customer Service Center will be closed on state and federal holidays only.

Please refer to section 4.3.1.3 for more information on training and documentation PCG will provide.

4.3.1.1 Vendor SHALL develop materials similar in content to the documents referenced in Section 2.2 of this RFQ. Provide the materials to WV DHHR in a format suitable for inclusion on the HCA or other web sites. Maintain and update the files as necessary or as requested by DHHR over the life of the contract update annually by July 1. DHHR will request revisions 30 days prior.

Apart from the specific requirements DHHR has listed in the RFQ, new development and customization of an application typically will result in a new product that is different from the previous product from a user interface perspective, a user experience perspective, and sometimes even a workflow perspective if the new application provides a more time and cost-efficient method of accomplishing the requirements. As a result of these unavoidable differences from the incumbent application, it is necessary for the new vendor to update the existing DHHR and incumbent vendor documentations and ensure that the information published is up-to-date, accurate, and reflective of the new features. While PCG has provided some examples of the documentations that typically will need to be updated as part of this process, there can certainly be more documentations that DHHR and/or the providers are specifically requesting. PCG has the necessary experience and technical writers on staff to develop comprehensive application documentations that will fit the needs of the stakeholders. We will provide application documents in a format that is suitable for inclusion on web interfaces. Annual updates will be made by July 1st , and all other necessary or requested updates will be made accordingly.

4.3.1.2 Within 30 working days, Vendor SHALL provide documentation to WV DHHR that details the operational processes of the web-based data submission system necessary for HCA staff to evaluate effectiveness and understand and communicate information about the system to data submitters. Acceptable format; word and Adobe PDF.

PCG will provide DHHR documentation that details the operational process of the PCG system within the required 30 working days of the award of the contract. PCG will submit the documentation to DHHR in an acceptable format, Microsoft Word and Adobe PDF. PCG understands the importance of effective communication throughout the project, particularly during the implementation phase. Communication management is central to the success of any project. It is now widely recognized to be one of the most important aspects of project management; long gone are the days when its importance was overlooked or undervalued. However, prioritizing the importance of communication is not the same as effectively executing it on a day-to-day basis. Successful communications management must be systematically planned, executed, managed, monitored, and evaluated throughout the lifecycle of a project. PCG will develop communication protocols for all stakeholders, including the West Virginia DHHR facility, and other system stakeholders, as appropriate and approved by the West Virginia DHHR. PCG will provide necessary documentation about the data submitters as part of our communication efforts

4.3.1.3 Vendor SHALL provide training and technical support to WV DHHR, data submitters, and/or their representatives on topics related to file formats, data submission, editing, and coding and billing standards.

Technical Support Customer Service

PCG currently maintains a call center facility to field incoming customer and technical support calls and to make outgoing follow-up resolution calls, as necessary. Utilizing a dedicated toll-free number, and dedicated, trained technical specialists, PCG will ensure your users are always supported. With extensive experience managing and operating call centers in several states across the country for more than 10 years, PCG can immediately staff this project with experienced customer and technical support specialists, each of whom has at least three years of experience. To ensure the professional, informed handling of customer inquiries, comments, and complaints, PCG maintains the following protocols:

- Customer and Technical Support Inquiries – Requests for assistance with the application can be submitted to PCG by electronic mail sent to our support email address, or by calling the toll-free number we will provide. Additional real time assistance will be provided through an on-line chat feature.

- Staffing – PCG will staff dedicated representatives that will handle the day-to-day operations as well as customer support.
- Hours of Operation – PCG's Technical Support and Customer Service will be open during business hours (EST), 8 hours per day, Monday through Friday. PCG's Technical Support and Customer Service will be closed on government and federal holidays.
- Request Recording – All incoming calls and emails for assistance are electronically logged and recorded, holding Help Desk representatives accountable to accurately document and appropriately respond to incoming queries.
- After-Hours Inquiries – PCG responds to after-hours inquiries immediately upon receiving the following day, including inquiries from e-mails and voicemails.
- Hearing Impaired Inquiries – PCG will offer TTY service for the hearing impaired.
- Foreign Language Inquiries – PCG will staff with bilingual, English and Spanish speaking representatives, to accommodate user language preferences.

Our experience in other states have shown that even if providers have actively engaged in pre go-live testing, the first few months after the go-live requires ongoing support. By leveraging our experience implementing applications in other states, PCG has developed an operations staffing approach that will ensure the support volume is properly managed.

The Technical Support and Customer Service Staff are responsible for the day-to-day operations and covers multiple functions, including but not limited to the following:

- Customer Support Staff will be the outward facing staff for facility interaction. These staff will have a thorough understanding of the application, and they will play a key role once the application is live in gaining buy-in, ownership, and commitment from facilities and other community stakeholders. In addition, Customer Support will maintain the toll-free number, support email inbox, and provide administrative support for reporting and issue tracking.

- Training Staff will provide ongoing provider and facility staff training, including on-site and webinar trainings. The training team will work very closely with Technical Support in order to identify patterns of support needs and focus training in a very skillful manner. They will be responsible for creating and maintaining the user and technical documentation, making updates as they are needed. If updates are made to any of the documentation it will be re-distributed to users and replaced on the application so the most current version of said document is always being used. Examples of documentation the training staff will provide is the application user guide, ANSI 837 companion guide, edit specifications, and more. The training staff will be available to provide training classes during pre and post implementation to ensure new staff members are always properly trained. The trainings can be tailored to the specific needs of the individual(s) being trained. DHHR staff will be offered the same opportunity for training and access to technical documentation. The training as well as documentation will provide information for DHHR staff to be able to utilize the maximum capabilities PCG's system offers them.

- Electronic Data Interchange (EDI) Staff manages all 837, 999, and 277 processes. This team will help support technical support to address any facility submission issues and concerns. This includes but is not limited to 837 file format assistance, 999 rejection errors, 837 file submissions and processing 277s.

- The Claims Editing and Auditing Staff are responsible for the on-going maintenance of the discharge data processing and grouper products to ensure the integrity and quality of all discharge data. This group of staff will be the experts in assisting providers with resolving claim- level errors and edits that need to be resolved and are up to date with billing and coding standards. In addition, the claims editing and auditing staff will be managing the utilization of the claim groupers and the quarterly

processes required to produce the various types of inpatient and eventually outpatient data extracts for DHHR.

Please refer to section 4.3.1 for more information on training.

4.3.1.3.1 Within 15 working days of the contract award, vendor SHALL provide WV DHHR staff with at least one on-site, hands-on training and provide user documentation and access to online resources such as help files and training videos that can be linked to on the HCA or other WV DHHR web sites.

PCG will provide WV DHHR staff with at least one on-site, hands on training at the location of their choice within 15 working days of the contract award. This training will cover the application to ensure DHHR staff is able to utilize the maximum capabilities that PCG's system has to offer. The provider user documentation as well as access to online resources will also be available at this time and presented to DHHR.

4.3.1.3.2 Within 15 working days of the contract award date vendor SHALL provide at least one live webinar for 70 data submitters and their representatives on topics related to file formats, data submission, editing, and coding and billing standards. Provide links that can be placed on the HCA or other WV DHHR web site to a video of the webinar or other training video that presents essentially the same material. Provide links to any other submitter specific documentation that is referenced in the training. A pre-recorded webinar must be available.

PCG will make available to all data submitters our published application documentation. PCG will provide at least one live webinar within 15 working days of the award of the contract for the 70 data submitters and their representatives. The training will allow PCG to directly communicate with the provider community and understand their perspectives regarding the transition and the application workflow. This webinar will include:

- File formats (837I, 999, 277)
- Process for submitting test files
- How to upload 837 files to the application
- How to review and correct claim errors
- Billing and coding standards
- General usage and navigation of the PCG application
- How to register a provider facility and set up users and roles

Once the provider trainings are completed, PCG will publish a preliminary environment for providers to submit and test 837 file submissions and provide the necessary help desk support staff to ensure that all questions from providers are answered in an efficient and responsive manner. This preliminary environment will imitate the post go-live production environment's 837 batch file submission process and edits and will allow the providers enough time to make the necessary changes to their 837 creating process to meet the requirements of the new application.

Recordings of these trainings will be available on PCG's application, WV DHHR's website, HCA website, and any other relevant sites for providers to review as needed. PCG will provide a pre-recorded webinar training prior to the live webinars that will also be available online.

4.3.1.4 Vendor SHALL make all training materials, including videos available to help desk staff to utilize in responding to user requests.

PCG will make all training materials available to any necessary internal staff that will be responding to and assisting application users. Members of the customer support staff will be responsible for creating, updating and maintaining the training materials, including videos, therefore they will be able to effectively respond to all user requests. We feel it is important that our help desk staff is involved with the documentation piece so they have a clear understanding of all components of the system. Please refer to section 4.3.1.3 for a more in-depth description of the customer support roles.

IV.3 Analytic Files [4.4]

4. MANDATORY REQUIREMENTS

IV.3 Analytic Files [4.4]

4.4.1 Vendor SHALL create and provide to DHHR weekly adjudicated analytic files containing submitted fields, appropriate groupers and adjustment factors, and other demographic, cost, clinical, and quality fields.

Public Consulting Group, Inc. (PCG) will provide the weekly adjudicate analytic files with at least the minimum data elements in the format prescribed by DHHR. These will be in some kind of text format, at the request of DHHR. These files can then be imported into DHHRs systems, currently Oracle and SAS. Each file will be generated weekly from our database and include all records and data fields submitted.

4.4.1.1 Vendor SHALL create and provide to DHHR, data file(s) containing all of the records and data elements submitted by hospitals, adjudicated records flagged for analysis, and processing and analytic fields created by the Vendor (including MDC, DRG, and other useful indicators of services, payment, cost, severity of illness, risk of mortality, intensity of service, and quality of care that will enhance DHHR analysis.

PCG will provide a data file that includes all of the data elements originally submitted by the hospitals as well as any additional desired fields created during the PCG processing cycle, PCG will use the MS-DRG Grouper, which will provide, weights, Major Diagnostic Category (MDC) and Diagnosis-Related Group (DRG). We would be happy to discuss the use of other groupers, as PCG has extensive experience using a number of 3M Groupers, such as Potentially Preventable Hospital Readmissions, APR-DRG, Population-Focused Preventables and EAPG (Enhance Ambulatory Patient Grouper).

Files can be made available via Secure File Transfer Protocol (SFTP). PCG will either arrange an SFTP site for DHHR's use, or PCG can place the files on an SFTP site under the control of DHHR, at DHHR's discretion.

4.4.1.2 Vendor SHALL deliver the file(s) to DHHR in a secure electronic format .PDF, .TXT or others as approved by DHHR and acceptable for import into the DHHR's then current operating environment.

PCG will work with DHHR to determine which file formats should be used for each kind of report/file transferred: Excel, CSV, PDF etc. PCG creates and delivers files to our clients in secure electronic formats continuously. We typically provide these using Secure File Transfer Protocol (SFTP).
PCG maintains SFTP sites for the use of PCG and our clients and partners. We can provide the data files using 128-bit SFTP encryption, where access to files is based on your SFTP user account. Files can be dropped in a folder that DHHR has appropriate permissions and DHHR can use an SFTP client to pick up the files. Alternatively, we can drop the files on a DHHR SFTP server for DHHR to pick up there; this is at DHHR's preference.

4.4.1.3 Vendor MUST maintain and provide to the HCA documentation, reference files, and data dictionaries detailing the contents of the data file(s) and any information necessary or useful for HCA in its review and analysis of the data, including but not limited to: a data

element frequency report; file layouts; load programs; code value definitions and labels; custom programming code; and descriptions of the methodologies related to the creation of the calculated fields added to the file(s) by the Vendor.

PCG understands that without proper documentation and reference materials a comprehensive system has little value. PCG will provide DHHR with the typical documentation, data dictionaries, and reference files that comprehensively cover our system including those prescribed above.

Please see Appendices B-F for some of the documentation we have provided for our New Jersey Client for whom we provide comparable services.

- Appendix B: NJ HealthCAP Implementation Guide
- Appendix C: NJ HealthCAP Data Dictionary and Extract File Layout
- Appendix D: NJ HealthCAP Edit Specifications
- Appendix E: NJ HealthCAP ANSI 837 Addendum Guide
- Appendix F: NJ HealthCAP Application User Guide (partial proprietary copy)

4.4.1.4 Vendor SHALL create and provide to the HCA, on a routine basis, new reports (current standard reports are described in the UB data request form available for download on the HCA website) from the analytic file(s) that summarize key utilization, access, cost ,and quality indicators, such as: patient days; case-mix; market share and service areas; and common DRGs/diagnoses/procedures by patient demographic characteristics, geographic region, and/or hospital. Propose a series of reports to be developed during the first project year. In subsequent project years, plan for three modifications to current reports and for the development of two new reports annually.

PCG will provide to the HCA three new reports the first year, and for each subsequent year PCG affirms that we will propose two new reports and three existing report modifications.
For the first year, we propose these three reports:

- DRG by hospital and gender/age range
- Procedures by hospital and gender/age range
- Average Patient Stay by hospital and gender/age range

PCG will work with the HCA to determine the exact formulation and methodology for each of these reports if they are acceptable to the HCA.

IV.4 Data Security and Privacy [4.5]

4. MANDATORY REQUIREMENTS

IV.4 Data Security and Privacy [4.5]

4.5.1 Vendor MUST implement administrative, physical, and technical safeguards to ensure the confidentiality, integrity and availability of all System data the Vendor creates, receives, maintains, or transmits, in accordance with federal and state laws and regulations, (including the HIPAA Security Rule, 45 CFR § 164.302), this contract, and DHHR policies.

Public Consulting Group, Inc. (PCG) is committed to safeguarding the privacy and confidentiality of customer and company information. Policies and standards issued by the PCG Information Security Office (InfoSec) have been written to assist in establishing and implementing PCG's information security program. These policies and standards were developed from careful examination and inclusion of National Institute of Standards and Technology (NIST) 800-53 (rev. 4), Health Insurance Portability and Accountability Act (HIPAA), Family Educational Rights and Privacy Act of 1974 (FERPA), and American Institute of Certified Public Accountants (AICPA) Attestation Standards, Section 101 Service Organization Control 2 (SOC2) controls. In addition, the policies and standards reflect international and federal laws, executive orders, directives, regulations, standards, and guidance.

These policies were approved by the Board of Directors and the effective and review dates are listed individually in each policy. Standards have been approved by the IT Committee.

PCG will take necessary steps to:

1. Assure appropriate protections and controls are developed and followed as defined in SOC II Type 2 guidelines.
2. Apply appropriate standards such as those outlined in NIST 800-53, FISMA, etc.
3. Comply with pertinent regulations (e.g. HIPAA, FERPA, AICPA) governing the access to protected data.

4.5.1.1 Within 30 working days, Vendor MUST comply with all HIPAA Security administrative safeguards, including: undertake a valid risk assessment and establish an effective risk management program for the System.

PCG has a Risk Management Plan (RMP) in place which documents the approach, procedures, and tools used to manage risk associated with the project. A risk is any factor that may potentially interfere with the scope, time, cost, or quality of the project and it is the recognition that a problem or opportunity might occur. When those problems, or risks are triggered, then they are referred to as issues.

PCG recognizes that unexpected things happen, and unforeseen events occur. The objective of PCG’s proven Risk and Issue Management strategy is to increase the impact of positive events and decrease the impact and probability of adverse events. As we have done for all other client projects, the PCG team will develop and document a Risk Management Plan that will include risk identification, analysis, response, and tracking processes. Regular internal risk meetings will be incorporated into our schedule. The plan will include the approach to identifying risk owners, and other roles required to ensure that a holistic and thorough approach to risk management, tracking, and reporting is adopted for this project. Perhaps the most important aspect of risk management is the active management of each and every risk; this ensures that all appropriate actions are taken to prevent a risk from occurring, mitigate its impact, or prevent it from becoming an issue.

This plan includes a comprehensive strategy and methodology for identifying, assessing, reporting, managing, and mitigating risks in all project periods. PCG's Risk Management Plan is designed in accordance with the Project Management Institute's Project Management Body of Knowledge risk management process criteria. Based on these criteria, the Risk Management Plan includes:

1. Risk identification methodology that identifies and classifies risks by severity, impact, and probability of occurrence.
2. Operational and system implementation risks, at both the agency and enterprise levels, including any that may pose a risk to the successful fulfillment of the contract.
3. Process for communicating and updating the State on project risks.
4. mitigation methodology, including examples of how the assessed risks will be managed, monitored, and how any new risks will be identified, assessed, tracked, and mitigated.

A risk item is a combination of project uncertainties, the probability of negative outcomes, and the possibility of adverse consequences as a result of those outcomes.

Risk management is the process of taking precautionary steps to address risk items. It assesses and controls risk items in order to maintain project performance and meet schedule and cost objectives.

4.5.1.1.2 Within 30 working days, implement procedures to regularly review records of information systems activity, such as audit logs, access reports, and security incident tracking reports.

PCG regularly audits access to its assets to ensure appropriate access levels are maintained. This process requires a dual review and re-approval of all accounts by the manager of the user and the owner of each asset. Any accounts for which access is rejected by the manager or owner are removed and that removal is documented through the access control process. Accounts that are found to have not been logged into for at least thirty days are also disabled through the access control process.

Accounts are also reviewed to ensure association with an active, individual member of PCG's workforce. Shared accounts are prohibited at PCG.

The logs of user activity within the system, including system access, are available to authorized user roles through standard audit reports found within the system.

All of these events are currently being logged on CloudTrail and stored on CloudWatch Logs. PCG also uses FIM (File Integrity Monitoring) tool to log and track file changes.

For security incident tracking reports, PCG ensures security incident response training is provided to each ITS operations employee during the onboarding process. Refresher training is required and provided to each ITS operations employee annually thereafter.

PCG develops and implements a security incident response plan. The incident response plan will include a Privacy Incident Response (PIR) Plan (related to PII) and will address all stages of incident response, including detection, analysis, containment, eradication, recovery and post-incident activity.

- To facilitate incident response operations, responsibility for incident handling operations are assigned to an incident response team. In the event that an incident occurs, the members of this team are charged with executing the incident response plan.

- Incident response plans are reviewed and, where applicable, revised on an annual basis. Upon completion of plan revision, updated plans are distributed to key stakeholders.

PCG tests the security incident response plan at least annually and makes improvements to the plan based on the results of the test.

4.5.1.1.3 Conduct security audits, at the request of DHHR or WVOT, to evaluate the appropriateness and effectiveness of policies and procedures for protection of privacy, confidentiality, and security of the System data, including an analysis of the mechanisms used for data transfer and storage. The audit may include a review of the networking and computer facilities used by the System, penetrating testing, or an active assault on the preliminary evaluation of basic data security issues; therefore, some sources of risk may only need to be evaluated categorically (i.e., significant vs. not significant). The frequency of reviews and updates is "within 365 days". The audit should be conducted by an external subcontractor with expertise in the field of data security. A report on the results of the security audit should contain at a minimum: effectiveness/ineffectiveness of current data security policy, and procedures, including receipt of data, storage, handling printouts, LAN access, remote access, staff knowledge and compliance, data transmission, an d loss control security risks not addressed in the report. If appropriate, the report should address how findings compared to standards relevant to general businesses that develop research files for the government. If significant data security risks are identified by the audit, the report should recommend measures by which such risks can be minimized. Additional audits may be required to assess new threats or to evaluate the effectiveness of remediation steps taken to resolve problems.

PCG conduct security audits annually, to evaluate the appropriateness and effectiveness of policies and procedures for protection of privacy, confidentiality, and security of the System data. PCG has strong mechanism to protect integrity of data used for data transfer and storage. The process for security audit and reports are listed as below.

Compliance

PCG promotes accountability, identifies and addresses gaps in compliance, and conducts regular compliance assessments. These assessments include both self-assessment procedures and assessment by third-parties to ensure compliance with established policies and standards. PCG recognizes that operational consistency is a cornerstone to a successful security program and strives to identify and remediate compliance gaps before they become security events that put PCG and its clients at risk.
Compliance gaps are identified through several mechanisms designed to examine the effectiveness of our security solutions, including regular collection of compliance metrics and review of audit logs and operational documentation. Compliance metrics comprise PCG's entire security program and intend to measure operational effectiveness of the designed security controls and identify areas where process or solution improvements are required. These metrics are designed to measure situations including, but not limited to, the following:

- Percentage of user accounts with access removed more than 48 hours after last day of employment (target: 0%)
- Percentage of user accounts with password not set to expire after 45 days (target: 0%)
- Percentage of computers with anti-virus agent installed, and computers with up-to-date anti-virus (target: 100%)
- Percentage of computers with latest patches installed (target 100%)
- Percentage of alert tickets that are acknowledged and handled appropriately (target: 100%)
- Percentage of staff with mandatory training completed within the past year (target: 100%)
- Percentage of network devices/applications set to send logs to logging tool for analysis (target: 100%)
- Percentage of changes to physical/logical access with an associated access request ticket (target: 100%)

PCG is evaluated at least annually by a third-party audit firm in good standing to validate the effectiveness of our security posture and all solutions in place. These evaluations compare PCG's security policies and

standards to its operational effectiveness to validate that documented actions are being performed as required. Additionally, the evaluations determine whether PCG is aligned with various assessment frameworks, such as SOC1 and SOC2. PCG's data centers and third-party IT service providers are subjected to annual external validation and auditing by a certified auditing firm in good standing. PCG maintains SOC 2 accreditation for our facilities and IT hosting providers. PCG participates in SOC2 Type II audits each year and maintains records of these attestations on file for review.

Upon contract award, PCG can share these audit reports or summaries with the State, however, we will require that an NDA must be signed.

Documentation

Significant investment has been made to create consistent documentation for both security governance and operations. PCG has developed a comprehensive set of information security policies and standards that align with appropriate regulations, standards, and other guidance, such as with NIST SP 800-53 rev. 4 and ISO 27001. These policies are critical to maintaining the appropriate level of emphasis on the security of our company and our clients. Operational documentation, including procedures and best practice documents, has also been created to ensure that operations are consistent and effective at maintaining the security controls that PCG has implemented.

PCG's policies and standards are classified as 'Sensitive' and cannot be shared with external parties without a Non-Disclosure Agreement (NDA) in place. PCG operates in a number of different industries and the policies do not provide a full picture of the security posture of our company. They additionally contain information that could compromise the security of our solutions that protect our data and data entrusted to us by our clients. Instead of providing policies as requested, we can provide a list of all policies along with a summary of what each contains. The full text of our policies can be made available for review following the signing of confidentiality agreements or the inclusion of appropriate confidentiality provisions upon reward of a contract.

Scope of Policies and Standards

PCG policies and standards reflect our commitment to information security and the degree by which we take the responsibility for security seriously. Our standards are built and independently tested through an annual SOC 2 Type II assessment conducted by an external auditing firm. These policies and standards govern all PCG business operations, data centers, users, and offices. Our hosting-related standards are currently specific to PCG data centers and do not include Amazon Web Services (AWS) or other cloud providers. AWS (and other cloud providers) provides their own SOC 2 Type II and FedRAMP compliance reports on their website that compliment PCG's SOC 2 Type II and security posture.

Audit and Logging

PCG utilizes multiple tools for log aggregation, including centralized log gathering and correlation with monitoring and alerting tools. These systems are monitored by a combination of internal resources and Alert Logic ActiveWatch, a third-party managed security service provider that delivers actionable intelligence for event remediation.

Whenever technically feasible, PCG's infrastructure systems feed log data into Alert Logic's Log Manager correlation engine that aggregates data and applies the logs to correlate events across multiple data feeds. This correlation applies not only to all of PCG's data feeds, but across data feeds that are fed to the engine from all clients making use of the Alert Logic tool. All logs and the correlation data are monitored 24/7 by the Security Operations Center, which is responsible for notifying the PCG Information Security Technical Services Team within 15 minutes of identifying any security events requiring additional investigation.

All of PCG's critical infrastructure generates logs whenever any of the following activities are requested to be performed by the system:

- Create, read, update, or delete confidential information
- Authentication events

- Privileged access activity Detection of suspicious/malicious activity such as from an Intrusion Detection/Intrusion Prevention System (IDS/IPS), anti-virus system, or anti-spyware system
- Grant, modify, or revoke access rights, including:
  - Adding a new user or group
  - Changing user privilege levels
  - Changing file permissions
  - Changing database object permissions
  - Changing firewall rules
  - User password changes
- System, network, or services configuration changes including installation of software patches and updates or other installed software changes

Log data is stored offsite to ensure it can be accessed in the case of an emergency/disaster scenario. It is preserved according to our data retention policy and can be used to investigate and audit specific events whenever necessary.

4.5.1.1.4 Have security policies and procedures in place for Vendor staff, which include appropriate sanctions for staff that act contrary to such policies and procedures. Implement a security awareness and training program for all members of the vendor workforce. The State may require that a vendor provide evidence of adequate background checks., including a nationwide record search, for individuals who are entrusted by the vendor to work with state information. Significant and substantive changes need to be submitted as far in advance as reasonably possible for DHHR consideration. It is possible that we (DHHR) may have to forward any proposed changes to our federal regulators for review and authorization at least 45-days in advance of implementation to production environments. DHHR will have to follow appropriate reporting methods for each federal agency as appropriate. Typical project status updates and reports take place weekly under normal circumstances. In times of urgency or emergency, reporting would take place immediately, but not to exceed one hour.

PCG has a security awareness and training program for all the employees, contractors and third parties, with access to PCG assets like information system, facilities and data. PCG also conduct the background checks for its above stated members. PCG agree to assist in DHHR communications with federal agencies within the stated timeline.

As per PCG Security Awareness Policy, PCG has deployed a training suite that was designed by Inspired eLearning, an external market-leading provider of security training recognized for adherence to security standards. The trainings are customized to include additional PCG-specific security training content and are updated annually by Inspired eLearning to reflect required changes to regulations or the security climate. Everyone in the PCG workforce is required to complete three trainings on an annual basis: Basic Security Training, Advanced Security Training, and HIPAA Training for Covered Entities. Although PCG is not always a “Covered Entity” as defined by HIPAA, we default to the higher training requirement to ensure the ability of our workforce to effectively recognize and address security situations that may arise.
The security training suite was developed to include the following types of content in order to accommodate various learning styles:

- Practical exercises in security and privacy awareness training that simulate actual cyber-attacks.
- Recognizing and reporting potential indicators of an insider threat.
- Practical exercises in security and privacy training that reinforce training objectives.
- Recognizing suspicious communications and anomalous behavior on PCG's information systems.

In addition to the required training suite, PCG’s Information Security team has implemented a comprehensive awareness program that spans all areas of security. The team regularly interacts with the PCG workforce to ensure security awareness through a number of avenues, including simulations of

security events, informational newsletters and marketing materials, and in-person site visits to a myriad of PCG office locations.

PCG Security Awareness and Training Policy, Scope Section indicates that this policy applies to anyone, including but not limited to employees, contractors and third parties, with access to PCG assets, such as information systems, facilities, and data. This PCG policy enforces the following PCG requirements:

1. All employees participate in security and privacy awareness training within thirty days of starting work and within thirty days of the annual anniversary of the training completion date thereafter.
2. Retraining shall occur sooner if there are material changes in security requirements or whenever PCG determines necessary to ensure firm-wide security awareness.
3. Training is completed by employee prior to them receiving any access to Protected Health Information (PHI).
4. PCG's security and privacy training ensures that all PCG employees understand their security and privacy responsibilities.
5. All PCG employees participate in security training within 30 days of starting work and on an annual basis thereafter.
6. Retraining shall occur sooner if there are material changes in security requirements or whenever PCG determines necessary to ensure firm-wide security awareness".
7. PCG's security and privacy training ensures that all PCG employees understand their security and privacy responsibilities. The organization provides role-based security-related training to personnel with assigned security roles and responsibilities.
8. All PCG employees participate in HIPAA training within 30 days of starting work and on an annual basis thereafter.
9. Retraining shall occur sooner if there are material changes in HIPAA requirements or whenever PCG determines necessary to ensure compliance with HIPAA requirements.
10. Training is completed by employee prior to them receiving any access to Protected Health Information (PHI).

4.5.1.1.5 Establish emergency/backup/disaster plans and contingencies for the System. Within 30 days of contract award, DHHR should receive copies and reserve the right to request changes.

PCG's has developed a comprehensive Disaster Recovery and Business Continuity Plan that addresses our technology infrastructure during disaster. Copies of the plan will be made available to DHHR within 30 days of contract award.

Disaster Recovery

PCG's Disaster Recovery Plans are designed to provide immediate response and subsequent recovery from any unplanned computing services interruption, such as loss of utility services, building evacuation, or a catastrophic event at the PCG data centers. Disaster Recovery Plans are tested annually (in both failover directions) and adapted as necessary to better ensure efficiency and success in meeting required Recovery Point Objectives (RPO) and Recovery Time Objectives (RTO). PCG has identified its RPO as requiring that systems are recovered to no earlier than the night prior to the disaster occurrence, and its RTO as being no more than 72 hours, unless otherwise required by client contract. As testing determines areas for improvement, the plans are updated to reflect any required changes.

Application Recovery

The Application Recovery Plans would be invoked once the Disaster Recovery Plan has been executed to a point where supporting infrastructure services have been recovered. These plans prioritize recovery of each application based on client Service Level Agreements in order to minimize client impact and/or downtime.

Emergency Action Plans

Emergency Action Plans are in place for each of the fifty-plus PCG offices in the United States and Canada to not only ensure the safety of our personnel, but also to minimize client impact if an office cannot be used following an emergency (such as major storms, etc.). Emergency Action Plans provide a strategy for each office to continue with business operations as normally as possible during an emergency event. The strategy invoked in each plan differs depending on the types of services offered in each office but may require employees to work remotely or to work from another PCG office location until normal business operations can be resumed.

Backup and Recovery

PCG utilizes a backup methodology to protect critical systems from failure by providing recovery options in the event of a data loss. This process is centrally managed and covers all of our North American locations. A copy of the backup data exists in our CommVault backup solution in our data centers. We use Iron Mountain to regularly remove our encrypted backup tapes to store remotely so that their storage location is not impacted if a data center is lost in a disaster.

4.5.2 Vendor MUST comply with all HIPAA Security physical safeguards, including the establishment of adequate Vendor facility access controls and device and media controls.

Data Center Hosting

PCG data and equipment is hosted at our two data centers, one in Watertown MA and other in Austin, TX.. The hosting centers are designed to withstand disastrous conditions pertinent to their locations to ensure our systems and equipment won't go down under extreme conditions and to allow for continued 24/7 operation of PCG's critical systems.

PCG's systems are also hosted by AWS, who is responsible for control of the system beyond the physical components PCG maintains. AWS User access privileges are restricted based on business need and job responsibilities. AWS employs the concept of least privilege, allowing only the necessary access for users to accomplish their job function.

PCG also leverages 3rd party cloud hosting solutions when applicable and those physical and environmental protections are covered under their SOC-1 and SOC-2 policies and standards.

PCG's data centers are SSAE 16/SOC certified, and feature many layered solutions to keep the environment secure, including, but not limited to, the following:

Physical Features

- Equipped with racks and cages to host equipment in secure in a secure environment
- Built on a raised floor to accommodate cabling and special wiring
- Temperature- and humidity- controlled environment
- Fault-tolerant design of cooling towers, water pumps and chillers
- Multiple air handling units to provide another level of redundancy
- Cooling units maintain uniform 72°F and 50% relative humidity levels

Disaster Readiness Features

- Fire detection and suppression systems
- Dual fire detection (photo-electronic ionization and sniffer) systems
- Central fire alarm system notification with a direct alarm to the local fire department

Connectivity Features

- Equipped to provide our system's Internet Protocol (IP) connectivity to our ISP's fiber network
- Built-in redundancy through router and switch configuration of the LAN design

- Dual ports from unique switches
- Scalability through 10 Mbps to 1000 Mbps bandwidth ports

Power System Features

- Dual power availability to each rack unit from independent power distribution units (PDUs), eliminating PDU loss as a single point of failure
- Redundant N+1 design of uninterruptible power supplies
- Redundant stand-by generator power supplies, to be used in the event of a commercial power feed failure

Data Center Access

Physical access to PCG's data centers is protected from unauthorized access by use of key cards or a 2-factor- authenticated man-trap (e.g., card-key, biometric scan), depending on location. Access authorization forms must be completed and authorized by management in order for any new employee to obtain an access badge to the data center facilities. Guest access is controlled via a formal request to the facility by authorized personnel and all guests must be escorted by PCG or facility staff at all times. Access to both data center facilities is revoked within 2 hours upon termination of an employee. The complete list of those with access to either/both data centers is reviewed on at least a quarterly basis to ensure all access is still valid and authorized.

PCG staff does not have access to 3rd party cloud hosting datacenters.

Local Site Office Physical Access

PCG uses a centralized badging system to ensure proper employee identification and access control throughout its facilities. Physical access at all facilities is granted through a role-based access model that designates appropriate access based on a matrix including facility zone (e.g. public, sensitive, operational), role (e.g., customer service, IT) and badge type (e.g. employee, contractor). Access is granted based on the least-privilege model and is reviewed on a quarterly basis for every office to ensure only those with continued business need have access to specific locations.

The centralized badging system additionally maintains audit logs for all PCG site access to allow for review both for inconsistencies and upon occurrence of suspected unauthorized access.

Physical Security

A number of physical security controls, in addition to physical access, are implemented at PCG. All PCG-owned or operated facilities use documented facility classification levels and zones to implement and maintain applicable physical security controls, processes, and procedures. In every office, physical zone designations are visible to indicate changes between zone types, for example between operational and sensitive areas.

PCG has a thorough clean desk policy that requires staff to maintain a clean desk whenever they are not physically present. This includes putting any sensitive materials into lockable storage, keeping work areas free of confidential information, and using privacy screen filters. It additionally requires that all PCG staff maintain physical control of laptops/notebooks whenever they are transported outside of the secured office environment.

Additional physical security controls include, but are not limited to:

1. Configuration of doors to close automatically
2. Marked "Exit Only" doors to prohibit re-entry
3. Configuration of desks and workstations to face away from windows at ground-level floors
4. Prohibiting usage of cameras and recording devices in Sensitive Areas
5. Requirement for any visitors that enter a PCG facility to fill out a Visitor's Log that records their name, host's name, date/time of arrival, and visitor badge number. Upon leaving the facility, the visitor must fill out date/time of departure

6. Dissemination of emergency action plans, including evacuation routes to use in the event of an emergency situation or power outage

Local Site Office Environmental Control

PCG provides protection against physical and environmental events that may cause disruption, damage, or destruction to PCG owned or operated facilities and sensitive information. Every PCG-owned or operated facility features automatic emergency lighting, known and easily accessible master shutoff or isolation valves for water systems, and automatic fire detection or suppression systems supported by an independent energy source.

PCG equipment/server rooms are dedicated spaces that cannot be used for other purposes. Every equipment room has protections in place, such as short-term backup power, dedicated HVAC systems, and 24/7 monitoring of all equipment rooms for power failure, HVAC alarms, and over-temperature conditions.

4.5.3.1 Vendor MUST comply with all HIPAA Security technical safeguards, including: Secure and appropriate authentication of all users of the data immediately, but no longer than one hour, upon initial receipt of request.

PCG does comply with all HIPPA security technical safeguard to secure and appropriate authentication of all users who access the data immediately and meet with requirement within the given timeframes required.

PCG is a service provider often responsible for handling sensitive data, and we are committed to safeguarding security, privacy and appropriate authentication of all users accessing the data.
PCG systems use a role-based access control system to grant access to data and systems for authorized users. All users are assigned a role (i.e., user type) as part of the account provisioning process. Access to data within the systems is restricted to just those areas to which a user's role has been authorized.
The system also incorporates the principle of least privilege to ensure that each role is granted the minimum acceptable access for the associated job function. Roles are based on the typical tiers of administrator rights, change/modify rights, and read only rights, although they may vary by system depending on the type of data or intended use of the system. The role-based access system also ensures separation of duties and requires that administrators use separate privileged and non-privileged accounts for administrative and non-administrative activities, respectively. Administrative account activity is logged and reviewed for anomalies and accounts are created, where technically feasible, with traceability to an individual.

PCG information systems automatically terminate a user session after 15 minutes of inactivity and shall retain the session lock until the user re-establishes access using appropriate identification and authentication procedures. PCG enforces a limit of five consecutive invalid logon attempts by a user during a 15-minute period.

PCG systems are developed around National Institute of Standards and Technology (NIST) and Medicaid Information Technology Architecture (MITA) guidelines. These guidelines lay out the necessary security frameworks needed to fulfill the major health information technology-related state and federal regulations, including:

- Health Insurance Portability and Accountability Act (HIPAA)
- Health Information Technology for Economic and Clinical Health (HITECH)
- Family Educational Rights and Privacy Act of 1974 (FERPA)

PCG remains committed to maintaining strict security and confidentiality standards. PCG will securely handle and store sensitive participant and provider information in accordance with HIPAA requirements, including the HITECH Act amendments. PCG's resources are compliant with industry standard physical and procedural safeguards (NIST SP 800-114, NIST SP 800-66, NIST 800-53A, ISO 17788, etc.) for confidential information (HITECH, 45 CFR Part 164).

At PCG, all development and production systems are secured in the data center. Only authorized PCG personnel are allowed access to the data center. All personnel must show ID and sign into the data center log at the security desk. Only PCG staff members whose names are on an authorized and approved list maintained by the data center security office can gain access to the data center. PCG also implements controls in information systems to limit access to only those individuals with both a need and right to have access. All other access is prohibited.

A key tenet of Information Security is the use of Authentication, Authorization, and Accounting (AAA) to control access to resources. PCG has implemented tools that allow for the use of AAA for access control so that network devices and other PCG assets are accessed securely, accounts are used as intended, and all activity is logged as it is performed. These tools require multi-factor authentication for VPN connection.

Multi-Factor Authentication

At a minimum, PCG ensures use of single-factor authentication for accessing systems classified as containing information that is not for public consumption. No anonymous access to these resources is permitted.

For remote access, PCG's information systems use multi-factor authentication to uniquely identify and authenticate users. Multi-factor authentication at PCG is employed using at least one factor is provided by a device separate from the system gaining access. PCG's multi-factor authentication solution is token-based, meaning that a user must have a username and strong password in order to start the authentication process, and they must also have access to a soft token (on their phone or computer) that provides a new unique number regularly to ensure that the account is being used only by the person with that token.

Password Management

User security for PCG systems and applications is based on the use of usernames and passwords. A unique 'SessionID' is established and used with each subsequent request. Further, a VerifyCode is used to prevent the URL from being passed between users. Additional security precautions for software applications to protect PHI and PII may include the following:

- ✓ Industry standard and flexibly configured password strength requirements:
  - Passwords must not contain the user's account name.
  - Passwords must contain a minimum of eight characters.
  - Passwords must contain characters from three of the following categories:
  - Uppercase letters of European languages
  - Lowercase letters of European languages
  - Base 10 digits (0 through 9)
  - Special characters (e.g. !, @, $, #, %, &)
  - Any Unicode character defined as an alphabetic character but is not uppercase or lowercase.
- ✓ Prevention of reusing four most recent passwords
- ✓ Requirement to change password at least every 45 days
- ✓ Lock-out after five unsuccessful authentication attempts
- ✓ Login and group disable capability
- ✓ User session time-out
- ✓ Encrypted storage of user credentials
- ✓ Encryption of passwords using a one-way hashing algorithm which prevents queries or reports from including usable account information

User accounts are provisioned with specific access; these methods are used to restrict a particular user to see only the data to which they have been granted access. Additional application-specific security precautions may include:

- ✓ Lexicon to protect against the use of "at risk" password values
- ✓ Multi-tier user identification

- ✓ Session-based IP Address revalidation. This check can be disabled if you are behind a firewall that periodically changes the apparent IP Address for a user.
- ✓ Multi-login controls—particularly against logging in simultaneously from multiple locations. The application may also be configured to authenticate the user with a remote authentication authority using several different methods, including LDAP / Active Directory, RADIUS, OpenID, and/or other customer-specific systems. When authenticated remotely, the user account in the application will not contain a password.

PCG applications are also hosted on AWS. PCG ensures that information systems uniquely identify and authenticate organizational users (or processes acting on behalf of organizational users) for local and remote access. Also, the AWS Identity and Access Management (AWS IAM) enables users to securely control access to AWS services and resources. AWS IAM provides the creation and management of AWS resource users and enables granting access to AWS resources for users managed outside of AWS in a corporate directory. AWS IAM offers greater security and control when using AWS.

PCG has AWS multi-factor authentication (MFA) implemented. PCG staff with privileged accounts can only access to the System via VPN which uses MFA, as well. Finally, PCG ensures that information systems implement multifactor authentication for local access to privileged and administrative accounts.

At the application level, PCG's uses multi-factor authentication to prevent unauthorized access. First, PCG "whitelists" agency IP addresses for system access to ensure only approved IPs are able to view and access the system's login page. Second, PCG requires authorized users to login to the system using NIST-based username and password requirements.

4.5.3.2 Vendor MUST comply with all HIPAA Security technical safeguards, including: Support role-based access to data.

PCG systems use a role-based access control system to grant access to data and systems for authorized users. All users are assigned a role (i.e., user type) as part of the account provisioning process. Access to data within the systems is restricted to just those areas to which a user's role has been authorized.

In addition to access and permission controls, the role-based system also defines which roles have the capability to add and/or modify the defined roles (i.e., access administration). The system also incorporates the principle of least privilege to ensure that each role is granted the minimum acceptable access for the associated job function. Roles are based on the typical tiers of administrator rights, change/modify rights, and read-only rights, although they may vary by system depending on the type of data or intended use of the system.

The role-based access system also ensures separation of duties and requires that administrators use separate privileged and non-privileged accounts for administrative and non-administrative activities, respectively. Administrative account activity is logged and reviewed for anomalies and accounts are created, where technically feasible, with traceability to an individual.

4.5.3.3 Vendor MUST comply with all HIPAA Security technical safeguards, including: Incorporate and employ an effective and efficient audit mechanism for tracking access to System data, including the preparation, update, and maintenance of audit logs.

PCG incorporate and employ an effective and efficient audit mechanism for tracking access of all its employees, contractors to the system data, PCG regularly prepare, update and maintain all the audit logs. PCG Audit and Accountability policy describes the PCG audit mechanism as stated below.

Audit logs recording user activities, exceptions, and information security events are necessary to detect and audit unauthorized access. The Audit and Accountability policy is to ensure all appropriate record auditable events that are required by state and federal laws are being followed.

PCG policy promotes accountability, identifies and addresses gaps in privacy compliance, and conducts regular internal assessments (self-assessments or third-party assessments on compliance gaps).

PCG ensures audit logs recording user and administrator activities, exceptions, and information security events designed to detect, and audit unauthorized information processing activities have been implemented and maintained.

PCG defines, reviews, and maintains a list of audited events (e.g., VPN access from non-PCG locations). Logs of these events are reviewed when required.

PCG generates audit records including, but not limited to, the following information:

- Time stamps
- Source and destination addresses
- User/process identifiers
- Event descriptions
- Success/fail indications
- Filenames involved
- Access control rules invoked
- Events of success or failure to event-specific results

PCG implements a tool to integrate audit review, analysis, and reporting to support organizational processes for investigation and response to suspicious activities and audit requests.

PCG analyzes and correlates audit records across different repositories throughout PCG to gain enterprise-wide situational awareness.

PCG employs defined measures to ensure that long-term audit records generated by the information system can be retrieved per the Legal Record Retention and Destruction Policy.

PCG ensures only a subset of privileged users are authorized to access audit management functionality and separation of duties is adhered to for this implementation.

PCG ensures the audit system has the capability to off-load audit records onto a different system/medium than the system being audited.

PCG ensures that the auditing system time stamps are synchronized with an authoritative time source as defined in PCG Hardened Systems Standard.

4.5.3.4 / 4.5.3.5 Vendor MUST comply with all HIPAA Security technical safeguards, including: Provide for automatic notification of certain non-routine or unscheduled access of System data to designated personnel, as appropriate.

In PCG, procedures are in place to regularly monitor the Information Security Program to ensure that it is operating in a manner reasonably calculated to prevent unauthorized access to or unauthorized use of confidential data and for escalating it as necessary. The monitoring shall include internal reviews by the Information Security Officer, annual SSAE 16 SOC I and SOC II audits and annual penetration/vulnerability testing. PCG comply with all the HIPPA security technical safeguard, to provide automatic notification of

any certain non-routine or unscheduled access of system data to designated personnel as listed in PCG Incident Response plan.

Events may be identified by almost anyone within PCG and could be reported through many communications channels within PCG. All of the PCG systems feed their data (over 100GB of data processed daily) to the SOC, which actively monitors the feeds 24/7 and notifies PCG's Security Operations Team within 15 minutes of identifying an event that requires additional investigation.

As an example of how the Incident Response Plan expects the lifecycle of an event to play out, here are the process steps that would occur when an event is identified by someone working on behalf of PCG:

1. Event is identified by PCG staff member, who contacts the Service Desk to report it.
2. The Service Desk contacts the ITS Operations Team and they conduct an initial investigation.
3. If the ITS Operations Team believes that the event may be a security incident, the Security Operations Team and Security Operations Manager are contacted via the incident escalation process.
4. The Security Operations Manager either confirms or denies that the event is an actual incident.
5. If the event is determined to be an incident, the Security Operations Manager opens cross-team communications with the ITS Operations Team and other teams at PCG, as required, to begin incident resolution. These communication lines remain open until the incident has been resolved or remediated.
6. The Security Operations Manager also contacts the Chief Information Security Officer, who opens communication with the Corporate Technology Executive Team, as appropriate, to determine next steps for action and communications.

4.5.3.6 Vendor MUST comply with all HIPAA Security technical safeguards, including: Employ systemic mechanisms, including anti-virus and intrusion detection software, to ensure the integrity of data from improper alteration and destruction, and to corroborate the data's ongoing integrity, in compliance with HIPAA.

PCG meets this requirement through our Malicious Code Protection Policy that employs or requires malicious code protection mechanisms at Network entry and exit points; end user compute devices including laptops, tablets, desktops, and mobile devices; all servers and server operating systems. All systems or services that directly receive external data from non PCG systems (e.g. email, FTP, etc.), and all systems (PCG-owned or otherwise) that access internal PCG networks.

PCG updates malicious code protection mechanisms (e.g., anti-virus signature definitions and reputation-based protection mechanisms) whenever new releases are available in accordance with PCG configuration management policy and procedures.

PCG configures malicious code protection mechanisms to:

- Perform checks as files are downloaded, opened, or executed
- Block or quarantine malicious code and notify an appropriate party in response to malicious code detection

Three types of malware detection and prevention are used at PCG:

1. PCG servers use Microsoft (MS) Systems Center Endpoint Protection (SCEP) to prevent and detect malware. The endpoint security client contains, eradicates, and/or quarantines infections.
2. PCG workstations use McAfee Endpoint Security Client or MS SCEP to prevent and detect malware. The endpoint security client contains, eradicates, and/or quarantines infections.
3. FireEye is installed on the PCG network to inspect all ingress/egress internet traffic for malware. Infections are contained or eradicated.

PCG utilizes Alert Logic's Threat Manager and FireEye's industry-leading intrusion detection systems (IDS), which provide near real-time visibility and analysis of the traffic on PCG's network. A content inspection area is used to analyze all traffic going to and from critical systems on the network. FireEye has the capability to detect multi-flow, multi-stage, zero-day, polymorphic, ransomware and other advanced attacks. These tools are also set to prevent callbacks for malware that may exist within the PCG network, causing the malware to be rendered useless as it cannot reach back to its host. All events that are detected by these tools are tied into the logging software also used by PCG, so that PCG's Security Operations Team is alerted when an event is detected that requires further investigation. The 24/7 Security Operations Center is also able to use the data from the IDS to analyze known threats in real-time when patterns of malicious activity or other anomalous traffic are observed.

4.5.4 Vendor SHALL ensure that data maintained on behalf of the system is not used, released, or sold without the specific authorization of DHHR, regardless of whether the data has been de-identified or included within a limited data set.

PCG agrees with this requirement, and thorough Data Classification Policy and Standard has been developed to ensure the appropriateness of controls in place as data travels within and outside of our network. Due to the nature of our business, most of the data that PCG handles is confidential or sensitive in nature. The Data Classification Policy clearly states that uncategorized data needs to assume the highest level of classification (confidential) and handled as appropriate for that level.

All data at PCG is assigned one of the following classifications: Public, Internal/Sensitive, or Confidential/Restricted. Documents or collections of data that contain multiple classifications of data are classified at the most secure classification level of any individual piece of information.

- All documentation and removable media that includes information or data is appropriately labeled:
  - Data or information stored on removable media must state the data classification on the removable media label.
  - Documentation is formatted to include a header/footer to indicate the classification of the information contained in the document. Proper formatting and labeling is outlined in the "Documentation Standard."

- Data at PCG may be shared or modified within the restrictions outlined below.
  - Public data may be disclosed without reservation but is protected from unauthorized modification.
  - Sensitive/Internal data is never shared externally with any third party without prior authorization from PCG Governance, Risk and Compliance or PCG Information Security. A signed contract and/or Non-Disclosure Agreement (NDA) may be required prior to sharing this information externally. This data is acceptable to share internally with all PCG employees who have a business reason for access but is protected from unauthorized modification.
  - Confidential/Restricted data is never shared externally without prior authorization from PCG Information Security or with any third party, unless a signed contract or NDA is in place between PCG and the third party. This data is only shared internally with those who have the appropriate access permissions and approved business justification. Confidential data is never used for testing and is protected from unauthorized modification.

All non-production data at PCG is de-identified/sanitized prior to usage in test or development systems so that it can no longer identify an individual. This helps to ensure the security of any confidential or sensitive personal information stored by PCG because it doesn't allow for unauthorized or accidental consumption of data by people with access to development/test environments who may not have that same access to production data.

4.5.5 Vendor SHALL implement appropriate notification procedures upon the discovery or suspicion of a breach of security of System data.

PCG has appropriate notification procedure in place upon the discovery or suspicion of a breach of security of system data, PCG employees are required to immediately report any suspected breach of confidential information or security to the Information Security team and to the GRC Officer for immediate investigation. If a breach is confirmed, PCG will notify the owner of the data and will take appropriate steps to correct the problem and to mitigate any harm. In the case of a security breach or incident, PCG staff will refer to the Incident Management Plan. This document contains the appropriate steps required to document actions and communication taken in connection with a breach, as well as to conduct the post-incident review of the events and the actions taken to improve security.

If it is determined that protected health information (PHI) or personally identifiable information (PII) has been accessed without authorization, the Information Security Operations Manager will notify the State contract administrator, the Office of Consumer Affairs & Business Regulation (OCABR), and the Attorney General's Office (as appropriate), describing the theft in detail, and working with authorities to investigate the crime and to protect the victim's identity. To the extent possible, PCG will also warn the victims of the theft so that they can take actions to protect their credit and identity.

PCG send notifications to appropriate parties in case of breach as indicated in our Incident Management Plan. The incident life cycle indicates what kind of breach will require what type of notification and resolution.

4.5.6 Vendor SHALL review and revise policies and procedures to ensure data security and privacy are in accordance with then current federal and state laws, and DHHR standards and policies.

PCG reviews and revises all the security policies and procedures at least annually. These policies and standards are careful examined with inclusion of National Institute of Standards and Technology (NIST) 800-53 (rev. 4), Health Insurance Portability and Accountability Act (HIPAA), Family Educational Rights and Privacy Act of 1974 (FERPA), and American Institute of Certified Public Accountants (AICPA) Attestation Standards, Section 101 Service Organization Control 2 (SOC2) controls. In addition, the policies and standards reflect international and federal laws, executive orders, directives, regulations, standards, and guidance.

4.5.7 The vendor SHALL certify that it is not currently under investigation by any state or federal authority for a breach of data security.

PCG certifies that is not currently under investigation by any state or federal authority for a breach of data security.

4.5.8 The vendor MUST disclose whether it has been involved in any breach of data security, and provide details relating to the causes of the breach, the mitigating actions taken in response to the breach, and whether notification of affected consumers was undertaken.

PCG does not have any information to disclose regarding involvement in any breach of data security.

4.5.9 The vendor MUST disclose details of any previous investigations by any state or federal authority related to privacy or security of patient information. The details must include the resulting corrective action plan or details of the final resolution, including the assessment of any fines or other sanctions against the vendor.

PCG does not have any information to disclose regarding any previous investigations by any state or federal authority related to privacy or security of patient information.

4.5.10 The vendor MUST certify that it has never been convicted of, charged with, or is under investigation for, violation of any criminal law, or violation of any civil law governing health care fraud, abuse, or waste.

PCG certifies that it has never been convicted of, charged with, or under investigation for violation of any criminal law. As to civil laws relating to health care fraud, waste, or abuse, PCG is cooperating in a federal civil investigation relating to its work for the State of New Jersey on behalf of New Jersey school districts, concerning Medicaid reimbursements for services the schools provided to special education students.

4.5.11 The vendor MUST certify that it does not employ any individuals who have been excluded or debarred by the federal or any state government from participating in any federal or state program or contract.

PCG certifies that it does not employ any individuals who have been excluded or debarred by the federal or any state government from participating in any federal or state program or contract.

IV.5 Project Management [4.6]

4. MANDATORY REQUIREMENTS

IV.5 Project Management [4.6]

4.6.1 Vendor MUST provide project management, consulting, analysis, and reporting services to ensure successful project implementation.

Public Consulting Group, Inc. (PCG) has extensive experience in project management, consulting, analysis, and reporting services required by this RFQ. For example, we are actively performing each of these services for our New Jersey Data Intermediary Services project which is highly comparable in scope and function to what is required by this RFQ. Each of these services are considered a core function for PCG projects of this nature and scope, which are more fully described in other sections of our proposal. In the section below, we provide you with background material on our project management methodologies and best practice approaches that have served both PCG and our clients well to in ensuring project timelines are met, communication is clear, and the quality of our work is unmatched.

Project Management Methodology

PCG Health understands that our projects involve many moving parts and sensitive timelines. Each project in our portfolio is assigned a project manager, who is assisted in their efforts by PCG Health's Project Management Office (PMO) throughout the project life cycle—Initiating, Planning, Executing, and Closing. Mr. Rick Dwyer has been assigned to as the project manager for this engagement. Mr. Dwyer will be overseeing the project schedule and budget as well as coordinating the activities of all participants (both internal and external) to ensure satisfactory communication and collaboration through-out the project. He brings prior experience working with large scale data intermediary projects, including being the project manager for the successful implementation of the New Jersey Data Intermediary project.

PMO Governance and Support

The PMO works with PCG Health's project managers as a third-party source of project management expertise and quality assurance, ensuring that Project Management Institute (PMI) standards are followed in all projects we undertake. The PMO abides by the project management processes and terminology laid out in the PMI's Project Management Body of Knowledge (PMBOK®) Guide. The PMO is led by PMI Project Management Professional (PMP)-certified employees with over a decade of previous project management experience.

Each project manager is required to draft certain project management documents in collaboration with the PMO as part of the project planning process. The PMO performs a needs assessment at the beginning of the project life cycle to determine the level of documentation needed to adequately address the project's requirements. These same processes will be used on this engagement, and we are confident that the project will be managed to the highest standard.

Training

PCG instills a project management culture in our employees from the start. Our junior-level hires attend a project management fundamentals course taught by PMI-certified PMPs as a core requirement. This project management education is further advanced through everyday project work, as PCG's senior project managers mentor junior staff through project management basics.

PCG encourages employees to acquire the PMP certification, and currently has many PMPs on staff to manage projects. Additionally, every employee has access to self-guided project management courses on Skillport, our internal training application. These tools allow project managers to receive just-in-time training whenever necessary. In short, all PCG project managers are supported by internal processes and practice area-level oversight, ensuring that projects are managed efficiently and with a standard level of documentation.

Project Management Life Cycle

PCG Health manages each project according to the PMBOK® Project Management Process, which defines the project life cycle in five phases: Initiating, Planning, Executing, Monitoring and Controlling, and Closing (depicted below). PCG will follow specific steps and create or monitor certain documents during each of these phases in order to ensure the project is efficiently managed.

The PMO will provide project management support and expertise to the project team during all five phases of the project life cycle.

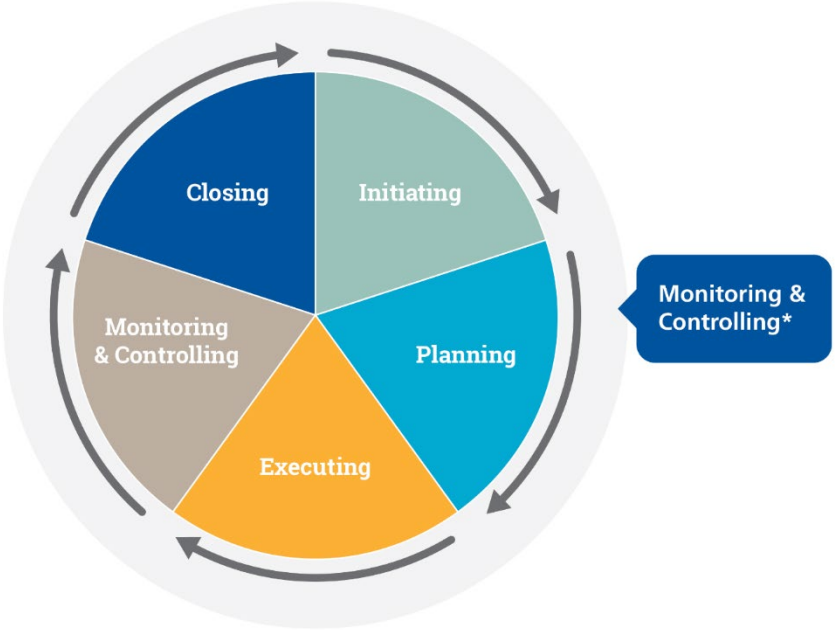


Figure IV.5.1: PMBOK Life Cycle.

Monitoring and Controlling, in addition to having its own phase in the life cycle, is a process group that occurs throughout the project life cycle as the project manager records and compiles work performance data and requests any needed project changes.

Initiating

When PCG Health prepares a response to a client's RFQ, the Initiation phase of the project life cycle begins. During initiation for this project, the PCG project team evaluated the RFQ, ensuring that we possess the necessary resources to carry out the project work. The project team then began compiling a preliminary Business Continuity Plan and searched the RFQ for any additional Business Continuity requirements. Finally, the project team collaborated to create high-level project documents based on the scope of work. These documents are an advance planning measure to provide initial estimates of the project's scope, budget, and resource needs. They will be refined once project work begins and PCG gathers more detailed project requirements from stakeholders.

Planning

The second piece of the project life cycle, Planning, begins once PCG and the client sign the project contract. Following contract approval, PCG will plan a brief phone call with the Department to precede the project's kick-off meeting. During this call, the client and the project manager will review the Statement of Work together to form an identical understanding of the project. This brief meeting establishes a mutual consensus of the project's structure and goals and enables PCG and the PMO to better refine the preliminary project documents for the kick-off meeting.

The planning phase concludes with the project kick-off meeting. At this meeting, PCG will gather detailed requirements from the project stakeholders, allowing us to finalize the project's Work Breakdown Structure (WBS), Schedule, and Communications Matrix. PCG will also use this meeting time to review potential risk factors with stakeholders in order to compile the initial Risk Register. Once these documents are complete, PCG will send them to the Department for a final approval and signoff.

Executing

The third piece of the project life cycle is the execution phase. During this time, PCG conducts project work according to the Project Management Plan. While project work is underway, PCG's project manager will gather team performance data (to be analyzed in Monitoring and Controlling), improve project efficiency, conduct meetings, and implement any approved changes resulting from the PCG Change Management Process. If needed, the project manager will also request changes to the project during this phase, which the stakeholders can approve or reject.

For day-to-day project operations, the project team will use Microsoft Project and Microsoft Team Foundation Server. These task-oriented project management software tools allow us to manage the project's day-to-day activities and track adherence to the schedule baseline. These tools also enable schedule modeling, so that the project manager can see the outcome that any alterations to the project schedule will cause. PCG can provide real-time project updates and reports to DHHR including active project resources, critical path, and estimated completion times as needed to help communicate progress status.

For an engagement of this size, and as required by the RFQ, PCG will be holding weekly project status meetings with daily updates where required. This meeting schedule will be documented in the finalized Communications Matrix developed within 15 days of the project kickoff.

Monitoring and Controlling

The fourth phase is Monitoring and Controlling, which occurs throughout the entire project life cycle. In Monitoring and Controlling, the project manager will continually analyze the team performance data gathered during Executing to see if project work is being conducted according to the Project Management Plan. If a potential variance from the project scope is identified, PCG and the project stakeholders will initiate the Change Management process.

The Change Management Plan is created during the Planning phase. This document outlines the process to be employed in the event that a change is proposed to any aspect of the project scope. All proposed change should be in the form of a change request, which can be submitted to the PCG project manager by any project team member or stakeholder.

As change requests are submitted to the project manager, the project manager will hold meetings with any affected stakeholders to assess the request. During this meeting, the project manager and stakeholders will determine whether to accept or reject the change request.

There will never be a point when PCG's project manager or project team will make changes to the project baselines without stakeholder knowledge. Instead, all change requests will first be submitted to the project manager and brought before the affected stakeholders to evaluate the risks, benefits, and impact of implementation. If the change request is approved, the project manager and stakeholders will determine the next steps (i.e., corrective or preventative actions) to implement the change. Though we expect minimal changes to the project's baseline, PCG's Change Management process is designed to effectively facilitate the implementation of any that occur.

Closing

The final phase in the project life cycle is Closing. This crucial step is completed annually in order to evaluate the previous year of PCG's project performance. To begin this phase, PCG ensures we have received client signoff on all deliverables. However, evaluation of our performance doesn't end with client signoff. PCG will also send an online Client Feedback Survey, which allows project stakeholders to provide feedback on PCG's project. At this juncture, PCG and the Department can also discuss reprioritization and any changes to the project scope that the client deems appropriate for the following year. To complete Closing, the PCG project team will collectively fill out an internal Lessons Learned survey to reflect on our project successes and areas for improvement. The collaborative survey response process gives PCG the chance to learn from past performance so that our work continually improves.

Consulting and Analysis

As a management and operational consulting firm, PCG specializes in assisting states with developing and implementing various health and human service initiatives. The team of operational and consulting staff that PCG proposes in Section III.1 Qualifications and Experience Section 3.1.4, collectively have over a hundred years of experience working around health care data analytics and data collection projects. We are confident that our team will be able to provide informative and thorough consulting and analysis services for successful implementation of the Hospital Inpatient Data System. Please refer to Section III. Qualifications and Experience Section 3.1.3 which provides details regarding many of the engagements where we have provided consulting and analytic services for similar healthcare data projects.

Project Management Documents

The PCG project team will produce four project management documents for the project. PCG has found these documents a highly successful way to distill PMBOK® best practices into four necessary pieces for project tracking. Beyond this, PCG will implement any further project management measures needed by DHHR. These documents are broken down in greater detail below.

To ensure standardization and quality of project management documents, the PMO will collaborate with project managers to create and QC the following documents. The PMO is always available to provide project management guidance to the PCG project team as needed.

Work Breakdown Structure (WBS)

PCG understands that formal planning and ongoing tracking are the foundation of effective project management. A Work Breakdown Structure (WBS) is the first project management document that we will produce for this project. It lays out the entire project scope determined during PCG and the DHHR's initial project requirements gathering sessions, ensuring that all scope is accounted for. The WBS first organizes the project by deliverables, then breaks the deliverables down into the smaller work packages and activities within each deliverable. The WBS is designed to keep the project team and stakeholders on the same page about project scope and will be updated as needed with approved project changes. The preliminary WBS will be presented to DHHR during the project kickoff meeting.

Schedule

The Schedule records the planned and actual dates and activity durations for all project activities in the WBS. To create the schedule, PCG identifies dependencies between activities and assigns a duration to each activity using a PERT analysis. This estimation method is an industry best practice that takes a weighted average of the most likely, best case, and worst-case activity durations. With estimated durations assigned, the schedule is uploaded to and managed using Microsoft Project, which allows PCG to easily produce Gantt charts and update the project schedule as needed.

Communications Matrix

The project team will use the Communications Matrix to manage PCG communications to all stakeholders. The Communications Matrix is a contact list that includes each stakeholder's project role, and preferred method and level of communication. This document dictates the frequency and type of project updates that each stakeholder receives, ensuring that each is given only updates relevant to their interest level. The

Communications Matrix will be finalized during project kickoff and continuously referenced throughout Executing as project communications are dispatched.

Risk Register

During the creation of these project documents, the PCG project manager will assess and identify possible risk factors. Each potential risk is assigned a gross risk rating based on its likelihood and impact, a mitigation strategy, a category, and an estimated trigger date. This enables the project manager and project team to prioritize and monitor identified risks at specific times during the project. By abiding by the industry best practice of documenting potential risks during the project planning phase, PCG aims to avert as many risks as possible and prepare the project team for any that arise. The initial risk register will be brought before DHHR at the project kickoff meeting, then monitored and appended throughout project execution. This approach ensures that all potential risk factors, whether they are planned in advance or arise during execution, are overseen.

Document Location

Once a document is approved, it is stored in a central database. This ensures that management can be updated at a glance about the status and compliance of Project Management for all projects under their supervision. PCG Health's standardized project management documents allow management to rapidly acclimatize themselves to an ongoing project in the case of transition or emergency.

4.6.1.1 Vendor shall communicate project status not less frequently than bi-weekly with DHHR regarding project status, including data submission activities, potential problems or barriers to project implementation, and contacts/communications with data submitters.

Thorough planning and ongoing monitoring of status are critical for any successful project. PCG's approach to status reporting is standardized enough to provide effective and efficient updates, yet flexible enough to address the specific needs of our clients. Our repeatable approach is based upon industry standards and best practices.

PCG will conduct project status meetings with DHHR on a bi-weekly basis with updates regarding data submission activities, potential issues to implementation, and contacts/communications with data submitters. PCG will conduct these meetings with DHHR via teleconference or videoconference, with the addition of two in-person meetings a year. These meetings will cover at a minimum:

- Project status regarding data submission activities
- Potential problems or barriers for project implementation
- Support with data submitters

The keys to PCG's status reporting are:

1. **Accuracy:** The information must be both timely and complete.
2. **Usefulness:** The information must be pertinent and insightful, not simply "project data."
3. **Consistency:** The sources and methods of reporting must be consistent by reporting period; status reports must reflect the information reported in previous reports.
4. **Efficiency:** The project management reporting process must be efficient and not be a drain on the task of managing the project and meeting the project's goals and objectives.

5. **Meets Expectations:** The format, contents, level-of-detail, and method of delivery must meet the requirements of both the State and PCG project teams. These expectations are captured in the Communications Management Plan and approved by all parties.
6. **Traceability:** The reports must be reviewed and approved by the management team.

PCG's approach to status reporting is standardized enough to provide effective and efficient updates, yet flexible enough to address the specific needs of our clients.

Bi-Weekly Status Reports

The bi-weekly meetings will be supplemented with a status report. For each bi-weekly update, PCG will develop a comprehensive project dashboard that discusses overall project health, key accomplishments, planned activities, deliverables status, and a summary of important project risks and issues. The report will be delivered to DHHR at an agreed-upon date and time.

Health

Project	Status*	Trending
Scope	Yellow	
Schedule	Yellow	
Budget	Yellow	
Overall	Yellow	

**Yellow Trending Green, Pending DHS Contingency Decision*

Budget Components ($M)

Component	Budget	YTD 2013 February	Remaining
Administration	15.30	3.54	11.76
CGI - PMO/Consulting	54.75	0.00	54.75
MVNP - Marketing	1.55	0.10	1.45
PCG - DDI	1.87	0.73	1.14
TurningPoint - IV&V	2.78	0.00	2.78
TOTAL	76.25	4.37	**71.88**

Currently recalculating 1st and 2nd Level 1 Grant Funds

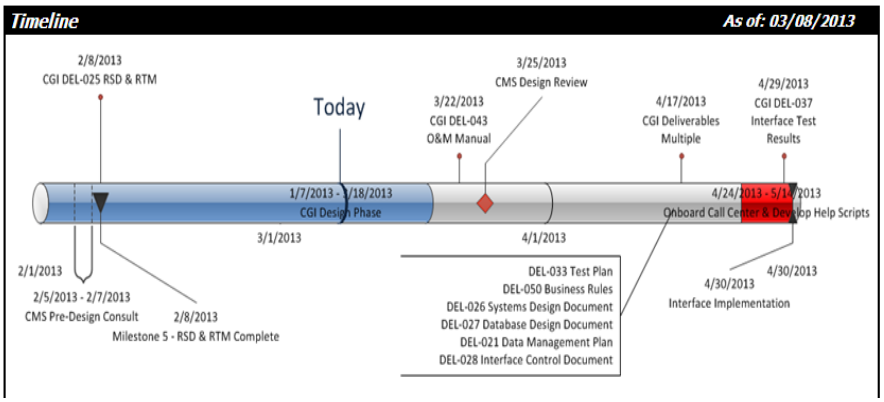


Figure IV.5.2: Example Project Status Dashboard.

Additional Project Meetings

In addition to the weekly status reports and bi-weekly status meetings, PCG can participate in all project-related meetings, as requested by DHHR. PCG's approach to each meeting in which we lead will be to prepare and distribute agendas and supporting materials at least 24 hours before a scheduled meeting. For each of these meetings, PCG will have a person designated to record key points and decisions and will be prepared to distribute them to meeting participants within one (1) business day in most cases and no more than five (5) business days in any case. Meeting participants will be asked to provide proposed additions and changes to the meeting notes when needed. Amended meeting notes will be redistributed to the meeting participants with the changes highlighted. A standardized template for status reports, dashboards, agendas, and meeting minutes will be proposed to the HCA Project Manager at the commencement of the engagement and will be used for all project meetings to ensure consistency.

4.6.1.2 Upon request, Vendor SHALL provide consultation and recommendations to DHHR regarding DHHR data analysis, reporting, and dissemination activities aimed at assessing the utilization, access, cost, and quality of healthcare.

As mentioned in Section 4.4.1.4 Analytic Files, PCG will work with HCA to update, create, and provide new analytical reports that summarize key utilization, access, cost, and quality indicators.

4.6.1.2 Within 30 working days, Vendor SHALL create systems, programs, and processes that are flexible enough to integrate updates and revisions in a timely manner, as required and/or requested by DHHR, without creating undue burden on resources.

PCG has the ability to be flexible and agile in order to respond to specific needs, challenges, and circumstances as they arise. Within 30 working days, PCG agrees to create systems, programs, and processes as requested. In order to track and implement project updates and revisions, the PCG project team will implement a Change Management methodology to document and manage any changes to systems, programs and processes. We will provide initial and on-going assessments of any issues that may require the change management process and will assist in the validation of changes as appropriate.

4.6.1.3 Vendor SHALL respond to DHHR inquiries or requests for technical assistance and/or project revisions/updates within two (2) business days, based on the urgency and importance of the issue as determined by the DHHR.

PCG will respond to DHHR inquiries or requests for technical assistant and/or project revisions/updates within two (2) business days, based on the urgency and importance of the issue.

4.6.1.4 Vendor SHALL acquire or provide any necessary hardware, software, and reference data files to complete all tasks the Vendor proposes to perform in fulfillment of the project specifications and to meet all applicable timeframes set forth in this RFQ. Data obtained for the sole purpose of the performance of this contract must not be used for any other purpose outside of the DHHR contract.

PCG agrees to acquire or provide any necessary hardware, software, and reference data files to complete all tasks in fulfillment of project specifications and to meet all applicable timeframes. Data obtained for the sole purpose of this contract will not be used for any other purpose outside of the DHHR contract.

4.6.1.5 Vendor SHALL cover all costs associated with providing technical assistance, training, and status reports to DHHR and data submitters, including teleconferencing, webinars, and/or travel to a minimum of two onsite meetings each year.

PCG will cover all costs associated with providing technical assistance, training, and status reports to DHHR and data submitters, including teleconferencing, webinars, and/or travel to a minimum of two onsite meetings each year.

IV.6 Optional Services [4.7]

4. MANDATORY REQUIREMENTS

IV.6 Optional Services [4.7]

4.7.1 The Vendor MUST include pricing for the optional services listed in 4.7.1.1 through 4.7.1.8. Pricing for optional services MUST be an hourly rate and MUST be separate from pricing for the Mandatory services enumerated in sections 4.2.1 through 4.2.11. The decision to utilize the optional services at any time during the contact is entirely at the discretion of DHHR. DHHR will request a Statement of Work (SOW) from the vendor for any optional services desired. The SOW MUST include a detailed breakdown of the hours required to complete the request. The SOW represents a not to exceed estimate. If the SOW is accepted by DHHR the work will be authorized through the Deliver Order (DO) process. No work may be billed for in the absence of a valid DO.

Vendor MUST provide an hourly rate for the services in 4.7.1.1 through 4.7.1.8. DHHR will request a statement of work (SOW) detailing the hours required for execution of the request for any optional services desired. The SOW represents a not to exceed price. Upon completion of the requested work, vendor will bill for hours actually worked up to the maximum number of hours included in the SOW.

4.7.1.1 Develop and deliver to AHRQ's Healthcare Cost and Utilization Project (HCUP) an annual adjudicated file, in a timeline and format required by DHHR.

The Agency for Healthcare Research and Quality (AHRQ) has been maintaining the Healthcare Cost and Utilization Project (HCUP) beginning with data for the year 1988. Public Consulting Group, Inc. (PCG) has extensive experience developing extracts from utilization data and will work with the State to develop the extracts in a cost-effective manner, using the mappings and tools we have used for the past ten-plus years.

PCG currently provides claims data extracts for our state clients as well as for business teams which use the data to help our clients make decisions based on that data, such as provider investigations or understanding case mixes.

PCG affirms that we will develop and deliver to AHRQ's Healthcare Cost and Utilization Project (HCUP) an annual adjudicated file, in a timeline and format required by DHHR, upon request by DHHR and in accordance with hourly rates for this optional service.

4.7.1.2 Prepare and provide to DHHR the annual standard aggregated public use data files and standard reports, as described on the UB data request form (See HCA Data Request Procedures and Forms in Section 2.2) to be disseminated by DHHR to data requesters.

PCG understands the 32 data fields that exist in the UB data request referred to in section 2.2 of the RFP. We are able to provide them in the four formats requested: PTDRG (grouped around DRGs), PTPC (grouped around the four payor groups), PTDX (grouped around diagnosis codes/groups) and PTZIP (grouped around patient discharge zip codes).
PCG affirms that we will prepare and provide to DHHR the annual standard aggregated public use data files and standard reports, as described on the UB data request upon request by DHHR and in accordance with hourly rates for this optional service.

4.7.1.3 Fulfill customer requests for subsets of adjudicated inpatient data, as approved and requested by DHHR, in accordance with then current DHHR policies and procedures (See Section 2.2 for the current data disclosure policy).

PCG will work with customers to fulfill their requests for subsets of the data that we collect, in full accordance with current data disclosure policies upon DHHR request and in accordance with hourly rates for this optional service.

4.7.1.4 Fulfill ad hoc analysis requests to answer occasional and special research questions of DHHR.

PCG will work with DHHR to fulfill ad hoc analysis requests as they arise. We will work with DHHR to determine what data should be interrogated and how the results should be presented to fulfill these requests.

PCG affirms that we will Fulfill customer requests for subsets of adjudicated inpatient data, as approved and requested by DHHR, in accordance with then current DHHR policies and procedures, upon request by DHHR and in accordance with hourly rates for this optional service.

4.7.1.5 Develop and provide to DHHR an analysis of the risk of reidentification of patients in the database based on the information contained in the final annual file in combination with other readily accessible data sources; recommend appropriate statistical disclosure limitation methods to increase patient confidentiality; and develop a limited data set, based on these recommendations, for release to requesters.

PCG has extensive experience working with state-wide databases, whether they be all-claims or Medicaid-only. One of the most important functions we perform for our external customers is providing de-identified healthcare data to our external customers.

Should the requirement for this optional service arise, PCG will work with DHHR to identify what other sources of health care data are likely readily available to the target customers and determine a way to de-identify that data to ensure no person is identifiable from the release of microdata.

PCG will work with DHHR to determine which statistical disclosure limitation method – principles-based and/or rules-based – should be used in each instance.

PCG affirms that we will develop and provide to DHHR an analysis of the risk of reidentification of patients in the database based on the information contained in the final annual file in combination with other readily accessible data sources; recommend appropriate statistical disclosure limitation methods to increase patient confidentiality; and develop a limited data set, based on these recommendations, for release to requesters, upon DHHR request and in accordance with hourly rates for this optional service.

4.7.1.6 Develop, validate, and implement methods to track patients within and between hospitals and encounters in order to estimate hospital readmissions and patient transfers, and develop a report summarizing the methodology and findings.

PCG has excellent experience with the 3M Potentially Preventable Hospital Readmissions Grouper (3M PPR-https://www.3m.com/3M/en_US/health-information-systems-us/providers/grouping-and-classification/pprs/). While this requirement does not ask PCG to identify Potentially Preventable Readmissions, the grouper does identify chains of admissions, that is when a readmission of any kind, preventable or not, occurs. PCG can use this highly configurable, industry-standard grouper to determine the actual occurrence of readmissions and patient transfers.

PCG will work with DHHR to fine-tune the 3M PPR configuration to determine the definition of readmissions and transfers and provide actual statistics instead of merely estimates. We will document all the methodology and findings.

PCG affirms we will develop, validate, and implement methods to track patients within and between hospitals and encounters in order to estimate hospital readmissions and patient transfers, and develop a report summarizing the methodology and findings, upon DHHR request and in accordance with hourly rates for this optional service.

4.7.1.7 Provide tools, products, report templates, software, and/or code for use by DHHR and/or external partners to conduct analysis of health care utilization, access, costs, and quality.

PCG affirms that we will work closely with DHHR and, if necessary, external partners, to determine what tools, products, report templates, software, and/or code they need to conduct their analysis of health care utilization, access, costs and quality, upon DHHR request and in accordance with hourly rates for this optional service.

4.7.1.8 Develop and implement new data submission system enhancements, data quality reports, or analytic reports, determined necessary to perform the functions of this project but not elsewhere specified or required by this RFP.

PCG affirms we will work closely with DHHR to determine new data submission system enhancements, data quality reports, or analytic reports that DHHR determines are necessary to the successful performance of the project that are not otherwise specified in the scope of work of this RFP, upon DHHR request and in accordance with hourly rates for this optional service.

IV.7 Data Ownership and Use [4.8]

4. MANDATORY REQUIREMENTS

IV.7 Data Ownership and Use [4.8]

4.8.1 The Vendor AGREES that all data and any software, programming code (including code to implement editing and adjudication procedures and to create non-proprietary analytic fields), file formats, or other deliverables developed to fulfill contract requirements, be the sole property of DHHR.

While Public Consulting Group, Inc. (PCG) does agree, per Section 4.8.1, that all data and any software, programming code, file formats or other deliverables developed to fulfill contract requirements will be the sole property of DHHR, PCG offers the following to clarify the proprietary rights of PCG's and DHHR's information: Such data and any software, programming code, file formats or other deliverables developed to fulfill contract requirements ("work product") do not include any Vendor Pre-existing Material, including but not limited to material that was developed prior to the Effective Date that is used, without modification, in the performance of the Contract. "Vendor Pre-existing Material" means materials, code, methodology, concepts, process, systems, technique, trade or service marks, copyrights, or other intellectual property right developed, licensed or otherwise acquired by Vendor, independent of the services to be rendered under this Contract. To the extent work product contains Vendor Pre-existing Material, Vendor hereby grants to DHHR an irrevocable, perpetual, nonexclusive, royalty-free, world-wide license to use, execute, reproduce, display, perform, and distribute copies of Vendor Pre-existing Material, but only as they are incorporated into and form a part of the work product developed for DHHR pursuant to this Contract."

4.8.2 The Vendor AGREES that all data related to the execution of the contract is collected on behalf of, and remains the property of, DHHR. Any other uses by the Vendor are subject to data use agreements which will be granted consistent with the Department's existing data use policies.

PCG agrees that all data related to the execution of the contract is collected on behalf of and remains the property of DHHR. Additionally, PCG agrees that any other use of the data will be consistent with the Department's existing data use policies and will incorporate the applicable data use agreements.

4.8.3 The Vendor AGREES to provide privacy and security safeguards to protect all data from any use or disclosure for any purpose other than that described within this solicitation or expressly authorized by the HCA Project Manager through written signed consent.

PCG agrees to provide privacy and security safeguards to protect all data from any use or disclosure for any purpose other than that described within this solicitation or expressly authorized by the HCA Project Manager through written signed consent. Please see Section IV.4 Data Security and Privacy [4.5] for our approach regarding data security and privacy.

IV.8 Milestones, Deliverables, and Service Level Agreements [4.9]

4. MANDATORY REQUIREMENTS

IV.8 Milestones, Deliverables, and Service Level Agreements [4.9]

4.9.1 The secure website MUST be available to data submitters and DHHR staff within 15 working days of contract award.

4.9.1.1 Regardless of the dates of contract award and go live dates for the web-based data submission system, the vendor AGREES to collect from submitters all data back to the expiration September 30, 2019.

Public Consulting Group, Inc. (PCG)'s system will be made available to data submitters and DHHR staff within fifteen working days of contract effective date. PCG agrees to collect from submitters all data back to the expiration September 30, 2019.

4.9.2 Live help desk support including telephone and on-line chat SHALL be available to data submitters, their representatives, and DHHR Staff a minimum of 8 hours per day, Monday thru Friday during daytime business hours (EST), not including federal holidays, commencing on the first day the secure website is made available.

PCG will provide live help desk support, including telephone, email and on-line chat, Monday thru Friday during business hours (EST) for a minimum of eight hours per day, commencing on the first day the system is made available. Please reference section IV.2 Documentation and Technical Support [4.3] for further information regarding our help desk support and technical assistance.

4.9.3 The Vendor SHALL conduct analyses to investigate and determine potential data quality issues, as requested by the HCA, within at least 10 working days of request.

PCG will conduct analyses to investigate and determine potential data quality issues within 10 working days of requests by HCA.

4.9.3.1 The Vendor MUST correct identified data submission errors that are determined cannot or should not be corrected by the data submitter, as requested and/or approved by DHHR, within at least 20 working days of request/approval.

PCG will correct identified data submission errors that are determined cannot or should not be corrected by the data submitted, as requested and/or approved by DHHR, within 20 working days of the request/approval.

4.9.3.2 The Vendor MUST correct any identified errors in the System or the resulting file(s), which are attributable to the Vendor, within at least 10 working days of request.

PCG will correct any identified errors in the system or the resulting file(s), which are attributable to PCG, within 10 working days of the request.

4.9.3.3 The Vendor SHALL certify that the disaster recovery plan, as approved by DHHR, has been tested and proven effective within 60 working days of contract award.

PCG will provide certification that the disaster recovery plan, as approved by DHHR, has been tested and proven effective within 60 days of contract effective date.

4.9.3.4 The Vendor MUST deliver a final complete data file, for the previous calendar year, with all identified data quality issues resolved, by June 1 each year.

PCG will provide a final complete data file, for the previous calendar year, with all identified data quality issues resolved, by June 1 for each contract year.

4.9.3.5 The Vendor SHALL, within 30 working days of the end of each contract year, provide to the HCA an annual report of the project, including but not limited to: project successes and barriers; revisions or updates implemented to the System during the project year; and any recommendations for future project and System enhancements.

Within 30 working days of the end of each contract year, PCG will provide an annual report of the project, including but not limited to: project successes and barriers; revisions or updates implemented to the System during the project year; and any recommendations for future project and System enhancements.

4.9.3.6 The Vendor SHALL, at least 90 working days prior to each contract year, submit to HCA a final and approved annual detailed work plan of key activities and projects to be completed during the next contract year. The work plan must include an implementation timeline for key project activities and identify responsible team members.

Within 90 days prior to each contract year, PCG will submit to HCA a final and approved annual detailed work plan of key activities and projects to be completed during the next contract yet. The project plan will include an implementation timeline for all key project activities and will identify responsible team members. Please see Section IV.5 Project Management [4.6] for further details regarding PCG's project management approach, including the detailed work plan.

4.9.3.7 The Vendor SHALL cooperate with DHHR and any subsequent Vendor should the contract, which is the subject of this RFQ, be terminated, and to deliver any and all data, documentation, and associated work products to DHHR or its designee within thirty (30) working days of receipt of notice of contract termination.

PCG will cooperate with DHHR and any subsequent Vendor should the contract be terminated. PCG will deliver any and all data, documentation, and associated work products to DHHR or its designee within 30 working days of receipt of notice of contract termination.

4.9.3.8 The Vendor SHALL destroy all data in the System at the end of the contract and/or upon the request of DHHR in accordance with NIST Special Publication 800-88 or the most current revision of that publication. Destruction of data SHALL NOT begin prior to receipt of written authorization from the DHHR Project Manager and SHALL be completed within 30 days of receipt of that authorization.

PCG will destroy all data in the system at the end of the contract and/or upon the request of DHHR in accordance with NIST Special Public 800-88 or the most current revision of this publication. Destruction of the data will not begin prior to the receipt of written authorization from the DHHR Project Manager and will be completed within 30 days of receipt of authorization.

4.9.3.9 If a Data breach is discovered or suspected Vendor SHALL immediately make the following notifications:

DHHR Project Manager by phone at 304-55-7000
WV Office of Technology Service Desk by phone 304- 558-9966
DHHR Security Team via email to: **DHHRIncident@wv.gov**.

Notification is REQUIRED upon the discovery of breach of security of System data, where the use or disclosure is not provided for by this RFQ or contract, of which it becomes aware, if the System data was, or is reasonably believed to have been, acquired by an unauthorized person.

If there is a suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this RFP or contract, or potential loss of System data affecting this RFP or contract, then notification must occur within 24 hours by the same methods above. The Vendor shall immediately investigate such security incident, breach, or unauthorized use or disclosure of System data. Within 72 hours of the discovery, the Vendor shall notify the HCA Project Manager of: (a) What data elements were involved and the extent of the data involved in the breach; (b) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed System data; (c) A description of where the System data is believed to have been improperly transmitted, sent, or utilized; (d) A description of the probable causes of the improper use or disclosure; and (e) Whether any federal or state laws requiring individual notifications of breaches are triggered. DHHR will coordinate with the Vendor to determine additional specific actions that will be required of the Vendor for mitigation of the breach, which may include notification to the individual or other authorities. All associated costs shall be borne by the Vendor. This may include, but not be limited to costs associated with notifying affected individuals.

If a data breach is discovered or suspected, PCG will issue the proper notifications and abide by the notification schedule and requirements as provided in Section 4.9.3.9. Further information regarding our Incident Management Plan can be found in Section IV.4 Data Security and Privacy [4.5].

IV.9 Invoices and Payments [4.10]

4. MANDATORY REQUIREMENTS

IV.9 Invoices and Payments [4.10]

4.10.1 Vendor SHALL submit quarterly invoices at the close of each calendar quarter for the inpatient and emergency department data systems and for any optional system modules ordered by authorized by DHHR in that calendar quarter.

Public Consulting Group, Inc. (PCG) will submit quarterly invoices at the close of each calendar quarter for the inpatient and emergency department data systems and for any optional system modules ordered by and authorized by DHHR in that calendar quarter.

4.10.2 For any optional services (See RFQ Section 4.7) ordered on a Delivery Order (DO) by DHHR the vendor MAY submit monthly invoices one month in arrears. Invoices will be for actual hours worked not to exceed the maximum number of hours authorized on the Delivery Order.

PCG understands and acknowledges that for any optional services ordered on a Delivery Order by DHHR, PCG may submit monthly invoices one month in arrears. Invoices will be for actual hours worked and will not exceed the maximum number of hours authorized on the Delivery Order.

4.10.3 Invoices for the inpatient and emergency department data systems and for any optional system modules ordered and authorized by DHHR will be reviewed by DHHR and paid in full if it is determined that all of the services, milestones, deliverables, and service level agreements for quarter have been met. If DHHR determines that there are significant unmet milestones, deliverables or service levels for the quarter DHHR will notify the vendor and may withhold payment of up to 15% of the invoice amount for each unmet item. Vendor MAY submit new invoices for withheld payments upon completion of the work.

PCG understands and acknowledges that DHHR may withhold up to 15% of the invoice amounts for the inpatient and emergency department data systems and for any optional system modules ordered and authorized by DHHR, if DHHR determines that there are significant unmet milestones, deliverables, or service levels for the quarter. PCG can submit new invoices for withheld payments upon completion of the work.

Appendices

Appendix A: Resumes
Appendix B: NJ HealthCAP Implementation Guide
Appendix C: NJ HealthCAP Data Dictionary and Extract File
Appendix D: NJ HealthCAP Edit Specifications
Appendix E: ANSI 837 Addendum Guide
Appendix F: NJ HealthCAP User Guide

Appendix A: Resumes

Appendix A: Resumes

LOGAN BARRON, TRAINER
OPERATIONS ANALYST AT PUBLIC CONSULTING GROUP, INC.

Ms. Logan Barron is currently an Operations Analyst located in PCG's Portsmouth, NH office. Ms. Barron has over four years of experience in the health care industry and has provided support for PCG's data intermediary project, contracted with the state of New Jersey's Department of Health, since the projects implementation with PCG. Ms. Barron is the lead analyst for operations and provider support, as well as the claims processing and auditing subject matter expert. Ms. Barron works directly with DOH staff to derive application requirements and business rules, as well as maintain consistent communications with the provider community (e.g. NJ Hospital Association, Patient Financial Services committees, hospital CFOs). Ms. Barron provides day-to-day support for the providers in New Jersey to assist with, but not limited to, the following tasks: claim errors, x12 837R file format inquiries, provider enrollment, provider and staff training, system technical issues, and other EDI inquiries. Due to her extensive knowledge and passion for customer support, Ms. Barron has been able to form strong relationships with the provider community in New Jersey. She is available by phone or email during standard business hours and provides timely responses to provider inquiries.

Ms. Barron played a key role in developing and implementing the current claims processing system for our New Jersey client. She performed user acceptance testing by creating test plans, test data and efficiently documented results and required changes that needed to be made to the system. Once the system was developed, she helped provide provider training for the hospitals in New Jersey. Ms. Barron created detailed application documentation that is available to all users and assisted the providers with using the application and submitting claim files in the required 837R file format. She is also responsible for training new PCG staff members on the system as well as on the provider support activities. To aid in this training she has created multiple policy and procedure documents.

Ms. Barron participated and assisted in many provider trainings, conference presentations, and panel discussions across the state of New Jersey discussing the application. She is the point of contact for any system issues, can identify the root-cause, and work with necessary PCG staff to resolve these issues in a timely and efficient manner. In this role, she has acquired very relevant experience assisting providers with navigating PCG's claims collection, processing, auditing, and warehousing application for the New Jersey DOH.

RELEVANT PROJECT EXPERIENCE
Department of Health, State of New Jersey
Data Intermediary Services (February 2017 – Present): Operations and Help Desk Lead

PROFESSIONAL BACKGROUND
Public Consulting Group, *Portsmouth, NH* July 2017 – Present
Operations Analyst

EDUCATION
The University of New Hampshire, *Durham, NH*
Bachelor of Science in Health Management and Policy, 2017

MICHAEL BEDFORD, TELECOMMUNICATION AND INTERNET SECURITY SPECIALIST
CHIEF INFOSEC AND CHIEF PRIVACY OFFICER AT PUBLIC CONSULTING GROUP, INC.

Versatile executive manager and system infrastructure architect specializing in cyber security, information privacy, and risk management across multiple industries including:

- Health and Human Services
- Labor and Workforce
- eCommerce
- Commercial, investment, and retail banking
- Healthcare and pharmaceuticals
- State and Federal government
- Industrial manufacturing
- Criminal Justice
- Public Utilities and SCADA

Effective IT leadership consistently delivering innovative ideas and proven results while building cohesive teams. Keen business acumen coupled with expert leadership skills and industry knowledge while continuing to deliver tangible results that exceed expectations.

QUALIFICATIONS

- 20+ years of enterprise technology management and consulting experience.
- Highly accomplished system and infrastructure design architect with hands on experience designing and deploying some of the most advanced CRM, ERP, order processing, VoIP, and eCommerce platforms in the industry.
- Expert with enterprise risk management, security policy development, risk assessment, security training, regulatory guidance.
- Compliance management and audit expertise with thorough knowledge of HIPAA, FISMA, SOX, GLB, PCI, IRS, FERPA, HITECH.
- Business continuity and disaster recovery design and deployment subject matter expert specializing in virtualization and cloud-based solutions.
- Adept in modern control concepts including data confidentiality and protection, access control and authentication, network security design, incident response and forensic data analysis.
- Expert in industry security frameworks including NIST 800 series, ISO 27000 series, COBiT, FIPS, and MITA.
- Highly Credentialed including CISSP, CIPM, GCSC, CISA, CISM, CBCP, MCSE, ITIL certifications.

RELEVANT PROJECT EXPERIENCE

Public Consulting Group, Inc., Boston, Massachusetts

(December 2013 – Present): Chief Information Security Officer and Chief Privacy Officer

Project: Lead the development and enforcement of a comprehensive risk management framework including corporate policy development, control assessment and improvement, training and awareness programs, audit and compliance, privacy and data confidentiality, security monitoring and security incident handling. Manage security policies, standards and controls across multiple international industries and teams, including public Healthcare, Human Services, Government, and Education. Manage the firm's external audit program including building and maintaining compliance with SSAE 16 - SOC I/II, ISO 27000, HITRUST and NIST 800-53. Provide strategic guidance for security risks, current vulnerabilities and countermeasures for hyrbrid computing and hosting solutions including IaaS, cloud computing, and SaaS. Manage the firm's Business

Continuity Program across all major stages of BCP development and maintenance. Deploy and manage the risk management framework for new business ventures, M+A activities, and evolving information security needs and threats. Lead the cyber incident response team and forensic analysis services. Responsible for the global privacy program and compliance with applicable privacy laws.

Accenture, Providence, Rhode Island

(January 2012 – December 2013): Executive Manager

Royal Bank of Scotland / Citizens Financial Group

Project: Service Delivery manager for the Americas, responsible for the Plan, Build, and Run lifecycle for a 5-year global outsourcing contract. Managed multiple teams of network architects, engineers, and operations staff with 57 onshore staff and over 200 offshore personnel. Accountable for the 24x7 network operations, strategic planning, budgeting, risk and audit including regulatory compliance, supplier management, and client relationship management.

Eclipse Solutions

(September 2005 – December 2011): Director of Enterprise Security and IT

Rhode Island Executive Office of Health and Human Services (EOHHS)
IT Planning for Medicaid and the Health Insurance Exchange

Project: Worked with various stakeholders, vendors and the State IT department to capture a 'real-world' view into the capabilities and risks to the current Medicaid environment. Built a technology roadmap to move the State into a modern computing era with a SOA based architecture. Designs for MMIS claims processing, Data Warehouse, Pharmacy, and Eligibility environments using the MITA framework as the core. Feedback from the DHHS federal budget committee regarding the RI MMIS strategy was, "innovative and forward thinking."

California Employment Development Department (EDD)
Unemployment Insurance Modernization IV&V

Project: Certified appropriate risk and security management plans and standards were developed in accordance to regulation and followed throughout the project lifecycle through RFP reviews; solution architecture assessments; solution security assessments, product vulnerability and risk assessments; and disaster recovery/ business continuity plan validation and verification.

California Employment Development Department (EDD)
Automated Collections Enhancement System IV&V

Project: Provided requirements traceability, security control validation and recommendations, assessment of proposed system design, implementation plans, and rollout strategies. Verification of data confidentiality, code vulnerability identification, and solution assessment against EDD security policies and standards including IRS Publication 1075 requirements.

California Department of Health Services
CA-Medicaid Management Information System IV+V

Project: Responsibilities included providing technical analysis of proposed technologies, plans, security controls, testing plans, and project management activities. Led security evaluation of the System Security Plans, MITA State Self-Assessment. Management level consulting with State and vendor proposed designs and integration/cutover strategies.

California Department of Justice (DOJ)
California Law Enforcement Telecommunication System
Project: Reviewed and updated of all CLETS policies and procedures for compliance with state and federal law, FBI mandated Criminal Justice Information Systems requirements, FIPS standards, and internal DOJ constraints. Duties included reviewing/assessing/auditing all connected agencies for compliance with defined practices, policies and procedures including technical system design review, and formulating recommendations for compliance. Security advisor to the DOJ on all high-profile security related matters including liaison to the FBI for policy decisions regarding national criminal justice security standards.

California Housing Finance Agency
Business Continuity Plan (BCP) Development
Project: Led the development of an Incident Management Plan, individual Business Resumption Plans, Communication Plans, and the Operational Recovery Plan (IT business resumption), mock disaster and tabletop exercises and training for senior staff and emergency management teams. Built BCP using DRII and SEMS/NEMS standards. Led a team that mapped out Agency critical services, dependencies, and developed recovery time objectives (RTO) for critical applications. Created a technical Operational Recovery Plan and processes to meet the RTOs using virtualization technology.

PROFESSIONAL BACKGROUND

Public Consulting Group, Boston, MA — December 2013 - Present

Accenture, Providence, Rhode Island — *January* 2012 – December 2013

Eclipse Solutions, New England, USA — *Sept*ember 2015 – December 2011

EDUCATION

California State University, Sacramento *(IP), California*
Bachelor of Science in Computer Engineering

Yuba Community College, *Marysville, California*
Associates of Science in Computer Engineering

CERTIFICATIONS

- Certified Information Systems Security Professional (CISSP)
- Microsoft Certified Systems Engineer Windows 2003 (MCSE Windows 2003)
- SANS GIAC Certified Security Consultant (GCSC)
- Microsoft Certified Systems Engineer Windows 2000 (MCSE Windows 2000)
- Certified Information Systems Auditor (CISA)
- Microsoft Certified Systems Engineer NT 4.0 (MCSE NT 4.0)
- Certified Information Security Manager (CISM)
- Microsoft Certified Systems Administrator for Windows 2003 (MCSA Windows 2003)
- Certified Security Professional (CompTIA Security+)
- Microsoft Certified Systems Administrator for Windows 2000 (MCSA Windows 2000)
- HIPAA Certified Professional (CHP)
- Microsoft Certified Professional + Internet
- HIPAA Certified Security Specialist (CHSS)

- (MCP+I)
- Citrix Certified Administrator XP 1.0 (CCA)
- Certified Technical Trainer (CompTIA CTT+)
- ITIL Certified (ITILF)
- Microsoft Certified Trainer (MCT)
- Certified Business Continuity Professional (CBCP)
- VMWare Certified Professional (VCP)
- Certified Information Privacy Manager (CIPM)

SPECIAL SKILLS

Program Knowledge:
HIPAA Compliance, ISO 27000 series; BS 17799; NIST/FIPS standards (NIST 800- 53, NIST 800-30, FIPS 197, FIPS 142, etc.); SOX; GLB; SB 1386; SOC I/II; Criminal Justice Information Security (CJIS) Policies; Information Technology Infrastructure Library (ITIL); Microsoft Operations Framework (MOF); Business Continuity Planning, Disaster Recovery Planning, Enterprise Architecture, Security Planning & Assessments, Technical Architecture Assessments, Policy and Procedure Analysis, Regulatory Compliance Assessment and Remediation, Incident Response planning, Software/System Development Life Cycle; Directory Services and Single Sign on (SSO), ITIL Assessment and remediation; Technology Solutions Development and Implementation, MITA framework, CMS conditions and standards, etc.

Hardware*:*
IBM eSeries x86 Servers; HP Proliant x86 Servers; Dell PowerEdge x86 Servers; Cisco PIX/ASA//CATOS/IOS/Nexus series networking devices and appliances; Palo alto firewall; ESS/EMC/HP/McData/Cisco SAN hardware; IBM Z Series mainframes IBM I/P series UNIX systems; Avaya PBX, RSA, Multiple NAS systems; wide range of tape backup systems and libraries; full range of PDUs; assortment of authentication devices (biometrics/proximity/Key FOB/etc), etc.

Network*:*
Routing and switching (Cisco 65xx, 72xx, 35xx, 45xx, Nexus 70xx, 50xx, 20xx) Firewalls (CheckPoint, Cisco ASA/ASA-X Palo Alto), Intrusion Detection/Prevention Systems (SourceFire, ArcSite, Symantec, AlertLogic, FireEye), Network Protocols (TCP/IP v4, v/6, IPX, etc.), DNS, DHCP, WINS, Nortel, WiFi, SAN fabric networks, PBX/Cisco VoIP and UNITY; VPN solutions (SSL, VPN client, etc.)

Platforms:
Windows NT 4.0/2000/2003/2007/2008/2012; RedHat Advanced Server, VMWare ESX / GSX, Cisco UCS, Avaya CMS/AES/PBX/Unity, Audix, Cisco CaS VOIP,

Software:
All MS Office products, .NET and BackOffice Servers (Exchange, SMS, SQL, IIS, Terminal Server, Application Center, IAS, etc.) Remedy, VMWare, Citrix, Siebel, SAP, Netware, Terminal emulators, QIP, PeopleSoft, assortment of network and system management software (HP OpenView, Tivoli, MOM, etc.), Oracle, FileMaker Pro; Directory Services, J2EE, IBM WebSphere, Forensic data gathering tools; vulnerability and network scanners (MBSA; Foundstone; Nessus; Snort; CoreImpact), ACF, RACF, Solera, SourceFire, AlgoSec, QRADAR, BlueCoat, Palo Alto, Gigamon Databases: Microsoft SQL 2000/2005/2008/2014, Oracle 8i/9i/10g/11x/12x; MySQL; DB2, ADABAS, etc.

CHERYL CARLISLE, FUNCTIONAL/OPERATIONAL LEAD
REVENUE CYCLE DIRECTOR AT PUBLIC CONSULTING GROUP, INC.

Cheryl Carlisle has been employed by Public Consulting Group since September 2013. She has over 28 years of experience in the healthcare and finance industry. Prior to working for Public Consulting Group, she was the Director of Operations for a medical practice in the state of New Hampshire.

RELEVANT PROJECT EXPERIENCE

New York Department of Health, Bureau of Early Intervention, State of New York

State Fiscal Agent (September 2013 – Present): Healthcare Revenue Cycle Operations Manager

Project: PCG is contracted with the New York State Department of Health, Bureau of Early Intervention to manage the EI State Fiscal Agent. This includes the development and maintenance of a web-based claiming application for EI providers. The NY BEI program is the largest in the country, with over 70,000 children in the program.

Ms. Carlisle: Oversees all Billing Operations for Early Intervention State Fiscal Agent project for the State of NY. Manages all aspects of claiming to third party payers and Medicaid. Revenue Cycle Management, analyzes and recommends program and process improvements to increase third party payer reimbursement. Improves provider relationships with provider outreach programs and solving escalated provider issues. Provides development of Business Requirements, System Requirements and Policies and Procedures for the Billing Operations Unit. Conducts meetings with the Department of Health, New York State Department of Financial Services, and insurers regarding Early Intervention program policies and payers' role and responsibilities. Manages process improvements including enrolling 1200 billing agencies in electronic 837 submissions through Emdeon, decreasing paper claiming by 94%, collaborates with Department of Financial Services and Department of Health to improve payer relationships and identify claiming rules applied to early intervention claims, provides guidance documentation on obtaining prior authorizations for early intervention services and develops business requirements to enhance the current billing system.

Advocates, Inc. State of Massachusetts:

Collection Services (March 2018-Present): Revenue Cycle Operations Director, Client Manager

Project. The goal of our contract with Advocates, Inc. Was to maximize revenue on claims

Oregon State Public Health Laboratory, State of Oregon

Third Party Billing Services (June 2015- Present): Revenue Cycle Operations Director, Client Manager

Project: The goal of the OSPHL is to maximize Medicaid and private insurance reimbursement for laboratory tests performed at the State Laboratory. The volume of billable services is approximately 120,000 per year. PCG accepts data from OR State Public Health Laboratory for claiming to third party payer and invoicing to their submitters. The first six months of billing resulted in $973,887 in payments for FY 2015.

Ms. Carlisle: Oversees all Billing Operations for Public Health Laboratory Services. Manages claiming to third party payers, Community Care Organizations, Medicare and Medicaid. Conducts weekly meetings with the client regarding billing activities and makes recommendations on revenue maximization. Manages contracting and credentialing for the client with third party payers and Medicare.

Michigan Department Community Health, Bureau of Laboratories, State of Michigan

Third Party Billing Services (June 2015 - Present): Revenue Cycle Operations Director, Client Manager

Project: The goal of the MDCH is to maximize Medicaid and private insurance reimbursement for laboratory tests performed at the State Laboratory. Laboratory services billed by PCG include STD

testing and blood lead tests. PCG accepts data from MI State Public Laboratory for claiming to third party payer and invoicing to their submitters.

Ms. Carlisle: Oversees all billing activities including, claims submission, rejection and denial management, payment posting, account receivable follow-up and submitter invoicing and collection follow-up. Conducts weekly meeting with the program director and other stakeholders. Consults with the client on best billing practices to increase revenue and provides training to submitters to decrease first submission rejections and denials.

Division of Medical Assistance, Central Billing Office, State of North Carolina

Medicare Part D State Operated Facility Billing (July 2015 – Present): Revenue Cycle Operations Director

*Projec*t: The goal of the NC DMA is to maximize Medicare reimbursement for Med D pharmacy claims for State owned facilities. The volume of billable claims is approximately158,500 claims per year. PCG accepts claims data from the NC Division of Medical Assistance for claiming to Medicare. PCG assists in rejection and denial management.

Ms. Carlisle: Manages all billing activities including the acceptance of claims from Pharmacy Management Vendor, eligibility verification, submission of Part D claims, resubmission of rejected claims, assists pharmacy staff in resolving/resubmitting clinical issues when needed. Manages monthly reports including analysis of rejected claims by pharmacy, reimbursement rate by pharmacy and NDC, aging reports and fiscal year revenue projections. Consults with the client in revenue maximization and identifying reimbursements that are higher than charge rates. Averaging 10.65 million in revenue for the state annually.

Department of Children and Families, State of Florida

Medicare and Medicaid Cost Reporting Services (July 2015 – Present): Revenue Cycle Director

Project: The goal of the FL DCF is to maximize Medicare reimbursement for Med D pharmacy claims for State owned facilities. The volume of billable services is approximately 6,000 claims per year. PCG accepts data from the FL Department of Children and Family Services for claiming to Medicare. PCG also performs Med D eligibility and assists in rejection and denial management.

Ms. Carlisle: Manages all billing activities including eligibility verification, Med D claim submission, rejection management and monthly reporting. Manages monthly reports include, claim result summary trends, average payment rate, rejection analysis and aging reports. Provides consultation for revenue cycle management and payer reimbursement.

Department of Human Services, State of Illinois

Revenue Maximization Medicare Part D Recoveries (July 2015 - Present): Revenue Cycle Director

Project: The goal of the IL DHS is to maximize Medicare reimbursement for Med D pharmacy claims for State owned facilities. The volume of billable claims is approximately 153,600 claims per year. PCG accepts claims data from IL Department of Human Services for claiming to Medicare. PCG also performs Med D eligibility verification and assists in rejection and denial management.

Ms. Carlisle: Manages all billing activities including eligibility verification, Med D claim submission, PDP client liaison, rejection management and resubmission of rejected claims. Manages monthly reporting and data analysis on rejection rates, payment reimbursement rates and projected revenue. Averaging 12 million dollars in revenue for the state annually.

Commonwealth Care Alliance (CCA), Commonwealth of Massachusetts

Third Party Administrator for One Care and Senior Care Programs (April 2015–June 2016): Claims Manager

Project: In this engagement, PCG provides Third Party Administrative (TPA) services on behalf of both One Care and Senior Care programs.
Ms. Carlisle: Oversaw the claims operations team and contracting team. Managed all claiming activities including professional, institutional and non-traditional claims. Implement and manage process improvements to increase efficiencies within claiming operations. Managed all contracting activities including provider adds, fee schedules and Medicare/Medicaid fee schedule updates.

Independence Care System (ICS), State of New York
Third Party Administrator for Fully-Integrated Dual Advantage (FIDA) Program (April 2015 – June 2016): Claims Manager

Project: In this engagement, PCG provides Third Party Administrative (TPA) and Management services for the Community Care Plus FIDA-MMP program.
Ms. Carlisle: Responsible for the oversight of the claims operations team and contracting team. Managed all claiming activities including professional, institutional and non-traditional claims. Implement and manage process improvements to increase efficiencies within claiming operations.

PROFESSIONAL BACKGROUND

Public Consulting Group, *Portsmouth, NH* September 2013 – Present

Women's Health Associates of Portsmouth, *Portsmouth, NH* December 1998 – December 2013

EDUCATION

UNH, Durham, NH, 2017 - Current
Accounting
Merrimack College, *Andover, MA 1987 - 2000*
Accounting and Finance
Kennebunk Community College, *Kennebunk, ME*
EHR Implementation Specialist – Certificate 2010

CERTIFICATIONS / PUBLICATIONS / SPECIAL SKILLS

- National Member MGMA
- Member HFMA
- Certified in EHR Implementation - 2010
- Trained "super user" in Greenway Practice Management System

REFERENCES

Constance Donohue
Director NY Early Intervention Program
constance.donohue@health.ny.gov

Julie Kusey
Laboratory Systems Section Manager, Michigan DOHHS
Bureau of Labs
517-335-9604
KuseyJ@michigan.gov

Sarah Humphreys, CHES
Client Services Coordinator, Oregon State Public Health Laboratory

503-693-4124
sarah.m.humphrey@dhsoha.state.or.us

KEVIN CARLSON, SYSTEM ADMINISTRATOR
CHIEF TECHNOLOGY OFFICER AT PUBLIC CONSULTING GROUP, INC.

Mr. Kevin Carlson has over 20 years in the Healthcare Technology space in capacity of an Entrepreneur and a C-Level Executive. Mr. Carlson has overseen the development and implementation of several large-scale EHR and RCM systems that continue to lead the industry today. He has also taken part in the implementation and roll-out of state-wide HIE systems. Currently, Mr. Carlson, as the CTO at PCG, oversees and architects the development and SAAS development rollouts of all the applications pertaining to the Healthcare division.

RELEVANT PROJECT EXPERIENCE

Public Consulting Group, Inc., Boston, Massachusetts

(June 2015 – Present): Chief Technology Officer

Mr. Carlson: Manager of the technology division of the Health Practice Area of Public Consulting Group. Oversees all the infrastructure and development that supports all of the Health applications that provide both internal and external business needs. Chief Architect of all new applications and oversees the development of all the applications which are written in the SQL, C#, and .NET Microsoft technologies. Supervises the development and support for all business intelligence analytical tools, leveraging commercial tools including Tableau and SAS. Member of the PCG Technology Steering Committee that works together to leverage the latest technology to grow and support the infrastructure across the entire company, including 40 offices worldwide and two geographically separate datacenters. In addition, takes part in the strategic directives that relate to SOC I and II as well as HIPAA compliance. Takes part in supporting client-facing activities, including sales and support. Finally, Mr. Carlson is a member of the Health Management team that provides business development and management experience to that company division.

LogixHealth, New Bedford, Massachusetts

(November 2012 – March 2015): Chief Information Officer

Mr. Carlson: Member of the executive team making tactical and strategic decisions growing the company during Mr. Carlson's tenure. Completely revamped the Technology Department, including going from an 8x5 to a 24x7 Infrastructure support team, migrating from a third-party development team to an in-house team, and cutting the technology spending by more than 30%. Oversaw the development of several Web-based applications which provided value-add benefits to the 200+ clients as well as internal operational teams. Those tools included Business Intelligence, data warehouses, and proprietary healthcare-centric applications aimed at improving the efficiency of hospital systems and the RCM process. Worked hand-in-hand with both internal business owners and clients, understanding the operational challenges that revolved around the RCM and hospital administration industry and leveraged technology to automate or streamline those processes while maintaining HIPAA integrity. Built and managed a technology department with 70 staff members, located in both the U.S. and India. Key stakeholder in starting the India-based subsidiary entirely owned by LogixHealth and moved 300+ FTEs of technology and business processing positions from outsourced vendors into the entity. This included several trips to Bangalore, India to oversee and manage the process. Coordinated data interfaces with hundreds of clients across the U.S. allowing LogixHealth to provide Coding and RCM services for both the hospitals and the providers. Lead the initiative to document all technical processes and procedures allowing for SSAE-16 certification.

Carlson Technology Healthcare Solutions, LLC. Derry, New Hampshire
(April 2012 – November 2012): Principal

Mr. Carlson: Provided consulting services as a hands-on Technology Executive working to help companies streamline and scale their Technology Departments by leveraging the latest technology resources on a global level. Performed consulting services for Intersystems on their HIE HealthShare product. Worked as part of the ICE team to implement and deploy HealthShare to the state of Rhode Island (CurrentCare). Worked with the Intersystems Active Analytics team (Deepsee) on building a Web-based BI tool to hook into their HIE product.

Advantage HealthCare (formerly AMSplus), Salem, New Hampshire
(January 2006 – April 2012): Chief Information Officer
(October 2004 – December 2005): Consultant

Mr. Carlson: Member of the Executive Team and took part in strategic and tactical decisions regarding all aspects of the company's operations and future. This included being a key player in several mergers and acquisitions. Oversaw the development of the Worx application, a Cache Web-based revenue cycle management system. This system was put into production in 2006 continued to be enhanced along with two other medical billing systems—one that was written in MUMPS and one in D3 (Pick). Seamlessly migrated (including data conversion) over 120 billing clients from multiple legacy billing applications to the Worx billing application transparently to both clients and billing operations. Designed, developed, and brought to market a Web-based BI system and back-end data warehouse for both 120+ clients and internal staff. Managed the day-to-day operations of the entire IT Department with 32 staff members, located in 12 offices across the U.S. and India. Traveled throughout the U.S. and abroad to oversee both operational and technology initiatives taken by the 10 U.S.-based offices and two India-based technology/data entry offices. Worked seamlessly with the sales and operations team to bring on new clients as well as changes in technology of existing clients. Lead the initiative to document all processes and procedures allowing for ISO 9001 certification.

Paradigm Solutions, Inc., Wrentham, Massachusetts
(October 1997 – December 2005): President

Mr. Carlson: Paradigm was founded by Kevin Carlson and William D. Dillon, MD to start a custom medical record development company to write custom electronic medical record software that will integrate seamlessly in medical practices to improve workflow and reduce costs. The company grew to include a transcription division, which synergized with the EMR division, a network division to provide network and computer support to clients, and a Web design and hosting company to complement both medical and other business across New England. Developed custom Electronic Medical Record application in Visual Basic and Microsoft SQL Server. EMR applications were deployed to specialties including Internal Medicine, Cardiology, Radiology, Endocrinology, Dialysis, and Orthopedics specialties. Performed IT Consulting Services for over 50 customers ranging from single-employee companies to organizations exceeding 500 employees in multiple countries. Managed a team of developers who worked on Web-based and EMR applications, as well as customized database applications. Managed the ISP division which hosted and maintained hundreds of Web sites, E-commerce sites, e-mail, DNS, and high-speed direct Internet connections. Managed a Medical Transcription division that transcribed medical records from medical practices into the EMR applications that the company designed. Performed management duties, including writing contracts, payroll, HR, and accounting. Interfaced with clients in roles including managing, sales, and technical support roles.

Suffolk University, Boston and Franklin, Massachusetts
(September 2001 – June 2004): Adjunct College Professor

Mr. Carlson: Taught Accredited and Non-Accredited College-level classes in Math, Computer Programming, Database Design, and Web Site Development.

Acadia Software, Boxborough, Massachusetts
(February 1996 – June 2004): Software Engineer

Mr. Carlson: Developed custom software applications to clients utilizing Delphi and Web-based technologies. Participated in developing the Web design application called Acadia Infuse, which was later commercialized into Cold Fusion. Primary Delphi developer on a three-person team to write an artificial intelligence software product that would algorithmically calculate future sales of a retail fast food chain restaurant based upon historical data and automatically schedule staff-based sales demand and the employee skill set. This product was financed by Micros and was later licensed to McDonalds, California Pizza Kitchen, and other fast food chain restaurants.

Charles Stark Draper Laboratory
(June 1994 – February 1996): Software Engineer

Mr. Carlson: Developed software to provide analysis and accuracy improvement for the Trident 1 and 2 GPS-Integrated guidance systems. Application was written and maintained in Fortran 77 and was re-written into Borland C++ during my tenure. Maintained all computer LANs in the test lab. Provided code and database support on all system tests. Attained Secret Clearance allowing classified work on several associated Navy Contracts.

PROFESSIONAL BACKGROUND

Public Consulting Group, Inc., *Boston, MA*	June 2015 – Present
LogixHealth, *New Bedford, MA*	November 2012 – March 2015
Carlson Technology Healthcare Solutions, LLC, *Derry, NH*	April 2012 – November 2012
Advantage HealthCare (formerly AMSplus), *Salem, NH*	October 2004 – April 2012
Paradigm Solutions, Inc., *Wrentham, MA*	October 1997 – December 2005
Suffolk University, *Boston and Franklin, MA*	September 2001 – June 2004
Acadia Software, *Boxborough, MA*	February 1996 – June 1998
Charles Stark Draper Laboratory, *Cambridge, MA*	June 1994 – February 1996

EDUCATION

Northeastern University, *Boston, MA*
Bachelor of Science, Computer Science, Minor in Business Administration and Mathematics, June 1998

CERTIFICATIONS / PUBLICATIONS / SPECIAL SKILLS

Proficient in C#, HTML, ASP .NET, VB .NET, Cache, SSRS/SSIS, TFS, Agile, Waterfall, Windows Server Family, Exchange, SQL Server, UNIX, LINUX, Network architecture and design, Web-based SAAS application architecture, database architecture, HIE System implementations

RICHARD J. DWYER, PROJECT MANAGER
MANAGER AT PUBLIC CONSULTING GROUP, INC.

Mr. Richard Dwyer, a Manager located in our Boston office since 1993, has over thirty years of experience in financial and operations management in corporate and healthcare provider and payer environments. For providers, Mr. Dwyer has been actively involved in improving revenue and management operations to optimize program revenues and to bring healthcare facilities into compliance with federal, state, and other third-party requirements. This work covers various provider settings and programs including hospitals, community mental health centers, federally qualified health centers, public health clinics, partial hospitals, and pharmacy (Medicare Part D) services. For payers, Mr. Dwyer has directed third party administration and related services for state agencies and private insurance companies who chose to outsource those functions. Mr. Dwyer has also directed numerous planning and evaluating projects involving mental health hospital and community-based programs. Through-out many of these engagements, expanded use of automated systems and providing system implementation and change management services was provided to achieve optimal results. Mr. Dwyer has earned both a BSBA and MBA from Babson College located in Wellesley, Massachusetts.

RELEVANT PROJECT EXPERIENCE

Department of Health, State of New Jersey

Data Intermediary Services (February 2017 – Present)

- Directed and administrated the implementation of our claims collection, processing, auditing, and warehousing application for inpatient and outpatient hospital claims.
- PCG is responsible for receiving and processing approximately 2.5 million inpatient and outpatient hospital and ASC claims annually resulting in provider payments in excess of $600M.
- PCG developed a NJ-specific 837 companion guide to apply NJ-specific 837 submission requirements to 837 files submitted by the providers through the applications.
- PCG leverages the latest system infrastructure to provide real-time claim edits for unique NJ logic to claims submitted through the application.
- The project requires regular communication with major stakeholders including the NJ Hospital Association, providers, and DOH staff.
- Key deliverables included developing business and system requirements, ANSI ASC X12N 837R Companion Guide, NJ-Specific Claim Edit Specifications, Provider Data Dictionary and Extract Layout, and application for claims collection, processing, auditing, and warehousing.

Division of Medical Assistance, Central Billing Office, State of North Carolina

Medicare Part D State Operated Facility Billing (July 2015 – Present): PCG Manager

Project: The goal of the NC DMA is to maximize Medicare reimbursement for Med D pharmacy claims for State owned facilities. The volume of billable claims is approximately158,500 claims per year. PCG accepts claims data from the NC Division of Medical Assistance for claiming to Medicare. PCG assists in rejection and denial management.

Department of Children and Families, State of Florida

Medicare Part D State Operated Facility Billing (July 2015 – Present): PCG Manager

Project: The goal of the FL DCF is to maximize Medicare reimbursement for Med D pharmacy claims for State owned facilities. The volume of billable services is approximately 6,000 claims per year. PCG accepts data from the FL Department of Children and Family Services for claiming to Medicare. PCG also performs Med D eligibility and assists in rejection and denial management.

Department of Human Services, State of Illinois

Revenue Maximization Medicare Part D Recoveries (July 2015 - Present): PCG Manager

Project: The goal of the IL DHS is to maximize Medicare reimbursement for Med D pharmacy claims for State owned facilities. The volume of billable claims is approximately 153,600 claims per year. PCG accepts claims data from IL Department of Human Services for claiming to Medicare. PCG also performs Med D eligibility verification and assists in rejection and denial management.

Mr. Dwyer: Directs and coordinates all project resources and development needs. He was heavily involved in the planning and development of the web-based electronic pharmacy claiming system designed to address the particular needs of state operated facilities. Largely utilized for the Medicare Part D program, this application consists of the technology to receive and warehouse large quantities of pharmacy data, to create claims for eligible participants and covered drugs, and to submit real-time electronic prescription drug claims to the appropriate payers. The application was designed to meet industry requirements and standards; it performs a variety of automated functions such as obtaining insurance eligibility data that is used to produce compliant claims for covered individuals.

Department of Health Care Finance, District of Columbia

Administrative Service Organization (September 2010 – Present): Project Director

- Oversee the entire implementation of a large scale ASO operation which involves leading a team of project managers, business teams and system IT Developers. Continue as Project Director to oversee on-going operations.
- Accomplishments during the project included developing a comprehensive standardized approach to Partner Agency Medicaid billing, building a compliance team for qualitative medical record reviews and designing a claiming system to process thousands of claims per month.
- Other services managed under the contract includes but is not limited to payment reimbursement services, weekly, monthly quarterly and yearly reporting, provider status call center and overall client management.
- The ASO is responsible for processing institutional, professional, transportation services on behalf of the department.

Department of Health, State of New Mexico

Regional Healthcare Reimbursement Training (July 2017 – June 2018): Project Director

- Directed the development of a state-wide revenue cycle training program for clinical and administrative personnel who perform Public Health Clinic services across the state.
- Conducted on-site assessments of representative public health clinics to assess current clinic operations and identify specific training subjects and needs.
- Supported the development of a training needs assessment survey sent to clinical and administrative staff for additional state-wide input.
- Issued a report of findings and recommendations for operational improvements and training needs to support improved revenue cycle performance.
- Developed revenue cycle training presentation material designed specifically to address the identified needs of the state.
- Will participate in upcoming regional staff training presentations across the state.
- Will develop an interactive on-line training tool to support the future training needs of new staff as well as annual refresher training of current staff.

Department of Health, Bureau of Early intervention, State of New York
State Fiscal Agent (April 2013 – Present): Implementation Director

- Directed the year one implementation of project operations of our claims processing, provider payment and commercial billing engagement with the Bureau of Early Intervention (BEI).
- PCG is responsible for receiving and processing approximately 9 million health care claims annually resulting in provider payments in excess of $600M for over 70,000 infants and toddlers with disabilities and their families.
- PCG developed four organizational units to serve the needs of this contract including Billing and Claiming, Information Technology, Customer Service and Accounting and Finance.
- PCG leverages a web-based claims engine to adjudicate and validate provider claims, provide a data warehouse for program reporting, and provide technical assistance and training on provider billing requirements.
- The project requires regular communication with major stakeholders including the BEI, providers and municipalities.
- Key deliverables included developing business and system requirements, policy and procedures, establishing process workflows, and implementing a claim submission to Medicaid and commercial payers and check run process to EI providers.

Commonwealth Care Alliance
Third Party Administrative Services
(July 2004 – June 2014): Project Director

- Directed third party administration operations for a Medicare Advantage Plan Senior Care Options (SCO) program as well as an integrated care organization for dually entitled recipients.
- PCG manages payment reimbursement services, weekly, monthly, quarterly and yearly reporting, provider call center operations and overall client management.
- As part of our claims operations, PCG manages provider web portal for claims submission, claims inquiry, and direct data entry.
- Manage the Electronic Data Interchange (EDI) process for claims submitted through clearinghouses and provide training for direct claim submitters.
- Manage paper claim submissions via a paper to EDI conversion process to automate claims processing and ensure standardization of claim rules.
- Process service authorizations via compliant 278 transactions.
- Manage provider check-run and bank reconciliations processes.
- Perform third party liability and subrogation functions.

Arizona Healthcare Cost Containment System, State of Arizona
Administrative Service Organization
(February 2009 – June 2014): Project Director

- Direct the overall client management for the ASO functions.
- PCG performs Third Party Administration services along with Administrative Service Organizational (ASO) functions in our agreement with Arizona Health Care Cost Containment System (AHCCCS).
- Developed a comprehensive and high-quality claims processing solution for submissions and processing of Direct Medical Services (DMS) claims by the Local Education Agencies' (LEA) and designated billing partners.

Department of Public Health, Lemuel Shattuck Hospital, Commonwealth of Massachusetts
Financial Management / Coding and Compliance Services
(December 2004 – October 2015): Project Director

- Direct the ongoing financial management operations of this 270-bed Massachusetts Department of Public Health Hospital.
- Accomplishments include the restructuring of the Patient Accounts and Information Management functional areas.
- Initial primary goals were to maximize reimbursement through effective accounts receivable management and reporting capabilities.
- Also included Medicare and Medicaid compliance reviews of ancillary department operations.
- The project included the development of annual revenue and cash flow budgeting models, standardized monthly financial reporting, the design and implementation of improved automated Management Information Systems, development of training and education material to enhance coding accuracy, and improved operational policies and procedures with appropriate documentation.
- Also standardized internal controls to promote integrity of the automated accounts receivable system, improved billing and collection processes and performance, restructured existing hospital processes to facilitate managed care reimbursement, enhanced compliance with federal, state, and other third-party payers, and improved operational efficiency and effectiveness.

Department of Health and Hospitals, State of Louisiana
Office of Public Health (July 2003 – June 2014): Project Director

- The Office of Public Health is responsible for the delivery, management and oversight of a variety of health care and health related programs including over 100 health clinics across the state.
- The primary goal of this project was to develop a web-based patient information system to improve the efficiency of collecting health care service data and improving the billing and collections of services.
- The primary role as Project Director for this engagement was to ensure project goals, assignments and tasks were met in a timely manner.
- Key assignments included business process analysis, business requirement development and documentation, development of end user documentation manuals and training materials, system design, development, testing and implementation.
- Further assignments for this project included the start-up of the revenue operations function responsible for billing and collecting revenues for the health clinics.

Department of Mental Health, Metro Boston Area Office, Commonwealth of Massachusetts
Financial Management Services (December 2004 – December 2012): Project Director

- Direct the financial management operations of three facilities for the Metro Boston Area Office.
- Engagement includes providing on-going assistance with the development of an area-wide compliance program.
- Settings include Outpatient Clinic, Partial Hospitalization, and Inpatient Psychiatric Hospitals.
- Primary accomplishments include the introduction of compliance assessments, corrective action plan development and implementation, and subsequent infrastructure redesign to maintain on-going compliant revenue operations.
- Successfully implemented Medicare billing, patient notification, level of care determination, and other revenue related program requirements for two newly certified DMH Inpatient Psychiatric Hospital Units.

- Enhanced benefit eligibility processes and improved management reporting, operational performance, and revenue results for all units.

Department of Social and Health Services, Mental Health Division, State of Washington
Compliance and Revenue Operations Improvement (January 2000 – July 2006): Project Director

- Directed the creation and development of a Medicare and Medicaid compliance program for three psychiatric hospitals operated by the State of Washington's Mental Health Division.
- This program incorporated the compliance guidelines issued by the Office of the Inspector General (OIG), broad multi-disciplinary participation of senior hospital personnel, and the concept of best business practices and process redesign.
- Project encompassed a compliance review of inpatient-routine and ancillary department operations to ensure full compliance with federal and state requirements.
- These reviews included process and work tool redesign and ongoing compliance monitoring to attain and maintain efficient, effective, and compliant operations.
- Other significant projects included a Client Movement Study designed to identify opportunities for improvement in business processes, staffing, and automated systems as they related to revenue operations; a Feasibility Study and Business Plan engagement designed to evaluate the automated system needs of the hospitals and to assess the possibility of the selection of a replacement system; and the improvement of Financial Reporting.

University of Massachusetts, Commonwealth of Massachusetts
Assess and Coordinate the Implementation of Medicare Part D Benefit for State Operated Facilities (December 2005 – June 2006): Implementation Project Manager

- Prepared an initial assessment of the impact of the Medicare Part D program on state operated facilities in the Commonwealth and coordinated the subsequent implementation of the Medicare Part D claiming process across all state facilities.
- Acting as project manager and working collaboratively with all involved state agencies, this project successfully responded to the requirements of the Medicare Part D program which impacted such areas as data flow design and management, pharmacy drug plan contracting, eligibility determinations, pharmacy and facility rate setting, Medicare D and facility pharmacy claiming, and statistical, financial, operational and management reporting among others.
- The long-term pharmacy claiming activities covered three state agencies which encompassed 19 facilities including acute inpatient psychiatric hospitals, intermediate care facilities, long-term care hospitals and a skilled nursing facility.
- The project successfully developed a claiming infrastructure that met the all filing requirements and deadlines and produced a steady flow of Medicare Part D revenue within 100 days of the project start date.

Department of Social and Health Services, Mental Health Division, State of Washington
Projecting Need for Inpatient & Residential Adult Behavioral Health Services (July 2004 – March 2005): Project Director

- Directed a detailed capacity and demand study of inpatient and residential services for adults and children.
- The scope included extensive collection of data from state operated psychiatric hospitals operated by the Mental Health Division and community services provided by Regional Support Networks (RSNs), development of a peer state baseline comparison study of state and private inpatient psychiatric facilities that analyzes current status of facilities and projects future trends; record

review and demand findings; and a final report detailing current inpatient and residential capacity and demand in the State.

Department of Public Health, Massachusetts Hospital School, Commonwealth of Massachusetts
Comprehensive Revenue Generation Assessment (December 2004 – July 2005): Project Director

- Directed a comprehensive compliance audit of this 100-bed Massachusetts Department of Public Health facility.
- This review encompassed medical records, revenue generating, and compliance functions. Produced final written report that identified compliance issues, regulatory citations, financial impact, and recommended corrective action plan.

Partners Health Care System, Massachusetts General Hospital
Revenue Operations and Financial Advisory Services (January 2001 – September 2006): Project Director

- Directed the review and assessment of revenue operations for six professional organizations within the Department of Psychiatry.
- The goal of this assessment was to identify and recommend enhancements to existing processes and to improve cash collection results.
- This assessment extended into a compliance review of the partial hospitalization program to ensure that the adequate provision and documentation of services as required by third party payers was occurring.
- A corrective action plan, which included the redesign of treatment plans, group notes, and the discharge summary, was presented for implementation.
- This engagement included the assumption of the on-going responsibilities for cash collection and accounts receivable management for the six professional organizations.

Department of Mental Retardation, Marquardt Nursing Center, Commonwealth of Massachusetts
Financial Management Services (July 1998 – November 2004): Project Director

- Directed the implementation of Medicare billing, patient notification, level of care determination, and other revenue-related requirements for this skilled facility.
- Redesigned processes educated staff on Medicare program requirements and eligibility determination processes and provided retrospective billing services.
- Also implemented changes resulting from Medicare's adoption of consolidated billing requirements and conducted compliance audits of medical record documentation.
- Currently direct the ongoing billing and collection operations as well as quarterly compliance audits to ensure continual compliance with federal and state requirements.

Harvard Pilgrim Health Care
Fee Schedule Development Project (December 2000 – April 2001): Project Director

- Directed a fee schedule rationalization engagement designed to provide a more equitable reimbursement methodology to applicable contracted providers as well as to simplify the administrative effort to maintain the fee schedules into the future.
- This project introduced Resource Based Relative Value Units as a basis in determining pricing for individual procedures and provided a flexible model for quantifying the financial impact of future fee schedule updates.

Cambridge Health Alliance
Revenue Operations and Financial Advisory Services (September 1998 – October 2001): Lead Consultant

- Directed the review of front-end operations for outpatient psychiatric services.

- Provided system enhancements for managed care authorization management, assessed operational processes from intake through encounter form submission, and implemented clinician encounter form tracking system to monitor receipt of outpatient service data for billing.

Department of Mental Health, Springfield Municipal Hospital, Commonwealth of Massachusetts
Revenue Operations and Financial Advisory Services (July 2000 – August 2001): Senior Consultant

- Performed detailed operations review of finance department including review of general accounting, financial statement preparation, and billing and collection functions.
- Analyzed other activities that support fiscal services such as admissions, social services, medical records, and ancillary departments.
- Drafted new policies and procedures that have been presented to hospital administration and to the Finance Committee of the Board of Trustees.

PROFESSIONAL BACKGROUND

Public Consulting Group, *Boston, MA* — September 1993 –Present

Bay State Health Care Centers, *Cambridge, MA* — September 1989 – September 1993

Organization Control Services, *Ann Arbor, MI* — June 1987 – August 1989

National Medical Care, *Woburn, MA* — August 1985 – June 1987

The Analytic Sciences Corporation, *Reading, MA* — July 1981 – August 1985

EDUCATION AND CERTIFICATIONS

Babson College, *Wellesley, MA*
Master of Business Administration, Management Concentration

Babson College, *Wellesley, MA*
Bachelor of Science in Business Administration, Finance Concentration

KELLIE MICALE, DATA ANALYST
DIRECTOR OF REPORTING AND ANALYSIS AT PUBLIC CONSULTING GROUP, INC.

Ms. Kellie Micale has 14 years of experience in healthcare specializing in Accounting and Financial reporting. Ms. Micale is a Certified Public Accountant. In all projects, she is responsible for setting operational goals and objectives and providing management oversight. Her blend of project experience, and technical knowledge allows her to handle a wide variety of projects in a highly effective manner.

RELEVANT PROJECT EXPERIENCE

New York Department of Health, Bureau of Early Intervention, State of New York

State Fiscal Agent (October 2013 – Present): Healthcare Accounting and Reporting Manager

Project: PCG is contracted with the New York State Department of Health, Bureau of Early Intervention to manage the EI Program. This includes the development and maintenance of a web-based claiming application for EI providers. The NY BEI program is the largest in the country, with over 70,000 children in the program.

Ms. Micale: Provides data analytic and financial reporting support to the program. She develops policy and procedures related to the processing and approving payments to vendors. She established a process to provide annual 1099 forms to providers by utilizing a third party vendor. Additionally, she is responsible to the preparation of business system requirements for the automation of invoicing, electronic funds transfer and other accounting system enhancements.

Michigan Department Community Health, Bureau of Laboratories, State of Michigan

Third Party Billing Services (October 2013 - Present): Healthcare Accounting and Reporting Manager

Project: The goal of the MDCH is to maximize Medicaid and private insurance reimbursement for laboratory tests performed at the State Laboratory. Laboratory services billed by PCG include STD testing and blood lead tests. PCG accepts data from MI State Public Laboratory for claiming to third party payer and invoicing to their submitters.

Ms. Micale: Responsible for organizing and leading client meetings to discuss financial and accounting issues. Responsible for reporting financial results to senior management on a monthly basis. Led the Accounting and Reporting team in the establishment of key reporting metrics and a reporting infrastructure.

Oregon State Public Health Laboratory, State of Oregon

Third Party Billing Services (October 2013- Present): Healthcare Accounting and Reporting Manager

Project: The goal of the OSPHL is to maximize Medicaid and private insurance reimbursement for laboratory tests performed at the State Laboratory. The volume of billable services is approximately 120,000 per year. PCG accepts data from OR State Public Health Laboratory for claiming to third party payer and invoicing to their submitters. The first six months of billing resulted in $973,887 in payments for FY 2015.

Ms. Micale: Responsible for organizing and leading client meetings to discuss financial and accounting issues. Responsible for reporting financial results to senior management on a monthly basis. Led the Accounting and Reporting team in the establishment of key reporting metrics and a reporting infrastructure.

Body Access, Andover, MA

Financial Services (December 2002 – May 2010): Healthcare Accounting and Reporting Manager

Ms. Micale: Responsible for preparing the financial data for the Business Plan. Managed financial operations including bill, payables, payroll and reporting and planning.

Blue Cross & Blue Shield of Massachusetts/Bay State Health Care, Boston, MA
Auditing Services (April 1992 – May 2001): Healthcare Accounting and Reporting Manager

Ms. Micale: Reported directly to the Controller and led the reporting team in the preparation of monthly and year-end financial statements. Analyzed monthly fluctuations and provided cost and utilization analyses. Reported key performance metrics and trends to Senior Management monthly. Prepared annual budgets and reforecasts for plans. Acted as a liaison between Product Management and other departments in investigating actual vs. plan fluctuations.

PROFESSIONAL BACKGROUND

Public Consulting Group, *Portsmouth, NH* — Oct. 2013 Year – Present

Body Access, *Andover, MA* — Dec 2002 – May 2010

Blue Cross & Blue Shield of Massachusetts, *Boston, MA* — April 1992 – May 1991

EDUCATION

Suffolk University, *Boston, MA*
Master's in Business Administration 1999

Boston College, *Chestnut Hill, MA*
Bachelor of Science in Accounting 1986

CERTIFICATIONS / PUBLICATIONS / SPECIAL SKILLS

Certified Public Accountant, State of MA

GLENN ANDERS SCHRODER, DEVELOPMENT MANAGER
DIRECTOR OF SOFTWARE ENGINEERING AT PUBLIC CONSULTING GROUP, INC.

Glenn Schroder, located in our Boston MA office, is the Director of Software Engineering for the Health practice area at PCG and will serve as development manager and technical architect for this project.

Mr. Schroder joined PCG in 2012 and has an extensive history and background in application development, systems analysis, and design since graduating with a degree in Computer Information Systems. Mr. Schroder began specializing in web-based application design and development in 2000 worked as an adjunct professor at Bryant University for several years, developing and teaching web application related development and design curriculums.

Since joining PCG, Mr. Schroder's primary responsibilities are as a system architect, preparing project proposals and estimates in response to user requirements, leading 'white board' architecture sessions, technology research, prototyping, managing development and teams of development engineers in PCG offices in Massachusetts, North Carolina, and New Hampshire. In his time with PCG, Mr. Schroder has made significant contributions on numerous successful new project implementations. Among those, he led efforts to design a highly interoperable distributed web-based system and database schema for a new North Carolina Provider Training and Screening system, Wisconsin and Colorado Medicaid Cost Reporting systems, a Colorado Substance Abuse and Mental Health system, a Low Income Subsidy system, and most recently PCG's MPA Navigator application for State and Federal Exchanges.

In addition to his work on new development, Mr. Schroder also has responsibility for leading efforts to refractor a number of client applications to bring those up to contemporary technology, heading up the HHS mobile application development initiatives and is called upon to develop prototypes to prove and evaluate new technology on various platforms.

RELEVANT PROJECT EXPERIENCE

NJ Data Intermediary Services, State of New Jersey
(May 2017 – January 2018):

Project: Directed the development for a comprehensive hospital, ambulatory, and long-term care facility provider claims data intake, querying, correction, and reporting system. A comprehensive web-based UI provides querying, editing, and reporting functionality. An EDI 837 file parser component validates input data format and performs NJ state specific edits on claims. Resulting 999 and 277 files are generated and accessed by providers. Claim data is run through multiple claim groupers (APR-DRG, APC, etc.). A data warehouse was developed to store claim data to satisfy extensive reporting requirements and for sending nightly claim file data extracts that are shared with the NJ DOH.

Mr. Schroder: Researched tools and architected a solution that would tie both 3rd party software together with PCG HSD in-house development to build a comprehensive system, including EDI, Geo-location, Invoicing and Billing, Claim Groupers, and reporting. Coordinated development efforts and had daily direct involvement with programming staff, business analysts, QA and database resources. Participating in weekly scrum calls and ongoing discussions with the business team and database analysts.

Arkansas Department of Human Services, State of Arkansas
Arkansas Works – Employer Sponsored Insurance Premium Assistance (August 2016 – January 2017):

Project: Lead the development on an effort to develop an eligibility and enrollment framework system that would replace the traditional fee-for-service Arkansas Medicaid expansion coverage purchased through qualified health plans through the marketplace. The system was developed in response to a new program passed by the Arkansas General Assembly intended to provide premium assistance through employer-sponsored coverage. The AR ESI system encompassed batch input, a web interface, and API calls to external Arkansas systems for verifying eligibility. The system seamlessly provides functionality and views of data for several different user roles

Mr. Schroder: Participated in the effort to identify and prioritize requirements. Led white-board design sessions with developers and business team. Oversee development and prepared process flow diagrams, technical and functional specifications. Participating in weekly scrum calls and ongoing discussions with the business team and database analysts. Direct involvement with integrating third-party UI design concepts and SOAP API components into development.

Wisconsin Department of Health, State of Wisconsin

Wisconsin Medicaid Cost Reporting (WIMCR) (June 2013 – September 2014):

Project: Collaborate with Wisconsin DHS to develop a WIMCR reporting methodology which consolidates twelve Medicaid reimbursable programs into a single web based financial report. Develop and manage a web-based tool to collect cost report data, generate notifications and apply automated reviews. Compile feedback from county stakeholders to ensure that all unique county agency structures and program specific concerns are addressed.

Mr. Schroder: Participated in the effort to scope out project size and costs. Led white-board design sessions with developers and business team. Oversee development and working closely with development team. Participating in weekly scrum calls and ongoing discussions with the business team and database analysts. Direct involvement with integrating third-party UI design concepts into development.

Information Technology Division, Public Consulting Group

Random Moment Time Study Mobile Application

Project: Researched technology, tools, and methodology for developing a mobile application version of the PCG Random Moment Time Study software. Selected the platform and mapped out the approach for building a mobile application that interfaces with service APIs that in turn connect to data.

Mr. Schroder: Procured software, hardware, and obtained necessary licensing. Worked directly with developers to build and then to deploy the mobile RMTS application.

Ohio Office of Medicaid, State of Ohio

Provider Oversight and Incident Investigation System

Project: Defined and refined system requirements.

Mr. Schroder: Conducted 'white board' architecture review meetings to capture system and component flow. Created technical specifications and architecture diagrams. Assembled a team of developers and managed them throughout the development phase of the project.

Oklahoma Trauma Fund Audit Department, State of Oklahoma

Oklahoma Trauma Fund Audit System: System Architect and Development Manager

Project: Developed a comprehensive architecture diagram, technical specifications, and levels of efforts.

Mr. Schroder: Led system design sessions. Designed the User Interface and created wire-frame mock-up screens. Assigned task of managing day-to-day development to a lead developer on my

team who in turn worked with another developer. Participated in weekly scrum meetings and provided strategic support and guidance as needed.

Colorado Community Behavioral Health, State of Colorado
Substance Abuse Disorder System System Architect and Development Manager

Mr. Schroder: Participated in all phases of the project from RFP through analysis, design, development, and user acceptance testing and production migration.

Hawaii Health Connector, State of Hawaii
Navigator System

Mr. Schroder: Assimilated high-level requirements and broke those down to system, application, and architectural components. Designed the Database schema. Created the User Interface and master style sheets for project. Led 'white board' architecture system design sessions with the client to scope-out enhancements and requirements on 5 project teams. Manage a team of three systems engineers throughout development.

Division of Medicaid (DOM), State of Mississippi
Mississippi AlloCAP™

Project: Determine direction and utilization of shift in technology design pattern for DOM implementation of AlloCAP™ and future implementations of AlloCAP™.

Mr. Schroder: Provided strategic direction. Realigned engineering resources within the ITD organization to best address the unique technical and business requirements of AlloCAP™. Supervise engineering resources on this project.

Division of Behavioral Health, State of Colorado
Substance Use Disorder Treatment

Mr. Schroder: Prepared project proposal and development estimates to business team. Determined the component architecture for the system, including integration with PCG's Health and Human Services Web Portal to leverage existing functionality for user management and user authentication. Created development estimates and broke project into phases and sprints. Manage two engineering resources on this project.

Colorado Medicaid, State of Colorado
Colorado Medicaid Uniform Cost Reporting

Mr. Schroder: Met with PCG Business analysts to refine objectives and created a detailed project proposal and component break-out. Designed system and functional architecture. Integrated this system into the HHS Web Portal. Managing an engineering resource assigned to this project as the state continues to add new expanded features and additional reports.

Information Technology Division, Public Consulting Group
Health and Human Services Web Portal

Project: Portal provides a single sign-on authentication solution for applications integrated with the HHS portal.

Mr. Schroder: Designed and developed an architecture platform that promotes shared processing and extensibility via SOA components.

Department of Health & Human Services, State of North Carolina
Provider Screening / Provider Training

Project: Created systems for automating the provider screening and training processes.
Mr. Schroder: Led the effort to design the system architecture, including integration with external vendors via SOA framework. Direct involvement with creation of the database schema and core processing components. Managed a team of 2 to 3 systems engineers throughout development.

PROFESSIONAL BACKGROUND

Public Consulting Group, *Boston MA* Nov. 2012 - Present

EDUCATION

Bryant University, *Smithfield, RI*
Bachelor of Science in Computer Information Systems

Northeastern University, *Boston, MA*
Various application development certification programs

MATTHEW SORRENTINO, PMP, EXECUTIVE SPONSOR
MANAGER AT PUBLIC CONSULTING GROUP, INC.

Mr. Sorrentino, a Manager and Center of Excellence (COE) in PCG's Austin office, is a health management consultant with 16 plus years of extensive Medicaid experience, specifically focusing on financial management services and solutions, program reviews, policy analysis, third party administrator services, and payment transformation for Medicaid agencies. In addition, Mr. Sorrentino has an in depth understanding of CHIP, Medicare, and other publicly funded healthcare programs.

Mr. Sorrentino's experience has included a particular focus within Medicaid reimbursement, both within institutional and community-based settings. Pertinent to institutional services, Mr. Sorrentino has assisted Medicaid programs to develop and implement inpatient and outpatient hospital payment methodologies, including transforming from cost based systems to acuity based rate methodologies, establishing inpatient and outpatient base rates, calculating upper payment limits (UPLs), designing provider assessments to generate new Medicaid funding streams, determining and designing disproportionate share hospital payments, and assisting states to implement pay for performance methodologies. Mr. Sorrentino has also led community-based rate setting efforts, including: the establishment of fee schedules for physician services, mental health services, school-based services, substance abuse services, and long-term care services, among others.

Mr. Sorrentino has assisted Medicaid programs to implement and administer Medicaid cost settlement and reconciliation programs, with a particular focus on school based, emergency medical services, and county-based services. This experience includes developing cost-based reimbursement methodologies, drafting and obtaining approval of Medicaid state plan amendments, and establishing best practices for ongoing operations. Mr. Sorrentino also spearheaded the development of PCG's web-based software solution to allow State Medicaid programs to manage and streamline Medicaid cost settlement program processes through the development of the Medicaid Cost Reporting and Claiming System (MCRCS) and now the PCG Claiming System.

Mr. Sorrentino has oversight for PCG Health's third-party administrator and claims processing services. Mr. Sorrentino oversees claims processing of over $500 million in annual claims per year. Furthermore, Mr. Sorrentino assisted in developing new services offerings, including case management and utilization management functions.

Most recently, Mr. Sorrentino has assisted Medicaid programs to implement innovative service delivery and payment strategies, from preserving UPL and uncompensated care funds as Medicaid agencies expand managed care delivery systems, to transforming Medicaid service delivery and payment systems with the establishment of delivery system reform incentive payment (DSRIP) programs. Mr. Sorrentino has navigated Medicaid agencies through all facets of these strategies from program design, to facilitating stakeholder engagement and feedback, to negotiating CMS approval, and ultimately program implementation.

RELEVANT PROJECT EXPERIENCE
Third Party Administrator & Claims Processing Services
NJ Data Intermediary Services, State of New Jersey
(May 2017 – January 2018):

- Oversaw and sponsored the implementation of our claims collection, processing, auditing, and warehousing application for inpatient and outpatient hospital claims.
- PCG is responsible for receiving and processing approximately 2.5 million inpatient and outpatient hospital and ASC claims annually resulting in provider payments in excess of $600M.
- PCG developed a NJ-specific 837 companion guide to apply NJ-specific 837 submission requirements to 837 files submitted by the providers through the applications.
- PCG leverages the latest system infrastructure to provide real-time claim edits for unique NJ logic to claims submitted through the application.
- The project requires regular communication with major stakeholders including the NJ Hospital Association, providers, and DOH staff.
- Key deliverables included developing business and system requirements, ANSI ASC X12N 837R Companion Guide, NJ-Specific Claim Edit Specifications, Provider Data Dictionary and Extract Layout, and application for claims collection, processing, auditing, and warehousing.

Common Care Alliance (CCA), Commonwealth of Massachusetts

Third Party Administrator (TPA) Services (July 2016 – Current): Executive Sponsor

Project: Executive sponsor for TPA and claims processing services on behalf of CCA. Oversee adjudication of annual claims exceeding $500M per year, as well as customer service, appeals, and other back office operations. Worked to restructure team by implementing structural changes, which lead to operational efficiencies.

Department of Financial Services, State of New York

Medical Indemnity Fund & Third-Party Administrator (TPA) Services (July 2016 – Current): Executive Sponsor & Implementation Project Manager

Project: Executive sponsor for TPA and claims processing services on behalf of the New York State Medical Indemnity Fund (MIF). Responsible for the launch of the MIF Administrator services, including organizing the procurement of a case management platform, recruiting and hiring a case management team, and working to develop policies and procedures for implementation of MIF administrator operations, which includes enrollment, prior authorization and utilization management, as well as case management functions.

Program Review Consulting Services

Health and Human Services Commission, State of Texas

Behavioral Health Programmatic and Financial Review (July 2011 – December 2012): Project Manager

Project: Completed comprehensive study of publicly funded behavioral health system. Comprehensively documented as is system of care and current financing model for Medicaid and block grant funded services to the indigent population. Conducted statewide stakeholder sessions to obtain feedback on current service delivery model to identify strengthens and weaknesses. Second phase of the project included the development of recommendations outlined in a formal report to the Texas Legislature to reform the public behavioral health system, including specific recommendations to reform service delivery and financing of Medicaid and block grant services in order to maximize resources, as well as improve the overall quality of care.

Mr. Sorrentino: Served as the Project Manager and was responsible for all facets of the project.

Department of Assistive and Rehabilitative Services, State of Texas

Early Childhood Intervention (ECI) Program Service Delivery Structure and Funding Infrastructure Assessment (January 2010 – September 2010): Project Manager

Project: Lead assessment of current service delivery system, contract structure and funding infrastructure. Managed staff to develop an alternative service delivery structures for DARS consideration using data analysis, and discussions with stakeholders within the early intervention system. Reviewed policy, program costs, revenue appropriation, and utilization data to identify potential funding improvements and additional funding sources. Developed report detailing the funding infrastructure necessary for the proposed structural changes and a financial model of the impact on the DARS ECI system.

Mr. Sorrentino: Served as the Project Manager and was responsible for all facets of the project.

Health and Human Services Commission, State of Texas

Capitated Managed Care Model of Dental Services (October 2012 - March 2013): Project Manager

Project: Under the provisions of the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver in 2012, effective March 1, 2012, the Health and Human Service Commission (HHSC) changed the service delivery model for Medicaid dental services from a fee-for-service (FFS) model to a capitated managed care model. Public Consulting Group, Inc. (PCG) was hired by HHSC to complete a comprehensive analysis and report evaluating the impact of providing dental services through a capitated managed care model based on access, quality and cost outcomes. PCG evaluated dental services provided before and after the transition to a managed care delivery system, specifically from March to September 2011 and from March to September 2012, respectively.

Mr. Sorrentino: Served as the Project Manager and was responsible for all facets of the project.

Medicaid Rate Setting & Reimbursement

Department of Health Delivery System Reform Incentive Payment Program, State of New York (September 2014 – Present): Project Implementation Manager

Mr. Sorrentino: Responsible for execution of key project deliverables, including development of oversight requirements for $12B state funding to 25 large hospital-led Performing Provider Systems (PPSs). Develops oversight requirements for areas such as: PPS Governance, Workforce Development, Financial Sustainability and Flow of Funds, Technology Infrastructure, and project compliance. Assisted to develop financial models to determine the valuation of achievement values, as well as provide recommendations on funds flow. Develops quality measure specification procedures for NQF quality measure baselines and performance as part of Pay for Performance payment methodology.

Health and Human Services Commission, State of Texas

Enhanced Ambulatory Patient Grouping (EAPG) Payment System (August 2014 – December 2016): Project Manager

Mr. Sorrentino: Overall project manager to assist HHSC to evaluate the implementation of an EAPG outpatient hospital reimbursement system. PCG developed Texas specific weights, modeled provider classification base rates, and performed fiscal impact analysis to understand changes to reimbursement. Furthermore, PCG assessed the impact EAPGs would have on existing business processes, including require policy changes, as well as claims adjudication processes that would be impacted. Finally, PCG supported the incorporation of EAPGs into the Medicaid managed care capitation rates.

Department of Health Care Policy & Financing, State of Colorado

Delivery System Reform Incentive Payment Program (March 2016 – 2018): Technical Adviser

Mr. Sorrentino: Responsible for providing technical assistance in drafting a concept paper to outline high level goals and objectives of a Section 1115 transformation waiver. The goal of the waiver is to preserve inpatient and outpatient hospital upper payment limit supplemental payments, while repurposing these funds to provide hospitals incentives to engage in system transformation. Mr. Sorrentino provided strategic direction on the design of the concept paper and the structure of the transformation program.

Executive Office of Health and Human Services, Commonwealth of Massachusetts

Enhanced Ambulatory Patient Grouping (EAPG) Rate Setting (July 2014 – June 2017): Project Director

Project: Assisting MassHealth in the implementation of a new outpatient hospital reimbursement methodology. This includes working through impact scenarios with MassHealth hospital leadership during a transition year, followed by implementation of a full EAPG methodology.

Mr. Sorrentino: Serves as the Project Director, providing client support and managing project resources.

Executive Office of Health and Human Services, Commonwealth of Massachusetts

Public Emergency Medical Services (EMS) Program Claiming (January 2014 – Present): Project Advisor

Project: Developed Massachusetts' first public EMS claiming program, developing a process that is compliant with all state and federal claiming rules and regulations. Designed the methodology, including developing the Medicaid State Plan amendment and obtaining CMA approval for the cost reporting methodology. The first year of this project yielded $5.9 million in federal revenue to the Commonwealth.

Mr. Sorrentino: As Project Director, oversaw methodology and calculations.

Department of Health Services, State of Wisconsin

FQHC Alternative Payment Methodology (December 2014 – 2017): Project Manager

Project: Working to assess the current FQHC alternative payment methodology, providing recommendations on changes to transition to a prospective payment system (PPS). This includes completing detailed FQCH profile analysis, determining viable alternative payment systems, and ultimately recommending and implementing a new reimbursement system.

Mr. Sorrentino: Serves as the Project Manager and is responsible for all facets of the project.

Department of Health Services, State of Wisconsin

Inpatient and Outpatient Rate Setting Project (July 2007- December 2015): Project Manager

Mr. Sorrentino: Lead the execution of inpatient and outpatient rate setting deliverables. Lead the drafting and submission of public notices and drafting of state plan amendments. Completed calculations of the upper payment limits to ensure rate increases adhered to federal requirements. Lead efforts in the development of creating various rate setting models to calculate Medicaid costs. Managed changes in rate setting methodology to move from statewide average base rate to provider specific cost based DRG base rates for acute care hospitals. Managed modeling efforts in determining budgetary impact of rate setting changes. Managed the design of per diem prospective payment methodology for psychiatric and rehabilitation hospitals. Oversaw the transition to an EAPG reimbursement methodology for outpatient hospital services. Managed and oversaw the completion of inpatient and outpatient rate calculations for over 140 hospitals within the State of Wisconsin.

Mr. Sorrentino: Served as the Project Manager and was responsible for all facets of the project.

Department of Health Services, State of Wisconsin

Provider Tax (March 2007 – December 2015*):* Project Manager

Project: Assisted DHS in the design, development, and approval (CMS and legislative) of a hospital assessment to support provider payment increases, funding for Medicaid expansion through a childless adult's waiver, Medicaid strategic initiatives and on-going program funding during budget shortfalls. Lead aggregate hospital Upper Payment Limit calculations to support proposed payment increases. Performed federal broad-based waiver test (p1/p2) to allow the state to exclude psychiatric hospitals from the assessment. Lead financial modeling to determine the net hospital-specific impact of the assessment and payment increases.

Mr. Sorrentino: Served as the Project Manager and was responsible for all facets of the project.

Department of Health Care Policy and Financing, State of Colorado

Hospital Provider Fee Consulting Services (July 2010 – June 2015): Technical Advisor

Project: Provided state with analytical and regulatory support throughout the development and approval of hospital provider fee. Participated in internal meetings with state staff on a weekly basis to prepare for monthly Board meetings. Supported the state in obtaining a waiver of a uniform tax rate (b1/b2) by providing technical expertise in payment modeling. Provided technical assistance in the development of the statewide Hospital UPL that served as the limit for hospital payments. Assisted the state with Medicare 2552 hospital cost report data aggregation.

Mr. Sorrentino: Served as a Technical Advisor and was responsible for all tackling challenges raised by CMS and other stakeholders on the intricacies of payment methodologies.

Department of Health and Human Services, State of North Carolina Division of Medical Assistance

Hospital Provider Fee Support (May 2011 – June 2012): Project Manager

Project: Consulted with DHHS and DMA on design and implementation of a hospital provider fee (tax) program. The initiative provided enhanced funding for eligible Medicaid services as well as state funding in support of the Medicaid DSH program. Analyzed inpatient and outpatient hospital upper payment limit (UPL) calculations, projected net impact on individual hospitals, and evaluated supplemental payment programs for qualifying hospitals.

Mr. Sorrentino: Served as the Project Manager and was responsible for all facets of the project.

Department of Health and Human Services, Division of Medical Assistance, State of North Carolina

Medicaid Physician Upper Payment Limit Project (July 2010 - Present): Project Manager

Project: Implemented Medicaid Upper Payment limit program for state university physician practice plans to provide supplemental payments in addition to prevailing Medicaid reimbursement rate. Evaluated commercial payer reimbursement rates for a variety of eligible groups and calculated Average Commercial Rate (ACR) for all procedure codes paid by Medicaid. Drafted State Plan Amendment (SPA) outlining eligible providers and reimbursement methodology. Supported DMA in SPA approval and provide ongoing payment processing.

Mr. Sorrentino: Served as the initial Project Manager and has since transitioned to the Engagement Manager, responsible for oversight of the Project Manager and execution of all UPL calculations.

Department of Health Services, State of Wisconsin

Physician Upper Payment Limit Project (July 2010 - 2018*):* Project Manager

Project: Manage the ongoing calculation of the Medicaid supplemental payment for the University of Wisconsin Medical Foundation. Determine the Average Commercial Rate (ACR) for paid Medicaid services and compare ACR to actual payment rates to compute supplemental payment amount. Responsible for rebasing the ACR every three years in accordance with the State plan.

Annual supplemental payments average $38M in all funds, or approximately $26M in federal funds per year.

Mr. Sorrentino: Served as the initial Project Manager and has since transitioned to the Engagement Manager, responsible for oversight of the Project Manager and execution of all UPL calculations.

Health Care Finance and Administration, State of Tennessee

Low Income Pool Consulting Project (July 2015 - 2017): Project Manager

Project: Assisting the State to assess the long-term viability of the low-income pool (LIP) funding streams. Responsible for completion of an analysis to assess the impact to uncompensated care costs if HCFA had elected to expand Medicaid. In the process of developing an independent report on the LIP's current funding allocations, as well as providing recommendations to transition funds to a value-based payment system.

Mr. Sorrentino: Serves as the Project Manager and was responsible for all facets of the project.

Department of Behavioral Health and Developmental Disabilities, State of Georgia

Rate Review Project (February 2012 – June 2014): Project Manager

Project: Lead the development of a Medicaid cost study for mental health and substance abuse services reimbursed under the Medicaid program. Required the development of cost surveys for a sample of public and private providers to evaluate the adequacy of Medicaid reimbursement rates. Developed and distributed cost study assisted providers through the completion of the cost study and performed rate comparison analysis to current Medicaid rates. Issued report identifying specific recommendations to make changes to certain Medicaid rates and services, as well as establish prospective processes to streamline and improve prospective rate setting processes.

Mr. Sorrentino: Served as the Project Manager and was responsible for all facets of the project.

Department of Mental Health, District of Columbia

Rate Review Project (February 2013 – June 2014): Project Manager

Project: Lead the development of a Medicaid cost study for mental health and substance abuse services reimbursed under the Medicaid program and rehabilitation program benefit. Required the development of cost surveys for a sample of public and private providers to evaluate the adequacy of Medicaid reimbursement rates. Developed and distributed cost study, assisted providers through the completion of the cost study, and performed rate comparison analysis to current Medicaid rates. Issued report identifying specific recommendations to make changes to certain Medicaid rates and services, as well as establish prospective processes to streamline and improve prospective rate setting processes.

Mr. Sorrentino: Served as the Project Manager and was responsible for all facets of the project.

School & County Based Cost Reporting and Cost Settlement

Department of Health Services, State of Wisconsin

School Based Services Cost Reporting / Reconciliation Initiative (January 2009 - Present): Project Manager

Project: Lead the compilation and settlement of initial school-based cost reports under new Medicaid State Plan. Assumed management responsibility of the integrated random moment time study process for both direct services as well as administrative claiming. Compiled time study rosters, trained school district staff on revised procedures and successfully implemented a web-based cost reporting and Medicaid reconciliation system. Managed the processing of over 400 school district desk audits and processing of Medicaid cost settlements.

Mr. Sorrentino: Served as the initial Project Manager and has since transitioned to the Engagement Manager, responsible for oversight of the Project Manager and execution of all project deliverables.

Kansas Department of Health Environment, State of Kansas

Medicaid Cost Reimbursement for School Based Services (July 2009 - Present): Project Manager

Project: KHDE contracted with PCG to develop a cost reimbursement methodology for the services provided by school districts and covered under the Medicaid program. Lead the development of the public notice and Medicaid state plan amendment. Assisted KHDE in responding to CMS questions and requests for additional information. Designed web-based cost reporting application to facilitate Medicaid cost settlement process. Managed trainings to school districts on the new annual cost reporting process. Directed the processing of Medicaid cost settlements. Responsible for the development of interim rates. Developed onsite field audits of LEAs to validate cost reports and supporting documentation.

Mr. Sorrentino: Served as the initial Project Manager and has since transitioned to the Engagement Manager, responsible for oversight of the Project Manager and execution of all project deliverables.

Department of Community Health, State of Georgia

Medicaid Cost Reimbursement for School Based Services: Project Manager

Project: DCH has contracted with PCG to implement a Medicaid cost settlement program. Lead the development and assisted DCH to obtain approval of the Medicaid state plan amendment to implement a cost settlement methodology. Developed cost reporting form and instructions, implemented the Medicaid Cost Reporting and Claiming System to automate the submission of the Medicaid cost reports, trained providers on how to complete cost reports, and calculated Medicaid cost settlements. Responsible for the development of onsite and remote audit program to validate cost reports.

Mr. Sorrentino: Served as the initial Project Manager and has since transitioned to the Engagement Manager, responsible for oversight of the Project Manager and execution of all project deliverables.

Arizona Health Care Cost Containment System, State of Arizona

Medicaid Cost Reimbursement for School Based Services: Project Manager

Project: AHCCCS contracted with PCG to implement a Medicaid cost settlement and reconciliation process. Lead the development and assisted AHCCCS to obtain approval of the Medicaid state plan amendment to implement a cost settlement methodology. Developed cost reporting form and instructions, implemented the Medicaid Cost Reporting and Claiming System to automate the submission of the Medicaid cost reports, trained providers on how to complete cost reports, and calculated Medicaid cost settlements. Responsible for the development of onsite and remote audit program to validate cost reports.

Mr. Sorrentino: Served as the initial Project Manager and has since transitioned to the Engagement Manager, responsible for oversight of the Project Manager and execution of all cost settlement project deliverables.

Department of Public Welfare, Commonwealth of Pennsylvania

Medicaid Cost Reimbursement for School Based Services*:* Project Manager

Project: PDW contracted with PCG to implement a Medicaid cost settlement and reconciliation process. Lead the development and design process to implement a cost settlement methodology. Developed cost reporting form and instructions, implemented the Medicaid Cost Reporting and Claiming System to automate the submission of the Medicaid cost reports, trained providers on how to complete cost reports, and calculated Medicaid cost settlements. Responsible for the oversight and project management of all program functions.

Mr. Sorrentino: Served as the initial Project Manager and has since transitioned to the Engagement Manager, responsible for oversight of the Project Manager and execution of all cost settlement project deliverables.

Department of Health Services, State of Wisconsin

Wisconsin Medicaid Cost Reporting (WIMCR) Settlement Project: Project Director

Project: Manage the review and submission of county Medicaid cost reports for eligible Medicaid services. The services subject to cost settlement include mental health, developmental disabilities, and long term supports. Cost reports are used to develop interim payment rates for Medicaid purposes. Assisted in the transformation of the cost allocation methodology, including the deployment of a robust web-based cost reporting application to facilitate cost reporting and settlement services.

Mr. Sorrentino: Serves as the Project Director and is responsible for the oversight of the Project Manager and execution of all cost settlement project deliverables.

PROFESSIONAL BACKGROUND

Public Consulting Group, *Austin, TX* 10/1/2002 – Present

Healthcare Financial Management Association (HFMA), 10/1/2002 – Present

Financial Management Association Honor's Society (FMA), 10/1/2002 – Present

EDUCATION

Clark University, *Worcester, MA*
Master's in Business Administration, 2006

Bentley College, *Waltham, MA*
Bachelor of Science in Finance, 2002

CERTIFICATIONS / PUBLICATIONS / SPECIAL SKILLS

- Project Management Professional
- Microsoft Access, Excel, Word, PowerPoint
- KPMG CMS 2552 Cost Reporting Software
- KPMG CMS 2540 Cost Reporting Software
- KPMG CMS 287 Cost Reporting Software
- KPMG CMS 288 Cost Reporting Software
- Training: SAS Visual Analytics, 2015

TEJA THOTTEMPUDI, LEAD DEVELOPER
LEAD SOFTWARE ENGINEER AT PUBLIC CONSULTING GROUP, INC.

Mr. Teja Thottempudi has 14 years of experience in designing, development, testing and integrating client/server and web technology-based projects using Microsoft technology stack. He is a Microsoft certified technology specialist (MCTS) and AWS Technical Professional. Primary areas of technical expertise include Web API, API Gateways, MVC 5.0, .Net Core, C#, VB.net , ASP.Net 1.1/2.0/3.5/4.0, MVC 3.0/4.0/5.0., Win Forms, Silverlight, ADO.Net, Entity Framework, HTML, AJAX, JavaScript, XML, Bootstrap, CSS, Crystal Reports, MOSS 2007 and SQL Server 2000/2005/2008/2014. Mr. Thottempudi is strong at RDBMS, My SQL, SQL server, writing complex SQL queries, trigger, cursors, stored procedures. He is an effective communicator committed team player, quick thinker, quick learner and rapid problem solver with commitment and a strong work ethic/ability to quickly adapt to new environments.

Mr. Thottempudi has developed web API's using ASP.NET Core, ASP.NET, C# and XML and has experience determining operational feasibility by evaluating analysis, problem definition, requirements, solution development, and proposed solutions. He is responsible for development of new programs, analyzes current programs and processes, and making recommendations which yield a more cost-effective product. Mr. Thottempudi is well versed in all stages of SDLC – Define, Design, Develop, Test and Deploy – and is a dedicated, hardworking individual with excellent interpersonal communications skills and ability to guide, motivate, and coach other developers.

Has experience in:

- Building, deploying, configuring and maintaining various types of windows, web-based applications.
- Serverless Stack development using AWS
- Designing of web pages and coding of client-side scripting & server-side scripting.
- Database communication and Development.
- Application Deployment and Configurations with Web Servers.
- ADO.Net (ActiveX Data Objects) Programming.
- Development/testing/integration of applications under n – Tier Architecture environment.
- Third party software's (Infragistics Control, Lead Tools Imaging Toolkit) and integrating them to .Net.
- Enterprise Library 3.0 for Data Access Application Block.
- Developing Business Intelligence Reports Using SSRS and Crystal Reports13.
- Source Code Management using Team foundation server. Implementing Business logic using reusable components (COM) with OOPS and subroutines (procedures, functions), libraries
- Automated Release management for different environments using new Microsoft tools which are integrated to TFS.
- Coding of forms with implementation of business logic and Presentation logic.

RELEVANT PROJECT EXPERIENCE
Public Consulting Group, Inc., Boston, Massachusetts
Department of Health, State of New Jersey
Data Intermediary Services (May 2017 – Present): Lead Software Engineer

Project: The NJ HealthCAP program is a Claim Analysis and Reporting system for counties certified as Medicaid providers. This program processes 837 EDI files and checks for data integrity and generate reports for NJ DOH (New Jersey Department of Health). The Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the

Department of Health and Human Services (HHS) establish national standards for electronic health care transactions for health plans and providers.

Mr. Thottempudi: Understanding business requirements that drive the analysis and design of technical solutions. Communicating with Client/Business users for Requirement gathering. Managing Team members in several layers (Web UI, Database & EDI). Develop web-based software applications using ASP.NET Razor, jQuery, Entity Framework 6.0,IIS and MVC 5.0 technologies. Develop EDI 837R Processing using HIPAA standards. Mobile friendly website using Bootstrap framework. Automated Release management for different environments using new AWS tools which are integrated to TFS. Version control using TFS 2017. Model user interface prototypes based on collected user requirements, test cases, and developmental objectives. Generate reports using SSRS (Reporting Services).

Wisconsin Department of Health, State of Wisconsin

Wisconsin Medicaid Cost Reporting (WIMCR) (May 2014 – Present): Lead Software Engineer

*Projec*t: The WIMCR program, is a cost-based payment system for counties certified as Medicaid providers of community-based services. WIMCR is administered by the Division of Health Care Access and Accountability (DHCAA) in the Wisconsin Department of Health Services (DHS). County providers participating in WIMCR receive a Medicaid payment from DHS based on actual costs incurred, as reported on annual cost reports. Centers for Medicare and Medicaid Services (CMS) require that federal payments are based on actual allowable and documented costs calculated using an assured cost-based accounting methodology. Consequently, county agencies are required to submit a cost report which reflects all WIMCR services that are provided by Medicaid certified providers.

Mr. Thottempudi: Technical Architect for WIMCR, understanding business requirements that drive the analysis and design of technical solutions. Develop web-based software applications using ASP.NET Razor using latest MVC 5.0 technologies. Database first methodology using Entity Framework 6.0. Mobile friendly website using Bootstrap framework. Automated Release management for different environments using new Microsoft tools which are integrated to TFS. Version control using TFS 2013. Model user interface prototypes based on collected user requirements, test cases, and developmental objectives. Plan and implement usability tests throughout development lifecycle and analyze results for resolving GUI-design issues. Diagnose and troubleshoot problems with proprietary or internally developed user interfaces. Participate in component and data architecture design, performance monitoring, product evaluation and buy vs. build recommendations. Responsible for development of new programs, analyzes current programs and processes, and making recommendations which yield a more cost-effective product. Responding promptly and professionally to bug reports and motivating team members. Experience in development/testing/integration of applications under n – Tier Architecture environment. Good experience in building, deploying, configuring and maintaining various types of windows, web-based applications. Developed client controls modal pages, tab pages, auto complete text boxes. Using jQueryUI. Use Css style sheets for designing the web application. Generate reports using SSRS (Reporting Services). Interact with management to explain each phase of the system process and address concerns raised. Build process of MS Build to compile and build latest source code from source code control and resource files into assemblies to build package (MSI) for deployment. SSL certificate installation.

Hawaii Health Connector, State of Hawaii

(August 2013 – January 2015): Lead / Senior Software Engineer

Project: The Hawaii Health Connector's Hi'i Ola program will provide Hawai'i's residents and businesses with in-person guidance and advice, from the time they begin to explore health insurance options to the time they choose and enroll in a plan. True to the Connector's mission, Hi'i Ola Specialists are consumer advocates, dedicated to empowering people to make the best health care decisions by making health insurance easier to understand and easier to purchase. Each is deeply committed to the health and well-being of everyone in our community. Ensures HIPAA compliance with secure login and data packages and redundancy of data. Browser based interface provides access whenever needed with fully searchable database.
Mr. Thottempudi: Lead software activities to understand business requirements that drive the analysis and design of technical solutions. Develop web-based software applications using ASP.NET technologies. Code front-end and back-end code including writing code behind and SQL queries and stored procedures. Code, install, test and debug user interfaces using appropriate tools or editors. Model user interface prototypes based on collected user requirements, test cases, and developmental objectives. Identify, recommend, and prioritize new user interface features and applications. Plan and implement usability tests throughout development lifecycle and analyze results for resolving GUI-design issues. Diagnose and troubleshoot problems with proprietary or internally developed user interfaces. Participate in component and data architecture design, performance monitoring, product evaluation and buy vs. build recommendations. Responsible for development of new programs, analyzes current programs and processes, and making recommendations which yield a more cost-effective product. Responding promptly and professionally to bug reports and motivating team members. Experience in development/testing/integration of applications under n – Tier Architecture environment. Good experience in building, deploying, configuring and maintaining various types of windows, web-based applications. Developed client controls using jQuery. Use Css style sheets for designing the web application. Used JQuery and AJAX Control tool kit for modal pages, tab pages, auto complete text boxes etc. Generate reports using SSRS (Reporting Services). Gather relevant information from customers and design systems in accordance with their requirements. Interact with management to explain each phase of the system process and address concerns raised. Build process of MS Build to compile and build latest source code from source code control and resource files into assemblies to build package (MSI) for deployment. Used TFS server for version controlling. Solve technical problems that arise and manage team members.

PROFESSIONAL BACKGROUND

Public Consulting Group, Inc., *Boston, MA* August 2013 – Present

XpertTech, Inc., *Woburn, MA* January 2010 – August 2013

Promantra Synergy Solutions, Inc., Hyderabad, India January 2004 – January 2010

EDUCATION

Bharathidasan University
Bachelor of Engineering, Electronics and Instrumentation Engineering, 2005

CERTIFICATIONS

- MCTS: Microsoft Windows Share Point Services 3.0: Application Development.
- MCTS: Microsoft Office Share Point Server 2007 Application Development.
- MVC 5.0 training certificate
- AWS Technical Professional

SPECIAL SKILLS

- Microsoft Technologies: C#. Net, Vb.Net, MOSS 2007.
- Database: My SQL, MS- SQL SERVER 2005/2008/2014, Oracle 9i.
- Web Technologies: ASP.NET 2.0, 3.0, 3.5, 4.0, 4.5 and 4.5.1 MVC 3.0/4.0/5.0.
- Internet/ Distributed Technologies: JQuery, JavaScript, AJAX, XML.
- IDE: Microsoft Visual Studio 2010/2012/2013/2015/2017.
- Web Servers: IIS 6.0, IIS 7.0, 7.5, Apache 2.2.
- Data Access: Entity Framework, ADO, ADO.NET, ODBC, OLEDB.
- Version Control Tools: Microsoft VSS, TFS 2017.
- Reporting Tools: SSRS (Reporting Services), Microsoft Reporting, Crystal Reports 9, 10,11,12,13.
- Third Party Controls: EDI Dev, Kendo MVC, Infragistics Net Advantage, Lead tools Imaging.

MARK TULLY, TECHNICAL ADVISOR
MANAGER AT PUBLIC CONSULTING GROUP, INC.

Mr. Mark M. Tully has been involved in helping provide access to medically underserved populations for over two decades, both in not-for-profit and government contract settings. As the director for PCG Health's Data Analytics Management, Mr. Tully has spearheaded PCG's adoption and use of sophisticated data analytics tools such as Tableau, Tableau Server and SAS Visual Analytics. As a Health Care Claims Subject Matter Expert, he has extensive experience in working with very large datasets, including All Payer Claims Databases and State Medicaid Claims Databases, for use in rate setting, reporting, fraud and abuse detection and performance management. Mr. Tully's expertise has been called on for projects such as pay-for-performance measurement, and audits of providers' information technology systems where fraud and abuse were suspected. His work also includes measuring and analyzing payment methodologies and determining whether certain services – such as hospital admissions, readmission, emergency room visits and ancillary services are preventable, utilizing the 3M Suite of Healthcare Analytics products. Mr. Tully has also worked extensively with the 3M rate groupers and managed the creation of and update to the Wisconsin Medicaid Comprehensive Claims Database.

RELEVANT PROJECT EXPERIENCE

Department of Health and Social Service, State of New Jersey
Data Intermediary Services (February 2017 – Present)

- Provide data intermediary services for all institutional providers in New Jersey, receiving claims as 837R, process through edits and 3M and Optum Groupers, maintain data warehouse of discharges and provide data feeds to state of New Jersey.
- Mr. Tully managed the technical adaptation of the 3M and Optum Groupers to ensure correct grouping within the timeframes as outlined in the contract.

Health and Human Services Commission, State of Texas
Outpatient Rate Setting (July 2014 – June 2015)

- Process historical claims data through the proprietary 3M Enhanced Ambulatory Patient Grouping System (EAPGS). Processed 376 million rows of data comprising 450 GB.
- Mr. Tully manages all the data and the deliverables process to the business team and ensures data quality and accuracy.

Executive Office of Health and Human Services, State of Massachusetts
Outpatient Rate Setting (July 2014 – May 2016)

- Process historical claims data through the proprietary 3M Enhanced Ambulatory Patient Grouping System (EAPGS). Has processed 43 million rows of data comprising 28 GB.
- Mr. Tully manages all the data and the deliverables process to the business team and ensures data quality and accuracy.

Health Care Policy Financing, State of Colorado
Outpatient Rate Setting (January 2014 – March 2016)

- Process historical claims data through the proprietary 3M Enhanced Ambulatory Patient Grouping System (EAPGS). Has processed 80 million rows of data comprising 31 GB.
- Mr. Tully manages all the data the deliverables process to the business team and ensures data quality and accuracy.

Maine Health Data Organization, State of Maine

All Payer Claims Database (July 2013 – June 2014)

- Design, build and maintain all aspects of the All Payer Claims Database for the State of Maine, as a subcontractor to Human Services Research Institute, Cambridge, MA.
- Mr. Tully provided guidance and support to the Data Modeling Workgroup to explore, define and ratify use cases for the data, support meta-data definitions and support the development of the Provider Index.

Department of Health Services, State of Wisconsin

Hospital Rate Setting (January 2011 – June 2016)

- Mange the delivery of 3M Enhanced Ambulatory Patient Grouping System (EAPGS) data from client contractor and provide the business team with timely updates of claims data for the Hospital Rate Setting Team.
- Mr. Tully managed the deliverables process to the business team and ensures data quality and accuracy.

Bureau of Early Intervention, State of New York

Early Intervention Billing Project (January 2015 – September 2015)

- Provide third-party and Medicaid billing for statewide Early Intervention providers, ensuring that all other insurances have been billed before Medicaid.
- Mr. Tully managed the development of a suite of over 25 reports for this project, which are used by state executives, providers, and PCG operations staff.

Department of Health Services, State of Wisconsin

Medicaid Claims Data Warehouse (January 2011 – Present)

- Comprehensive Medicaid claims data warehouse for PCG's projects with Wisconsin DHS. Maintain data for Fee-for-Service claims since January 2011 and Encounter claims since January 2013. Database contains 28 tables, consisting of almost 600 columns and 3.2 billion rows. Its 741 GB of data is comprised of claims, provider enrollment and recipient enrollment.
- Mr. Tully managed the design of the data model and managed the recent update of data elements for this database. He supervised the update of the Encounter data in 2013, and currently supervises any data analytics from the data warehouse and its continued maintenance.

PROFESSIONAL BACKGROUND

Public Consulting Group, Inc., *Boston MA* March 2008 – Present

Community Correctional Alternatives, *Waterville, ME* August 2006 – February 2008
Executive Director

Public Consulting Group, Inc., *Boston MA* June 1999 – July 2006

EDUCATION

Colgate University, Hamilton, NY
Bachelor of Arts, Philosophy

CERTIFICATIONS / PUBLICATIONS / SPECIAL SKILLS

- SQL Server Management Studio
- 3M Suite of Products:
    - APR-DRG, EAPGS, MS-DRG, APC, CRG Groupers

    - Population Focused Preventables
    - Potentially Preventable Complications
    - Potentially Preventable Readmissions
- Tableau
- Tableau Server Administration
- SAS Visual Analytics
- IBM Fraud and Abuse Management System
- ACS Fraud and Abuse Detection System. Dashboard Development.
- Microsoft Word, Excel, Power Point, Access.

Appendix B: NJ HealthCAP Implementation Guide

NJ HealthCAP Implementation Guide

State of New Jersey
Department of Health

Version 1.4 (09/12/2017)

For questions and comments please contact:

Email: NJ_HealthCAP@pcgus.com

PCG Health
Public Focus. Proven Results.™

TABLE OF CONTENTS

A. INTRODUCTION

The State of New Jersey Department of Health (DOH) has contracted with Public Consulting Group, Inc. (PCG) to act as the data intermediary for the collection of hospital provider discharge data in accordance with New Jersey Administrative Code (NJAC) 8:31B subchapter 2, Hospital Reporting of Uniform Bill Data (inpatient, same-day surgery, same-day medical, emergency department outpatient, and other outpatient). PCG will be replacing the current NJ data intermediary, Nuance, and implementing PCG's proprietary application, NJ HealthCAP, as a result of a competitive bid.

DOH and PCG have partnered together to develop an application that will leverage modern infrastructure technologies, such as cloud-based hosting, and intuitive UI/UX designs to ensure an efficient and comfortable user experience. This application will also provide hospital users with automated functionalities to reduce administrative burden and the duration of the claim submission and revision cycle. All aspects of the NJ HealthCAP application will comply with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Specifically, the NJ HealthCAP system will collect, edit, correct, and report submitted discharge data from enrolled providers. Example functionalities of the application include:

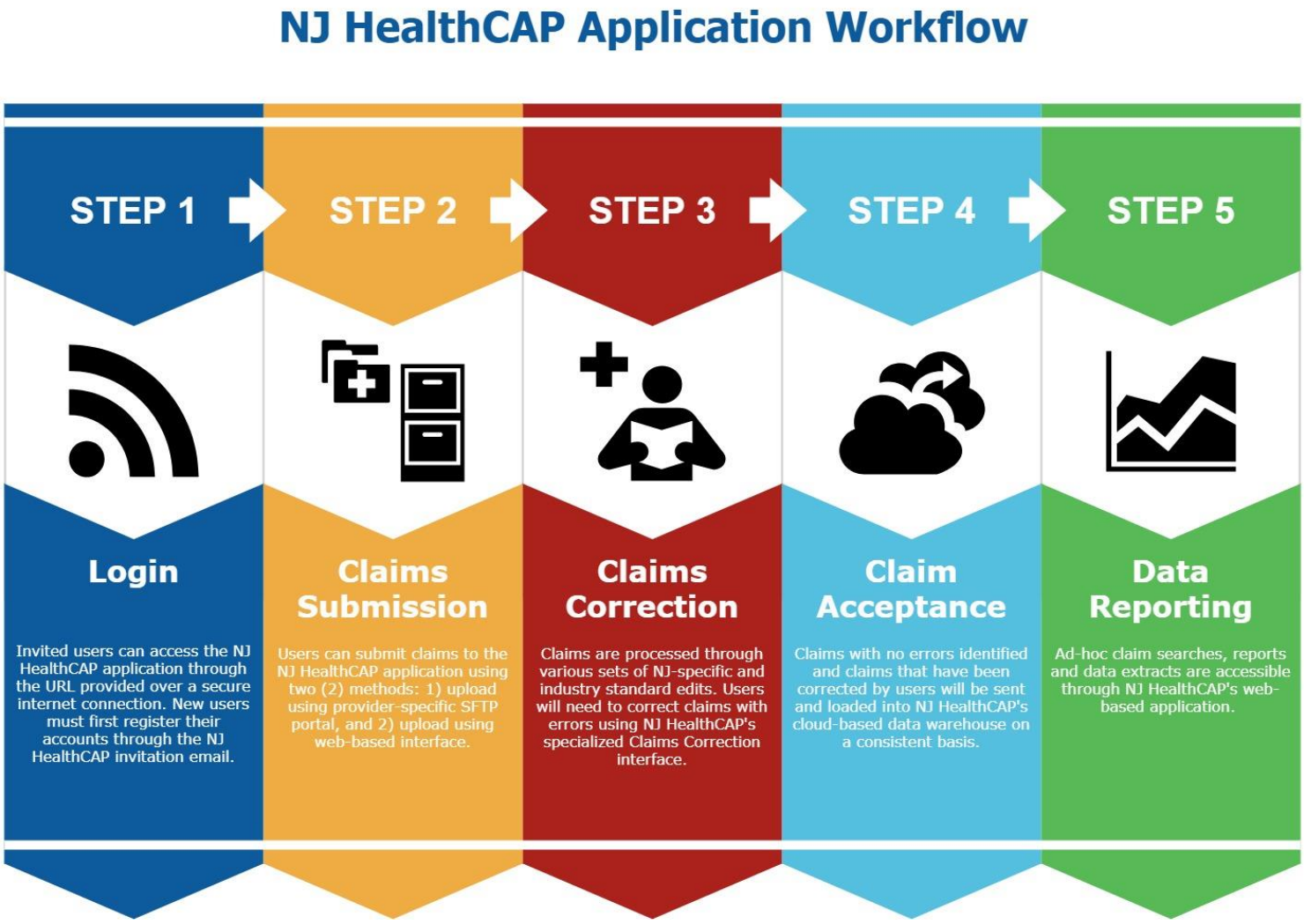
- Automated daily 837R file pickup/sweep from provider-specific secure FTP sites maintained by PCG, in addition to manual file upload
- Modern and intuitive user interface with site navigation similar to current popular sites
- Predictive data selection and text completion functionality for added efficiency in revising errored claims
- Comprehensive claims submission statistics report for ad-hoc monitoring

This implementation guide outlines the steps and processes necessary to transition your facility from the current Nuance NJDDCS application to the new NJ HealthCAP web-based application developed by PCG. Please peruse this guide and its appendices and distribute, if necessary, to appropriate personnel at your facility. The completed and signed copies of this guide's appendices will need to be submitted to PCG in order to start the implementation and transition process at your facility. **Please submit the signed appendices to "NJ_HealthCAP@pcgus.com".**

Summarized steps to take:

1. Review NJ HealthCAP Implementation Guide
2. Review, complete, and sign Pre-Implementation Forms and Checklists (Appendix A)
    a. Confirm provider information and read-through of Implementation Guide
    b. Identify key personnel per designated categories
    c. Confirm minimum system requirements
    d. Select implementation phase preferences
3. Review, complete, and sign Secure FTP Access Confirmation (Appendix B)
4. Review NJ HealthCAP Data Dictionary (Appendix C)
5. Review NJ-Specific Claim Edits (Appendix D)
6. Review ANSI 837 Addendum Guide for NJ HealthCAP (Appendix E)
7. Complete NJ HealthCAP Post-Implementation Survey (Online Survey)

B. NJ HEALTHCAP WORKFLOW



C. FACILITY DELIVERABLES

Specific deliverables and milestones requested of all participating facilities include:

1. Documents

1. Implementation Guide Signature Sheet (Appendix A)
2. Provider Contact Designation Forms (Appendix A)
    a. General Facility Resource
    b. Provider Operations Contacts
    c. Provider Billing Contact
3. Provider Implementation Phase Selections (Appendix A)
4. Project Sponsor Designation (Appendix A)
5. Provider National Provider Identifier (NPI) Confirmation (Appendix A)
6. Application Technical Requirements Checklist (Appendix A)
7. Secure FTP Access Confirmation (Appendix B)
8. Post-Implementation Survey (Online Survey)

2. Key Milestones

1. Secure FTP portal access
2. 837R file format confirmation (PCG will provide written confirmation for providers whose data file formats are accepted into the NJ HealthCAP system)
3. Attendance at NJ HealthCAP on-site provider trainings (Attendance will be recorded at all of the training sessions)
4. Establishment and confirmation of a provider-specific online billing account

D. APPLICATION DOCUMENTATION

PCG will provide the following list of technical documentation and general application resources for the NJ HealthCAP application. All documents listed below will be distributed to providers prior to the implementation date, and uploaded to the “Resources” section of the application dashboard for convenient access.

- NJ HealthCAP ANSI 837 Addendum Guide (Appendix E)
- NJ HealthCAP User Guide (Still in Development)
- NJ HealthCAP Data Dictionary (Appendix C, Still in Development)
- NJ-Specific Claim Edits (Appendix D)
- NJ HealthCAP Provider Training Presentation
- NJ HealthCAP Frequently Asked Questions (FAQ)

E. IMPLEMENTATION OVERVIEW

1. Timeframe

In accordance with DOH requirements and PCG's application implementation best practices, the NJ HealthCAP application beta testing and implementation process have been projected to span two (2) months, with all hospitals completing the implementation process by September 30, 2017, and transitioning to the NJ HealthCAP application on: **October 1, 2017 at 12 AM EST**.

The NJ HealthCAP implementation process will be parsed into five (5) 1-week phases around August, with each phase consisting of a maximum of nineteen (19) providers. The implementation phases will begin after providers submit all required implementation documents and signatures as described in this Implementation Guide. Providers will be placed into specific phases on a priority basis according to the phase selection preferences outlined in this document. PCG reserves the right to move providers to a different phase if the provider is not prepared to proceed with their implementation.

The list below describes the specific date ranges applicable to each phase cycle:

Phase 1 – 7/31/2017 to 8/4/2017

Phase 2 – 8/7/2017 to 8/11/2017

Phase 3 – 8/14/2017 to 8/18/2017

Phase 4 – 8/21/2017 to 8/25/2017

Phase 5 – 8/28/2017 to 9/1/2017

2. Process

PCG has provided a high-level list of specific tasks and topics that will be covered and addressed as part of the NJ HealthCAP provider implementation process. These tasks will require the cooperation of the individual providers to ensure a timely resolution of all potential problems and compliance with New Jersey claim submission requirements. Prerequisite documents are files that must be reviewed, signed, and returned to PCG in order to register your facility into one of the five (5) implementation assistance phases. The listed tasks are summarized steps of the implementation assistance process leading up to the application go-live.

PREREQUISITES

1. Implementation Guide Signature Sheet (Appendix A)
2. Provider Contact Designation Forms (Appendix A)
    a. General Facility Resource
    b. Provider Operations Contacts
    c. Provider Billing Contact
3. Provider Implementation Phase Selections (Appendix A)
4. Project Sponsor Designation (Appendix A)
5. Provider National Provider Identifier (NPI) Confirmation (Appendix A)
6. Application Technical Requirements Checklist (Appendix A)
7. Secure FTP Access Confirmation (Appendix B)

TASKS

1. Provider submits NJ HealthCAP 837R file to PCG via designated folder on PCG's secure FTP portal.

2. PCG assesses and certifies 837R data file for format according to published Addendum Guide.
3. If applicable, PCG reports and discusses data format issues and/or errors with provider.
4. If applicable, provider revises 837R data file according to NJ HealthCAP formatting requirements.
5. Format revision process is repeated until both PCG and provider certify the accuracy of 837R data files.
6. Provider completes post-implementation checklist and survey.
7. PCG conducts on-site provider trainings to present the application and answer any technical questions.
8. PCG distributes account creation emails and steps to provider sponsors.
9. Provider sponsors set up additional user accounts.
10. Provider sponsors set up and confirm facility-specific billing accounts.

3. Technical Instructions

The technical instructions in this section will provide facility users with specific implementation and go-live steps to ensure that the provider's live claims data before and after implementation is accurately transitioned from Nuance to PCG.

837R DATA FILE CERTIFICATION

Providers should submit example 837R data files representing **10 days'** worth of inpatient discharges, other outpatient (same-day surgery and medical), and emergency department visits through the provider-specific PCG secure FTP portal assigned in Appendix B. The data contained in these example files should be direct copies of claims data that are currently being sent to Nuance. Once PCG has received the providers' 837R data files through the provider-specific SFTP portals, PCG will assess the formatting accuracy of example files and verify that the file format is in compliance with the NJ HealthCAP 837R Addendum Guide.

Please note that when uploading the 837R files to PCG's SFTP portal, the 837R files for a specific provider (by NPI and Provider ID) should be placed into the "**inbound"** folder for that specific provider (by NPI and/or Provider ID). Files placed outside of "inbound" folders will not be uploaded into the NJ HealthCAP application, and will result in delinquent claim submission notices.

PCG will provide each provider with detail explanations for all identified file format discrepancies, and assist each provider in addressing these discrepancies in an efficient and expedient manner. For some providers, this will be an iterative process in which the provider and PCG will need to cooperate extensively to ensure that all file format issues have been resolved prior to application release.

Once a provider has resolved all 837R data file format issues, PCG will officially close out the provider's implementation and note that the provider is ready for application release.

PROVIDER BILLING & INVOICING ACCOUNT SETUP

PCG will be utilizing an online billing and invoicing application, Zoho, to manage all invoicing and payment functionalities for provider claims accepted by the NJ HealthCAP application on a monthly basis. After the implementation assistance phase has concluded, PCG will be setting up each provider's billing account in Zoho using the provider's unique Provider Number. Once PCG has completed the set up for a specific provider, the provider's Billing Contact (designated in Appendix A.2) will receive an automated email from Zoho to finish the account creation process.

PCG will utilize Zoho for all invoicing and payment resolution needs and therefore will not be sending paper invoices to the hospital community through standard mail. All providers will have access to both the monthly summary invoice and the detail invoice identifying all claims that were billed to the provider within a designated monthly billing period.

APPLICATION RELEASE CLAIMS SUBMISSION AND MANAGEMENT

Introduction

The NJ HealthCAP application is currently planned to be deployed on **October 1, 2017 at 12:00 AM Eastern Standard Time (EST)**. All hospital providers currently participating in the NJ Discharge Data Collection System will continue to submit inpatient, other outpatient, and emergency department (ED) discharges to the current Nuance application until 11:59 PM EST on September 30, 2017. All 837R data files **generated/uploaded** by providers starting on and after midnight on October 1st will need to be either uploaded to the provider-specific PCG secure FTP folder, or manually uploaded to the NJ HealthCAP application through the web interface functionality.

If there are any changes to the planned October 1st deployment of the NJ HealthCAP application, PCG will notify the provider community, via email, **no later than September 15, 2017**, with a new date for anticipated deployment. If PCG is unable to go live on October 1st as planned, Nuance will continue to support the system. Files will continue to be sent to Nuance for processing. If this is the case, Nuance will continue to bill hospitals for services until such time that NJ HealthCAP is fully deployed and operational.

Pending/Error Claims

For inpatient, other outpatient, and ED claims submitted to the current Nuance application prior to the NJ HealthCAP application release date, providers will be responsible for ensuring that these claims are accepted (all errors and issues resolved) into Nuance's data warehouse prior to the NJ HealthCAP application release date and time. This means that for claims that are submitted to the current Nuance application before October 1st, the providers will have until 11:59 PM on September 30th to ensure that these claims are fully corrected and accepted by the current Nuance application. All errored claims not resolved in the Nuance application by 12:00 AM on October 1st will be deleted from the current Nuance application, and will need to be resubmitted through PCG's NJ HealthCAP application accordingly. Nuance will provide the NJ Department of Health (DOH) with this list of deleted pending/error claims for each provider to ensure that these claims will be resubmitted by the appropriate providers. Claim identification elements from Nuance's list of deleted pending/error claims include:

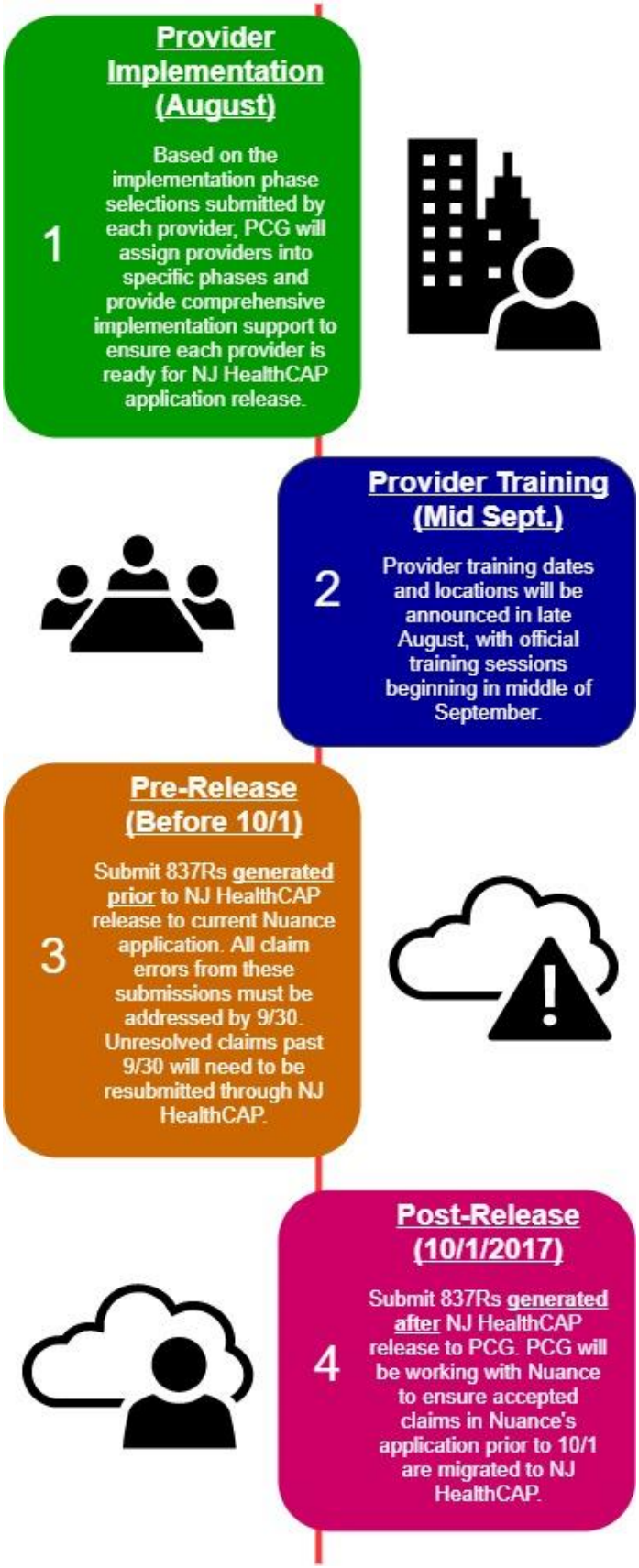
- Patient Control Number
- Medical Record Number
- Hospital Provider Number
- Patient Gender
- Patient's Date of Birth
- Type of Bill
- Admit Date
- Discharge Date

Starting at 12:00 AM EST on October 1, 2017, all 837R data files generated by providers will be submitted to the NJ HeathCAP application and no longer need to be sent to the current Nuance application. From the NJ HealthCAP application release date forward, all claims processing and editing activity for 837R data files submitted after the release date and time will be conducted through the NJ HealthCAP application only.

Transition Claim Reconciliation

After the NJ HealthCAP release date, all duplicate accepted claims identified in the data from the Nuance application when compared to the claims in the NJ HealthCAP processing database and accepted claim data warehouse will be deleted. This policy assumes that the claim version that is currently in the NJ HealthCAP system is the latest version, and all revisions to these claims will need to be performed through the NJ HealthCAP application.

The process flow in the following page displays a graphical representation of the NJ HealthCAP application release timeline.


Provider Implementation (August)
1
Based on the implementation phase selections submitted by each provider, PCG will assign providers into specific phases and provide comprehensive implementation support to ensure each provider is ready for NJ HealthCAP application release.
Provider Training (Mid Sept.)
2
Provider training dates and locations will be announced in late August, with official training sessions beginning in middle of September.
Pre-Release (Before 10/1)
3
Submit 837Rs generated prior to NJ HealthCAP release to current Nuance application. All claim errors from these submissions must be addressed by 9/30. Unresolved claims past 9/30 will need to be resubmitted through NJ HealthCAP.
Post-Release (10/1/2017)
4
Submit 837Rs generated after NJ HealthCAP release to PCG. PCG will be working with Nuance to ensure accepted claims in Nuance's application prior to 10/1 are migrated to NJ HealthCAP.

F. RESOURCE AND CONTACT INFORMATION

The resources and contact information listed below is intended to assist providers in navigating the transition the NJ HealthCAP application and ensure that the claims data provided is accurate and timely.

Managing Entities

Public Consulting Group (PCG)
148 State Street
Boston, MA 02109
Website: www.publicconsultinggroup.com

New Jersey Department of Health
369 South Warren Street
Trenton, NJ 08608
Website: www.nj.gov/health/

PCG Contacts

Steven Wang, Consultant
Phone: 512-287-4702
Email: NJ_HealthCAP@pcgus.com

Alexis Guevara, Business Analyst
Phone: 844-880-8709
Email: NJ_HealthCAP@pcgus.com

Logan Barron, Operations Analyst
Phone: 844-880-8709
Email: NJ_HealthCAP@pcgus.com

Rick Dwyer, Manager
Phone: 844-880-8709
Email: NJ_HealthCAP@pcgus.com

NJ Department of Health Contact

Abate Mammo, Executive Director
Center for Health Statistics and Informatics
Email: Abate.Mammo@doh.nj.gov

www.publicconsultinggroup.com

Appendix C: NJ HealthCAP Data Dictionary and Extract File

PUBLIC CONSULTING GROUP

NJ HealthCAP

Data Dictionary and Extract File Layout

Release 1.9

April 24, 2019

Copyright

Document Information

Filename:	NJ HealthCAP Data Dictionary and Extract File Layout
Archive Location:	

Document Control

Version	Date Changed	Completed by	Description of Changes
0.1	June, 2017	R Foster	First Draft
1.0	August, 2017	D Johar	Initial Release
1.1	September, 2017	S Wang	Edit
1.2	September, 2017	S Wang	Updated Transfer In/Out Code List
1.3	November, 2017	S Wang	Added Out of State NPI to Transfer In/Out List
1.4	November, 2017	S Wang	Added “Unknown” Country Code for homeless patients
1.5	December, 2017	S Wang	Removed “Maximum Field Length” field from the data extract layout table
1.6	June 6, 2018	S Wang	Updated edit descriptions for Transfer In/Out codes, Revenue Code Days/Units, Admit Date, Principal Diagnosis Code, Statement From Date, and Statement Thru Date.
1.7	August 13, 2018	L Barron	Updated NPIs on transfer in/out tables
1.8	November 2, 2018	S Wang	Corrected NPI list
1.9	April 24, 2019	L Barron	Updated edit descriptions on page 19 and 56

Contents

Introduction

This Data Dictionary and Data Extract File Layout is a user-friendly reference guide to the data elements used in New Jersey Health Claim Analysis and Processing (NJ HealthCAP) application. The following is a list of the data elements included with each entry:

- Field Name
- ASC X12N/00501X225 ANSI 837R (Health Care Institutional Claims for Data Reporting) Location
- Definition – A brief description of the field
- External Code Source
- Requirements – An indication if the field is required for Inpatients, Same Day Surgeries, Same Day Medicals, and/or Emergency Department Outpatients
- Valid Codes – A description of the valid data for that particular data element. Code lists are included, if appropriate.
- Edit requirements – A description of the edit(s) for the field
- Guidelines – General rules to follow for the use of a particular field
- State Added/Mandated Fields

This document is available for download by authorized users at njhealthcap.pcgus.com. As edits and codes are changed, this document will be updated to contain the latest information.

For questions regarding the information contained herein, please contact NJ HealthCAP Help Desk via email at NJ_HealthCAP@pcgus.com.

Data Elements

Accident State

Field # 35 in NJ HEALTHCAP Extract File Layout

For patient visits related to an auto accident, the two-character state abbreviation where the accident occurred.

- External Code Source: ISO 3166-2 Codes for the representation of names of countries and their subdivisions
- Required for: All patients
- 837 Location: 2300 Loop, REF02, Code Qualifier "LU"
- Valid Codes: Any valid two-digit alpha character abbreviation for American state, American possession, Canadian province, or other (refer to Patient State for full listing of valid codes)
- Edit:
    1. Accident State must be either blank or a valid state code

Acute Days

Field # 62 in NJ HEALTHCAP Extract File Layout

The numbers of days of a hospital stay at the acute level of care.

This code is not required to be reported by hospitals. Instead, it will be calculated for inpatients as follows:

ACU Days = Total Days – (SNF Days + ICF Days + RES Days)

Total Days are calculated as per length of stay (LOS) in hospital.

- Inpatient Claims, LOS calculation: Discharge Date – Admission Date
- Inpatient LOS Calculation for Interim Claims (if Patient Discharge Status = '30'): (Thru Date - Admission Date) + 1

Address Line 1

Field # 77 in NJ HEALTHCAP Extract File Layout

Postal Address line 1 refers to either Patient/Provider or Facility address entered in line 1.

This code is not required to be reported by hospitals. Instead, it will be calculated for all patients using Smarty Street for address validation.

- Required for: All patients

Address Line 2

Field # 78 in NJ HEALTHCAP Extract File Layout

Postal Address line 2 refers to either Patient/Provider or Facility address entered in line 2.

This code is not required to be reported by hospitals. Instead, it will be calculated for all patients using Smarty Street for address validation.

- Required for: All patients

Admission Hour

Field # 32 in NJ HEALTHCAP Extract File Layout

The code referring to the hour during which the patients was admitted for inpatients or outpatient care.

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual
- Required for: All patients
- 837 Location: 2300 Loop, DTP03
- Valid Codes: 00-23 or 99
- Edit:

1. Admission Hour must be 00-23 or 99

Admission/Start of Care Date (Admission Date)

Field # 9 in NJ HEALTHCAP Extract File Layout

The start date for this episode of care. For inpatient services, this is the date of admission. For all other services, the date the episode of care began.

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.
- Required for: All patients
- 837 Location: 2300 Loop, DTP03, Code Qualifier "435"
- Valid Codes: A valid date in CCYYMMDD
- Edits:
    1. Admission Date must be a valid date and must be less than today's date.
    2. The Admission Date cannot be before 2005.
    3. The Admit Date must be a valid date and must be from an open year (outpatient only)

Admitting Diagnosis Code

Field # 93 in NJ HEALTHCAP Extract File Layout

The ICD-10 diagnosis code describing the patient's diagnosis at the time of admission.

- External Code Source: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).
- Required for: Inpatients
- 837 Location: 2300 Loop, HI01-02, Code Qualifier "ABJ"
- Valid Codes: Valid ICD-10-CM codes as defined by CDC
- Edits:

1. Admitting Diagnosis Code cannot be blank and must be a valid diagnosis code.
2. If present on outpatients, the Admitting Diagnosis code must be valid.

Attending Physician National Provider Identifier (NPI)

Field # 48 in NJ HEALTHCAP Extract File Layout

The attending physician's National Provider Identifier number.

- External Code Source: Center's for Medicare and Medicaid Services National Provider Identifier
- Required for: All Patients
- 837 Location: 2310A Loop, NM109, Code Qualifier "XX"
- Valid Codes: A valid NPI number
- Edit:
    1. If present, the Attending Physician NPI must be 10 digits and a valid NPI number (using the Luhn algorithm).

Luhn Algorithm

Example NPI: 1234567893

Step 1: Validate NPI is ten digits long.

Step 2: Double the value of alternate digits, beginning with the first digit, not including the tenth digit.

NPI without check digit (first nine positions): 123456789

Double the value of alternate digits, beginning with the first digit: 2 6 10 14 18

Step 3: Add constant 24, plus the individual digits of products of doubling, plus unaffected (those not doubled in step 2) digits.

24 + 2 + 6 + 1 + 0 + 1 + 4 + 1 + 8 + 2 + 4 + 6 + 8 = 67

If the resulting number ends with a 0 (e.g. 40), then the tenth digit of the NPI should be 0. If the resulting number does not end in 0, proceed to step 4.

Step 4: Subtract from next higher number ending in zero.

70 – 67 = 3

Tenth digit should be 3

Attending Physician State License Number

Field # 47 in NJ HEALTHCAP Extract File Layout The attending physician's state license number

- External Code Source: New Jersey Division of Consumer Affairs, Board of Medical Examiners.
- Required for: All Patients
- 837 Location: 2310A Loop, REF02, Code Qualifier "0B"
- Valid Codes:
  - For New Jersey physicians, one of the following:
    - The first two characters must equal 'NJ' followed by seven or eight alphanumeric characters and no spaces
    - The first two characters must equal '22', '25', '26' or '35' followed by ten alphanumeric characters and no spaces
  - For physicians outside New Jersey the first two characters must equal any valid two-digit alpha character abbreviation for American state, American possession, or Canadian province followed by alphanumeric character(s)
- Edits:

  1. The Attending Physician State Code (which is the first two characters of the Attending Physician License Number) must be a valid state, '22', '25', '26' or '35'.

  2. If the Attending Physician State Code equals 'NJ', then check to see that the number after the state code is seven or eight characters in length and does not contain a space. If the first two characters are '22', '25', '26', or '35', then check to verify that the number after the state code is ten characters in length and does not contain a space.

  3. If the Attending Physician State Code is valid, and does not equal 'NJ', '22', '25', '26' or '35', then verify that the number after the state code is not blank.

Baby's Birthweight in Grams

Field # 57 in NJ HEALTHCAP Extract File Layout

A newborn's (patient age less than 29 days) birthweight in grams – this will be collected using Value Code 54.

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.
- Required for: Inpatients
- 837 Location: Value Code
- Valid Codes: Numbers between 0100 and 9000
- Edits:

  1. If a Patient's Age is less than 29 days and the Priority Type of Visit Code is 4 (Newborn), then Value Code 54 must be present, and the value code amount must be between 0100 and 9000 grams.

  2. The Baby's Birthweight in Grams must be greater than or equal to 1000 if the Patient's Age is less than 29 days, the Priority Type of Visit Code is 4 (Newborn), the patient was discharged to home (discharge status 01) and the length of stay was less than four days.

  3. If a Patient's Age is less than 29 days and the Priority Type of Visit Code is not 4, Baby's Birthweight in Grams is not required.

City

Field # 79 in NJ HEALTHCAP Extract File Layout

Postal City refers to Patient/Provider or Facility town or municipality

This code is not required to be reported by hospitals. Instead, it will be calculated for all patients using Smarty Street for address validation.

- Required for: All patients

Condition Codes

Field # 87 in NJ HEALTHCAP Extract File Layout

A code used to identify conditions or events relating to this bill that may affect processing.

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.

- Required for: All Patients
- 837 Location: 2300 Loop, HI01-02 to HI12-02, Code Qualifier “BG”
- Valid Codes:

Code	Definition
01	Military Service Related
02	Condition is Employment Related
03	Patient Covered by Insurance Not Reflected Here
04	Information Only Bill
05	Lien Has Been Filed
06	ESRD Patient in First 18 Months of Entitlement Covered by Employer Group Health Insurance
07	Treatment of Non-Terminal Condition for Hospice Patient
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage
09	Neither Patient nor Spouse is Employed
10	Patient and/or Spouse is Employed but No EGHP Exists
11	Disabled Beneficiary but No LGHP
17	Patient is Homeless
18	Maiden Name Retained
19	Child Retains Mother's Maiden Name
20	Beneficiary Requested Billing
21	Billing of Denial Notice
22	Patient on Multiple Drug Regimen
23	Home Care Giver Available
24	Home IV Patient Also Receiving-HHA Services

Code	Definition
25	Patient is Non-U.S. Resident
26	VA Eligible Patient Chooses to Receive Services in a Medicare Certified Facility
27	Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test
28	Patient and/or Spouse's EGHP is Secondary to Medicare
29	Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare
30	Qualifying Clinical Trials
31	Patient is Student (Full Time - Day)
32	Patient is Student (Cooperative/Work Study Program)
33	Patient is Student (Full Time - Night)
34	Patient is Student (Part Time)
36	General Care Patient in a Special Unit
37	Ward Accommodation at Patient Request
38	Semi-Private Room Not Available
39	Private Room Medically Necessary
40	Same Day Transfer
41	Partial Hospitalization
42	Continuing Care Not Related to Inpatient Admission
43	Continuing Care Not Provided Within Prescribed Post-discharge window
44	Inpatient Admission Changed to Outpatient
45	Ambiguous Gender Category
46	Non-Availability Statement on File
48	Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)
49	Product Replacement Within Product Lifecycle

Code	Definition
50	Product Replacement for Known Recall of a Product
51	Attestation of Unrelated Outpatient Non diagnostic Services (effective for discharges on/after 4/1/2011)
53	Initial placement of a medical device provided as part of a clinical trial or a free sample (effective for discharges on/after 01/01/2016)
54	No Skilled Home Health Visits in Billing Period. Policy Exception Documented at the Home Health Agency (effective for discharges on/after 07/01/2016)
55	SNF Bed Not Available
56	Medical Appropriateness
57	SNF Readmission
58	Terminated Medicare Advantage Enrollee
59	Non-primary ESRD Facility
60	Day Outlier
61	Cost Outlier
66	Provider Does Not Wish Cost Outlier Payment
67	Beneficiary Elects Not to Use Life Time Reserve (LTR) Days
68	Beneficiary Elects to use Life Time Reserve (LTR) Days
69	IME/DGME/N&HA Payment Only
70	Self Administered Anemia Management Drug
71	Full Care Unit
72	Self Care Unit
73	Self Care Training
74	Home
75	Home - 100 Percent Reimbursed

Code	Definition
76	Back-up in Facility Dialysis
77	Provider Accepts or is Obligated/Required due to a Contractual Arrangement or Law to Accept Payment by a Primary Payer as Payment in Full
78	New Coverage Not Implemented by HMO
79	CORF Services Provided Offsite
80	Home Dialysis - Nursing Facility
81	C-Sections/Inducts Performed at <39 Weeks Gestation For Med Necessity
82	C-Sections/Inducts Performed at <39 Weeks Gestation Electively
83	C-Sections/Inducts Performed at 39 Weeks Gestation or Greater
A0	TRICARE External Partnership Program
A1	EPSDT/CHAP
A2	Physically Handicapped Children's program
A3	Special Federal Funding
A4	Family Planning
A5	Disability
A6	Vaccines/Medicare 100% Payment
A9	Second Opinion Surgery
AA	Abortion Performed Due to Rape
AB	Abortion Performed Due to Incest
AC	Abortion Performed due to Serious Fetal Genetic Defect, Deformity or Abnormality
AD	Abortion Performed due to a Life Endangering Physical Condition
AE	Abortion Performed due to Physical Health of Mother that is not Life Endangering
AF	Abortion Performed due to Emotional/psychological Health of the Mother
AG	Abortion Performed due to Social or Economic Reasons

Code	Definition
AH	Elective Abortion
AI	Sterilization
AJ	Payer Responsible for Co-payment
AK	Air Ambulance Required
AL	Specialized Treatment/bed Unavailable - Alternate Facility transport
AM	Non-emergency Medically Necessary Stretcher Transport Required
AN	Preadmission Screening Not Required
B0	Medicare Coordinated Care Demonstration Claim
B1	Beneficiary is Ineligible for Demonstration Program
B2	Critical Access Hospital Ambulance Attestation
B3	Pregnancy Indicator
B4	Admission Unrelated to Discharge on Same Day
C1	Approved as Billed
C2	Automatic Approval as Billed Based on Focused Review
C3	Partial Approval
C4	Admission/Services denied
C5	Post Payment Review Applicable
C6	Admission Preauthorization
C7	Extended Authorization
D0	Changes to Service Dates
D1	Changes to Charges
D2	Changes in Revenue Codes/HCPCS/HIPPS Rate Codes
D3	Second or Subsequent Interim PPS Bill

Code	Definition
D4	Change in clinical codes (ICD) for Diagnosis and/or Procedure Codes
D5	Cancel to Correct Insured's ID or Provider ID
D6	Cancel Only to Repay a Duplicate or OIG Overpayment
D7	Change to Make Medicare the Secondary Payer
D8	Change to Make Medicare the Primary Payer
D9	Any Other Change
DR	Disaster Related
E0	Change in Patient Status
G0	Distinct Medical Visit
H0	Delayed Filing; Statement of Intent Submitted
H2	Discharged by Hospital Provider for Cause
P1	Do Not Resuscitate Order (DNR)
P7	Admitted Directly through facility's Emergency Department
R1	Mathematical or Computational Mistake (effective for discharges on/after 04/01/2015)
R2	Inaccurate Data Entry (effective for discharges on/after 04/01/2015)
R3	Misapplication of a Fee Scheduled (effective for discharges on/after 04/01/2015)
R4	Computer Errors (effective for discharges on/after 04/01/2015)
R5	Incorrectly Identified Duplicates (effective for discharges on/after 04/01/2015)
R6	Other Clerical/Minor Error or Omission (effective for discharges on/after 04/01/2015)
R7	Correction other than Clerical Error (effective for discharges on/after 04/01/2015)
R8	New and Material Evidence (effective for discharges on/after 04/01/2015)
R9	Faculty Evidence (effective for discharges on/after 04/01/2015)

Code	Definition
W0	United Mine Workers of America (UMWA) Demonstration Indicator
W2	Duplicate of Original Bill
W3	Level I Appeal
W4	Level II Appeal
W5	Level III Appeal

- Edits:
    1. A Condition Code field cannot be valued if the preceding Condition Code field is blank.
    2. Condition Code must be blank or must be valid code on Condition Code table.
- Guidelines:
    - If the patient has a DNR on file, Condition Code P1 must be reported.
    - If the patient's condition is related to their employment, Condition Code 02 must be reported.
    - With the exception of the two requirements stated above, hospitals should report any/all other Condition Codes as required for normal billing practices. All Condition Codes reported must be valid as per the National Uniform Billing Committee's UB04 Specifications Manual.

Discharge Date

Field # 4 in NJ HEALTHCAP Extract File Layout

The date when a patient is discharged from the hospital

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.
- Required for: Inpatients
- 837 Location: 2300 Loop, DTP03, Code Qualifier "DT"
- Valid Codes: A valid date equal to or greater than admission date

- Edits:
    1. Admission Date must not be greater than the Discharge Date.
    2. Discharge Date must be a valid date and not greater than the state's cut-off date; this date will vary.
    3. Discharge date must be less than or equal to today's current date.

Discharge Hour

Field # 37 in NJ HEALTHCAP Extract File Layout

Code indicating the discharge hour of the patient from inpatient care.

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.
- Required for: Inpatients
- 837 Location: 2300 Loop, DTP03, Code Qualifier "DT "
- Valid Codes: 00-23 or 99
- Edit:
    1. Discharge Hour must be 00-23 or 99 for final-billed patients (XXX1, XXX4, XXX7).

DRG Number (Hospital DRG)

Field # 65 in NJ HEALTHCAP Extract File Layout

Indication of how the patient has been grouped by the facility.

External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.

- Required for: Inpatients
- 837 Location: 2300 Loop, HI01-02, Code Qualifier "DR" (Diagnosis Related Group)

Estimated Amount Due from All Payers

Field # 60 in NJ HEALTHCAP Extract File Layout

Amount of money due the hospital from all insurance payers.

- External Code Source: ANSI 837 ASC X12N/005010X225 Data Reporting Guide
- Required for: All Patients
- 837 Location: 2300 Loop, AMT02, Code Qualifier "C5"
- Valid Codes: Any whole dollar amount less than or equal to $9,999,999 – cents are invalid
- Edits:
    1. If Primary Payer Code is 031 or 039, then the Estimated Amount Due from Primary Payer must equal zeroes.
    2. If Primary Payer Code is not 031 or 039, then the Estimated Amount Due from Primary Payer must be greater than zeroes.
    3. The Estimated Amount Due from Primary Payer cannot be greater than $9,999,999.

Estimated Amount Due from Patient

Field # 59 in NJ HEALTHCAP Extract File Layout

Amount of money due the hospital from patient

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.
- Required for: All Patients
- 837 Location: 2300 Loop, AMT02, Code Qualifier "F3"
- Valid Codes: Any whole dollar amount less than or equal to $9,999,999 – cents are invalid
- Edits:
    1. If Payer Code is either 031 or 039, then the Estimated Amount Due from Patient must be greater than zeroes.
    2. The Estimated Amount Due from Patient cannot be greater than 9,999,999.

External Cause of Injury Code(s) (E-Codes)

Field # 85 in NJ HEALTHCAP Extract File Layout for External cause of Injury Code

Field # 86 in NJ HEALTHCAP Extract File Layout for External cause of Injury Code Present on Admission (POA) Indicator

Code signifying a diagnosis of an injury, poisoning, or adverse effect

- External Code Source: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).
- Required for: All Patients
- 837 Location: 2300 Loop, HI01-02 to HI12-02, Code Qualifier "ABN"
- Valid Codes: External Cause of Injury Codes defined by the CDC
- Edits:
  1. If the External Cause of Injury Code is not blank, then it must be a valid External Cause of Injury Code.
  2. An External Cause of Injury Code may not be valued if the preceding External Cause of Injury Code is blank.
  3. The External Cause of Injury Code POA Indicator must be Y, N, U, W. It can either be 1 or Null if the Diagnosis Code is on the list of CDC exempt codes

HCPCS Code

Field # 104 in NJ HEALTHCAP Extract File Layout

The Healthcare Common Procedure Coding System applicable to ancillary service and outpatient bills

- External Code Sources: Health Care Finance Administration Common Procedural Coding System.
- Required for: Outpatients
- 837 Location: 2400 Loop, SV202-02, Code Qualifier "HC"
- Valid Codes: 5-digit alphanumeric characters
- Edits:

1. HCPCS codes must be on list of valid codes.
2. HCPCS codes must be present on those revenue codes defined by CMS as requiring HCPCS codes.

HCPCS Modifier 1

Field # 105 in NJ HEALTHCAP Extract File Layout

Code describing additional information associated with HCPCS code

- External Code Sources: Health Care Finance Administration Common Procedural Coding System.
- Required for: Outpatients
- 837 Location: 2400 Loop, SV202-03, Code Qualifier "HC"
- Valid Codes: two-digit alphanumeric characters
- Edit:
    1. HCPCS Modifier 1 must either be blank or a valid code.

HCPCS Modifier 2

Field # 106 in NJ HEALTHCAP Extract File Layout

Code describing additional information associated with HCPCS code

- External Code Sources: Health Care Finance Administration Common Procedural Coding System.
- Required for: Outpatients
- 837 Location: 2400 Loop, SV202-04, Code Qualifier "HC"
- Valid Codes: two-digit alphanumeric characters
- Edits:
    1. HCPCS Modifier 2 must either be blank or valid code.
    2. HCPCS Modifier 2 may not be present if HCPCS Modifier 1 is not present.

HCPCS Modifier 3

Field # 107 in NJ HEALTHCAP Extract File Layout

Code describing additional information associated with HCPCS code

- External Code Sources: Health Care Finance Administration Common Procedural Coding System.
- Required for: Outpatients
- 837 Location: 2400 Loop, SV202-05, Code Qualifier “HC”
- Valid Codes: two-digit alphanumeric characters
- Edits:
    1. HCPCS Modifier 3 must either be blank or valid code.
    2. HCPCS Modifier 3 may not be present if HCPCS Modifier 2 is not present.

HCPCS Modifier 4

Field # 108 in NJ HEALTHCAP Extract File Layout

Code describing additional information associated with HCPCS code

- External Code Sources: Health Care Finance Administration Common Procedural Coding System.
- Required for: Outpatients
- 837 Location: 2400 Loop, SV202-06, Code Qualifier “HC”
- Valid Codes: two-digit alphanumeric characters
- Edits:
    1. HCPCS Modifier 4 must either be blank or valid code.
    2. HCPCS Modifier 4 may not be present if HCPCS Modifier 3 is not present.

Hospital Provider Number

Field # 1 in NJ HEALTHCAP Extract File Layout

State assigned provider number (PTAN + Facility Identifier)

- External Code Source: New Jersey Department of Health.
- Required for: All Claim Files
- 837 Location: 2010AA Loop, REF02, Code Qualifier "1J"
- Valid Codes: Valid state assigned provider number

I/O (Inpatient/Outpatient) Indicator

Field # 20 in NJ HEALTHCAP Extract File Layout

Code identifying patient as an inpatient or outpatient

- Required for: This field is not required, but may be reported by hospitals
- 837 Location: 2300 Loop, K301, position 46
- Valid Codes: I or O
- Edit:
    1. I/O Indicator can only be I or O.

Facilities may choose to provide an Inpatient/Outpatient indicator on their files, and NJEdits will verify it is present on each claims, and is either an "I" or an "O". If no indicator is provided, the NJ HealthCAP application will calculate and populate this field when the data is loaded based on the following methodology:

- Bill Type beginning with 013 = Outpatient
- Bill Type beginning with 011 or 012 = Inpatient

Latitude

Field # 83 in NJ HEALTHCAP Extract File Layout

Using degrees of latitude, the addresses are converted into geographic coordinates

This code is not required to be reported by hospitals. Instead, it will be calculated for all patients with geo codes address verification.

- Required for: All Patients, Providers and Facilities

Longitude

Field # 84 in NJ HEALTHCAP Extract File Layout

Using degrees of longitude, the addresses are converted into geographic coordinates

This code is not required to be reported by hospitals. Instead, it will be calculated for all patients with geo codes address verification.

- Required for: All Patients, Providers and Facilities

Length of Stay (LOS)

The number of days a patient spends in the hospital. This field is calculated.

- Required for: Inpatients
- Valid Codes: Numbers between 1 and 365
- Edits:
    1. Inpatients should have a Length of Stay less than 365 days.
    2. Outpatients may only have a Length of Stay of 0 or 1 days, with the following exceptions:
        a. ED Outpatients (with a revenue code of 045X) may have a LOS up to two days.
        b. ED Observation patients (with a revenue code of 0762 or a HCPCS code of G0378) may have a LOS greater than one day.
- Inpatient LOS Calculation: Discharge Date - Admission Date

- Inpatient LOS Calculation for Interim Claims (if Patient Discharge Status = '30'): (Thru Date - Admission Date) + 1
- Outpatient LOS Calculation: Thru Date – From Date

Medical Record Number

Field # 7 in NJ HEALTHCAP Extract File Layout

A number assigned to a patient and used upon each admittance (Inpatients) or visit (Outpatients) to the same hospital

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.
- Required for: All Patients
- 837 Location: 2300 Loop, REF02, Code Qualifier "EA"
- Valid Codes: Any alphanumeric characters 4 to 24 characters in length
- Edit:
    1. Medical Record Number must be at least 4 but not more than 24 characters.

Mother's Medical Record Number

Field # 58 in NJ HEALTHCAP Extract File Layout

The medical record number of the mother of a newborn (patient age less than 29 days) – used only on newborn claims.

- Required for: Inpatients
- 837 Location: 2300 Loop, REF02, Code Qualifier "MRN"
- Valid Codes: Any alphanumeric characters 4 to 24 characters in length
- Edit:
    1. If the patient's Admission Date equals to the patient's Birth Date, and the Point of Origin = 5 (Born in this facility), then the Mother's Medical Record Number cannot be blank. Mother's Medical Record Number must be at least 4 but not more than 24 characters.

Non-Acute Days

Field # 63 in NJ HEALTHCAP Extract File Layout

The numbers of days of a hospital stay at the non-acute level of care.

This code is not required to be reported by hospitals. Instead, it will be calculated for inpatients as follows:

Non-ACU Days = SNF Days + ICF Days + RES Days

SNF, ICF and RES Day are calculated from Occurrence Span Codes and Dates mentioned in below section.

SNF Code – 75 (SNF level of Care Dates)

ICF Code – M3 (ICF Level of Care Dates)

RES Code – M4 (Residential Level of Care)

Occurrence Codes and Dates

Occurrence Code - Code – Field # 111 in NJ HEALTHCAP Extract File Layout

Occurrence Code - Date – Field # 112 in NJ HEALTHCAP Extract File Layout

The code and associated date defining a significant event relating to this bill that may affect payer processing.

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.
- Required for: All Patients
- 837 Location: 2300 Loop, HI01-02 to HI12-02, Code Qualifier "BH"
- Valid Codes:

Code	Definition
01	Accident/Medical Coverage
02	No Fault Insurance Involved - Including Auto Accident/Other
03	Accident/Tort Liability

Code	Definition
04	Accident/Employment Related
05	Accident/No Medical or Liability Coverage
06	Crime Victim
09	Start of Infertility Treatment Cycle
10	Last Menstrual Period
11	Onset of Symptoms/Illness
12	Date of Onset for a Chronically Dependent Individual
16	Date of Last Therapy
17	Date Outpatient Occupational Therapy Plan Established or Last Reviewed
18	Date of Retirement Patient/Beneficiary
19	Date of Retirement Spouse
20	Date Guarantee of Payment Began
21	Date UR Notice Received
22	Date Active Care Ended
24	Date Insurance Denied
25	Date Benefits Terminated by Primary Payer
26	Date SBF Bed Became Available
27	Date of Hospice Certification or Re-Certification
28	Date Comprehensive Outpatient Re-Habilitation Plan Established or Last Reviewed
29	Date Outpatient Physical Therapy Plan Established or Last Reviewed
30	Date Outpatient Speech Pathology Plan Established or Last Reviewed
31	Date Beneficiary Notified of Intent to Bill (Accommodations)
32	Date Beneficiary Notified of Intent to Bill (Procedures of Treatment)

Code	Definition
33	First Day of the Co-ordination Period for ESRD Beneficiaries Covered by EGHP
34	Date of Election of Extended Care Facilities
35	Date Treatment Started for Physical Therapy
36	Date of Inpatient Hospital Discharge for Covered Transplant Patients
37	Date of Inpatient Hospital Discharge for Non-Covered Transplant Patient
38	Date Treatment Started for Home IV Therapy
39	Date Discharged on a Continuous Course if IV Therapy
40	Scheduled Date of Admission
41	Date of First Pre-Admission Testing
42	Date of Discharge
43	Scheduled date of Canceled Surgery
44	Date Treatment Started Occupational Therapy
45	Date Treatment Started for Speech Therapy
46	Date Treatment Started for Cardiac Rehabilitation
47	Date Cost Outlier Status Begins
50	Assessment Date
51	Date of Last KT/V Reading (effective for discharges on/after 01/01/2015)
52	Medical Certification/Recert Date
54	Physician Follow-up Date
55	Date of Death (effective for discharges on/after 10/01/12)
A1	Birth Date - Insured A
A2	Effective Date - Insured A Policy
A3	Benefits Exhausted

Code	Definition
A4	Split Bill Date
B1	Birth Date - Insured B
B2	Effective Date - Insured B Policy
B3	Benefits Exhausted
C1	Birth Date - Insured C
C2	Effective Date - Insured C Policy
C3	Benefits Exhausted

- Edits:
  1. An Occurrence Code may not be present without an Occurrence Code Date.
  2. The Occurrence Code Date must be a valid date, less than the current date and, excluding codes A1, B1 and C1, must be equal to or greater than the patient's birth date.
  3. The Occurrence code must be blank or must be a valid Occurrence Code as defined by the NUBC.
  4. An Occurrence Code Date must not be present without an Occurrence Code.
  5. An Occurrence Code may not be valued if the preceding Occurrence Code is not valued.
- Guidelines:
  - If the patient's visit is the result of an accident, Occurrence Codes 01-05 must be reported as appropriate. For example, if the patient's accident occurred at work, Occurrence Code 04 should be reported with the date of the accident.
  - Apart from the requirement stated above, hospitals should report any/all other Occurrence Codes and Dates as required for normal billing practices. All Occurrence Codes reported must be valid as per the National Uniform Billing Committee's UB04 Specifications Manual, and all Occurrence Dates reported must be valid dates and appropriate for the Occurrence Code being reported.

Occurrence Span Codes and Dates

Occurrence Span Code – Field # 113 in NJ HEALTHCAP Extract File Layout

Occurrence Span Code - Date From – Field # 114 in NJ HEALTHCAP Extract File Layout

Occurrence Span Code – Date Thru – Field # 115 in NJ HEALTHCAP Extract File Layout

A code and the related dates that identify an event that relates to the payment of the claim.

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.
- Required for: All Patients
- 837 Location: 2300 Loop, HI01-02 to HI12-02, Code Qualifier "BI"
- Valid Codes:

Code	Definition
70	Qualifying Stay Dates for SNF Use Only
71	Prior Stay Dates
72	First/Last Visit Dates
73	Benefit Eligibility Period
74	Non-covered Level of Care/Leave of Absence Dates
75	SNF Level of Care Dates
76	Patient Liability
77	Provider Liability Period
78	SNF Prior Stay Dates
79	Payer Code
80	Prior Same-SNF Stay Dates for Payment Ban Purposes
81	Antepartum Days
M0	QIO/UR Approved Stay Dates
M1	Provider Liability - No Utilization
M2	Inpatient Respite Dates

Code	Definition
M3	ICF Level of Care
M4	Residential Level of Care

- Edits:

  1. An Occurrence Span Code may not be present without Occurrence Span From and Thru Dates.

  2. For Occurrence Span Codes 70, 71, 72, 73 and 78, the Occurrence Span Code From Date must be a valid date and must be equal to or greater than the patient's birth date.

  3. The Occurrence Span Code must be blank or must be a valid Occurrence Span Code as defined by the NUBC.

  4. An Occurrence Span From or Thru Date must not be present without an Occurrence Span Code.

  5. An Occurrence Span Thru Date must be greater than the Occurrence Span From Date.

  6. An Occurrence Span Code may not be valued if the preceding Occurrence Span Code is not valued.

  7. For Occurrence Span Codes 74, 75, 76, 77, M0, M1, M2, M3 and M4, the Occurrence Span From Date must not be less than the Admission Date.

  8. For Occurrence Span Codes 74, 75, 76, 77, M0, M1, M2, M3 and M4, the Occurrence Span Thru Date must not be greater than the Statement Thru Date.

- Guidelines:

  - 1. If the patient's visit includes non-acute care days (ICF, SNF or Residential days), Occurrence Span Codes 75, M3, and/or M4 must be reported as appropriate for the patient. The Occurrence Span From and Through Dates should indicate the dates of the patient's stay at the non-acute level of care.

  - 2. Apart from the requirement stated above, hospitals should report any/all other Occurrence Span Codes and Dates as required for normal billing practices. All Occurrence Span Codes reported must be valid as per the National Uniform Billing Committee's UB04 Specifications Manual, and all Occurrence Span Dates reported must be valid dates and appropriate for the Occurrence Span Code being reported.

Operating Physician National Provider Identifier (NPI)

Field # 50 in NJ HEALTHCAP Extract File Layout

The National Provider Identifier of the individual with the primary responsibility for performing the surgical procedure(s). Required when a surgical procedure code is listed on the claim.

- External Code Source: Center's for Medicare and Medicaid Services National Provider Identifier
- Required for: All Patients
- 837 Location: 2310B Loop, NM109, Code Qualifier "XX"
- Valid Codes: A valid NPI number
- Edits:
    1. Patients with procedure codes must have an Operating Physician NPI number.
    2. The Operating Physician's NPI number must be either blank or a valid NPI number (using the Luhn algorithm).

Luhn Algorithm

Example NPI: 1234567893

Step 1: Validate NPI is 10 digits long.

Step 2: Double the value of alternate digits, beginning with the first digit, not including the 10th digit.

NPI without check digit (first nine positions): 123456789

Double the value of alternate digits, beginning with the first digit: 2 6 10 14 18

Step 3: Add constant 24, plus the individual digits of products of doubling, plus unaffected (those not doubled in step 2) digits.

24 + 2 + 6 + 1 + 0 + 1 + 4 + 1 + 8 + 2 + 4 + 6 + 8 = 67

If the resulting number ends with a 0 (e.g. 40), then the tenth digit of the NPI should be 0. If the resulting number does not end in 0, proceed to Step 4.

Step 4: Subtract from next higher number ending in zero.

70 – 67 = 3

Tenth digit should be 3.

Operating Physician State License Number

Field # 49 in NJ HEALTHCAP Extract File Layout

The state license number of the individual with the primary responsibility for performing the surgical procedure(s). Required when a surgical procedure code is listed on the claim.

- External Code Source: New Jersey Division of Consumer Affairs, Board of Medical Examiners.
- Required for: All Patients
- 837 Location: 2310B Loop, REF02, Code Qualifier “0B”
- Valid Codes:
    - For New Jersey physicians, one of the following:
        - The first two characters must equal ‘NJ’ followed for seven or eight alphanumeric characters and no spaces.
        - The first two characters must equal ‘22’, ‘25’, ‘26’, or ‘35’ followed by ten alphanumeric characters and no spaces.
    - For physicians outside New Jersey the first two characters must equal any valid two-digit alpha character abbreviation for American state, American possession, or Canadian province followed by alphanumeric character(s).
- Edits:

    1. The Operating Physician’s State Code (which is the first two characters of the License Number) must be a valid state, ‘22’, ‘25’, ‘26’, or ‘35’.

    2. If the Operating Physician’s State Code equals ‘NJ’, then check to see that the number after the state code is 7 or 8 characters in length and does not contain a space. If the first two characters are ‘22’, ‘25’, ‘26’ or ‘35’, then check to see the number after the state code is 10 characters in length and does not contain a space.

    3. If the Operating Physician’s State Code is valid, and does not equal 'NJ', ‘22’, ‘25’, ‘26’ or ‘35’, then check to see that the position after the state code is not blank.

    4. Inpatients with procedure codes must have an Operating Physician’s State License Number.

Other Diagnosis Codes

Other Diagnosis Code Field # 96 in NJ HEALTHCAP Extract File Layout

Other Diagnosis Code Present on Admission (POA) Indicator Field # 97 in NJ HEALTHCAP Extract File Layout

The ICD-10-CM diagnoses codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital stay. There can be up to 24 Other Diagnosis Codes.

- External Code Source: International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
- Required for: All patients
- 837 Location: 2300 Loop, HI01-02 to HI12-02, Code Qualifier "ABF"
- Valid Codes: Valid ICD-10-CM codes as defined by CDC
- Edits:
    1. Diagnosis Codes cannot be duplicated.
    2. If there is a diagnosis code in any diagnosis code field, then the codes in the preceding fields must not be blank.
    3. If an Other Diagnosis Code is present, the corresponding Present on Admission Indicator must be valued.

Other Operating Physician National Provider Identifier (NPI)

Field # 52 in NJ HEALTHCAP Extract File Layout

The National Provider Identifier of the individual performing a second surgical procedure or assisting the Operating Physician.

- External Code Source: Center's for Medicare and Medicaid Services National Provider Identifier
- Required for: All Patients
- 837 Location: 2310C Loop, NM109, Code Qualifier "XX"
- Valid Codes: A valid NPI number
- Edit:
    1. The Other Operating Physician's NPI number must be either blank or a valid NPI number (using the Luhn algorithm).

Luhn Algorithm

Example NPI: 1234567893

Step 1: Validate NPI is 10 digits long.

Step 2: Double the value of alternate digits, beginning with the first digit, not including the 10th digit.

NPI without check digit (first nine positions): 123456789

Double the value of alternate digits, beginning with the first digit: 2 6 10 14 18

Step 3: Add constant 24, plus the individual digits of products of doubling, plus unaffected (those not doubled in step 2) digits.

24 + 2 + 6 + 1 + 0 + 1 + 4 + 1 + 8 + 2 + 4 + 6 + 8 = 67

If the resulting number ends with a 0 (e.g. 40), then the 10th digit of the NPI should be 0. If the resulting number does not end in 0, proceed to step 4.

Step 4: Subtract from next higher number ending in zero.

70 – 67 = 3

Tenth digit should be 3

Other Operating Physician State License Number

Field # 51 in NJ HEALTHCAP Extract File Layout

The state license number of the individual performing a second surgical procedure or assisting the Operating Physician.

- External Code Source: New Jersey Division of Consumer Affairs, Board of Medical Examiners.
- Required for: All Patients
- 837 Location: 2310C Loop, REF02, Code Qualifier “0B”
- Valid Codes:
    - For New Jersey physicians, one of the following:
        - The first two characters must equal ‘NJ’ followed for seven or eight alphanumeric characters and no spaces

- The first two characters must equal ‘22’, ‘25’, ‘26’, or ‘35’ followed by 10 alphanumeric characters and no spaces
- For physicians outside New Jersey the first two characters must equal any valid two-digit alpha character abbreviation for American state, American possession, or Canadian province followed by alphanumeric character(s)

- Edits:

  1. The Other Operating Physician’s State License number must either be blank or the Other Operating Physician’s State Code (which is the first two characters of the License Number) must be a valid state, ‘22’, ‘25’, ‘26’, or ‘35’.

  2. If the Other Operating Physician’s State Code equals ‘NJ’, then check to see that the number after the state code is 7 or 8 characters in length and does not contain a space. If the first two characters are ‘22’, ‘25’, ‘26’, or ‘35’, then check to see the number after the state code is 10 characters in length and does not contain a space.

  3. If the Other Operating Physician’s State Code is valid, and does not equal 'NJ', ‘22’, ‘25’, ‘26’, or ‘35’, then check to see that the position after the state code is not blank.

Patient Control Number

Field # 5 in NJ HEALTHCAP Extract File Layout

A unique number assigned to a patient by the facility, to facilitate posting of payment information and identification of the billed claim

- External Code Source: National Uniform Billing Committee’s UB04 Specifications Manual.
- Required for: All Patients
- 837 Location: 2300 Loop, CLM01
- Valid Codes Any alphanumeric characters 4 to 20 characters in length
- Edit:
  1. The Patient Control Number cannot equal spaces and must be at least 4 but not more than 20 characters in length.
  2. The Patient Control Number cannot be changed on claims previously sent.

Note: Records maintained in the NJ HEALTHCAP Data Warehouse, as well as those transmitted to the NJDOH, are keyed upon a combination of the hospital's 7-digit provider number (31XXXXX) and the patient control number. If a patient is reported under multiple

patient control numbers (for the same episode of care), there will be duplicate claims in both the data warehouse and the database at the NJDOH.

Patient Discharge Status (Discharge [Patient] Status Code)

Field # 16 in NJ HEALTHCAP Extract File Layout

A code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill, as reported in the Statement Covers Period.

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.
- Required for: All Patients
- 837 Location: 2300 Loop, CL103
- Valid Codes:

Code	Description
01	Discharged/Transferred to home/self-care (routine discharge)
02	Discharged/Transferred to short-term general hospital for inpatient care
03	Discharged/Transferred to skilled nursing facility (SNF)
04	Discharged/Transferred to a Facility that Provides Custodial or Supportive Care
05	Discharged/Transferred to a designated Cancer Center or Children's Hospital
06	Discharged to home under care of organized home health service provider
07	Left against medical advice
09	Admitted as an inpatient to this hospital (outpatient only)
20	Expired (no autopsy – or did not recover, Christian Science Patient)
21	Discharged/Transferred to Court/Law Enforcement
30	Still a Patient
43	Discharged/Transferred to a federal hospital

Code	Description
50	Hospice – Home
51	Hospice – Medical Facility
61	Discharged/transferred within this institution to hospital-based Medicare approved swing bed
62	Discharged/transferred to another rehab facility
63	Discharged/transferred to a long-term care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare.
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.
66	Discharged/Transferred to a Critical Access Hospital
69	Discharged/Transferred to a designated Disaster Alternative Care Site
70	Discharged/Transferred to another type of healthcare institution not elsewhere defined in this list
81	Discharged to home or self-care with a planned acute care hospital inpatient readmission
82	Discharged/Transferred to short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission
83	Discharged/Transferred to skilled nursing facility (SNF) with a planned acute care hospital inpatient readmission
84	Discharged/Transferred to a Facility that Provides Custodial or Supportive Care with a planned acute care hospital inpatient readmission
85	Discharged/Transferred to a designated Cancer Center or Children’s Hospital with a planned acute care hospital inpatient readmission
86	Discharged to home under care of organized home health service provider with a planned acute care hospital inpatient readmission
87	Discharged/Transferred to Court/Law Enforcement with a planned acute care hospital inpatient readmission

Code	Description
88	Discharged/Transferred to a federal hospital with a planned acute care hospital inpatient readmission
89	Discharged/Transferred within this institution to hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission
90	Discharged/Transferred to another rehab facility with a planned acute care hospital inpatient readmission
91	Discharged/Transferred to a long-term care hospital with a planned acute care hospital inpatient readmission
92	Discharged/Transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission
93	Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
94	Discharged/Transferred to a Critical Access Hospital with a planned acute care hospital inpatient readmission
95	Discharged/Transferred to another type of healthcare institution not elsewhere defined in this list with a planned acute care hospital inpatient readmission

- Edits:

  1. Patient Discharge Status must be either 01, 02, 03, 04, 05, 06, 07, 20, 21, 30, 43, 50, 51, 61, 62, 63, 64, 65, 66, 69, 70, 81, 82, 83, 84, 85, 85, 87, 88, 89, 90, 91, 92, 93, 94 or 95.
  2. For outpatients, Patient Discharge Status may also be 09.

Patient Type Flag

Field # 64 in NJ HEALTHCAP Extract File Layout

Identifies the types of patients in the extract file.

This code is not required to be reported by hospitals. Instead, it will be calculated for all patients as follows:

The following table lists and describes the Patient Type Flag Codes.

Code	Description
0	Inpatient
1	Same Day Surgery (SDS)
2	ER Outpatient
3	Other Outpatient

The following table lists the Patient Type Criteria.

Patient Type	Criteria
Inpatient	Bill Type = 011X or 012X
Same Day Surgery	Bill Type = 013X, and LOS = 0, and Discharge Status Code = 01 or 06, and Revenue Code = 036X
ER Outpatient	Bill Type = 013X and Revenue Code = 045X
Other Outpatient	Bill Type = 013X and not SDS or ER

Patient's Age in Days

Field # 26 in NJ HEALTHCAP Extract File Layout

The patient's age in days.

This code is not required to be reported by hospitals. Instead, it will be calculated for all patients as follows:

Patient's Age in Days = Admission Date – Date of Birth (represented in days)

Patient's Age in Years

Field # 25 in NJ HEALTHCAP Extract File Layout

The patient's age in years.

This code is not required to be reported by hospitals. Instead, it will be calculated for all patients as follows:

Patient's Age in Years = Admission Date – Date of Birth (represented in whole years)

Patient's City

Field # 11 in NJ HEALTHCAP Extract File Layout

The city where the patient resides.

External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.

- Required for: All Patients
- 837 Location:
    - 2010BA Loop, N401
    - 2010CA Loop, N401
- Valid Codes: Any valid city using up to 30 alpha characters
- Edit:
    1. The Patient's City cannot be blank.

Patient's Country

Field # 14 in NJ HEALTHCAP Extract File Layout

The country where the patient resides.

- External Code Source: ISO 3166-2 Codes for the representation of names of Countries and their subdivisions.
- Required for: All Patients
- 837 Location:

- 2010BA Loop, N404
- 2010CA Loop, N404

- Valid Codes:

Code	Country Name
AF	AFGHANISTAN
AL	ALBANIA
DZ	ALGERIA
AS	AMERICAN SAMOA
AD	ANDORRA
AO	ANGOLA
AI	ANGUILLA
AQ	ANTARCTICA
AG	ANTIGUA AND BARBUDA
AR	ARGENTINA
AM	ARMENIA
AW	ARUBA
AU	AUSTRALIA
AT	AUSTRIA
AZ	AZERBAIJAN
BS	BAHAMAS
BH	BAHRAIN
BD	BANGLADESH
BB	BARBADOS
BY	BELARUS
BE	BELGIUM

Code	Country Name
BZ	BELIZE
BJ	BENIN
BM	BERMUDA
BT	BHUTAN
BO	BOLIVIA
BQ	BONAIRE, SINT EUSTATIUS AND SABS
BA	BOSNIA AND HERZEGOVINA
BW	BOTSWANA
BV	BOUVET ISLAND
BR	BRAZIL
IO	BRITISH INDIAN OCEAN TERRITORY
BN	BRUNEI DARUSSALAM
BG	BULGARIA
BF	BURKINA FASO
BI	BURUNDI
KH	CAMBODIA
CM	CAMEROON
CA	CANADA
CV	CAPE VERDE
KY	CAYMAN ISLANDS
CF	CENTRAL AFRICAN REPUBLIC
TD	CHAD
CL	CHILE
CN	CHINA

Code	Country Name
CX	CHRISTMAS ISLAND
CC	COCOS (KEELING) ISLANDS
CO	COLOMBIA
KM	COMOROS
CG	CONGO
CD	CONGO, THE DEMOCRATIC REPUBLIC OF THE
CK	COOK ISLANDS
CR	COSTA RICA
CI	CÔTE D'IVOIRE
HR	CROATIA
CU	CUBA
CY	CYPRUS
CZ	CZECH REPUBLIC
DK	DENMARK
DJ	DJIBOUTI
DM	DOMINICA
DO	DOMINICAN REPUBLIC
EC	ECUADOR
EG	EGYPT
SV	EL SALVADOR
GQ	EQUATORIAL GUINEA
ER	ERITREA
EE	ESTONIA
ET	ETHIOPIA

Code	Country Name
FK	FALKLAND ISLANDS (MALVINAS)
FO	FAROE ISLANDS
FJ	FIJI
FI	FINLAND
FR	FRANCE
GF	FRENCH GUIANA
PF	FRENCH POLYNESIA
TF	FRENCH SOUTHERN TERRITORIES
GA	GABON
GM	GAMBIA
GE	GEORGIA
DE	GERMANY
GH	GHANA
GI	GIBRALTAR
GR	GREECE
GL	GREENLAND
GD	GRENADA
GP	GUADELOUPE
GU	GUAM
GT	GUATEMALA
GN	GUINEA
GW	GUINEA-BISSAU
GY	GUYANA
HT	HAITI

Code	Country Name
HM	HEARD ISLAND AND MCDONALD ISLANDS
VA	HOLY SEE (VATICAN CITY STATE)
HN	HONDURAS
HK	HONG KONG
HU	HUNGARY
IS	ICELAND
IN	INDIA
ID	INDONESIA
IR	IRAN, ISLAMIC REPUBLIC OF
IQ	IRAQ
IE	IRELAND
IL	ISRAEL
IT	ITALY
JM	JAMAICA
JP	JAPAN
JO	JORDAN
KZ	KAZAKHSTAN
KE	KENYA
KI	KIRIBATI
KP	KOREA, DEMOCRATIC PEOPLE'S REPUBLIC OF
KR	KOREA, REPUBLIC OF
KW	KUWAIT
KG	KYRGYZSTAN
LA	LAO PEOPLE'S DEMOCRATIC REPUBLIC

Code	Country Name
LV	LATVIA
LB	LEBANON
LS	LESOTHO
LR	LIBERIA
LY	LIBYAN ARAB JAMAHIRIYA
LI	LIECHTENSTEIN
LT	LITHUANIA
LU	LUXEMBOURG
MO	MACAO
MK	MACEDONIA, THE FORMER YUGOSLAV REPUBLIC OF
MG	MADAGASCAR
MW	MALAWI
MY	MALAYSIA
MV	MALDIVES
ML	MALI
MT	MALTA
MH	MARSHALL ISLANDS
MQ	MARTINIQUE
MR	MAURITANIA
MU	MAURITIUS
YT	MAYOTTE
MX	MEXICO
FM	MICRONESIA, FEDERATED STATES OF
MD	MOLDOVA, REPUBLIC OF

Code	Country Name
MC	MONACO
MN	MONGOLIA
MS	MONTSERRAT
MA	MOROCCO
MZ	MOZAMBIQUE
MM	MYANMAR
NA	NAMIBIA
NR	NAURU
NP	NEPAL
NL	NETHERLANDS
AN	NETHERLANDS ANTILLES
NC	NEW CALEDONIA
NZ	NEW ZEALAND
NI	NICARAGUA
NE	NIGER
NG	NIGERIA
NU	NIUE
NF	NORFOLK ISLAND
MP	NORTHERN MARIANA ISLANDS
NO	NORWAY
OM	OMAN
PK	PAKISTAN
PW	PALAU
PS	PALESTINIAN TERRITORY, OCCUPIED

Code	Country Name
PA	PANAMA
PG	PAPUA NEW GUINEA
PY	PARAGUAY
PE	PERU
PH	PHILIPPINES
PN	PITCAIRN
PL	POLAND
PT	PORTUGAL
PR	PUERTO RICO
QA	QATAR
RE	RÉUNION
RO	ROMANIA
RU	RUSSIAN FEDERATION
RW	RWANDA
SH	SAINT HELENA
KN	SAINT KITTS AND NEVIS
LC	SAINT LUCIA
PM	SAINT PIERRE AND MIQUELON
VC	SAINT VINCENT AND THE GRENADINES
WS	SAMOA
SM	SAN MARINO
ST	SAO TOME AND PRINCIPE
SA	SAUDI ARABIA
SN	SENEGAL

Code	Country Name
CS	SERBIA AND MONTENEGRO
SC	SEYCHELLES
SL	SIERRA LEONE
SG	SINGAPORE
SK	SLOVAKIA
SI	SLOVENIA
SB	SOLOMON ISLANDS
SO	SOMALIA
ZA	SOUTH AFRICA
GS	SOUTH GEORGIA AND THE SOUTH SANDWICH ISLANDS
ES	SPAIN
LK	SRI LANKA
SD	SUDAN
SR	SURINAME
SJ	SVALBARD AND JAN MAYEN
SZ	SWAZILAND
SE	SWEDEN
CH	SWITZERLAND
SY	SYRIAN ARAB REPUBLIC
TW	TAIWAN, PROVINCE OF CHINA
TJ	TAJIKISTAN
TZ	TANZANIA, UNITED REPUBLIC OF
TH	THAILAND
TL	TIMOR-LESTE

Code	Country Name
TG	TOGO
TK	TOKELAU
TO	TONGA
TT	TRINIDAD AND TOBAGO
TN	TUNISIA
TR	TURKEY
TM	TURKMENISTAN
TC	TURKS AND CAICOS ISLANDS
TV	TUVALU
UG	UGANDA
UA	UKRAINE
AE	UNITED ARAB EMIRATES
GB	UNITED KINGDOM
US	UNITED STATES
UM	UNITED STATES MINOR OUTLYING ISLANDS
UY	URUGUAY
UZ	UZBEKISTAN
VU	VANUATU
VE	VENEZUELA
VN	VIET NAM
VG	VIRGIN ISLANDS, BRITISH
VI	VIRGIN ISLANDS, U.S.
WF	WALLIS AND FUTUNA
EH	WESTERN SAHARA

Code	Country Name
YE	YEMEN
ZM	ZAMBIA
ZW	ZIMBABWE
XX	UNKNOWN

- Edit:
    1. If the Patient's State is XX (foreign), the Patient's Country cannot be blank and must be a valid country code.

Patient's Date of Birth

Field # 24 in NJ HEALTHCAP Extract File Layout

The patient's date of birth

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.
- Required for: All Patients
- 837 Location, one of the following:
    - 2010BA Loop DMG02, Code Qualifier "D8"
    - 2010CA Loop, DMG02, Code Qualifier "D8"
- Valid Codes: A valid date equal to or less than the Admission Date
- Edits:
    1. The century for the birth date year must start with either '18', '19', or '20'.
    2. The Patient's Birth Date must be a valid date.
    3. The Patient's Birth Date must be less than or equal to the Admission Date.
    4. The patient's age cannot be greater than 124 years.

Patient's Ethnicity Code

Field # 23 in NJ HEALTHCAP Extract File Layout

Code identifying patient's ethnicity

External Code Source: Office of Management and Budget (OMB) 15 Unique Identifier Ethnicity Codes.

- Required for: All Patients
- 837 Location, one of the following:
    - 2010BA Loop, DMG05-03, Code Qualifier "RET"
    - 2010CA Loop, DMG05-03, Code Qualifier "RET"

  The Ethnicity code should follow the second RET qualifier in the segment.
- Valid Codes:

Code	Description
21865	No, not Spanish/Hispanic/Latino
21485	Yes, Mexican, Mexican American, Chicano
21808	Yes, Puerto Rican
21824	Yes, Cuban
21550	Yes, Central or South American
21880	Yes, Other Spanish/Hispanic/Latino
21870	Unknown/Unavailable
21875	Declined to Answer

- Edit:
    1. Patient's Ethnicity Code must not be blank and must be a valid code on the Ethnicity table.

Patient's Full Name

Patient's First Name – Field # 27 in NJ HEALTHCAP Extract File Layout

Patient's Last Name – Field # 28 in NJ HEALTHCAP Extract File Layout

Patient's Middle Initial – Field # 29 in NJ HEALTHCAP Extract File Layout

The first name, last name and middle initial of the patient

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.
- Required for: All Patients
- 837 Location, one of the following:
    - 2010BA Loop, NM103, 104 and 105, Code Qualifier "IL"
    - 2010CA Loop, NM103, 104 and 105, Code Qualifier "QC"
- Edits:
    1. The Patient First Name cannot be numeric or blank.
    2. The Patient Last Name cannot be numeric or blank.
    3. The Patient Middle Initial must either be an alpha character or be blank.

Patient's Gender

Field # 18 in NJ HEALTHCAP Extract File Layout

Code identifying the patient's gender at date of admission (Inpatient) or start of service (Outpatient)

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.
- Required for: All Patients
- 837 Location:

    - 2010BA Loop, DMG03
    - 2010CA Loop, DMG03
- Valid Codes:
    - F = Female
    - M = Male
    - U = Undetermined
- Edits:
    1. Patient’s Gender must be either ‘F’, ‘M’, or ‘U’.
    2. If a Revenue Codes equals either '0112', '0122', '0132', '0142', '0152', or '0721', then the Patient Gender must be 'F'.
    3. Patient’s Gender Code ‘U’ is valid only for patients < 29 days old.

Patient’s Marital Status

Field # 17 in NJ HEALTHCAP Extract File Layout

Code identifying patient’s marital status

- External Code Source: ANSI 837 ASC X12N/005010X225 Data Reporting Guide.
- Required for: All Patients
- 837 Location:
    - 2010BA Loop, DMG04
    - 2010CA Loop, DMG04
- Valid Codes:

Code	Description
A	Common Law
B	Registered Domestic Partner

Code	Description
C	Not Applicable
D	Divorced
I	Single
K	Unknown
M	Married/Civil Union
R	Unreported
S	Separated
U	Unmarried
W	Widowed
X	Legally Separated

- Edit:
    1. Marital Status cannot be blank and must be on the list of valid marital status code.
    2. If Marital Status equals ‘S’, then the Patient’s Age must be greater than or equal to 18.

Patient’s Occupation

Field # 31 in NJ HEALTHCAP Extract File Layout

The patient’s occupation

- Required for: All Patients
- 837 Location: 2300 Loop, K301, positions 26-45
- Valid Codes: Any alphanumeric characters up to 20 positions in length, and special characters “#” and “-”

Suggested Occupation List
ACCOUNTANT

Suggested Occupation List
ADMIN ASSISTANT
AIDE
ASSEMBLER
ASSOCIATE
ATTORNEY
BARTENDER
BUS DRIVER
BUSINESS OWNER
CARPENTER
CASHIER
CLERICAL WORKER
CONSTRUCTION WORKER
CONSULTANT
CONTRACTOR
COOK
CORRECTIONS OFFICER
COUNSELOR
CUSTODIAN
DATA ENTRY
DIETARY AIDE
DISPATCHER
ELECTRICIAN
EMT
ENGINEER

Suggested Occupation List
EXECUTIVE
FACTORY WORKER
FINANCIAL ANALYST
FIREFIGHTER
FOOD SERVICE
HAIRDRESSER
HELPER
HOME HEALTH AIDE
HOUSEKEEPER
INSPECTOR
INSTALLER
LAB TECH
LABORER
LANDSCAPER
LOADER
MACHINE OPERATOR
MACHINIST
MAINTENANCE
MANAGER
MECHANIC
MEDICAL ASSISTANT
MILITARY
NURSE
NURSING ASSISTANT

Suggested Occupation List
OPERATOR
PACKER
PAINTER
PHYSICIAN
PLUMBER
POLICE OFFICER
PROGRAMMER
REALTOR
RECEPTIONIST
SALESPERSON
SECRETARY
SECURITY
SELF EMPLOYED
SOCIAL WORKER
STOCKER
SUPERVISOR
TEACHER
TEACHER ASSISTANT
TECHNICIAN
TELLER
THERAPIST
TRUCK DRIVER
WAIT STAFF
WAREHOUSE WORKER

Suggested Occupation List
WELDER
Patients with No Occupation
DECLINED TO PROVIDE
DISABLED
HOMEMAKER
RETIRED
STUDENT
UNEMPLOYED

- Edit:
    1. If patient's age is greater than 18, the Occupation Code cannot be blank.

Patient's Primary Language Spoken

Field # 30 in NJ HEALTHCAP Extract File Layout

Code identifying the primary language spoken by the patient. External Code Source: ISO 639-2 Codes

- Required for: All Patients
- 837 Location: 2300 Loop, K302, positions 47-49
- Valid Codes:

Code	Language
AFR	Afrikaans
AFA	Afro-Asiatic languages unspecified
ALB	Albanian
ARA	Arabic
ARM	Armenian

Code	Language
BEL	Belarusian
BEN	Bengali
BOS	Bosnian
BUL	Bulgarian
BUR	Burmese
CAU	Caucasian languages unspecified
CHI	Chinese
SCR	Croatian
CZE	Czech
DUT	Dutch
ENG	English
EST	Estonian
FRE	French
CPF	French Creole
GER	German
GRE	Greek, Modern
GUJ	Gujarati
HEB	Hebrew
HIN	Hindi
HMN	Hmong-Mien
HUN	Hungarian
INE	Indo-European languages unspecified
IND	Indonesian
ITA	Italian

Code	Language
JPN	Japanese
KAN	Kannada
KOR	Korean
KRO	Kru
LAO	Lao
LIT	Lithuanian
MAC	Macedonian
MAL	Malayalam
MAR	Marathi
MKH	Mon-Khmer, Cambodian
NAV	Navajo
NOR	Norwegian
PAN	Panjabi
PER	Persian
POL	Polish
POR	Portuguese
CPP	Portuguese Creole
RUM	Romanian
RUS	Russian
SCC	Serbian
SLA	Slavic languages unspecified
SLO	Slovak
SPA	Spanish
SWA	Swahili

Code	Language
SWE	Swedish
SYR	Syriac
TGL	Tagalog
TAM	Tamil
TEL	Telugu
THA	Thai
TUR	Turkish
UKR	Ukrainian
URD	Urdu
VIE	Vietnamese
YID	Yiddish
YOR	Yoruba
OTH	Other languages

- Edit:

  1. The Patient's Primary Language Spoken must be a valid code on the list unless the Patient's Birth Date equals the Admission Date.

Patient's Race

Field # 21 in NJ HEALTHCAP Extract File Layout Code identifying patient's race.

- External Code Source: Office of Management and Budget (OMB) 15 Unique Identifier Ethnicity Codes.
- Required for: All Patients
- 837 Location:

- 2010BA Loop, DMG05-03, Code Qualifier “RET”
- 2010CA Loop, DMG05-03, Code Qualifier “RET”.

The Race Code should follow the first RET qualifier in the segment.

- Valid Codes:

Code	Description
21063	White
20545	Black or African American
10025	American Indian or Alaskan Native
20297	Asian Indian
20347	Chinese
20362	Filipino
20396	Japanese
20404	Korean
20479	Vietnamese
20289	Other Asian
20792	Native Hawaiian
20867	Guamanian or Chamorro
20800	Samoan
25007	Other Pacific Islander
21380	Multiracial: White and Black or African American
21381	Multiracial: White and American Indian or Alaskan Native
21382	Multiracial: White and Asian
21383	Multiracial: Black or African American and American Indian or Alaskan Native
21311	Other Race
21385	Unknown/Unavailable

Code	Description
21390	Declined to Answer

- Edit:
    1. Patient's Race must not be blank and must be valid code on race code table.

Patient's Reason for Visit

Patient's Reason for Visit 1 – Field # 90 in NJ HEALTHCAP Extract File Layout

Patient's Reason for Visit 2 – Field # 91 in NJ HEALTHCAP Extract File Layout

Patient's Reason for Visit 3 – Field # 92 in NJ HEALTHCAP Extract File Layout

The ICD-10-CM diagnosis code(s) describing the patient's reason for visit at the time of outpatient registration.

- External Code Source: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM).
- Required for: Outpatients
- 837 Location: 2300 Loop, HI101-2 to HI103-2, Code Qualifier "APR"
- Valid Codes: Any valid ICD-10-CM diagnosis code
- Edits:
    1. If the bill type is 013X, the Patient's Reason for Visit 1 code must not be blank, and must be a valid ICD-10-CM diagnosis code.
    2. If any Patient's Reason for Visit Code is present, it must be valid ICD-10-CM diagnosis code.
    3. A Patient's Reason for Visit Code may not be valued if the preceding Patient's Reason for Visit code is not valued.

Patient's Relationship to Primary Insured

Field # 39 in NJ HEALTHCAP Extract File Layout

Code indicating the relationship of the patient to the individual holding the primary insurance.

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.
- Required for: All Patients
- 837 Location, one of the following:
    - 2000B Loop, SBR02
    - 2000C Loop, PAT01
- Valid Codes:

Code	Definition
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

- Edit:
    1. Patient's Relationship to Primary insured cannot be blank and must be valid relationship code.

Patient's Relationship to Secondary Insured

Field # 40 in NJ HEALTHCAP Extract File Layout

Code indicating the relationship of the patient to the individual holding the secondary insurance.

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.
- Required for: All Patients
- 837 Location: 2320 Loop, SBR02
- Valid Codes:

Code	Definition
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

- Edit:

  1. If Secondary Payer Code is not blank, Patient's Relationship to Secondary Insured cannot be blank and must be a valid relationship code.

Patient's Residence Code

Field # 15 in NJ HEALTHCAP Extract File Layout

Code indicating the county or municipality where patient's address is located

External Code Source: State of New Jersey Municipality Codes

- Required for: All Patients

- 837 Location: 2300 Loop, K301, positions 1-4
- Valid Codes:

Code	Municipality	County for NJ Municipalities
0101	Absecon City	Atlantic
0102	Atlantic City	Atlantic
0103	Brigantine City	Atlantic
0104	Buena Boro	Atlantic
0105	Buena Vista Township	Atlantic
0106	Corbin City	Atlantic
0107	Egg Harbor City	Atlantic
0108	Egg Harbor Township	Atlantic
0109	Estell Manor City	Atlantic
0110	Folsom Boro	Atlantic
0111	Galloway Township	Atlantic
0112	Hamilton Township	Atlantic
0113	Hammonton Town	Atlantic
0114	Linwood City	Atlantic
0115	Longport Boro	Atlantic
0116	Margate City	Atlantic
0117	Mullica Township	Atlantic
0118	Northfield City	Atlantic
0119	Pleasantville City	Atlantic
0120	Port Republic City	Atlantic
0121	Somers Point City	Atlantic
0122	Ventnor City	Atlantic

Code	Municipality	County for NJ Municipalities
0123	Weymouth Township	Atlantic
0201	Allendale Boro	Bergen
0202	Alpine Boro	Bergen
0203	Bergenfield Boro	Bergen
0204	Bogota Boro	Bergen
0205	Carlstadt Boro	Bergen
0206	Cliffside Park Boro	Bergen
0207	Closter Boro	Bergen
0208	Cresskill Boro	Bergen
0209	Demarest Boro	Bergen
0210	Dumont Boro	Bergen
0211	Elmwood Park Boro	Bergen
0212	East Rutherford Boro	Bergen
0213	Edgewater Boro	Bergen
0214	Emerson Boro	Bergen
0215	Englewood City	Bergen
0216	Englewood Cliffs Boro	Bergen
0217	Fair Lawn Boro	Bergen
0218	Fairview Boro	Bergen
0219	Fort Lee Boro	Bergen
0220	Franklin Lakes Boro	Bergen
0221	Garfield City	Bergen
0222	Glen Rock Boro	Bergen
0223	Hackensack City	Bergen

Code	Municipality	County for NJ Municipalities
0224	Harrington Park Boro	Bergen
0225	Hasbrouck Heights Boro	Bergen
0226	Haworth Boro	Bergen
0227	Hillsdale Boro	Bergen
0228	Hohokus Boro	Bergen
0229	Leonia Boro	Bergen
0230	Little Ferry Boro	Bergen
0231	Lodi Boro	Bergen
0232	Lyndhurst Township	Bergen
0233	Mahwah Township	Bergen
0234	Maywood Boro	Bergen
0235	Midland Park Boro	Bergen
0236	Montvale Boro	Bergen
0237	Moonachie Boro	Bergen
0238	New Milford Boro	Bergen
0239	North Arlington Boro	Bergen
0240	Northvale Boro	Bergen
0241	Norwood Boro	Bergen
0242	Oakland Boro	Bergen
0243	Old Tappan Boro	Bergen
0244	Oradell Boro	Bergen
0245	Palisades Park Boro	Bergen
0246	Paramus Boro	Bergen
0247	Park Ridge Boro	Bergen

Code	Municipality	County for NJ Municipalities
0248	Ramsey Boro	Bergen
0249	Ridgefield Boro	Bergen
0250	Ridgefield Park Township	Bergen
0251	Ridgewood Township	Bergen
0252	River Edge Boro	Bergen
0253	River Vale Township	Bergen
0254	Rochelle Park Township	Bergen
0255	Rockleigh Boro	Bergen
0256	Rutherford Boro	Bergen
0257	Saddle Brook Township	Bergen
0258	Saddle River Boro	Bergen
0259	South Hackensack Township	Bergen
0260	Teaneck Township	Bergen
0261	Tenafly Boro	Bergen
0262	Teterboro Boro	Bergen
0263	Upper Saddle River Boro	Bergen
0264	Waldwick Boro	Bergen
0265	Wallington Boro	Bergen
0266	Washington Township	Bergen
0267	Westwood Boro	Bergen
0268	Woodcliff Lake Boro	Bergen
0269	Wood Ridge Boro	Bergen
0270	Wyckoff Township	Bergen
0301	Bass River Township	Burlington

Code	Municipality	County for NJ Municipalities
0302	Beverly City	Burlington
0303	Bordentown City	Burlington
0304	Bordentown Township	Burlington
0305	Burlington City	Burlington
0306	Burlington Township	Burlington
0307	Chesterfield Township	Burlington
0308	Cinnaminson Township	Burlington
0309	Delanco Township	Burlington
0310	Delran Township	Burlington
0311	Eastampton Township	Burlington
0312	Edgewater Park Township	Burlington
0313	Evesham Township	Burlington
0314	Fieldsboro Boro	Burlington
0315	Florence Township	Burlington
0316	Hainesport Township	Burlington
0317	Lumberton Township	Burlington
0318	Mansfield Township	Burlington
0319	Maple Shade Township	Burlington
0320	Medford Township	Burlington
0321	Medford Lakes Boro	Burlington
0322	Moorestown Township	Burlington
0323	Mount Holly Township	Burlington
0324	Mount Laurel Township	Burlington
0325	New Hanover Township	Burlington

Code	Municipality	County for NJ Municipalities
0326	North Hanover Township	Burlington
0327	Palmyra Boro	Burlington
0328	Pemberton Boro	Burlington
0329	Pemberton Township	Burlington
0330	Riverside Township	Burlington
0331	Riverton Boro	Burlington
0332	Shamong Township	Burlington
0333	Southampton Township	Burlington
0334	Springfield Township	Burlington
0335	Tabernacle Township	Burlington
0336	Washington Township	Burlington
0337	Westampton Township	Burlington
0338	Willingboro Township	Burlington
0339	Woodland Township	Burlington
0340	Wrightstown Boro	Burlington
0401	Audubon Boro	Camden
0402	Audubon Park Boro	Camden
0403	Barrington Boro	Camden
0404	Bellmawr Boro	Camden
0405	Berlin Boro	Camden
0406	Berlin Township	Camden
0407	Brooklawn Boro	Camden
0408	Camden City	Camden
0409	Cherry Hill Township	Camden

Code	Municipality	County for NJ Municipalities
0410	Chesilhurst Boro	Camden
0411	Clementon Boro	Camden
0412	Collingswood Boro	Camden
0413	Gibbsboro Boro	Camden
0414	Gloucester City	Camden
0415	Gloucester Township	Camden
0416	Haddon Township	Camden
0417	Haddonfield Boro	Camden
0418	Haddon Heights Boro	Camden
0419	Hi Nella Boro	Camden
0420	Laurel Springs Boro	Camden
0421	Lawnside Boro	Camden
0422	Lindenwold Boro	Camden
0423	Magnolia Boro	Camden
0424	Merchantville Boro	Camden
0425	Mount Ephraim Boro	Camden
0426	Oaklyn Boro	Camden
0427	Pennsauken Township	Camden
0428	Pine Hill Boro	Camden
0429	Pine Valley Boro	Camden
0430	Runnemede Boro	Camden
0431	Somerdale Boro	Camden
0432	Stratford Boro	Camden
0433	Tavistock Boro	Camden

Code	Municipality	County for NJ Municipalities
0434	Voorhees Township	Camden
0435	Waterford Township	Camden
0436	Winslow Township	Camden
0437	Wood Lynne Boro	Camden
0501	Avalon Boro	Cape May
0502	Cape May City	Cape May
0503	Cape May Point Boro	Cape May
0504	Dennis Township	Cape May
0505	Lower Township	Cape May
0506	Middle Township	Cape May
0507	North Wildwood City	Cape May
0508	Ocean City	Cape May
0509	Sea Isle City	Cape May
0510	Stone Harbor Boro	Cape May
0511	Upper Township	Cape May
0512	West Cape May Boro	Cape May
0513	West Wildwood Boro	Cape May
0514	Wildwood City	Cape May
0515	Wildwood Crest Boro	Cape May
0516	Woodbine Boro	Cape May
0601	Bridgeton City	Cumberland
0602	Commercial Township	Cumberland
0603	Deerfield Township	Cumberland
0604	Downe Township	Cumberland

Code	Municipality	County for NJ Municipalities
0605	Fairfield Township	Cumberland
0606	Greenwich Township	Cumberland
0607	Hopewell Township	Cumberland
0608	Lawrence Township	Cumberland
0609	Maurice River Township	Cumberland
0610	Millville City	Cumberland
0611	Shiloh Boro	Cumberland
0612	Stow Creek Township	Cumberland
0613	Upper Deerfield Township	Cumberland
0614	Vineland City	Cumberland
0701	Belleville Town	Essex
0702	Bloomfield Town	Essex
0703	Caldwell Boro	Essex
0704	Cedar Grove Township	Essex
0705	East Orange City	Essex
0706	Essex Fells Boro	Essex
0707	Fairfield Boro	Essex
0708	Glen Ridge Twp	Essex
0709	Irvington Twp	Essex
0710	Livingston Township	Essex
0711	Maplewood Township	Essex
0712	Millburn Township	Essex
0713	Montclair Town	Essex
0714	Newark City	Essex

Code	Municipality	County for NJ Municipalities
0715	North Caldwell Boro	Essex
0716	Nutley Twp	Essex
0717	City Of Orange Twp	Essex
0718	Roseland Boro	Essex
0719	South Orange Village Twp	Essex
0720	Verona Twp	Essex
0721	West Caldwell Twp	Essex
0722	West Orange Town	Essex
0801	Clayton Boro	Gloucester
0802	Deptford Township	Gloucester
0803	East Greenwich Township	Gloucester
0804	Elk Township	Gloucester
0805	Franklin Township	Gloucester
0806	Glassboro Boro	Gloucester
0807	Greenwich Township	Gloucester
0808	Harrison Township	Gloucester
0809	Logan Township	Gloucester
0810	Mantua Township	Gloucester
0811	Monroe Township	Gloucester
0812	National Park Boro	Gloucester
0813	Newfield Boro	Gloucester
0814	Paulsboro Boro	Gloucester
0815	Pitman Boro	Gloucester
0816	South Harrison Township	Gloucester

Code	Municipality	County for NJ Municipalities
0817	Swedesboro Boro	Gloucester
0818	Washington Township	Gloucester
0819	Wenonah Boro	Gloucester
0820	West Deptford Township	Gloucester
0821	Westville Boro	Gloucester
0822	Woodbury City	Gloucester
0823	Woodbury Heights Boro	Gloucester
0824	Woolwich Township	Gloucester
0901	Bayonne City	Hudson
0902	East Newark Boro	Hudson
0903	Guttenberg Town	Hudson
0904	Harrison Town	Hudson
0905	Hoboken City	Hudson
0906	Jersey City	Hudson
0907	Kearny Town	Hudson
0908	North Bergen Township	Hudson
0909	Secaucus Town	Hudson
0910	Union City	Hudson
0911	Weehawken Township	Hudson
0912	West New York Township	Hudson
1001	Alexandria Township	Hunterdon
1002	Bethlehem Township	Hunterdon
1003	Bloomsbury Boro	Hunterdon
1004	Califon Boro	Hunterdon

Code	Municipality	County for NJ Municipalities
1005	Clinton Town	Hunterdon
1006	Clinton Township	Hunterdon
1007	Delaware Township	Hunterdon
1008	East Amwell Township	Hunterdon
1009	Flemington Boro	Hunterdon
1010	Franklin Township	Hunterdon
1011	Frenchtown Boro	Hunterdon
1012	Glen Gardner Boro	Hunterdon
1013	Hampton Boro	Hunterdon
1014	High Bridge Boro	Hunterdon
1015	Holland Township	Hunterdon
1016	Kingwood Township	Hunterdon
1017	Lambertville City	Hunterdon
1018	Lebanon Boro	Hunterdon
1019	Lebanon Township	Hunterdon
1020	Milford Boro	Hunterdon
1021	Raritan Township	Hunterdon
1022	Readington Township	Hunterdon
1023	Stockton Boro	Hunterdon
1024	Tewksbury Township	Hunterdon
1025	Union Township	Hunterdon
1026	West Amwell Township	Hunterdon
1101	East Windsor Township	Mercer
1102	Ewing Township	Mercer

Code	Municipality	County for NJ Municipalities
1103	Hamilton Township	Mercer
1104	Hightstown Boro	Mercer
1105	Hopewell Boro	Mercer
1106	Hopewell Township	Mercer
1107	Lawrence Township	Mercer
1108	Pennington Boro	Mercer
1109	Princeton Boro	Mercer
1110	Princeton Township	Mercer
1111	Trenton City	Mercer
1112	Robbinsville Twp	Mercer
1113	West Windsor Township	Mercer
1201	Carteret Boro	Middlesex
1202	Cranbury Township	Middlesex
1203	Dunellen Boro	Middlesex
1204	East Brunswick Township	Middlesex
1205	Edison Township	Middlesex
1206	Helmetta Boro	Middlesex
1207	Highland Park Boro	Middlesex
1208	Jamesburg Boro	Middlesex
1209	Old Bridge Township	Middlesex
1210	Metuchen Boro	Middlesex
1211	Middlesex Boro	Middlesex
1212	Milltown Boro	Middlesex
1213	Monroe Township	Middlesex

Code	Municipality	County for NJ Municipalities
1214	New Brunswick City	Middlesex
1215	North Brunswick Township	Middlesex
1216	Perth Amboy City	Middlesex
1217	Piscataway Township	Middlesex
1218	Plainsboro Township	Middlesex
1219	Sayreville Boro	Middlesex
1220	South Amboy City	Middlesex
1221	South Brunswick Township	Middlesex
1222	South Plainfield Boro	Middlesex
1223	South River Boro	Middlesex
1224	Spotswood Boro	Middlesex
1225	Woodbridge Township	Middlesex
1301	Allenhurst Boro	Monmouth
1302	Allentown Boro	Monmouth
1303	Asbury Park City	Monmouth
1304	Atlantic Highlands Boro	Monmouth
1305	Avon By The Sea Boro	Monmouth
1306	Belmar Boro	Monmouth
1307	Bradley Beach Boro	Monmouth
1308	Brielle Boro	Monmouth
1309	Colts Neck Township	Monmouth
1310	Deal Boro	Monmouth
1311	Eatontown Boro	Monmouth
1312	Englishtown Boro	Monmouth

Code	Municipality	County for NJ Municipalities
1313	Fair Haven Boro	Monmouth
1314	Farmingdale Boro	Monmouth
1315	Freehold Boro	Monmouth
1316	Freehold Township	Monmouth
1317	Highlands Boro	Monmouth
1318	Holmdel Township	Monmouth
1319	Howell Township	Monmouth
1320	Interlaken Boro	Monmouth
1321	Keansburg Boro	Monmouth
1322	Keyport Boro	Monmouth
1323	Little Silver Boro	Monmouth
1324	Loch Arbour Village	Monmouth
1325	Long Branch City	Monmouth
1326	Manalapan Township	Monmouth
1327	Manasquan Boro	Monmouth
1328	Marlboro Township	Monmouth
1329	Matawan Boro	Monmouth
1330	Aberdeen Township	Monmouth
1331	Middletown Township	Monmouth
1332	Millstone Township	Monmouth
1333	Monmouth Beach Boro	Monmouth
1334	Neptune Township	Monmouth
1335	Neptune City Boro	Monmouth
1336	Tinton Falls Boro	Monmouth

Code	Municipality	County for NJ Municipalities
1337	Ocean Township	Monmouth
1338	Oceanport Boro	Monmouth
1339	Hazlet Township	Monmouth
1340	Red Bank Boro	Monmouth
1341	Roosevelt Boro	Monmouth
1342	Rumson Boro	Monmouth
1343	Sea Bright Boro	Monmouth
1344	Sea Girt Boro	Monmouth
1345	Shrewsbury Boro	Monmouth
1346	Shrewsbury Township	Monmouth
1347	Lake Como (South Belmar Boro)	Monmouth
1348	Spring Lake Boro	Monmouth
1349	Spring Lake Heights Boro	Monmouth
1350	Union Beach Boro	Monmouth
1351	Upper Freehold Township	Monmouth
1352	Wall Township	Monmouth
1353	West Long Branch Boro	Monmouth
1401	Boonton Town	Morris
1402	Boonton Township	Morris
1403	Butler Boro	Morris
1404	Chatham Boro	Morris
1405	Chatham Township	Morris
1406	Chester Boro	Morris
1407	Chester Township	Morris

Code	Municipality	County for NJ Municipalities
1408	Denville Township	Morris
1409	Dover Town	Morris
1410	East Hanover Township	Morris
1411	Florham Park Boro	Morris
1412	Hanover Township	Morris
1413	Harding Township	Morris
1414	Jefferson Township	Morris
1415	Kinnelon Boro	Morris
1416	Lincoln Park Boro	Morris
1417	Madison Boro	Morris
1418	Mendham Boro	Morris
1419	Mendham Township	Morris
1420	Mine Hill Township	Morris
1421	Montville Township	Morris
1422	Morris Township	Morris
1423	Morris Plains Boro	Morris
1424	Morristown Town	Morris
1425	Mountain Lakes Boro	Morris
1426	Mount Arlington Boro	Morris
1427	Mount Olive Township	Morris
1428	Netcong Boro	Morris
1429	Parsippany Troy Hills To	Morris
1430	Long Hill Twp	Morris
1431	Pequannock Township	Morris

Code	Municipality	County for NJ Municipalities
1432	Randolph Township	Morris
1433	Riverdale Boro	Morris
1434	Rockaway Boro	Morris
1435	Rockaway Township	Morris
1436	Roxbury Township	Morris
1437	Victory Gardens Boro	Morris
1438	Washington Township	Morris
1439	Wharton Boro	Morris
1501	Barnegat Light Boro	Ocean
1502	Bayhead Boro	Ocean
1503	Beach Haven Boro	Ocean
1504	Beachwood Boro	Ocean
1505	Berkeley Township	Ocean
1506	Brick Township	Ocean
1507	Toms River Township	Ocean
1508	Eagleswood Township	Ocean
1509	Harvey Cedars Boro	Ocean
1510	Island Heights Boro	Ocean
1511	Jackson Township	Ocean
1512	Lacey Township	Ocean
1513	Lakehurst Boro	Ocean
1514	Lakewood Township	Ocean
1515	Lavallette Boro	Ocean
1516	Little Egg Harbor Townsh	Ocean

Code	Municipality	County for NJ Municipalities
1517	Long Beach Township	Ocean
1518	Manchester Township	Ocean
1519	Mantoloking Boro	Ocean
1520	Ocean Township	Ocean
1521	Ocean Gate Boro	Ocean
1522	Pine Beach Boro	Ocean
1523	Plumsted Township	Ocean
1524	Point Pleasant Boro	Ocean
1525	Point Pleasant Beach Bor	Ocean
1526	Seaside Heights Boro	Ocean
1527	Seaside Park Boro	Ocean
1528	Ship Bottom Boro	Ocean
1529	South Toms River Boro	Ocean
1530	Stafford Township	Ocean
1531	Surf City Boro	Ocean
1532	Tuckerton Boro	Ocean
1533	Barnegat Township	Ocean
1601	Bloomingdale Boro	Passaic
1602	Clifton City	Passaic
1603	Haledon Boro	Passaic
1604	Hawthorne Boro	Passaic
1605	Little Falls Township	Passaic
1606	North Haledon Boro	Passaic
1607	Passaic City	Passaic

Code	Municipality	County for NJ Municipalities
1608	Paterson City	Passaic
1609	Pompton Lakes Boro	Passaic
1610	Prospect Park Boro	Passaic
1611	Ringwood Boro	Passaic
1612	Totowa Boro	Passaic
1613	Wanaque Boro	Passaic
1614	Wayne Township	Passaic
1615	West Milford Township	Passaic
1616	Woodland Park Boro	Passaic
1701	Alloway Township	Salem
1702	Elmer Boro	Salem
1703	Elsinboro Township	Salem
1704	Lower Alloways Creek	Salem
1705	Mannington Township	Salem
1706	Oldmans Township	Salem
1707	Penns Grove Boro	Salem
1708	Pennsville Township	Salem
1709	Pilesgrove Township	Salem
1710	Pittsgrove Township	Salem
1711	Quinton Township	Salem
1712	Salem City	Salem
1713	Carneys Township	Salem
1714	Upper Pittsgrove Townshi	Salem
1715	Woodstown Boro	Salem

Code	Municipality	County for NJ Municipalities
1801	Bedminster Township	Somerset
1802	Bernards Township	Somerset
1803	Bernardsville Boro	Somerset
1804	Bound Brook Boro	Somerset
1805	Branchburg Township	Somerset
1806	Bridgewater Township	Somerset
1807	Far Hills Boro	Somerset
1808	Franklin Township	Somerset
1809	Green Brook Township	Somerset
1810	Hillsborough Township	Somerset
1811	Manville Boro	Somerset
1812	Millstone Boro	Somerset
1813	Montgomery Township	Somerset
1814	North Plainfield Boro	Somerset
1815	Peapack Gladstone Boro	Somerset
1816	Raritan Boro	Somerset
1817	Rocky Hill Boro	Somerset
1818	Somerville Boro	Somerset
1819	South Bound Brook Boro	Somerset
1820	Warren Township	Somerset
1821	Watchung Boro	Somerset
1901	Andover Boro	Sussex
1902	Andover Township	Sussex
1903	Branchville Boro	Sussex

Code	Municipality	County for NJ Municipalities
1904	Byram Township	Sussex
1905	Frankford Township	Sussex
1906	Franklin Boro	Sussex
1907	Fredon Township	Sussex
1908	Green Township	Sussex
1909	Hamburg Boro	Sussex
1910	Hampton Township	Sussex
1911	Hardyston Township	Sussex
1912	Hopatcong Boro	Sussex
1913	Lafayette Township	Sussex
1914	Montague Township	Sussex
1915	Newton Town	Sussex
1916	Ogdensburg Boro	Sussex
1917	Sandyston Township	Sussex
1918	Sparta Township	Sussex
1919	Stanhope Boro	Sussex
1920	Stillwater Township	Sussex
1921	Sussex Boro	Sussex
1922	Vernon Township	Sussex
1923	Walpack Township	Sussex
1924	Wantage Township	Sussex
2001	Berkeley Heights Townshi	Union
2002	Clark Township	Union
2003	Cranford Township	Union

Code	Municipality	County for NJ Municipalities
2004	Elizabeth City	Union
2005	Fanwood Boro	Union
2006	Garwood Boro	Union
2007	Hillside Township	Union
2008	Kenilworth Boro	Union
2009	Linden City	Union
2010	Mountainside Boro	Union
2011	New Providence Boro	Union
2012	Plainfield City	Union
2013	Rahway City	Union
2014	Roselle Boro	Union
2015	Roselle Park Boro	Union
2016	Scotch Plains Township	Union
2017	Springfield Township	Union
2018	Summit City	Union
2019	Union Township	Union
2020	Westfield Town	Union
2021	Winfield Township	Union
2101	Allamuchy Township	Warren
2102	Alpha Boro	Warren
2103	Belvidere Township	Warren
2104	Blairstown Township	Warren
2105	Franklin Township	Warren
2106	Frelinghuysen Township	Warren

Code	Municipality	County for NJ Municipalities
2107	Greenwich Township	Warren
2108	Hackettstown Town	Warren
2109	Hardwick Township	Warren
2110	Harmony Township	Warren
2111	Hope Township	Warren
2112	Independence Township	Warren
2113	Knowlton Township	Warren
2114	Liberty Township	Warren
2115	Lopatcong Township	Warren
2116	Mansfield Township	Warren
2117	Oxford Township	Warren
2118	Pahaquarry Township	Warren
2119	Phillipsburg Town	Warren
2120	Pohatcong Township	Warren
2121	Washington Boro	Warren
2122	Washington Township	Warren
2123	White Township	Warren

Out of State Residence Codes	Location
3000	Delaware
4000	Maryland
5000	New York
5100	NY – BRONX
5200	NY – BROOKLYN

Out of State Residence Codes	Location
5300	NY – MANHATTAN
5400	NY – QUEENS
5500	NY – STATEN ISLAND
5600	NY – NASSAU COUNTY
5700	NY – ORANGE COUNTY
5800	NY – PUTNAM COUNTY
5900	NY – ROCKLAND COUNTY
6100	NY – SUFFOLK COUNTY
6200	NY – SULLIVAN COUNTY
6300	NY – WESTCHESTER CTY
6800	NY – ALL OTHER A-K
6900	NY – ALL OTHER L-Z
7000	PENNSYLVANIA
7100	PA – BERKS COUNTY
7200	PA – BUCKS COUNTY
7300	PA – CARBON COUNTY
7400	PA – CHESTER COUNTY
7500	PA – DELAWARE COUNTY
7600	PA – LEHIGH COUNTY
7700	PA – MONROE COUNTY
7800	PA – MONTGOMERY COUNTY
7900	PA – NORTHAMPTON COUNTY
8100	PA – PHILADELPHIA COUNTY
8200	PA – PIKE COUNTY

Out of State Residence Codes	Location
8300	PA – WAYNE COUNTY
8900	PA – ALL OTHER PA COUNTIES
9000	Unassigned
9100	Alabama
9102	Arizona
9103	Arkansas
9104	California
9105	Colorado
9106	Connecticut
9108	DC
9109	Florida
9110	Georgia
9111	Idaho
9112	Illinois
9113	Indiana
9114	Iowa
9115	Kansas
9116	Kentucky
9117	Louisiana
9118	Maine
9120	Massachusetts
9121	Michigan
9122	Minnesota
9123	Mississippi

Out of State Residence Codes	Location
9124	Missouri
9125	Montana
9126	Nebraska
9127	Nevada
9128	New Hampshire
9130	New Mexico
9132	North Carolina
9133	North Dakota
9134	Ohio
9135	Oklahoma
9136	Oregon
9138	Rhode Island
9139	South Carolina
9140	South Dakota
9141	Tennessee
9142	Texas
9143	Utah
9144	Vermont
9145	Virginia
9146	Washington
9147	West Virginia
9148	Wisconsin
9149	Wyoming
9150	Alaska

Out of State Residence Codes	Location
9151	Hawaii
9152	Puerto Rico
9153	Virgin Islands
9299	Canada
9399	All Other Countries and American Territories

- Edit:
    1. Residence Code cannot = ‘9999’ and must be in Residence Code Table.
    2. If state is NJ, then Residence Code must be between 0101-2123.

Patient’s Social Security Number

Field # 38 in NJ HEALTHCAP Extract File Layout

The patient’s Social Security Number

- Required for: Optional field
- 837 Location, one of the following:
    - 2010BA Loop, REF02, Code Qualifier “SY”
    - 2010CA Loop, REF02, Code Qualifier “SY”
- Valid Codes: Nine digits
- Edits:
    1. Social Security Number either be blank or 9 digits.

Patient's State

Field # 13 in NJ HEALTHCAP Extract File Layout

The state where the patient resides

- External Code Source: ISO 3166-2 Codes for the representation of names of Countries and their subdivisions.
- Required for: All Patients
- 837 Location, one of the following:
    - 2010BA Loop, N402
    - 2010CA Loop, N402
- Valid Codes: Any valid two-digit alpha character abbreviation for American state, American possession, Canadian province, or other

Code	State
AA	APO Military – American Post Office
AB	Alberta
AE	FPO Military – Foreign Post Office
AK	Alaska
AL	Alabama
AP	Armed Forces Pacific
AR	Arkansas
AS	American Samoa
AZ	Arizona
BC	British Columbia
CA	California
CO	Colorado
CT	Connecticut

Code	State
CZ	Canal Zone
DC	District of Columbia
DE	Delaware
FL	Florida
FM	Federated States of Micronesia
GA	Georgia
GU	Guam
HI	Hawaii
IA	Iowa
ID	Idaho
IL	Illinois
IN	Indiana
KS	Kansas
KY	Kentucky
LA	Louisiana
LB	Labrador
MA	Massachusetts
MB	Manitoba
MD	Maryland
ME	Maine
MH	Marshall Islands
MI	Michigan
MN	Minnesota
MO	Missouri

Code	State
MP	Northern Mariana Islands
MS	Mississippi
MT	Montana
NB	New Brunswick
NC	North Carolina
ND	North Dakota
NE	Nebraska
NF	Newfoundland
NL	Newfoundland and Labrador
NH	New Hampshire
NJ	New Jersey
NM	New Mexico
NS	Nova Scotia
NT	Northwest Territory
NU	Nunavut
NV	Nevada
NY	New York
OH	Ohio
OK	Oklahoma
ON	Ontario
OR	Oregon
PA	Pennsylvania
PE	Prince Edward Island
PR	Puerto Rico

Code	State
QB	Quebec
RI	Rhode Island
SC	South Carolina
SD	South Dakota
SK	Saskatchewan
TN	Tennessee
TT	Trust Territories
TX	Texas
UT	Utah
VA	Virginia
VI	Virgin Islands
VT	Vermont
WA	Washington
WI	Wisconsin
WV	West Virginia
WY	Wyoming
XX	If Other Than Us or Canada
YK	Yukon

- Edit:
    1. The Patient State must equal a valid state code for the United States, Canada, and XX for other.

Patient's Street Address

Field # 10 in NJ HEALTHCAP Extract File Layout

The address where patient resides

- Required for: All Patients
- 837 Location, one of the following:
    - 2010BA Loop, N301
    - 2010CA Loop, N301
- Valid Codes: Any valid address using up to 20 alphanumeric characters
- Edits:
    1. The Patient's Street Address must not be blank.
    2. The only special characters allowed in Patient's Street Address are "#", "/", "\", "-", "." and ",".

Patient's Zip Code

Field # 12 in NJ HEALTHCAP Extract File Layout

The zip code of patient's place of residence

- External Code Source: National ZIP Code and Post Office Directory, Publication 65, United States Postal Service
- Required for: All Patients
- 837 Location: 2010CA Loop, N403
- Valid Codes: Any valid ZIP code five5 to nine alphanumeric characters in length
- Edits:

    1. The Patient's Zip Code must be numeric and greater than zeroes if not a foreign address (Patient's State = XX) or Canadian address (Patient's State = AB, BC, LB, MB, NB, NF, NS, NT, ON, PE, QB, SK, YK).

    2. The first 2 digits of the Patient's Zip Code must be in the ranges for each state if not a foreign address.

    3. If the Residence Code is a valid NJ Residence Code then the first two characters of the Patient Zip Code must be either '07' or '08'.

4. The Patient's Zip Code cannot contain a dash (-).

Payer Codes (Primary, Secondary, Tertiary)

Primary Payer Code – Field # 41 in NJ HEALTHCAP Extract File Layout

Secondary Payer Code – Field # 42 in NJ HEALTHCAP Extract File Layout

Tertiary Payer Code – Field # 42 in NJ HEALTHCAP Extract File Layout

Three-digit numeric character representing insurance payers

- Required for: All Patients
- 837 Location:
    - 2010BB Loop, NM109, Code Qualifier "PI" (Primary)
    - 2330B Loop, NM109, Code Qualifier "PI" (Secondary/Tertiary)
- Valid Codes:

Payer Number	Payer Description	Payer Type	Payer Type Description
007	Affordable Care Health Insurance	7	Other
008	NJ Family Care	7	Other
009	Section 1011 Undocumented Aliens	1	Medicare
010	Alabama B/C	3	Blue Cross
011	Title XVIII (Medicare) Part A	1	Medicare
012	Title XIX (Medicaid)	2	Medicaid
013	Title V (Maternal & Child Health)	7	Other
014	Champus	7	Other
015	Title XVIII (Medicare) Part B	1	Medicare
016	Department of Vocational Rehabilitation	7	Other

Payer Number	Payer Description	Payer Type	Payer Type Description
017	Title XVIII (Medicare) Part B Phys.	1	Medicare
018	New Jersey State Health Benefits	7	Other
019	Other Government	7	Other
020	Arkansas B/C	3	Blue Cross
022	New Jersey Blue Cross - Fep		Blue Cross
025	Garden State Blue Cross	3	Blue Cross
026	New Jersey Blue Cross - Host		Blue Cross
029	Other Blue Cross	3	Blue Cross
030	Arizona B/C	3	Blue Cross
031	Direct Pay	4	Self-Pay
032	Americaid Inc.	5	HMO
033	American Preferred Provider Plan, Inc.	5	HMO
034	United Health Care	5	HMO
035	MEDI-Group Inc. (HMO Blue)	5	HMO
036	Principal HMO	5	HMO
037	Mission Health Plans	5	HMO
039	Other Source of Patient Pay	4	Self-Pay
040	California B/C All Other Groups	3	Blue Cross
045	HIP of NJ	5	HMO
047	HMO Blue (Medigroup Central)	5	HMO
048	HMO Of PA-NJ (US Healthcare	5	HMO
050	Colorado B/C	3	Blue Cross
056	Cigna Healthcare of Northern NJ, Inc.	5	HMO

Payer Number	Payer Description	Payer Type	Payer Type Description
058	Prucare of NJ	5	HMO
059	Other HMO	5	HMO
060	Connecticut B/C	3	Blue Cross
070	Delaware B/C	3	Blue Cross
072	Oxford Health Plan	5	HMO
073	Nyl Care Health Plans Of NJ, Inc.	5	HMO
074	Cigna Health Care of NJ Inc. South	5	HMO
076	Premier Preferred Care of NJ	7	Other
077	QualMed	5	HMO
078	Amerihealth HMO, Inc.	5	HMO
080	Washington DC B/C	3	Blue Cross
081	Atlanticare Health Plan	5	HMO
082	Medicare Contracted Payers	1	Medicare
083	Medicaid Contracted Payers	2	Medicaid
084	First Option Health Plan	5	HMO
087	Liberty Health Plan	5	HMO
088	Managed Health Care Systems of NJ, Inc.	5	HMO
090	Florida B/C	3	Blue Cross
091	Union Insurance	7	Other
092	Personnel Health Program	7	Other
093	Magnet (Magna Care)	7	Other
094	Physician Health Services of NJ, Inc.	5	HMO
095	Indigent	7	Other

Payer Number	Payer Description	Payer Type	Payer Type Description
096	Qualcare	5	HMO
097	University Health Plans, Inc.	5	HMO
098	Hospital Responsibility	7	Other
099	Other Miscellaneous	7	Other
101	Georgia B/C All Other Groups	3	Blue Cross
105	Aetna	6	Commercial
106	New Jersey Carpenters' Health Fund	6	Commercial
107	AARP	6	Commercial
110	Idaho B/C	3	Blue Cross
115	Connecticut General	6	Commercial
120	Continental Assurance	6	Commercial
121	Illinois B/C	3	Blue Cross
125	Equitable	6	Commercial
130	Indiana B/C	3	Blue Cross
131	Guardian Life	6	Commercial
135	Intercontinental	6	Commercial
140	Iowa B/C All Other Groups	3	Blue Cross
142	John Hancock	6	Commercial
145	Massachusetts Mutual	6	Commercial
150	Kansas B/C	3	Blue Cross
151	Metropolitan Life	6	Commercial
155	Mutual of Omaha	6	Commercial
160	Kentucky B/C	3	Blue Cross

Payer Number	Payer Description	Payer Type	Payer Type Description
161	New York Life	6	Commercial
165	Provident Alliance	6	Commercial
170	Louisiana B/C	3	Blue Cross
171	Prudential	6	Commercial
175	Travelers	6	Commercial
180	Maine B/C	3	Blue Cross
181	Washington National Insurance	6	Commercial
185	NJ Auto Dealers	6	Commercial
186	Allstate	6	Commercial
187	Mutual Life of N.Y.	6	Commercial
188	National Assoc. of Letter Carriers	6	Commercial
189	Local Union Insurance	6	Commercial
190	Maryland B/C	3	Blue Cross
191	Lincoln National	6	Commercial
192	New Jersey Turnpike Authority	6	Commercial
193	Rasmussen	6	Commercial
194	Inter County Health Plan	6	Commercial
195	American Postal Workers	6	Commercial
196	Leader Administrators	6	Commercial
197	Fred S. James (James Benefit)	6	Commercial
198	Mail Handlers Benefit Plan	6	Commercial
199	Other Commercial Insurance	6	Commercial
200	Massachusetts B/C	3	Blue Cross

Payer Number	Payer Description	Payer Type	Payer Type Description
205	Aetna Work. Comp.	7	Other
210	Michigan B/C	3	Blue Cross
211	Insurance Company of No. America WC	7	Other
215	Liberty Mutual WC	7	Other
220	Minnesota B/C	3	Blue Cross
221	Employers Mutual WC	7	Other
225	New Jersey Manufacturers Work. Comp.	7	Other
230	Mississippi B/C	3	Blue Cross
231	Travelers Work. Comp	7	Other
240	Missouri B/C Kansas City	3	Blue Cross
241	Missouri B/C St. Louis	3	Blue Cross
250	Montana B/C	3	Blue Cross
260	Nebraska B/C	3	Blue Cross
265	Nevada B/C	3	Blue Cross
270	New Hampshire B/C	3	Blue Cross
280	New Jersey B/C All Other Groups	3	Blue Cross
281	NJ Non-Group Line of Business	3	Blue Cross
290	New Mexico B/C	3	Blue Cross
299	Other Worker's Compensation	7	Other
301	New York B/C Buffalo	3	Blue Cross
303	New York B/C NYC	3	Blue Cross
304	New York B/C Rochester	3	Blue Cross
305	New York B/C Syracuse	3	Blue Cross

Payer Number	Payer Description	Payer Type	Payer Type Description
306	New York B/C Utica	3	Blue Cross
309	Allstate No Fault	7	Other
310	North Carolina B/C	3	Blue Cross
311	New Jersey Manufacturers No Fault	7	Other
315	State Farm No Fault	7	Other
320	North Dakota B/C	3	Blue Cross
332	Ohio B/C Cincinnati	3	Blue Cross
333	Ohio B/C Cleveland	3	Blue Cross
340	Oklahoma B/C	3	Blue Cross
350	Oregon B/C	3	Blue Cross
351	Portland Oregon B/C	3	Blue Cross
361	Pennsylvania B/C Harrisburg	3	Blue Cross
362	Pennsylvania B/C Philadelphia	3	Blue Cross
363	Pennsylvania B/C Pittsburgh	3	Blue Cross
364	Pennsylvania B/C Wilkes Barre	3	Blue Cross
370	Rhode Island B/C	3	Blue Cross
380	South Carolina B/C	3	Blue Cross
390	Tennessee B/C Chattanooga	3	Blue Cross
392	Tennessee B/C Memphis	3	Blue Cross
399	Other No Fault	7	Other
400	Texas B/C	3	Blue Cross
410	Utah Blue Cross	3	Blue Cross
415	Vermont B/C	3	Blue Cross

Payer Number	Payer Description	Payer Type	Payer Type Description
423	Virginia B/C All Other Groups	3	Blue Cross
430	Alaska/Washington St B/C	3	Blue Cross
443	W Virginia B/C All Other Groups	3	Blue Cross
450	Wisconsin B/C	3	Blue Cross
460	Wyoming B/C	3	Blue Cross
470	Puerto Rico B/C	3	Blue Cross
471	Hawaii - All Other Groups	3	Blue Cross
865	Pa Blue Cross - Camp Hill	3	Blue Cross

- Edits:
    1. Primary Payer Code must not be blank and must be a valid code on the payer code table.
    2. Secondary Payer Code must be a valid code on the payer code table.
    3. Tertiary Payer Code must be a valid code on the payer code table.
    4. Tertiary Payer Code cannot be present without a Secondary Payer Code.

Point of Origin Code (Admission Source Type)

Field # 34 in NJ HEALTHCAP Extract File Layout

A code indicating the patient's point of origin for this admission or visit.

- External Code Source: National Uniform Billing Committee's UB04 Specifications Manual.
- Required for: All patients
- 837 Location: 2300 Loop, CL102
- Valid Codes:

Code	Non-Newborn Description	Newborn Description
1	Non-Health Care Facility Point of Origin	N/A
2	Clinic or Physician's Office	N/A
4	Transfer from Hospital Different from this Facility	N/A
5	Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)	Born inside this hospital
6	Transfer from another Health Care Facility	Born outside this hospital
8	Court/Law Enforcement	N/A
9	Information Not Available	N/A
D	Transfer from Inpatient Hospital in Same Facility Resulting in Separate Claim to Payer	N/A
E	Transfer from Ambulatory Surgery Center	N/A
F	Transfer from Hospice and is under a Hospice Plan of Care or enrolled in a Hospice Program	N/A

- Edits:
    1. If Priority Type of Visit = 1, 2, 3, 5 or 9, then Point of Origin must be either 1, 2, 4, 5, 6, 8, 9, D, E or F.
    2. If Priority Type of Visit = 4, then Point of Origin must be either 5 or 6.

Primary Insured's ID Number

Field # 44 in NJ HEALTHCAP Extract File Layout

The insured's identification number as assigned by the primary insurance payer. For Medicare, this is the HIC number.

- Required for: All Patients
- 837 Location: 2010BA Loop, NM109, Code Qualifier "MI"
- Valid Codes: alphanumeric characters

- Edit:
    1. Insured ID Number must not be blank unless the primary payer code is self-pay (payer codes 031, 039 or 095).

Principal Diagnosis Code

Field # 94 in NJ HEALTHCAP Extract File Layout for Principal Diagnosis Code.

Field # 95 in NJ HEALTHCAP Extract File Layout for Principal Diagnosis Code Present on Admission (POA) Indicator.

The ICD-10-CM codes describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).

- External Code Source: International Classification of Diseases, 9th/10th Revision, Clinical Modification (ICD-10-CM).
- Required for All patients
- 837 Location: 2300 Loop, HI01-02, Code Qualifier “ABK”
- Valid Codes Valid ICD-10-CM codes as defined by CDC
- Edits:
    1. Diagnosis Codes cannot be duplicated.
    2. If there is a diagnosis code in any diagnosis code field, then the codes in the preceding fields must not be blank.
    3. Diagnosis Codes Z51.5 (ICD-10) are invalid as a principal diagnosis code.
    4. The Diagnosis Code POA must be Y, N, U, W, or 1/Null (if Diagnosis Code is on the list of CDC exempt codes)
    5. The Principal Diagnosis code must not be blank or null

Priority Type of Visit (Admission/Visit Type)

Field # 33 in NJ HEALTHCAP Extract File Layout

A code indicating the priority of this admission/visit.

- External Code Source: National Uniform Billing Committee’s UB04 Specifications Manual.

- Required for All patients
- 837 Location: 2300 Loop, CL101
- Valid Codes

Code	Description
1	Emergency
2	Urgent
3	Elective
4	Newborn
5	Trauma Center
9	Information Not Available

- Edits:
    1. Priority Type of Visit must be either 1, 2, 3, 4, 5, or 9.
    2. If Priority Type of Visit = 4, then age in days must be less than 29 days.
    3. If Priority Type of Visit = 1, 2, 3, 5, or 9, then patient's birth date must be less than admission date.

Procedure Codes

Principal Procedure Code – Field # 98 in NJ HEALTHCAP Extract File Layout

Other Procedure Code - Code – Field # 100 in NJ HEALTHCAP Extract File Layout

Principal	The chief procedure performed on a patient admitted into (Inpatients) or receiving care (Outpatients) at the hospital for the episode of care
2nd-25th	Additional procedures performed occurring while admitted (Inpatients) or when receiving care (Outpatients) for the episode of care – there can be up to 24 additional procedure codes

- External Code Source: International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-PCS).
- Required for Inpatients
- 837 Location:
    - 2300 Loop, HI01-2 (Principal)
    - 2300 HI01 to HI12 (2nd- 25th Other Procedure Code)
- Valid Codes Any valid ICD-10-PCS procedure code
- Edits:
    1. If the Procedure Code Date is valued, then the Procedure Code must not be blank.
    2. If a Procedure Code is valued, then any Procedure Code in the preceding fields must not be blank.

Procedure Code Dates

Principal Procedure Date – Field # 99 in NJ HEALTHCAP Extract File Layout

(Other Procedure Code - Date – Field # 101 in NJ HEALTHCAP Extract File Layout

Principal	The date the principal procedure was performed
2nd-25th	The dates the additional procedures were performed. There can be up to 24 additional procedure dates

- Required for: Inpatients
- 837 Location:
    - 2300 Loop, HI01-3, Code Qualifier “BBR” (Principal)
    - 2300 Loop HI01 to HI12, Code Qualifier “BBQ” (2nd- 25th Other Procedure Code Date)
- Valid Codes: A valid date
- Edits:

1. If the Procedure Code is valued, then the Procedure Code Date cannot be blank.
2. The Procedure Code Date must be greater than or equal to the Admission and/or Statement From Date.
3. The Procedure Code Date must be less than or equal to the Discharge Date.
4. The Procedure Code Date must be a valid date.

Readmission Code

Field # 36 in NJ HEALTHCAP Extract File Layout

Code signifying that a patient has been admitted into an acute care facility for a second time within 7 days

- Required for: Inpatients
- 837 Location: 2300 Loop, K301, position 25
- Valid Codes
  - 0 = No
  - 1 = Yes
  - 9 = Unknown
- Edit:
  1. Readmission Code must be '0', '1' or '9', if the patient's birth date is less than admission date.

Record Number

Field # 6 in NJ HEALTHCAP Extract File Layout

Number assigned to each claim in data extract. Each claim can be assigned multiple record numbers if claim contains more codes than can be outputted onto one line of the extract.

Referring Physician National Provider Identifier (NPI)

Field # 56 in NJ HEALTHCAP Extract File Layout

The National Provider Identifier number of the provider who send the patient to another provider for services. Required on an outpatient when the referring provider is different from the attending physician.

- External Code Source: Center's for Medicare and Medicaid Services National Provider Identifier
- Required for: All Patients
- 837 Location: 2310F Loop, NM109, Code Qualifier "XX"
- Valid Codes: A valid NPI number
- Edits:
    1. If provided, the Referring Physician NPI must be 10 digits and must be a valid NPI number.
    2. The Referring Physician's NPI number is required if the Referring Physician's State License Number is not blank.

Referring Physician State License Number

Field # 55 in NJ HEALTHCAP Extract File Layout

The state license number of the provider who send the patient to another provider for services. Required when the referring provider is different from the attending physician.

- External Code Source: New Jersey Division of Consumer Affairs, Board of Medical Examiners.
- Required for: All Patients
- 837 Location: 2310F Loop, REF02, Code Qualifier "0B"
- Valid Codes:
    - New Jersey physicians, one of the following:
        - The first two characters must equal 'NJ' followed for seven or eight alphanumeric characters and no spaces
        - The first two characters must equal '22', '25', '26', or '35', followed by ten alphanumeric characters and no spaces.
    - For physicians outside New Jersey the first two characters must equal any valid two-digit alpha character abbreviation for American state, American possession, or Canadian province followed by alphanumeric character(s).

- Edits:

  1. The Referring Physician's State License number must either be blank or the Referring Physician's State Code (which is the first two characters of the License Number) must be a valid state, '22', '25', '26', or '35'.

  2. If the Referring Physician's State Code equals 'NJ', then check to see that the number after the state code is 7 or 8 characters in length and does not contain a space. If the first two characters are '22', '25', '26', or '35', then check to see the number after the state code is 10 characters in length and does not contain a space.

  3. If the Referring Physician's State Code is valid, and does not equal 'NJ', '22', '25', '26', or '35', then check to see that the position after the state code is not blank.

  4. The Referring Physician's State License Number is required if the Referring Physician's NPI number is not blank.

Rendering Physician National Provider Identifier (NPI)

Field # 54 in NJ HEALTHCAP Extract File Layout

The National Provider Identifier number of the health care professional who delivers or completes a particular medical service or non-surgical procedure.

- External Code Source: Center's for Medicare and Medicaid Services National Provider Identifier
- Required for: All Patients
- 837 Location: 2310D Loop, NM109, Code Qualifier "XX"
- Valid Codes: A valid NPI number
- Edits:

  1. If the Rendering Physician's NPI is not blank, it must be 10 digits and must be a valid NPI number.
  2. The Rendering Physician's NPI number is required if the Rendering Physician's State License Number is not blank.

Rendering Physician State License Number

Field # 53 in NJ HEALTHCAP Extract File Layout

The state license number of the health care professional who delivers or completes a particular medical service or non-surgical procedure.

- External Code Source: New Jersey Division of Consumer Affairs, Board of Medical Examiners.
- Required for: All Patients
- 837 Location: 2310D Loop, REF02, Code Qualifier “0B”
- Valid Codes:
    - For New Jersey physicians, one of the following:
        - The first two characters must equal ‘NJ’ followed for seven or eight alphanumeric characters and no spaces
        - The first two characters must equal ‘22’, ‘25’, ‘26’ or ‘35’, followed by ten alphanumeric characters and no spaces
    - For physicians outside New Jersey – the first 2 characters must equal any valid two-digit alpha character abbreviation for American state, American possession, or Canadian province followed by alphanumeric character(s)

Edits:

1. The Rendering Physician’s State License number must either be blank or the Rendering Physician’s State Code (which is the first two characters of the License Number) must be a valid state, ‘22’, ‘25’, ‘26’, or ‘35’.

2. If the Rendering Physician’s State Code equals ‘NJ’, then check to see that the number after the state code is 7 or 8 characters in length and does not contain a space. If the first two characters are ‘22’, ‘25’, ‘26’, or ‘35’, then check to see the number after the state code is 10 characters in length and does not contain a space.

3. If the Rendering Physician’s State Code is valid, and does not equal 'NJ', ‘22’, ‘25’, ‘26’, or ‘35’ then check to see that the position after the state code is not blank.

4. The Rendering Physician’s State License Number is required if the Rendering Physician’s NPI number is not blank.

Revenue Code

Field # 102 in NJ HEALTHCAP Extract File Layout

Code describing the kind of service patient received and is being charged for.

External Code Source: National Uniform Billing Committee’s UB04 Specifications Manual.

- Required for: All Patients

- 837 Location: 2400 Loop, SV201
- Edits:
    1. If the Revenue Code Services Units is valued, then the Revenue Code must be valued.
    2. If Revenue Code Total Charges is valued, then Revenue Code must be valued.
    3. The Revenue Code must be found in Revenue Code Table.
    4. If a Revenue Code equals either '0111', '0121', '0131', '0141', '0151', '0201', '0202', or '0231', then the Patient's Age must be greater than or equal to 19 years.
    5. If a Revenue Code equals either '0113', '0123', '0133', '0143', '0153', or '0203', then the Patient's Age must be less than or equal to 18 years.
    6. If a Revenue Code equals '017X', then the Patient's Age must be less than 1 year.
    7. Trauma Revenue Codes (068X) may only be used when Priority Type of Visit equals 5.
    8. There must be at least one Revenue Code Line on every record.

Revenue Code Total Charges

Field # 110 in NJ HEALTHCAP Extract File Layout

Total charges incurred for each revenue code line item. This may not be the same as charges billed to the payer.

- Required for: All Patients
- 837 Location: 2400 Loop, SV203
- Valid Codes: Any dollar amount less than or equal to $9,999,999
- Edit:
    1. If the Revenue Code is valid then the Revenue Code Total Charges must be greater than zeroes.
    2. Total Charge for a Revenue Code Line Item cannot be greater than 9,999,999.

Revenue Code Days, Units, or Times (DUTS)

Field # 109 in NJ HEALTHCAP Extract File Layout

A number count of accommodation days, units of service, number of times and/or number of visits per revenue code line item.

- Required for: All Patients
- 837 Location: 2400 Loop, SV205
- Valid Codes: Any number using the format '0000'
- Edits:
    1. If the Revenue Code is valid, then the Days/Units/Time (Revenue Service Units) must be Numeric and not negative
    2. If the Revenue Code prefix equals either 010, 011, 012, 013, 014, 015, 016, 017, 018, 020, or 021, then the Days/Units/time (Revenue Service Units) cannot be zeroes.
    3. The sum of the total days for a routine Revenue Code line should equal the actual length of stay.

Statement Covers Period (From Date and Thru Date)

Statement From Date – Field # 8 in NJ HEALTHCAP Extract File Layout

Statement Thru Date – Field # 3 in NJ HEALTHCAP Extract File Layout

Dates indicating the beginning and ending services dates for this episode of care.

- Required for: All Patients
- 837 Location: 2300 Loop, DTP03
- Valid Codes: Valid dates in CCYYMMDD format
- Edits:
    1. The Statement From date must be a valid date and must be equal to or prior to the Statement Thru date.
    2. The Statement Thru date must be a valid date.
    3. Statement From and Thru Date must not be blank or null.

State

Field # 80 in NJ HEALTHCAP Extract File Layout

The state where the patient resides

This code is not required to be reported by hospitals. Instead, it will be calculated for all patients using smarty street for address verification

- Required for: All patients

Total Charges for Claim

Field # 61 in NJ HEALTHCAP Extract File Layout

Total of all revenue code charges on claim.

This code is not required to be reported by hospitals. Instead, it will be calculated for all patients.

Transfer Out Code (Transfer Destination Code)

Field # 46 in NJ HEALTHCAP Extract File Layout

Code identifying the acute care facility patient is being transferred/referred to

- Required for: All Patients
- 837 Location: 2300 Loop, K301, positions 15-24
- Valid Codes: Valid facility NPI number

Hospital	Provider Number	NPI Number	Facility Number
AcuteCare Specialty Hospital of Kimball	3120171	1659376317	23359
Atlanticare Regional Medical Center (Mainland)	3100641	1013919315	10101
Atlanticare Regional Medical Center (City)	3100642	1013919315	10102
Bayonne Medical Center	3100250	1821101239	10901

Hospital	Provider Number	NPI Number	Facility Number
Bayshore Community Hospital	3101120	1760994412	11301
Bergen Regional Medical Center	3100580	1689682999	10201
Cape Regional Medical Center	3100110	1053382697	10501
Capital Health System - Fuld Campus	3100920	1275583726	11102
Capital Health System - Mercer Campus	3100440	1073516183	11104
Care One at Raritan Bay Medical Center	3120180	1497754006	23098
CareOne at HackensackUMC Pascack Valley	3120182	1497754006	24795
CareOne at Trinitas Regional Medical Center	3120181	1497754006	24426
CentraState Healthcare System	3101110	1295718450	11302
Chilton Hospital	3100170	1811994809	11401
Christ Hospital	3100160	1871859306	10902
Clara Maass Medical Center	3100090	1902901333	10701
Columbus Hospital LTACH	3120240	1104144641	24009
Community Medical Center	3100410	1013010917	11501
Cooper Health System	3100140	1568442309	10402
Deborah Heart & Lung Ctr.	3100310	1467440743	20301
East Orange General Hosp	3100830	1013386143	10704
Englewood Hospital & Med Ctr	3100450	1083612881	10202
Hackensack UMC at Pascack Vallley	3101300	1205176062	24745
Hackensack University Med Ctr	3100010	1457456279	10204
HackensackUMC Mountainside	3100540	1982720249	10708
Hackettstown Community Hospital	3101150	1518969419	12101
Hoboken University Medical Center	3100400	1043475668	10908
Holy Name Hospital	3100080	1104859131	10205
Hudson Regional Medical Center	3101189	1710491253	10906
Hunterdon Medical Center	3100050	1922095116	11001
Inspira Health Center Bridgeton	3100322	1104870161	10601
Inspira Medical Center Elmer	3100690	1255396024	11701
Inspira Medical Center Vineland	3100324	1164487542	10603

Hospital	Provider Number	NPI Number	Facility Number
Inspira Medical Center Woodbury, Inc.	3100810	1184601288	10801
Jersey City Medical Center	3100740	1689744856	10904
Jersey Shore University Medical Center	3100730	1790297547	11303
JFK Medical Center	3101080	1659387975	11201
Kennedy Memorial Hospitals - Cherry Hill	3100862	1386746592	10401
Kennedy Memorial Hospitals - Stratford	3100863	1386746592	10403
Kennedy Memorial Hospitals - Washington Twsp.	3100861	1386746592	10802
Kindred Hospital New Jersey-Morris County	3120200	1962580803	23144
Kindred Hospital New Jersey-Rahway	3120201	1609954551	23268
Kindred Hospital New Jersey-Wayne	3120202	1376621235	24048
Lourdes Medical Center of Burlington County	3100610	1053316844	10303
Lourdes Specialty Hospital of Southern New Jersey	3120220	1578543468	23471
Memorial Hospital of Salem County, Inc.	3100910	1306817978	11702
Monmouth Medical Center	3100750	1609983790	11304
Monmouth Medical Center Southern Campus	3100840	1225133473	11502
Morristown Memorial Hospital	3100150	1053384776	11403
Mount Vernon Hospital	3300860	1992131320	5903001H
Newark Beth Israel Medical Center	3100020	1215027966	10709
Newton Memorial Hosp.	3100280	1790789212	11902
Ocean Medical Center	3100522	1477065126	11505
Our Lady of Lourdes Medical Ctr	3100290	1235134024	10404
Overlook Hospital	3100510	1740254143	12005
Palisades Medical Center	3100030	1730692344	10905
Prime Healthcare Services – St. Mary's Passaic, LLC	3100060	1770901761	11606
Raritan Bay Medical Center - Old Bridge	3100391	1790297455	11203
Raritan Bay Medical Center - Perth Amboy	3100392	1790297455	11206
Riverview Medical Center	3100340	1710499462	11305
Robert Wood Johnson University Hosp	3100380	1346243375	11202
Robert Wood Johnson University Hosp at Hamilton	3101100	1629069638	11101
Robert Wood Johnson University Hosp at Rahway	3100240	1861486870	12006

Hospital	Provider Number	NPI Number	Facility Number
Robert Wood Johnson University Hospital Somerset	3100480	1528197357	11802
Select Specialty Hospital - Northeast NJ - Rochelle	3120190	1093713521	23048
Shore Memorial Hospital	3100470	1629070149	10103
Southern Ocean Medical Center	3101130	1831601590	11504
St. Barnabas Medical Center	3100760	1396857488	10710
St. Clare's Hospital/Denville	3100500	1598144362	11406
St. Clare's Hospital/Dover	3100502	1598144362	11402
St. Clare's Hospital/Sussex	3101200	1598144362	11903
St. Francis Medical Center	3100210	1255419651	11105
St. Joseph's Regional Medical Center	3100190	1669462420	11605
St. Joseph's Wayne Hospital	3100191	1669462420	11603
St. Luke's Warren Hospital	3100600	1760488266	12102
St. Michael's Medical Center	3100960	1699777458	10713
St. Peter's University Hospital	3100700	1114924834	11205
Thomas Jefferson University Hospitals	3901740	1215916002	200801
Trinitas Hospital	3100270	1770583999	12007
University Hospital (UMDNJ)	3101190	1215998323	10702
University Medical Center of Princeton at Plainsboro	3100100	1689714255	11103
Valley Hospital	3100120	1013912633	10211
Virtua - Memorial Hosp. of Burlington Cty	3100570	1134125016	10301
Virtua - West Jersey Hospital - Berlin	3100222	1528064409	10407
Virtua - West Jersey Hospital - Marlton	3100224	1528064409	10302
Virtua - West Jersey Hospital - Voorhees	3100221	1528064409	10405
Virtua - West Jersey Hospital-Camden	3100223	1528064409	10406
Bayonne Medical Center Psych	31S0250	1568669380	10901
Bergen Regional Medical Center Psych	31S0580	1952456295	10201
Capital Health System - Fuld Campus Psych	31S0920	1700836285	11102
CentraState Healthcare System Psych	31S1110	1982636270	11302
Clara Maass Medical Center Psych	31S0090	1114179025	10701
East Orange General Hosp Psych	31S0830	1659740785	10704

Hospital	Provider Number	NPI Number	Facility Number
Englewood Hospital Psych	31S0450	1124071980	10202
Hackensack University Med Ctr Psych	31S0010	1932200623	10204
HackensackUMC Mountainside Psych	31S0540	1841444718	10708
Hoboken University Medical Center Psych	31S0400	1053576678	10908
Holy Name Hospital- Psych	31S0080	1609945963	10205
Hunterdon Medical Center Psych	31S0050	1932122744	11001
Inspira Medical Center Bridgeton	31S0320	1831143890	10603
Inspira Medical Center Woodbury, Inc. Psych	31S0810	1629055694	10801
Jersey City Medical Center Psych	31S0740	1497825665	10904
JFK Medical Center Rehab	31T1080	1114932548	22293
Lourdes Medical Center of Burlington County Psych	31S0610	1285630087	10303
Monmouth Medical Center Psych	31S0750	1497900781	11304
Morristown Memorial Hospital Psych	31S0150	1891731998	11403
Morristown Memorial Hospital Rehab	31T0150	1700822806	11404
Newark Beth Israel Medical Center Psych	31S0020	1043457955	10709
Newton Memorial Hosp. Psych	31S0280	1790789212	11902
Our Lady of Lourdes Medical Ctr Rehab	31T0290	1255336731	10404
Overlook Hospital Psych	31S0510	1083650188	12005
Riverview Medical Center Rehab	31T0340	1356853907	11305
Robert Wood Johnson University Hospital Somerset Psych	31S0480	1922428796	11802
St. Clare's Hospital/Denville- Bontoon Psych	31S0500	1902286172	11406
St. Joseph's Wayne Hospital Rehab	31T0191	1609847870	11603
Trinitas Hospital Psych	31S0270	1770583999	12007
University Medical Center of Princeton Psych	31S0100	1518009588	11103
University Medical Center of Princeton Rehab	31T0100	1902948821	11103
Virtua - Memorial Hosp. of Burlington Cty Psych	31S0570	1174529846	10301
Default Out of State Hospital	9999999	9999999999	99999

- Edit:

1. If the Patient Status Code equals ‘02’, then the Transfer Out Code must be a valid facility NPI number in the transfer NPI list

Type of Bill

Field # 19 in NJ HEALTHCAP Extract File Layout The type of bill

- External Code Source: National Uniform Billing Committee’s UB04 Specifications Manual.
- Required for: All patients
- 837 Location: 2300 Loop, CLM05-1 and CLM05-3
- Valid Codes: 0111, 0112, 0113, 0114, 0115, 0117, 0118, 0121, 0122, 0123, 0124, 0125, 0127, 0128, 0131, 0135, 0137, 0138
  - Facility and patient type (Second and third digits)
    - 011X – Inpatient
    - 012X – Inpatient Medicare Part B, Denials
    - 013X – SDS or Outpatient
  - Claim type/frequency (Fourth digit)
    - XXX1 – New claim
    - XXX2 – Interim, first claim
    - XXX3 – Interim, continuing claim
    - XXX4 – Interim, last claim
    - XXX5 – Late charge
    - XXX7 – Replacement of prior claim
    - XXX8 – Void of prior claim
- Edits:
  1. Bill Type must be either 0111, 0112, 0113, 0114, 0115, 0117, 0118, 0121, 0122, 0123, 0124, 0125, 0127, 0128, 0131, 0137 or 0138.

2. Bill types 011X and 012X must have an I/O indicator of ‘I’ and 013X must have an I/O indicator of ‘O’.
3. If Bill Type does not equal either 0131, 0135, or 0137, Total Days must equal Length of Stay [LOS].
4. Inpatient Bill Types ‘‘0112’, ‘0113’, ‘0122’ and ‘0123’ can only have Patient Status = 30.
5. If bill type equals 0131, 0135, or 0137, LOS cannot be greater than 1.

Transfer in Code (UB Referral Source Code)

Field # 45 in NJ HEALTHCAP Extract File Layout

Code identifying the acute care facility from which the patient was transferred/referred.

- Required for: All Patients
- 837 Location: 2300 Loop, K301, positions 5 to 14
- Valid Codes: Valid facility NPI number

Hospital	Provider Number	NPI Number	Facility Number
AcuteCare Specialty Hospital of Kimball	3120171	1659376317	23359
Atlanticare Regional Medical Center (Mainland)	3100641	1013919315	10101
Atlanticare Regional Medical Center (City)	3100642	1013919315	10102
Bayonne Medical Center	3100250	1821101239	10901
Bayshore Community Hospital	3101120	1760994412	11301
Bergen Regional Medical Center	3100580	1689682999	10201
Cape Regional Medical Center	3100110	1053382697	10501
Capital Health System - Fuld Campus	3100920	1275583726	11102
Capital Health System - Mercer Campus	3100440	1073516183	11104
Care One at Raritan Bay Medical Center	3120180	1497754006	23098
CareOne at HackensackUMC Pascack Valley	3120182	1497754006	24795
CareOne at Trinitas Regional Medical Center	3120181	1497754006	24426
CentraState Healthcare System	3101110	1295718450	11302
Chilton Hospital	3100170	1811994809	11401
Christ Hospital	3100160	1871859306	10902

Hospital	Provider Number	NPI Number	Facility Number
Clara Maass Medical Center	3100090	1902901333	10701
Columbus Hospital LTACH	3120240	1104144641	24009
Community Medical Center	3100410	1013010917	11501
Cooper Health System	3100140	1568442309	10402
Deborah Heart & Lung Ctr.	3100310	1467440743	20301
East Orange General Hosp	3100830	1013386143	10704
Englewood Hospital & Med Ctr	3100450	1083612881	10202
Hackensack UMC at Pascack Vallley	3101300	1205176062	24745
Hackensack University Med Ctr	3100010	1457456279	10204
HackensackUMC Mountainside	3100540	1982720249	10708
Hackettstown Community Hospital	3101150	1518969419	12101
Hoboken University Medical Center	3100400	1043475668	10908
Holy Name Hospital	3100080	1104859131	10205
Hudson Regional Hospital	3101189	1710491253	10906
Hunterdon Medical Center	3100050	1922095116	11001
Inspira Health Center Bridgeton	3100322	1104870161	10601
Inspira Medical Center Elmer	3100690	1255396024	11701
Inspira Medical Center Vineland	3100324	1164487542	10603
Inspira Medical Center Woodbury, Inc.	3100810	1184601288	10801
Jersey City Medical Center	3100740	1689744856	10904
Jersey Shore University Medical Center	3100730	1790297547	11303
JFK Medical Center	3101080	1659387975	11201
Kennedy Memorial Hospitals - Cherry Hill	3100862	1386746592	10401
Kennedy Memorial Hospitals - Stratford	3100863	1386746592	10403
Kennedy Memorial Hospitals - Washington Twsp.	3100861	1386746592	10802
Kindred Hospital New Jersey-Morris County	3120200	1962580803	23144
Kindred Hospital New Jersey-Rahway	3120201	1609954551	23268
Kindred Hospital New Jersey-Wayne	3120202	1376621235	24048
Lourdes Medical Center of Burlington County	3100610	1053316844	10303

Hospital	Provider Number	NPI Number	Facility Number
Lourdes Specialty Hospital of Southern New Jersey	3120220	1578543468	23471
Memorial Hospital of Salem County, Inc.	3100910	1306817978	11702
Monmouth Medical Center	3100750	1609983790	11304
Monmouth Medical Center Southern Campus	3100840	1225133473	11502
Morristown Memorial Hospital	3100150	1053384776	11403
Mount Vernon Hospital	3300860	1992131320	5903001H
Newark Beth Israel Medical Center	3100020	1215027966	10709
Newton Memorial Hosp.	3100280	1790789212	11902
Ocean Medical Center	3100522	1477065126	11505
Our Lady of Lourdes Medical Ctr	3100290	1235134024	10404
Overlook Hospital	3100510	1740254143	12005
Palisades Medical Center	3100030	1730692344	10905
Prime Healthcare Services – St. Mary's Passaic, LLC	3100060	1770901761	11606
Raritan Bay Medical Center - Old Bridge	3100391	1790297455	11203
Raritan Bay Medical Center - Perth Amboy	3100392	1790297455	11206
Riverview Medical Center	3100340	1710499462	11305
Robert Wood Johnson University Hosp	3100380	1346243375	11202
Robert Wood Johnson University Hosp at Hamilton	3101100	1629069638	11101
Robert Wood Johnson University Hosp at Rahway	3100240	1861486870	12006
Robert Wood Johnson University Hospital Somerset	3100480	1528197357	11802
Select Specialty Hospital - Northeast NJ - Rochelle	3120190	1093713521	23048
Shore Memorial Hospital	3100470	1629070149	10103
Southern Ocean Medical Center	3101130	1831601590	11504
St. Barnabas Medical Center	3100760	1396857488	10710
St. Clare's Hospital/Denville	3100500	1598144362	11406
St. Clare's Hospital/Dover	3100502	1598144362	11402
St. Clare's Hospital/Sussex	3101200	1598144362	11903
St. Francis Medical Center	3100210	1255419651	11105
St. Joseph's Regional Medical Center	3100190	1669462420	11605
St. Joseph's Wayne Hospital	3100191	1669462420	11603

Hospital	Provider Number	NPI Number	Facility Number
St. Luke's Warren Hospital	3100600	1760488266	12102
St. Michael's Medical Center	3100960	1699777458	10713
St. Peter's University Hospital	3100700	1114924834	11205
Thomas Jefferson University Hospitals	3901740	1215916002	200801
Trinitas Hospital	3100270	1770583999	12007
University Hospital (UMDNJ)	3101190	1215998323	10702
University Medical Center of Princeton at Plainsboro	3100100	1689714255	11103
Valley Hospital	3100120	1013912633	10211
Virtua - Memorial Hosp. of Burlington Cty	3100570	1134125016	10301
Virtua - West Jersey Hospital - Berlin	3100222	1528064409	10407
Virtua - West Jersey Hospital - Marlton	3100224	1528064409	10302
Virtua - West Jersey Hospital - Voorhees	3100221	1528064409	10405
Virtua - West Jersey Hospital-Camden	3100223	1528064409	10406
Bayonne Medical Center Psych	31S0250	1568669380	10901
Bergen Regional Medical Center Psych	31S0580	1952456295	10201
Capital Health System - Fuld Campus Psych	31S0920	1700836285	11102
CentraState Healthcare System Psych	31S1110	1982636270	11302
Clara Maass Medical Center Psych	31S0090	1114179025	10701
East Orange General Hosp Psych	31S0830	1659740785	10704
Englewood Hospital Psych	31S0450	1124071980	10202
Hackensack University Med Ctr Psych	31S0010	1932200623	10204
HackensackUMC Mountainside Psych	31S0540	1841444718	10708
Hoboken University Medical Center Psych	31S0400	1053576678	10908
Holy Name Hospital- Psych	31S0080	1609945963	10205
Hunterdon Medical Center Psych	31S0050	1932122744	11001
Inspira Medical Center Bridgeton	31S0320	1831143890	10603
Inspira Medical Center Woodbury, Inc. Psych	31S0810	1629055694	10801
Jersey City Medical Center Psych	31S0740	1497825665	10904
JFK Medical Center Rehab	31T1080	1114932548	22293
Lourdes Medical Center of Burlington County Psych	31S0610	1285630087	10303

Hospital	Provider Number	NPI Number	Facility Number
Monmouth Medical Center Psych	31S0750	1497900781	11304
Morristown Memorial Hospital Psych	31S0150	1891731998	11403
Morristown Memorial Hospital Rehab	31T0150	1700822806	11404
Newark Beth Israel Medical Center Psych	31S0020	1043457955	10709
Newton Memorial Hosp. Psych	31S0280	1790789212	11902
Our Lady of Lourdes Medical Ctr Rehab	31T0290	1255336731	10404
Overlook Hospital Psych	31S0510	1083650188	12005
Riverview Medical Center Rehab	31T0340	1356853907	11305
Robert Wood Johnson University Hospital Somerset Psych	31S0480	1922428796	11802
St. Clare's Hospital/Denville- Bontoon Psych	31S0500	1902286172	11406
St. Joseph's Wayne Hospital Rehab	31T0191	1609847870	11603
Trinitas Hospital Psych	31S0270	1770583999	12007
University Medical Center of Princeton Psych	31S0100	1518009588	11103
University Medical Center of Princeton Rehab	31T0100	1902948821	11103
Virtua - Memorial Hosp. of Burlington Cty Psych	31S0570	1174529846	10301
Default Out of State Hospital	9999999	9999999999	99999

- Edit:

  1. If the Admission Source Code equals ‘4’ and the Admission Type equals ‘1’, ‘2’, ‘3’,’5’ or ‘9’, then the Transfer In code must be a valid NPI Number in the transfer NPI list

Value Codes and Amounts

Value Code – Code – Field # 88 in NJ HEALTHCAP Extract File Layout

Value Code – Amount – Field # 89 in NJ HEALTHCAP Extract File Layout

A code indicating a valued amount related to this bill that may affect processing.

- External Code Source: National Uniform Billing Committee’s UB04 Specifications Manual.

- Required for: All Patients
- 837 Location: 2300 Loop, HI02-05 to HI12-05
- Valid Codes:

Code	Definition
01	Most Common Semi-private Rate
02	Hospital has no Semi-private rooms
04	Professional Component Charges Which are Combined Billed
05	Professional Component included in Charges and also Billed Separate to Carrier
06	Blood Deductible
08	Life Time Reserve Amount in the First Calendar Year
09	Coinsurance Amount in the First Calendar Year
10	Lifetime Reserve Amount in the Second Calendar Year
11	Coinsurance Amount in the Second Calendar Year
12	Working Aged Beneficiary/Spouse With Employer Group Health Plan
13	ESRD Beneficiary in a Medicare Coordination Period With an Employer Group Health Plan
14	No-Fault, Including Auto/Other
15	Worker's Compensation
16	PHS, or Other Federal Agency
21	Catastrophic
22	Surplus
23	Recurring Monthly Income
24	Medicaid Rate Code
25	Offset to the Patient- Payment Amount - Prescription Drugs
26	Offset to the Patient- Payment Amount - Hearing and Ear Services

Code	Definition
27	Offset to the Patient-Payment Amount - Vision and Eye Services
28	Offset to the Patient-Payment Amount - Dental Services
29	Offset to the Patient-Payment Amount - Chiropractic Services
30	Preadmission Testing
31	Patient Liability Amount
32	Multiple Patient Ambulance Transportation
33	Offset to the Patient-Payment Amount - Podiatric Services
34	Offset to the Patient-Payment Amount - Other Medical Services
35	Offset to the Patient-Payment Amount - Other Medical Services
37	Units of Blood Furnished
38	Blood Deductible Units
39	Units of Blood Replaced
40	New Coverage Not Implemented by HMO (for inpatient services only)
41	Black Lung
42	VA
43	Disabled Beneficiary Under Age 65 with LGHP
44	Amount provider agreed to accept from primary payer when this amount is less than charges but higher than payment received
45	Accident Hour
46	Number of Grace Days
47	Any Liability Insurance
48	Hemoglobin Reading
49	Hematocrit Reading
50	Physical Therapy Visit

Code	Definition
51	Occupational Therapy Visit
52	Speech Therapy Visit
53	Cardiac Rehab Visits
54	Newborn Birth Weight in Grams
55	Eligibility Threshold for Charity Care
56	Skilled Nurse - Home Visit Hours (HHA only)
57	Home Health Aide - Home Visit Hours (HHA only)
58	Arterial Blood Gas (PO2/PA2)
59	Oxygen Saturation (O2 Sat/Oximetry)
60	HHA Branch MSA
61	Place of Residence Where Service is Furnished (HHA and Hospice)
66	Medicaid Spend down Amount
67	Peritoneal Dialysis
68	EPO-Drug
69	State Charity Care Percent
80	Covered Days
81	Non-Covered Days
82	Co-insurance Days
83	Lifetime Reserve Days
A0	Special Zip Code Reporting
A1	Deductible Payer A
A2	Coinsurance Payer A
A3	Estimated Responsibility Payer A
A4	Covered Self-Administrable Drugs - Emergency

Code	Definition
A5	Covered Self-Administrable Drugs - Not Self - Administrable in Form and Situation Furnished to Patient
A6	Covered Self-Administrable Drugs - Diagnostic Study and Other
A7	Co-payment Payer A
A8	Patient Weight
A9	Patient Height
AA	Regulatory Surcharges, Assessments, Allowances or Healthcare Related Taxes Payer A
AB	Other Assessments or Allowances (e.g., Medical Education) Payer A
B1	Deductible Payer B
B2	Coinsurance Payer B
B3	Estimated Responsibility Payer B
B7	Co-payment Payer B
BA	Regulatory Surcharges, Assessments, Allowances or Healthcare Related Taxes Payer B
BB	Other Assessments or Allowances (e.g., Medical Education) Payer B
C1	Deductible Payer C
C2	Coinsurance Payer C
C3	Estimated Responsibility Payer C
C7	Co-payment Payer C
CA	Regulatory Surcharges, Assessments, Allowances or Health Care Related Taxes Payer C
CB	Other Assessments or Allowances (e.g., Medical Education) Payer C
D3	Patient Estimated Responsibility
D4	Clinical Trial Number Assigned by NLM/NIH
FC	Patient Paid Amount
FD	Credit from Manufacturer for Replaced Medical Device

Code	Definition
G8	Facility where Inpatient Hospice Service is Delivered
Y1	Part A Demonstration Payment
Y2	Part B Demonstration Payment
Y3	Part B Coinsurance
Y4	Conventional Provider Payment Amount for Non- Demonstration Claims
Y5	Part B Deductible (effective for discharges on/after 4/1/13)

- Edits:
    1. A Value Code cannot be present without a Value Code Amount.
    2. A Value Code Amount cannot be present without a Value Code.
    3. A Value Code field cannot be valued if the preceding Value Code field is blank.
    4. The Value Code Amount must be a whole number if the Value Code equals 32, 37, 38, 39, 46, 50, 51, 52, 53, 56, 57, 60, 61, 67, 68, 80, 81, 82, 83, or A0.
    5. If the Value Code is 02, the Value Code Amount must be 0.00.
    6. If the Value Code is 45, the Value Code Amount must be 00-23 or 99.
- Guidelines:
    - If the patient is an inpatient newborn, Value Code 54 must be reported and the Value Code Amount must be between 0100 and 9000.

      54 – Actual birth weight or weight at time of admission for an extramural birth. Required on all claims with Type of Admission of 4, and on other claims as required by state law.
    - Apart from the requirement stated above, hospitals should report any/all other Value Codes and Amounts as required for normal billing practices. All Value Codes reported must be valid as per the National Uniform Billing Committee's UB04 Specifications Manual, and all Value Code Amounts reported must be valid and appropriate for the Value Code being reported.

Zip Code/Zip Code4

Field # 81 in NJ HEALTHCAP Extract File Layout for Zipcode

Field # 82 in NJHEALTHCAP Extract File Layout for Zipcode4

The zip code of patient/provider/facility place of residence

This code is not required to be reported by hospitals. Instead, it will be calculated for all patients using smarty street for address verification.

- Required for: All patients

NJ HealthCAP Data Extract File Layout

The following NJ HEALTHCAP data extract file layout will be used for both inpatient and outpatient (SDS, SDM, ER Outpatient, and Other Outpatient) extracts. The inpatient and outpatient data extract will be in same file layout. The data extract file uses a character-delimited text extract file layout. The character delimiter is an asterisk (*).

Field Number	Description	Repeats with Cont. Record	Required I/P	Required O/P	Load Data Type	State Added/Mandated Field
0	Date Sent to DOH	X[1]	Y	Y	Date	+
1	Hospital Provider Number	X[1]	Y	Y	Varchar	
2	BLANK	X[1]	N/A	N/A		
3	Statement Thru Date	X[1]	Y	Y	Date	
4	Discharge Date	X[1]	Y	N	Date	+
5	Patient Control Number	X[1]	Y	Y	Varchar	
6	Record Number[4]	X[2]	Y	Y	Varchar	
7	Medical Record Number		Y	Y	Varchar	

Field Number	Description	Repeats with Cont. Record	Required I/P	Required O/P	Load Data Type	State Added/Mandated Field
8	Statement From Date		Y	Y	Date	
9	Admission/Start of Care Date (Admission Date)		Y	Y	Date	
10	Patient’s Street Address		Y	Y	Varchar	
11	Patient’s City		Y	Y	Varchar	
12	Patient’s Zip Code		Y	Y	Varchar	
13	Patient’s State		Y	Y	Varchar	
14	Patient Country		Y	Y	Varchar	
15	Patient's Residence Code		Y	Y	Varchar	+
16	Patient Discharge Status		Y	Y	Varchar	
17	Patient's Marital Status		Y	Y	Varchar	
18	Patient's Gender		Y	Y	Varchar	
19	Type of Bill[4]		Y	Y	Varchar	
20	I/O (Inpatient/Outpatient) Indicator		Y	Y	Varchar	+
21	Patient's Race		Y	Y	Varchar	
22	BLANK		N/A	N/A		
23	Patient's Ethnicity Code		Y	Y	Varchar	
24	Patient's Date of Birth		Y	Y	Date	
25	Patient’s Age in Years		Y	Y	Numeric	
26	Patient's Age in Days		Y	Y	Numeric	
27	Patient's First Name		Y	Y	Varchar	
28	Patient's Last Name		Y	Y	Varchar	
29	Patient's Middle Initial		Y	Y	Varchar	

Field Number	Description	Repeats with Cont. Record	Required I/P	Required O/P	Load Data Type	State Added/Mandated Field
30	Patient's Primary Language Spoken		Y	Y	Varchar	+
31	Patient's Occupation		Y	Y	Varchar	+
32	Admission Hour		Y	Y	Varchar	
33	Priority Type of Visit (Admission/Visit Type)		Y	Y	Varchar	
34	Point of Origin Code (Admission Source Type)		Y	Y	Varchar	
35	Accident State		Y	Y	Varchar	
36	Readmission Code		Y	Y	Varchar	+
37	Discharge Hour		Y	Y	Varchar	
38	Patient's Social Security Number		Y	Y	Varchar	
39	Patient's Relationship to Primary Insured		Y	Y	Varchar	
40	Patient's Relationship to Secondary Insured		Y	Y	Varchar	
41	Primary Payer Code		Y	Y	Varchar	
42	Secondary Payer Code		Y	Y	Varchar	
43	Tertiary Payer Code		Y	Y	Varchar	
44	Primary Insured's ID Number		Y	Y	Varchar	
45	Transfer In Code (UB Referral Source Code)		Y	Y	Varchar	+
46	Transfer Out Code (Transfer Destination Code)		Y	Y	Varchar	+
47	Attending Physician State License Number		Y	Y	Varchar	
48	Attending Physician National Provider Identifier (NPI)		Y	Y	Varchar	
49	Operating Physician State License		Y	Y	Varchar	

Field Number	Description	Repeats with Cont. Record	Required I/P	Required O/P	Load Data Type	State Added/Mandated Field
50	Operating Physician National Provider Identifier (NPI)		Y	Y	Varchar	
51	Other Operating Physician State License		Y	Y	Varchar	
52	Other Operating Physician National Provider Identifier (NPI)		Y	Y	Varchar	
53	Rendering Physician State License		Y	Y	Varchar	
54	Rendering Physician National Provider Identifier (NPI))		Y	Y	Varchar	
55	Referring Physician State License		Y	Y	Varchar	
56	Referring Physician National Provider Identifier (NPI)		Y	Y	Varchar	
57	Baby's Birthweight in Grams		Y	N	Numeric	
58	Mother's Medical Record Number		Y	N	Varchar	
59	Estimated Amount Due from Patient		Y	Y	Numeric	
60	Estimated Amount Due from All Payers		Y	Y	Numeric	
61	Total Charges for Claim		Y	Y	Numeric	
62	Acute Days[4]		Y	N	Numeric	
63	Non-Acute Days[4]		Y	N	Numeric	
64	Patient Type Flag		Y	Y	Varchar	
65	DRG Number (Hospital DRG)		Y	N	Varchar	
Grouper Section						
66	N/A		N/A	N/A		
67	N/A		N/A	N/A		
68	N/A		N/A	N/A		

Field Number	Description	Repeats with Cont. Record	Required I/P	Required O/P	Load Data Type	State Added/Mandated Field
69	N/A		N/A	N/A		
70	N/A		N/A	N/A		
71	N/A		N/A	N/A		
72	N/A		N/A	N/A		
73	N/A		N/A	N/A		
74	N/A		N/A	N/A		
75	N/A		N/A	N/A		
End of Grouper Section						
76	BLANK		N/A	N/A		
Geocodes Section						
77	Address Line 1				Varchar	
78	Address Line 2				Varchar	
79	City				Varchar	
80	State				Varchar	
81	Zip code				Varchar	
82	Zip Code4				Varchar	
83	Latitude				Varchar	
84	Longitude				Varchar	
End of Geocodes Section						
External Cause of Injury Code (E-Code) Section - repeats six times (maximum number of codes = 12)						
85	External Cause of Injury Code	X[3]	Y	Y	Varchar	
86	External Cause of Injury Code Present on Admission (POA) Indicator	X[3]	Y	Y	Varchar	

Field Number	Description	Repeats with Cont. Record	Required I/P	Required O/P	Load Data Type	State Added/Mandated Field
End of External Cause of Injury Code Section						
Condition Code Section - repeats six times (maximum number of codes = 24)						
87	Condition Code	X[3]	Y	Y	Varchar	
End of Condition Code Section						
Value Code Section - repeats 6 times (maximum number of codes = 12)						
88	Value Code – Code	X[3]	Y	Y	Varchar	
89	Value Code – Amount	X[3]	Y	Y	Numeric	
End of Value Code Section						
90	Patient's Reason For Visit 1		N	Y	Varchar	
91	Patient's Reason For Visit 2		N	Y	Varchar	
92	Patient's Reason For Visit 3		N	Y	Varchar	
93	Admitting Diagnosis Code		Y	N	Varchar	
94	Principal Diagnosis Code		Y	Y	Varchar	
95	Principal Diagnosis Code Present on Admission (POA) Indicator		Y	Y	Varchar	
Diagnosis Code Section - repeats 12 times (maximum number of codes = 24)						
96	Other Diagnosis Code	X[3]	Y	Y	Varchar	
97	Other Diagnosis Code Present on Admission (POA) Indicator	X[3]	Y	Y	Varchar	
End of Diagnosis Code Section						
98	Principal Procedure Code		Y	N	Varchar	
99	Principal Procedure Date		Y	N	Date	
Other Procedure Code Section - repeats 12 times (maximum number of codes = 24)						
100	Other Procedure Code – Code	X[3]	Y	N	Varchar	

Field Number	Description	Repeats with Cont. Record	Required I/P	Required O/P	Load Data Type	State Added/Mandated Field
101	Other Procedure Code – Date	X[3]	Y	N	Date	
End of Other Procedure Code Section						
Revenue Code Section - repeats 20 times (maximum number of codes = 999)						
102	Revenue Code	X[3]	Y	Y	Varchar	
103	N/A		N/A	N/A		
104	HCPCS Code	X[3]	N	Y	Varchar	
105	HCPCS Modifier 1	X[3]	N	Y	Varchar	
106	HCPCS Modifier 2	X[3]	N	Y	Varchar	
107	HCPCS Modifier 3	X[3]	N	Y	Varchar	
108	HCPCS Modifier 4	X[3]	N	Y	Varchar	
109	Revenue Code Units, Days, or Times (DUTS)	X[3]	Y	Y	Numeric	
110	Revenue Code Total Charges	X[3]	Y	Y	Numeric	
End of Revenue Code Section						
Occurrence Code Section - repeats six times (maximum number of codes = 24)						
111	Occurrence Code – Code	X[3]	Y	Y	Varchar	
112	Occurrence Code – Date	X[3]	Y	Y	Date	
End of Occurrence Code Section						
Occurrence Span Code Section - repeats six times (maximum number of codes = 24)						
113	Occurrence Span Code	X[3]	Y	Y	Varchar	
114	Occurrence Span Code - Date From	X[3]	Y	Y	Date	
115	Occurrence Span Code - Date Thru	X[3]	Y	Y	Date	
End of Occurrence Span Code Section						

Field Number	Description	Repeats with Cont. Record	Required I/P	Required O/P	Load Data Type	State Added/Mandated Field
116	End of Record Indicator[5]		Y	Y		

[1] This item will appear on every line

[2] This item will increment with multiple lines of data

[3] This item may have multiple lines of data

[4] This item will be Zero- filled

Each record is terminated with a line feed character

NJ HealthCAP Data Dictionary and Data Extract File Layout Revision Log

Version	Revision
1.5	Removed “Maximum Field Length” field

Appendix D: NJ HealthCAP Edit Specifications

Health Claim Analysis and Processing

Edit Specifications

Release 1.7

April 24, 2019

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Document Information

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Document Control

Version	Date Changed	Completed By	Description of Changes
0.1	June, 2017	R Foster	First Draft
1.0	Sept, 2017	D Johar	Initial Release
1.1	September 14, 2017	Steven Wang	Revision for Edit #108
1.2	October 12, 2017	Steven Wang	Added Edit #147
1.3	March 14, 2018	Steven Wang	Added Edits #148, #149, #150
1.4	June 6, 2018	Steven Wang	Updated edits #123, #133, #134
1.5	June 26, 2018	Logan Barron	Added Edit #151
1.6	February 5, 2019	Steven Wang	Updated description for edit #136
1.7	April 24, 2019	Logan Barron	Updated description for edits #17 and #76

Contents

Edit Specifications

General Information

The New Jersey Health Claim Analysis and Processing (NJ HealthCAP) application uses the inpatient and outpatient Medicare Code Editor, National Correct Coding Initiative (NCCI), and Medically Unlikely Edits (MUE) guidelines to perform a variety of clinical content edit verifications, including but not limited to:

- Invalid Diagnosis or Procedure Code
- E-Code as Principal Diagnosis
- Duplicate of Principal Diagnosis Code
- Age Conflict (based on Diagnosis and Procedure Codes)
- Sex Conflict (based on Diagnosis and Procedure Codes)

Edit Types

This section identifies the edit types in NJ HealthCAP.

Fatal Edits

Fatal Edits are those edits that indicate that the data in a required field is either missing or incorrect. Users must change the data in that field (or a related field, in the case of relational edits) to a valid entry in order for the edit to clear. The claim will not be accepted into the data warehouse if there are any fatal edits remaining. The edits have the following characteristics:

- Fatal edits can be both standard and relational.
- Standard edits indicate the data within that field is invalid or missing. For example, the Patient Control Number field is blank.
- Relational edits verify that data in two or more fields match the edit requirements. For example, the patient's diagnosis is for females only but the designated gender is male.

Verifiable Edits

Verifiable edits are warnings that alert the user that an unexpected condition exists that requires verification. An example of this type of edit is a patient's length of stay exceeding 365 days.

The logic used to process a Verifiable Edit is identical to the logic used for Fatal Edit with the exception that a single-byte field is associated with each Verifiable Edit. It is used to hold the confirmation state of the warning.

The edit condition will continue to be triggered until one of the following occurs:

- The user confirms the warning is a true situation and not an error.
- The user changes the value of the discharge date (updating the LOS), thus failing the statement Length of Stay is > 365

NJ HealthCAP Edits

The following table identifies the error messages in NJ HealthCAP.

Note: F = Fatal edit, V = Verifiable edit

Ref No.	Edit Logic	Error Message	Type	Patient Type	Field Being Edited	NJ HealthCAP Specific Notes
1	Accident State must be either blank or a valid state code	Accident State invalid	F	Both	Accident State	
2	Admission Hour must be **<24 or 99**	Admission Hour not 00-23 or 99	F	Both	Admission Hour	
3	The Admission Date must be a valid date and must be less than today's date	Admission Date invalid	F	Both	Admission Date	
4	The Admission Date cannot be before 2005	Admit Date must be greater than 2005	F	Both	Admission Date	
5	Admitting Diagnosis Code cannot be blank and must be a valid diagnosis code	Admitting Diagnosis Code required/invalid	F	Inpatient Only	Admitting Diagnosis Code	Admitting diagnosis code required for inpatients only. If present on an outpatient, it must be valid diagnosis code.
6	Attending Physician's NPI must be **blank** or a valid **NPI** (10 digits and using the Luhn algorithm)	Invalid Attending Physician NPI number	F	Both	Attending Physician National Provider Identifier (NPI)	
7	The Attending Physician State Code (which is the first two characters of the Attending Physician License Number) must be a **valid state, 22**, **25**, **26**, or **35**	Attending Physician State License Number invalid	F	Both	Attending Physician State License Number	

8	If the Attending Physician State Code (the first two characters of the Physician License Number) = '**NJ**' then check to see that the number after the state code is 7 or 8 characters in length and does not contain a space. If the first two characters are **22**, **25**, **26**, or **35**, then check to see the number after the state code is **10** characters in length and does not contain a space.	Attending Physician State License Number invalid	F	Both	Attending Physician State License Number	
9	If the Attending Physician State Code [the first two characters of the Physician License Number] is valid, and <> **NJ**, **22**, **25**, **26**, or **35**, then check to see that the number after the state code is not **'blank'**	Attending Physician State License Number invalid	F	Both	Attending Physician State License Number	
10	If Age in Days < **29** Priority Type of Visit Code = **4**, then Birth Weight must be between **0100** and **9000** grams	Newborn Birth Weight must be between 0100 and 9000 grams	F	Inpatient Only	Baby's Birth Weight in Grams	
11	If Age in Days < **29**, Priority Type of Visit Code = **4**, Patient's Discharge Status = **01** and **LOS < 4**, then Birth Weight in grams must be greater than or equal to **1000**	Low birthweight for newborn with LOS less than 4 days and routine discharge	F	Inpatient Only	Baby's Birth Weight in Grams	
12	If Age in Days < **29** and Priority Type of Visit Code <> **4**, Baby's Birthweight in Grams is not required.	Birthweight not present on newborn claim, patient may not group	V	Inpatient Only	Baby's Birth Weight in Grams	
13	A Condition Code field cannot be valued if the preceding Condition Code field is blank	Condition Code may not be present if the preceding Condition Code is blank	F	Both	Condition Codes 2- 24	
14	Condition Code must be blank or must be valid code on Condition Code table	Condition Code invalid	F	Both	Condition Codes 2- 24	If the patient has a DNR on file, Condition Code **P1** must be reported. If the patient's condition is related to their employment, Condition Code **02** must be reported

15	The Diagnosis Code POA Indicator must be **Y**, **N**, **U**, **W**. It can either be **1 or Null** if the Diagnosis Code is on the list of CDC exempt codes	Present on Admission Indicator required/invalid	F	Inpatient Only	Diagnosis Code Present on Admission (POA) Indicator (1- 25)	
16	Admission Date must not be greater than the Discharge Date (final bills only)	Admission Date must be less than or equal to Discharge Date	F	Inpatient Only	Discharge Date	
17	The Discharge Date must be a valid date, less than or equal the current date and must be from an open year (field required on final bills only)	Discharge Date Invalid	F	Inpatient Only	Discharge Date	
18	Discharge Hour must be **00-23** or **99** for final-billed patients (**XXX1**, **XXX4**, **XXX7**)	Discharge Hour invalid	F	Inpatient Only	Discharge Hour	
19	If Primary Payer Code is **031** or **039** then Payer Estimated Amount Due must equal zeroes	Self-pay patient – report under Estimated Amount Due from Patient	F	Both	Estimated Amount Due from All Payers	
20	If Primary Payer Code is not **031** or **039** then the Payer Estimated Amount Due must be greater than zeroes	Payer Estimated Amount Due invalid	F	Both	Estimated Amount Due from All Payers	
21	Payer Estimated Amount Due cannot be greater than **9,999,999**	Payer Estimated Amount Due over 9,999,999	V	Both	Estimated Amount Due from All Payers	
22	If Primary Payer Code equals either **031** or **039** then the Patient Estimated Amount Due must be greater than zeroes	Patient Estimated Amount Due invalid	F	Both	Estimated Amount Due from Patient	
23	Patient Estimated Amount Due cannot be greater than **9,999,999**	Patient Estimated Amount Due invalid	F	Both	Estimated Amount Due from Patient	
24	If any of the External Cause of Injury (EIC) codes is not '**blank**' then it must be a valid code.	External Cause of Injury Code invalid	F	Both	External Cause of Injury Codes (E- Codes)	
25	An External Cause of Injury Code cannot be valued if the preceding External Cause of Injury Code is blank	ECI Code may not be present if previous ECI Code is blank	F	Both	External Cause of Injury Codes (E- Codes) 2-12	

26	The External Cause of Injury Code POA Indicator must be **Y**, **N**, **U**, **W**. It can either be **1 or Null** if the Diagnosis Code is on the list of CDC exempt codes	Present on Admission Indicator invalid	F	Inpatient Only	External Cause of Injury Code (E- Code) Present on Admission (POA) Indicator (1- 12)	
27	If Bill Type equals **0131**, **0135**, **0137** all Revenue Codes must have a HCPCS code unless the Revenue Code is on the CMS list of exempt revenue codes	HCPCS Code required	F	Outpatient Only	HCPCS Code	
28	HCPCS Code must be on list of valid codes	HCPCS Code invalid based on Discharge Date or patient's gender	F	Outpatient Only	HCPCS Code	
29	**HCPCS** Modifier **1** must either be blank or a valid code on Modifier table.	Invalid HCPCS Modifier	F	Outpatient Only	HCPCS Modifier 1	
30	**HCPCS** Modifier **2** must either be blank or a valid code on Modifier table.	Invalid HCPCS Modifier	F	Outpatient Only	HCPCS Modifier 2	
31	**HCPCS** Modifier **3** must either be blank or a valid code on Modifier table.	Invalid HCPCS Modifier	F	Outpatient Only	HCPCS Modifier 3	
32	**HCPCS** Modifier **4** must either be blank or a valid code on Modifier table.	Invalid HCPCS Modifier	F	Outpatient Only	HCPCS Modifier 4	
33	A **HCPCS** Modifier (**2-4**) cannot be valued unless the previous Modifier is valued.	HCPCS Modifier cannot be present if previous Modifier is blank	F	Outpatient Only	HCPCS Modifier (2-4)	
34	Inpatient/Outpatient indicator can only be **I** or **O**	I/O indicator can only be "I" or "O"	F	Both	I/O (Inpatient/ Outpatient) Indicator	
35	Length of Stay should be less than **365**	Length of Stay > 365 Days	V	Inpatient Only	Length of Stay (LOS)	
36	Length of Stay greater than 1 day is only allowed on ED Observation patients (with a revenue code of **0762** or a **HCPCS** code of **G0378**)	Bill types 0131-0137 cannot have a LOS greater than 1	F	Outpatient Only	Length of Stay (LOS)	

37	Length of Stay up to **2** days is only allowed on ED outpatients (with a **revenue** code of **045X**).	Outpatient with a LOS greater than one	V	Outpatient Only	Length of Stay (LOS)	
38	Medical Record Number must be at least **4** but not more than **24** characters	Medical Record Number blank or less than 4 characters	F	Both	Medical Record Number	
39	Mother's Medical Record Number must be at least 4 but not more than **24** characters if Admission Date equals patient's Birth Date, and the Point of Origin = **5** (Born in this facility)	Mother's Medical Record is missing/less than 4 characters	F	Inpatient Only	Mother's Medical Record Number	
40	Occurrence Code must be blank or must be a valid Occurrence Code on the Occurrence Code table (as defined by NUBC)	Occurrence Code invalid	F	Both	Occurrence Code	If the patient's visit is the result of an accident, Occurrence Codes 01-05 must be reported as appropriate
41	An Occurrence Code Date may not be present without an Occurrence Code	Occurrence Date may not be present if Occurrence Code is blank	F	Both	Occurrence Code	
42	An Occurrence Code field cannot be valued when the preceding Occurrence Code field is blank	Occurrence Code may not be present if previous Occurrence Code is blank	F	Both	Occurrence Codes 2- 24	
43	An Occurrence Code may not be present without an Occurrence Code Date	Occurrence Date must be present when if Occurrence Code is present	F	Both	Occurrence Code Date	
44	Occurrence Code Date must be a valid date, less than current date and, excluding codes **A1**, **B1** and **C1**, must be greater than or equal to patient's birth date	Occurrence Date invalid	F	Both	Occurrence Code Date	

45	Occurrence Span Code must be blank or must be a valid Occurrence Span Code on the Occurrence Span Code table (as defined by NUBC)	Occurrence Span Code invalid	F	Both	Occurrence Span Code	If the patient's visit includes non-acute care days (ICF, SNF or Residential days), Occurrence Span Codes 75, M3, and/or M4 must be reported as appropriate for the patient. The Occurrence Span From and Through Dates should indicate the dates of the patient's stay at the non- acute level of care.
46	An Occurrence Span Code cannot be present without Occurrence Code From and Thru Dates	Occurrence Span From Date required/Occurrence Span Thru Date required	F	Both	Occurrence Span Code	
47	An Occurrence Span Code field cannot be valued when the preceding Occurrence Span Code field is blank	Occurrence Span Code may not be present if previous Occurrence Span Code is blank	F	Both	Occurrence Span Codes 2-24	
48	An Occurrence Span From Date cannot be present without an Occurrence Span Code	Occurrence Span From Date may not be present if Occurrence Span Code is blank	F	Both	Occurrence Span From Date	
49	For Occurrence Span Codes **74**, **75**, **76**, **77**, **M0**, **M1**, **M2**, **M3** and **M4**, the Occurrence Span From Date must not be less than the Admission Date	Occurrence Span From Date must be greater than or equal to Admission Date	F	Both	Occurrence Span From Date	
50	For Occurrence Span Codes **70**, **71**, **72**, **73** and **78**, the Occurrence Span From Date must be a valid date and must be greater than the patient's birth date	Occurrence Span From Date must be greater than or equal to Patients Birth Date	F	Both	Occurrence Span From Date	
51	An Occurrence Span Thru Date cannot be present without an Occurrence Span Code	Occurrence Span Thru Date may not be present if Occurrence Span Code is blank	F	Both	Occurrence Span Thru Date	
52	An Occurrence Span Thru Date must be greater than Occurrence Span From Date	Occurrence Span Thru Date must be greater than Occurrence Span From Date	F	Both	Occurrence Span Thru Date	

53	For Occurrence Span Codes **74**, **75**, **76**, **77**, **M0**, **M1**, **M2**, **M3** and **M4**, the Occurrence Span Thru Date must not be greater than the Statement Thru Date	Occurrence Span Thru Date must be less than or equal to Statement Thru Date	F	Both	Occurrence Span Thru Date	
54	Patients with procedure codes must have an operating physician license number	Procedure Code present, Operating Physician License Number must be present	F	Inpatient Only	Operating Physician State License Number	
55	If the Operating/Other Physician License Number is not 'blank', the Operating Physician's State Code (which is the first two characters of the Operating/Other License Number) must be a **valid state**, **22**, **25**, **26** or **35**	Operating/Other Operating Physician State License Number invalid	F	Both	Operating/Other Physician State License Number	
56	If the Operating/Other Physician License Number is not "**blank**", and the first two characters = **'NJ'** then check to see that the number after the state code is **7** or **8** characters in length and does not contain a space. If the first two characters are **22**, **25**, **26** or **35**, then check to see that the number after the state code is **10** characters in length and does not contain a space.	Operating/Other Operating Physician State License Number invalid	F	Both	Operating/Other Physician State License Number	
57	If the Operating/Other Physician License Number is not 'blank' and the first two characters are a valid state, but the state <> **NJ**, **22**, **25**, **26** or **35** then check to see that the position after the state code is not 'blank'	Operating/Other Operating Physician State License Number invalid	F	Both	Operating/Other Physician State License Number	
58	Patients with procedure codes must have an operating physician NPI number	Procedure Code present, Operating Physician NPI Number must be present	F	Inpatient Only	Operating Physician National Provider Identifier (NPI)	

59	Operating/Other Physician's NPI must be blank or a valid NPI (using Luhn algorithm)	Operating/Other Operating Physician NPI number invalid	F	Both	Operating/Other Physician National Provider Identifier (NPI)	
60	Duplicate Diagnosis code is found	Duplicate Diagnosis Code	F	Both	Other Diagnosis Codes (2-25)	
61	If there is a Diagnosis Code in any diagnosis code field, then the codes in the preceding fields must not be blank	Diagnosis Code may not be present when previous Diagnosis Code is blank	F	Both	Other Diagnosis Codes (2-25)	
62	Patient Control Number cannot equal spaces and must be at least **4** but not more than **20** characters	Patient Control Number cannot equal spaces and must be at least 4 characters	F	Both	Patient Control Number	
64	Patient Discharge Status must be either **01**,**02**, **03**, **04**, **05**, **06**, **07**, **20**, **21**, **30**, **43**, **50**, **51**, **61**, **62**, **63**, **64**, **65**, **66**, **69**, **70**, **81**, **82**, **83**, **84**, **85**, **86**, **87**, **88**, **89**, **90**, **91**, **92**, **93**, **94** or **95**	Patient Status invalid	F	Both	Patient Discharge Status (Discharge [Patient] Status Code)	
65	Patient Discharge Status can be **09**	Patient Status invalid	F	Outpatient Only	Patient Discharge Status (Discharge [Patient] Status Code)	
66	Patient City cannot be blank	Patients City required	F	Both	Patient's City	
67	Patient Country Code cannot be blank and must be valid code on country list if Patient's State = '**XX'**	Patients Country invalid	F	Both	Patient's Country	
68	The Century corresponding to the Patient's Date of Birth must equal either **18**, **19** or **20**	The Patient age must not be greater than 124	F	Both	Patient's Date of Birth	
69	The Patient's Date of Birth must be a valid date	[Date] is not a valid date format	F	Both	Patient's Date of Birth	
70	The Patient's Date of Birth must be less than or equal to the Admission Date	The Patient Birth Date must be less than or equal to the Admission Date	F	Both	Patient's Date of Birth	
71	The Patient's age cannot be greater than **124** years	The Patient age must not be greater than 124	F	Both	Patient's Date of Birth	
72	Patient's Ethnicity must be either **21485**, **21550**, **21808**, **21824**, **21865**, **21870**, **21875** or **21880**	Hispanic Ethnicity invalid	F	Both	Patient's Ethnicity Code	

73	Patient First Name cannot be numeric or blank	Patient First Name invalid	F	Both	Patient's First Name	
74	Patient's Gender must be either **M**, **F** or **U**	Patient's gender invalid	F	Both	Patient's Gender	
75	Gender code **U** valid only for patients **< 29** Days of Age	Gender code U valid only for patients < 29 days old	F	Both	Patient's Gender	
76	If the Revenue Code is valid and the Revenue Code equals either **0112**, **0122**, **0132**, **0142**, **0152**, **0721**, then the Patients Gender must be **F**	Revenue Code invalid based on discharge date, patient type, or patient gender	F	Both	Patient's Gender	
77	Patient Last Name cannot be numeric or blank	Patient Last Name invalid	F	Both	Patient's Last Name	
78	Marital Status cannot be blank and must be on the list of valid marital status codes	Marital Status invalid	F	Both	Patient's Marital Status	
79	If Marital Status equals '**S'**, then the Patient's Age must be greater than or equal to **18**	Marital Status is Separated, but patient age is under 18	F	Both	Patient's Marital Status	
80	Patient Middle Initial must either be blank, or alpha character	Patient Middle Initial invalid	F	Both	Patient's Middle Initial	
81	If the patient's age is greater than **18**, the occupation code cannot be blank	Patient Occupation cannot be blank	F	Both	Patient's Occupation	
82	Primary Language Spoken cannot be blank and must be a valid code on the table unless patient's birth date = admission date	Patients Primary Language Spoken missing/invalid	F	Both	Patient's Primary Language Spoken	
83	Patient's Race must not be blank and must be a valid code on the race code table	Patient Race Code invalid	F	Both	Patient's Race	
84	If Bill Type is **013X**, the Patient's Reason for Visit Code **1** may not be blank and must be a valid diagnosis code	Patient Reason for Visit Code required/Invalid Diagnosis Code, or Diagnosis Code invalid for patient's gender	F	Outpatient Only	Patient's Reason for Visit	

85	If not blank, the Patient's Reason for Visit Code must be a valid diagnosis code	Invalid Diagnosis Code, or Diagnosis Code invalid for patient's gender	F	Outpatient Only	Patient's Reason for Visit	
86	The Patient's Reason for Visit Code **2** may not be valued if the Patient's Reason for Visit Code **1** is blank	Patient Reason for Visit Code may not be present if previous Patient Reason for Visit Code is blank	F	Outpatient Only	Patient's Reason for Visit	
87	The Patient's Reason for Visit Code **3** may not be valued if the Patient's Reason for Visit Code **2** is blank	Patient Reason for Visit Code may not be present if previous Patient Reason for Visit Code is blank	F	Outpatient Only	Patient's Reason for Visit	
88	Patient's Relationship to Insured **1** cannot be blank and must be a valid code on the table	Patients Relationship to Primary Insured invalid	F	Both	Patient's Relationship to Primary Insured	
89	Patient's Relationship to Insured **2** cannot be blank and must be a valid code on the table if Secondary Payer Code is not blank	Patients Relationship to Secondary Insured invalid	F	Both	Patient's Relationship to Secondary Insured	
90	Residence Code cannot = **9999** and must be in Residence Code Table	Residence Code invalid	F	Both	Patient's Residence Code	
91	If state is NJ, then Residence Code must be between **0101- 2123**	Patient State is NJ, Residence Code must be 0101-2123	F	Both	Patient's Residence Code	
92	Social Security Number may either be blank or 9 digits	Patients Social Security Number invalid – please use 9 digits with no dashes (e.g. 999999999)	F	Both	Patient's Social Security Number	
93	Patient State must equal a valid state code (United States and Canada and XX for other)	Patient State must be a valid state from table	F	Both	Patient's State	
94	Patient Street Address cannot be blank	Patients Street Address required	F	Both	Patient's Street Address	
95	The only special characters allowed in Patient Street Address are **"#", "/",** "\", **"-", "."** and **","**	Patients Street Address must not contain any special characters	F	Both	Patient's Street Address	
96	The Patient's Zip Code must be numeric and greater than zeroes if not a foreign or Canadian address	Patient Zip Code invalid	F	Both	Patient's Zip Code	

97	The Patient Zip Code must be in table ranges (US addresses) or not blank (non-US addresses)	Patient Zip Code invalid	F	Both	Patient's Zip Code	
98	If the Residence Code is a valid NJ residence code (as found in the NJ Resident Code Table) then the first two character of the Patient Zip Code must be either an **07** or **08**	Patient Zip Code invalid	F	Both	Patient's Zip Code	
99	The Patient's Zip Code cannot contain a dash (-)	Patient Zip Code must not contain any special characters	F	Both	Patient's Zip Code	
100	If the Priority of Visit = **1**, **2**, **3**, **5** or **9** then the Patient's Point of Origin must be either **1**, **2**, **4**, **5**, **6**, **8**, **9**, **D**, **E** or **F**	Point of Origin invalid	F	Both	Point of Origin Code (Admission Source Type)	
101	If Priority of Visit = **4** then Patient's Point of Origin must equal either **5** or **6**	Point of Origin invalid	F	Both	Point of Origin Code (Admission Source Type)	
102	Insured ID cannot be blank unless patient is self-pay (payer codes **031**, **039** or **095**)	Insureds Identification required	F	Both	Primary Insured's ID Number	
103	Primary Payer Code must not be blank and must be a valid code on the payer code table	Primary Payer Code invalid	F	Both	Primary Payer Code	
105	Diagnosis Code Z51.5 **(ICD- 10)** is invalid as a principal diagnosis code	The Diagnosis Code present cannot be used as the Principal Diagnosis	F	Both	Principal Diagnosis Code	
106	Priority of Visit must be either **1**, **2**, **3**, **4**, **5** or **9**	Priority of Visit Code invalid	F	Both	Priority Type of Visit (Admission/Visit Type)	
107	If Priority of Visit equals **4** then Age in Days must be **<= 28**	Priority of Visit Code invalid (newborn code used for non-newborn patient)	F	Both	Priority Type of Visit (Admission/Visit Type)	
108	If Priority of Visit equals either **1, 2, 3**, **5** or **9** then Age in Days at admission must be **> 0**	Priority of Visit invalid for newborn patient	F	Both	Priority Type of Visit (Admission/Visit Type)	
109	If Procedure Code Date is valued then Procedure Code must not be blank	Procedure Date may not be present if Procedure Code is blank	F	Inpatient Only	Procedure Code (1- 25)	

110	If there is a procedure code in any procedure code field, then the codes in the preceding fields must not be blank.	Procedure Code may not be present if previous Procedure Code is blank	F	Inpatient Only	Procedure Code (2- 25)	
111	If Procedure Code is valued (not blank) then Procedure Code Date must be a valid date	Procedure Date required	F	Inpatient Only	Procedure Date (1- 25)	
112	The Procedure Code Date must be greater than or equal to the Admission and/or Statement From Date	Procedure Date must be greater than or equal to Admission and/or Statement From Date	F	Inpatient Only	Procedure Date (1- 25)	
113	The Procedure Code Date must be less than or equal to the Discharge Date	Procedure Date must be less than or equal to Statement Thru Date	F	Inpatient Only	Procedure Date (1- 25)	
114	Readmission Code must be '0', '1' or '9' if patient's birth date is less than the admission date	Readmission Code must be 0, 1 or 9	F	Inpatient Only	Readmission Code	
115	If Revenue Code Service Units is valued [does not equal spaces or zeroes] then Revenue Code must be valued [not equal to spaces or zeroes]	Revenue Code invalid based on discharge date, patient type, or patient gender	F	Both	Revenue Code	
116	If Revenue Code Total Charge is valued [does not equal spaces or zeroes] then Revenue Code must be valued [not equal to spaces or zeroes]	Revenue Code invalid based on discharge date, patient type, or patient gender	F	Both	Revenue Code	
117	The Revenue Code must be found in the Revenue Code table	Revenue Code invalid based on discharge date, patient type, or patient gender	F	Both	Revenue Code	
118	If Revenue Code is Valid and equals either **0111**, **0121**, **0131**, **0141**, **0151**, **0201**, **0202** or **0231** then the patient's age must be greater than or equal to **19**	Age and Rev Code Conflict	V	Inpatient Only	Revenue Code	

119	If Revenue Code is Valid equals either **0113**, **0123**, **0133**, **0143**, **0153** or **0203** then the patient's age must be less than or equal to **18**	Age and Rev Code Conflict	V	Inpatient Only	Revenue Code	
120	If Revenue Code is Valid and equals **017X** then the patient's age must be less than **1**	Age and Rev Code Conflict	V	Inpatient Only	Revenue Code	
121	Trauma Revenue Codes (**068X**) may only be used when Priority of Visit is **5** (trauma)	Trauma Revenue Codes may only be used when Admission Type = 5	F	Both	Revenue Code	
122	There must be at least one Revenue Code Line on every record	No revenue lines have been entered for this record	V	Both	Revenue Code	
123	If Revenue Code is valid then Revenue Service Units must be Numeric and not negative	Days/Units/Time must be present and not a negative value	F	Both	Revenue Code Days, Units, or Time (DUTS)	
124	If Revenue Code prefix equals either **010**, **011**, **012**, **013**, **014**, **015**, **016**, **017**, **018**, **020** or **021** then Revenue Code Units cannot be zeroes	Days/Units/Time must be present	F	Inpatient Only	Revenue Code Days, Units, or Time (DUTS)	
125	The sum of the total days for a routine Revenue Code Line should equal the actual length of stay	Total Days for Revenue Code line items should be equal to total LOS	V	Inpatient Only	Revenue Code Days, Units, or Time (DUTS)	
126	If Revenue Code is Valid then Revenue Code Total Charges must be greater than zero	Revenue Line Item with no charges	V	Both	Revenue Code Total Charges	
127	Total Charge for a Revenue Code Line Item cannot be greater than **9,999,999**	Total Charge for revenue line item greater than $9,999,999.00	V	Both	Revenue Code Total Charges	
128	Secondary Payer Code must be a valid code on the payer code table	Secondary Payer Code invalid	F	Both	Secondary Payer Code	
129	Service From Date must not be greater then the Service Thru Date	Statement From Date must be less than or equal to Statement Thru Date	F	Both	Statement From Date	
131	Tertiary Payer Code must be a valid code on the payer code table	Tertiary Payer Code invalid	F	Both	Tertiary Payer Code	

132	Tertiary payer code cannot be present without secondary payer code present	Tertiary Payer Code may not be present if Secondary Payer Code is blank	F	Both	Tertiary Payer Code	
133	If the Point of Origin Code is **4** and the Priority of Visit Code is **1**, **2**, **3**, **5** or **9** then the Transfer In Code must be a valid hospital NPI number in the transfer NPI list	Transfer In Code invalid	F	Both	Transfer In Code (UB Referral Source Code)	
134	If the Patient Discharge Status Code = **02** then the Transfer Out Code must be a valid facility NPI number in the transfer NPI list	Transfer Out Code not a valid NPI number	F	Both	Transfer Out Code (Transfer Destination Code)	
135	Bill Type must be either **0111, 0112, 0113, 0114, 0115, 0117, 0118, 0121,0122, 0123, 0124,0125, 0127, 0128,0131, 0135, 0137, 0138**	Type of Bill invalid	F	Both	Type of Bill	
136	Bill types **011X** and **012X** must have an I/O indicator of **I** and **013X** must have an I/O indicator of **O**	Invalid Bill Type for inpatients/Invalid Bill Type for outpatients	F	Both	Type of Bill	
137	Inpatient Bill Types **0112**, **0113**, **0122** and **0123** can only have a patient status of **30**	Interim bill types may only use a patient Discharge Status of '30'	F	Inpatient Only	Type of Bill	
138	If bill type equals **0131**, **0135** or **0137**, LOS cannot be greater than **1**	Bill types 0131-0137 cannot have a LOS greater than 1	F	Both	Type of Bill	
139	If bill type does not equal either **0131**, **0135** or **0137**, Total Days must equal Length of Stay (LOS)	Total Days for Revenue Code line items should be equal to total LOS	V	Inpatient Only	Type of Bill	
140	A Value Code cannot be present without a Value Code Amount	Value Code Amount may not be blank	F	Both	Value Code	
141	If Age in Days < **29** and Priority Type of Visit Code = **4**, then Value Code **54** must be present	At least one Value Code must contain the birthweight on a newborn claim	F	Inpatient Only	Value Code	Value Code Amount must be actual Birth Weight or weight at time of admission for an extramural birth. Required on all claims with Priority Type of Visit of 4 and on other claims as required by state law.

142	A Value Code Amount cannot be present without a Value Code	Value Code Amount may not be present if Value Code is blank	F	Both	Value Code Amount	
143	If the Value Code is **45**, the Value Code Amount must be **00- 23** or **99**	Accident Hour must be 00-23 or 99	F	Both	Value Code Amount	
144	If Value Code is **32**, **37**, **38**, **39**, **46**, **50**, **51,** **52**, **53**, **56**, **57**, **60**, **61**, **67**, **68**, **80**, **81**, **82**, **83**, or **A0** there can be no decimal place	Value Code Amount must contain whole numbers only	F	Both	Value Code Amount	
145	A Value Code field cannot be valued if the preceding Value Code field is blank	Value Code may not be present when preceding Value Code is not present	F	Both	Value Codes 2-24	
146	If the Value Code is **02**, the Value Code Amount must be **0.00**	Hospital has no Semi- private rooms must be $0.00	F	Both	Value Code Amount	
147	The Admit Date must be a valid date and must be from an open year	Admit Date Invalid (Must be from an open year)	F	Outpatient Only	Admit Date	
148	The Principal Diagnosis code must not be blank or null	Principal Diagnosis Required	F	Both	Principal Diagnosis	
149	Statement From Date must not be blank or null	Statement From Date Required	F	Both	Statement From Date	
150	Statement Thru Date must not be blank or null	Statement Thru Date Required	F	Both	Statement Thru Date	
151	The Insurance ID must be 50 characters or less.	Insured ID should be 50 characters or less.	F	Both	Insured ID #	

Appendix E: ANSI 837 Addendum Guide

New Jersey Health Claim Analysis and Processing Addendum Guide

Release 1.5

January 2018

http://www.publicconsultinggroup.com

Table 1 Health Claim Analysis and Processing Addendum Guide Revision History

Version	Date	Author	Description
0.1	June, 2017	Brad	Draft
1.0	June, 2017	Richard Foster	Reformatted draft to meet PCG standards. Initial version
1.1	July, 2017	Harish Sharma	Reformatted and corrected segment information.
1.2	August, 2017	Deepti Johar	Updated segment information
1.3	August, 2017	Harish Sharma	✓ Review and correction. ✓ Using ICD 10 Codes. ✓ Stricken NM1 & REF segment - Other Payer Patient information, Loop 2330C. (Refer Implementation guide - D.2.26) ✓ Added Loop IDs to each segment
1.4	August, 2017	Harish Sharma	Corrected Data Elements usage for Situational Segments
1.5	January 22, 2018	Logan Barron	Corrected Data Elements usage for Required Segments

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Contents

1 INTRODUCTION

The Health Claim Analysis and Processing Addendum Guide provides you with information about the data elements and segment required for electronic claim submissions.

Introduction

The Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Department of Health and Human Services (HHS) establish national standards for electronic health care transactions for health plans and providers. The 837 X12N Implementation Guides were implemented as the standard documents to be used to comply with claims transaction compliance for electronic data interchange in health care.

PCG has prepared this document as a guide to the data elements and segment requirements for electronic claim submissions. The purpose of this document is to provide guidelines for creating daily ASC X12N / 005010X225 ANSI 837, Health Care Service: Data Reporting File format as it is implemented for the New Jersey Discharge Data Collection System. The intended audience for this document should be the technical team responsible for creating the specifications needed to submit a HIPAA compliant electronic claims file. This information should be coordinated with the healthcare provider's billing practice to ensure accuracy and completion of all necessary data requirements.

Scope

For the health care industry, to achieve the potential administrative cost savings with Electronic Data Interchange (EDI), standards have been developed and need to be implemented consistently by all organizations. To facilitate a smooth transition into the EDI environment, uniform implementation is critical. This is the technical report document for the ANSI ASC X12N 837 Health Care Claims (837R) transaction for institutional claims for Data Reporting. This document provides a definitive statement of what trading partners must be able to support in this version of the 837. This document is intended to be compliant with the data standards set out by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The goals of the Health Claim Analysis and Processing (NJ HealthCAP) application is to:

- Simplify the existing process
- To be easy to read and follow
- Reduce costs to the hospitals
- Improve data timeliness, accuracy and availability.

The goals for this document are to:

- provide the user with technical document for information on ASC X12N / 005010X225 ANSI 837, Health Care Service: Data Reporting file format for electronic claims.
- enable the user (when used in conjunction with the 837R) to create a X12-837file that conforms to the NJ HealthCAP project
- enable the user (when used in conjunction with the 837R) to create a X12-837 file that is free from data errors.

How to use this Document

General Guidelines for the NJ HealthCAP 837 file

While the NJ HealthCAP is utilizing a standard format, there are a few exceptions to standard ANSI logic that should be noted:

1. Fields marked **"Required"** but without any specific NJ HealthCAP requirements / guidelines

   There are several fields that are required in order to create a valid 837 file, such as the receiver and sender ids, but have no specific requirements for this project other than they be present. These fields are used by NJ HealthCAP to validate that the "envelope" is intact, and not to validate individual data elements. Values used for payer submissions and / or defaulted values are acceptable.
2. Fields marked **"NOT USED"**

   The X225R Implementation Guide contains several data elements that are not collected for the purposes of this project. These fields are all marked "NOT USED" within this document, although they may be listed as Required or Situational in the standard X225R. Any field marked "NOT USED" within this document will be ignored when loaded into the NJ HealthCAP application. However, we will not reject a claim if data is provided within a "NOT USED" field. Facilities may choose to provide additional data elements in their files at their discretion, especially if this incurs less programmatic changes when creating their files.

   To assist those facilities who choose to provide additional data elements, the standard guidelines are included in this document for data elements normally listed as Required or Situational in the X225R, but listed here as Not Used.
3. Carriage Returns / Line Feeds **(CR / LF)**

   Our loading process has been programmed to accept 837 files with or without CR / LF's in the data. However, given a choice, our preference is to have a CR / LF following each segment terminator.
4. Segments marked with **multiple repeats**

   In some instances, there are segments which have multiple repeats allowed but not needed for NJ HealthCAP application. These segments have been marked with both the standard number of allowable repeats and the NJ HealthCAP number in parenthesis. If you choose to send additional repeats not needed for this project, they will be ignored.

System Information

This section provides general information about the NJ HealthCAP project, as well as information to help you understand the contents of this guide.

System Availability

PCG's NJ HealthCAP Web portal is available 24 hours a day. If the portal undergoes any system maintenance or upgrades and becomes unavailable, PCG notifies all providers accessing the Web portal. Clear communication will be sent prior to and directly after each maintenance period.

Minimum System Requirements

- Computer / Processor - PC with 233 MHz Pentium processor or higher
- Operating System - Windows 7 or later
- Memory - 128 MB of RAM (256 MB recommended) for use on Windows 7 or later
- Hard Drive / Storage - From 3 GB up to 7 GB
- Document Reader - Microsoft Office Word, Microsoft Office Excel
- Recommended Browser - Google Chrome (any 64- bit Version), IE 11 or higher

837 Claim Submission Policies

The following is a list of the policies to be followed when submitting 837 claims:

- Validation of the member identification number is essential. If this number is not provided or is not correct, the claim will be rejected.
- Claims requiring attachments (medical documentation, invoices, etc.) cannot be submitted via EDI at this time.
- ICD-10 Diagnosis coding must be submitted to the highest level of specificity. All codes should be submitted with a fourth and / or fifth digit when appropriate to the medical condition. PCG NJ HealthCAP can currently accept up to 24 secondary or other diagnosis codes.
- Modifiers must be included next to the CPT / HCPCS code on the line item wherever applicable. Pricing modifiers should be applied in the first modifier position to ensure appropriate pricing rules. Ensure that multiple modifiers are separated by HIPAA delimiting characters.

The following is a list of data element types (DT) as specified in the Implementation Guide:

Table 2-1 Data Type Elements

Symbol	Type	Description
Nn	Numeric	N" **indicates that it is numeric and "n" indicates** the number of decimal positions to the right of the implied decimal point.
N0	Numeric	If n is 0, "N" is equivalent to "N0".
R	Decimal	A decimal data element contains an explicit decimal point, and is used for numeric values that have a varying number of decimal positions
ID	Identifier	An identifier data element contains a value from predefined list of values.

AN	String	A string data element is a sequence of any characters from the basic or extended character sets.
DT	Date	A date data element expresses the standard date in either YYMMDD or CCYYMMDD format.
TM	Time	A time data element expresses the ISO standard time in HHMMSS format

The following is a list of data segment types (DS) as specified in the Implementation Guide:

Table 2-2 Data Segment Elements

<table>
<tr><th>Symbol</th><th>Type</th><th colspan="2">Description</th></tr>
<tr><td>M</td><td>Mandatory</td><td colspan="2">The designated data element or composite data structure must be present in the segment.</td></tr>
<tr><td>O</td><td>Optional</td><td colspan="2">The presence of a value for a simple data element or the presence of value for any of the component data elements of a composite data structure is at the option of the sender.</td></tr>
<tr><td rowspan="5">X</td><td rowspan="5">Relational</td><td colspan="2">Relational conditions may exist among two or more simple data elements within the same data segment based on the presence or absence of one of those data elements (presence means a data element must not be empty). Relational conditions are specified by a condition code (see table below) and the reference designators of the affected data elements. A data element may be subject to more than one relational condition.</td></tr>
<tr><td colspan="2">The definitions for each of the condition codes used within syntax notes are detailed below:</td></tr>
<tr><td>CONDITION CODE</td><td>DEFINITION</td></tr>
<tr><td>P-Paired or Multiple</td><td>If any element specified in the relational condition is present, then all of the elements specified must be present.</td></tr>
<tr><td>R- Required</td><td>At least one of the elements specified in the condition must be present.</td></tr>
<tr><td>E- Exclusion</td><td>Not more than one of the elements specified in the condition may be present.</td></tr>
</table>

The following is a list of delimiters as specified in the Implementation Guide:

Table 2-3 identifies the delimiters used.

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

System Error Messages

The following is the contact information that the end user should utilize if experiences any errors or difficulties:

Email Id: NJ_HealthCAP@pcgus.com

Disclaimer This document has been prepared as a companion document to the implementation guide and will clarify when conditional data elements and segments must be used for reporting. This companion guide document supplements, but does not supersede any requirements in the standard 837R X 225 version 5010.

2 SEGMENTS AND LOOPS

This chapter provides information about the segments and loops used by Health Claim Analysis and Processing (NJ HealthCAP) application.

This chapter provides information about the following segments:

ISA: Interchange Control Header

The Interchange Sender Acknowledgment (ISA) is a fixed record length segment and all positions within each of the data elements must be filled. This is the first element separator to be used through the entire interchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire interchange.

Note: *Spaces in the following example are represented by "." for clarity.*

Loop : `Header`
Usage : `Required`
Repeat : `1`
Example : `ISA*00*..........*00*SECRET....*30*SUBMITTER.ID...*30*RECEIVER.ID....*930602*1253*^* 00501*000000905*0*T*:~`

Table 2-1 Interchange Control

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	ISA01 / I01	Authorization Information Qualifier	M 1	ID	2 / 2	**Enter the following: *"00"*** (No Authorization Information Present)
Required	ISA02 / I02	Authorization Information	M 1	AN	10 / 10	**Enter the following: *10 Spaces***
Required	ISA03 / I03	Security Information Qualifier	M 1	ID	2 / 2	**Enter the following: *"00"*** (No Security Information Present)
Required	ISA04 / I04	Security Information	M 1	AN	10 / 10	**Enter the following: *10 Spaces***
Required	ISA05 / I05	Interchange ID Qualifier	M	ID	2 / 2	ID qualifies the Sender in ISA06. Use: ***ZZ*** ***Note:*** *Although this data element is required to create a valid ANSI 837, there are no NJ_HealthCAP-specific data requirements for this field.*
Required	ISA06 / I06	Interchange Sender ID	M	AN	15 / 15	Use Your Assigned Submitter ID; fill 15 positions. ***Note:*** *Although this data element is required to create a valid ANSI 837, there are no NJ_HealthCAP-specific data requirements for this field.*
Required	ISA07 / I05	Interchange ID Qualifier	M	ID	2 / 2	ID qualifies the Receiver in ISA08; Use: ***ZZ*** ***Note:*** *Although this data element is required to create a valid ANSI 837, there are no NJ_HealthCAP-specific data requirements for this field.*
Required	ISA08 / I07	Interchange Receiver ID	M	AN	15 / 15	Enter Receiver ID; fill 15 positions ***Note:*** *Although this data element is required to create a valid ANSI 837, there are no NJ_HealthCAP-specific data requirements for this field.*
Required	ISA09 / I08	Interchange Date	M	DT	6 / 6	**Enter the following:** Date of the Interchange in ***YYMMDD*** format
Required	ISA10 / I09	Interchange Time	M	TM	4 / 4	**Enter the following:** Time of the interchange in ***HHMM*** format

Required	ISA11 / I10	Repetition Separator	M	ID	1 / 1	**Enter the following: *"^"*** (carat) ***Note:*** *The repetition separator is a delimiter and not a data element.*
Required	ISA12 / I11	Interchange Control Version Number	M	ID	5 / 5	**Enter the following: *00501*** (for US EDI ASCI X12)
Required	ISA13 / I12	Interchange Control Number	M	N0	9 / 9	**Enter the following:** Unique 9-digit number assigned by sender can be 000000001 ***Note:*** *The Interchange Control Number, ISA13, must be identical to the associated Interchange Trailer IEA02.*
Required	ISA14 / 113	Acknowledgement Requested	M	ID	1 / 1	**Enter one of the following:** ***0*** (No Acknowledgment Requested) ***1*** (Interchange Acknowledgment Requested)
Required	ISA15 / I14	Usage Indicator	M	ID	1 / 1	**Enter one of the following: *"P"*** = Production Data
Required	ISA16 / I15	Component Element Separator	M		1 / 1	**Enter the following: *":"*** (Colon) Type is not applicable; the component element separator is a delimiter and not a data element; this field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator

GS: Functional Group Header

The purpose of the functional group segment is to indicate the beginning of a functional group and to provide control information.

Loop : `Header`
Usage : `Required`
Repeat : `1`
Example : `GS*HC*SENDER CODE*RECEIVER CODE* 19940331* 0802* 1*X*005010X225~`

Table 2-2 Functional Group

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	GS01 / 479	Functional Identifier Code	M	ID	2 / 2	**Enter the following: *"HC"*** (Health Care Claim (837))
Required	GS02 / 142	Application Sender's Code	M	AN	2 / 15	Code identifying the party sending transmission ***Note:*** *Although this data element is required to create a valid ANSI 837, there are no NJ_HealthCAP-specific data requirements for this field.*
Required	GS03 / 124	Application Receiver's Code	M	AN	2 / 15	Code identifying the party receiving transmission ***Note:*** *Although this data element is required to create a valid ANSI 837, there are no NJ_HealthCAP-specific data requirements for this*

						field.
Required	GS04 / 373	Date	M	DT	8 / 8	**Enter the following:** Functional group creation date in ***CCYYMMDD*** *format.*
Required	GS05 / 337	Time	M	TM	4 / 8	**Enter the following:** Functional group creation time 24-hour military clock. The recommended format is ***HHMM.***
Required	GS06 / 28	Group Control Number	M	N0	1 / 9	Assigned number originated and maintained by the sender *in* ***GS06*** *and* ***GE02*** *must be identical*
Required	GS07 / 455	Responsible Agency Code	M	ID	1 / 2	**Enter the following:** ***"X"*** (for Accredited Standards Committee X12)
Required	GS08 / 480	Version / Release / Industry Identifier Code	M	AN	1 / 12	**Enter the following:** ***005010X225***

ST: Transaction Set Header

Loop : `Header`
Usage : `Required`
Repeat : `1`
Example : `ST*837*987654*005010X225~`

Table 2-3 Transaction Set Header

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	ST01 / 143	Transaction Set Identifier Code	M	ID	3 / 3	**Enter the following:** ***"837"*** (for Health Care Claim (837))
Required	ST02 / 329	Transaction Set Control Number	M	AN	4 / 9	Assigned number by the sender *in* ***ST02*** *and* ***SE02*** *must be identical*
Required	ST03 / 1705	Implementation Convention Reference	O	AN	1 / 35	**Enter the following:** ***005010X225*** (Draft Approved Standard for X12 5010) This field contains the same value as GS08

BHT: Beginning of Hierarchical Transaction

Loop : Header
Usage : Required
Repeat : 1
Example : BHT*0019*00*0123*19960618*0932~

Table 2-4 Beginning of Hierarchical Transaction

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	BHT01 / 1005	Hierarchical Structure Code	M	ID	4 / 4	**Enter the following:** ***"0019"*** (Information Source, Subscriber Dependent)
Required	BHT02 / 353	Transaction Set Purpose Code	M	ID	2 / 2	**Enter the following:** ***"00"*** (for original issue)
Required	BHT03 / 127	Reference Identification	O	AN	1 / 30	**Enter the following:** Originators assigned reference number
Required	BHT04 / 373	Date	O	DT	8 / 8	**Enter the following:** Transaction creation date ***CCYYMMDD***
Required	BHT05 / 337	Time	O	TM	4 / 8	**Enter the following:** 24-hour military clock ***HHMM*** format
Not Used	BHT06 / 640	Transaction Type Code	O	ID	2 / 2	

1000A: NM1: Submitter Name

Loop : 1000A – SUBMITTER NAME | Loop Repeat: 1
Usage : Required
Repeat : 1
Example : NM1*41*2*ABC Submitter*****46*999999999~

Table 2-5 Submitter Name

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	NM101 / 98	Entity Identifier Code	M	ID	2 / 3	**Enter the following:** ***"41"*** (Submitter)
Required	NM102 / 1065	Entity Type Qualifier	M	ID	1 / 1	**Enter the following:** **1** - Person **2 -** Non-Person Entity
Required	NM103 / 1035	Name – Last or Organization Name	O	AN	1 / 35	Submitter Last or Organization Name
Situational	NM104 / 1036	Name – First	O	AN	1 / 25	Submitter First Name
Situational	NM105 / 1037	Name – Middle	O	AN	1 / 25	Submitter Middle Name
Not Used	NM106 / 1038	Name – Prefix	O	AN	1 / 10	

Not Used	NM107 / 1039	Name – Suffix	O	AN	1 / 10	
Required	NM108 / 66	Identification Code Qualifier	X	ID	1 / 2	**Enter the following: *"46"*** (Electronic transmitter ID established by Trading Partner Agreement)
Required	NM109 / 67	Identification Code	X	AN	2 / 80	Submitter Identifier
Not Used	NM110 / 706	Entity Relationship Code	X	ID	2 / 2	
Not Used	NM111 / 98	Entity Identifier Code	O	ID	2 / 3	
Not Used	NM112 / 1035	Name Last or Organization Name	O	AN	1 / 60	

1000A: PER: Submitter Contact Information

Loop : `1000A – SUBMITTER NAME`
Usage : `Required`
Repeat : `2 (NJ HealthCAP 1)`
Example : `PER*IC*JANE DOE*TE*8009999999~`

Table 2-6 Submitter Contact Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	PER01 / 366	Contact Function Code	M	ID	2 / 2	
Required	PER02 / 93	Name	O	AN	1 / 60	**Enter the following:** Submitter Contact Name
Not Used	PER03 / 365	Communication Number Qualifier	X	ID	2 / 2	**Enter one of the following:** ***"EM"*** (for Electronic Mail) ***"FX"*** (for facsimile) ***"TE"*** (for Telephone Number)
Not Used	PER04 / 364	Communication Number	X	AN	1 / 256	**Enter the following:** Phone Number, including country or area code where applicable
Not Used	PER05 / 365	Communication Number Qualifier	X	ID	2 / 2	**Enter one of the following:** **"EM"** (for Electronic Mail) **"EX"** (for Telephone Extension) **"FX"** (for Facsimile) **"TE"** (for Telephone)
Not Used	PER06 / 364	Communication Number	X	AN	1 / 256	**Enter the following:** (Phone Number including country or area code where applicable)
Not Used	PER07 / 365	Communication Number Qualifier	X	ID	2 / 2	**Enter one of the following:** ***"EM"*** (for Electronic Mail) ***"EX"*** (for Telephone Extension) ***"FX"*** (for Facsimile) ***"TE"*** (for Telephone)

Not Used	PER08 / 364	Communication Number	X	AN	1 / 256	**Enter the following:** (Phone Number, including country or area code where applicable)
Not Used	PER09 / 443	Contact Inquiry Reference	O	AN	1 / 20	

1000B: NM1: Receiver Name

Loop : `1000B – RECEIVER NAME | Loop Repeat: 1`
Usage : `Required`
Repeat : `1`
Example : `NM1*40*2*NJDOH*****46*NJDOH ~`

Table 2-7 Receiver Name

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	NM101 / 98	Entity Identifier Code	M	ID	2 / 3	**Enter the following:** ***"40"*** (Receiver)
Required	NM102 / 1065	Entity Type Qualifier	M	ID	1 / 1	**Enter the following:** ***"2"*** (Non-Person Entity)
Required	NM103 / 1035	Name – Last or Organization Name	O	AN	1 / 60	***NJDOH (****New Jersey Department of Health)*
Not Used	NM104 / 1036	Name – First	O	AN	1 / 25	
Not Used	NM105 / 1037	Name – Middle	O	AN	1 / 25	
Not Used	NM106 / 1038	Name – Prefix	O	AN	1 / 10	
Not Used	NM107 / 1039	Name – Suffix	O	AN	1 / 10	
Required	NM108 / 66	Identification Code Qualifier	X	ID	2 / 80	**Enter the following:** ***"46"*** (Electronic Transmitter Identification Number (ETIN))
Required	NM109 / 67	Identification Code	X	AN	6 / 6	**Enter the following:** ***NJDOH*** (New Jersey Department of Health)
Not Used	NM110 / 706	Entity Relationship Code	X	ID	2 / 2	
Not Used	NM111 / 98	Entity Identifier Code	O	ID	2 / 3	
Not Used	NM112 / 1035	Name Last or Organization Name	O	AN	1 / 60	

2000A: HL: Service Provider Hierarchical Level

Loop : 2000A – SERVICE PROVIDER HIERARCHICAL LEVEL | Loop Repeat: >1
Usage : Required
Repeat : 1
Example : HL*1**20*1~

Table 2-8 Service Provider Hierarchical Level

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	HL01 / 628	Hierarchical Identifier Code	M	AN	1 / 12	**Enter the following:** Must begin with a "**1**" and increment by one each time an HL Segment is used. This will typically be a '1'
Not Used	HL02 / 734	Hierarchical Parent ID Number	O	AN	1 / 12	
Required	HL03 / 735	Hierarchical Level Code	M	ID	1 / 2	**Enter the following:** ***"20"*** (Information Source)
Required	HL04 / 736	Hierarchical Child Code	O	ID	1 / 1	**Enter the following:** ***"1"*** (Additional subordinate HL Data Segment in this Hierarchical Structure)

2010AA: NM1: Service Provider Name

Loop : 2010AA – SERVICE PROVIDER HIERARCHICAL LEVEL | Loop Repeat: 1
Usage : Required
Repeat : 1
Example : NM1*SJ*2*ABC HOSPITAL*****XX*1234567890~

Table 2-9 Service Provider Name

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	NM101 / 98	Entity Identifier Code	M	ID	2 / 3	**Enter the following:** ***"SJ"*** (Service Provider)
Required	NM102 / 1065	Entity Type Qualifier	M	ID	1 / 1	**Enter the following:** ***"2"*** (Non-Person Entity)
Required	NM103 / 1035	Name – Last or Organization Name	O	AN	1 / 60	**Enter the following:** Service Provider Last or Organizational Name
Not Used	NM104 / 1036	Name – First	O	AN	1 / 35	
Not Used	NM105 / 1037	Name – Middle	O	AN	1 / 25	
Not Used	NM106 / 1038	Name – Prefix	O	AN	1 / 10	
Not Used	NM107 / 1039	Name – Suffix	O	AN	1 / 10	

Required	NM108 / 66	Identification Code Qualifier	X	ID	1 / 2	**Enter the following:** ***"XX"*** National Provider Identifier
Required	NM109 / 67	Identification Code	X	AN	2 / 80	**Enter the following:** Service Provider Identifier Centers for Medicare and Medicaid Service National Provider Identifier
Not Used	NM110 / 706	Entity Relationship Code	X	ID	2 / 2	
Not Used	NM111 / 98	Entity Identifier Code	O	ID	2 / 3	
Not Used	NM112 / 1035	Name Last or Organization Name	O	AN	1 / 60	

2010AA: REF: Service Provider Secondary Identification

Loop : `2010AA – SERVICE PROVIDER NAME`
Usage : `Required`
Repeat : `4 (NJ HealthCAP 1)`
Example : `REF*IJ*123456789~`

Table 2-10 Service Provider Secondary Identification

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	REF01 / 128	Reference Identification Qualifier	M	ID	2 / 3	**Enter the following**: ***"1J"*** Facility ID Number
Required	REF02 / 127	Reference Identification	X	AN	1 / 50	**Enter the following:** ***NJDOH*** *Provider Number*
Not Used	REF03 / 352	Description	X	AN	1 / 80	
Not Used	REF04 / C040	Reference Identifier	O			

2000B: HL: Subscriber Hierarchical Level

If the insured and the patient are the same person, use this HL to identify the insured / patient, skip the subsequent (PATIENT) HL, and proceed directly to Loop ID-2300.

Loop : 2000B – SUBSCRIBER HIERARCHICAL LEVEL | Loop Repeat: >1
Usage : Required
Repeat : 1
Example : HL*2*1*22*1~

Table 2-11 Subscriber Hierarchical Level

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	HL01 / 628	Hierarchical ID Number	M	AN	1 / 12	HL01 must contain a unique alphanumeric number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.
Required	HL02 / 734	Hierarchical Parent ID Number	O	AN	1 / 12	HL02 identifies the hierarchical ID number of the HL segment to which the current HL segment is subordinate.
Required	HL03 / 735	Hierarchical Level Code	M	ID	1 / 2	HL03 indicates the context of the series of segments following the current HL segment up to the next occurrence of an HL segment in the transaction. **Enter the following**: ***"22"*** (Subscriber)
Required	HL04 / 736	Hierarchical Child Code	O	ID	1 / 1	HL04 indicates whether there are subordinate (or child) HL segments related to the current HL Segment. **Enter one of the following:** ***"0"*** -- No subordinate HL segment in this hierarchical structure ***"1"*** -- Additional subordinate HL Data segment in this hierarchical structure

2010B: SBR: Subscriber Information

Loop : 2000B – SUBSCRIBER HIERARCHICAL LEVEL
Usage : Required
Repeat : 1
Example : SBR*P**GRP01020102******CI~

Table 2-12 Subscriber Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	SBR01 / 1138	Payer Responsibility Sequence Number Code	M	ID	1 / 1	**Enter the following: *"P"***(Primary)
Situational	SBR02 / 1069	Individual Relationship Code	O	ID	2 / 2	**Enter the following: *"18"*** (Self)
Not Used	SBR03 / 127	Reference Identification	O	AN	1 / 30	Insured Policy or Group Number
Not Used	SBR04 / 93	Name	O	AN	1 / 60	Insured Group or Plan Name
Not Used	SBR05 / 1336	Insurance Type Code	O	ID	1 / 3	
Not Used	SBR06 / 1143	Coordination of Benefits Code	O	ID	1 / 1	
Not Used	SBR07 / 1073	Yes / No Condition or Response Code	O	ID	1 / 1	
Not Used	SBR08 / 584	Employment Status Code	O	ID	2 / 2	

Not Used	SBR09 / 1032	Claim Filling Indicator Code	O	ID	2 / 2	**Enter one of the following:** ***"09"*** (Self-Pay) ***"10"*** (Central Certification) ***"11"*** (Other Non-Federal Programs) ***"12"*** (Preferred Provider Organization (PPO)) ***"13"*** (Point of Service (POS)) **"14"** (Exclusive Provider Organization (EPO)) ***"15"*** (Indemnity Insurance) ***"16"*** (Health Maintenance Organization (HMO) Medicare Risk) ***"AM"*** (Automobile Medical) ***"BL"*** (Blue Cross / Blue Shield) ***"CHI***" (Champus) ***"CI"*** (Commercial Insurance Co.) ***"DS"*** (Disability) ***"HM"*** (Health Maintenance Organization) ***"LI"*** (Liability) ***"LM"*** (Liability Medical) ***"MA"*** (Medicare Part A) ***"MB"*** (Medicare Part B) ***"MC***" (Medicaid) ***"OF"*** (Other Federal Program) ***"TV"*** (Title V) ***"VA"*** (Veteran Administration Plan) ***"WC"*** (Workers' Compensation Health Claim) ***"ZZ"*** (Mutually Defined)

2000B: PAT: Patient Information

This segment is required when the patient is a same person as the patient Loop ID-2000B SBR02=18, and information in PAT09 is required by state or federal law or regulations. If not required by this implementation guide, do not send.

Loop : 2000B – PATIENT HIERARCHICAL LEVEL
Usage : Situational
Repeat : 1
Example : PAT*********Y~

Table 2-22 Patient Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Not Used	PAT01 / 1069	Individual Relationship Code	O	ID	2 / 2	
Not Used	PAT02 / 1384	Patient Location Code	O	ID	1 / 1	
Not Used	PAT03 / 584	Employment Status Code	O	ID	2 / 2	
Not Used	PAT04 / 1220	Student Status Code	O	ID	1 / 1	
Not Used	PAT05 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	PAT06 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	PAT07 / 355	Unit or Basis for Measurement Code	X	ID	2 / 2	
Not Used	PAT08 / 81	Weight	X	R	1 / 10	
Situational	PAT09 / 1073	Yes / No Condition or Response Code	O	ID	1 / 1	**Enter one of the following:** ***"N"*** (No) ***"U"*** (Unknown) ***"Y"*** (Yes)

2010BA: NM1: Subscriber Name

In worker's compensation or other property and casualty claims, the subscriber may be a non-person entity, such as the employer.

Loop : `2010BA – SUBSCRIBER NAME | Loop Repeat: 1`
Usage : `Required`
Repeat : `1`
Example : `NM1*IL*1*DOE*JOHN*T***MI*123456~`

Table 2-14 Subscriber Name

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	NM101 / 98	Entity Identifier Code	M	ID	2 / 3	**Enter the following: *"IL"*** (Insured or Subscriber)
Required	NM102 / 1065	Entity Type Qualifier	M	ID	1 / 1	**Enter one of the following:** ***"1"*** (Person Entity) ***"2"*** (Non-Person Entity)
Required	NM103 / 1035	Name – Last or Organization Name	O	AN	1 / 60	**Enter the following:** (Subscriber Last Name)
Situational	NM104 / 1036	Name – First	O	AN	1 / 35	Subscriber First Name
Situational	NM105 / 1037	Name – Middle	O	AN	1 / 25	Subscriber Middle Name
Not Used	NM106 / 1038	Name – Prefix	O	AN	1 / 10	
Not Used	NM107 / 1039	Name – Suffix	O	AN	1 / 10	

Required	NM108 / 66	Identification Code Qualifier	X	ID	1 / 2	**Enter the following: *"MI"*** Member Identification Number
Required	NM109 / 67	Identification Code	X	AN	2 / 80	**Enter the following:** (**Subscriber / Member ID**) ***NJ HealthCAP*** – Insured ID, HIC number
Not Used	NM110 / 706	Entity Relationship Code	X	ID	2 / 2	
Not Used	NM111 / 98	Entity Identifier Code	O	ID	2 / 3	
Not Used	NM112 / 1035	Name Last or Organization Name	O	AN	1 / 60	

2010BA: N3: Subscriber Address

This segment is required when the patient is the same person as the subscriber. (Required when Loop ID 2000B | SBR02 =18 (self)).

Loop : 2010BA – SUBSCRIBER NAME
Usage : Situational
Repeat : 1
Example : N3*125 CITY AVENUE ~

Table 2-15 Subscriber Address

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	N301 / 166	Address Information	M	AN	1 / 55	**Enter the following:** (Subscriber Address Line)
Situational	N302 / 166	Address Information	O	AN	1 / 55	**Enter the following:** (Subscriber Address Line)

2010BA: N4: Subscriber City, State, ZIP Code

This segment is required when the patient is the same person as the subscriber. (Required when Loop ID 2000B | SBR02 =18 (self)).

Loop : 2010BA – SUBSCRIBER NAME
Usage : Situational
Repeat : 1
Example : N4*CENTERVILLE*PA*17111~

Table 2-16 Subscriber City, State, ZIP Code

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	N401 / 19	City Name	O	AN	2 / 30	**Enter the following:** (Subscriber City Name)
Required	N402 / 156	State or Province Code	O	ID	2 / 2	**Enter one of the following:** Subscriber State Code Code Source "22": States and Outlying Areas of the U.S. "XX" (Report state code for foreign (outside of US and Canada) patients)
Required	N403 / 116	Postal Code	O	ID	3 / 15	**Enter the following:** Subscriber Postal Zone or Zip Code
Situational	N404 / 26	Country Code	O	ID	2 / 3	**Required** if address is outside of the US Code Source "5": Countries, Currencies and Funds
Not Used	N405 / 309	Location Qualifier	X	ID	1 / 2	
Not Used	N406 / 310	Location Identifier	O	AN	1 / 30	
Not Used	N407 / 1715	Country Subdivision Code	X	ID	1 / 3	

2010BA: DMG: Subscriber Demographic Information

This segment is required when the patient is the same person as the subscriber. (Required when Loop ID 2000B | SBR02 = 18 (self)). In DMG05, report the race code first, and then the ethnicity code.

Loop : 2010BA – SUBSCRIBER NAME
Usage : Situational
Repeat : 1
Example : DMG*D8*19290730*M*I*:RET:10025^:RET:21337~

Table 2-17 Subscriber Demographic Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	DMG01 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following: *"D8"*** CCYYMMDD
Required	DMG02 / 1251	Date Time Period	X	AN	8 / 8	Subscriber Birth Date
Required	DMG03 / 1068	Gender Code	O	ID	1 / 1	**Enter one of the following:** ***"F"*** (Female) ***"M"*** (Male) ***"U"*** (Undetermined)
Required	DMG04 / 1067	Marital Status Code	O	ID	1 / 1	**Enter one of the following:** ***"A"*** (COMMON LAW) ***"B"*** (REGISTERED DOMESTIC PARTNER) ***"C"*** (NOT APPLICABLE) ***"D"*** (DIVORCED) ***"I"*** (SINGLE) ***"K"*** (UNKNOWN) ***"M"*** (MARRIED / CIVIL UNION) ***"R"*** (UNREPORTED) ***"S"*** (SEPARATED) ***"U"*** (UNMARRIED) ***"W"*** (WIDOWED) ***"X"*** (Legally Separated) **SITUATIONAL RULE:** The patient marital status code is to be reported when required by state or federal law of regulations.
Required	DMG05 / C056	Composite Race or Ethnicity Information	X		1 / 10	To send general and detailed information on the race and ethnicity
Not Used	DMG05-1 / 1109	Race or Ethnicity Code	O	ID	1 / 1	
Required	DMG05-2 / 1270	Code List Qualifier Code	X	ID	1 / 3	**Enter the following: *"RET"*** (Classification of Race or Ethnicity)

Required	DMG05-3 / 1271	Industry Code	X	AN	1 / 30	Code Identifying a code from a specific industry code list. **Note**: Please refer to the NJ HealthCAP data dictionary for a complete list of codes allowable here. *The Race code should be reported after the first RET qualifier, and the Ethnicity code after the second RET qualifier.*
Not Used	DMG06 / 1066	Citizenship Status Code	O	ID	1 / 2	
Not Used	DMG07 / 26	Country Code	O	ID	2 / 3	
Not Used	DMG08 / 659	Basis of Verification Code	O	ID	1 / 2	
Not Used	DMG09 / 380	Quantity	O	R	1 / 15	
Not Used	DMG10 / 1270	Code List Qualifier Code	X	ID	1 / 3	
Not Used	DMG11 / 1271	Industry Code	X	AN	1 / 30	

2010BA: REF: Subscriber Secondary Identification

This field is optional, but if provided will be used by the NJ HealthCAP to track patients with multiple admission. If provided, usage for this field is when subscriber is the patient.

Loop : `2010BA – SUBSCRIBER NAME`
Usage : `Situational`
Repeat : `4 (NJ HealthCAP - 1)`
Example : `REF*SY*030385074~`

Table 2-18 Subscriber Secondary Identification

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	REF01 / 128	Reference Identification Qualifier	M	ID	2 / 3	**Enter the following: *"SY"*** (Social Security Number)
Required	REF02 / 127	Reference Identification	X	AN	1 / 30	**Enter the following:** "Social Security Number"
Not Used	REF03 / 352	Description	X	AN	1 / 80	
Not Used	REF04 / C040	Reference Identifier	O			

2010BB: NM1: Payer Name

This is the primary payer or only payer.

Loop : 2010BB – PAYER NAME | Loop Repeat: 1
Usage : Required
Repeat : 1
Example : NM1*PR*2*ABC INSURANCE CO*****PI*059~

Table 2-19 Payer Name

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	NM101 / 98	Entity Identifier Code	M	ID	2 / 3	**Enter the following: *"PR"*** (Payer)
Required	NM102 / 1065	Entity Type Qualifier	M	ID	1 / 1	**Enter one of the following: *"2"*** (Non-Person Entity)
Not Used	NM103 / 1035	Name – Last or Organization Name	O	AN	1 / 60	**Enter the following:** (Payer Last Name)
Not Used	NM104 / 1036	Name – First	O	AN	1 / 35	
Not Used	NM105 / 1037	Name – Middle	O	AN	1 / 25	
Not Used	NM106 / 1038	Name – Prefix	O	AN	1 / 10	
Not Used	NM107 / 1039	Name – Suffix	O	AN	1 / 10	
Required	NM108 / 66	Identification Code Qualifier	X	ID	1 / 2	**Enter one of the following:** ***"PI"*** (Payer Identification) ***"XV"*** (Centers for Medicare and Medicaid Services Plan ID). **Note:** XV is required when the National Plan ID is implemented
Required	NM109 / 67	Identification Code	X	AN	2 / 80	**Enter the following: *"NNN"*** (NJDOH Primary Payer Code)
Not Used	NM110 / 706	Entity Relationship Code	X	ID	2 / 2	
Not Used	NM111 / 98	Entity Identifier Code	O	ID	2 / 3	
Not Used	NM112 / 1035	Name Last or Organization Name	O	ID	1 / 60	

2010BB: REF: Payer Secondary Identification

Loop : 2010BB – PAYER NAME
Usage : Situational (NJ HealthCAP – Optional)
Repeat : 3 (NJ HealthCAP – 1)
Example : REF*FY*030385074~

Table 2-20 Payer Secondary Identification

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	REF01 / 128	Reference Identifier Qualifier	M	ID	2 / 3	
Required	REF02 / 127	Reference Identification	X	AN	1 / 50	
Not Used	REF03 / 352	Description	X	AN	1 / 80	
Not Used	REF04 / C040	Reference Identifier	O			

2000C: HL: Patient Hierarchical Level

This segment is required when the patient is a different person than the subscriber. There are no HLs subordinate to the Patient HL.

Loop : 2000C – PATIENT HIERARCHICAL LEVEL | Loop Repeat: >1
Usage : Situational
Repeat : 1
Example : HL*3*2*23*0~

Table 2-21 Patient Hierarchical Level

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	HL01 / 628	Hierarchical ID Number	M	AN	1 / 12	A Unique number assigned by the sender to identify a particular data segment in a hierarchical structure. Should contain a unique alphanumerical number for each occurrence of the HL segment in the transaction set. For example, HL01 could be used to indicate the number of occurrences of the HL segment, in which case the value of HL01 would be "1" for the initial HL segment and would be incremented by one in each subsequent HL segment within the transaction.
Required	HL02 / 734	Hierarchical Parent ID Number	O	AN	1 / 12	Identification number of the next higher hierarchical data segment that the data segment being described is subordinate to.
Required	HL03 / 735	Hierarchical Level Code	M	ID	1 / 2	**Enter the following: *"23"*** (Dependent)
Required	HL04 / 736	Hierarchical Child Code	O	ID	1 / 1	**Enter the following: *"0"*** (No Subordinate HL Segment in This Hierarchical Structure The claim loop (Loop ID-2300) can be used only when HL04 has no subordinate levels (HL04 = 0).

2000C: PAT: Patient Information

This segment is required when the patient is a different person than the subscriber.

Loop : `2000C – PATIENT HIERARCHICAL LEVEL`
Usage : `Situational`
Repeat : `1`
Example : `PAT*19********N ~`

Table 2-22 Patient Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	PAT01 / 1069	Individual Relationship Code	O	ID	2 / 2	**Enter one of the following:** ***"01"*** (SPOUSE) ***"19"*** (CHILD) ***"20"*** (EMPLOYEE) ***"21"*** (UNKNOWN) ***"39"*** (ORGAN DONOR) ***"40"*** (CADAVER DONOR) ***"53"*** (LIFE PARTNER) ***"G8"*** (OTHER RELATIONSHIP)
Not Used	PAT02 / 1384	Patient Location Code	O	ID	1 / 1	
Not Used	PAT03 / 584	Employment Status Code	O	ID	2 / 2	
Not Used	PAT04 / 1220	Student Status Code	O	ID	1 / 1	
Not Used	PAT05 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	PAT06 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	PAT07 / 355	Unit or Basis for Measurement Code	X	ID	2 / 2	
Not Used	PAT08 / 81	Weight	X	R	1 / 10	
Not Used	PAT09 / 1073	Yes / No Condition or Response Code	O	ID	1 / 1	**Enter one of the following:** ***"N"*** (No) ***"U"*** (Unknown) ***"Y"*** (Yes)

2010CA: NM1: Patient Name

The segment is required when the patient is a different person than the subscriber.

Loop : `2010CA – PATIENT NAME | Loop Repeat: 1`
Usage : `Required`
Repeat : `1`
Example : `NM1*QC*1*DOE*SALLY*J ~`

Table 2-23 Patient Name

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	NM101 / 98	Enter Identifier Code	M	ID	2 / 3	**Enter the following:** ***"QC"*** Patient
Required	NM102 / 1065	Entity Type Qualifier	M	ID	1 / 1	**Enter the following:** ***"1"*** (Person)

Required	NM103 / 1035	Name Last or Organization Name	O	AN	1 / 60	**Enter the following:** Patient Last Name
Required	NM104 / 1036	Name First	O	AN	1 / 35	**Enter the following:** Patient First Name
Situational	NM105 / 1037	Name Middle	O	AN	1 / 25	**Enter the following:** Patient Middle Name
Not Used	NM106 / 1038	Name Prefix	O	AN	1 / 10	
Not Used	NM107 / 1039	Name Suffix	O	AN	1 / 10	**Enter the following:** Patient Name Suffix
Not Used	NM108 / 66	Identification Code Qualifier	X	ID	1 / 2	
Not Used	NM109 / 67	Identification Code	X	AN	2 / 80	
Not Used	NM110 / 706	Entity Relationship Code	X	ID	2 / 2	
Not Used	NM111 / 98	Entity Identifier Code	O	ID	2 / 3	
Not Used	NM112 / 1035	Name Last or Organization Name	O	AN	1 / 60	

2010CA: N3: Patient Address

This segment is required when the patient is a different person than the subscriber.

Loop : `2010CA – PATIENT NAME`
Usage : `Required`
Repeat : `1`
Example : `N3*RFD 10*100 COUNTRY LANE~`

Table 2-24 Patient Address

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	N301 / 166	Address Information	M	AN	1 / 55	**Enter the following:** (Patient Address Line)
Situational	N302 / 166	Address Information	O	AN	1 / 55	**Enter the following:** (Patient Address Line)

2010CA: N4: Patient City, State, ZIP Code

This segment is required when the patient is a different person than the subscriber.

Loop : 2010CA – PATIENT NAME
Usage : Required
Repeat : 1
Example : N4*CORNFIELD TOWNSHIP*IA*99999~

Table 2-25 Patient City, State, ZIP Code

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	N401 / 19	City Name	O	AN	2 / 30	**Enter the following:** (Patient City Name)
Required	N402 / 156	State or Province Code	O	ID	2 / 2	**Enter the following:** (Patient State Code) aa: US State or Canadian Providence Code. Code Source 22: States and Outlying area of the US xx: Foreign address
Required	N403 / 116	Postal Code	O	ID	3 / 15	**Enter the following:** (Patient Postal Code or Zip Code)
Situational	N404 / 26	Country Code	O	ID	2 / 3	Required if Address is outside of US **Note:** Please refer to the NJ HealthCAP data dictionary for a complete list of codes allowable here.
Not Used	N405 / 309	Location Qualifier	X	ID	1 / 2	Qualifying code for the 2010CA Patient City Zip Code
Not Used	N406 / 310	Location Identifier	O	AN	1 / 30	
Not Used	N407 / 1715	Country Subdivision Code	X	ID	1 / 3	

2010CA: DMG: Patient Demographic Information

This segment is required when the patient is a different person than the subscriber.
Note: *In DMG05, report the race code first, and then the ethnicity code.*

Loop : 2010CA – PATIENT NAME
Usage : Required
Repeat : 1
Example : DMG*D8*19290730*M*I*:RET:10025^:RET:21337~

Table 2-26 Patient Demographic Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	DMG01 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following: *"D8"***
Required	DMG02 / 1251	Date Time Period	X	AN	8 / 8	**Enter the following:** Patient Birth Date in Format ***CCYYMMDD***
Required	DMG03 / 1068	Gender Code	O	ID	1 / 1	**Enter one of the following:** ***"F"*** (Female) ***"M"*** (Male) ***"U"*** (Unknown)
Required	DMG04 / 1067	Marital Status Code	O	ID	1 / 1	**Enter one of the following:** ***"A"*** (Common Law) ***"B"*** (Registered Domestic Partner) ***"C"*** (Not Applicable) ***"D"*** (Divorced) ***"I"*** (Single) ***"K"*** (Unknown) ***"M"*** (Married / Civil Union) ***"R"*** (Unreported) ***"S"*** (Separated) ***"U"*** (Unmarried) ***"W"*** (Widowed) ***"X"*** (Legally Separated)
Required	DMG05 / C056	Composite Race or Ethnicity Information	X		1 / 10	To send general and detailed information on the race and ethnicity
Not Used	DMG05-1 / 1109	Race or Ethnicity Code	O	ID	1 / 1	
Required	DMG05-2 / 1270	Code List Qualifier Code	X	ID	1 / 3	**Enter the following: *"RET"*** (Classification of Race or Ethnicity)
Required	DMG05-3 / 1271	Industry Code	X	AN	1 / 30	Code Identifying a code from a specific industry code list. **Note**: Please refer to the NJ HealthCAP Data dictionary for a complete list of codes allowable here
Not Used	DMG06 / 1066	Citizenship Status Code	O	ID	1 / 2	
Not Used	DMG07 / 26	Country Code	O	ID	2 / 3	
Not Used	DMG08 / 659	Basis of Verification Code	O	ID	1 / 2	
Not Used	DMG09 / 380	Quantity	O	R	1 / 15	
Not Used	DMG10 / 1270	Code List Qualifier Code	X	ID	1 / 3	
Not Used	DMG11 / 1271	Industry Code	X	AN	1 / 30	

2010CA: REF: Patient Secondary Identification

This field is optional, but if provided will be used by the NJ HealthCAP to track patients with multiple admission. If provided, usage for this field is when the patient is a different person than the subscriber.

Loop : 2010CA – PATIENT NAME
Usage : Required
Repeat : 4 (NJ HealthCAP – 1)
Example : REF*SY*443101012~

Table 2-27 Patient Secondary Identification Number

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	REF01 / 128	Reference Identification Qualifier	M	ID	2 / 3	**Enter the following: *"SY"*** (Social Security Number)
Required	REF02 / 127	Reference Identification	X	AN	1 / 30	**Enter the following:** Social Security Number
Not Used	REF03 / 352	Description	X	AN	1 / 80	
Not Used	REF04 / C040	Reference Identifier	O			

2300: CLM: Claim Information

For purposes of this documentation, the claim detail information is presented only in the dependent level. Specific claim detail information can be given in either the subscriber or the dependent hierarchical level. Because of this ability the claim information is said to "float." Claim information is positioned in the same hierarchical level that describes its owner-participant, either the subscriber or the dependent. In other words, the claim information, loop 2300, is placed following loop 2010BB in the subscriber hierarchical level when the patient is the subscriber, or it is placed at the patient / dependent hierarchical level when the patient is the dependent of the subscriber as shown here. When the patient is the subscriber, loops 2000C and 2010CA are not sent.

Loop : 2300 – CLAIM INFORMATION | Loop Repeat: 100
Usage : Required
Repeat : 1
Example : CLM*01319300001*500***011:A:1 ~

Table 2-28 Claim Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	CLM01 / 1028	Claim Submitter's Identifier	M	AN	1 / 38	***Patient Control Number*** (Maximum field length 20)
Required	CLM02 / 782	Monetary Amount	O	R	1 / 18	Monetary Amount (Total Claim Charge Amount). This amount is the total of the charges in the SV2 segments. Zero (0) is not a valid Amount.
Not Used	CLM03 / 1032	Claim Filling Indicator Code	O	ID	1 / 2	
Not Used	CLM04 / 1343	Non-Institutional Claim Type Code	O	ID	1 / 2	
Required	CLM05 / C023	Health Care Service Location Information	O			**Enter the following:** Type of Bill
Required	CLM05-1 / 1331	Facility Code Value	M	AN	1 / 3	**Enter the following:** Facility Type Code
Required	CLM05-2 / 1332	Facility Code Qualifier	O	ID	1 / 2	**Enter the following:** ***"A"*** (Uniform Billing Claim Form Bill Type)
Required	CLM05-3 / 1325	Claim Frequency Type Code	O	ID	1 / 1	**Enter the following:** Claim Frequency Code
Not Used	CLM06 / 1073	Yes / No Condition or Response Code	O	ID	1 / 1	
Not Used	CLM07 / 1359	Provider Accept Assignment Code	O	ID	1 / 1	
Not Used	CLM08 / 1073	Yes / No Condition or Response Code	O	ID	1 / 1	
Not Used	CLM09 / 1363	Release of Information Code	O	ID	1 / 1	
Not Used	CLM10 / 1351	Patient Signature Source Code	O	ID	1 / 1	
Not Used	CLM11 / C024	Related Causes Information	O			
Not Used	CLM12 / 1366	Special Program Code	O	ID	2 / 3	
Not Used	CLM13 / 1073	Yes / No Condition or Response Code	O	ID	1 / 1	
Not Used	CLM14 / 1338	Level of Service Code	O	ID	1 / 3	
Not Used	CLM15 / 1073	Yes / No Condition or Response Code	O	ID	1 / 1	
Not Used	CLM16 / 1360	Provider Agreement Code	O	ID	1 / 1	
Not Used	CLM17 / 1029	Claim Status Code	O	ID	1 / 2	
Not Used	CLM18 / 1073	Yes / No Condition or Response Code	O	ID	1 / 1	
Not Used	CLM19 / 1383	Claim Submission Reason Code	O	ID	2 / 2	
Not Used	CLM20 / 1514	Delay Reason Code	O	ID	1 / 2	

2300: DTP: Discharge Date and Hour

This segment is required on all final inpatient claims / encounters (XXX1, XXX4, XXX5 and XXX7).

Loop : 2300 – CLAIM INFORMATION
Usage : Situational
Repeat : 1
Example : DTP*096*DT*200610271130~

Table 2-29 Discharge Date and Hour

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	DTP01 / 374	Date / Time Qualifier	M	ID	3 / 3	**Enter the following:** ***"096 "***(Discharge)
Required	DTP02 / 1250	Date Time Period Format Qualifier	M	ID	2 / 3	**Enter the following: *"DT"*** (Date and Time Expressed in Format ***CCYYMMDDHHMM***)
Required	DTP03 / 1251	Date Time Period	M	AN	1 / 35	Discharge Hour. Expression of a date, a time, or range of dates, times or dates and times.

2300: DTP: Statement Dates

Loop : 2300 – CLAIM INFORMATION
Usage : Required
Repeat : 1
Example : DTP*434*RD8*19981209-19981214~

Table 2-30 Statement Dates

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	DTP01 / 374	Date / Time Qualifier	M	ID	3 / 3	**Enter the following: *"434"*** (Statement)
Required	DTP02 / 1250	Date / Time Format Qualifier	M	ID	2 / 3	**Enter the following*: "RD8"*** (Range of Dates Expressed in Format ***CCYYMMDD-CCYYMMDD***)
Required	DTP03 / 1251	Date Time Period	M	AN	1 / 35	**Enter the following:** Statement From or To Date

2300: DTP: Admission Date and Hour

Loop : 2300 – CLAIM INFORMATION
Usage : Required
Repeat : 1
Example : DTP*435*DT*19961013~

Table 2-31 Admission Date and hour

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	DTP01 / 374	Date / Time Qualifier	M	ID	3 / 3	**Enter the following: *"435"*** (Admission)
Required	DTP02 / 1250	Date / Time Format Qualifier	M	ID	2 / 3	**Enter the following: *"DT"*** (Range of Dates Expressed in Format ***CCYYMMDDHHMM***)
Required	DTP03 / 1251	Date Time Period	M	AN	1 / 35	**Enter the following:** Admission Date and Hour

2300: CL1: Institutional Claim Code

Loop : 2300 – CLAIM INFORMATION
Usage : Required
Repeat : 1
Example : CL1*1*7*30~

Table 2-32 Institutional Claim Code

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	CL101 / 1315	Priority of Visit Code	O	ID	1 / 1	Code indicating the priority of admission. Please refer to the NJ HealthCAP Data Dictionary for a list of valid codes for this field.
Required	CL102 / 1314	Point of Origin Code	O	ID	1 / 1	Code indicating the patient's point of origin of this admission. Please refer to the NJ HealthCAP Data Dictionary for a list of valid codes for this field.

Required	CL103 / 1352	Patient Status Code	O	ID	1 / 2	Code indicating the patient status as of the "statement covers through date". Please refer to the NJ HealthCAP Data Dictionary for a list of valid codes for this field.
Not Used	CL104 / 1345	Nursing Home Residential Status Code	O	ID	1 / 1	

2300: PWK: Claim Supplemental Information

This segment is required when there is either a paper attachment following this claim, or when there are electronic attachments transmitted in another functional group.

Loop : `2300 – CLAIM INFORMATION`
Usage : `Situational`
Repeat : `10`
Example : `PWK*OB*BM***AC*DMN0012~`

Table 2-33 Claim Supplemental Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	PWK01 / 755	Report Type Code	M	ID	2 / 2	
Required	PWK02 / 756	Report Transmission	O	ID	1 / 2	
Not Used	PWK03 / 757	Report Copies Needed	O	N0	1 / 2	
Not Used	PWK04 / 98	Entity Identifier Code	O	ID	2 / 3	
Required	PWK05 / 66	Identification Code Qualifier	X	ID	1 / 2	**Enter the following: *"AC"*** (Attachment Control Number)
Required	PWK06 / 67	Identification Code	X	AN	2 / 80	Code identifying a party or other code
Not Used	PWK07 / 352	Description	O	AN	1 / 80	
Not Used	PWK08 / C002	Actions Indicated	O			
Not Used	PWK09 / 1525	Request Category Code	O	ID	1 / 2	

2300: AMT: Payer Estimated Amount Due

This segment is required when any NJ HealthCAP payer code on this claim is not 031 or 039 (self-pay).

Loop : 2300 – CLAIM INFORMATION
Usage : Situational
Repeat : 1
Example : AMT*C5*1996~

Table 2-34 Payer Estimated Amount Due

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	AMT01 / 522	Amount Qualifier Code	M	ID	1 / 3	**Enter the following: *"C5"*** (Claim Amount Due - Estimated)
Required	AMT02 / 782	Monetary Amount	M	R	1 / 18	Estimated Claim Due Amount
Not Used	AMT03 / 478	Credit / Debit Flag Code	O	ID	1 / 1	

2300: AMT: Patient Estimated Amount Due

This segment is required when the only NJ HealthCAP payer code present is 039 or 031 (self-pay) on this claim.

Loop : 2300 – CLAIM INFORMATION
Usage : Situational
Repeat : 1
Example : AMT*F3*123~

Table 2-35 Patient Estimated Amount Due

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	AMT01 / 522	Amount Qualifier Code	M	ID	1 / 3	**Enter the following: *"F3"*** (Patient Responsibility - Estimated)
Required	AMT02 / 782	Monetary Amount	M	R	1 / 18	Patient Responsibility Amount
Not Used	AMT03 / 478	Credit / Debit Flag Code	O	ID	1 / 1	

2300: REF: Auto Accident State

This segment is required when the services reported on this claim are related to an auto accident and the accident occurred in the US or Canada.

Loop : 2300 – CLAIM INFORMATION
Usage : Situational
Repeat : 1
Example : REF*LU*NJ ~

Table 2-36 Auto Accident State

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	REF01 / 128	Reference Identification Qualifier	M	ID	2 / 3	**Enter the following: *"LU"*** (Location Number)
Required	REF02 / 127	Reference Identification	X	AN	1 / 50	Auto Accident State or Province Code Please refer NJ HealthCAP Data Dictionary for a list of valid state and province code.
Not Used	REF03 / 352	Description	X	AN	1 / 80	
Not Used	REF04 / C040	Reference Identifier	O			

2300: REF: Medical Record Number

Loop : 2300 – CLAIM INFORMATION
Usage : Required
Repeat : 1
Example : REF*EA*1230484376R ~

Table 2-37 Medical Record Number

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	REF01 / 128	Reference Identification Qualifier	M	ID	2 / 3	**Enter the following: *"EA"*** (Medical Record Identification Number)
Required	REF02 / 127	Reference Identification	X	AN	1 / 50	**Enter the following:** Medical Record Number
Not Used	REF03 / 352	Description	X	AN	1 / 80	
Not Used	REF04 / C040	Reference Identifier	O			

2300: REF: Mother's Medical Record for Newborns

This segment is required on all newborn claims for which the birth occurred in-house and on the date of admission.

Loop : 2300 – CLAIM INFORMATION
Usage : Situational
Repeat : 1
Example : REF*MRN*1230484376R~

Table 2-38 Mother's Medical Record For Newborns

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	REF01 / 128	Reference Identification Qualifier	M	ID	2 / 3	**Enter the following: *"MRN"*** (Mother's Medical Record Identification Number)
Required	REF02 / 127	Reference Identification	X	AN	1 / 50	**Enter the following:** Mother's Medical Record Number
Not Used	REF03 / 352	Description	X	AN	1 / 80	
Not Used	REF04 / C040	Reference Identifier	O			

2300: K3: File Information

Loop : 2300 – CLAIM INFORMATION
Usage : Required
Repeat : 10 (NJ HealthCAP – 1)
Example : K3*150811111111112222222222NMANAGER IENG~

Table 2-39 File Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	K301 / 449	Fixed Format Information	M	AN	1 / 80	Data in a fixed form agreed upon by sender and receiver
Not Used	K302 / 1332	Record Format Code	O	ID	1 / 2	
Not Used	K303 / C001	Composite Unit of Measure	O			

K301 Layout:

Data Element	Length	Type
Residence Code	4	N
Transfer In Code	10	N
Transfer Out Code	10	N
Readmission Code	1	C
Occupation	20	C
I/O Indicator	1	C
Primary Language Spoken	3	C
Total	**49**	

Notes: Spaces equaling the data element length must be used if a data element cannot be supplied.

2300: NTE: Claim Note

Loop : 2300 – CLAIM INFORMATION
Usage : Situational (NJ HealthCAP – Optional)
Repeat : 10
Example : NTE*DGN*PATIENT REQUIRES TUBE FEEDING~

Table 2-40 Claim Note

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	NTE01 / 363	Note Reference Code	O	ID	3 / 3	Code Identifying the functional area or purpose for which the note applies
Required	NTE02 / 352	Description	M	AN	1 / 80	A free-form description to clarify the related data element and their content

2300: HI: Principal Diagnosis

Loop : 2300 – CLAIM INFORMATION
Usage : Required
Repeat : 1
Example : HI*ABK:9976:::::::Y~

Table 2-41 Principal Diagnosis

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	HI01 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI01-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following:** ***"ABK"*** (Principal Diagnosis(ICD-10-CM))
Required	HI01-2 / 1271	Industry Code	M	AN	1 / 30	Code Identifying a code from a specific industry code list
Not Used	HI01-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI01-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI01-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI01-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI01-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI01-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI01-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	**Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Not Used	HI02 / C022	Health Care Code Information	O			
Not Used	HI03 / C022	Health Care Code Information	O			
Not Used	HI04 / C022	Health Care Code Information	O			
Not Used	HI05 / C022	Health Care Code Information	O			
Not Used	HI06 / C022	Health Care Code Information	O			
Not Used	HI07 / C022	Health Care Code Information	O			
Not Used	HI08 / C022	Health Care Code Information	O			
Not Used	HI09 / C022	Health Care Code Information	O			
Not Used	HI10 / C022	Health Care Code Information	O			
Not Used	HI11 / C022	Health Care Code Information	O			
Not Used	HI12 / C22	Health Care Code Information	O			

2300: HI: Admitting Diagnosis

This segment is required on inpatient claims.

Loop : 2300 – CLAIM INFORMATION
Usage : Situational
Repeat : 1
Example : HI*ABJ:9976~

Table 2-42 Admitting Diagnosis

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	HI01 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI01-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following:** ***"ABJ"*** (Admitting Diagnosis (ICD-10-CM))
Required	HI01-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list
Not Used	HI01-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI01-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI01-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI01-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI01-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI01-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI01-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Not Used	HI02 / C022	Health Care Code Information	O			
Not Used	HI03 / C022	Health Care Code Information	O			
Not Used	HI04 / C022	Health Care Code Information	O			
Not Used	HI05 / C022	Health Care Code Information	O			
Not Used	HI06 / C022	Health Care Code Information	O			
Not Used	HI07 / C022	Health Care Code Information	O			
Not Used	HI08 / C022	Health Care Code Information	O			
Not Used	HI09 / C022	Health Care Code Information	O			
Not Used	HI10 / C022	Health Care Code Information	O			
Not Used	HI11 / C022	Health Care Code Information	O			
Not Used	HI12 / C022	Health Care Code Information	O			

2300: HI: Patient Reason for Visit

This segment is required on outpatient claims.

Loop : 2300 – CLAIM INFORMATION
Usage : Situational
Repeat : 1
Example: HI*APR:99376*APR:75108*APR:0381~

Table 2-43 Patient Reason for Visit

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	HI01 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI01-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following:** ***"APR"*** (Patient Reason for Visit(ICD-10-CM))
Required	HI01-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list.
Not Used	HI01-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI01-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI01-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI01-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI01-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI01-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI01-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI02 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI02-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following:** ***"APR"*** (Patient Reason for Visit(ICD-10-CM))
Required	HI02-2 / 1271	Industry Code	M	AN	1 / 30	Code Identifying a code from a specific industry code list.
Not Used	HI02-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI02-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI02-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI02-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI02-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI02-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI02-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI03 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI03-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter one of the following:**

						"APR" (Patient Reason for Visit(ICD-10-CM))
Required	HI03-2 / 1271	Industry Code	M	AN	1 / 30	Code Identifying a code from a specific industry code list.
Not Used	HI03-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI03-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI03-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI03-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI03-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI03-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI03-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Not Used	HI04 / C022	Health Care Code Information	O			
Not Used	HI05 / C022	Health Care Code Information	O			
Not Used	HI06 / C022	Health Care Code Information	O			
Not Used	HI07 / C022	Health Care Code Information	O			
Not Used	HI08 / C022	Health Care Code Information	O			
Not Used	HI09 / C022	Health Care Code Information	O			
Not Used	HI10 / C022	Health Care Code Information	O			
Not Used	HI11 / C022	Health Care Code Information	O			
Not Used	HI12 / C022	Health Care Code Information	O			

2300: HI: External Cause of Injury

This segment is required when an external cause of injury is needed to describe an injury, poisoning, or adverse effect.

Loop : `2300 – CLAIM INFORMATION`
Usage : `Situational`
Repeat : `1`
Example : `HI*ABN:E9782:::::::N*ABN:E4125:::::::Y ~`

Table 2-4 External Cause of Injury

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	HI01 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI01-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter one of the following:** ***"ABN"*** - EXTERNAL CAUSE OF INJURY (ICD-10-CM)
Required	HI01-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: External Cause of Injury
Not Used	HI01-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI01-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI01-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI01-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI01-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI01-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI01-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI02 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI02-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter one of the following:** ***"ABN"*** - EXTERNAL CAUSE OF INJURY (ICD-10-CM)
Required	HI02-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: External Cause of Injury
Not Used	HI02-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI02-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI02-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI02-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI02-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI02-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI02-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI03 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.

Required	HI03-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter one of the following:** ***"ABN"*** - EXTERNAL CAUSE OF INJURY (ICD-10-CM)
Required	HI03-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: External Cause of Injury
Not Used	HI03-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI03-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI03-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI03-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI03-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI03-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI03-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI04 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI04-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter one of the following:** ***"ABN"*** - EXTERNAL CAUSE OF INJURY (ICD-10-CM)
Required	HI04-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: External Cause of Injury
Not Used	HI04-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI04-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI04-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI04-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI04-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI04-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI04-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI05 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI05-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter one of the following:** ***"ABN"*** (EXTERNAL CAUSE OF INJURY (ICD-10-CM))
Required	HI05-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry:

						External Cause of Injury
Not Used	HI05-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI05-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI05-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI05-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI05-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI05-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI05-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	**Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI06 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI06-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter one of the following:** ***"ABN"*** (EXTERNAL CAUSE OF INJURY (ICD-10-CM))
Required	HI06-2 / 1271	Industry Code	M	AN	1 / 30	External Cause of Injury
Not Used	HI06-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI06-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI06-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI06-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI06-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI06-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI06-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	**Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI07 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI07-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter one of the following:** ***"ABN"*** (EXTERNAL CAUSE OF INJURY (ICD-10-CM))
Required	HI07-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: External Cause of Injury
Not Used	HI07-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI07-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI07-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI07-6 / 380	Quantity	O	R	1 / 15	

Not Used	HI07-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI07-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI07-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	**Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI08 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI08-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter one of the following:** ***"ABN"*** (EXTERNAL CAUSE OF INJURY (ICD-10-CM))
Required	HI08-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: External Cause of Injury
Not Used	HI08-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI08-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI08-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI08-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI08-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI08-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI08-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI09 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI09-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter one of the following:** ***"ABN"*** (EXTERNAL CAUSE OF INJURY (ICD-10-CM))
Required	HI09-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: External Cause of Injury
Not Used	HI09-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI09-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI09-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI09-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI09-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI09-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI09-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:**

						"Y" (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI10 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI10-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter one of the following:** ***"ABN"*** (EXTERNAL CAUSE OF INJURY (ICD-10-CM))
Required	HI10-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: External Cause of Injury
Not Used	HI10-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI10-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI10-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI10-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI10-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI10-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI10-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI11 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI11-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter one of the following:** ***"ABN"*** (EXTERNAL CAUSE OF INJURY (ICD-10-CM))
Required	HI11-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: External Cause of Injury
Not Used	HI11-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI11-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI11-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI11-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI11-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI11-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI11-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records)

						"W" (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI12 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI12-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter one of the following:** ***"ABN"*** (EXTERNAL CAUSE OF INJURY (ICD-10-CM))
Required	HI12-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. In12: External cause of injury
Not Used	HI12-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI12-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI12-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI12-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI12-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI12-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI12-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)

2300: HI: Diagnosis Related Group Information

This segment is required on inpatient claims.

Loop : 2300 – CLAIM INFORMATION
Usage : Situational
Repeat : 1
Example : HI*DR:123~

Table 2-45 Diagnosis Related Group Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	HI01 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI01-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"DR"*** (Diagnosis Related Group (DRG))
Required	HI01-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: Diagnosis Related Group (DRG) Code
Not Used	HI01-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI01-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI01-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI01-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI01-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI01-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI01-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Not Used	HI02 / C022	Health Care Code Information	O			
Not Used	HI03 / C022	Health Care Code Information	O			
Not Used	HI04 / C022	Health Care Code Information	O			
Not Used	HI05 / C022	Health Care Code Information	O			
Not Used	HI06 / C022	Health Care Code Information	O			
Not Used	HI07 / C022	Health Care Code Information	O			
Not Used	HI08 / C022	Health Care Code Information	O			
Not Used	HI09 / C022	Health Care Code Information	O			
Not Used	HI10 / C022	Health Care Code Information	O			
Not Used	HI11 / C022	Health Care Code Information	O			
Not Used	HI12 / C022	Health Care Code Information	O			

2300: HI: Other Diagnosis Information

This segment is required when other condition(s) co-exists with the principal diagnosis, co-exists at the time of admission or develop subsequently during the patient's treatment.

Loop : 2300 – CLAIM INFORMATION
Usage : Situational
Repeat : 2
Example : HI*ABF:V9782:::::::N ~

Table 2-46 Other Diagnosis Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	HI01 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI01-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"ABF"*** (Diagnosis(ICD-10-CM))
Required	HI01-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: Other Diagnosis
Not Used	HI01-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI01-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI01-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI01-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI01-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI01-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI01-9 / 1073	Yes / No Condition Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI02 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI02-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"ABF"*** (Diagnosis (ICD-10-CM))
Required	HI02-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: Other Diagnosis
Not Used	HI02-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI02-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI02-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI02-6 / 380	Quantity	O	R	1 / 15	

Not Used	HI02-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI02-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI02-9 / 1073	Yes / No Condition Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI03 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI03-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"ABF"*** (Diagnosis (ICD-10-CM))
Required	HI03-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: Other Diagnosis
Not Used	HI03-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI03-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI03-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI03-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI03-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI03-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI03-9 / 1073	Yes / No Condition Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI04 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI04-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"ABF"*** (Diagnosis (ICD-10-CM))
Required	HI04-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: Other Diagnosis
Not Used	HI04-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI04-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI04-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI04-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI04-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI04-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI04-9 / 1073	Yes / No Condition Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:**

						"Y" (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI05 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities
Required	HI05-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"ABF"*** (Diagnosis (ICD-10-CM))
Required	HI05-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: Other Diagnosis
Required	HI05-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI05-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI05-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI05-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI05-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI05-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI05-9 / 1073	Yes / No Condition Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI06 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI06-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"ABF"*** (Diagnosis (ICD-10-CM))
Required	HI06-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: Other Diagnosis
Not Used	HI06-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI06-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI06-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI06-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI06-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI06-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI06-9 / 1073	Yes / No Condition Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)

Situational	HI07 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI07-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"ABF"*** (Diagnosis (ICD-10-CM))
Required	HI07-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: Other Diagnosis
Not Used	HI07-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI07-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI07-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI07-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI07-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI07-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI07-9 / 1073	Yes / No Condition Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI08 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI08-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"ABF"*** (Diagnosis (ICD-10-CM))
Required	HI08-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: Other Diagnosis
Not Used	HI08-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI08-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI08-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI08-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI08-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI08-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI08-9 / 1073	Yes / No Condition Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI09 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI09-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"ABF"*** (Diagnosis (ICD-10-CM))
Required	HI09-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: Other Diagnosis

Not Used	HI09-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI09-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI09-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI09-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI09-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI09-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI09-9 / 1073	Yes / No Condition Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI10 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI10-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following*: "ABF"*** (Diagnosis (ICD-10-CM))
Required	HI10-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: Other Diagnosis
Not Used	HI10-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI10-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI10-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI10-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI10-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI10-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI10-9 / 1073	Yes / No Condition Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI11 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI11-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"ABF"*** (Diagnosis (ICD-10-CM))
Required	HI11-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: Other Diagnosis
Not Used	HI11-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI11-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI11-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI11-6 / 380	Quantity	O	R	1 / 15	

Not Used	HI11-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI11-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI11-9 / 1073	Yes / No Condition Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)
Situational	HI12 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI12-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"ABF"*** (Diagnosis (ICD-10-CM))
Required	HI12-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: Other Diagnosis
Not Used	HI12-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI12-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI12-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI12-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI12-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI12-8 / 1271	Industry Code	X	AN	1 / 30	
Situational	HI12-9 / 1073	Yes / No Condition Response Code	X	ID	1 / 1	Present on Admission Indicator **Enter one of the following:** ***"Y"*** (Yes) ***"N"*** (No) ***"U"*** (No information in the records) ***"W"*** (Clinically undetermined) ***"1"*** (Exempt from POA requirements)

2300: HI: Principal Procedure

This segment is required on inpatient claims or encounters when a procedure was performed.

Loop : 2300 – CLAIM INFORMATION
Usage : Situational
Repeat : 1
Example : HI*BBR:92795:D8:19980321~

Table 2-47 Principal Procedure

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	HI01 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI01-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BBR"*** (ICD Clinical Modification(ICD-10-CM)) Principal Procedure
Required	HI02-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list. Industry: Principal Procedure Code
Required	HI01-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following: *"D8"*** Date Expressed in Format CCYYMMDD Use code D8 when the value in data element HI01-1 equals "BR"
Required	HI01-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or range of dates and times. Required when HI01-3 is used.
Not Used	HI01-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI01-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI01-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI01-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI01-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Not Used	HI02 / C022	Health Care Code Information	O			
Not Used	HI03 / C022	Health Care Code Information	O			
Not Used	HI04 / C022	Health Care Code Information	O			
Not Used	HI05 / C022	Health Care Code Information	O			
Not Used	HI06 / C022	Health Care Code Information	O			
Not Used	HI07 / C022	Health Care Code Information	O			
Not Used	HI08 / C022	Health Care Code Information	O			
Not Used	HI09 / C022	Health Care Code Information	O			
Not Used	HI10 / C022	Health Care Code Information	O			
Not Used	HI11 / C022	Health Care Code Information	O			
Not Used	HI12 / C022	Health Care Code Information	O			

2300: HI: Other Procedure

This segment is required on inpatient claims or encounters when a procedure was performed.

Loop : 2300 – CLAIM INFORMATION
Usage : Situational
Repeat : 2
Example : HI*BBQ:92795:D8:19980321~

Table 2-48 Other Procedure Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	HI01 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI01-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following*: "BBQ"*** (ICD Clinical Modification (ICD-10-PCS) Procedure)
Required	HI01-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Procedure Code
Required	HI01-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following: *"D8"*** Date expressed in Format ***CCYYMMDD***
Required	HI01-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or range of dates and times
Not Used	HI01-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI01-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI01-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI01-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI01-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI02 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI02-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BBQ"*** (ICD Clinical Modification (ICD-10-PCS) Procedure)

Required	HI02-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Procedure Code
Required	HI02-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following*: "D8"*** Date expressed in Format ***CCYYMMDD***
Required	HI02-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or range of dates and times
Not Used	HI02-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI02-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI02-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI02-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI02-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI03 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI03-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BBQ"*** (ICD Clinical Modification (ICD-10-PCS) Procedure)
Required	HI03-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Procedure Code
Required	HI03-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following*:"D8"*** Date expressed in Format CCYYMMDD
Required	HI03-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or range of dates and times
Not Used	HI03-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI03-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI03-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI03-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI03-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI04 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI04-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BBQ***" (ICD Clinical Modification (ICD-10-PCS) Procedure)

Required	HI04-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Procedure Code
Required	HI04-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following**: ***"D8"*** Date expressed in Format ***CCYYMMDD***
Required	HI04-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or range of dates and times
Not Used	HI04-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI04-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI04-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI04-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI04-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI05 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI05-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BBQ***" (ICD Clinical Modification (ICD-10-PCS) Procedure)
Required	HI05-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Procedure Code
Required	HI05-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following**: ***"D8"*** Date expressed in Format ***CCYYMMDD***
Required	HI05-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or range of dates and times
Not Used	HI05-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI05-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI05-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI05-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI05-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI06 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.

Required	HI06-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BBQ*** (ICD Clinical Modification (ICD-10-PCS) Procedure)
Required	HI06-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Procedure Code
Required	HI06-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following**: ***"D8"*** Date expressed in Format ***CCYYMMDD***
Required	HI06-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or range of dates and times
Not Used	HI06-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI06-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI06-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI06-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI06-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI07 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI07-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BBQ*** (ICD Clinical Modification (ICD-10-PCS) Procedure)
Required	HI07-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Procedure Code
Required	HI07-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following**: ***"D8"*** Date expressed in Format ***CCYYMMDD***
Required	HI07-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or range of dates and times
Not Used	HI07-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI07-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI07-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI07-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI07-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	

Situational	HI08 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI08-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BBQ*** (ICD Clinical Modification (ICD-10-PCS) Procedure)
Required	HI08-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Procedure Code
Required	HI08-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following**: ***"D8"*** Date expressed in Format ***CCYYMMDD***
Required	HI08-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or range of dates and times
Not Used	HI08-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI08-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI08-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI08-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI08-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI09 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI09-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BBQ*** (ICD Clinical Modification (ICD-10-PCS) Procedure)
Required	HI09-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Procedure Code
Required	HI09-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following**: ***"D8"*** Date expressed in Format ***CCYYMMDD***
Required	HI09-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or range of dates and times
Not Used	HI09-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI09-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI09-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI09-8 / 1271	Industry Code	X	AN	1 / 30	

Not Used	HI09-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI10 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI10-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BBQ*** (ICD Clinical Modification (ICD-10-PCS) Procedure)
Required	HI10-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Procedure Code
Required	HI10-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following**: ***"D8"*** Date expressed in Format ***CCYYMMDD***
Required	HI10-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or range of dates and times
Not Used	HI10-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI10-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI10-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI10-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI10-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI11 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI11-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BBQ*** (ICD Clinical Modification (ICD-10-PCS) Procedure)
Required	HI11-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Procedure Code
Required	HI11-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following**: ***"D8"*** Date expressed in Format ***CCYYMMDD***
Required	HI11-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or range of dates and times
Not Used	HI11-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI11-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI11-7 / 799	Version Identifier	O	AN	1 / 30	

Not Used	HI11-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI11-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI12 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI12-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BBQ*** (ICD Clinical Modification (ICD-10-PCS) Procedure)
Required	HI12-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Procedure Code
Required	HI12-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following**: ***"D8"*** Date expressed in Format ***CCYYMMDD***
Required	HI12-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or range of dates and times
Not Used	HI12-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI12-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI12-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI12-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI12-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	

2300: HI: Occurrence Span Information

This segment is required when occurrence span information applies to the claim or the encounter.

Loop : 2300 – CLAIM INFORMATION
Usage : Situational
Repeat : 2
Example : HI*BI:70:RD8:19981202-19981212~

Table 2-49 Occurrence Span Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	HI01 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI01-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BI"*** (Occurrence Span)
Required	HI01-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Span Code
Required	HI01-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following: *"RD8"*** (Range of dates expressed in Format ***CCYYMMDD-CCYYMMDD***) Code indicating the date format, time format, or date and time format
Required	HI01-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence or Occurrence Span Code Associated Date
Not Used	HI01-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI01-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI01-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI01-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI01-9 / 1073	Yes / No Condition or Response Code	X	ID		
Situational	HI02 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI02-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BI"*** (Occurrence Span)
Required	HI02-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Span Code
Required	HI02-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following: *"RD8"*** (Range of

						dates expressed in Format ***CCYYMMDD-CCYYMMDD***) Code indicating the date format, time format, or date and time format
Required	HI02-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence or Occurrence Span Code Associated Date
Not Used	HI02-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI02-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI02-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI02-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI02-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI03 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI03-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BI"*** (Occurrence Span)
Required	HI03-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Span Code
Required	HI03-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following: *"RD8"*** (Range of dates expressed in Format ***CCYYMMDD-CCYYMMDD***) Code indicating the date format, time format, or date and time format
Required	HI03-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence or Occurrence Span Code Associated Date
Not Used	HI03-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI03-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI03-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI03-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI03-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI04 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI04-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BI"*** (Occurrence Span)
Required	HI04-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Span Code

Required	HI04-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following: *"RD8"*** (Range of dates expressed in Format ***CCYYMMDD-CCYYMMDD***) Code indicating the date format, time format, or date and time format
Required	HI04-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence or Occurrence Span Code Associated Date
Not Used	HI04-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI04-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI04-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI04-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI04-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI05 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI05-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BI"*** (Occurrence Span)
Required	HI05-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Span Code
Required	HI05-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following: *"RD8"*** (Range of dates expressed in Format ***CCYYMMDD-CCYYMMDD***) Code indicating the date format, time format, or date and time format
Required	HI05-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence or Occurrence Span Code Associated Date
Not Used	HI05-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI05-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI05-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI05-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI05-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI06 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI06-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BI"*** (Occurrence Span)
Required	HI06-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Span Code

Required	HI06-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following: *"RD8"*** (Range of dates expressed in Format ***CCYYMMDD-CCYYMMDD***) Code indicating the date format, time format, or date and time format
Required	HI06-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence or Occurrence Span Code Associated Date
Not Used	HI06-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI06-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI06-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI06-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI06-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI07 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI07-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BI"*** (Occurrence Span)
Required	HI07-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Span Code
Required	HI07-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following: *"RD8"*** (Range of dates expressed in Format ***CCYYMMDD-CCYYMMDD***) Code indicating the date format, time format, or date and time format
Required	HI07-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence or Occurrence Span Code Associated Date
Not Used	HI07-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI07-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI07-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI07-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI07-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI08 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI08-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BI"*** (Occurrence Span)
Required	HI08-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Span Code

Required	HI08-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following: *"RD8"*** (Range of dates expressed in Format ***CCYYMMDD-CCYYMMDD***) Code indicating the date format, time format, or date and time format
Required	HI08-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence or Occurrence Span Code Associated Date
Not Used	HI08-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI08-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI08-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI08-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI08-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI09 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI09-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BI"*** (Occurrence Span)
Required	HI09-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Span Code
Required	HI09-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following: *"RD8"*** (Range of dates expressed in Format ***CCYYMMDD-CCYYMMDD***) Code indicating the date format, time format, or date and time format
Required	HI09-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence or Occurrence Span Code Associated Date
Not Used	HI09-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI09-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI09-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI09-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI09-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI10 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI10-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BI"*** (Occurrence Span)
Required	HI10-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Span Code

Required	HI10-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following: *"RD8"*** (Range of dates expressed in Format ***CCYYMMDD-CCYYMMDD***) Code indicating the date format, time format, or date and time format
Required	HI10-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence or Occurrence Span Code Associated Date
Not Used	HI10-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI10-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI10-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI10-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI10-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI11 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI11-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BI"*** (Occurrence Span)
Required	HI11-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Span Code
Required	HI11-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following: *"RD8"*** (Range of dates expressed in Format ***CCYYMMDD-CCYYMMDD***) Code indicating the date format, time format, or date and time format
Required	HI11-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence or Occurrence Span Code Associated Date
Not Used	HI11-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI11-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI11-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI11-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI11-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI12 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI12-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BI"*** (Occurrence Span)
Required	HI12-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Span Code

Required	HI12-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following: *"RD8"*** (Range of dates expressed in Format ***CCYYMMDD-CCYYMMDD***) Code indicating the date format, time format, or date and time format
Required	HI12-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence or Occurrence Span Code Associated Date
Not Used	HI12-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI12-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI12-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI12-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI12-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	

2300: HI: Occurrence Information

This segment is required when occurrence information applies to the claim or encounter.

Loop : `2300 – CLAIM INFORMATION`
Usage : `Situational`
Repeat : `2`
Example : `HI*BH:42:D*:19981208~`

Table 2-50 Occurrence Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	HI01 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI01-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BH"*** (Occurrence)
Required	HI01-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Code Industry
Required	HI01-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following*: "D8"*** (Date Expressed in Format ***CCYYMMDD***)
Required	HI01-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence Code Associated Date
Not Used	HI01-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI01-6 / 380	Quantity	O	R	1 / 15	

Not Used	HI01-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI01-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI01-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI02 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI02-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BH"*** (Occurrence)
Required	HI02-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Code Industry
Required	HI02-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following*: "D8"*** (Date Expressed in Format ***CCYYMMDD***)
Required	HI02-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence Code Associated Date
Not Used	HI02-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI02-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI02-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI02-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI02-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI03 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI03-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BH"*** (Occurrence)
Required	HI03-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Code Industry
Required	HI03-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following*: "D8"*** (Date Expressed in Format ***CCYYMMDD***)
Required	HI03-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence Code Associated Date
Not Used	HI03-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI03-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI03-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI03-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI03-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI04 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI04-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BH"*** (Occurrence)
Required	HI04-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence

						Code Industry
Required	HI04-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following*: "D8"*** (Date Expressed in Format ***CCYYMMDD***)
Required	HI04-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence Code Associated Date
Not Used	HI04-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI04-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI04-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI04-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI04-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI05 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI05-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BH"*** (Occurrence)
Required	HI05-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Code Industry
Required	HI05-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following*: "D8"*** (Date Expressed in Format ***CCYYMMDD***)
Required	HI05-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence Code Associated Date
Not Used	HI05-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI05-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI05-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI05-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI05-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI06 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI06-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BH"*** (Occurrence)
Required	HI06-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Code Industry
Required	HI06-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following*: "D8"*** (Date Expressed in Format ***CCYYMMDD***)
Required	HI06-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence Code Associated Date
Not Used	HI06-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI06-6 / 380	Quantity	O	R	1 / 15	

Not Used	HI06-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI06-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI06-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI07 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI07-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BH"*** (Occurrence)
Required	HI07-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Code Industry
Required	HI07-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following*: "D8"*** (Date Expressed in Format ***CCYYMMDD***)
Required	HI07-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence Code Associated Date
Not Used	HI07-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI07-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI07-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI07-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI07-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI08 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI08-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BH"*** (Occurrence)
Required	HI08-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Code Industry
Required	HI08-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following*: "D8"*** (Date Expressed in Format ***CCYYMMDD***)
Required	HI08-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence Code Associated Date
Not Used	HI08-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI08-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI08-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI08-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI08-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI09 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI09-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BH"*** (Occurrence)
Required	HI09-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence

						Code Industry
Required	HI09-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following*: "D8"*** (Date Expressed in Format ***CCYYMMDD***)
Required	HI09-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence Code Associated Date
Not Used	HI09-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI09-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI09-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI09-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI09-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI10 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI10-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BH"*** (Occurrence)
Required	HI10-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Code Industry
Required	HI10-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following*: "D8"*** (Date Expressed in Format ***CCYYMMDD***)
Required	HI10-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence Code Associated Date
Not Used	HI10-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI10-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI10-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI10-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI10-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI11 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI11-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BH"*** (Occurrence)
Required	HI11-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Code Industry
Required	HI11-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following*: "D8"*** (Date Expressed in Format ***CCYYMMDD***)
Required	HI11-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence Code Associated Date
Not Used	HI11-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI11-6 / 380	Quantity	O	R	1 / 15	

Not Used	HI11-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI11-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI11-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI12 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI12-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BH"*** (Occurrence)
Required	HI12-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Occurrence Code Industry
Required	HI12-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	**Enter the following*: "D8"*** (Date Expressed in Format ***CCYYMMDD***)
Required	HI12-4 / 1251	Date Time Period	X	AN	1 / 35	Expression of a date, a time, or a range of dates, times, or dates and times Industry: Occurrence Code Associated Date
Not Used	HI12-5 / 781	Monetary Amount	O	R	1 / 18	
Not Used	HI12-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI12-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI12-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI12-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	

2300: HI: Value Information

This segment is required when value information applies to the claim or the encounter.

Loop : 2300 – CLAIM INFORMATION
Usage : Situational
Repeat : 2
Example : HI*BE:08:::1740~

Table 2-51 Value Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	HI01 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI01-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following:** ***"BE"*** (Value) Code identifying a specific industry code list
Required	HI01-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Value Code
Not Used	HI01-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI01-4 / 1251	Date Time Period	X	AN	1 / 35	
Required	HI01-5 / 782	Monetary Amount	O	R	1 / 18	Industry: Value Code Associated Amount
Not Used	HI01-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI01-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI01-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI01-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI02 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI02-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following:** ***"BE"*** (Value) Code identifying a specific industry code list
Required	HI02-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Value Code
Not Used	HI02-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI02-4 / 1251	Date Time Period	X	AN	1 / 35	
Required	HI02-5 / 782	Monetary Amount	O	R	1 / 18	Industry: Value Code Associated Amount
Not Used	HI02-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI02-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI02-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI02-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI03 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI03-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following:** ***"BE"*** (Value) Code identifying a specific industry code list
Required	HI03-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Value Code
Not Used	HI03-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI03-4 / 1251	Date Time Period	X	AN	1 / 35	
Required	HI03-5 / 782	Monetary Amount	O	R	1 / 18	Industry: Value Code Associated Amount
Not Used	HI03-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI03-7 / 799	Version Identifier	O	AN	1 / 30	

Not Used	HI03-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI03-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI04 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI04-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BE"*** (Value) Code identifying a specific industry code list
Required	HI04-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Value Code
Not Used	HI04-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI04-4 / 1251	Date Time Period	X	AN	1 / 35	
Required	HI04-5 / 782	Monetary Amount	O	R	1 / 18	Industry: Value Code Associated Amount
Not Used	HI04-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI04-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI04-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI04-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI05 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI05-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BE"*** (Value) Code identifying a specific industry code list
Required	HI05-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Value Code
Not Used	HI05-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI05-4 / 1251	Date Time Period	X	AN	1 / 35	
Required	HI05-5 / 782	Monetary Amount	O	R	1 / 18	Industry: Value Code Associated Amount
Not Used	HI05-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI05-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI05-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI05-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	Yes / No Condition or Response Code
Situational	HI06 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI06-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BE"*** (Value) Code identifying a specific industry code list
Required	HI06-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Value Code
Not Used	HI06-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI06-4 / 1251	Date Time Period	X	AN	1 / 35	
Required	HI06-5 / 782	Monetary Amount	O	R	1 / 18	Industry: Value Code Associated Amount
Not Used	HI06-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI06-7 / 799	Version Identifier	O	AN	1 / 30	

Not Used	HI06-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI06-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI07 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI07-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BE"*** (Value) Code identifying a specific industry code list
Required	HI07-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Value Code
Not Used	HI07-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI07-4 / 1251	Date Time Period	X	AN	1 / 35	
Required	HI07-5 / 782	Monetary Amount	O	R	1 / 18	Industry: Value Code Associated Amount
Not Used	HI07-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI07-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI07-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI07-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI08 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI08-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BE"*** (Value) Code identifying a specific industry code list
Required	HI08-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Value Code
Not Used	HI08-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI08-4 / 1251	Date Time Period	X	AN	1 / 35	
Required	HI08-5 / 782	Monetary Amount	O	R	1 / 18	Industry: Value Code Associated Amount
Not Used	HI08-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI08-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI08-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI08-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI09 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI09-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BE"*** (Value) Code identifying a specific industry code list
Required	HI09-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Value Code
Not Used	HI09-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI09-4 / 1251	Date Time Period	X	AN	1 / 35	
Required	HI09-5 / 782	Monetary Amount	O	R	1 / 18	Industry: Value Code Associated Amount
Not Used	HI09-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI09-7 / 799	Version Identifier	O	AN	1 / 30	

Not Used	HI09-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI09-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI10 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI10-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BE"*** (Value) Code identifying a specific industry code list
Required	HI10-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Value Code
Not Used	HI10-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI10-4 / 1251	Date Time Period	X	AN	1 / 35	
Required	HI10-5 / 782	Monetary Amount	O	R	1 / 18	Industry: Value Code Associated Amount
Not Used	HI10-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI10-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI10-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI10-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI11 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI11-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BE"*** (Value) Code identifying a specific industry code list
Required	HI11-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Value Code
Not Used	HI11-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI11-4 / 1251	Date Time Period	X	AN	1 / 35	
Required	HI11-5 / 782	Monetary Amount	O	R	1 / 18	Industry: Value Code Associated Amount
Not Used	HI11-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI11-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI11-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI11-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI12 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI12-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BE"*** (Value) Code identifying a specific industry code list
Required	HI12-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Value Code
Not Used	HI12-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI12-4 / 1251	Date Time Period	X	AN	1 / 35	
Required	HI12-5 / 782	Monetary Amount	O	R	1 / 18	Industry: Value Code Associated Amount
Not Used	HI12-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI12-7 / 799	Version Identifier	O	AN	1 / 30	

Not Used	HI12-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI12-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	

2300: HI: Condition Information

This segment is required when condition information applies to the claim or the encounter.

Loop : 2300 – CLAIM INFORMATION
Usage : Situational
Repeat : 2
Example : HI*BG:67~

Table 2-52 Condition Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	HI01 / C022	Health Care Code Information	M			To send health care codes and their associated dates, amounts, and quantities.
Required	HI01-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BG"*** (Condition) Code identifying a specific industry code list
Required	HI01-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Condition Code
Not Used	HI01-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	Date Time Response
Not Used	HI01-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI01-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI01-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI01-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI01-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI01-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI02 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI02-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BG"*** (Condition) Code identifying a specific industry code list
Required	HI02-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Condition Code

Not Used	HI02-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI02-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI02-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI02-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI02-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI02-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI02-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI03 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI03-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BG"*** (Condition) Code identifying a specific industry code list
Required	HI03-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Condition Code
Not Used	HI03-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI03-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI03-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI03-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI03-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI03-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI03-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI04 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI04-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BG"*** (Condition) Code identifying a specific industry code list
Required	HI04-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Condition Code
Not Used	HI04-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI04-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI04-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI04-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI04-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI04-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI04-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	

Situational	HI05 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI05-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BG"*** (Condition) Code identifying a specific industry code list
Required	HI05-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Condition Code
Not Used	HI05-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI05-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI05-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI05-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI05-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI05-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI05-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI06 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI06-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BG"*** (Condition) Code identifying a specific industry code list
Required	HI06-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Condition Code
Not Used	HI06-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI06-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI06-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI06-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI06-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI06-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI06-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI07 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI07-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BG"*** (Condition) Code identifying a specific industry code list
Required	HI07-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Condition Code

Not Used	HI07-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI07-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI07-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI07-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI07-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI07-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI07-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI08 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI08-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BG"*** (Condition) Code identifying a specific industry code list
Required	HI08-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Condition Code
Not Used	HI08-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI08-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI08-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI08-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI08-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI08-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI08-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI09 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI09-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BG"*** (Condition) Code identifying a specific industry code list
Required	HI09-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Condition Code
Not Used	HI09-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI09-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI09-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI09-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI09-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI09-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI09-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	

Situational	HI10 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI10-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BG"*** (Condition) Code identifying a specific industry code list
Required	HI10-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Condition Code
Not Used	HI10-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI10-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI10-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI10-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI10-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI10-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI10-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI11 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI11-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BG"*** (Condition) Code identifying a specific industry code list
Required	HI11-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Condition Code
Not Used	HI11-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI11-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI11-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI11-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI11-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI11-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI11-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	
Situational	HI12 / C022	Health Care Code Information	O			To send health care codes and their associated dates, amounts, and quantities.
Required	HI12-1 / 1270	Code List Qualifier Code	M	ID	1 / 3	**Enter the following: *"BG"*** (Condition) Code identifying a specific industry code list
Required	HI12-2 / 1271	Industry Code	M	AN	1 / 30	Code indicating a code from a specific industry code list Industry: Condition Code

Not Used	HI12-3 / 1250	Date Time Period Format Qualifier	X	ID	2 / 3	
Not Used	HI12-4 / 1251	Date Time Period	X	AN	1 / 35	
Not Used	HI12-5 / 782	Monetary Amount	O	R	1 / 18	
Not Used	HI12-6 / 380	Quantity	O	R	1 / 15	
Not Used	HI12-7 / 799	Version Identifier	O	AN	1 / 30	
Not Used	HI12-8 / 1271	Industry Code	X	AN	1 / 30	
Not Used	HI12-9 / 1073	Yes / No Condition or Response Code	X	ID	1 / 1	

2310A: NM1: Attending Provider Name

Loop : `2310A – ATTENDING PROVIDER NAME | Loop Repeat: 1`
Usage : `Required`
Repeat : `1`
Example : `NM1*71*******XX*1234567891~`

Table 2-53 Attending Provider Name

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	NM101 / 98	Entity Identifier Code	M	ID	2 / 3	**Enter the following: *"71"*** (Attending Physician)
Not Used	NM102 / 1065	Entity Type Qualifier	M	ID	1 / 1	**Enter the following: *"1"*** (Person)
Not Used	NM103 / 1035	Name Last or Organization Name	O	AN	1 / 60	Attending Physician Last Name
Not Used	NM104 / 1036	Name First	O	AN	1 / 35	Attending Physician First Name
Not Used	NM105 / 1037	Name Middle	O	AN	1 / 25	Attending Physician Middle Name
Not Used	NM106 / 1038	Name Prefix	O	AN	1 / 10	
Not Used	NM107 / 1039	Name Suffix	O	AN	1 / 10	
Required	NM108 / 66	Identification Code Qualifier	X	ID	1 / 2	**Enter the following: *"XX"*** (Centers for Medicare and Medicaid Services)
Required	NM109 / 67	Identification Code	X	AN	2 / 80	Code Identifying a party or other code. **Enter the following:** Attending Physician Primary Identifier
Not Used	NM110 / 706	Entity Relationship Code	X	ID	2 / 2	
Not Used	NM111 / 98	Entity Identifier Code	O	ID	2 / 3	
Not Used	NM112 / 1035	Name Last or Organization Name	O	AN	1 / 60	

2310A: REF: Attending Provider Secondary Identification

Loop : 2310A – ATTENDING PROVIDER NAME
Usage : Required
Repeat : 5 (NJ HealthCAP - 1)
Example : REF*0B*25NJMA01234500~

Table 2-54 Attending Provider Secondary Identification

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	REF01 / 128	Reference Identification Qualifier	M	ID	2 / 3	**Enter the following: *"0B"*** (State License Number)
Required	REF02 / 127	Reference Identification	X	AN	1 / 30	Attending Physician State License Number
Not Used	REF03 / 352	Description	X	AN	1 / 80	
Not Used	REF04 / C040	Reference Identifier	O			

2310B: NM1: Operating Physician Name

This segment is required when any surgical procedure code is listed on this claim.

Loop : 2310B – OPERATING PHYSICIAN NAME | Loop Repeat: 1
Usage : Situational
Repeat : 1
Example : NM1*72*******XX*1234567891~

Table 2-55 Operating Physician Name

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	NM101 / 98	Entity Identifier Code	M	ID	2 / 3	**Enter the following: *"72"*** (Operating Physician)
Not Used	NM102 / 1065	Entity Type Qualifier	M	ID	1 / 1	Code qualifying the type of entity **Enter the following: *"1"*** (Person)
Not Used	NM103 / 1035	Name Last or Organization Name	O	AN	1 / 60	Operating Physician Last Name
Not Used	NM104 / 1036	Name First	O	AN	1 / 35	Operating Physician First Name
Not Used	NM105 / 1037	Name Middle	O	AN	1 / 25	Operating Physician Middle Name
Not Used	NM106 / 1038	Name Prefix	O	AN	1 / 10	
Not Used	NM107 / 1039	Name Suffix	O	AN	1 / 10	Operating Physician Name Suffix

Required	NM108 / 66	Identification Code Qualifier	X	ID	1 / 2	**Enter the following: *"XX"*** (HCFA National Provider Identifier)
Required	NM109 / 67	Identification Code	X	AN	2 / 80	Operating Physician Primary Identifier
Not Used	NM110 / 706	Entity Relationship Code	X	ID	2 / 2	
Not Used	NM111 / 98	Entity Identifier Code	O	ID	2 / 3	
Not Used	NM112 / 1035	Name Last or Organization Last	O	AN	1 / 60	

2310B: REF: Operating Physician Secondary Identification

This segment is required when any surgical procedure code is listed on this claim

Loop : `2310B – OPERATING PHYSICIAN NAME`
Usage : `Situational`
Repeat : `5 (NJ HealthCAP - 1)`
Example : `REF*0B*25NJMA01234500~`

Table 2-56 Operating Physician Secondary Identification

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	REF01 / 128	Reference Identification Qualifier	M	ID	2 / 3	**Enter the following: *"0B"*** (State License Number)
Required	REF02 / 127	Reference Identification	X	AN	1 / 30	Operating Physician state license number
Not Used	REF03 / 352	Description	X	AN	1 / 80	
Not Used	REF04 / C040	Reference Identifier	O			

2310C: NM1: Other Operating Physician Name

This segment is required when another operating physician is involved.

Loop : 2310C – OTHER OPERATING PHYSICIAN NAME | Loop Repeat: 1
Usage : Situational
Repeat : 1
Example : NM1*ZZ*******XX*1234567891~

Table 2-57 Other Operating Physician Name

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	NM101 / 98	Entity Identifier Code	M	ID	2 / 3	**Enter the following: *"ZZ"*** (Mutually Defined (Other Operating Physician))
Not Used	NM102 / 1065	Entity Type Qualifier	M	ID	1 / 1	Code qualifying the type of entity **Enter the following: *"1"*** (Person)
Not Used	NM103 / 1035	Name Last or Organization Name	O	AN	1 / 60	Other Operating Physician Last Name
Not Used	NM104 / 1036	Name First	O	AN	1 / 35	Other Operating Physician First Name
Not Used	NM105 / 1037	Name Middle	O	AN	1 / 25	Other Operating Physician Middle Name
Not Used	NM106 / 1038	Name Prefix	O	AN	1 / 10	
Not Used	NM107 / 1039	Name Suffix	O	AN	1 / 10	Other Operating Physician Name Suffix
Required	NM108 / 66	Identification Code Qualifier	X	ID	1 / 2	**Enter the following: *"XX"*** (HCFA National Provider Identifier)
Required	NM109 / 67	Identification Code	X	AN	2 / 80	Other Operating Physician Primary Identifier
Not Used	NM110 / 706	Entity Relationship Code	X	ID	2 / 2	
Not Used	NM111 / 98	Entity Identifier Code	O	ID	2 / 3	
Not Used	NM112 / 1035	Name Last or Organization Name	O	AN	1 / 60	

2310C: REF: Other Operating Physician Secondary Identification

This segment if required when another operating physician is involved.

Loop : 2310C – OTHER OPERATING PHYSICIAN NAME
Usage : Situational
Repeat : 5 (NJ HealthCAP – 1)
Example : REF*0B*25NJMA01234500~

Table 2-58 Other Operating Physician Secondary Identification

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	REF01 / 128	Reference Identification Qualifier	M	ID	2 / 3	**Enter the following:** ***"0B"*** (State License Number)
Required	REF02 / 127	Reference Identification	X	AN	1 / 30	Other Operating Physician State License Number
Not Used	REF03 / 352	Description	X	AN	1 / 80	
Not Used	RED04 / C040	Reference Identifier	O			

2310D: NM1: Rendering Provider Name

This segment is required when the rendering provider is different than the attending provider.

Loop : 2310D – RENDERING PROVIDER NAME | Loop Repeat: 1
Usage : Situational
Repeat : 1
Example : NM1*82*1*Meyers*Jane****XX*123456781~

Table 2-59 Other Operating Physician Secondary Identification

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	NM101 / 98	Entity Identifier Code	M	ID	2 / 3	**Enter the following:** ***"82"*** (Rendering Provider)
Not Used	NM102 / 1065	Entity Type Qualifier	M	ID	1 / 1	**Enter the following:** ***"1"*** (Person)
Not Used	NM103 / 1035	Name Last or Organization Name	O	AN	1 / 60	Rendering Physician Last Name
Not Used	NM104 / 1036	Name First	O	AN	1 / 35	Rendering Physician First Name
Not Used	NM105 / 1037	Name Middle	O	AN	1 / 25	Rendering Physician Middle Name
Not Used	NM106 / 1038	Name Prefix	O	AN	1 / 10	
Not Used	NM107 / 1039	Name Suffix	O	AN	1 / 10	Rendering Physician Name Suffix

Required	NM108 / 66	Identification Code Qualifier	X	ID	1 / 2	**Enter the following: *"XX"*** (HFCA National Provider Identifier)
Required	NM109 / 67	Identification Code	X	AN	2 / 80	Rendering Physician Primary Identifier
Not Used	NM110 / 706	Entity Relationship Code	X	ID	2 / 2	
Not Used	NM111 / 98	Entity Identifier Code	O	ID	2 / 3	
Not Used	NM112 / 1035	Name Last or Organization Name	O	AN	1 / 60	

2310D: REF: Rendering Provider Secondary Identification

This segment is required when the rendering provider is different than the attending provider.

Loop : `2310D – RENDERING PROVIDER NAME`
Usage : `Situational`
Repeat : `5 (NJ HealthCAP – 1)`
Example : `REF*0B*25NJMA01234500~`

Table 2-60 Rendering Provider Secondary Identification

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	REF01 / 128	Reference Identification Qualifier	M	ID	2 / 3	**Enter the following:** ***"0B"*** (State License Number)
Required	REF02 / 127	Reference Identification	X	AN	1 / 30	Rendering Physician State License Number
Not Used	REF03 / 352	Description	X	AN	1 / 80	
Not Used	REF04 / C040	Reference Identifier	O			

2310F: NM1: Referring Provider Name

This segment is required when the rendering provider is different than the attending provider.

Loop : `2310F – REFERRING PROVIDER NAME | Loop Repeat: 1`
Usage : `Situational`
Repeat : `1`
Example : `NM1*DN*******XX*1234567891~`

Table 2-61 Referring Provider Name

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	NM101 / 98	Entity Identifier Code	M	ID	2 / 3	**Enter the following: *"DN"*** (Referring Provider)
Not Used	NM102 / 1065	Entity Type Qualifier	M	ID	1 / 1	**Enter the following: *"1"*** (Person)
Not Used	NM103 / 1035	Name Last or Organization Name	O	AN	1 / 60	Referring Physician Last Name
Not Used	NM104 / 1036	Name First	O	AN	1 / 35	Referring Physician First Name
Not Used	NM105 / 1037	Name Middle	O	AN	1 / 25	Referring Physician Middle Name
Not Used	NM106 / 1038	Name Prefix	O	AN	1 / 10	
Not Used	NM107 / 1039	Name Suffix	O	AN	1 / 10	Referring Physician Name Suffix
Required	NM108 / 66	Identification Code Qualifier	X	ID	1 / 2	**Enter the following: *"XX"*** (HCFA National Provider)
Required	NM109 / 67	Identification Code	X	AN	2 / 80	Referring Physician Primary Identifier
Not Used	NM110 / 706	Entity Relationship Code	X	ID	2 / 2	
Not Used	NM111 / 98	Entity Identifier Code	O	ID	2 / 3	
Not Used	NM112 / 1035	Name Last or Organization Name	O	AN	1 / 60	

2310F: REF: Referring Provider Secondary Identification

This segment is required when the rendering provider is different than the attending provider.

Loop : 2310F – RENDERING PROVIDER NAME
Usage : Situational
Repeat : 5 (NJ HealthCAP – 1)
Example : REF*0B*25NJMA01234500~

Table 2-62 Referring Provider Secondary Identification

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	REF01 / 128	Reference Identification Qualifier	M	ID	2 / 3	**Enter the following:** ***"0B"*** (State License Number)
Required	REF02 / 127	Reference Identification	X	AN	1 / 30	Referring Provider State License Number
Not Used	REF03 / 352	Description	X	AN	1 / 80	
Not Used	REF04 / C040	Reference Identifier	O			

2320: SBR: Other Subscriber Information

This segment is required if other payers are known to potentially be involved in paying on this claim. All information contained in the 2320 Loop applies only to the payer who is identified in the 2330B Loop of this iteration of the 2320 Loop. It is specific only to that payer. If information on additional payers is reported, run the 2320 Loop again with its respective 2330 Loops.

Loop : 2320 – OTHER SUBSCRIBER INFORMATION | Loop Repeat: 10
Usage : Situational (NJ HealthCAP – Optional)
Repeat : 1
Example : SBR*S*01~

Table 2-63 Other Subscriber Information

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	SBR01 / 1138	Payer Responsibility Sequence Number Code	M	ID	1 / 1	**Enter the following:** ***"S"*** (Secondary) ***"T"*** (Tertiary)
Required	SBR02 / 1069	Individual Relationship Code	O	ID	2 / 2	**Enter the following:** ***"01"*** (Spouse) ***"18"*** (Self) ***"19"*** (Child) ***"20"*** (Employee)

						"21" (Unknown) "***39"*** (Organ Donor) ***"40"*** (Cadaver Donor) "***53"*** (Life Partner) ***"G8"*** (Other Relationship)
Not Used	SBR03 / 127	Reference Identification	O	AN	1 / 30	Insured Group or Policy Number
Not Used	SBR04 / 93	Name	O	AN	1 / 60	Other Insured Group Name
Not Used	SBR05 / 1336	Insurance Type Code	O	ID	1 / 3	
Not Used	SBR06 / 1143	Coordination of Benefits Code	O	ID	1 / 1	
Not Used	SBR07 / 1073	Yes / No Condition or Response Code	O	ID	1 / 1	
Not Used	SBR08 / 584	Employment Status Code	O	ID	2 / 2	
Not Used	SBR09 / 1032	Claim Filling Indicator Code	O	ID	1 / 2	Code Identifying type of claim ***Enter one of the following:*** ***"10"*** (Central Certification) ***"11"*** (Other Non-Federal Programs) ***"12"*** *(Preferred Provider Organization (PPO))* ***"13"*** (Point of Service (POS)) ***"14"*** (Exclusive Provider Organization (EPO)) ***"15"*** (Indemnity Insurance) ***"16"*** (Health Maintenance Organization (HMO) Medicare Risk) ***"AM"*** (Automobile Medical) ***"BL"*** (Blue Cross / Blue Shield) ***"CH"*** (Champus) ***"CI"*** (Commercial Insurance Co.) ***"DS"*** (Disability) ***"HM"*** (Health Maintenance Organization) ***"LI"*** (Liability) ***"LM"*** (Liability Medical) ***"MA"*** (Medicare Part A) ***"MB"*** (Medicare Part B) ***"MC"*** (Medicaid) ***"OF"*** (Other Federal Program) ***"TV"*** (Title V) ***"VA"*** (Veteran Administration Plan) ***"WC"*** (Workers' Compensation Health Claim) ***"ZZ"*** (Mutually Defined)

2320: AMT: Payer Paid Payment

This segment is required when the present payer has paid an amount to the provider towards this bill.

Loop : 2320 – OTHER SUBSCRIBER INFORMATION
Usage : Situational (NJ HealthCAP – Optional)
Repeat : 1
Example : AMT*C4*150~

Table 2-64 Amt Payer Prior Payment

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	AMT101 / 522	Amount Qualifier Code	M	ID	1 / 3	**Enter the following: *"C4"*** (Prior Payment – Actual)
Required	AMT102 / 782	Monetary Amount	M	R	1 / 18	Prior Payment Amount
Not Used	AMT103 / 478	Credit / Debit Flag Code	O	ID	1 / 1	

2330A: NM1: Other Subscriber Name

Loop : 2330A – OTHER SUBSCRIBER NAME
Usage : Required (NJ HealthCAP - Optional)
Repeat : 1
Example : NM1*IL*DOE*JOHN*T**R*MI*43140~

Table 2-65 Other Subscriber Name

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	NM101 / 98	Entity Identifier Code	M	ID	2 / 3	**Enter the following: *"IL"*** (Insured or Subscriber)
Required	NM102 / 1065	Entity Type Qualifier	M	ID	1 / 1	**Enter the following: *"1"*** (Person)
Not Used	NM103 / 1035	Name Last or Organization Name	O	AN	1 / 60	Other Insured Last Name
Not Used	NM104 / 1035	Name First	O	AN	1 / 35	Other Insured First Name
Not Used	NM105 / 1037	Name Middle	O	AN	1 / 25	Other insured Middle Name
Not Used	NM106 / 1038	Name Prefix	O	AN	1 / 10	
Not Used	NM107 / 1039	Name Suffix	O	AN	1 / 10	Other Insured Name Suffix
Required	NM108 / 66	Identification Code Qualifier	X	ID	1 / 2	**Enter the following: *"MI"*** (Member Identification Number)

Required	NM109 / 67	Identification Code	X	AN	2 / 80	Other Insured Primary Identifier
Not Used	NM110 / 706	Entity Relationship Code	X	ID	2 / 2	
Not Used	NM111 / 98	Entity Identifier Code	O	ID	2 / 3	
Not Used	NM112 / 1035	Name Last or Organization Name	O	AN	1 / 60	

2330A: REF: Other Subscriber Secondary Identification

Loop : 2330A – OTHER SUBSCRIBER NAME
Usage : Situational (NJ HealthCAP - Optional)
Repeat : 3
Example : REF*SY*030385074~

Table 2-66 Other Subscriber Secondary Identification

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	REF01 / 128	Reference Identification Qualifier	M	ID	2 / 3	**Enter the following: *"SY"*** (Social Security Number)
Required	REF02 / 127	Reference Identification	X	AN	1 / 30	**Enter the following:** Social Security Number
Not Used	REF03 / 352	Description	X	AN	1 / 80	
Not Used	REF04 / C040	Reference Identifier	O			

2330B: NM1: Other Payer Name

Loop : 2330B – OTHER PAYER NAME | Loop Repeat: 1
Usage : Required
Repeat :1
Example : NM1*PR*******PI*059~

Table 2-67 Other Payer Name

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	NM101 / 98	Entity Identifier Code	M	ID	2 / 3	**Enter the following*: "PR"*** (Payer)
Not Used	NM102 / 1065	Entity Type Qualifier	M	ID	1 / 1	**Enter the following**: *"2"* (Non-Person Entity)
Not Used	NM103 / 1035	Name Last or Organization Name	O	AN	1 / 60	Payer Name
Not Used	NM104 / 1036	Name First	O	AN	1 / 35	Payer First Name
Not Used	NM105 / 1037	Name Middle	O	AN	1 / 25	
Not Used	NM106 / 1038	Name Prefix	O	AN	1 / 10	
Not Used	NM107 / 1039	Name Suffix	O	AN	1 / 10	
Required	NM108 / 66	Identification Code Qualifier	X	ID	1 / 2	**Enter the following:** ***"PI"*** (Payer Identification) Use for Payer Identification codes other than Self, Charity, and Unknown ***"XV"*** (Centers for Medicare and Medicaid Services Plan ID Required when the National Plan ID is implemented.
Required	NM109 / 67	Identification Code	X	AN	2 / 80	**Enter the following: *"NNN"*** (NJDOH Other Payer Code)
Not Used	NM110 / 706	Entity Relationship Code	X	ID	2 / 2	
Not Used	NM111 / 98	Entity Identifier Code	O	ID	2 / 3	
Not Used	NM112 / 1035	Name Last or Organization Name	O	AN	1 / 60	

2330B: REF: Other Payer Secondary Identification

Loop : 2330B – OTHER PAYER NAME
Usage : Situational (NJ HealthCAP - Optional)
Repeat : 2
Example : REF*FY*030385074~

Table 2-68 Payer Secondary Identification

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	REF01 / 128	Reference Identification Qualifier	M	ID	2 / 3	**Enter the following: *"2U"*** (Payer Identification Number)
Required	REF02 / 127	Reference Identification	X	AN	1 / 30	**Enter the following:** Payer Additional Identifier
Not Used	REF03 / 352	Description	X	AN	1 / 80	
Not Used	REF04 / C040	Reference Identifier	O			

2400: LX: Service Line Number

The Service Line LX segment begins with 1 and is incremented by one for each additional service line of a claim. The LX functions as a line counter.

Loop : 2400 – SERVICE LINE NUMBER | Loop Repeat: 999
Usage : Required
Repeat : 1
Example : LX*1~

Table 2-71 Service Line Number

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	LX01 / 554	Assigned Number	M	N0	1 / 6	Number assigned for differentiation within a transaction set. This is the service line number. Begin with 1 and increment by 1 for each new LX segment within a claim.

2400: SV2: Institutional Service Line

All charges incurred during the patient's stay or visit should be reported, regardless of what has been billed to insurance.

Loop : `2400 – SERVICE LINE NUMBER`
Usage : `Required`
Repeat : `1`
Example : `SV2*300*HC:80019*73.42*UN*1~`

Table 2-72 Institutional Service Line

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	SV201 / 234	Product / Service ID	X	AN	1 / 48	Service Line Revenue Code See Code Source 132: ***National Uniform Billing Committee (NUBC) Codes.***
Situational	SV202 / C003	Composite Medical Procedure Identifier	X			Service Line Procedure Code
Required	SV202-1 / 235	Product / Service ID Qualifier	M	ID	2 / 2	**Enter the following***: "HC"* (HCFA Common Procedural Coding System (HCPCS) Codes (CPT Codes are reported under HC)
Required	SV202-2 / 234	Product / Service ID	M	AN	1 / 48	HCPCS Procedure Code
Situational	SV02-3 / 1339	Procedure Modifier	O	AN	2 / 2	HCPCS Modifier 1 Use this modifier for the first procedure code modifier. This data element is required when the Provider needs to convey additional clarification for the associated procedure code. ***See NUBC UB92 manual or CMS website***
Situational	SV202-4 / 1339	Procedure Modifier	O	AN	2 / 2	HCPCS Modifier 2 ***See SV202-3***
Situational	SV202-5 / 1339	Procedure Modifier	O	AN	2 / 2	HCPCS Modifier 3 ***See SV202-3***
Situational	SV202-6 / 1339	Procedure Modifier	O	AN	2 / 2	HCPCS Modifier 4 ***See SV202-3***
Not Used	SV202-7 / 352	Description	O	AN	1 / 80	
Not Used	SV202-8 / 234	Product / Service ID	O	AN	1 / 48	
Required	SV203 / 782	Monetary Amount	O	R	1 / 18	Service Line Charge Amount Use this amount to indicate the total charge amount
Required	SV204 / 355	Unite or Basis for Measurement Code	X	ID	2 / 2	**Enter one of the following:** ***"DA"*** (Days) ***"UN"*** (Unit)
Required	SV205 / 380	Quantity	X	R	1 / 15	Service Line Units

						Numeric Value of quantity
Not Used	SV206 / 1371	Unit Rate	O	R	1 / 10	Service Line Rate Amount
Not Used	SV207 / 782	Monetary Amount	O	R	1 / 18	Service Line Non – Covered Charge Amount
Not Used	SV208 / 1073	Yes / No Condition or Response Code	O	ID	1 / 1	
Not Used	SV209 / 1345	Nursing Home Residential Status Code	O	ID	1 / 1	
Not Used	SV210 / 1337	Level of Care Code	O	ID	1 / 1	

2400: DTP: Service Line Date

Loop : 2400 – SERVICE LINE NUMBER
Usage : Situational (NJ HealthCAP - Optional)
Repeat : 1
Example : DTP*472*D8*20040819~

Table 2-73 Service Line Date

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	DTP01 / 374	Date / Time Qualifier	M	ID	3 / 3	**Enter the following: *"472"*** (Service)
Required	DTP02 / 1250	Date Time Period Format Qualifier	M	ID	2 / 3	**Enter one of the following:** ***"D8"*** (Date Expressed in Format ***CCYYMMDD***) ***"RD8"*** (Range of Dates Expressed in Format ***CCYYMMDD-CCYYMMDD***)
Required	DTP03 / 1251	Date Time Period	M	AN	1 / 35	Service Date Expression of a date, a time, or range of dates, times or dates and times

2420A: NM1: Operating Physician Name

Loop : 2420A – OPERATING PHYSICIAN NAME | Loop Repeat: 1
Usage : Situational (NJ HealthCAP - Optional)
Repeat : 1
Example : NM1*72*1*MEYERS*JANE****XX*1234567891~

Table 2-74 Operating Physician Name

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	NM101 / 98	Entity Identifier Code	M	ID	2 / 3	**Enter the following: *"72"*** (operating Physician
Required	NM102 / 1065	Entity Type Qualifier	M	ID	1 / 1	**Enter the following: *"1"*** (Person)
Not Used	NM103 / 1035	Name Last or Organization Name	O	AN	1 / 60	Operating Physician Last Name
Not Used	NM104 / 1036	Name First	O	AN	1 / 35	Operating Physician First Name
Not Used	NM105 / 1037	Name Middle	O	AN	1 / 25	Operating Physician Middle Name
Not Used	NM106 / 1038	Name Prefix	O	AN	1 / 10	

Not Used	NM107 / 1039	Name Suffix	O	AN	1 / 10	Operating Physician Name Suffix
Required	NM108 / 66	Identification Code Qualifier	X	ID	1 / 2	**Enter the following: *"XX"*** (HCFA National Provider Identifier)
Required	NM109 / 67	Identification Code	X	AN	2 / 80	Operating Physician Primary Identifier
Not Used	NM110 / 706	Entity Relationship Code	X	ID	2 / 2	
Not Used	NM111 / 98	Entity Identifier Code	O	ID	2 / 3	
Not Used	NM112 / 1035	Name Last or Organization Name	O	AN	1 / 60	

2420A: REF: Operating Physician Secondary Identification

This segment is required to report the Operating Practitioner's state license / UPIN. NJ HealthCAP.

Loop : `2420A – OPERATING PHYSICIAN NAME`
Usage : `Situational (NJ HealthCAP - Optional)`
Repeat : `5`
Example : `REF*0B*NJMA12345~`

Table 2-75 Operating Physician Secondary Identification

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	REF01 / 128	Reference Identification Qualifier	M	ID	2 / 3	**Enter the following: *"0B"*** (State License Number)
Required	REF02 / 127	Reference Identification	X	AN	1 / 30	Operating Physician Secondary Identifier
Not Used	REF03 / 352	Description	X	AN	1 / 80	
Not Used	REF04 / C040	Reference Identifier	O			

2420B: NM1: Other Operating Physician Name

This segment is required when another operating physician is involved.

Loop : 2420B – OTHER OPERATING PHYSICIAN NAME | Loop Repeat: 1
Usage : Situational (NJ HealthCAP - Optional)
Repeat : 1
Example : NM1*ZZ*1*MEYERS*JANE****XX*1234567891~

Table 2-76 Other Operating Physician Name

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	NM101 / 98	Entity Identifier Code	M	ID	2 / 3	**Enter the following: *ZZ (***Mutually Defined (Other Operating Physician))
Required	NM102 / 1065	Entity Type Qualifier	M	ID	1 / 1	**Enter the following: *"1"*** (Person)
Not Used	NM103 / 1035	Name Last or Organization Name	O	AN	1 / 60	Other Operating Physician Last Name
Not Used	NM104 / 1036	Name First	O	AN	1 / 35	Other Operating Physician First Name
Not Used	NM105 / 1037	Name Middle	O	AN	1 / 25	Other Operating Physician Middle Name
Not Used	NM106 / 1038	Name Prefix	O	AN	1 / 10	
Not Used	NM107 / 1039	Name Suffix	O	AN	1 / 10	Other Operating Physician Name Suffix
Required	NM108 / 66	Identification Code Qualifier	X	ID	1 / 2	**Enter the following: *XX*** (HCFA National Provider Identifier)
Required	NM109 / 67	Identification Code	X	AN	2 / 80	Other Operating Physician Primary Identifier
Not Used	NM110 / 706	Entity Relationship Code	X	ID	2 / 2	
Not Used	NM111 / 98	Entity Identifier Code	O	ID	2 / 3	
Not Used	NM112 / 1035	Name Last or Organization Name	O	AN	1 / 60	

2420B: REF: Other Operating Physician Secondary Identification

This segment is required to report the Other Operating Physician's state License / UPIN.

Loop : 2420B – OTHER OPERATING PHYSICIAN NAME
Usage : Situational (NJ HealthCAP - Optional)
Repeat : 5
Example : REF*0B*NJMA12345~

Table 2-77 Other Operating Physician Secondary Identification

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	REF01 / 128	Reference Identification Qualifier	M	ID	2 / 3	**Enter the following: *"0B"*** (State License Number)
Required	REF02 / 127	Reference Identification	X	AN	1 / 30	Other Operating Physician Secondary Identifier
Not Used	REF03 / 352	Description	X	AN	1 / 80	
Not Used	REF04 / C040	Reference Identifier	O			

SE: Transaction Set Trailer

Loop : Trailer
Usage : Required
Repeat : 1
Example : SE*1230*987654~

Table 2-78 Transaction Set Trailer

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	SE01 / 96	Number of Included Segments	M	N0	1 / 10	**Enter the following:** "Transaction Segment Count"
Required	SE02 / 329	Transaction Set Control Number	M	AN	4 / 9	Must match number in ***ST02***

GE: Functional Group Trailer

Loop : Trailer
Usage : Required
Repeat : 1
Example : GE*1*1~

Table 2-79 Functional Group (Trailer)

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	GE01 / 97	Number of Transaction Sets Included	M	N0	1 / 6	Total Number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element
Required	GE02 / 28	Group Control Number	M	N0	1 / 9	Assigned Number originated and maintained by the sender. Must match the number in ***GS06***

IEA: Interchange Control Trailer

Loop : Trailer
Usage : Required
Repeat : 1
Example : IEA*1*000000905~

Table 2-80 Interchange Control Trailer

Usage	Reference ID	Reference Description	Attributes			NJ HealthCAP Notes / Comments
Required	IEA01 / 16	Number of Included Functional Groups	M	N0	1 / 5	A count of the number of functional groups included in an interchange
Required	IEA02 / I12	Interchange Control Number	M	N0	9 / 9	A control number assigned by the interchange sender. Must match ***ISA13***

Appendix F: NJ HealthCAP User Guide

NJ HealthCAP User Guide

State of New Jersey
Department of Health

Version 1.2 (03/29/2018)

For questions and comments please contact:

Email: NJ_HealthCAP@pcgus.com

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