# COMMUNITY CONTRACT AND MANAGEMENT SYSTEM
# (CCMS)
# INSTRUCTION MANUAL

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## PREFACE

This instruction manual is meant to serve as a reference tool and though it may need to be read from front to back the first time, it is organized to facilitate quick reference for on-going operation. It is organized in the following major sections and appendices.

| | |
|---|---|
| Section I | Introduction<br>Provides a basic description of the Community Contract and Management System, its operations, equipment and software requirements and who to contact with questions. |
| Section II | General Operating Instructions<br>Covers basic menus, common screens, system error messages, and steps to follow each month. |
| Section III | Individual Module Operation<br>Provides instructions for the data entry screens associated with CORE information for the individual. |
| Section IV | Billing Module Operation<br>Provides instructions for the data entry screens associated with the billing process. |
| Section V | PAR Module Operation<br>Provides instructions for the data entry screens associated with Medicaid prior authorization. |
| Section VI | AMPS Batch Module Operation<br>Provides instructions for the data entry screens associated with batch submission of Medicaid claims. |
| Section VII | PQ Module Operation<br>Provides instructions for the data entry screens associated with Program Quality monitoring. |
| Section VIII | System Functions<br>Provides instructions for the CCMS system level tasks. |
| Section IX | Reports<br>Provides instructions for generating basic reports and the CCMS standard report screen. |
| Appendix A | Field Definitions and Minimum Reporting Criteria<br>Provides codes and definitions for the primary files and data fields and explains the requirements for state-wide and historical fields. |

Appendix B Billing Methodologies
Explains concepts of individual and contract maximums and how each billing methodology is implemented.

Appendix C Billing Reporting Requirements
Provides detailed requirements and definitions for billing reporting required by DDD.

Appendix D Error Messages
Contains data entry error messages specific to each module, grouped by module, and error messages for edit reports.

Appendix E File Structure and Field Names
Contains a definition of each primary file used in the system, the fields contained in the file and a short description of each field's use.

TABLE OF CONTENTS


| | | | |
|---|---|---|---|
| I. | INTRODUCTION | | |
| | Summary of CCMS Operation and Requirements | | I - 1 |
| | A. | What is CCMS? | I - 1 |
| | B. | CORE and Billing Coordinators | I - 2 |
| | C. | How CCMS Designed | I - 3 |
| | D. | What is Needed to use CCMS | I - 3 |
| | E. | Who to Contact With Questions | I - 4 |
| II. | GENERAL OPERATING INSTRUCTIONS | | |
| | A. | CCMS Startup and Menus | II - 1 |
| | B. | Common Screen Elements and Message Screens | II - 11 |
| | C. | System Error Messages | II - 16 |
| | D. | Steps to Follow Each Month | II - 19 |
| III. | INDIVIDUAL MODULE | | |
| | A. | Individual Main Data Screen | III - 1 |
| | B. | Day Program Screen | III - 7 |
| | C. | Residential Screen | III - 8 |
| | D. | Support Services Screen | III - 10 |
| | E. | Address Data Screen | III - 11 |
| | F. | Waiting List Registry Screen | III - 13 |
| | G. | Optional Data Screen | III - 16 |
| IV. | BILLING MODULE | | |
| | A. | Billing Data Menu | IV - 1 |
| | B. | Comprehensive Batch Screen | IV - 3 |
| | C. | Comprehensive Browse Transaction Screen (Full Grid) | IV - 8 |
| | D. | Comprehensive Browse Transaction Screen (Part Grid) | IV - 11 |
| | E. | Support Batch Screen | IV - 14 |
| | F. | Support Browse Transaction Screen (Full Grid) | IV - 19 |
| | G. | Support Browse Transaction Screen (Part Grid) | IV - 22 |
| | H. | Other Services Batch Screen | IV - 25 |
| | I. | Other Services Browse Transaction Screen | IV - 29 |
| | J. | Contract Record Entry Screen | IV - 32 |
| | K. | Contract Adjustment/Special Billing Screens | IV - 38 |
| | L. | Mass Contract Update Screen | IV - 42 |
| | M. | SLS/CES Rates Update Screen | IV - 44 |
| | N. | Provider Record Entry Screen | IV - 46 |
| V | PAR MODULE | | |
| | A. | PAR Data Menu | V - 1 |
| | B. | PAR Update Screen | V - 3 |
| | C. | Create Update Files Screen | V - 9 |
| | D. | PA Change Log Update Screen | V - 10 |

| | | | |
|---|---|---|---|
| VI | AMPSBATCH MODULE | | |
| | A. | AMPSbatch Menu | VI - 1 |
| | B. | AMPSbatch Selection Screen | VI - 2 |
| | C. | AMPSbatch ReBill Screen | VI - 10 |
| VII | PQ MODULE | | |
| | A. | PQ Data Menu | VII - 1 |
| | B. | Service Agency Screen | VII - 2 |
| | C. | Program Approval Screen | VII - 6 |
| | D. | Survey Screens | VII - 10 |
| VIII | SYSTEM FUNCTIONS | | |
| | A. | File Updates Menu | VIII - 1 |
| | B. | Agency File Screen | VIII - 3 |
| | C. | Code Table Screen | VIII - 5 |
| | D. | HCPCS File Screen | VIII - 8 |
| | E. | AMP System Variables Screen | VIII - 10 |
| | F. | File Maintenance Menu | VIII - 12 |
| | G. | Index Files | VIII - 14 |
| | H. | Auxiliary File Indexing | VIII - 16 |
| | I. | Backup Data Files to Disk | VIII - 18 |
| | J. | Recover Data Files from Disk | VIII - 20 |
| | K. | Data Warehouse File Creation | VIII - 22 |
| | L. | Import/Export Menu | VIII - 24 |
| | L.1 | Import Client Data | VIII - 26 |
| | L.2 | Export Client Data | VIII - 28 |
| | L.3 | Import Billing Data | VIII - 29 |
| | L.4 | Export Billing Data | VIII - 31 |
| | M. | DDD Update Screen | VIII - 32 |
| | N. | Posting Screen | VIII - 34 |
| | O. | AMPSBatch Menu | VIII - 38 |
| | P. | AMPSBatch Create Transmission File | VIII - 40 |
| | Q. | AMPSBatch File Transmission | VIII - 42 |
| | R. | AMPSBatch Report Retrieval Screen | VIII - 44 |
| | S. | AMPSBatch Archive Screen | VIII - 48 |
| | T. | History File Update Screen | VIII - 51 |
| | U. | DDD Create Transmission Files | VIII - 53 |
| | V. | DDD File Transmission Screen | VIII - 55 |
| | W. | Close Out the Month Processing | VIII - 57 |
| | X. | System Security Screen | VIII - 59 |
| | Y. | System Lock Function | VIII - 61 |
| | Z. | All Log-In's Today Function | VIII - 63 |
| IX | REPORTS | | |
| | A. | Individual Reports Menu | IX - 1 |

## APPENDICES


| | | | |
|---|---|---|---|
| A | DEFINITIONS | | |
| | I. | CCMSAGCY - CCMS Agency File | A - 1 |
| | II. | CLMAND – Consumer Mandatory (CORE) File | A - 6 |
| | III. | CLWAIT – Consumer Waiting List Registry File | A - 42 |
| | IV. | CLADDR – Consumer Address File | A - 46 |
| | V. | BIBATCH - Billing Batch File | A - 18 |
| | VI. | BITRAN - Billing Transaction File | A - 53 |
| | VII. | BICONTR - Billing Contract File | A - 62 |
| | VIII. | BIL_RATE – Billing Rate File | A - 69 |
| | IX. | RATEPROV - Rate Provider File | A - 71 |
| | X. | PAR - Prior Authorization File | A - 75 |
| | XI. | AMPBTRN – AMP Billing Transaction File | A - 83 |
| | XII. | AMPTRAN – AMP Transaction File | A - 84 |
| | XIII. | PQSAGY – PQ Service Agency File | A - 86 |
| | XIV. | PQPROG – PQ Program Approval File | A - 88 |
| | XV. | PQSURVEY – PQ Survey File | A - 90 |
| | XVI. | CCMSCODE - CCMS Code Table File | A - 93 |
| B | BILLING METHODOLOGIES | | |
| | I. | System Wide Definition | B - 1 |
| | II. | Encounter Data Reporting | B - 3 |
| | III. | Reimbursement Methods | B - 4 |
| C | BILLING REPORTING REQUIREMENTS | | |
| | I. | DDD Data Collection/Reporting Definitions | C - |
| D | ERROR MESSAGES | | |
| | I. | Summary of Error Messages Covered | D - 1 |
| | II. | Individual Module Data Entry Error Messages | D - 2 |
| | III. | Billing Module Data Entry Error Messages | D - 20 |
| | IV. | PAR Module Data Entry Error Messages | D - 24 |
| | V. | AMPSbatch Module Data Entry Error Messages | D - 27 |
| | VI. | Posting Error Messages | D - 28 |
| | VII. | Billing to CORE Crosscheck Error Messages | D - 31 |
| | VIII. | CORE to Billing Crosscheck Error Messages | D - 34 |
| | IX. | Year to Date Crosschecks | D - 36 |
| | X. | Data Edit Review Error Messages | D - 38 |
| E | FILE STRUCTURE AND FIELD NAMES | | |
| | I. | CCMSAGCY - Agency File | E - I |
| | II. | CLMAND - Consumer Mandatory (CORE) File | E - II |
| | III. | CLADDR - Consumer Address File | E - III |
| | IV. | CLWAIT - Waiting List Registry File | E - IV |
| | V. | CLHIST - Consumer History File | E - V |

| | | |
|---|---|---|
| VI. | BIBATCH - Billing Batch File | E - VI |
| VII. | BITRAN - Billing Transaction File | E - VII |
| VIII. | BIHOURS - Billing Hours File | E - VIII |
| IX. | BICLYTD - Billing Client Year to Date File | E - IX |
| X. | BICONTR - Billing Contract File | E - X |
| XI. | BIPROV – Medicaid Provider File | E - XI |
| XII. | BIL_RATE – Billing Rate File | E - XII |
| XIII. | PAR - Prior Authorization | E - XIII |
| XIV. | AMPBTRN - AMPSbatch Billing System Transaction Interface File | E - XIV |
| XV. | AMPTRAN - AMPSbatch Transaction File | E - XV |
| XVI. | AMPCLAIM - AMPSbatch Claim File | E - XVI |
| XVII. | PQSAGY - Program Quality Service Agency File | E - XVII |
| XVIII. | PQPROG - Program Quality Program Approval File | E - XVIII |
| XIX. | PQSURVEY - Program Quality Survey File | E - XIX |
| XX. | CCMSCODE - CCMS Code Table File | E - XX |

# COMMUNITY CONTRACT AND MANAGEMENT SYSTEM
# INTRODUCTION

## A. What is the Community Contract and Management System (CCMS)

The Community Contract and Management System (CCMS) is a computerized data system for the State of Colorado Division for Developmental Disabilities (DDD). The system is used to authorize services, collect individual data and bill for services for people with developmental disabilities. The system is composed of five different modules described below:

### 1. Individual (CORE) Module

This module collects and reports basic information about persons with developmental disabilities such as demographics, disabilities and services received. Information must be entered about persons who are on a waiting list, as well as persons receiving services. This information is entered at agency sites and transmitted monthly to DDD to update statewide files. Several informational and management reports can be printed at the agency sites to help in the administration and planning of services for that site.

The main consumer file, for which the monthly updates are transmitted to DDD, is the mandatory CORE file of the system. There are also several optional files linked to the CORE file which can be used to collect and report additional information needed only at the agency site, such as relative's addresses, agency defined services needed, etc. The main optional file can be tailored to each agency's specific needs because it allows dynamic definition of field types, sizes and uses.

### 2. Billing Module

This module prepares the monthly bills for agencies for services they and their subcontract providers render under contract to DDD. It is designed to calculate total bills, produce contract status reports, track billing status changes and produce automated batch claims for the Medicaid Management Information System (MMIS). Units of service or dollar amounts billed must be entered monthly for each person served and are posted to year-to-date fields in consumer and contract records. The billing is entered at agency sites and transmitted monthly to DDD to update statewide files. Several reports can be printed to display billing information for the month and/or for year-to-date totals in order to monitor individual consumer and contract level utilization.

The contract file contains DDD contract records that authorize each agency to bill for particular services and are based on the agency's contract with DDD

This module is also used to enter and update contract records at the DDD site. Records are entered or updated to authorize agencies to bill up to the contract dollar amount for specific services specified in their contract with DDD. New entries and updates are transmitted to agencies monthly to affect the billing for that month.

### 3. PAR Module

This module is used to prior authorize Medicaid Waiver services for individuals. There are several Medicaid Waivers administered by DDD, and all require that the person first be enrolled in the appropriate waiver before approved services may be billed. Prior authorization records are entered at the DDD site and transmitted monthly to each agency in a file containing only the data for their agency.

Prior authorization entries and changes are transmitted to the Medicaid Fiscal Agent for use in the MMIS for payment of claims for authorized services.

**4. AMPSbatch Module**

This module creates automated Medicaid claims from the Medicaid billing transactions, which are entered at agency sites, and transmits them from the agency sites to the Medicaid Fiscal Agent Automated Medicaid Payment System (AMPS) each month. Agencies then receive automated reports from AMPS notifying them of the status of submitted claims.

No data input is required for Medicaid claims because the data is already available from the billing information that was entered. The module includes a rebill function so claims, which are rejected by AMPS or denied by MMIS, may be rebilled until they are paid or deemed not collectible.

**5. PQ Module**

This module tracks program approvals and surveys conducted by the Program Quality (PQ) section of DDD. It assists PQ staff to report on surveys conducted during the fiscal year and identify programs and agencies for which surveys need to be scheduled for the upcoming fiscal year.

This module and the data associated with it is available only at the DDD site.

## B. CORE and Billing Coordinators

Each agency must designate a coordinator for the CCMS CORE and Billing modules to act as a liaison to the DDD Business Analyst and Information Technology staff. The CORE and Billing coordinators may be the same person, depending on business operations in your agency. The CORE and Billing coordinators are responsible for reporting system problems to the Colorado Department of Human Services (CDHS) Help Desk and directing questions or issues about the business operation of CCMS to the DDD Business Analyst. All user questions or problems must go through the CORE and Billing coordinators before DDD will address them.

Your agency should also designate a CCMS System Administrator to be responsible to create log-ins for new users and maintain information for existing users. The administrator should also ensure that monthly processes are completed in a timely manner and that all CCMS program updates have been installed for the month. The system administrator can also be the CORE or Billing coordinator.

## C. How the Community Contract and Management System was Designed

CCMS was designed by the Program Evaluation and Information Services Section of Division for Developmental Disabilities with the assistance of the CORE and Billing Steering Committees composed of representatives from Community Centered Boards (CCBs), Regional Centers (RCs), and Division for Developmental Disabilities program staff. All agencies were surveyed by phone or on-site visits at several stages in the development of the system to provide them the opportunity for input.

The Community Contract and Management System was designed and programmed by Division for Developmental Disabilities. It is a distributed data processing system, which operates separately at 23 different agency sites and at the DDD central office. It may be operated in either a standalone or a network mode. Consumer and billing information is entered at the 23 agency sites and transmitted monthly to DDD to update state-wide files. Contract, provider and prior authorization information is entered at the DDD site and transmitted monthly to agencies to update their files. The system is programmed in the Visual Foxpro 7.0 database programming language for operation in a Windows environment on IBM-compatible micro computers.

Agencies may create their own databases and link them to any of the CCMS Visual Foxpro databases. However there are two restrictions on use of the CCMS databases and programs in conjunction with agency created databases and programs:

1. No changes or updates can be made to CCMS database files or programs

2. If additional memory, disk space, etc. is required because of the agency additions, the agency is responsible for upgrading computer hardware and software as needed.

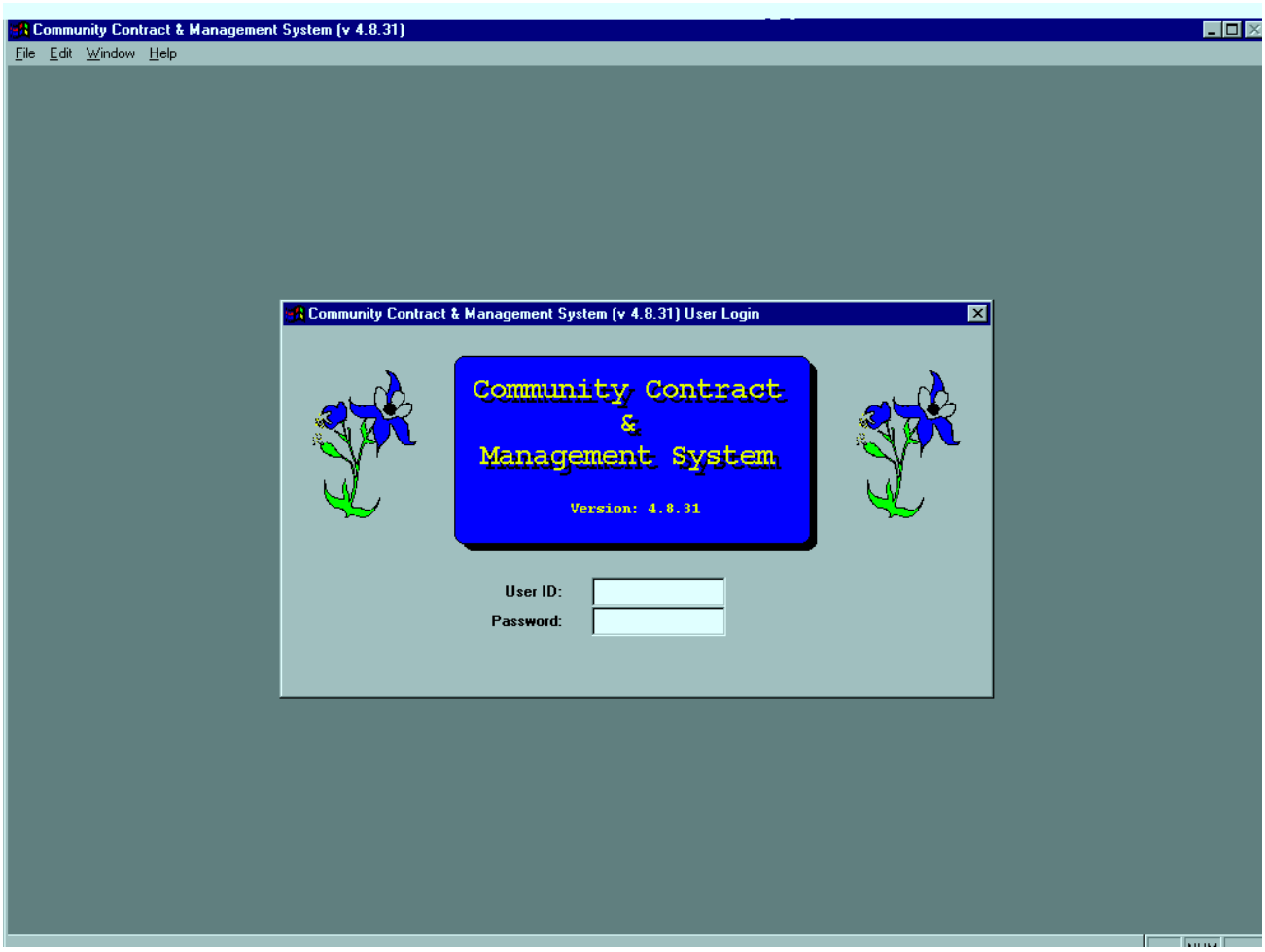
## D. What is Needed to use the Community Contract and Management System

CCMS requires an IBM compatible personal computer with a minimum of 250 megabytes of memory (512 MB preferred), an 80 gigabyte hard drive running at 1.2Ghz, Microsoft Windows 2000 or Windows XP, Visual Foxpro runtime and Crystal Report runtime libraries. Agencies that have been running CCMS prior to October 2004, can continue in their current computer configuration, but the purchase of a new computer must meet this requirement.

Several additional software packages and hardware components are required for the main CCMS machine. The main CCMS machine will be a workstation that can be accessed by CCMS Information Technology Services support staff using a remote software application. Additionally, transmission of data files must take place from this workstation. The required software packages change as interface requirements change, so contact DDD for a current list.

## E. Who to Contact With Questions

Please direct all questions about this manual to the Program Evaluation and Information Services unit of Division for Developmental Disabilities (866-7450.)

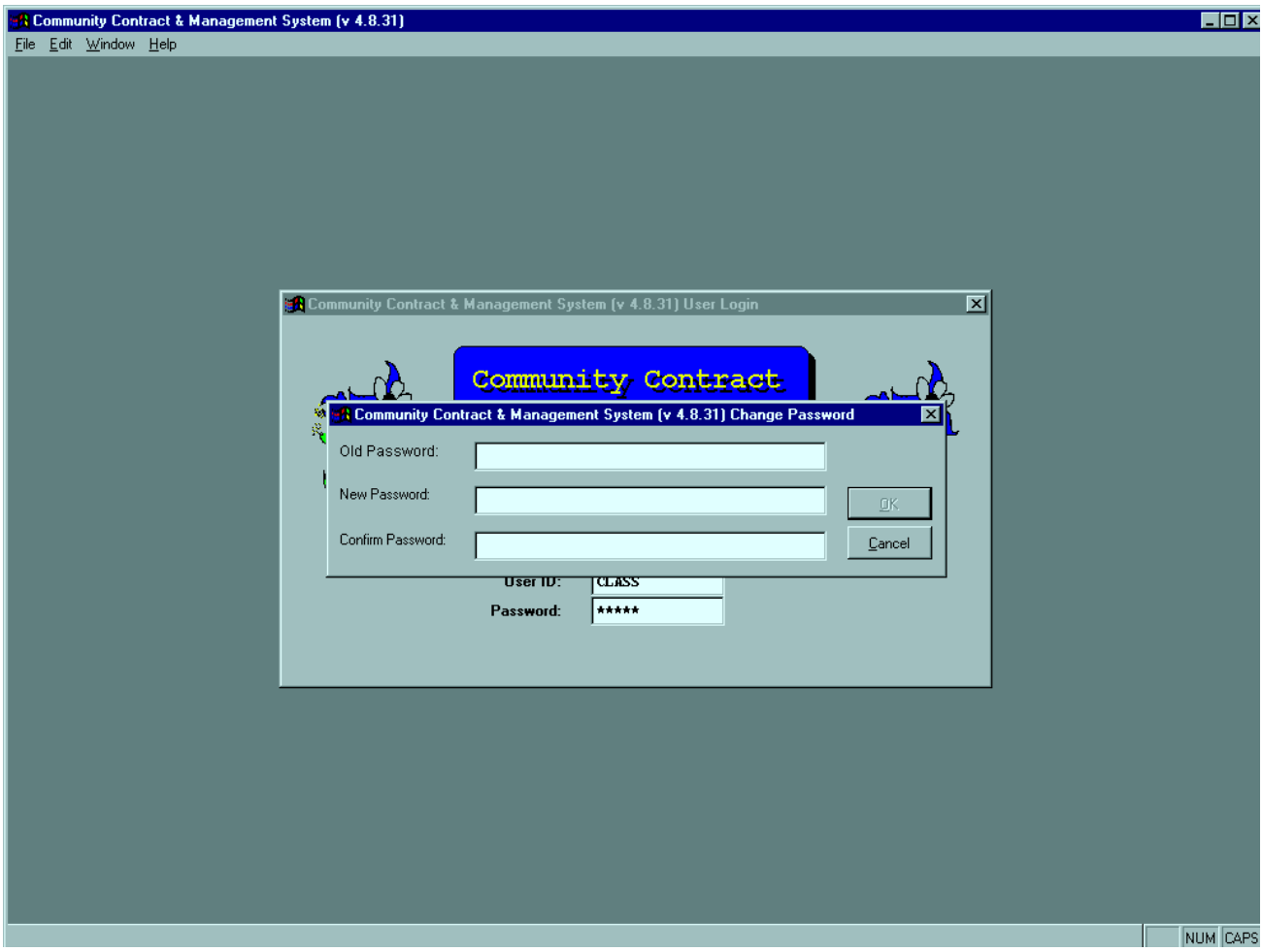



This is the **System Startup** screen for the Community Contract and Management System (CCMS) and will be presented after you have selected the CCMS icon from your Windows Desktop or Menu.

The latest CCMS software version is displayed for informational purposes.

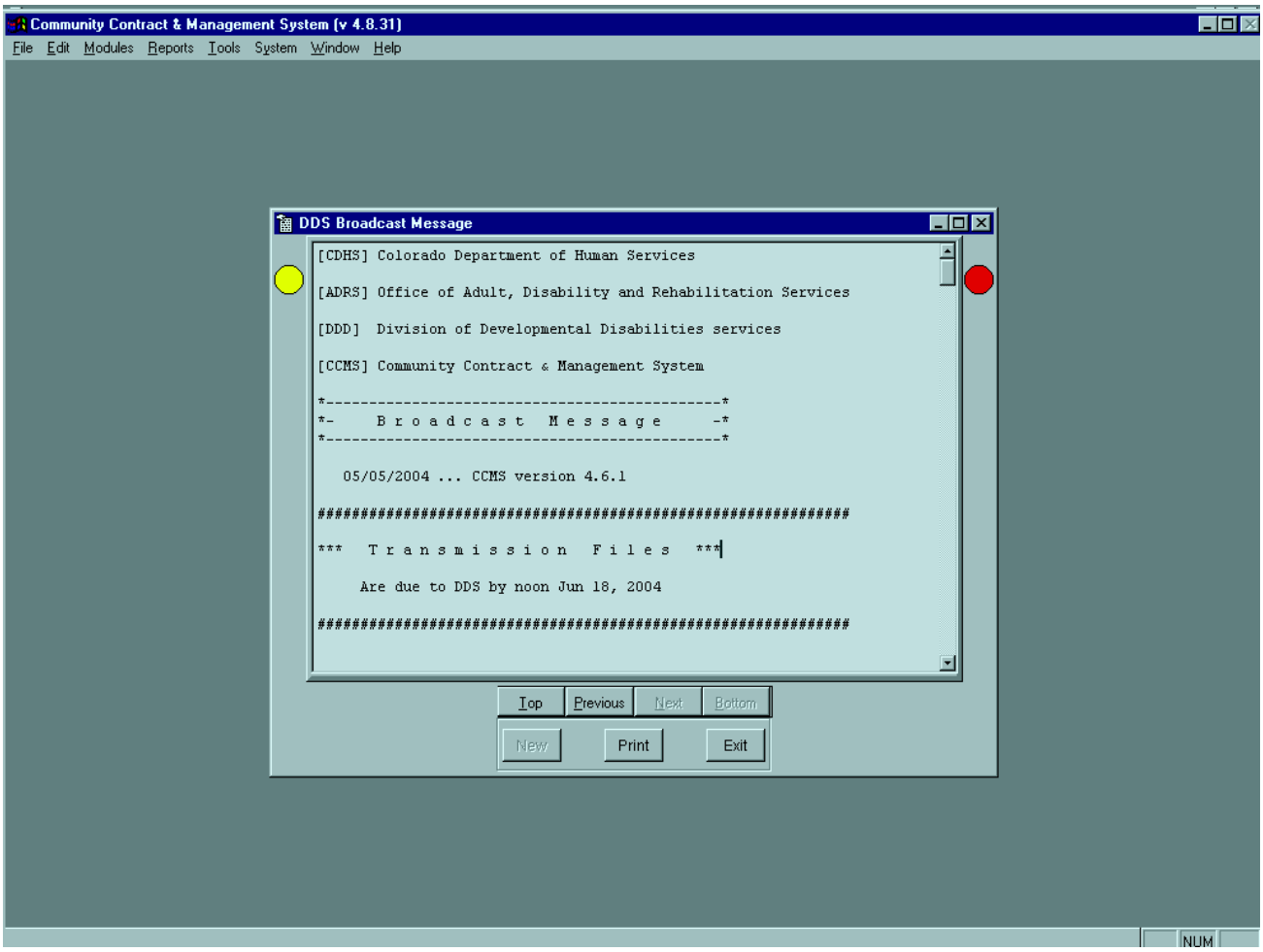
Each user must have a unique user ID and password in order to enter the system. **Type your user ID in the first field and your password in the second field**. The password is case sensitive, so you must enter it with the correct lower and upper case letters. Once the password is validated, you will be allowed into the system. You will be allowed three attempts to log in. If the third attempt fails, you will be denied access to the system. The CCMS System Administrator must be contacted to reset your password after an unsuccessful attempt to log in.

If your password has expired, you will have 5 grace log-ins available to you until mandatory password change is required.




This is the **Password Change** screen that will appear automatically after 40 days have elapsed from the last date a user changed his password and the 5 grace log-ins have expired. You must change your password at a minimum every 40 days. Also, if a user had an unsuccessful login and had to contact the system administrator to reset his password, the screen will allow the user to enter a new password and proceed into CCMS.

**Do not give anyone your password**. In order to protect the security of the information contained in the CCMS data files, each user is responsible to safeguard his password so it cannot be used for unauthorized access of confidential information.

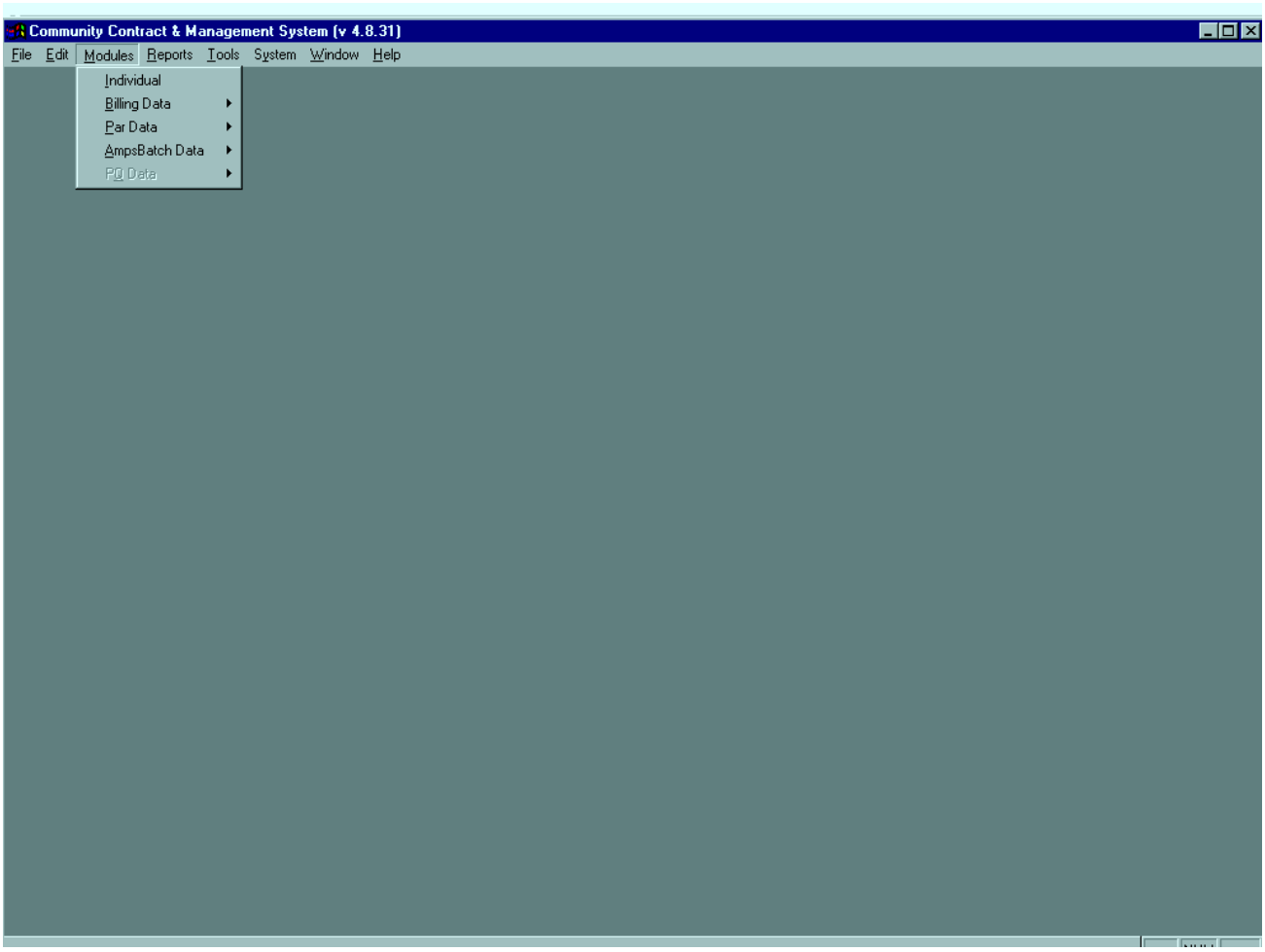



This is the **Broadcast Message** screen that contains informational updates for CCMS. This screen will be presented at least once a month to users who have logged into CCMS during the month. The information on this screen is updated monthly when DDD updates have been downloaded and processed for the month. If a user has already been presented this screen for the month, it will not be displayed again until the next DDD update file is processed.

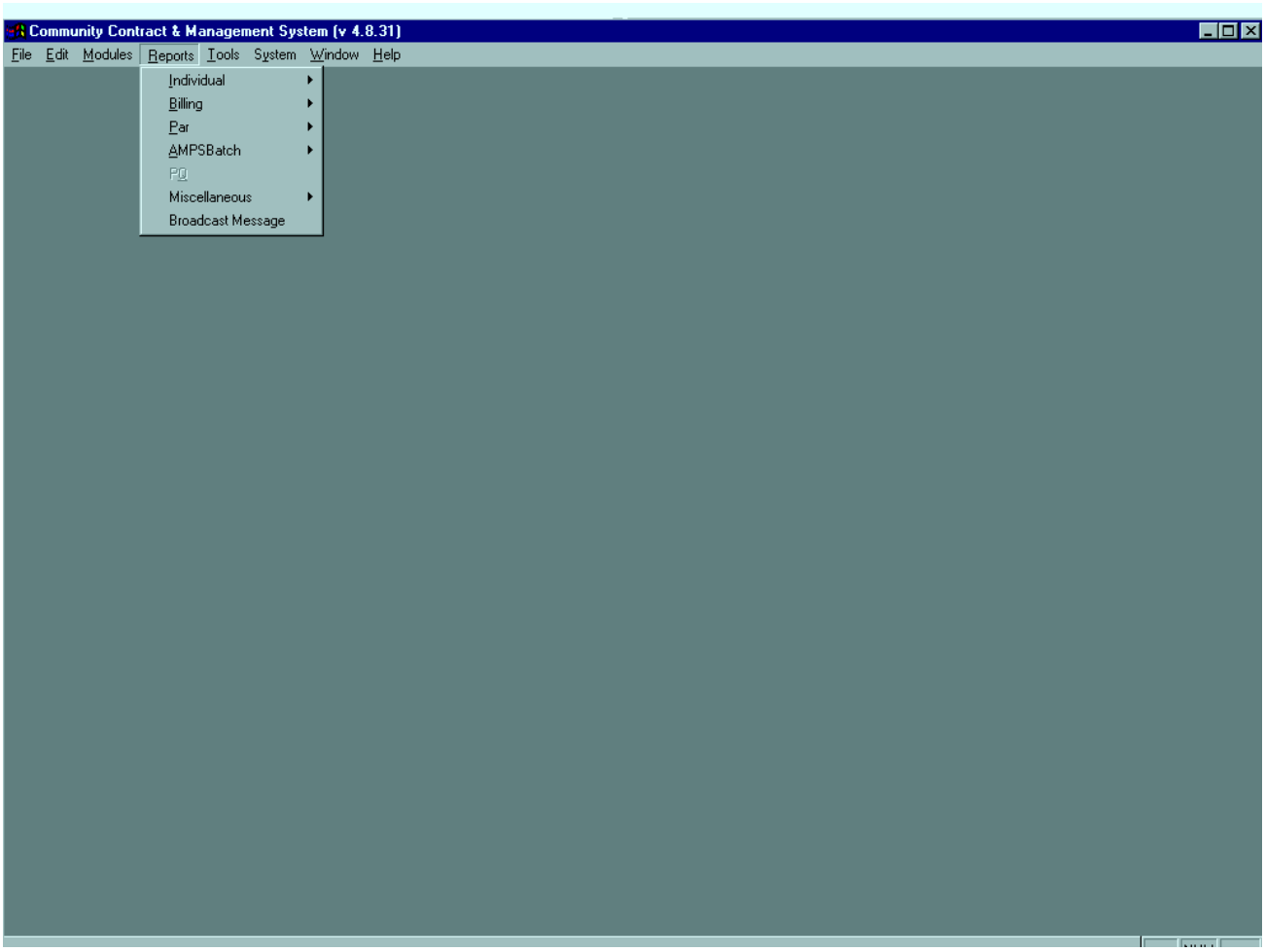
This message can also be access from the Reports menu by selecting the Broadcast Message report.


This is the **CCMS main menu** that appears after your user ID and password have been accepted by the System Startup screen. Selection of items from the main menu bar may be made by **clicking on the menu item with the mouse.** A drop down menu appears beneath each menu item when it is selected. Selection of items from the drop down menus can be made by **clicking on the item with the mouse** or **using the cursor keys to move upward and downward** through the menu selections and **pressing Enter** on a selection when it is highlighted. If an arrow appears to the right of the menu item on a drop down menu, it means there is an additional pop up menu that will appear to the side of that menu item when you select it.

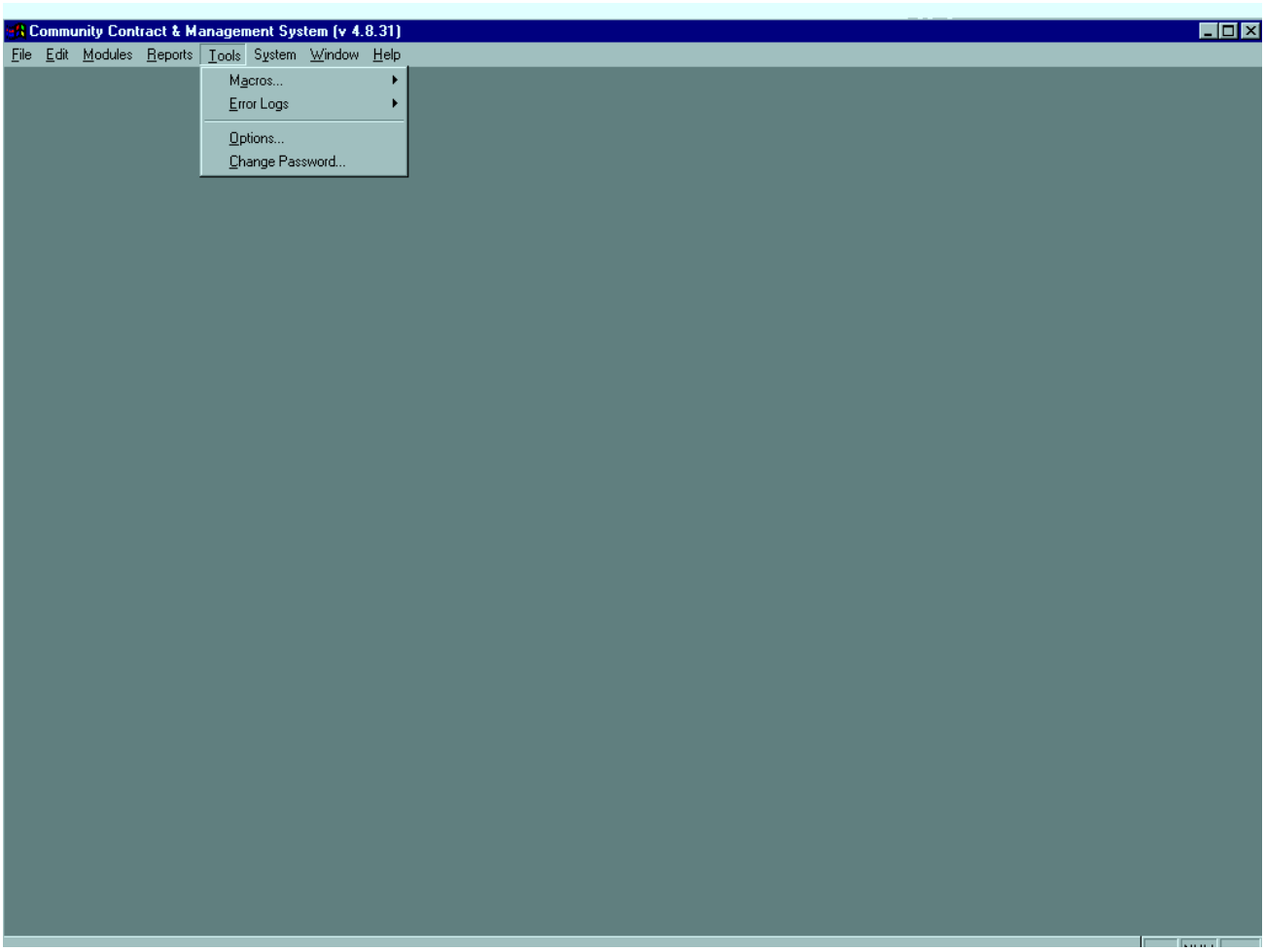
The **File menu** item will provide you with a drop down menu that displays selections for system options and actions. Use the **Printer Setup** selection to change your printer options for older reports. To set printer options for the newer Crystal Reports, you must go into the control panel and set up your printer options there. Crystal Reports uses the Window's default printer. Select **User Login** to log in as a new user. Select **Exit** to exit from CCMS and return to the Windows Program Manager.



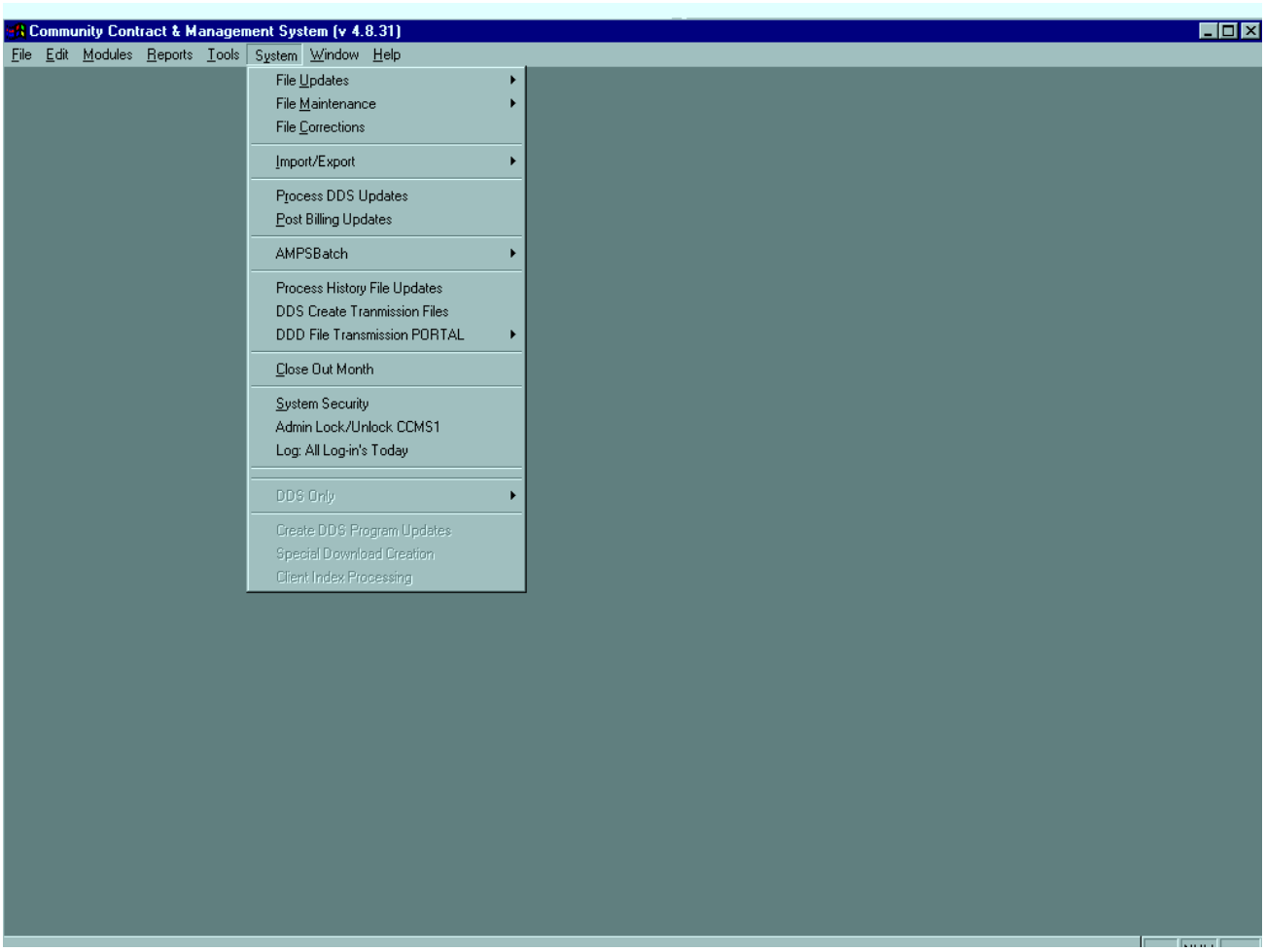

The **Modules menu** item will provide you with a drop down menu that displays the modules available in the system. Your ability to select each item on the Modules menu is determined by the security level that has been assigned to you. If you do not have security rights to an item on the Modules menu, you will not be able to select it. **Refer to Sections III through VII for an explanation of each item on the Modules menu.**



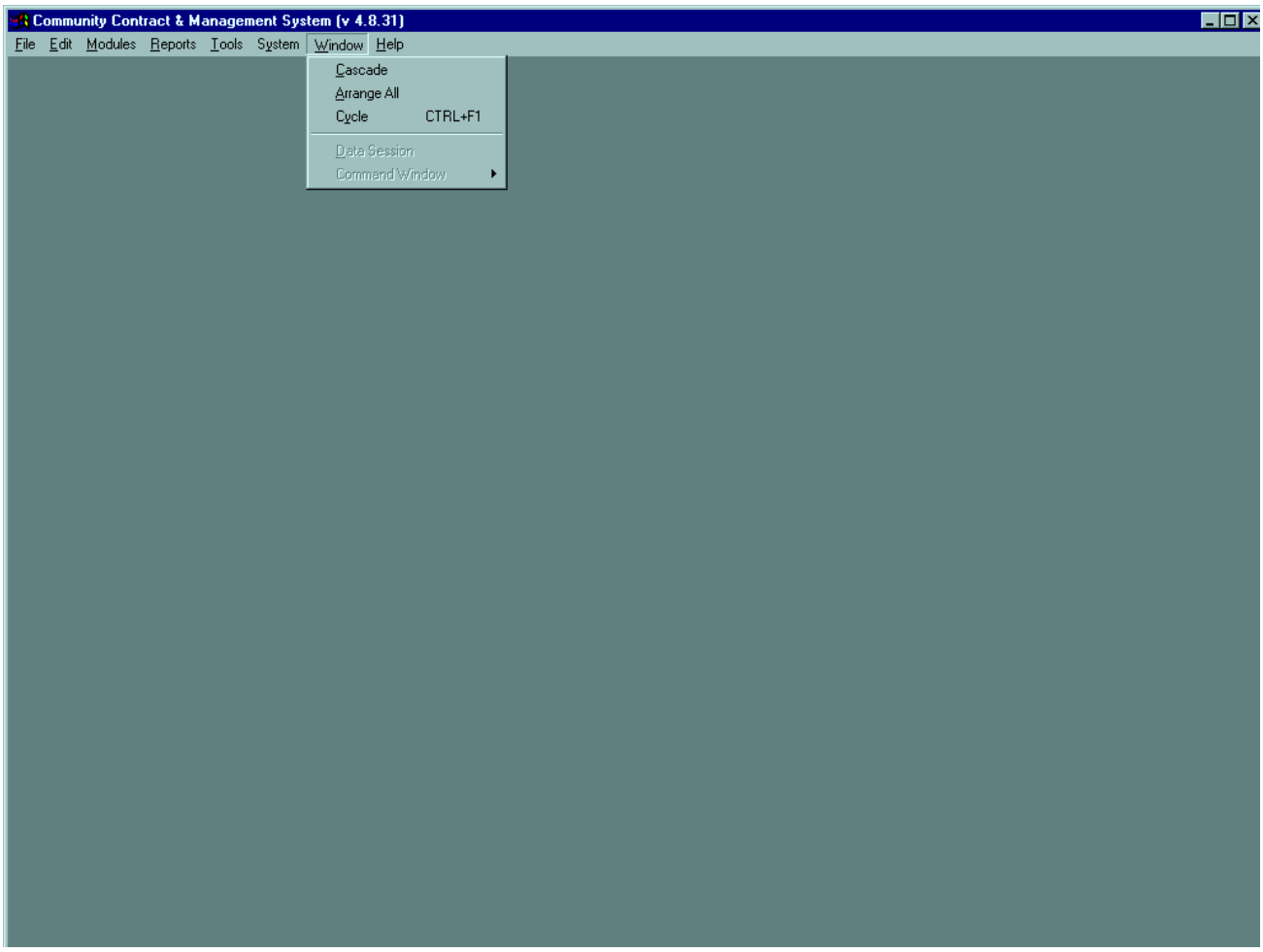

The **Reports menu** item will provide you with a drop down menu that displays selections for reports for each of the modules as well as miscellaneous system reports. Your ability to select the report items for each of the modules is determined by the security level that has been assigned to you for each of those modules. If you do not have security rights to a module, you will not be able to select the report item for that module. **Refer to Section IX for an explanation of the Report Interface.**




The **Tools menu** selection includes several utilities that apply to system operation. The **Options** selection allows you to set options such as whether you want the system to require that you press the Enter key at the end of data entry in every field. The **Error Logs** selection allows access to an error log file that reports system errors to assists technical support staff in troubleshooting problems. Selecting the **Change Password** item brings the user to the **Password Change** screen to change his password before the required 40-day time limit has elapsed.




The **System menu** item will provide you with a drop down menu that displays selections for system level functions. Your ability to select the items on the Systems menu is determined by the security level that has been assigned to you. If you do not have security rights to a system function, you will not be able to select that item from the menu. **Refer to Section VIII for an explanation of each item on the System menu.**




The **Window menu** item will provide you the ability to arrange windows currently displayed on the screen. Windows are displayed in the middle of the screen as menu items are selected, so windows that have been displayed as a result of selecting previous menu choices are covered up. Select the **Cascade** option to show a portion of each window in a cascading configuration. Select the **Arrange All** option to show a portion of each window across the screen. Press the **Cycle or CTRL+F1 key** to cycle or move between windows.


The **Help menu** item will allow you to display information about the current version and contact **information for the Community Contract and Management System**. Currently there is no **Help** functionality available in CCMS, so that menu choice is disabled.

## Common Screen Elements

Most screens will contain fields of data into which you will enter information. **Fields will be either enabled or disabled** depending upon the security level of the user, whether posting has taken place for a billing record, whether a field entry is appropriate for a particular program etc. Disabled fields will appear dimmed on the screen and you will not be able to activate them with either the mouse or the cursor.

**Optional fields** are differentiated by a light blue color. If a field is optional, you do not have to enter data into it.

**Required fields** displayed in white, or grayed out if entry into them is conditional depending on factors such as program and funding type. Although required fields do not have to be completed initially; they must be corrected or updated prior to transmission of the data to DDD for the month.

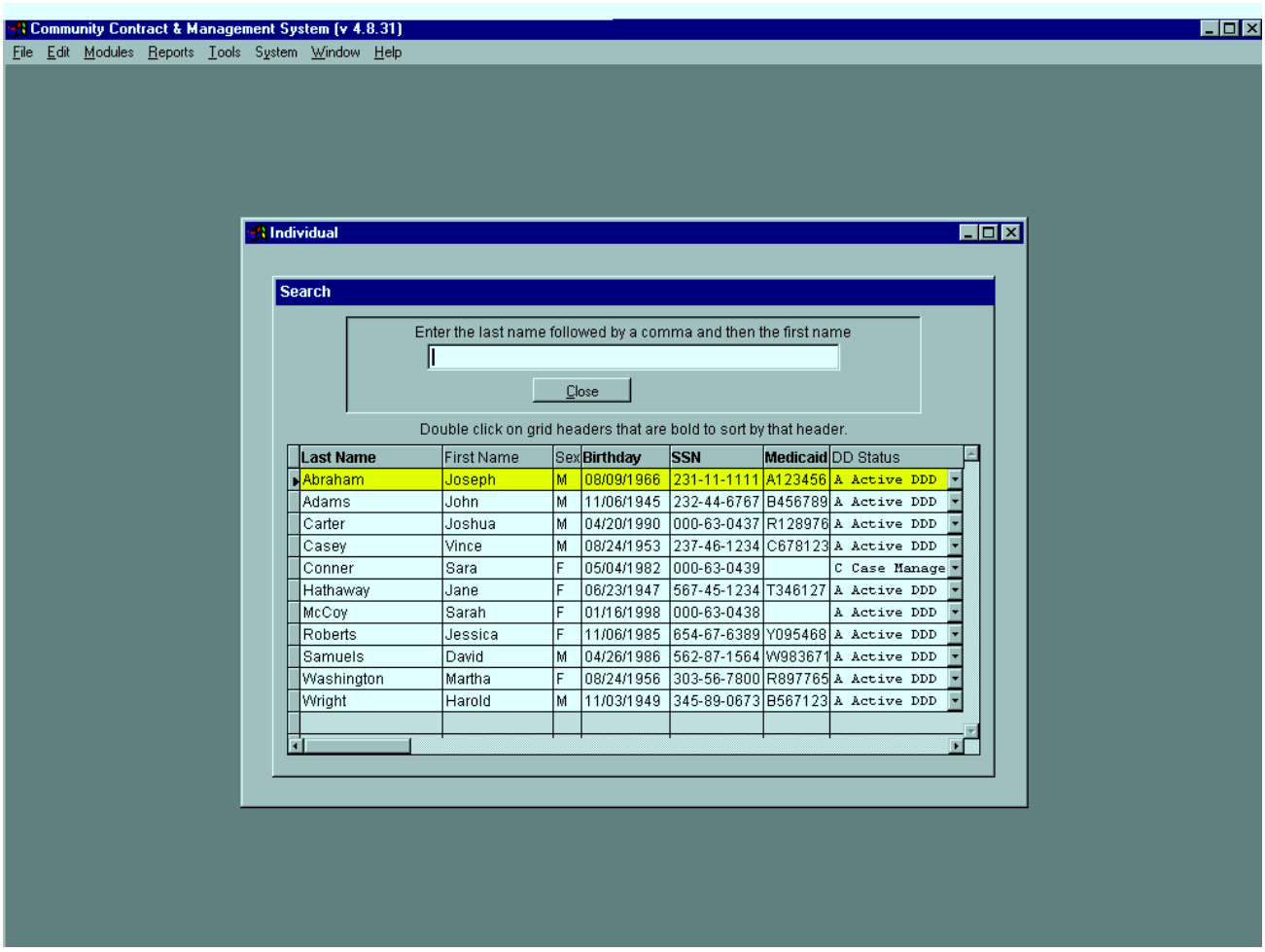
**Mandatory fields** are displayed in a salmon color and are fields which must be entered in order for a record to be accepted when you press the Save button. **If you fail to enter data in a mandatory field, an error message will be displayed when you attempt to save the record**, and you will not be allowed to exit the data entry screen until you have entered data into the mandatory fields.

Most screens throughout the system will contain **buttons** that operate the same from screen to screen. **The common buttons appearing throughout the system are:**

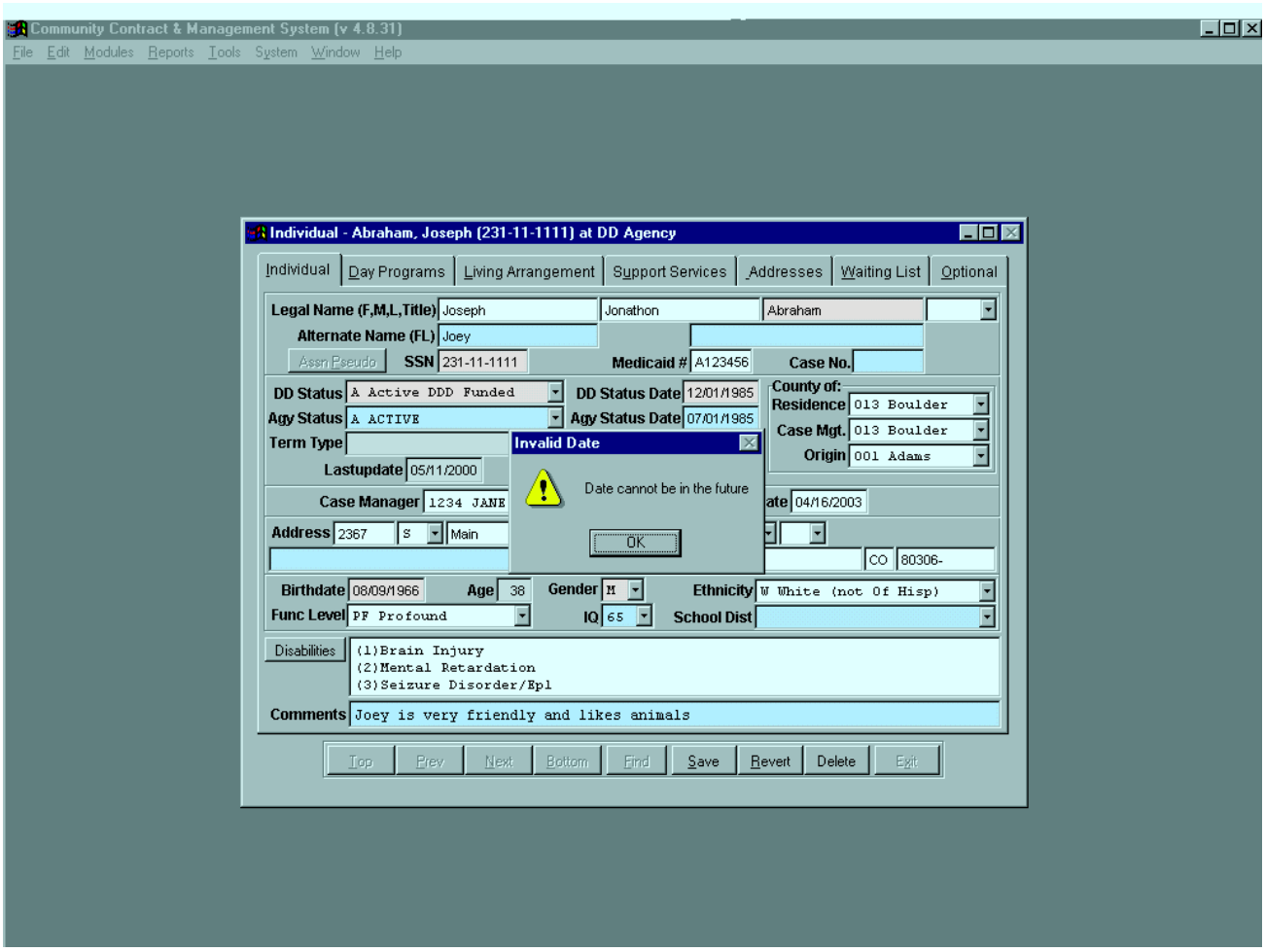
| | |
|---|---|
| **TOP** | will move you to first record. |
| **PREV** | will move you back one record and display it on the screen |
| **NEXT** | will move you forward one record and display it on the screen |
| **BOTTOM** | will move you to last record. |
| **FIND** | will allow you to enter a name, SSN etc. to find a record and display it on the screen |
| **EDIT** | will allow you to enable the fields on an existing record for update |
| **ADD / NEW** | will display a new blank record for entry |
| **REPEAT** | will display a new record for entry using the same values as the previous record |
| **FILTER** | will allow you to filter for only certain records to be displayed |
| **SAVE** | will save **ALL** changes made to a record since the last Save |
| **REVERT** | will undo **ALL** changes made to a record since the last Save |
| **DELETE** | will delete the current record |
| **EXIT** | will exit you from the window |

## Common Message Screens

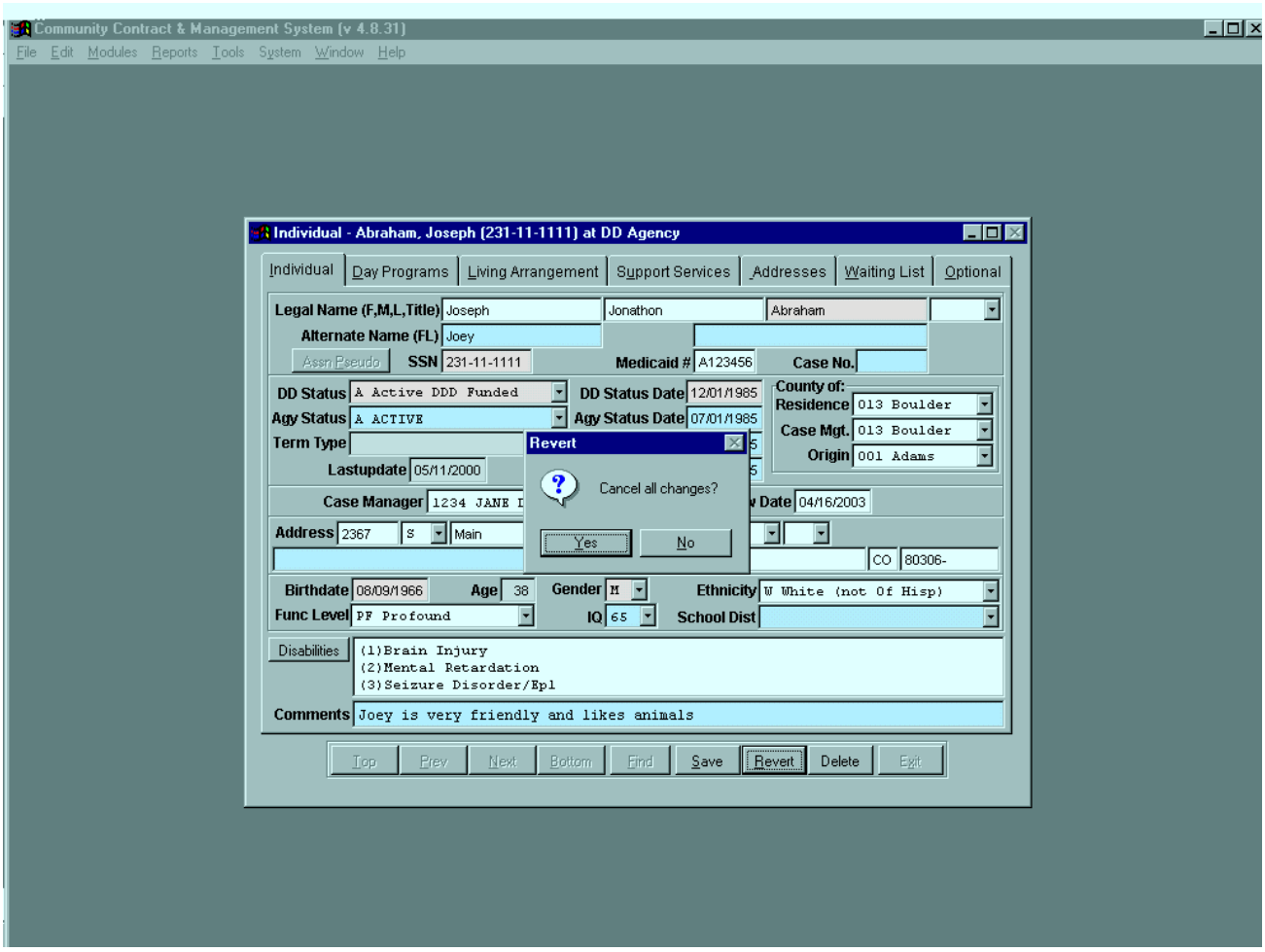
The system uses several common pop-up screens to display information, ask for confirmation or allow you to make additional selections. Following is a summary of those screens and their operation.



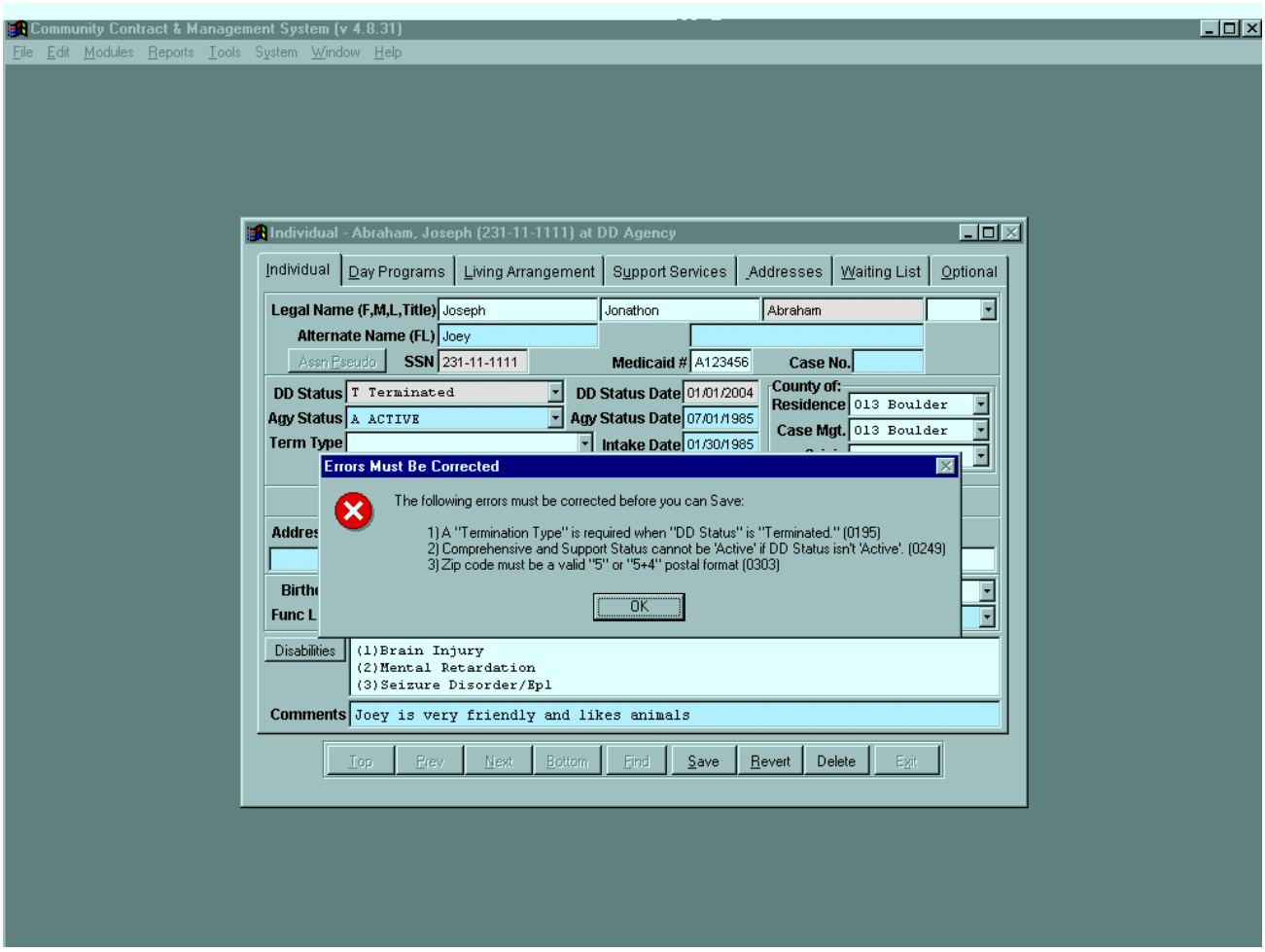

The **Search screen** is displayed when you select the **FIND button** from a data entry screen. This screen allows you to **search** for a record based on the index tags or search keys that are used by the file. The search keys are indicated by bolded column headings in the middle of the Search screen. Double click on the column you wish to search by and **type the value you wish to search for** at the top of the Search screen. It does not matter whether you enter the value in upper or lower case letters. The system will search for the appropriate match either way. You may also enter a **partial value** and the system will find the first record that matches the partial value you have entered. For example, if you are searching by Last Name order and you enter the letters **ada** in the search field, the system will find the first record which begins with those three letters whether it be **Adams, Adamson, adams, etc. To search by social security number order, enter a whole or partial social security number with the dashes included.**



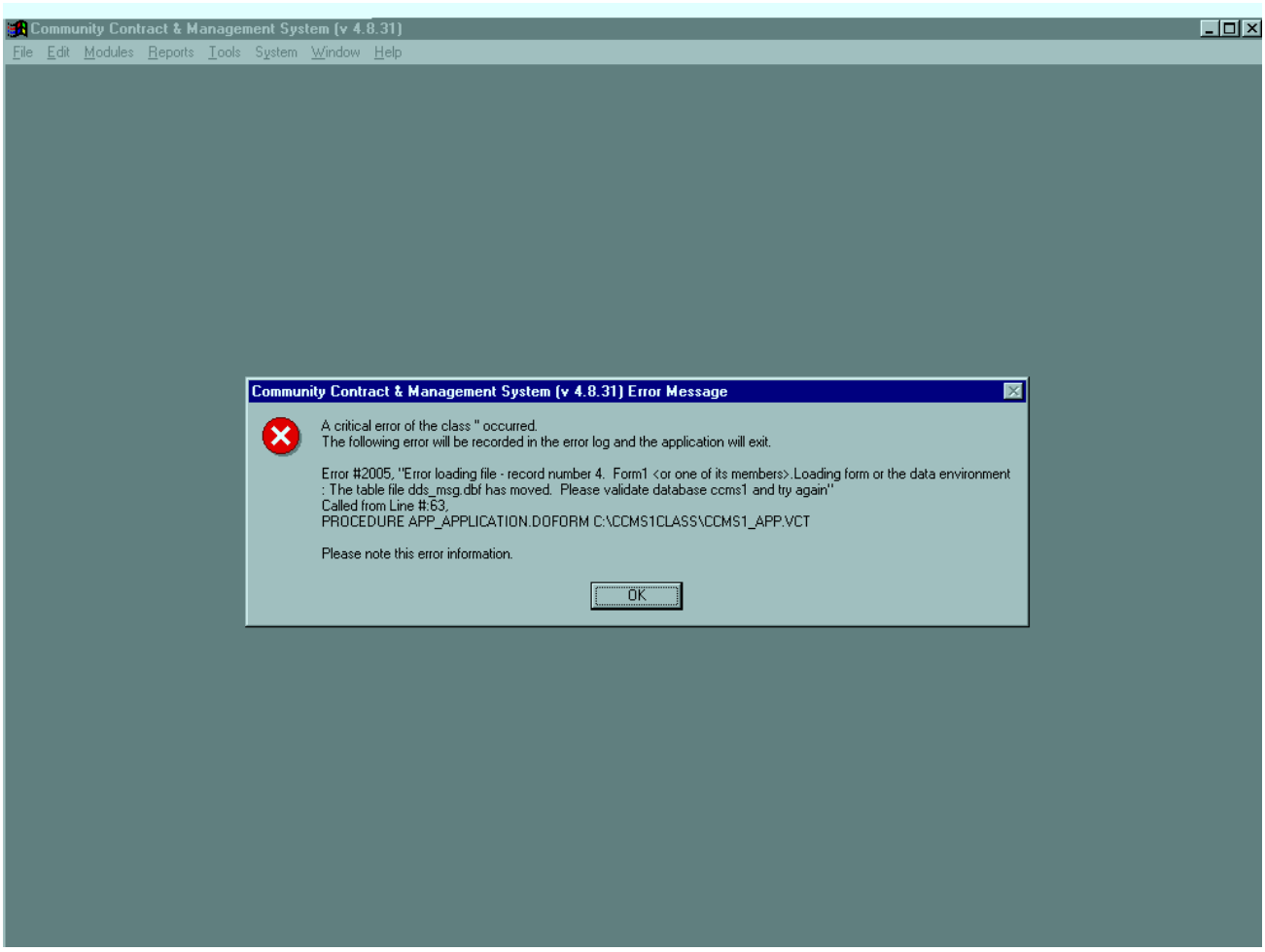

A **Warning screen** is displayed when you have attempted an **invalid entry or action.** You will not be allowed to proceed with that entry or action and must return to the main screen and correct the entry or select another action.




A **Confirm screen** is displayed when you have selected an action which requires confirmation before the system proceeds. This screen may be presented when changes to a record are being discarded, when a selected function will take a while to process, when a system wide action has been selected, etc. Press the **Yes button** to proceed with the action or the **No button** to cancel the action.




An **Errors Must be Corrected** screen is displayed when there are errors resulting from a record update. If there are multiple errors that cannot be displayed in the message screen, they will be displayed on a full screen message where they can be evaluated one at a time.




The **Community Contract & Management System (v 9.9.99) Error Message screen** is presented when a command that could not be executed was encountered in a program. CCMS uses an error trapping program which attempts to identify the problem and then provides information to the user about what the problem might be. Errors should be reported to your CCMS System Administrator immediately. Your System Administrator may also be your CORE or Billing coordinator. Write down the error message that appears **word for word** (or print it using the free "PrintScreen" utility provided by DDD)**.** The **System Administrator** must contact the Help Desk to report the problem following the instructions below:

**CDHS Help Desk**
303-866-5204(metro Denver)
877-487-4871 (toll free)
OR
eMail: pc.helpdesk@state.co.us

Please include the following Information in the Help Desk request:

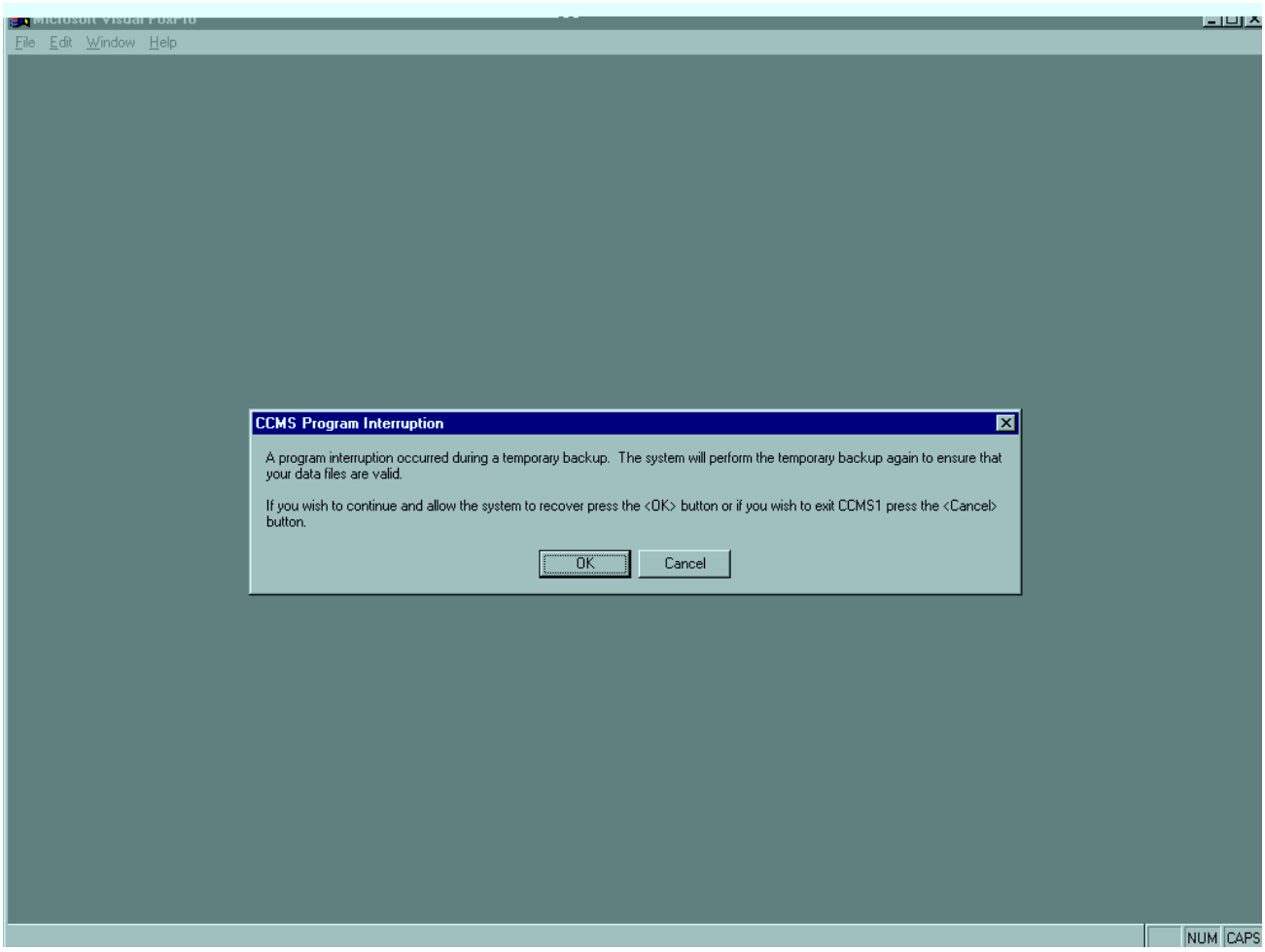
**Request Area**: CCMS and Version Number (e.g., 9.9.99)
**Request Priority**: 3 (standard response time)
If it is critical to operate the system immediately, request a Priority 1 for immediate response
**UserID:** State of Colorado network ID (if you are a state employee, otherwise doesn't apply)
**Name:** Your Name
**Phone#:** Your Phone Number
**Location:** Your Location (DDD, RC name or CCB name)
**Problem:** CCMS Module affected (Individual, Billing, AMPSbatch, PAR, etc).

- Error message or problem.
- Any other useful information to assist in solving the problem, including details on what point in the process that was being performed where the error occurred.

Example:

**Request Area**: CCMS v4.8.31
**Request Priority**: 3
**Name:** Jane Smith
**Phone#:** (720)123-4567 x987
**Location:** MyCCB
**Problem:** CCMS Startup.

- Error #2005, "Error loading file – record number 4. Form1 <or one of its members>.
  Loading form on the data environment: The table file dds_msg.dbf has moved. Please validate database ccms1 and try again"
  Called from line #63.
  Procedure APP_APPLICATION.DOFORM C:\CCMS1CLASS\CCMS1_APP.VCT
- Could this have anything to do with us removing the "data" directory?




The **CCMS Program Interruption error screen** is presented whenever you attempt to enter CCMS after a critical system function has been interrupted. A special indicator field in the agency file keeps track of the system function being performed. If the function is interrupted abnormally due to power failure, a programming bug, etc., this indicator will alert the system that files may no longer be valid.

Critical system functions make extensive changes and updates to data files, so they always perform a temporary backup of the current files to another place on the disk before proceeding with the system function. In order to ensure the integrity of the files, **the system will recover from the temporary backup. Click on the OK button** and the system will copy the files from the temporary backup subdirectory over the current files. If you have not been given the highest security level in CCMS, you will be required to log-out and contact your System Administrator to perform the recovery.

## Steps to Follow Each Month

The following steps must be performed each month in order to complete the billing and data transmission cycle. The order below reflects the logical flow of the steps, but some of the steps will be intermixed as different functions are performed by different staff, or if you normally post batches and services selectively rather than all at once.

1. Enter New Codes
   If you are adding any new programs, locations, subcontractors or other coded information, you must make sure the computer is provided those codes and their descriptions before using them on data entry screens. Refer to Section VIII for entry of codes.

2. Enter New CORE Records
   Persons who are new to your agency must have a CORE record entered before any other records, including a billing transaction, may be entered for that person. Refer to Section III for entry of CORE records.

3. Receive and Process DDD Updates
   The DDD Updates will contain, at a minimum, an update to your PAR (Medicaid Prior Authorization) file each month. You may also receive updates to Provider and Contract files. Changes to CCMS programs and DDD defined codes may also be included in the updates. Refer to Section VIII for instructions on receiving and processing DDD Updates.

4. Review the DDD Broadcast Message
   The Broadcast Message contains information about program updates to CCMS being installed with the DDD Updates. Important dates and special instructions for upcoming requirements are also detailed in this message. The Broadcast Message is presented to a user automatically once each month when the user logs into CCMS after the DDD Update file has been processed for the month.
   **CORE and Billing Coordinators must take special note of the information in the Broadcast Message and ensure that all users are aware of operational changes and requirements.**
   The Broadcast Message also includes contact information for the Help Desk and DDD program and business staff; specific dates related to the DDD Updates and Transmissions to DDD; information on how to sign up for the CCMS ListServ to receive CCMS specific emails from DDD.

5. Review and Organize Attendance and Expense Reports
   Organize your Attendance and Expense Reports by the batch characteristics you have determined. This will make your data entry and checking more efficient. For each individual on the report, calculate the enrolled units or service costs and the number of absences (if applicable) for this month. Remember to do this for adjustment entries. Be sure that income amounts are entered for State funded Group Residential entries.
   Sum the individual unit or service cost totals for all entries in a batch to obtain a batch control total. Remember to include adjustment amounts. Units vary by program type and may be days of service or number of contacts. Service costs are only appropriate for support programs. This batch control total will be used to machine-check your entries.

6. Enter Billing Batches
   Enter billing information from the Attendance and Expense Reports into the appropriate batches. Remember to enter transactions for billings that were rejected at posting in the prior month's billing. Create new batches for new programs. Refer to Section IV for entry of billing information.

7. Print Batch Listings
   Print batch listings and use them to check your data entry. If the batch control total matches with the actual total, a certification block is printed on the batch listing and the system updates an indicator in the batch record to verify that a final print has been obtained. If you later make changes to a batch for which you have already performed a final print, you will be required to reprint the batch listing to make sure correct information is reflected on the listing. You will not be allowed to post a batch until a final print has been completed.

8. Print Crosscheck Error Report
   Print the Crosscheck Error Reports to compare the billing information you have entered with the information in the CORE record. Discrepancies in status, program, funding or location will be reported. You must also produce a final crosscheck error report prior after posting has been completed and prior to creating DDD Transmission files for the month.

9. Update the Batches to Make Corrections
   If you found errors or omissions as a result of reviewing the batch listing and crosscheck reports, or if your actual total did not match your batch control total, then you would need to make corrections to the batch. Reprint the batch listing after making additional entries or making changes to a batch.

10. Post Batches and Enter Estimates
    You can post batches individually, by service type (Comprehensive, Support and Other) or for all services at once. All batches you select to post must first have a final print. If your agency uses the estimated billing method for State funded services, enter an estimate for the next month on the posting screen. Estimates must be entered prior to printing summary bills and transmitting files to DDD in order for the estimate to be reflected on next month's billings. You may change the estimate entry at any time prior to creating your DDD transmission files, but the final summary bill you print must reflect the last estimate entered on the posting screen. Refer to Section VIII for instructions on posting batches and entering estimates.

11. Print Posting Error Report
    After each posting, you must print a posting error report before you can post additional batches and you must print the final posting error report before you can transmit files to DDD. This report will indicate if any transactions were rejected and the reason for rejection. It may also provide informative messages for transactions that were not rejected. Billing transactions rejected during posting do NOT go on to the AMPSbatch module for creation of Medicaid claims. Rejected billing transactions must be re-entered in the next month’s billing.

12. Create AMPSbatch Transmission Files and Transmit
    Medicaid billing transactions must be converted to automated Medicaid claims and transmitted to the Medicaid Fiscal Agent for payment. You should create and transmit AMPSbatch files after each posting that involves Medicaid billings. Refer to Section VIII for instructions on creating and transmitting AMPSbatch transmission files.

13. Receive AMPSbatch Reports and Reconcile AMPSbatch Claims
    Within 24 hours after an AMPSbatch file has been transmitted, you should retrieve reports from the Medicaid Fiscal Agent to determine the status of submitted claims. You will receive both AMP Accepted/Rejected reports and MMIS Remittance reports from the bulletin board. MMIS Remittance reports are generally not available for up to 7 days. Refer to Section VIII for instructions on retrieving reports from the Medicaid Fiscal Agent and reconciling AMPSbatch claims.

14. Rebill Rejected or Denied Medicaid Claims
    Claims that have been rejected by the Medicaid Fiscal Agent must be rebilled within 60 days of the last adverse action (rejection or denial). Before rebilling claims, research the reason for rejection or denial to determine whether the claim should be rebilled at all or whether the claim should be modified to request a different amount or dates of service. You may wait until the next billing cycle to rebill rejected or denied claims as long as it is within the 60 day deadline. Refer to Section VIII for instructions on rebilling Medicaid claims.

15. Print monthly Billing and AMPSbatch Reports for Your Agency

The following reports provide the detail and summary information for the completed billing month and should be printed for use by your agency.

- Enrollment Changes - these reports provide a listing of billing status changes that occurred during the billing month and can be useful in identifying CORE updates that must be entered.
- Transaction Listings - when printed after final posting, these reports provide the detail of the transactions that were accepted and posted by the system for the billing month.
- Contract Status Reports - when printed after final posting, these reports provide the year-to-date billed totals up to and including the current billing month, for both DDD and any optional Subcontract/cost center contract records entered by your agency.
- Summary Bills - these reports may only be printed after final posting and provide a summary of the total billed for this billing month, by State and Medicaid funding for both DDD and any optional Subcontract/cost center contract records entered by your agency. The State DDD summary bill is used by DDD to make payment to your agency while the Medicaid DDD summary bill is used as a record of the amount billed to the Medicaid Fiscal Agent by your agency.
- Waiver Nonservice Termination Report
- This report identifies consumers currently enrolled in a Medicaid Waiver program that had no services reported for the current billing month. If the individual is no longer enrolled in a Waiver program, he must be terminated. A copy of this report must be sent to DDD Medicaid Operations verifying termination or explaining why no services were provided for the month.
- AMPSbatch Medicaid Submission File Claims Report - this report provides the detail of the claims that were submitted to the Medicaid Fiscal Agent in each AMPSbatch file created for the billing month.
- AMPSbatch Fiscal Agent / CCMS Paid Differences
- This report identifies claims reimbursed differently than the units or amount submitted in the claim by CCMS. If differences show up on this report, contact the DDD Business Analyst to report the discrepancy.

16. Send monthly Billing Reports to DDD

    Billing reports must be generally be received by DDD no later than the date established for transmission of files for that month (generally the 19th or 20th of the month). For the final Fiscal Year billing for the June billing month, reports must be received by the 10th ***calendar*** day of the month. Only the following reports must be sent to DDD:

    - DDD State Funded Summary Bill - this bill must be signed by an authorized person at your agency.
    - DDD Medicaid and State Funded Contract Status Reports - **ONLY** for the final June billing for the fiscal year

    Mail the reports to:

    North Central District Accounting Office
    4055 So. Lowell Blvd.
    Denver, CO 80236

17. Complete CORE Updates

    Enter and update CORE records and the associated records in the Waiting List, Address, and Optional files. All updates related to service information for the current billing month need to be entered prior to transmitting files to DDD. Refer to Section III for entering CORE and related records.

18. Process History File Updates

    Changes that have been entered to the CORE Consumer Mandatory file, including social security number and name changes, will not be reflected in the History File until you have processed them against the file. This may be done just prior to creating the DDD Transmission files when the system will require that History File updates be processed, or you may choose to do it yourself so you can print History reports which reflect the latest information at any time.

19. Print Data Edit Review Error Report

    Print the Data Edit Review Report to identify missing and invalid data in CORE records. You must also produce a final data edit review report after making corrections to CORE records and prior to creating DDD Transmission files for the month.

20. Make CORE Corrections

    Make corrections to CORE records based on the errors that were flagged on the CORE Data Edit Review report. Refer to Section III for entry and update of CORE records.

21. Print Standard Reports for Your Agency

    The following reports may be printed at any time during the month. However, you may find it useful to set up a schedule to print the following standard reports so you can update hardcopy files and printed lists on a regular basis.

    - CCMS Face Sheet - Latest Updates - this report provides a full page display of the data contained in a CORE Consumer Mandatory record and the related Waiting List, Address and Optional records. When changes have been made in any of the fields in the record during the month, a Last Update field is automatically completed by the system to record the date of change. Face Sheets can be printed based on the date the record was last updated so you may print a new Face Sheet for only changed records.
    - Name Lists - there may a variety of Name List reports your agency uses for cross reference and general information. Printing these reports after all updates have been entered will provide a current list of information.
    - Waiting List Reports - these reports can be printed for each type of Waiting List or for all services. When printed after all updates have been entered, these reports provide the most current waiting list data for your agency.
    - History Report - this report provides a listing of all the information contained in the History File for an individual. If you have made changes to historical fields in a CORE Consumer Mandatory record, you may wish to print a History Report as well as a new Face Sheet.
    - IP Cover Sheet Reports - this report is required for all individuals in a Medicaid Waiver funded program and must be produced annually and sent to DDD to reflect the latest Individualized Plan information. You may print these reports monthly for all IP staffings due within the next month or on an as needed basis for specific persons.

22. Print Final Crosscheck and Data Edit Review Reports

    You must generate and print a "final" copy of these reports after posting has been completed and after all possible errors have been corrected. When you generate these reports, error database files are created which are sent to DDD when files are transmitted and are used to monitor contract compliance with data accuracy requirements.

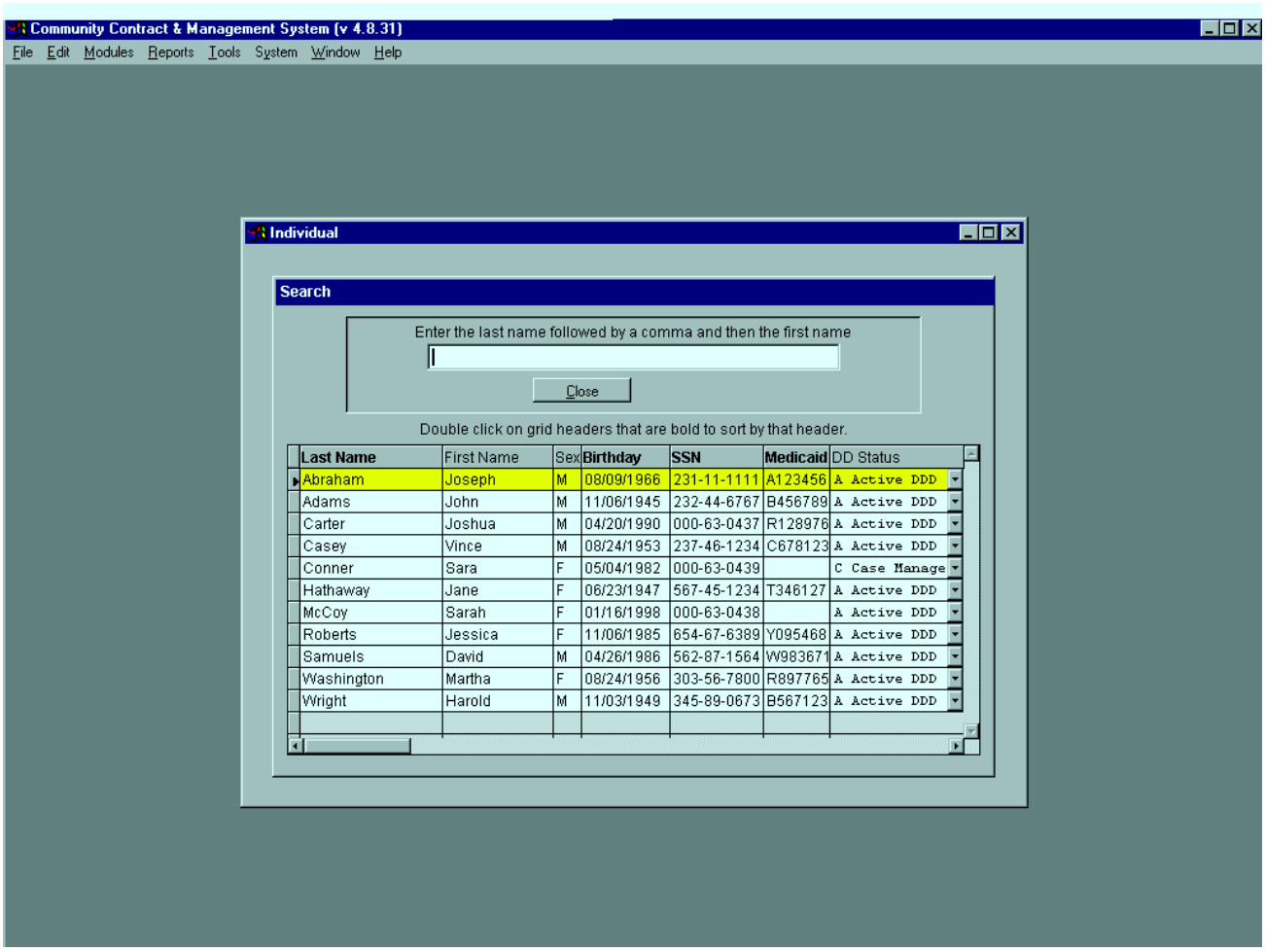
23. Transmit Files to DDD

    Files must be transmitted to DDD ***no later than the date specified in the monthly Broadcast Message*** (generally the 19th calendar day of the month). Refer to Section VIII for instructions on creating and transmitting DDD Transmission files.

24. Close Out the Month
    Make sure you have printed all needed reports for the current billing month. Wait until you have received payment from DDD for your State Funded billing for the month before closing out the month, in order to ensure that the Accounting section has received and processed the billing. Refer to Section VIII for instructions on Closing out the Month.

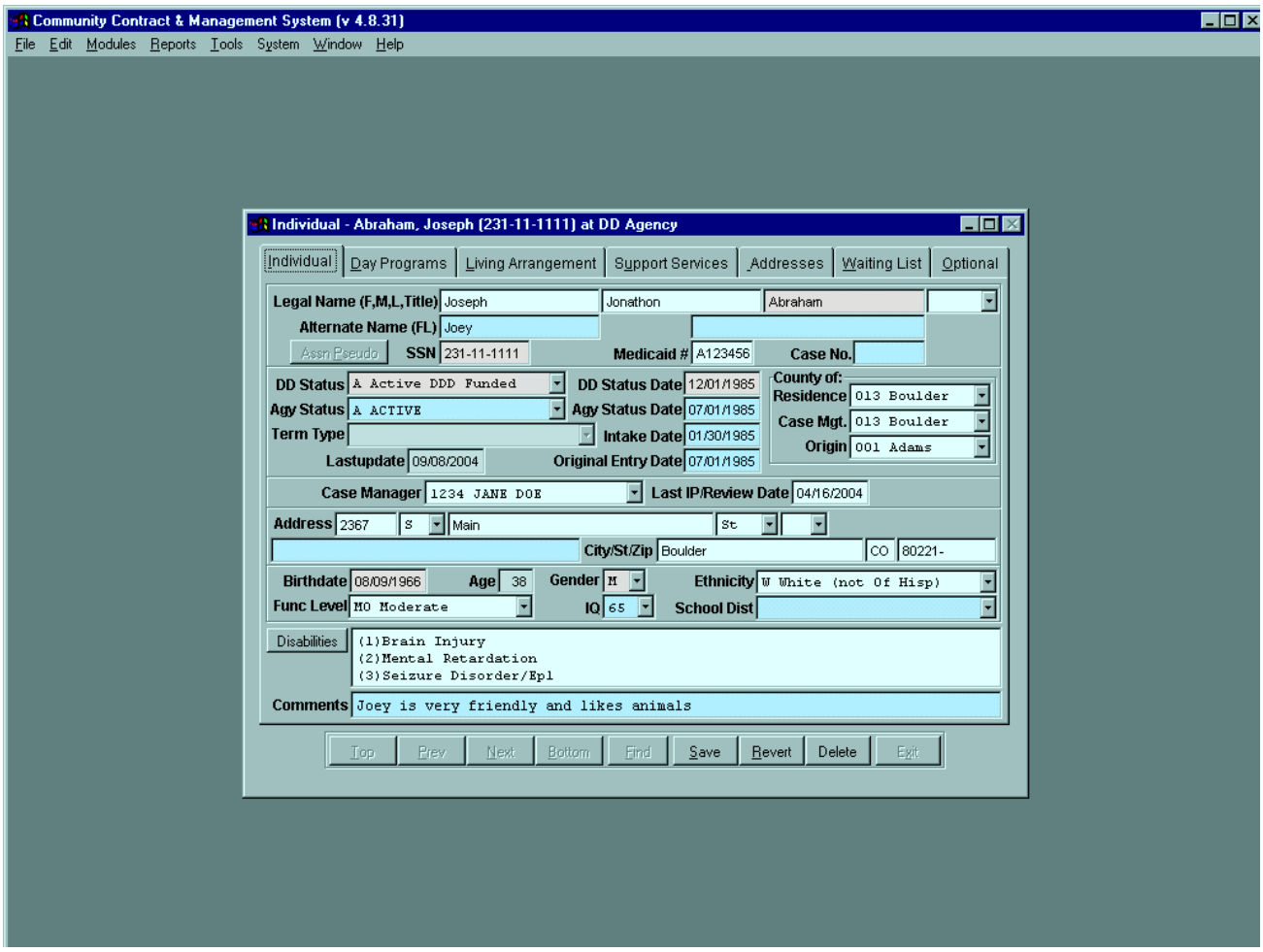
25. Archive AMPSbatch Files
    The files used to create the Medicaid claims in the AMPSbatch module accumulate records of claims activity on a monthly basis. These files tend to get very large over time and can slow down processing and are more prone to corruption of data as they get larger. You should choose to archive these files on a regular basis to clean up disk space and improve processing time. Refer to Section VIII for instructions on AMPSbatch Archive

26. System Security
    If you have new staff or changes in staffing assignments which impact who should have access to different CCMS functions, enter these changes in the security file. Refer to Section VIII for instructions on updating system security.




Before accessing the CORE records that contain information about the individuals served by an Agency, the **Search screen** is presented to select a record. You reach this screen by **selecting Individual from the CCMS Modules drop down menu.**

You must first choose a record on the **Search screen** that is presented after accessing the Individual module menu choice. Refer to Section II for further information about the **Search screen**. You can scroll through a list of records or type a search value on the screen and then **press the Close button** to bring up the selected record on the screen. You should search for an individual both by name and social security number to ensure you identify an existing record before adding a new record.




The **Individual Main Data screen** is the first of seven data entry screens and is used to begin entry for a new record or to identify an existing record from the CORE client mandatory file, which contains demographic and program information about persons with developmental disabilities. A **CORE record** must be entered before any other records (Waiting List, Address, Billing, etc.) may be entered for an individual. You reach this screen after identifying a record on the **Search screen**.

The **Tabs** at the top of the screen allow you to move between data in the CORE record and related records in the Address, Waiting List and Optional files. Records for only one individual at a time are presented on these screens.

Your **security level** will determine whether you have the ability to **enter data** on this screen and the related CORE screens, or may only **view the data** on the screen. If you have been given rights for viewing data only, the fields will appear dimmed and you will not be able to move the cursor to them to enter data. The **Add and Edit buttons** will also be disabled, but you can access the **Tabs** at the top the screen to move between data screens.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

You must enter the **Last Name, Social Security Number, Birth Date, Gender, DD Status and DD Status Date** at a minimum in order to enter a new record. You may leave other data blank temporarily but missing data errors will be generated on the Data Edit Review report to flag those fields, which are blank and require data entry. Fields with light blue background are optional fields and do not require entry of data. Other fields may require entry of data dependent upon the DD Status.

If you do not know the social security number of the person for whom you are entering a new record, press the **Assn Pseudo button** to have the system assign a temporary pseudo social security number. You will have to update this number to the real number when it is known.

The address fields have been formatted to meet State of Colorado guidelines for standardization of address data. Enter the street number in the first field of the address, a beginning direction (if needed) in the second field of the address, the actual street name in the third field of the address, a type in the fourth field of the address and an ending direction (if needed) in the fifth field of the address. You must use the pre-assigned codes for beginning direction, type and ending direction, which are available from a drop down list. Use the Freeform address area to enter apartment number, Post Office Box, etc. When you enter or update an address on this screen, the address information is transferred to the 'Self' address record in the Address file.

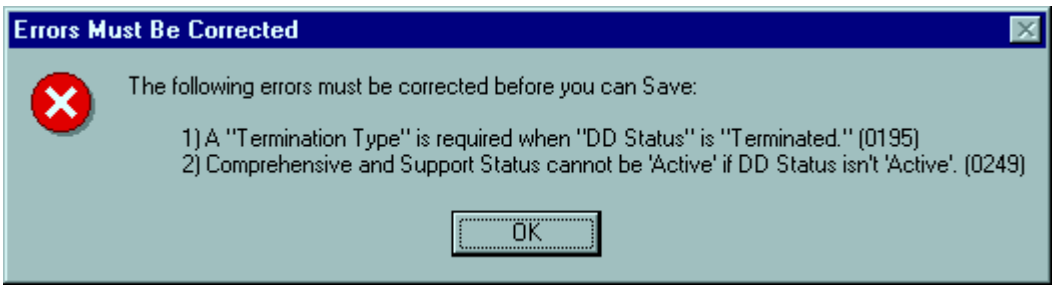
Up to eight disabilities may be entered on this screen or you may **press the Disabilities button** to display a pop-up screen on which you may choose up to eight disabilities from a multiple list and rearrange them in the order in which you wish them to appear on the main screen. The optional comment field allows you to enter notes about this person. You may enter as much text as desired. The comments will scroll in the **Comments** section on the screen.

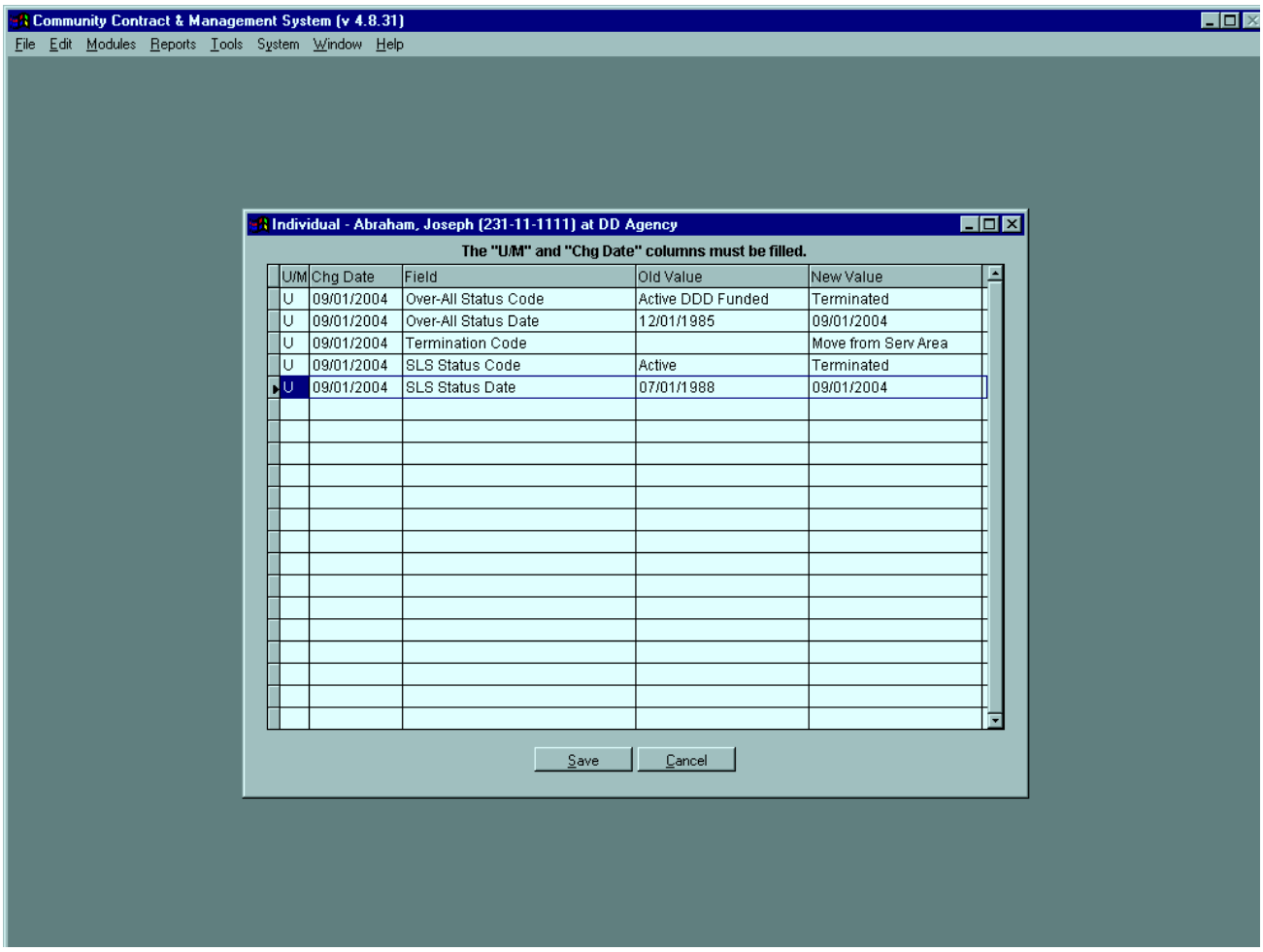
Use the **Add button** at the bottom of the screen to add records for a new individual. Press the **Find button** to find another individual's record(s). Use the **Prev and Next buttons or Top and Bottom buttons** at the bottom of the screen to move backward and forward through the records in the file.

**The Save, Revert and Delete buttons** are initially disabled or dimmed and will become enabled when you have chosen the **Edit button** to make changes to the records for the selected individual. Any changes you have made will not actually be saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made to the records. The **Revert button** will discard all changes made to the records for the selected individual since the last time you saved changes. Use the **Exit button** to exit from this data entry screen.

When you select the **Save button** to save changes made to the records, the system will perform several edits to verify that mandatory data has been entered and notify you with an error message if fields require updating immediately (see example below).

**You will have to correct the errors before you can save the changes to the records.** This may mean that you will need to research the required information from the paper record or contact a case manager for additional information. If you are unable to obtain the required information immediately, you may **select the Revert button to discard** your changes and update the record later when you have all the required information.



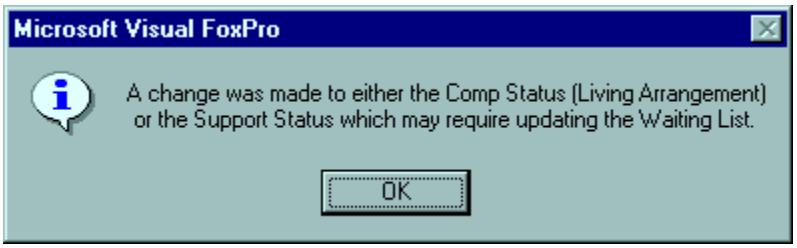


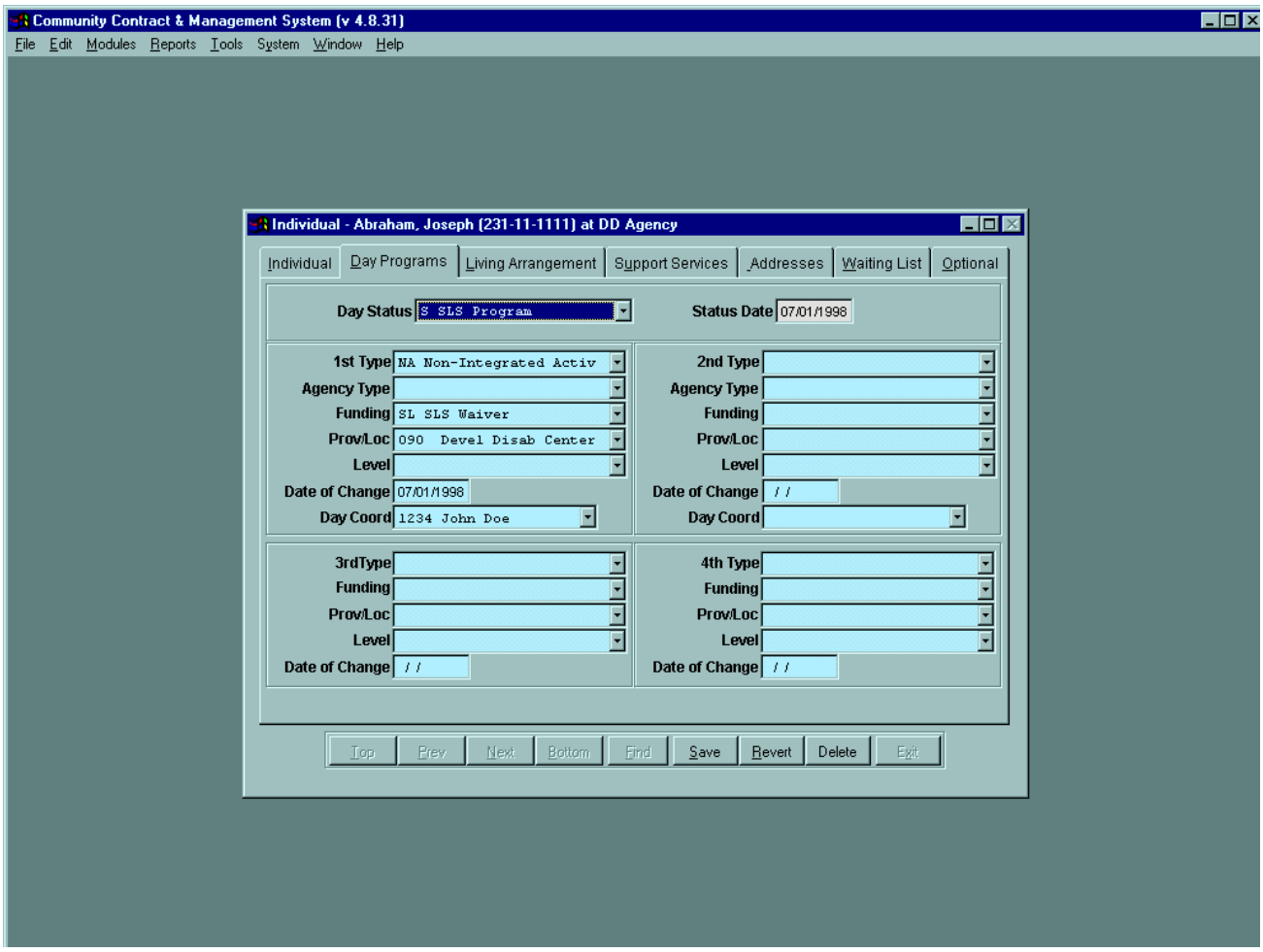

When you select the **Save button** to save changes made to this record and you have made changes to historical fields, the **Update/Mistake Selection screen** above will appear for you to indicate whether changes to historical data are **Update or Mistake changes (U/M). Refer to Appendix A for further explanation of Update and Mistake entry for historical fields.** You must indicate whether each change you made is an **Update change,** which means an actual change occurred from the previous data, or a **Mistake change**, which means that the previous data was incorrect and this change is a correction. For each Update change, the date corresponding to the data must also change. For example, if the DD Status is changed as an Update from Active to Terminated, then the DD Status date must also change to show the actual date of termination. For Mistake changes, the corresponding date does not have to change because you may just be correcting an erroneous entry of the status, but the status date is already correct.

You must enter a U or an M in the left column for each field, which has changed. You will also have to enter a date of change **(Chg Date)** if there is no date associated with the field on the main screen. For example, when you change the county of case management, you must also enter a date in the Update/Mistake Selection screen to indicate when the change occurred.

When you have finished entering the U/M types and dates of change, press the **Save button** to save the U/M entries or the **Cancel button** to cancel the changes and return to the **Main Data screen.**

If the Comprehensive or Support Status fields have been updated to an Active status, the message below will be displayed as a reminder that Waiting List records must also be updated. **You will need to determine if the status change affects any Waiting List records and update them accordingly.** Remember to update your agency's internal management Waiting List records as well.



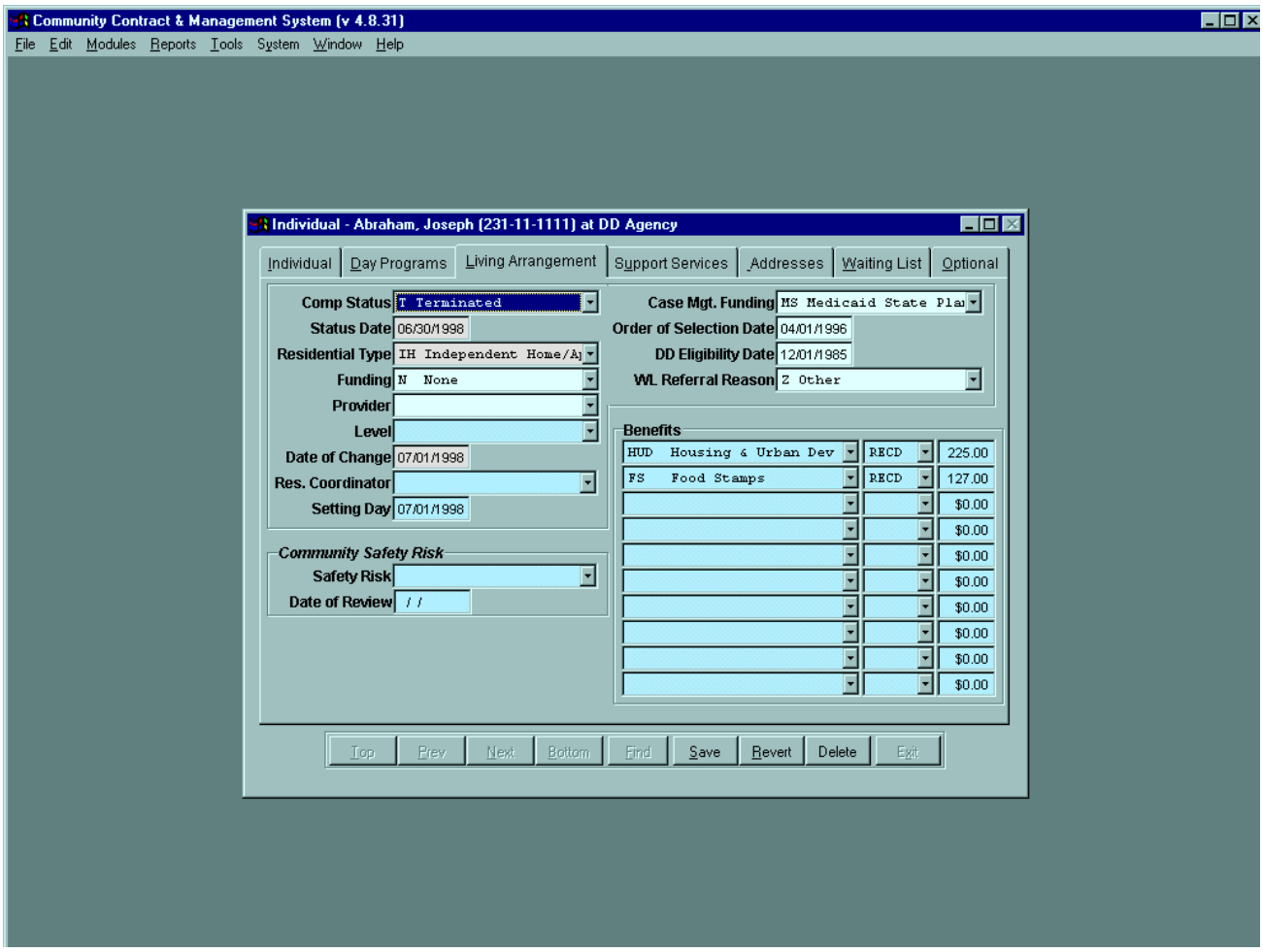



The **Day Programs screen** allows display and entry of current day program information for the individual record displayed on the **Main Data screen**. You reach this screen by **pressing the Day Programs Tab** on the **Main Data screen**.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

You must enter **Day Status and Status Date** at a minimum on this screen in order to enter a new record. **Entry of day program services is entirely optional**. You may enter up to four concurrent day programs on this screen. Each day program set has a **Date of Change** field associated with it and this field must be completed when one of the other fields in this set is changed as an **Update change**.




The **Current Living Arrangement (Residential) screen** allows display and entry of current living arrangement information for the individual record displayed on the **Main Data screen**. You reach this screen by **pressing the Living Arrangement Tab** on the **Main Data screen**.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

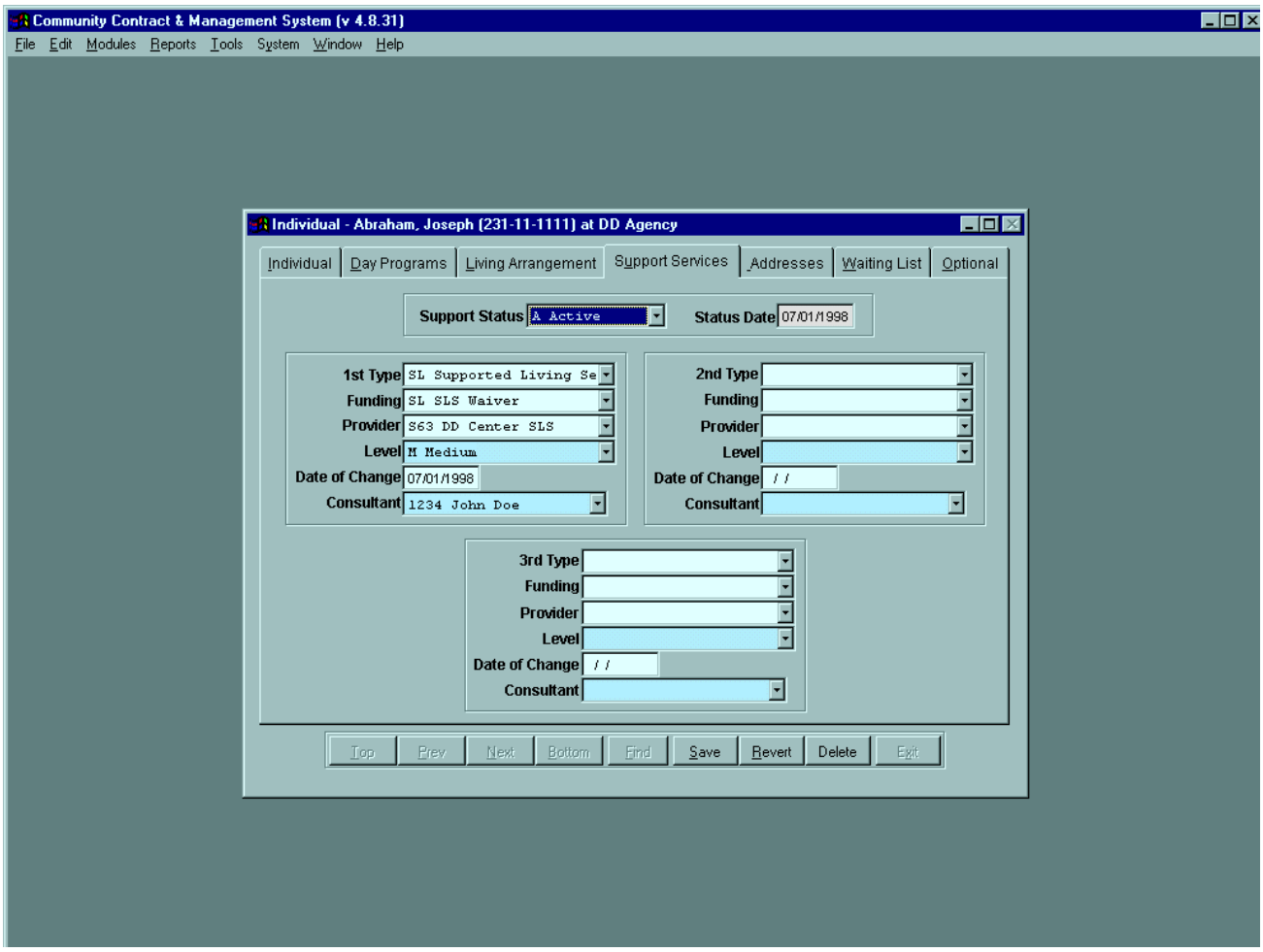
Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

You must enter **Comp Status and Status Date** at a minimum on this screen in order to enter a new record. You must enter the current living arrangement for each individual on this screen, regardless of whether the person is receiving DDD funded services. The residential set has a **Date of Change** field associated with it and this field must be completed when one of the other fields in this set is changed as an **Update change**.

This screen is also used to track the **Waiting List Order of Selection and DD Eligibility dates.** Entry of these dates and of **Case Management Funding** is required depending on the status of the record. Entry of **Waiting List Referral Reason** field is required if the Order of Selection Date is completed and is 1/1/2000 or later (the date that this field became available for entry and update).

The **Benefits section** is used to record benefits, which are not DDD funded. The first column of the section contains the benefit code and the second column contains the benefit description. The third column contains the benefit status of RECD, NEED or BOTH so you may indicate whether this benefit is one that the person is currently receiving, one that he needs or one that he is receiving but needs more of. This field is a spinner field. You change it by pressing the spacebar when the cursor is in the field or by pressing the first letter of the option you wish to select. The fourth column may be used to record an actual amount of benefits received. **Entry of benefit information is entirely optional.**

The **Community Safety Risk** fields are used to track individuals who have been convicted of a crime or otherwise present a risk to the community in which they reside.

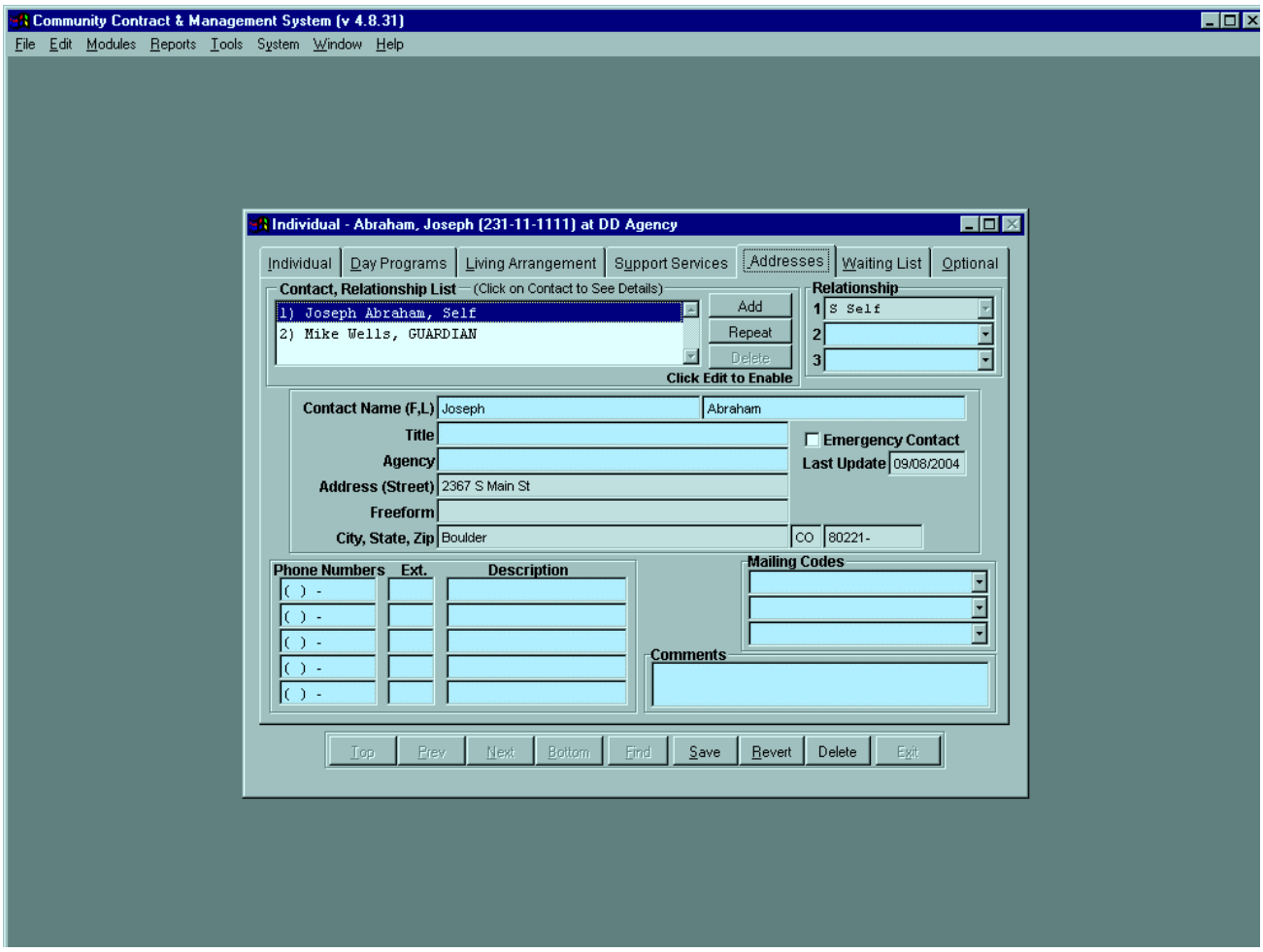



The **Support Services screen** allows display and entry of current Support Services information for the individual record displayed on the **Main Data screen**. You reach this screen by **pressing the Support Services Tab** on the **Main Data screen**.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

You must enter **Support Status and Status Date** at a minimum on this screen in order to enter a new record. You may enter up to three concurrent support services on this screen. Each support service set has a **Date of Change** field associated with it and this field must be completed when one of the other fields in this set is changed as an **Update change**.




The **Addresses screen** allows display and entry of addresses and contacts into an Address file for the individual identified on the **Main Data screen**. You reach this screen by **pressing the Addresses Tab** on the **Main Data screen**.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

An address record with an **S - Self relationship will already have been automatically entered** into the Address file and will be the first record displayed. You cannot change the S - Self relationship code in the first relationship field nor can you update the address for the individual on the "Self" record. It must be updated on the **Main Data screen** and it will be automatically transferred to this record.

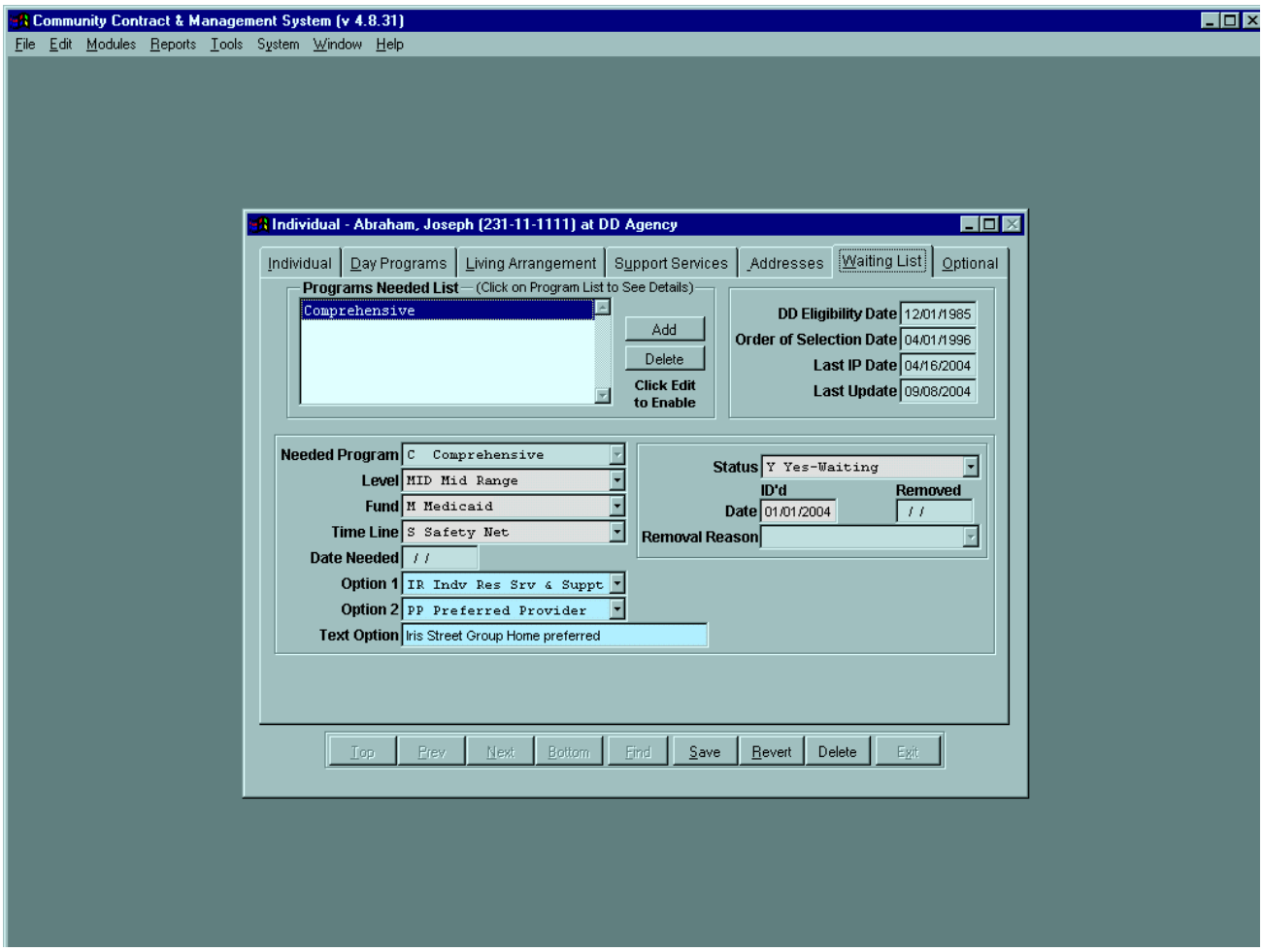
You can enter **three Relationship codes on each address record.** For example, if a person resides with his parents, you can enter the second Relationship code as P - Parents on the "Self" address record so that the record is used to identify both the person's address and his parent's address. The system automatically enters the person's name as the contact name when the record is initially created, but you may change the contact name to the parent's or any other name.

**You may enter as many address records for a person as you need. Use the Add or Repeat button** at the top of the screen to create new address records for a person. You must enter a Relationship 1 for each address record. You cannot enter a new record with an S - Self relationship in the Relationship 1 field because the system uses that field and code to uniquely identify the address record which belongs to the individual, in order to be able to update the address from the Main Data screen. However, you can use the S - Self relationship in the second or third field.

**The Mailing Codes fields can be used to identify which address records should be accessed for special mailings (e.g. Fundraising, Parent Volunteer, Staffing, etc.).** Your agency defines and assigns the Relationship and Mailing codes used on this screen (except for the S - Self relationship which is pre-defined by the system).

The optional comment field allows you to enter notes about this contact. You may enter as much text as desired. The comments will scroll in the **Comments** section on the screen.

**To delete an Address record, select the Delete button** at the top of the screen. You will not be allowed to delete the "Self" Address record.




The **Waiting List Registry screen** allows display and entry of waiting list information into a Waiting List file for the individual identified on the **Main Data screen**. You reach this screen by **pressing the Waiting List Tab** on the **Main Data screen**.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

**Use the Add button** at the top of the screen to create new Waiting List records for a person. Waiting list information can be entered for Comprehensive services or a variety of Support services. The **Needed Program** field must be completed in order to identify the type of service this record refers to before other related fields can be completed. The **Level field** is applicable only to Comprehensive and Family Support Services Program (FSSP) in order to identify a pre-defined level of service needed. You will not be able to enter it for other programs.

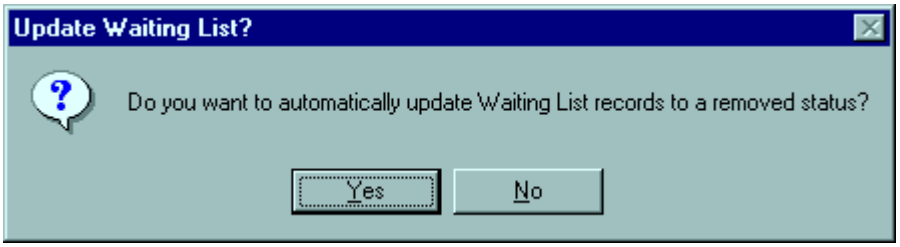
The **Timeline** field must be entered and may either be a pre-defined span of time selected from a list of valid codes, or D – See Date. If the Timeline is D, the **Date Needed** field must also be entered and must reflect a specific date at which it is expected this need must be met.

The **Status** field must be entered and reflects the current status of the record. The **Date ID'd** field is also required and must reflect the date this need was first identified.

There are two types of waiting list records based on the status of the record. **The status of Y – Yes-Waiting** identifies a waiting list record which meets criteria for a person who needs a new resource from the State. **The status of I – Internal Management** identifies a waiting list record for a need, which your agency wishes to track so internal decisions can be made to shift funding already in place. A person may have only one record with a status of Y and one record with a status of I at any time for each Needed Program. A status of Y can only be changed to a status of R – Removed. A status of I can only be changed to a status of X – Internal Removed. This ensures that records can continue to be identified as either Waiting records or Internal Management records, even after the person is removed from the waiting list.

If a status is changed to a removed status (R or X), you will also be required to enter the **Date Removed and Removal Reason**. Once you have changed a record to a removed status, it cannot be changed back to an active status (Y or I) unless you are making a correction to the record. Each record with a removed status contains complete waiting list information which reflects the need that was identified, the span of time before the need was met or dropped and the reason that the person was removed from the list for that need. You may only change a status back to an active status (Y or I) as a correction to a mistake, if you incorrectly changed the status in the first place. You will receive a prompt **"Are you correcting a mistake?"** and if you answer yes, you will be allowed to continue with the status change. If you answer no, you will not be allowed to change the status. **If a person has a new need for the same program, you must add a new Waiting List record**.

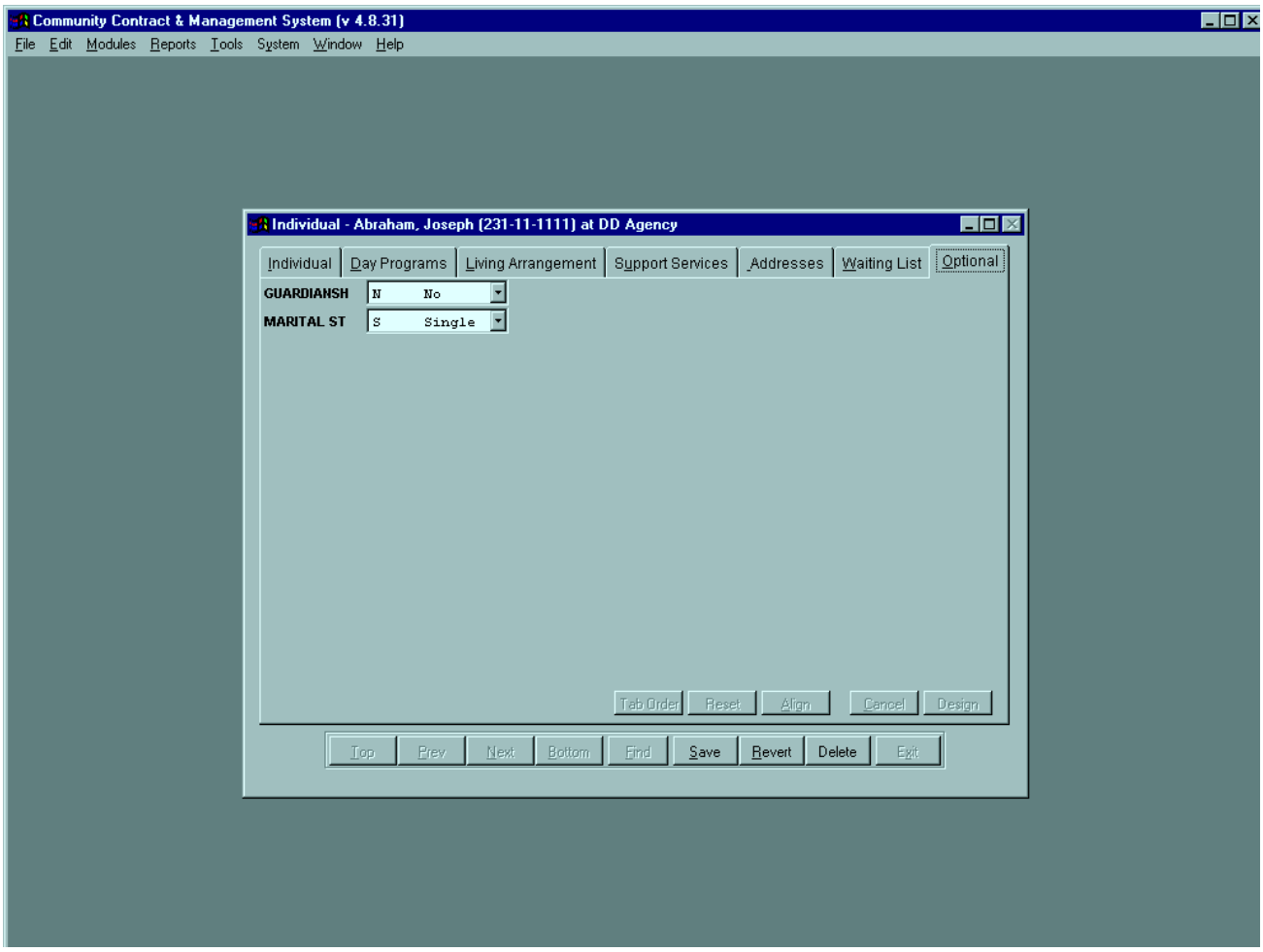
**If the DD Overall Status is changed to T – Terminated on the Main Data screen, the status of all currently active (Y or I) Waiting List records can also be changed to Removed (R or X) automatically.** The message below will appear and if you answer Yes, the automatic update will take place. The Reason for Removal will also be completed automatically with the reason code "T – Term Overall Status.




**The Option 1 and Option 2** fields can be used to enter codes which further identify waiting list records for report sorting and selection criteria. They could be used to monitor internal management

issues such as whether a person prefers an individual or a group setting, whether the person needs a higher rate than is currently being received, whether the person has a preferred provider of service, etc. Your agency defines and assigns the waiting list optional codes. They must be entered in the Table file before they can be used on this screen. The optional **Comment** field allows you to enter freeform notes about this need up to 40 characters long.

**To delete a Waiting List record, select the Delete button** at the top of the screen. Do not delete a waiting list record unless it was entered in error. Waiting list records maintain history for waiting list needs that have been identified in the past for an individual.

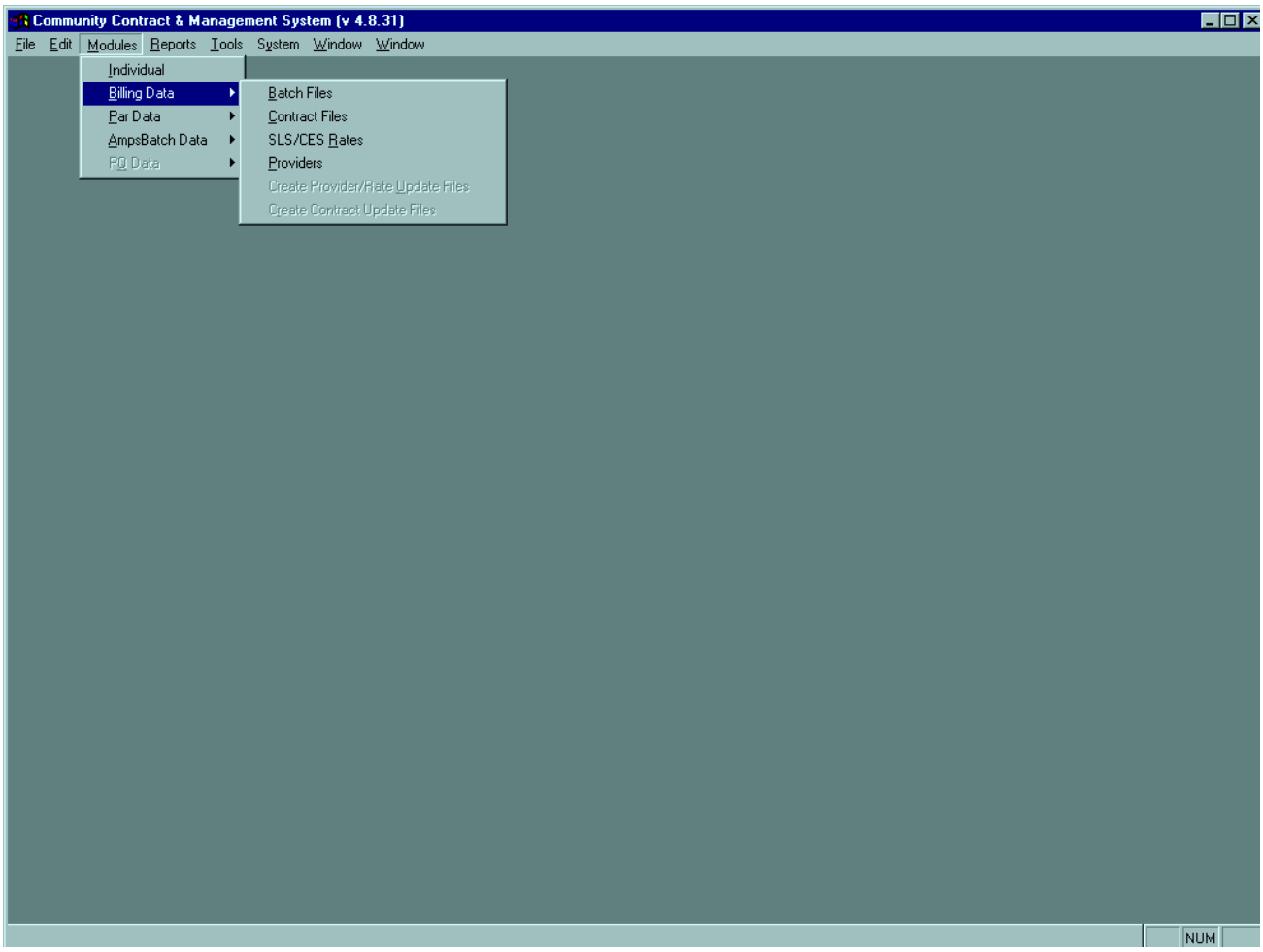



The **Optional screen** allows display and entry of Agency defined optional information into an Optional record for the individual identified on the **Main Data screen**. You reach this screen by **pressing the Optional Tab** on the **Main Data screen**.

**Each agency must maintain its own definitions of the codes and data requirements for each field on this screen as the optional file is defined by the agency.**

Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

The screen contains additional buttons for design of the optional file. As of the updating of this manual (10/01/2004), there is a moratorium on re-design of the optional file, so no instructions are included in this version of the CCMS manual.




The **Billing Data menu** is used to select the functions that may be performed in the Billing module. You reach the Billing Data menu by **selecting Billing Data from the CCMS Modules drop down menu**. Click on the Billing menu item with the mouse pointer to get a drop down menu that displays selections for the Billing module. Your ability to access the Billing Data menu is determined by the security level that has been assigned to you. If you do not have security rights to Billing functions, you will not get to the drop down menu.

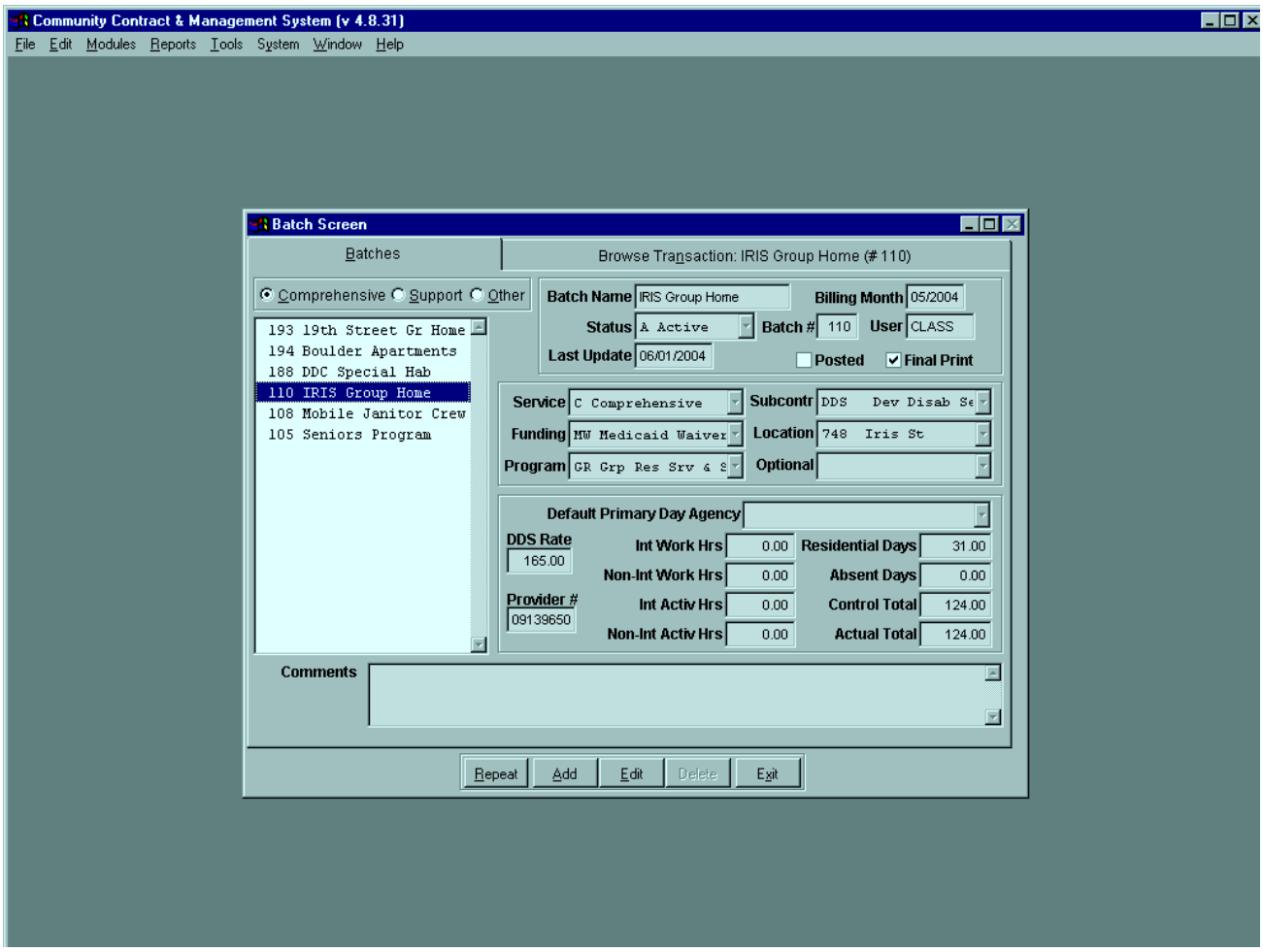
The **Batch Files** menu choice allows Agencies to enter billing information in a batch of transactions that share common characteristics. The billing information entered into each batch of transactions shares the same service, funding and program type. Each batch is also associated with a DDD contract record and Medicaid provider record (if the billings are funded by Medicaid). No billings can be submitted for an individual unless the Agency has been authorized to bill for the service via a contract with DDD. Additionally, Medicaid provider authorization must also be provided by DDD in order to bill for Medicaid services. **This menu choice is not available at the DDD site because billings are not entered by DDD.**

The **Contract Files** menu choice allows you to view and update Contract records.

The **SLS/CES Rates** menu choice allows you to view and update billing rates that are specific to the Supported Living Services and Children's Extensive Support programs.

The **Providers** menu choice allows you to view and update Medicaid Provider records.

The last two menu choices, **Create Provider/Rate Update Files and Create Contract Update Files**, are only available to DDD and are used to write out copies of updated Contract and Provider files. These updates are sent to each Agency monthly to provider updated billing rates and provider approval information.




The **Comprehensive Batch screen** is used to begin entry or update for a batch of Comprehensive billing transactions that have common characteristics. You reach the Comprehensive Batch screen by **selecting Billing Data from the CCMS Modules drop down menu** and then **Batch Files** from the Billing Data side menu.

When you first select **Batch Files** from the Billing Data side menu, the default selection is the first Comprehensive batch in the system, and a Batch screen is displayed for that batch. A list of all Comprehensive Billing batches is displayed on the left side of the screen with buttons above the list for **Comprehensive, Support and Other**. Click on the buttons to display a list of batches for each billing service type. Click on a line in the list to select the batch and display the batch record.

The Batch screen contains two **Tabs**. The first tab presents the batch record that contains a display of the common characteristics on the batch. The second tab presents the transactions included in the batch. You can only display and update one Billing batch at a time.

Your **security level** will determine whether you have the ability to **enter data** on this screen or may only **view the data** on the screen. If you have been given rights for viewing data only, the fields will

appear dimmed and you will not be able to move the cursor to them to enter data. If this batch has already been posted for the billing month, you will not be able to update any fields on the screen regardless of your security level. **The Repeat, Add, Edit, Revert and Save buttons** will also be disabled if you do not have rights to enter data or the batch has been posted, but you can access the tabs at the top of the screen to move between batch record and detailed transaction data.

Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

**There are two types of Comprehensive batches.** Batches in which only encounter data for hours or occurrences are reported are **Hours Reporting Only batches** and are identified by an entry of "999" in the Residential Location field. The transactions in this type of Comprehensive batch will only report information on a part grid transaction screen. Batches in which days in residence are reported are **Residential Reporting batches** and are identified by the entry of a Residential Program and a Residential Location that refer to a specific residential provider of service. The transactions in this Comprehensive batch will report the number of days in residence and the number of absent days with the residential provider on either a full grid or part grid transaction screen. It may also report encounter data for some or all of the individuals reported in the batch. **Your Agency chooses whether to enter different batches for residential and hours reporting or use the same batch for both reporting.** Your decision should be based on how you receive information. Generally batches should be entered based on data which is received at the same time, so you do not have to repeatedly update the batch as more information is received.

In order to enter a new Billing batch, **press the Add button** and then select the correct contract record from the pop-up message **"Select the contract record to be used for this new batch"**. The **Service, Funding and Subcontractor fields are automatically entered** for you based on the contract record that is selected. You must enter the **Residential Program and Residential Location** at a minimum on this screen in order to enter a new batch record for Comprehensive Residential Reporting. If you are entering a batch for Comprehensive Hours Only Reporting, the Residential Location field must be "999 – Hours Reporting Only" and the Residential Program field must be blank. Fields with a light blue color are optional fields and do not require entry of data. Other fields may require entry of data dependent upon the billing program.

On already existing batch records, you will not be allowed to change the Funding, Program or Location fields because they are the unique identifiers for the matching transactions entered into this batch. The identifying information entered in the batch record is carried forward to new billing transactions that are entered into the batch to reduce the amount of data entry you must perform for billing transactions. Once this information has been entered into the batch record and the associated billing transactions, it is saved from month to month so you do not have to re-enter it.

You need to enter the **Batch Name field** for each batch, using a descriptive name that is meaningful to your Agency. The batch name is displayed when you choose to print or post batches and will help you to identify the batches you wish to select. The **Status field** indicates whether this batch is a currently active, inactive or terminated batch. If you wish to keep batch records after you have terminated all the transactions in the batch, the terminated status will alert you and the system that nothing is to be entered for the batch.

The **Batch # is assigned in sequential order automatically** by the system and you cannot enter or change it. The **Billing Month, Posted and Final Print fields are displayed** based on information that is automatically updated by the system. The **Last Update and User fields display** information about when and by which user the batch record was last updated.

The **Optional field** can be used to enter codes that further identify billing transactions for report sorting and selection criteria. For example, you may wish to identify whether each person with a billing transaction entry in an Hours Reporting Only batch is part of a specific work crew or has an independent job, so you can sort transaction listings by this information. The optional code entered on the Batch screen will automatically be carried forward to each new billing transaction and you may then change it during entry or update of each billing transaction. Your Agency defines and assigns the billing optional codes. They must be entered in the CCMS Table file before they can be used on this screen.

The **Primary Day Agency field** identifies the primary day provider for most individuals in this batch. The primary day agency entered on the Batch screen will automatically be carried forward to each new billing transaction and you may then change it during entry or update of each billing transaction. If the entries in this batch will be for individuals who have a variety of primary day providers, you should leave this field blank and enter the specific day provider into each individual transaction. If the batch is a Residential Reporting batch and you will not be entering any day program hours of service in the transactions, you should also leave this field blank.

**The DDD Rate and Provider # fields** will be automatically entered and displayed based on the matching contract and provider records. Each batch record must have a matching contract record authorizing your Agency to bill for the program and funding type entered on the Batch screen. The DDD rate will be taken from that contract record for Residential Reporting batches. If the Residential Program is Medicaid funded, there must also be a matching provider record authorizing billing for Medicaid. If either of these records is missing, you will not be able to save a new batch record.

**Enter the Residential Days** for Residential Reporting batches. Also enter the **Absent Days** for Residential Reporting batches if most persons being reported in the batch had a common number of absences. If you enter the residential days or absences in these fields, it will be automatically carried forward into each new billing transaction you enter.

**The Control Total Field must be entered monthly for Residential Reporting batches** to record the total number of days to be entered into the batch for the month. If the actual total does not match

with the control total entered, then you will need to check your entries for accuracy to determine if you forgot to enter a transaction or entered one incorrectly. The **Actual Total field** will be updated automatically by the system as you enter and update billing transactions in the batch. **Hours Reporting Only batches do not require a Control Total and will not accumulate an Actual Total.** For Hours Reporting Only batches, these fields will be Zero.

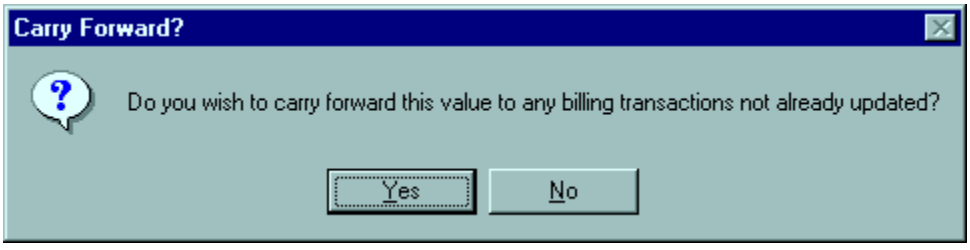
Each batch of transactions must be printed and reviewed for accuracy (including Hours Reporting Only batches). A final batch printing (where the actual and control totals match) must be completed before the batch can be posted. The **Final Print** display at the top of the screen will be Y (Yes) if a final print has occurred.

The **Comments** field at the bottom of the screen can be used for reminders or information about this batch.

Press the **Edit button** to open this batch of transactions for editing. The **Repeat button** is used to repeat the values on this screen to create a new batch record. When your repeat a batch record, only the values in the batch record are carried forward; you will need to enter individual transactions in the new batch.

The **Save, Revert and Delete buttons** are initially disabled or dimmed and will become enabled when you have made any changes to the Billing batch, including changes to the transactions contained in the batch. Any changes you have made will not actually be saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made. The **Revert button** will discard all changes made since the last time you saved changes.

When you select the **Save button** to save changes made to an existing batch, and you have entered **Common Residential Days or Absent Days values** on the Batch screen, the system will check to see if there are un-entered billing transactions for this batch and display the **Carry Forward screen** below for you to indicate whether you wish to have these values transferred to transactions in the batch. (An un-entered billing transaction is one for which you have not individually performed data entry of billing figures during the billing month and which has not previously had common batch figures transferred to it.)

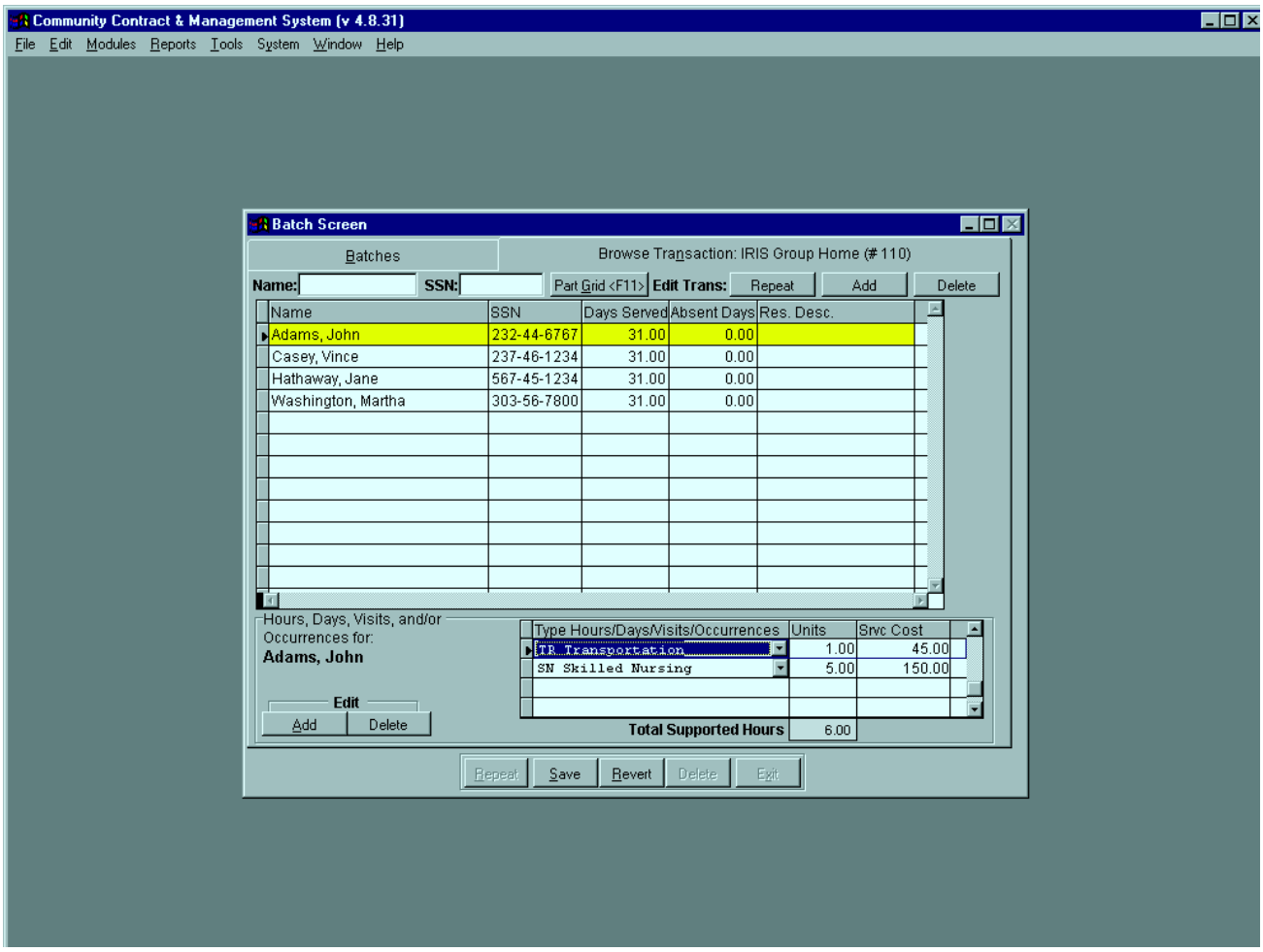



Answer "Yes" to the question above if you wish to carry forward the common values to each transaction in the batch. **If you answer Yes,** all the billing transactions in this batch, which have not been entered individually, will automatically be updated with the common values and you will only have to change billing transactions individually that require different entries. **If you answer No,** none

of the billing transactions will be updated automatically, and you will have to enter billing figures into them all individually. Once you answer Yes to this question, you will not be able to carry forward common values again during the current billing month. Further changes to the common values will only be carried forward to new billing transactions you enter into the batch.

Press the **Delete button** to delete the batch record along with all associated transactions in the batch. A batch record may need to be deleted because it was entered in error or is no longer needed. You may also choose to delete a batch of transactions and re-enter the transactions in different batches. Batch entry provides a tool to enter billing transactions based on how you do business in your Agency. If the batch organization is no longer working efficiently at your Agency, you can delete and re-create batches in other configurations. **Do not delete the existing batch until it has been posted for the current billing month to process the transactions in the batch.** The batch can be deleted in the following billing month, if desired. The batch can also be retained as a terminated batch in order to enter previous month's adjustments.

**If a person changes Residential program, funding or location, you must terminate the transaction(s) in the batch and enter a new transaction(s) for the new program, funding or location for that person.** This means you will be entering the billing transaction into a different batch. The new transaction must be an admission transaction showing the date the person was admitted into the new program/funding/location.




The **Browse Transaction screen** is used to enter billing figures into billing transactions associated with the batch record displayed on the Batch screen. You reach the Browse Transaction screen by **selecting the Browse Transaction tab.**

The Browse Transaction screen displays the transactions in a spreadsheet or **grid format** for easier data entry. The fields are displayed in a logical order based upon the most commonly updated fields for the program that is being entered. Notice that the name and social security number are displayed on this Browse Transaction screen for your information (but cannot be updated). Some fields can only be updated in a full screen mode. Press the **Part Grid button** or **F11** to change the display from the full grid above to a part grid where additional fields can be displayed and entered.

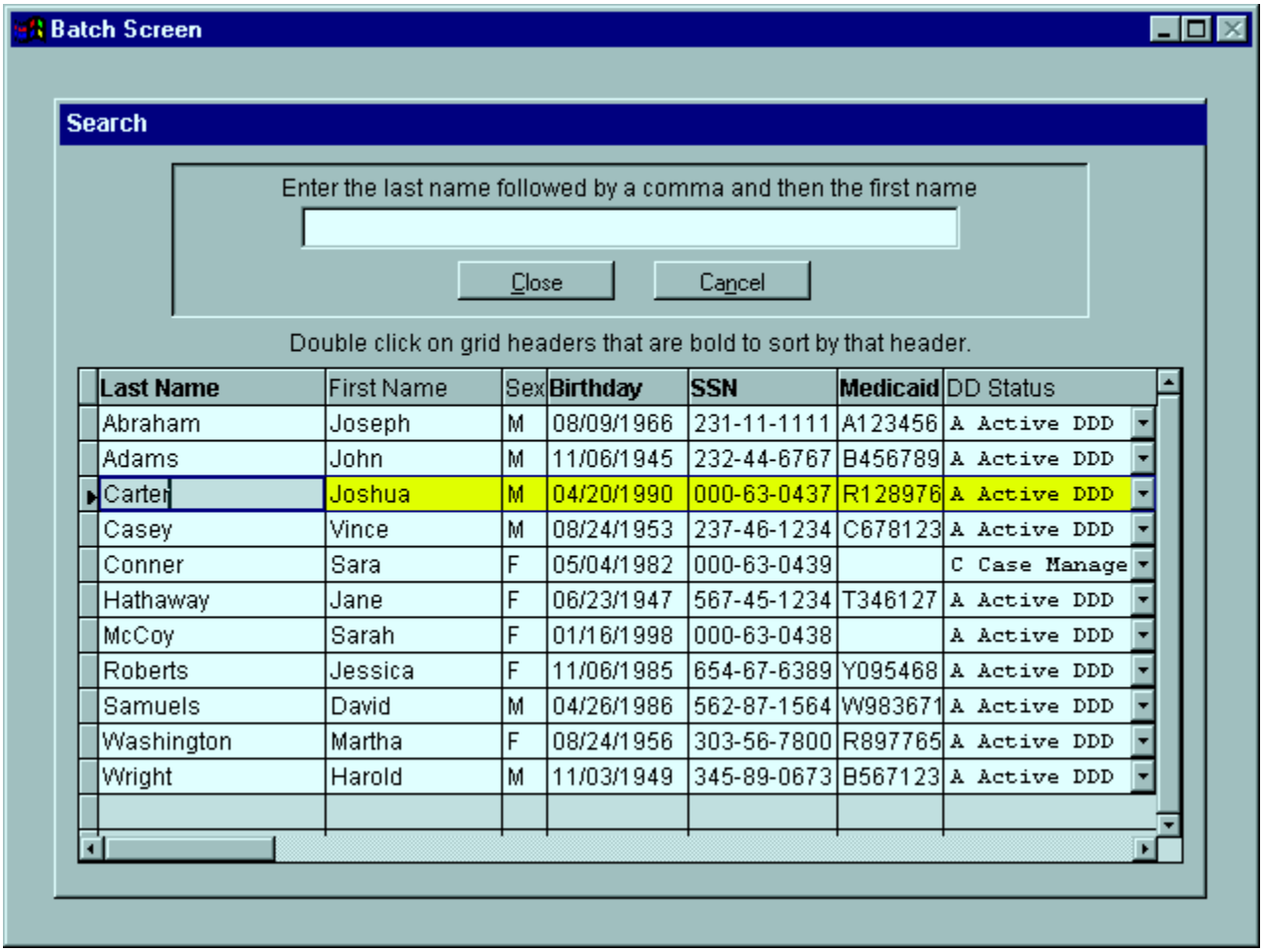
The order and width of the columns on the Browse Transaction screen may be rearranged to suit your particular data entry needs. **To move a column on the screen**, place your cursor on the field name above the column, press down and hold the left mouse button while dragging the field name to the left or to the right. **To change the size of a column on the screen**, place your cursor on the vertical line between the columns so the cursor takes on the appearance of a cross. Hold down on the left mouse

button and drag the column line to the left to make the column smaller or to the right to make the column larger.

**Use the Add or Repeat button** at the top of the screen to add transactions to the batch. You may enter as many records for a person as needed. **To delete a transaction from the batch, select the Delete button** at the top of the screen.

Before pressing the **Repeat button**, click on the line in the grid for the individual you wish to repeat a billing transaction. The **Repeat button** copies forward the information from the selected transaction and you must edit the information as needed for the new transaction. The original transaction is not changed.

The **Add button** creates a new billing transaction in the batch. Before you can add a transaction, you must first identify a matching CORE record on the **Search** screen below. **You cannot enter a billing transaction for a person unless the CORE record has already been entered**.



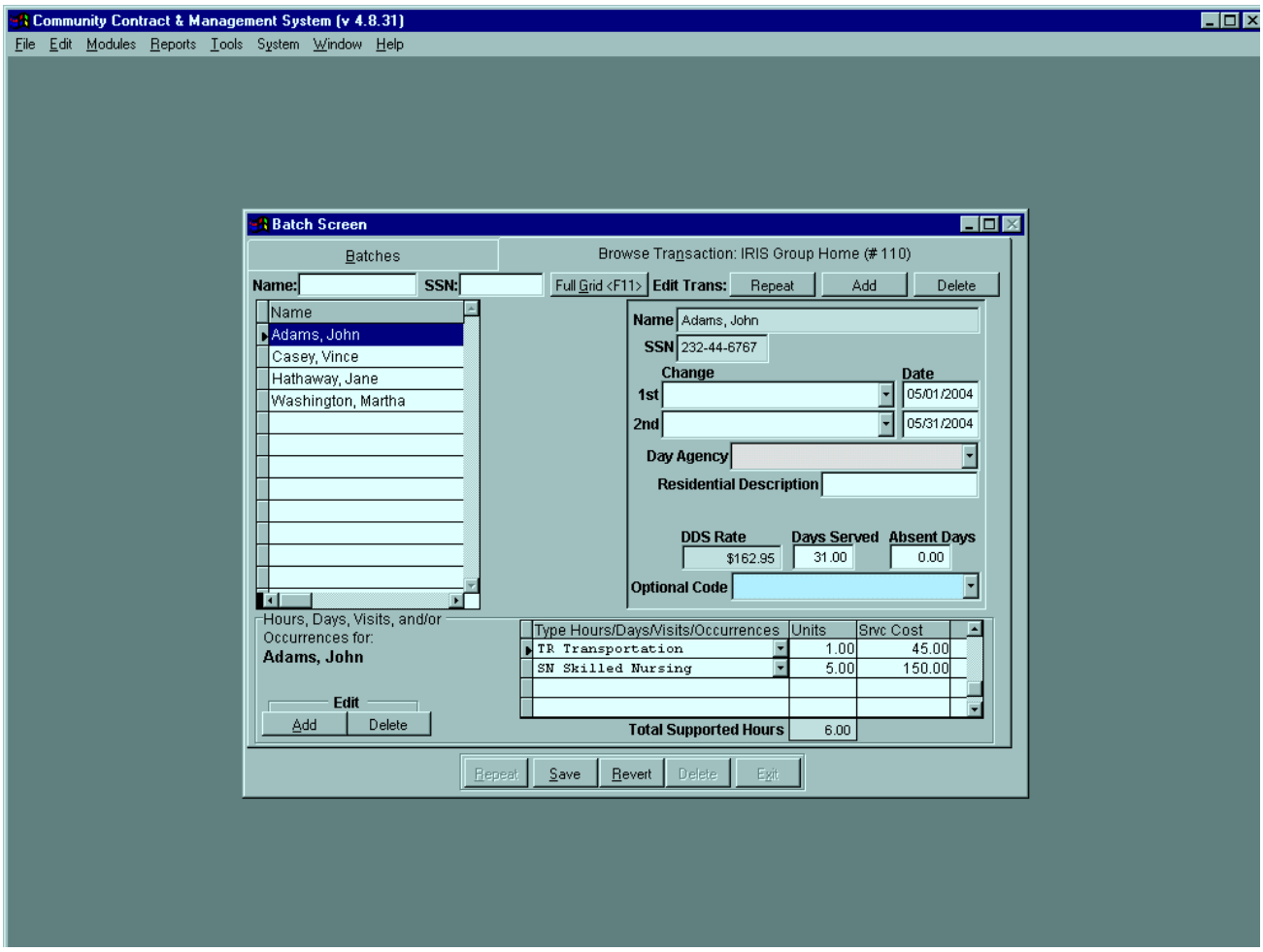
Enter the identifying information in the middle of the Search screen or scroll through the records and select the matching record. **Press the Close button** after identifying the correct individual. **Press the Cancel button** if you are unable to find a CORE match for this person.

**Click on the name of an individual** on full grid screen to select the record for data entry. **Press the F12 key** move to the next record in the list or scroll through the list and select the record to be updated.

**Enter the Days Service** and **Absent Days** for each individual displayed on the full grid screen. If you entered the residential days or absences on the Batch screen, those values would have been carried forward to each transaction in the batch. Change the number of days for those individuals who need to be billed for a different number residential days. Entry of the **Residential Description field is optional** and will display on printed reports and will also carry forward to billing transactions in future months.

**State Income Reporting fields** (not displayed on this screen) must be completed for State funded Residential Reporting transactions. These fields are accessed by scrolling across the list of fields and making the appropriate entry into each field. The system uses these fields to calculate an amount due for each transaction based upon the amount of income being received. **Wages entered must be for only the month being billed**, as the system performs a calculation for disregarded and applied earnings based on the assumption that the earnings are for only one month.

Below the grid format on the screen is a section entitled **Hours, Days, Visits and/or Occurrences** for entry of hours or occurrences of day program or other residential services. The encounter information must be entered for all persons receiving Comprehensive Services. Enter the encounter **Units** based on the current definition of encounter reporting for the Type of Hours/Days/Visits/Occurrences. Entry of the **Service Cost in each record is optional.**




The **Comprehensive Services Part Grid** display is used to enter billing transactions for Comprehensive services in a full screen mode. You reach the Comprehensive Services part grid screen by pressing the **Part Grid button** from the Browse Transaction full grid screen. Press the Full Grid button or F11 to return to the full grid screen. Most of the fields available for data entry on the full grid screen are also available on the part grid screen. **Hours Reporting Only batches only use the part grid screen.**

**The 1st and 2nd Date fields** will have been entered automatically by the computer when the previous billing month was closed out and will be the first and last day of the current billing month. These are the dates the services were provided during the billing month and are used as the From and Through dates of service for Medicaid claims produced for Residential Reporting transactions. You **must** change the dates if there was a change that occurred during the month. For example, if a person was discharged on the 15th of the month, the second date must be changed to the 14th of the month**, because that is the last billable day for Medicaid. The 1st Change and 2nd Change fields are used to enter status changes** that **occurred.** In the preceding example, a discharge code ("DI – Discharged") must be entered in the second change field. The Enrollment Change report prints out a listing of the changes that occurred during the month based on the 1st Change and 2nd

Change entries in the billing transactions. These changes can be compared with the CORE records to make sure that corresponding updates have been entered where necessary.

If there is more than one span of service that must be reported in the current billing month, create multiple transactions to report each span of service by using the **Repeat or Add buttons** at the top of the screen. **Medicaid services cannot be billed for more than one Medicaid facility at the same time**. If an individual entered a hospital during the month, a billing transaction for that span of service must reflect only the number of absent days because the residential days or not billable to Medicaid. For example, if an individual entered the hospital in on 5/11/2004 and returned to the residence on 5/13/2004, transactions should be entered as follows:

| From Date of Service | Thru Date of Service | Residential Days | Absent Days |
|---|---|---|---|
| 5/1/2004 | 5/10/2004 | 10 | 0 |
| 5/11/2004 | 5/12/2004 | 0 | 2 |
| 5/13/2004 | 5/31/2004 | 19 | 0 |

If a previously entered billing transaction for a past month of service requires adjustment, create a new transaction using the **Repeat or Add buttons** at the top of the screen. Change the dates of service to reflect the period of service that requires adjustment. In order to accurately reflect the corrected billing figures, you must first enter a transaction reversing the previously reported figures. Then enter a second transaction correctly reporting the billing figures.

**It is imperative that previously entered billing transaction are adjusted when appropriate or the year-to-date contract figures will not reflect the correct billing or encounter data.**

**Days Served, Absent Days, and Primary Day Agency will already be entered** for each record if you had entered common values on the Batch screen and transferred them to billing transactions. **The Primary Day Agency MUST be entered if any Supported Day Program hours are reported in a transaction, in order to identify the agency that provided the support.**

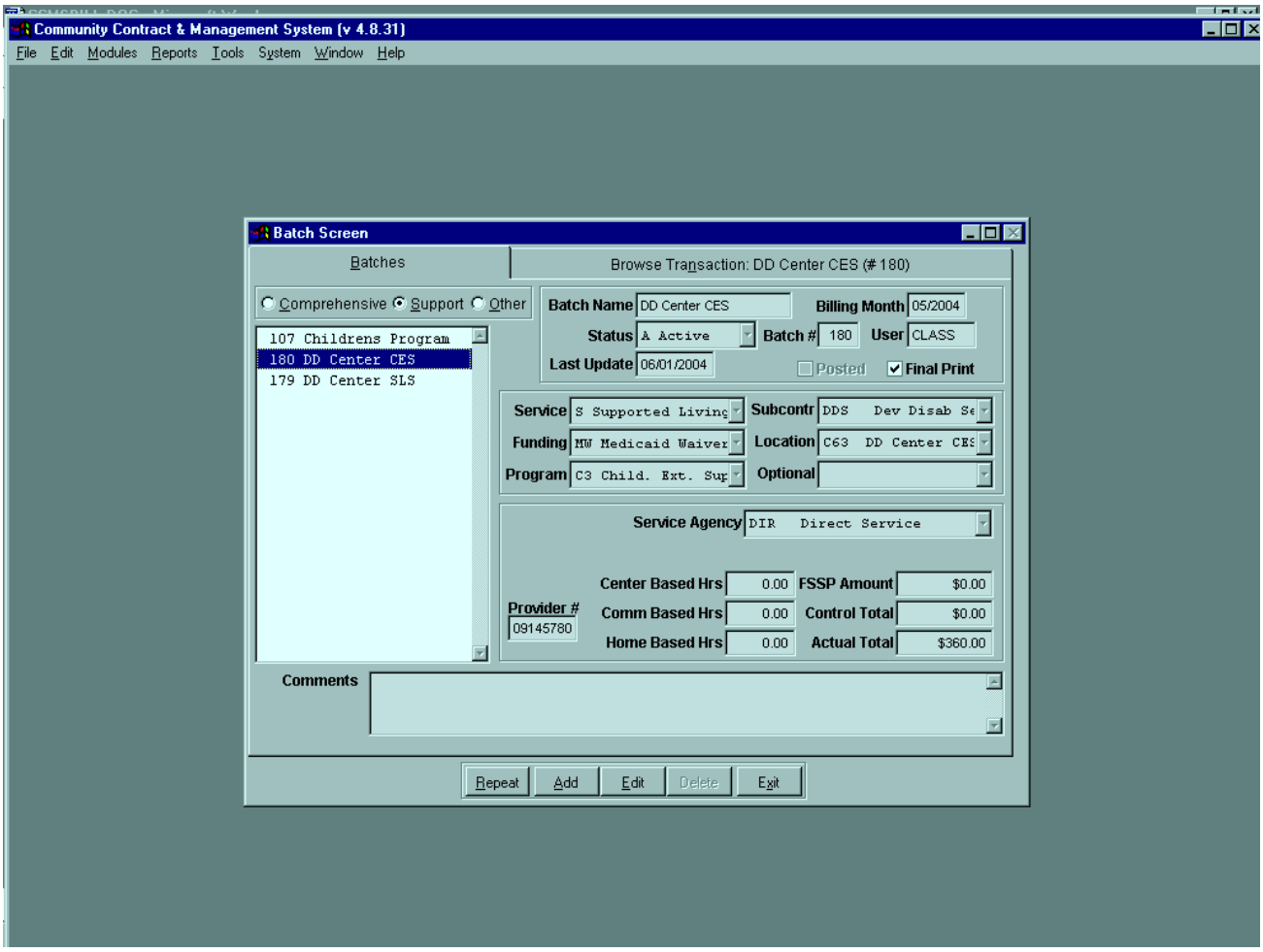
Entry of the **Residential Description field is optional** and will display on printed reports and will also carry forward to billing transactions in future months.

**The DDD Rate field** will have been entered from the value on the Batch screen. You cannot change this rate unless you are entering an adjustment transaction for a period of time when the rate was different. **If the 1st and 2nd dates are not within the current billing month, the entry is an adjustment for previous dates of service**. When you enter a transaction for a previous month of service, the DDD Rate field is enabled so you may change the rate to reflect the correct rate for that period of time, if necessary.

The **Optional field** is entered on the Batch screen and transferred to new billing transactions. You may then change it during entry or update of each billing transaction. Your Agency defines and assigns the billing optional codes. They must be entered in the CCMS Table file before they can be used on this screen.

The full grid screen also displays a section entitled **Hours, Days, Visits and/or Occurrences** for entry of hours or occurrences of day program or other residential services. The encounter information must be entered for all persons receiving Comprehensive Services. Enter the encounter **Units** based on the current definition of encounter reporting for the Type of Hours/Days/Visits/Occurrences. Entry of the **Service Cost in each record is optional.**

**You may enter as many records for a person as needed. Press the Add button** on this section of the screen to add records for the selected individual and choose the appropriate entry from the **drop down list. Press the Delete button** to delete a record for the selected individual.




The **Support Batch screen** is used to begin entry or update for a batch of Support Services billing transactions that have common characteristics. You reach the Support Batch screen by **selecting Billing Data from the CCMS Modules drop down menu** and then **Batch Files** from the Billing Data side menu.

When you first select **Batch Files** from the Billing Data side menu, the default selection is the first Comprehensive batch in the system, and a Batch screen is displayed for that batch. Click above the list of batches on the **Support button** to display a list of Support batches. Click on a line in the list to select the batch and display the batch record.

The Batch screen contains two **Tabs**. The first tab presents the batch record that contains a display of the common characteristics on the batch. The second tab presents the transactions included in the batch. You can only display and update one Billing batch at a time.

Your **security level** will determine whether you have the ability to **enter data** on this screen or may only **view the data** on the screen. If you have been given rights for viewing data only, the fields will appear dimmed and you will not be able to move the cursor to them to enter data. If this batch has

already been posted for the billing month, you will not be able to update any fields on the screen regardless of your security level. **The Repeat, Add, Edit, Revert and Save buttons** will also be disabled if you do not have rights to enter data or the batch has been posted, but you can access the tabs at the top of the screen to move between batch record and detailed transaction data.

Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

In order to enter a new Billing batch, **press the Add button** and then select the correct contract record from the pop-up message **"Select the contract record to be used for this new batch**". The **Service, Funding and Subcontractor fields are automatically entered** for you based on the contract record that is selected. You must enter the **Support Program and Support Location** at a minimum on this screen in order to enter a new batch record for Support services reporting. Fields with a light blue color are optional fields and do not require entry of data. Other fields may require entry of data dependent upon the billing program.

On already existing batch records, you will not be allowed to change the Funding, Program or Location fields because they are the unique identifiers for the matching transactions entered into this batch. The identifying information entered in the batch record is carried forward to new billing transactions that are entered into the batch to reduce the amount of data entry you must perform for billing transactions. Once this information has been entered into the batch record and the associated billing transactions, it is saved from month to month so you do not have to re-enter it.

You need to enter the **Batch Name field** for each batch, using a descriptive name that is meaningful to your Agency. The batch name is displayed when you choose to print or post batches and will help you to identify the batches you wish to select. The **Status field** indicates whether this batch is a currently active, inactive or terminated batch. If you wish to keep batch records after you have terminated all the transactions in the batch, the terminated status will alert you and the system that nothing is to be entered for the batch.

The **Batch # is assigned in sequential order automatically** by the system and you cannot enter or change it. The **Billing Month, Posted and Final Print fields are displayed** based on information that is automatically updated by the system. The **Last Update and User fields display** information about when and by which user the batch record was last updated.

The **Optional field** can be used to enter codes that further identify billing transactions for report sorting and selection criteria. For example, you may wish to identify whether each person with a billing transaction entry in a batch has a Supported Living coordinator by the code assigned to that coordinator, so you can sort transaction listings by this information. The optional code entered on the Batch screen will automatically be carried forward to each new billing transaction and you may then

change it during entry or update of each billing transaction. Your Agency defines and assigns the billing optional codes. They must be entered in the CCMS Table file before they can be used on this screen.

The **Service Agency field** identifies the service agency providing service and is informational only. It does not get carried over to individual transactions in the batch.

**The Provider # field** will be automatically entered and displayed based on the matching provider record. Each batch record must have a matching contract record authorizing your Agency to bill for the program and funding type entered on the Batch screen. If the Support Program is Medicaid funded, there must also be a matching provider record authorizing billing for Medicaid. If either of these records is missing, you will not be able to save a new batch record.

**The Center Based Hours, Community Based Hours and Home Based Hours fields** are only used for the Early Intervention program and should be entered only if most persons had the same number of hours of service. If you enter figures in one or more of these fields, they will be carried forward to transactions entered into the batch.

**The FSSP Amount** field applies only to Family Support Services Program and should be entered if most persons being reported in the batch had the same dollar amount of service. If you enter an amount in this field, it will be carried forward to transactions entered into the batch.

**The Control Total Field must be entered** to record the total amount of service to be entered into the batch for the month. If the actual total does not match with the control total entered, then you will need to check your entries for accuracy to determine if you forgot to enter a transaction or entered one incorrectly. The **Actual Total field** will be updated automatically by the system as you enter and update billing transactions in the batch. **Early Intervention batches do not require a Control Total and will not accumulate an Actual Total.** Entry of costs for the **Supported Living Services program** is optional and will not accumulate an Actual Total if no costs are entered into billing transactions.

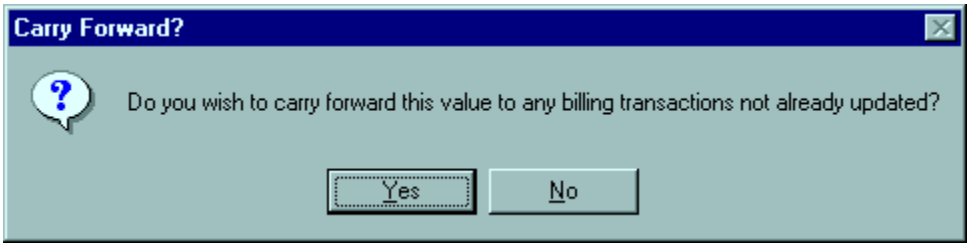
A final batch printing (where the actual and control totals match) must be completed before the batch can be posted. The **Final Print** display at the top of the screen will be Y (Yes) if a final print has occurred.

The **Comments** field at the bottom of the screen can be used for reminders or information about this batch.

Press the **Edit button** to open this batch of transactions for editing. The **Repeat button** is used to repeat the values on this screen to create a new batch record. When your repeat a batch record, only the values in the batch record are carried forward; you will need to enter individual transactions in the new batch.

The **Save, Revert and Delete buttons** are initially disabled or dimmed and will become enabled when you have made any changes to the Billing batch, including changes to the transactions contained in the batch. Any changes you have made will not actually be saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made. The **Revert button** will discard all changes made since the last time you saved changes.

When you select the **Save button** to save changes made to an existing batch, and you have entered **Common Early Intervention Hours or a common Family Support Services Amount value** on the Batch screen, the system will check to see if there are un-entered billing transactions for this batch and display the **Carry Forward screen** below for you to indicate whether you wish to have these values transferred to transactions in the batch. (An un-entered billing transaction is one for which you have not individually performed data entry of billing figures during the billing month and which has not previously had common batch figures transferred to it.)

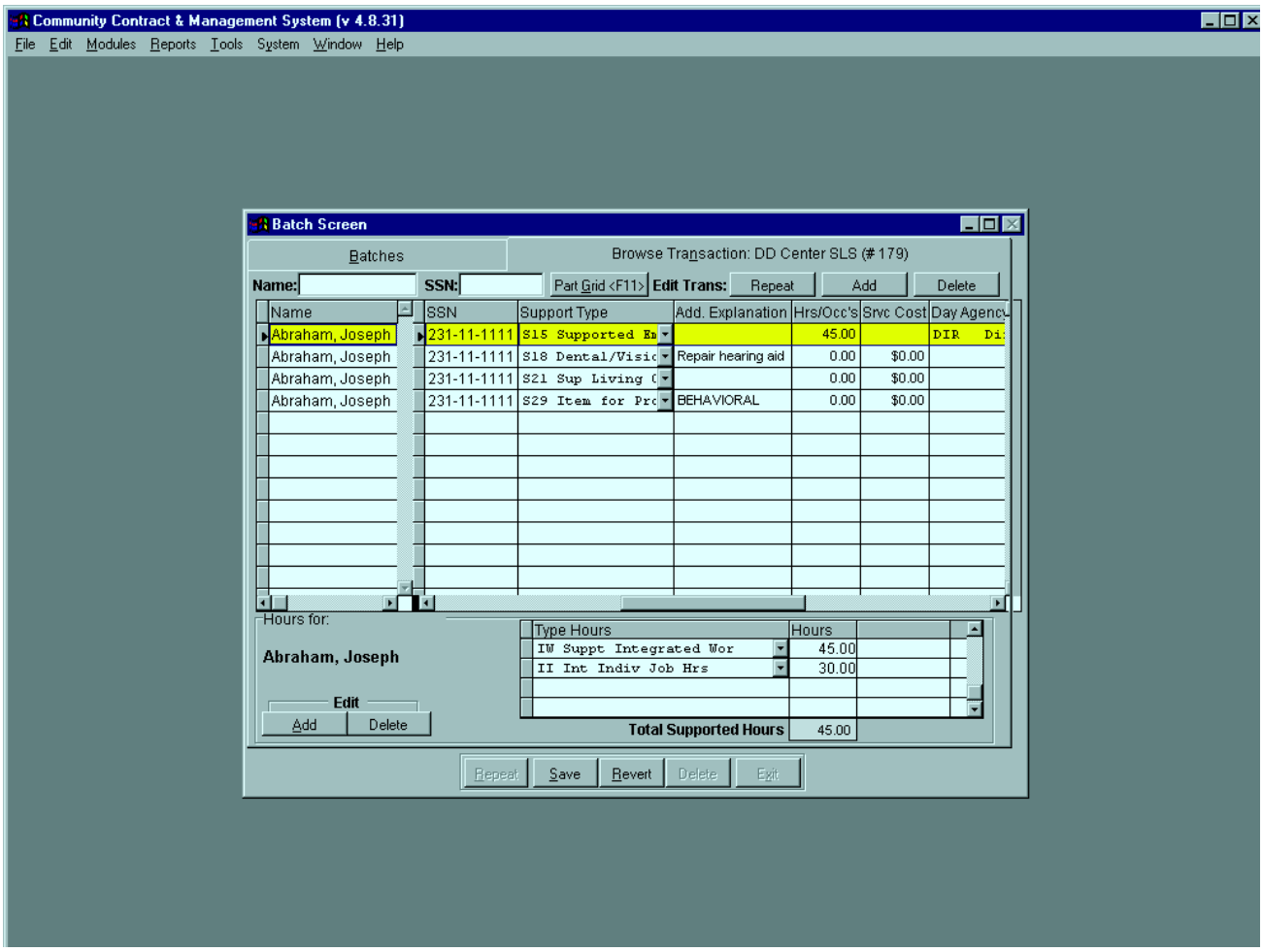



Answer "Yes" to the question above if you wish to carry forward the common values to each transaction in the batch. **If you answer Yes,** all the billing transactions in this batch, which have not been entered individually, will automatically be updated with the common values and you will only have to change billing transactions individually that require different entries. **If you answer No,** none of the billing transactions will be updated automatically, and you will have to enter billing figures into them all individually. Once you answer Yes to this question, you will not be able to carry forward common values again during the current billing month. Further changes to the common values will only be carried forward to new billing transactions you enter into the batch.

Press the **Delete button** to delete the batch record along with all associated transactions in the batch. A batch record may need to be deleted because it was entered in error or is no longer needed. You may also choose to delete a batch of transactions and re-enter the transactions in different batches. Batch entry provides a tool to enter billing transactions based on how you do business in your Agency. If the batch organization is no longer working efficiently at your Agency, you can delete and re-create batches in other configurations. **Do not delete the existing batch until it has been posted for the current billing month to process the transactions in the batch.** The batch can be deleted in the following billing month, if desired. The batch can also be retained as a terminated batch in order to enter previous month's adjustments.

**If a person changes Support program, funding or location, you must terminate the transaction(s) in the batch and enter a new transaction(s) for the new program, funding or location for that person.** This means you will be entering the billing transaction into a different

batch. The new transaction must be an admission transaction showing the date the person was admitted into the new program/funding/location.




The **Browse Transaction screen** is used to enter billing figures into billing transactions associated with the batch record displayed on the Batch screen. You reach the Browse Transaction screen by **selecting the Browse Transaction tab.**

The Browse Transaction screen displays the transactions in a spreadsheet or **grid format** for easier data entry. The fields are displayed in a logical order based upon the most commonly updated fields for the program that is being entered. Notice that the name and social security number are displayed on this Browse Transaction screen for your information (but cannot be updated). Some fields can only be updated in a full screen mode. Press the **Part Grid button** or **F11** to change the display from the full grid above to a part grid where additional fields can be displayed and entered.

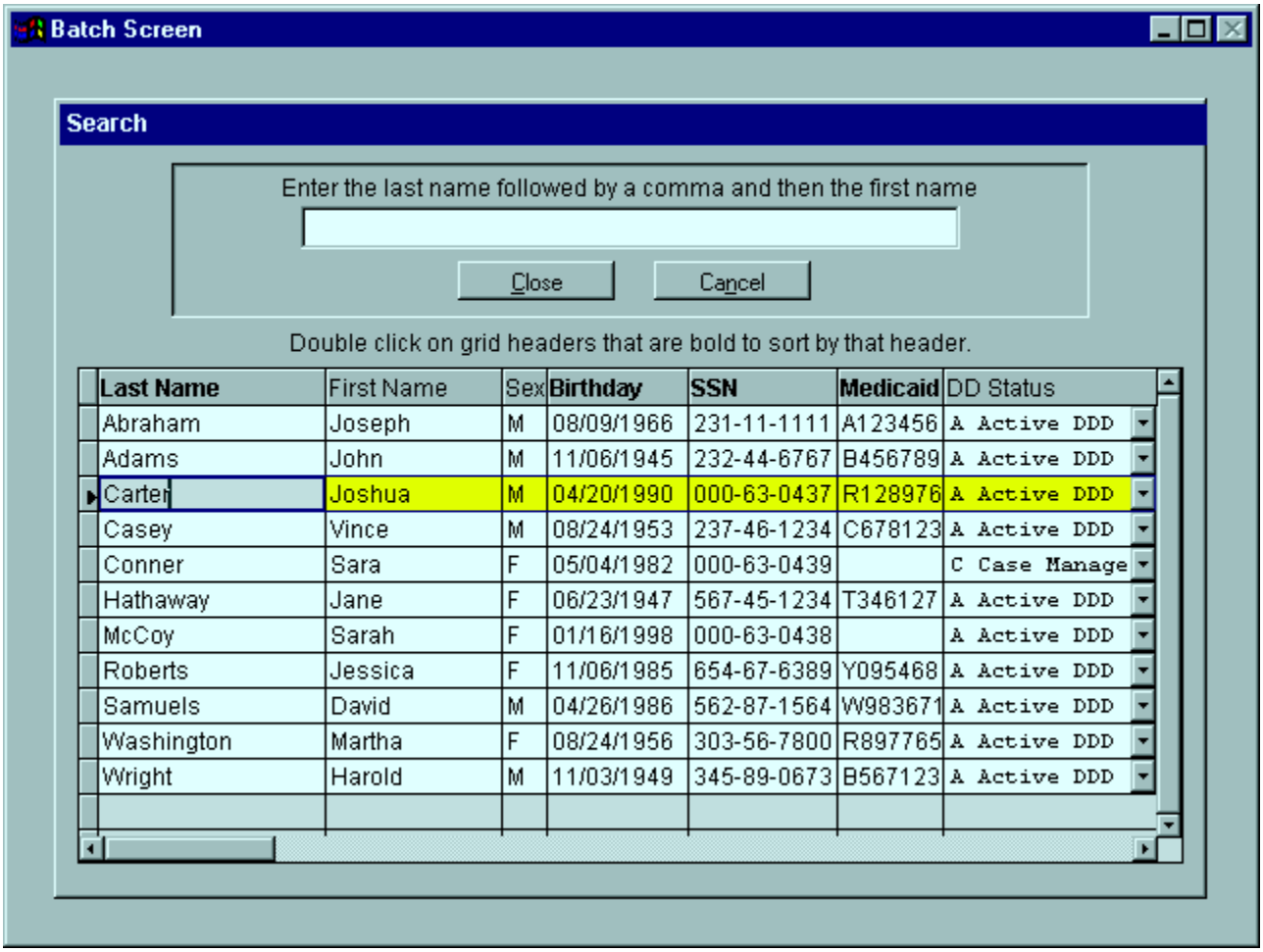
The order and width of the columns on the Browse Transaction screen may be rearranged to suit your particular data entry needs. **To move a column on the screen**, place your cursor on the field name above the column, press down and hold the left mouse button while dragging the field name to the left or to the right. **To change the size of a column on the screen**, place your cursor on the vertical line between the columns so the cursor takes on the appearance of a cross. Hold down on the left mouse

button and drag the column line to the left to make the column smaller or to the right to make the column larger.

**Use the Add or Repeat button** at the top of the screen to add transactions to the batch. You may enter as many records for the person as needed. **To delete a transaction from the batch, select the Delete button** at the top of the screen.

Before pressing the **Repeat button**, click on the line in the grid for the individual you wish to repeat a billing transaction. The **Repeat button** copies forward the information from the selected transaction and you must edit the information as needed for the new transaction. The original transaction is not changed.

The **Add button** creates a new billing transaction in the batch. Before you can add a transaction, you must first identify a matching CORE record on the **Search** screen below. **You cannot enter a billing transaction for a person unless the CORE record has already been entered**.



Enter the identifying information in the middle of the Search screen or scroll through the records and select the matching record. **Press the Close button** after identifying the correct individual. **Press the Cancel button** if you are unable to find a CORE match for this person.

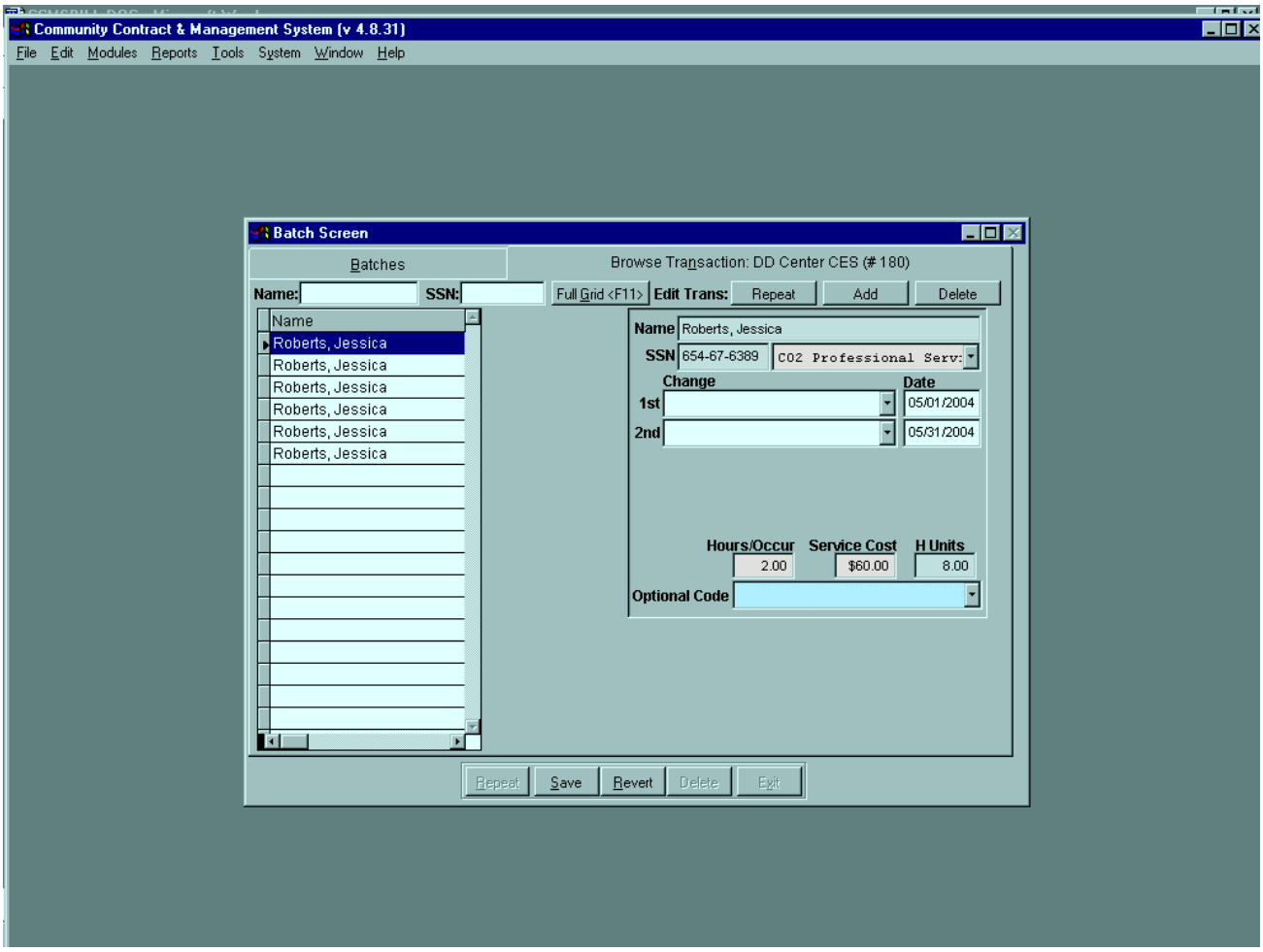
**Click on the name of an individual** on full grid screen to select the record for data entry. **Press the F12 key** move to the next record in the list or scroll through the list and select the record to be updated.

**Entry of billing information on the full grid screen is dependent on program type.**
Supported Living Services Program – Select a **Support Type** from the **drop down list** under the Support Type column. Provide an additional explanation, if required, in the freeform **Additional Explanation** column. Enter **Hours/Occurrences** for each transaction. Entry of **Service Cost** is optional. A **Day Agency** must be entered if the transaction is reporting hours of day program services.
Children's Extensive Support Program - Select a **Support Type** from the **drop down list** under the Support Type column. Provide an additional explanation, if required, in the freeform **Additional Explanation** column. Enter **Hours/Occurrences** for each transaction. Entry of **Service Cost** is required.
Family Support Services Program - Select a **Support Type** from the **drop down list** under the Support Type column. Entry of **Service Cost** is required.
Early Intervention Services Program – This program can only be entered on a part grid screen.

The Additional Explanation field is used to enter further description of a service or payment. If there is more than one item to be reported, either enter multiple transactions or describe both items so the Additional Explanation field can clearly identify each one. **If entering multiple transactions for Children's Extensive Support Waiver, you must ensure that the dates of service being reported do not overlap or the billing will be considered a duplicate entry for purposes of Medicaid claim payment.**

**The Primary Day Agency MUST be entered if any Supported Day Program** hours are reported in a transaction, in order to identify the agency that provided the support.

Below the grid format on the screen is a section entitled **Hours** for entry of hours of day program services for the **Supported Living Services Program.** The encounter information must be entered for all persons receiving day program services under the Supported Living Services Program. This section of the screen will appear only when a **day program Support Type** is selected under the Support Type column on the top part of the screen. Enter the encounter **Hours** based on the current definition of encounter reporting for the Type of Day Program Hours. The supported day program hours are aggregated by the system, and **the Hours/Occurrences column on the top part of the screen is automatically updated with the total**.




The **Support Services Part Grid** display is used to enter billing transactions for Support services in a full screen mode. You reach the Support Services part grid screen by pressing the **Part Grid button** from the Browse Transaction full grid screen. Most of the fields available for data entry on the full grid screen are also available on the part grid screen**. Early Intervention batches use only the part grid screen.**

**The 1st and 2nd Date fields** will have been entered automatically by the computer when the previous billing month was closed out and will be the first and last day of the current billing month. These are the dates the services were provided during the billing month and are used as the From and Through dates of service for Medicaid claims produced for Residential Reporting transactions. You **must** change the dates if there was a change that occurred during the month. For example, if a person was terminated on the 15th of the month, the second date must be changed to the 14th of the month**, because that is the last billable day for Medicaid. The 1st Change and 2nd Change fields are used to enter status changes** that **occurred.** In the preceding example, a discharge code ("TA – Terminated from Active") must be entered in the second change field. The Enrollment Change report prints out a listing of the changes that occurred during the month based on the 1st

Change and 2nd Change entries in the billing transactions. These changes can be compared with the CORE records to make sure that corresponding updates have been entered where necessary.

If there is more than one span of service that must be reported in the current billing month, create multiple transactions to report each span of service by using the **Repeat or Add buttons** at the top of the screen. **Medicaid services cannot be billed for more than one Medicaid facility at the same time**. If an individual entered a hospital during the month, do not enter a billing transaction for that span of service. For example, if an individual entered the hospital in on 5/11/2004 and returned home on 5/13/2004, transactions should be entered as follows:

| From Date of Service | Thru Date of Service | Hours/Occurrences | Service Cost |
|---|---|---|---|
| 5/1/2004 | 5/10/2004 | (as reported) | (as reported) |
| 5/13/2004 | 5/31/2004 | (as reported) | (as reported) |

If a previously entered billing transaction for a past month of service requires adjustment, create a new transaction using the **Repeat** or **Add** buttons at the top of the screen. Change the dates of service to reflect the period of service that requires adjustment. In order to accurately reflect the corrected billing figures, you must first enter a transaction reversing the previously reported figures. Then enter a second transaction correctly reporting the billing figures. **When entering adjustments to previously reported billing transactions, both the Support Hours and Service Cost fields must be adjusted for programs that originally reported cost of service**.

**It is imperative that previously entered billing transaction are adjusted when appropriate or the year-to-date contract figures will not reflect the correct billing or encounter data.**

**The Payment Type? field** (not shown in the above screen) applies only to persons receiving Supported Employment services. If the payment to the provider is being made on the basis of an expected outcome, this field must be completed with the appropriate code.

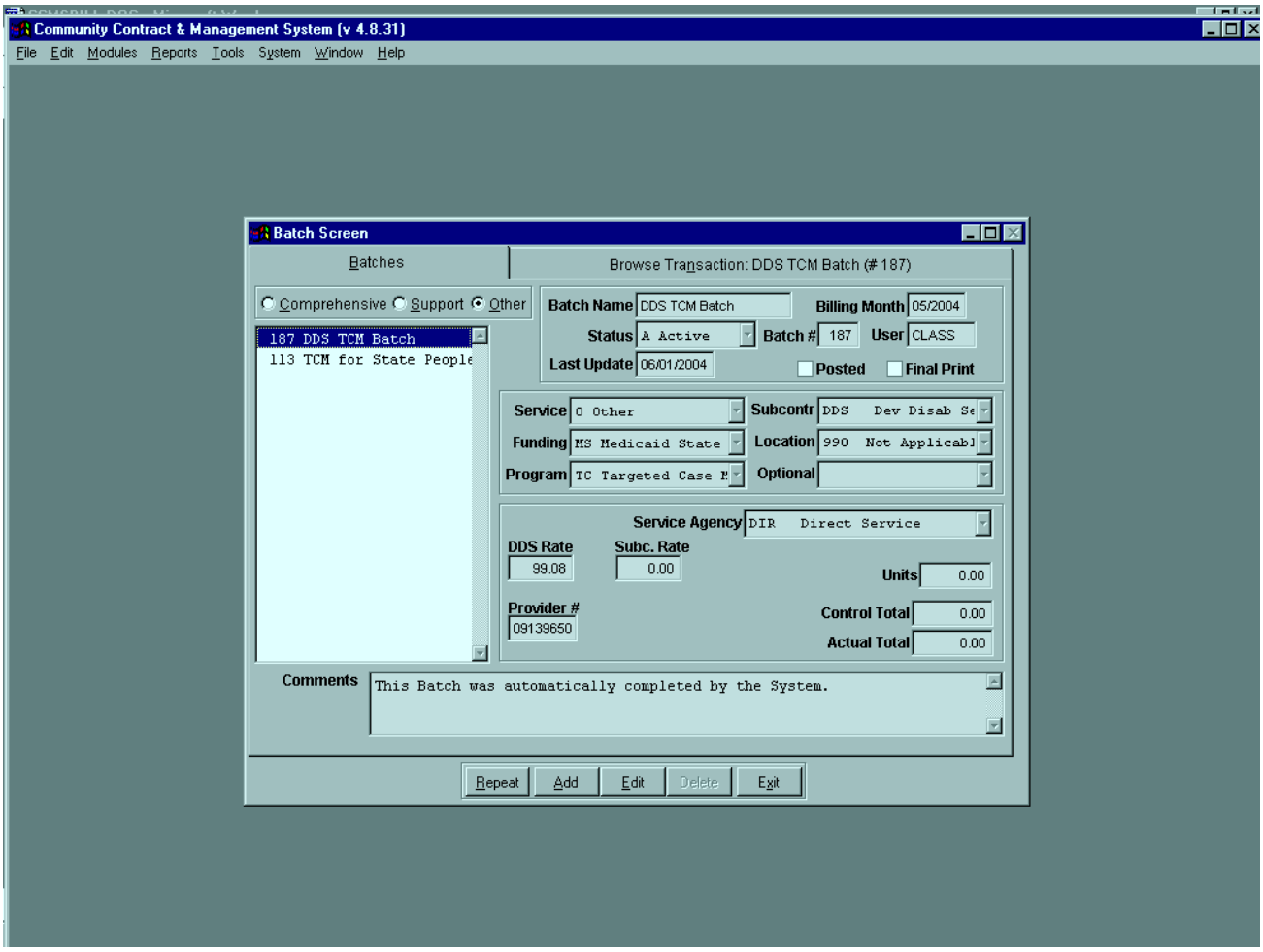
**The Termination Reason field** (not shown in the above screen) applies only to persons receiving Early Intervention or Family Support services. If an individual is terminated from Early Intervention services, this field must be completed. Completion of the field for Family Support services is optional.

The **Optional field** is entered on the Batch screen and transferred to new billing transactions. You may then change it during entry or update of each billing transaction. Your Agency defines and assigns the billing optional codes. They must be entered in the CCMS Table file before they can be used on this screen.

The part grid screen also contains a section entitled **Hours** for entry of hours of day program services for the **Supported Living Services or Early Intervention Services.** This section of the screen will appear only when a **day program Support Type** is selected under the Support Type column on the top part of the screen for **Supported Living Services Program** or when the program is **Early Intervention Services**. Encounter information must be entered for all persons receiving these

services. Enter the encounter **Hours** based on the current definition of encounter reporting for the Type of Day Program Hours.

**You may enter as many records for a person as needed. Press the Add button** on this section of the screen to add records for the selected individual and choose the appropriate entry from the **drop down list. Press the Delete button** to delete a record for the selected individual.




The **Other Services Batch screen** is used to begin entry or update for a batch of Other Services billing transactions that have common characteristics. You reach the Other Services Batch screen by **selecting Billing Data from the CCMS Modules drop down menu** and then **Batch Files** from the Billing Data side menu.

When you first select **Batch Files** from the Billing Data side menu, the default selection is the first Comprehensive batch in the system, and a Batch screen is displayed for that batch. Click above the list of batches on the **Other button** to display a list of Other Services batches. Click on a line in the list to select the batch and display the batch record.

The Batch screen contains two **Tabs**. The first tab presents the batch record that contains a display of the common characteristics on the batch. The second tab presents the transactions included in the batch. You can only display and update one Billing batch at a time.

Your **security level** will determine whether you have the ability to **enter data** on this screen or may only **view the data** on the screen. If you have been given rights for viewing data only, the fields will appear dimmed and you will not be able to move the cursor to them to enter data. If this batch has

already been posted for the billing month, you will not be able to update any fields on the screen regardless of your security level. **The Repeat, Add, Edit, Revert and Save buttons** will also be disabled if you do not have rights to enter data or the batch has been posted, but you can access the tabs at the top of the screen to move between batch record and detailed transaction data.

Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

In order to enter a new Billing batch, **press the Add button** and then select the correct contract record from the pop-up message **"Select the contract record to be used for this new batch"**. The **Service, Funding and Subcontractor fields are automatically entered** for you based on the contract record that is selected. You must enter the **Other Services Program and Other Services Location** at a minimum on this screen in order to enter a new batch record for Other Services reporting. Fields with a light blue color are optional fields and do not require entry of data. Other fields may require entry of data dependent upon the billing program.

On already existing batch records, you will not be allowed to change the Funding, Program or Location fields because they are the unique identifiers for the matching transactions entered into this batch. The identifying information entered in the batch record is carried forward to new billing transactions that are entered into the batch to reduce the amount of data entry you must perform for billing transactions. Once this information has been entered into the batch record and the associated billing transactions, it is saved from month to month so you do not have to re-enter it.

You need to enter the **Batch Name field** for each batch, using a descriptive name that is meaningful to your Agency. The batch name is displayed when you choose to print or post batches and will help you to identify the batches you wish to select. The **Status field** indicates whether this batch is a currently active, inactive or terminated batch. If you wish to keep batch records after you have terminated all the transactions in the batch, the terminated status will alert you and the system that nothing is to be entered for the batch.

The **Batch # is assigned in sequential order automatically** by the system and you cannot enter or change it. The **Billing Month, Posted and Final Print fields are displayed** based on information that is automatically updated by the system. The **Last Update and User fields display** information about when and by which user the batch record was last updated.

The **Optional field** can be used to enter codes that further identify billing transactions for report sorting and selection criteria. For example, you may wish to identify the case manager assigned to each person with a billing transaction, so you can sort transaction listings by this information. The optional code entered on the Batch screen will automatically be carried forward to each new billing transaction and you may then change it during entry or update of each billing transaction. Your

Agency defines and assigns the billing optional codes. They must be entered in the CCMS Table file before they can be used on this screen.

The **Service Agency field** identifies the service agency providing service and is informational only. It does not get carried over to individual transactions in the batch.

**The DDD Rate and Provider # fields** will be automatically entered and displayed based on the matching contract and provider record. Each batch record must have a matching contract record authorizing your Agency to bill for the program and funding type entered on the Batch screen. The DDD rate will be taken from that contract record for Other Services batches. If the Other Services Program is Medicaid funded, there must also be a matching provider record authorizing billing for Medicaid. If either of these records is missing, you will not be able to save a new batch record.

**The Units field** should be entered for batches in which you are reporting units of service and if most persons had the same number of units of service. If you enter any information in the Units field, it will be automatically carried forward into each new billing transaction you enter.

**The Control Total Field must be entered** to record the total number of units to be entered into the batch for the month. If the actual total does not match with the control total entered, then you will need to check your entries for accuracy to determine if you forgot to enter a transaction or entered one incorrectly. The **Actual Total field** will be updated automatically by the system as you enter and update billing transactions in the batch. Each batch of transactions must be printed and reviewed for accuracy.

A final batch printing (where the actual and control totals match) must be completed before the batch can be posted. The **Final Print** display at the top of the screen will be Y (Yes) if a final print has occurred.

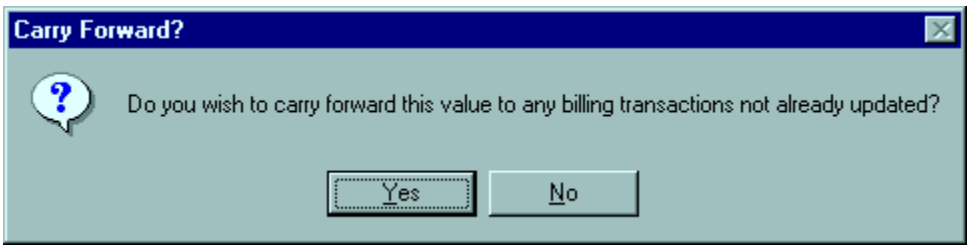
The **Comments** field at the bottom of the screen can be used for reminders or information about this batch.

Press the **Edit button** to open this batch of transactions for editing. The **Repeat button** is used to repeat the values on this screen to create a new batch record. When your repeat a batch record, only the values in the batch record are carried forward; you will need to enter individual transactions in the new batch.

The **Save, Revert and Delete buttons** are initially disabled or dimmed and will become enabled when you have made any changes to the Billing batch, including changes to the transactions contained in the batch. Any changes you have made will not actually be saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made. The **Revert button** will discard all changes made since the last time you saved changes.

When you select the **Save button** to save changes made to an existing batch, and you have entered **Common Units** on the Batch screen, the system will check to see if there are un-entered billing

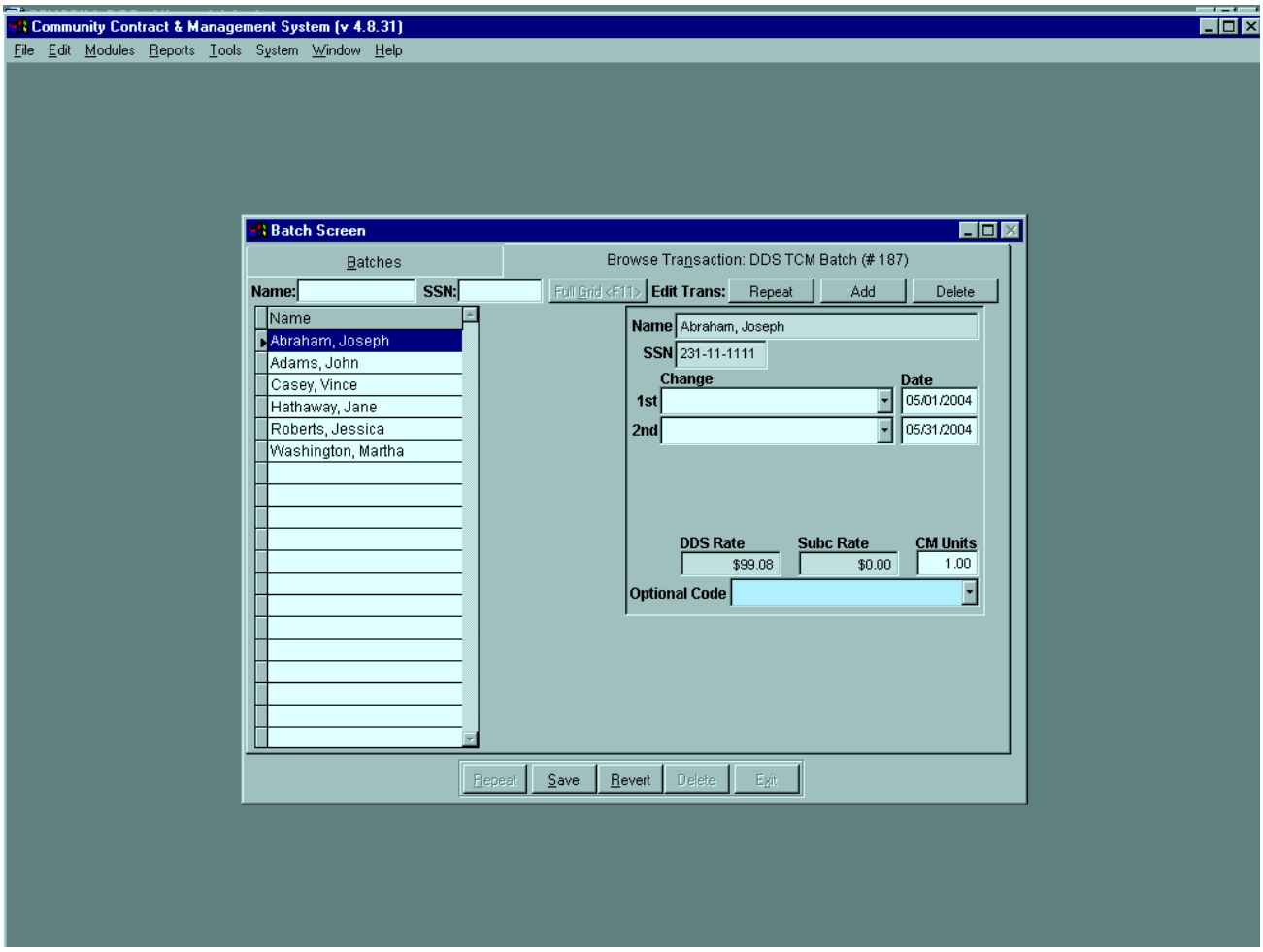
transactions for this batch and display the **Carry Forward screen** below for you to indicate whether you wish to have these values transferred to transactions in the batch. (An un-entered billing transaction is one for which you have not individually performed data entry of billing figures during the billing month and which has not previously had common batch figures transferred to it.)




Answer "Yes" to the question above if you wish to carry forward the common values to each transaction in the batch. **If you answer Yes,** all the billing transactions in this batch, which have not been entered individually, will automatically be updated with the common values and you will only have to change billing transactions individually that require different entries. **If you answer No,** none of the billing transactions will be updated automatically, and you will have to enter billing figures into them all individually. Once you answer Yes to this question, you will not be able to carry forward common values again during the current billing month. Further changes to the common values will only be carried forward to new billing transactions you enter into the batch.

Press the **Delete button** to delete the batch record along with all associated transactions in the batch. A batch record may need to be deleted because it was entered in error or is no longer needed. You may also choose to delete a batch of transactions and re-enter the transactions in different batches. Batch entry provides a tool to enter billing transactions based on how you do business in your Agency. If the batch organization is no longer working efficiently at your Agency, you can delete and re-create batches in other configurations. **Do not delete the existing batch until it has been posted for the current billing month to process the transactions in the batch**. The batch can be deleted in the following billing month, if desired. The batch can also be retained as a terminated batch in order to enter previous month's adjustments.

**If a person changes Other Services program, funding or location, you must terminate the transaction(s) in the batch and enter a new transaction(s) for the new program, funding or location for that person.** This means you will be entering the billing transaction into a different batch. The new transaction must be an admission transaction showing the date the person was admitted into the new program/funding/location.

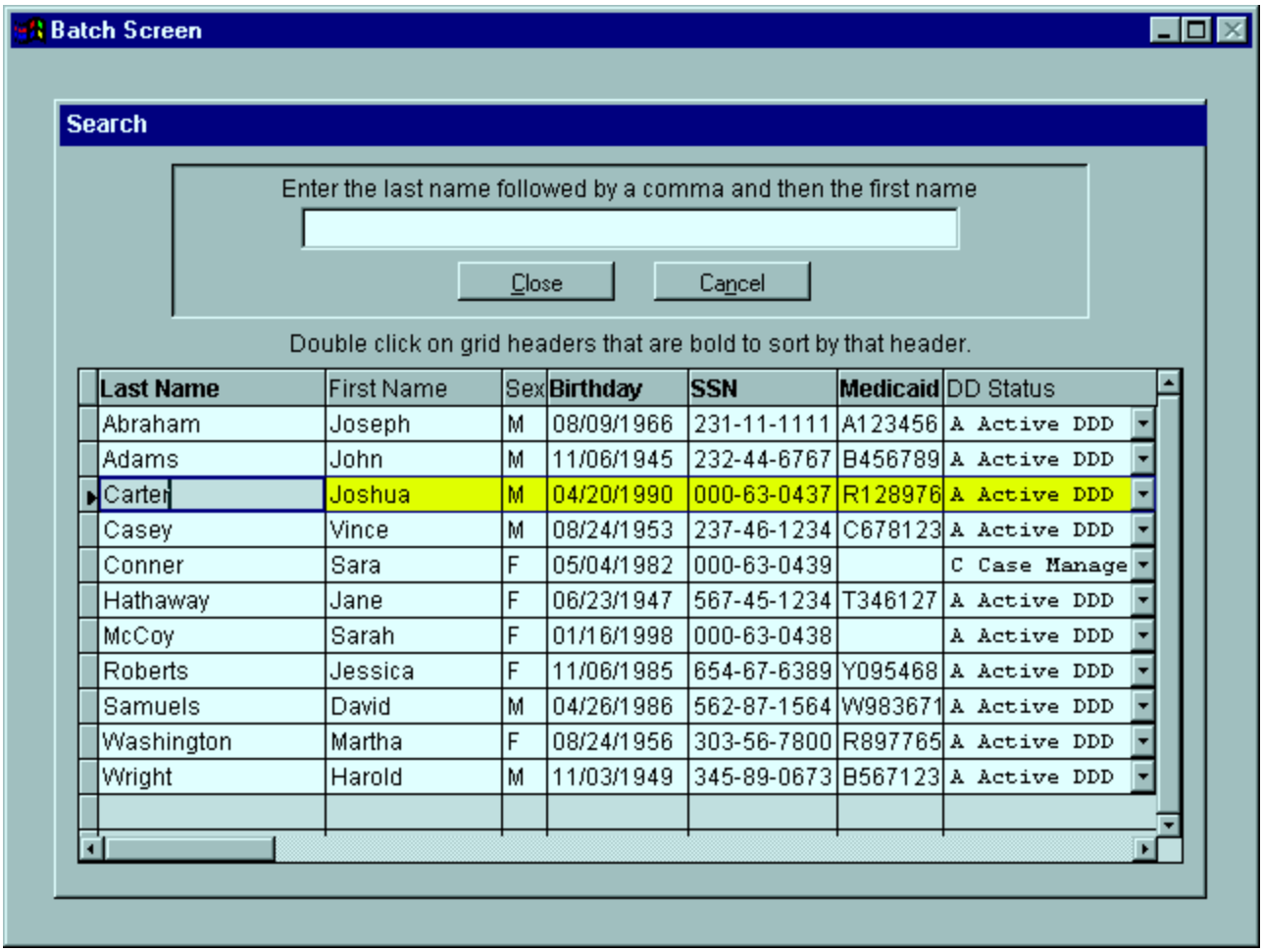



The **Other Services Part Grid** display is used to enter billing transactions for Other services in a full screen mode. A full grid display is not available for Other Services billing. You reach the Other Services screen by selecting the Browse Transaction tab from the Batch screen.

**Use the Add or Repeat button** at the top of the screen to add transactions to the batch. You may enter as many records for a person as needed. **To delete a transaction from the batch, select the Delete button** at the top of the screen.

Before pressing the **Repeat button**, click on the line in the grid for the individual you wish to repeat a billing transaction. The **Repeat button** copies forward the information from the selected transaction and you must edit the information as needed for the new transaction. The original transaction is not changed.

The **Add button** creates a new billing transaction in the batch. Before you can add a transaction, you must first identify a matching CORE record on the **Search** screen below. **You cannot enter a billing transaction for a person unless the CORE record has already been entered**.




| Last Name | First Name | Sex | Birthday | SSN | Medicaid | DD Status |
|---|---|---|---|---|---|---|
| Abraham | Joseph | M | 08/09/1966 | 231-11-1111 | A123456 | A Active DDD |
| Adams | John | M | 11/06/1945 | 232-44-6767 | B456789 | A Active DDD |
| Carter | Joshua | M | 04/20/1990 | 000-63-0437 | R128976 | A Active DDD |
| Casey | Vince | M | 08/24/1953 | 237-46-1234 | C678123 | A Active DDD |
| Conner | Sara | F | 05/04/1982 | 000-63-0439 | | C Case Manage |
| Hathaway | Jane | F | 06/23/1947 | 567-45-1234 | T346127 | A Active DDD |
| McCoy | Sarah | F | 01/16/1998 | 000-63-0438 | | A Active DDD |
| Roberts | Jessica | F | 11/06/1985 | 654-67-6389 | Y095468 | A Active DDD |
| Samuels | David | M | 04/26/1986 | 562-87-1564 | W983671 | A Active DDD |
| Washington | Martha | F | 08/24/1956 | 303-56-7800 | R897765 | A Active DDD |
| Wright | Harold | M | 11/03/1949 | 345-89-0673 | B567123 | A Active DDD |

Enter the identifying information in the middle of the Search screen or scroll through the records and select the matching record. **Press the Close button** after identifying the correct individual. **Press the Cancel button** if you are unable to find a CORE match for this person.

**Click on the name of an individual** on the screen to select the record for data entry. **Press the F12 key** move to the next record in the list or scroll through the list and select the record to be updated.

**The 1st and 2nd Date fields** will have been entered automatically by the computer when the previous billing month was closed out and will be the first and last day of the current billing month. These are the dates the services were provided during the billing month and are used as the From and Through dates of service for Medicaid claims produced for Residential Reporting transactions. You **must** change the dates if there was a change that occurred during the month. For example, if a person was terminated on the 15th of the month, the second date must be changed to the 14th of the month**, because that is the last billable day for Medicaid. The 1st Change and 2nd Change fields are used to enter status changes** that **occurred.** In the preceding example, a discharge code ("TA – Terminated from Active") must be entered in the second change field. The Enrollment Change report prints out a listing of the changes that occurred during the month based on the 1st

Change and 2nd Change entries in the billing transactions. These changes can be compared with the CORE records to make sure that corresponding updates have been entered where necessary.

If there is more than one span of service that must be reported in the current billing month, create multiple transactions to report each span of service by using the **Repeat or Add buttons** at the top of the screen. **Medicaid services cannot be billed for more than one Medicaid facility at the same time**. If an individual entered a hospital during the month, do not enter a billing transaction for that span of service. For example, if an individual entered the hospital in on 5/11/2004 and returned home on 5/13/2004, transactions should be entered as follows:

| From Date of Service | Thru Date of Service | Hours/Occurrences | Service Cost |
|---|---|---|---|
| 5/1/2004 | 5/10/2004 | (as reported) | (as reported) |
| 5/13/2004 | 5/31/2004 | (as reported) | (as reported) |

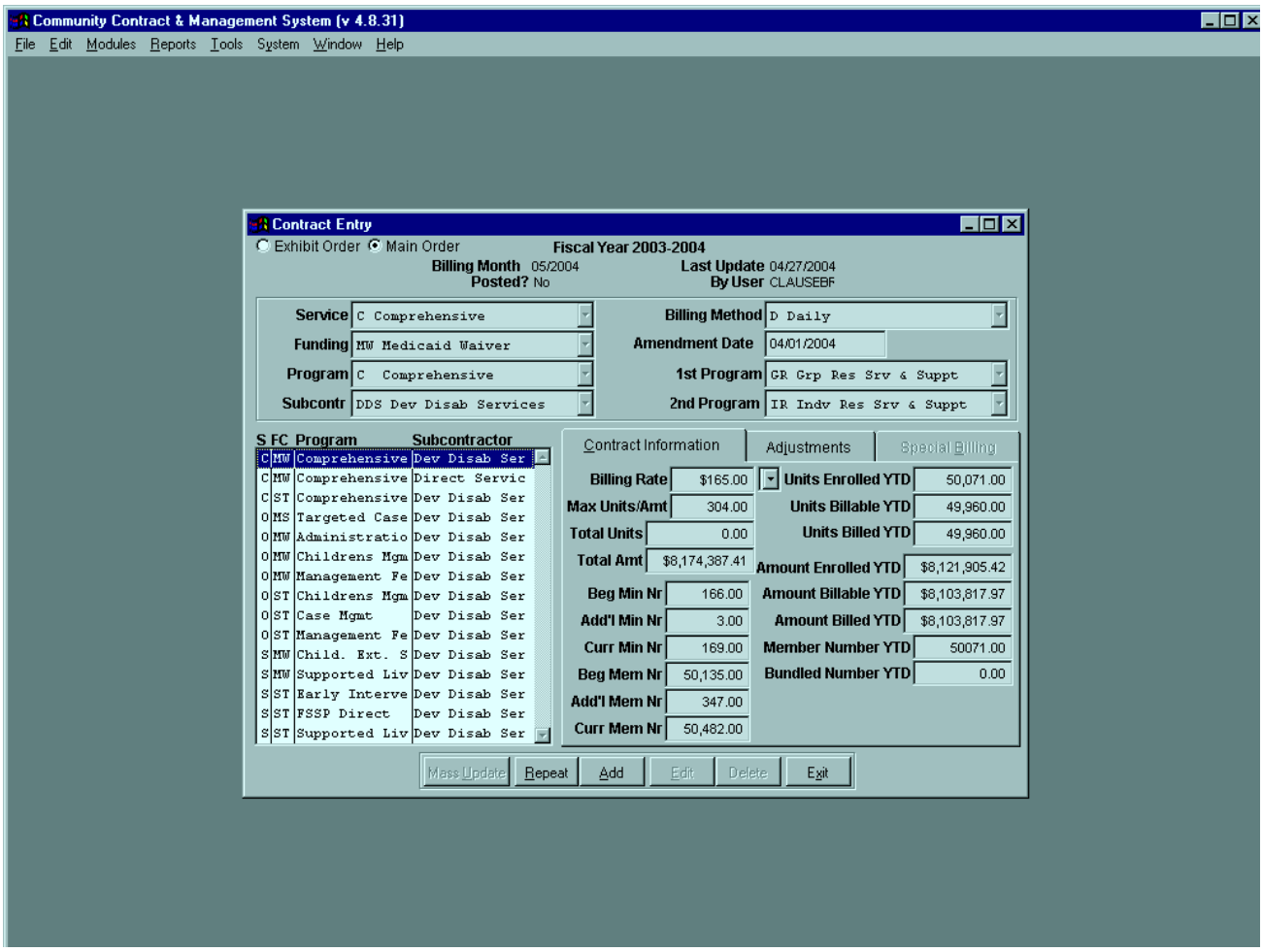
If a previously entered billing transaction for a past month of service requires adjustment, create a new transaction using the **Repeat or Add buttons** at the top of the screen. Change the dates of service to reflect the period of service that requires adjustment. In order to accurately reflect the corrected billing figures, you must first enter a transaction reversing the previously reported figures. Then enter a second transaction correctly reporting the billing figures.

**It is imperative that previously entered billing transaction are adjusted when appropriate or the year-to-date contract figures will not reflect the correct billing or encounter data.**

**Units will already be entered** for each record if you had entered common values on the Batch screen and transferred them to billing transactions.

**The DDD and Subcontract Rate field** will have been entered from the values on the Batch screen. You cannot change this rate unless you are entering an adjustment transaction for a period of time when the rate was different. **If the 1st and 2nd dates are not within the current billing month, the entry is an adjustment for previous dates of service**. When you enter a transaction for a previous month of service, the rate fields are enabled so you may change the rate to reflect the correct rate for that period of time, if necessary.

The **Optional field** is entered on the Batch screen and transferred to new billing transactions. You may then change it during entry or update of each billing transaction. Your Agency defines and assigns the billing optional codes. They must be entered in the CCMS Table file before they can be used on this screen.




**The Contract Record Entry screen** is used to enter DDD contract and Agency subcontract records. You reach the Contract Record Entry screen by **selecting Billing Data from the CCMS Modules drop down menu** and then **Contract Files** from the Billing Data side menu.

The Contract screen contains three **Tabs**. The first tab displays the values in the contract record. The second tab displays adjustments for the current billing month against the contract record. The third tab is used to enter adjustments against the Family Support Services contract to report non-person specific expenses for the current billing month.

Your **security level** will determine whether you have the ability to **enter data** on this screen or may only **view the data** on the screen. If you have been given rights for viewing data only, the fields will appear dimmed and you will not be able to move the cursor to them to enter data. **The Repeat, Add, Edit, Revert and Save buttons** will also be disabled if you do not have rights to enter data.

Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

**Press the Add button** to add a new contract record. You must enter the **Service, Funding, Program, Subcontract and Billing Method fields** at a minimum on this screen in order to enter a new contract record. **Billing Rate, Maximum Units/Amount and Total Units** are entered dependent on program type. **Total Amount** is the total of the contract for the specified program. There are two types of contract records, those with DDD in the Subcontract field and those with a code other than DDD in the Subcontract field. **The records that do not contain DDD in the Subcontract field are referred to as subcontract records.**

**Agencies are not allowed to enter or update DDD contract records**. DDD contract records are entered at DDD and transmitted to the Agency at the beginning of the billing month along with other DDD updates. When a DDD contract record is displayed on the screen by an Agency, all the fields are disabled. However, you can choose the **Repeat button** to add a new subcontract record which repeats the values of the DDD contract record, so you don't have to retype them all for your subcontract entry. You will not be allowed to save a new subcontract record until you have changed the Subcontract field from DDD to one of your subcontract codes.

**When entering or updating DDD contract records, the user must specify the Agency for which to enter or update records**. A **drop down list** will be displayed at the top of the screen to select an Agency to work with (not available at an Agency site). To update or enter DDD contract records for another Agency, select a new Agency from the drop down list.

**The DDD contract record is an Agency's authorization to bill for the program(s) and funding type contained in the contract record.** Contract records generally reflect the contract lines that are outlined in the contract exhibits attached to an Agency's formal written contract agreement. More than one type of service may be included in a contract line, so the contract record allows for recording program types that are authorized under a contract line. If only the **Program field** is entered into a contract record, that is the program for which billing has been authorized. If the **1st Program and/or 2nd Program field** is entered, that is the program type(s) for which billing has been authorized. In the Contract Record Entry screen displayed above, the contract line is for Comprehensive Services and the program types that may be billed against this contract line are "GR – Group Residential Services and Supports" and "IR – Individual Residential Services and Supports". When entering billing batches, the system checks the contract file for a matching DDD contract record (and subcontract record, if applicable) to verify that the program being billed has been authorized in the contract record. If no contract record exists or the contract record does not contain the program type being billed, an error message will be displayed and a batch for that program cannot be entered.

**Agencies may enter subcontract records in order to accumulate billing and/or service information for their purchase of service programs or for cost centers they have identified within their direct service programs.** The accumulation of billing information will be different based on the service type of the subcontract record as follows:

1. Comprehensive Services
   Comprehensive Services are paid by DDD based on a comprehensive rate averaged across all providers, and for a maximum number of days in the year for each person. It is unlikely that your Agency will use this same payment methodology to pay your purchase of service agencies. A variety of payment methods may be used for payments to providers, and it is not possible for the system to account for all possible methods to post an amount to be paid to your purchase of service agencies. Consequently, the only billing method that will be allowed for Comprehensive Service subcontract records is "M – Monthly". This will allow posting of a monthly payment figure based on $1/12^{th}$ of the contract amount. In order to assist your Agency to determine how many days of service have been provided and how many days have been considered billable for DDD payment, the number of days enrolled, billable and billed contained in the billing transactions associated with this subcontract record will also be posted to the subcontract record.

2. Support Services
   Support Services are paid by DDD based on either a monthly billing methodology, reimbursement for the actual cost of service or a reimbursement of a bundled rate for certain services. Each subcontract record you enter should reflect the same billing method as the DDD contract record as that is how the information will post to subcontract records as well. The hours and dollar amount of service entered into billing transactions that record Service Cost, will post to the subcontract record to record Units Enrolled and Amount Enrolled. Programs that do not record service cost in the billing transactions, e.g. Early Intervention, will not post anything to the enrolled figures. The hours and dollar amount of payment will also post, where appropriate, to record Units Billable and Amount Billable.

3. Other Services
   Other Services are paid by DDD based on a unit rate. Each subcontract record you enter should reflect the same billing method as the DDD contract record as that is how the information will post to subcontract records as well. The units of service entered into billing transactions will post to the subcontract records to record Units Enrolled and Billable. The dollar amount of payment will also post to record Amount Enrolled and Billable. The amount posted to the subcontract record will be based on the number of units times the subcontract rate entered into the subcontract record.

Subcontract records are identified by entering a subcontract code other than DDD in the **Subcontract** field. You must first assign subcontract codes and enter them into your CCMS Table file before you may enter them on this screen. After entering a subcontract record on this screen, the subcontract code assigned to the record **MUST** be entered on the Batch screen for the associated

billing program in order for the system to know that the billing transactions in that batch must be aggregated against the subcontract record when the transactions are posted. In order to aggregate billings against a subcontract record follow the steps below:

1. Assign a subcontract code for the subcontractor or cost center for which you wish to aggregate billing information and enter it into the Table file under the "Subcontrct" Look Up name. You may find it convenient to use the same code that has been assigned as a location code or you may assign a generic code similar to how service agency codes are assigned. Deciding how to assign a subcontract code should be based on the level at which you wish aggregation of billing information to take place. For example, use the location code of "748", for Iris Street Group Home, to post to a specific group home or cost center subcontract record or use "MLH", for Martin Luther Homes, to post to a service agency subcontract record.

2. Enter a new subcontract record using the appropriate Service, Funding and Program codes and enter the subcontract code you assigned under the "Subcontrct" Look Up Name in the Table file. Be sure to enter the appropriate 1st Program and 2nd Program if required in order to authorize billing for a program other than that contained in the Program field (e.g. 1st Program of "IR – IRSS" for the contract Program code of "C – Comprehensive"). For Other Services contract records, also be sure to enter a Billing Rate as this is the rate that will be used to calculate the amounts to be posted to the subcontract record.

3. Enter the subcontract code in the Subcontract field on the Billing Batch screen when entering a new batch record or for an existing batch record for which you wish to begin aggregation against a subcontract record. If you do not enter the subcontract code in the batch record, the system will not know that it should be aggregating the transactions in the batch against a subcontract record in addition to the DDD contract record.

The contract record contains fields to accumulate the year-to-date billing information for each program in order to monitor the utilization of contract amounts and discontinue payment of State funded contracts when the contract amount has been exceeded. The current year-to-date values for each contract record are displayed on the screen in the **YTD fields** for your information. Be sure to check the **Posted? field** at the top of the screen to determine if the values completely reflect the latest billing information. **The YTD fields will not reflect the full month billing until the Posted? field displays Final.**

Press the **Edit button** to open this contract record for editing. The Edit button is only available at DDD for records that are DDD created records. The **Repeat button** is used to repeat the values on this screen to create a new contract record.

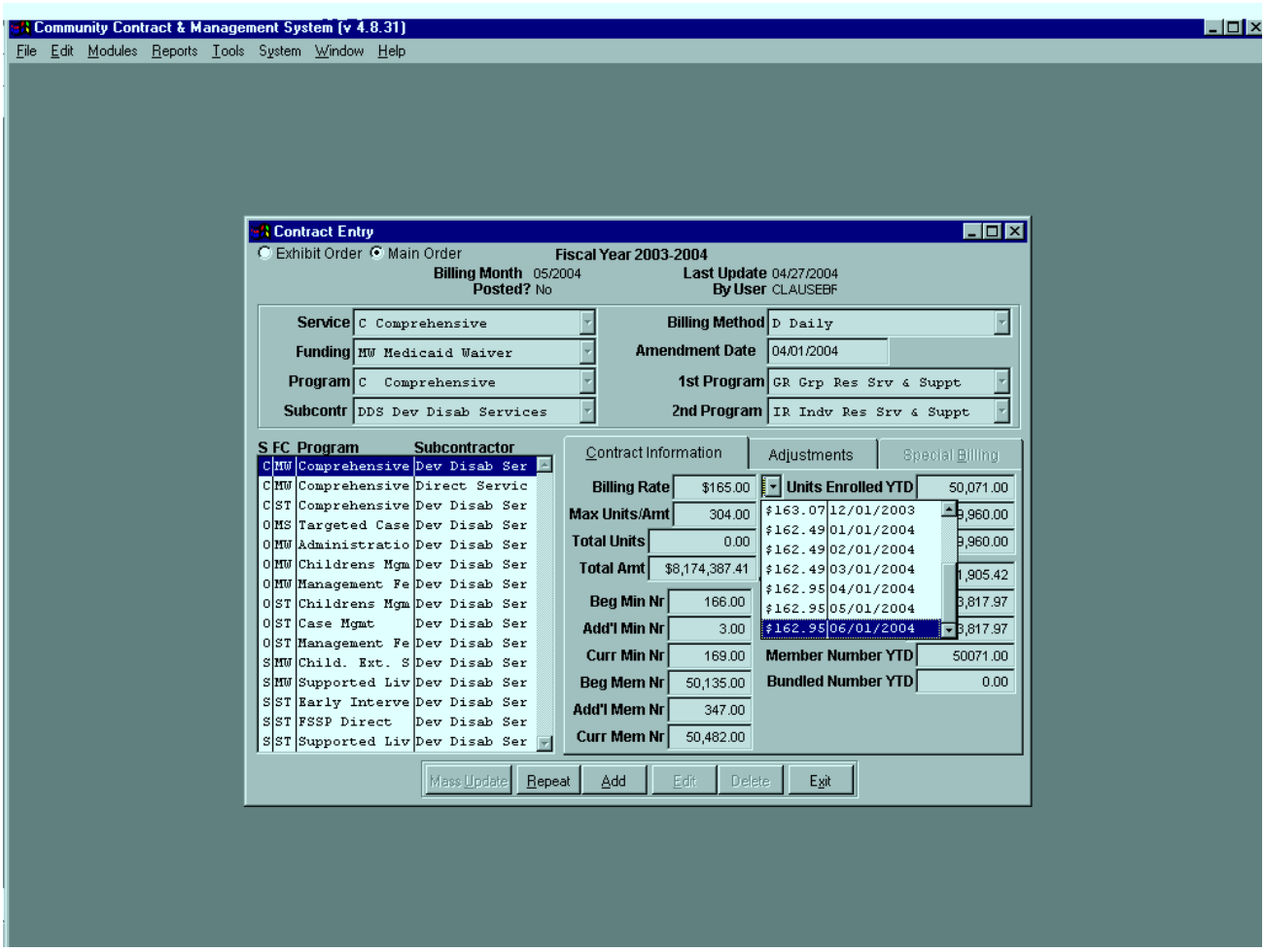
The **Save, Revert and Delete buttons** are initially disabled or dimmed and will become enabled when you have made any changes to the contract record. Any changes you have made will not actually be

saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made. The **Revert button** will discard all changes made since the last time you saved changes.

**Press the Delete button** to delete a contract record. When you select to **delete a contract record** you will be asked to confirm your action. The system will check to see if any billings have been posted to the contract record for the fiscal year and will not allow you to delete the contract record if it contains any year-to-date billing figures.

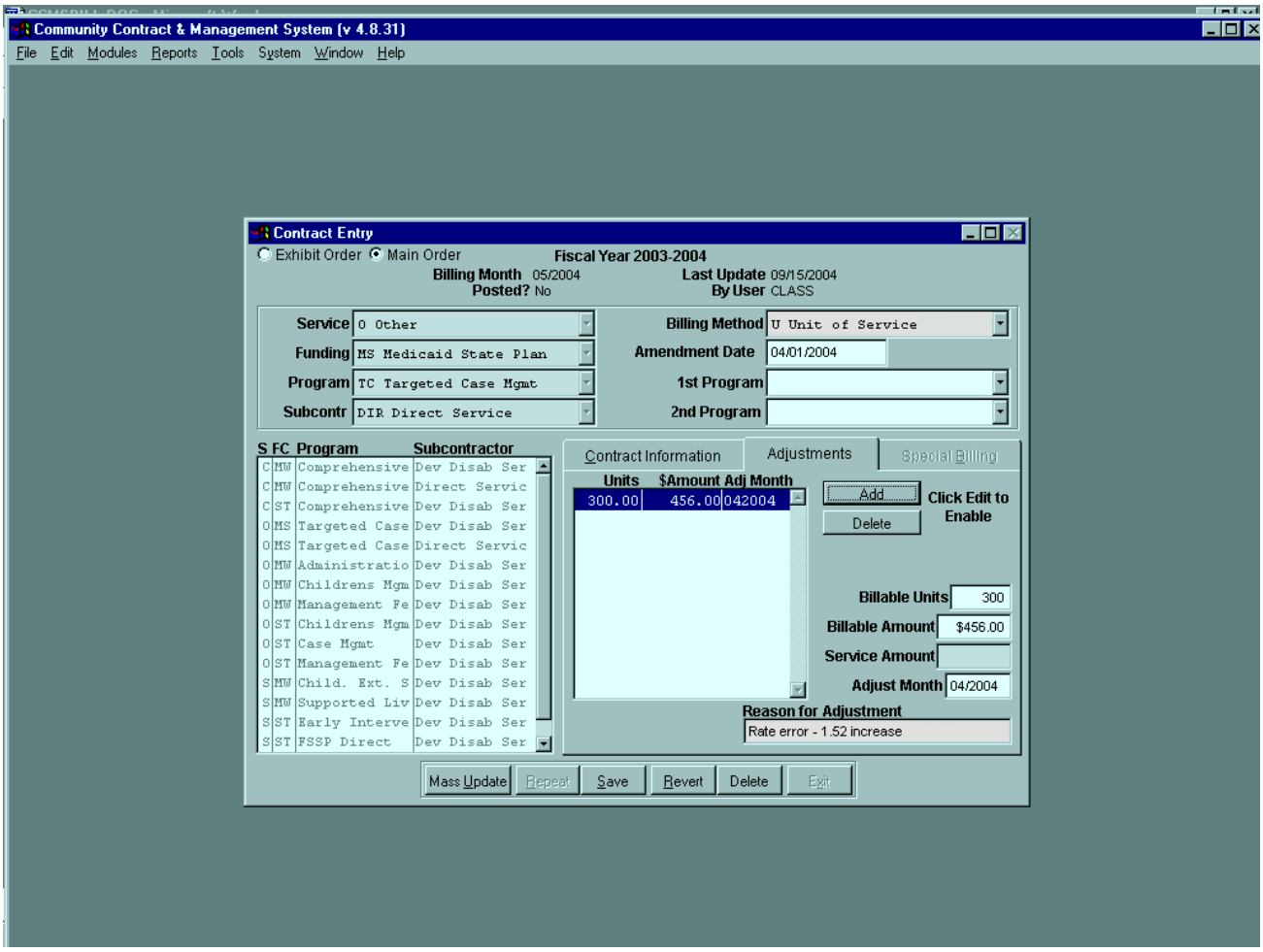
**Press the Mass Update button** to perform an update of the rate, maximum units, billing methodology and amendment date fields across all similar contract records.

To enter a contract adjustment against a contract record, **select the Contract Adjustment tab** on the Contract screen. To enter a Special Billing against a contract record, **select the Special Billing tab** on the Contract screen.




**The Contract Rate drop down list** displays monthly rates for the current fiscal year for the contract record selected. Only contract records that contain a billing rate will have a monthly rate displayed for each month of the fiscal year. You reach the Contract Rate drop down list by clicking on the arrow next to the **Billing Rate field.**

Rates cannot be changed on this drop down list. In order to change a billing rate, it is updated in the Billing Rate field on the Contract Record Entry screen. The change will be effective for the Billing Month, which is displayed at the top of the screen. **No retroactive rates may be entered.** When a billing rate is changed on the Contract Record Entry screen, the Contract Rate drop down list is updated to change the rate for that month and all future months within the fiscal year.




**The Contract Adjustment screen** is used to enter DDD contract and Agency subcontract adjustments. You reach the Contract Adjustment screen by **selecting the Adjustment tab** from the Contract screen.

**Press the Edit button** to add or update contract adjustment records. If this is a DDD contract record, only DDD will have access to the Edit button. **Agencies may display DDD contract adjustments but are not allowed to enter or update them.** DDD contract adjustments are entered at DDD and transmitted to the Agency at the beginning of the billing month along with other DDD updates.

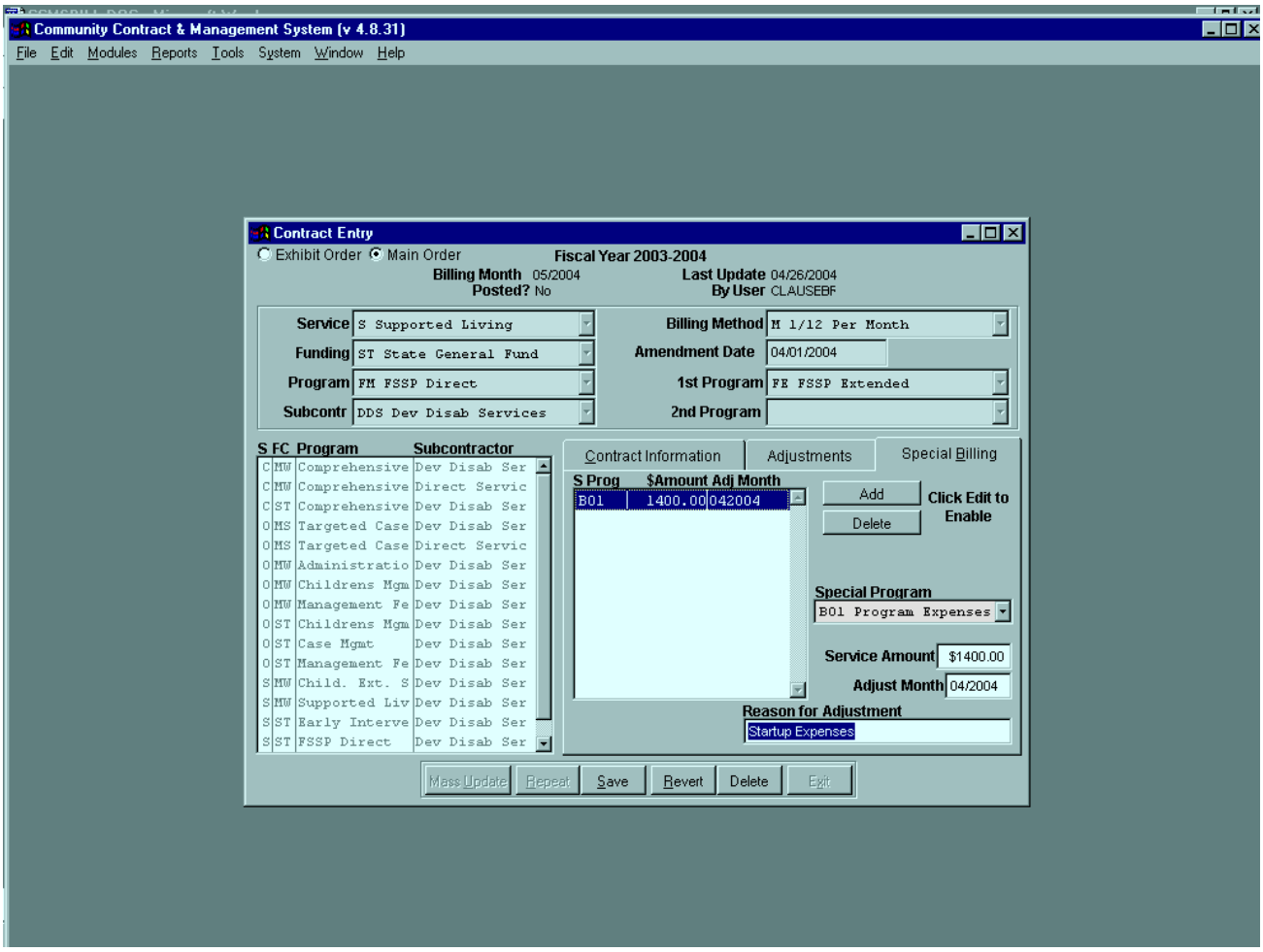
**Press the Add button** in the middle of the screen to add an adjustment billing transaction. **To delete an adjustment billing transaction, select the Delete button**.

Depending on the type of Contract record, either the **Billable Units and Billable Amount or the Service Amount must be entered** at a minimum on this screen in order to enter a new contract

adjustment record**.** You must also enter the **Adjustment Month and Reason for Adjustment fields**.

The Contract Adjustment screen is used to make lump sum adjustments to the DDD contract or Agency subcontract record identified on the Contract screen. Lump sum adjustments may be needed to correct the YTD figures in cases where the system contained an incorrect Medicaid rate in comparison to the actual rate that was paid for Medicaid claims. DDD contract adjustment entries will usually be of this nature. Agencies may wish to enter subcontract adjustments for subcontract records that were entered sometime after the first of the year, but they want the YTD figures to reflect any billing for that purchase of service agency or cost center from the beginning of the fiscal year, as well as future billings that will be posted against the subcontract record.

**Contract adjustments are posted against the billable and billed fields in the contract record but not against the enrolled fields.** Since these adjustments are not specific to individuals, it would no longer be possible to track the enrolled figures back to the individual transactions if the enrolled YTD fields were affected by the adjustment. After a contract adjustment entry has been posted against a contract record, the Amount Enrolled YTD and Amount Billable YTD figures will be different from each other.




**The Special Billing screen** is used to enter Agency billings against the Family Support Services Program. You reach the Special Billing screen by **selecting the Special Billing tab** from the Contract screen. At this time, only the Family Support Services Program (FSSP) contract record will allow entry of special billings.

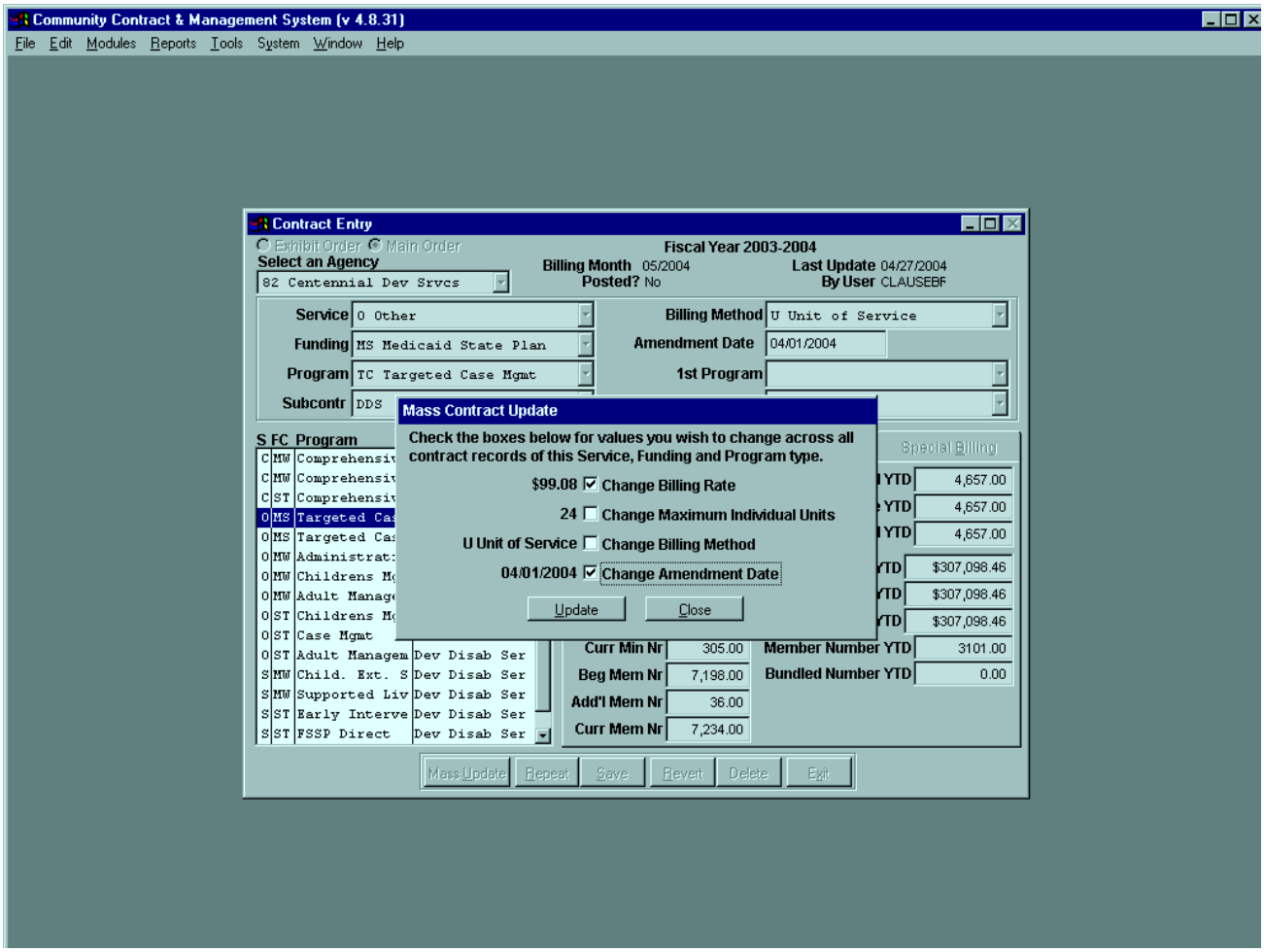
**Press the Edit button** to add or update the special billing records. Only Agencies can enter special billing records. They are transmitted to DDD in the monthly transmission of data files.

**Press the Add button** in the middle of the screen to add a special billing transaction. **To delete a special billing transaction, select the Delete button**.

The Special Billing Entry screen is used to enter non-person specific billings against the DDD contract or Agency subcontract record identified on the Contract Record Entry screen. Special billings may be entered monthly or as costs arise for the program being billed. You must enter the **Special Program and Service Amount fields** at a minimum on this screen in order to enter a new special billing record. The program identified in the Special Program field identifies the purpose for

the special billing, but **you may add an additional explanation in the Reason for Adjustment field if you wish.**

**Special billings for FSSP are posted against the "enrolled amount" fields in the contract record, but not against the billable or billed fields.** Because FSSP is paid at 1/12th of the total contract amount, special billing entries cannot affect the actual amount to be billed.



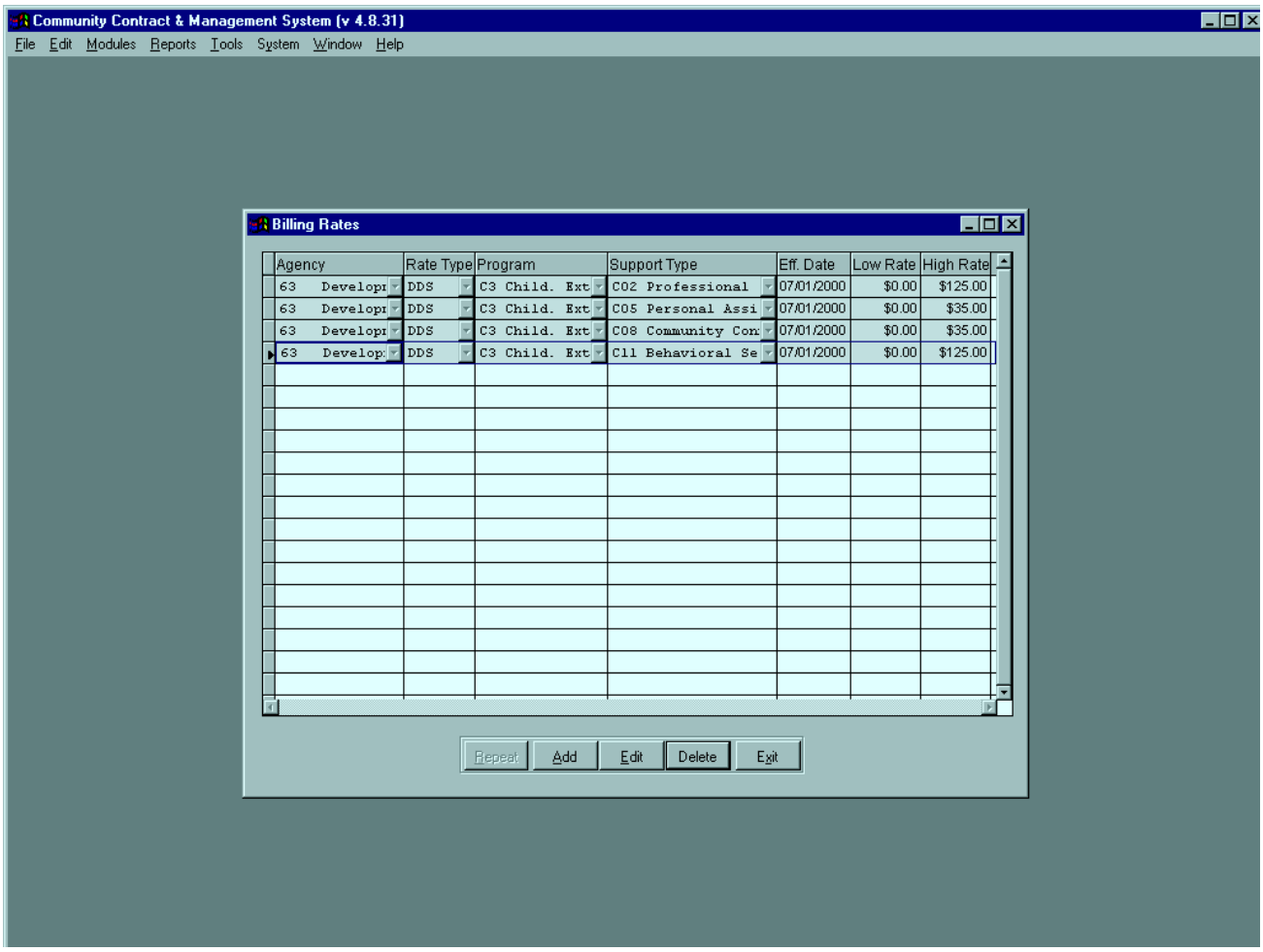

**The Mass Contract Update screen** is used to make mass changes to the rate, maximum units, billing methodology and amendment date fields across all similar contract records. You reach the Mass Contract Update screen by **pressing the Mass Update button after you have selected a Contract record to update.**

**Performing a mass update of these fields is generally done at the beginning of the fiscal year** when rates and amendment dates usually change. At Agency sites, all subcontract records across all subcontract codes that have the same service, funding and program type, will be changed to the new field values. At the DDD site all DDD contract records across all Agencies that have the same service, funding and program type, will be changed to the new field values.

The information displayed on the screen is pulled from the contract record currently displayed on the Contract Record Entry screen. You cannot update the fields on this screen. You must update them as needed on the Contract Record Entry screen and save the changes to the contract record before selecting the Mass Update menu option. **Click with the mouse pointer on each check box** in front

of a field you wish to have changed. **Click again to remove the X** to indicate you do not wish to have a field value changed.

Press the **Update button** to process the changes against all similar contract records. Press the **Close button** when finished to return to the Contract Record Entry screen.




**The SLS/CES Rates Update screen** is used to enter DDD rates and Agency rates for Supported Living Services and Children's Extensive Support programs. You reach the Billing Rates screen by **selecting Billing Data from the CCMS Modules drop down menu** and then **SLS/CES Rates** from the Billing Data side menu.

Your **security level** will determine whether you have the ability to **enter data** on this screen or may only **view the data** on the screen. If you have been given rights for viewing data only, the fields will appear dimmed and you will not be able to move the cursor to them to enter data. If this batch has already been posted for the billing month, you will not be able to update any fields on the screen regardless of your security level. **The Repeat, Add, Edit, Revert and Save buttons** will also be disabled if you do not have rights to enter data.

Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

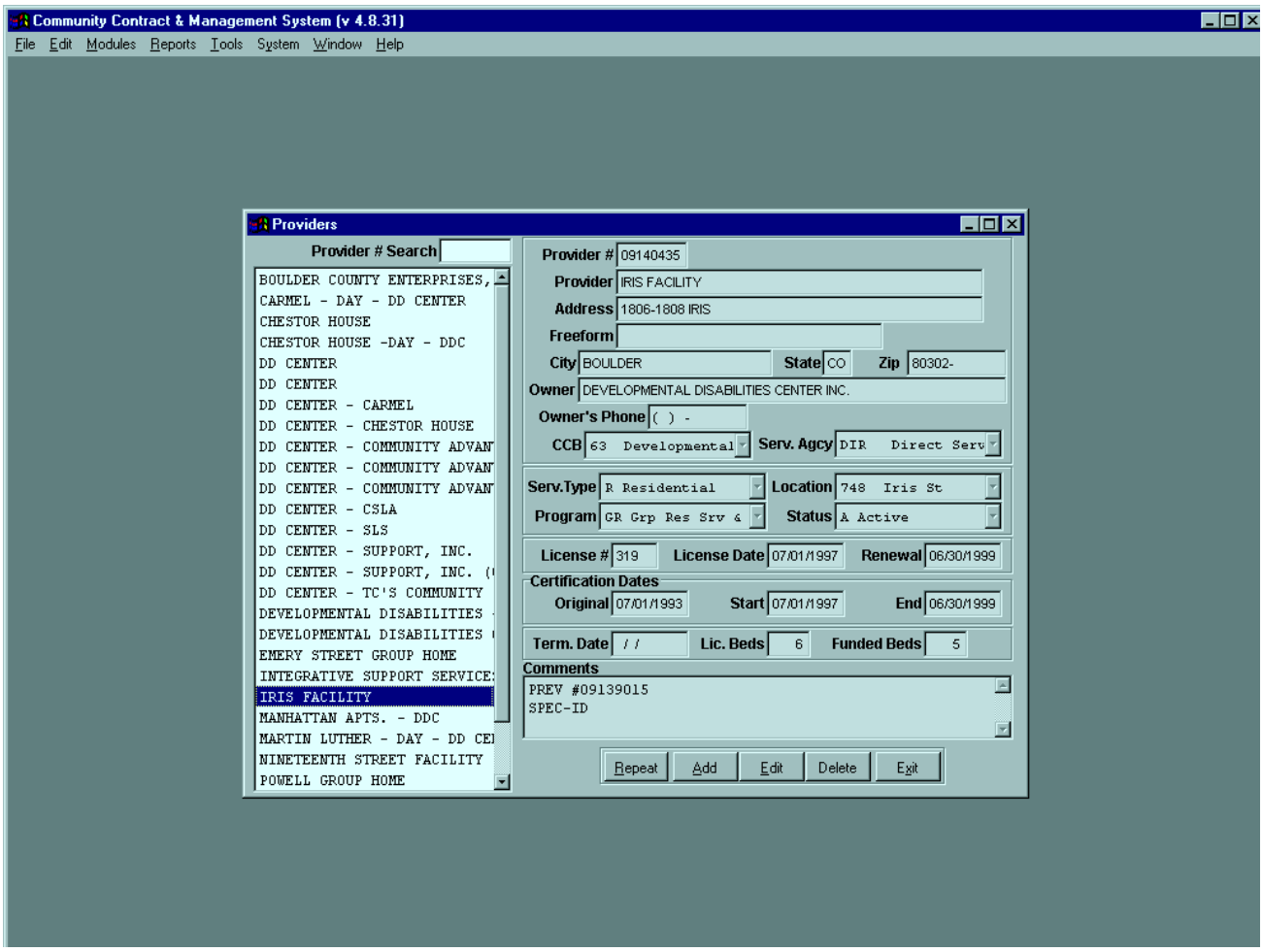
**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

Press the **Add button** to add a new rate record. You must enter the **Agency, Rate Type, Program, Support Type, Effective Date and High Rate** at a minimum on this screen in order to enter a new rate record.

**Agencies are not allowed to enter or update DDD rate records**. DDD rate records are entered at DDD and transmitted to the Agency at the beginning of the billing month along with other DDD updates. When a DDD rate record is displayed on the screen by an Agency, all the fields are disabled. However, you can choose the **Repeat button** to add a new rate record which repeats the values of the DDD rate record, so you don't have to retype them all for your rate record entry. The **Rate Type** field is automatically changed to Agency when a new record is entered at an Agency site.

Press the **Edit button** to open this rate record for editing. The Edit button is only available at DDD for records that are DDD created records. The **Repeat button** is used to repeat the values on this screen to create a new rate record.

The **Save, Revert and Delete buttons** are initially disabled or dimmed and will become enabled when you have made any changes to the rate record. Any changes you have made will not actually be saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made. The **Revert button** will discard all changes made since the last time you saved changes.




**The Provider Record Entry screen** is used to enter Medicaid provider records. You reach the Provider Record Entry screen by **selecting Billing Data from the CCMS Modules drop down menu** and then **Providers** from the Billing Data side menu.

Your **security level** will determine whether you have the ability to **enter data** on this screen or may only **view the data** on the screen. If you have been given rights for viewing data only, the fields will appear dimmed and you will not be able to move the cursor to them to enter data. If this batch has already been posted for the billing month, you will not be able to update any fields on the screen regardless of your security level. **The Repeat, Add, Edit, Revert and Save buttons** will also be disabled if you do not have rights to enter data.

Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

**Press the Add button** to enter a new provider record. You must enter the **Provider Number, Provider Name, Agency, Service Type, Status and Certification date** at a minimum on this screen in order to enter a new provider record. Provider numbers that begin with "DDS" are assigned by DDD to differentiate a number that has not been established by the Medicaid Fiscal agent. DDD assigns unique provider numbers to aid in tracking and reporting for approved providers.

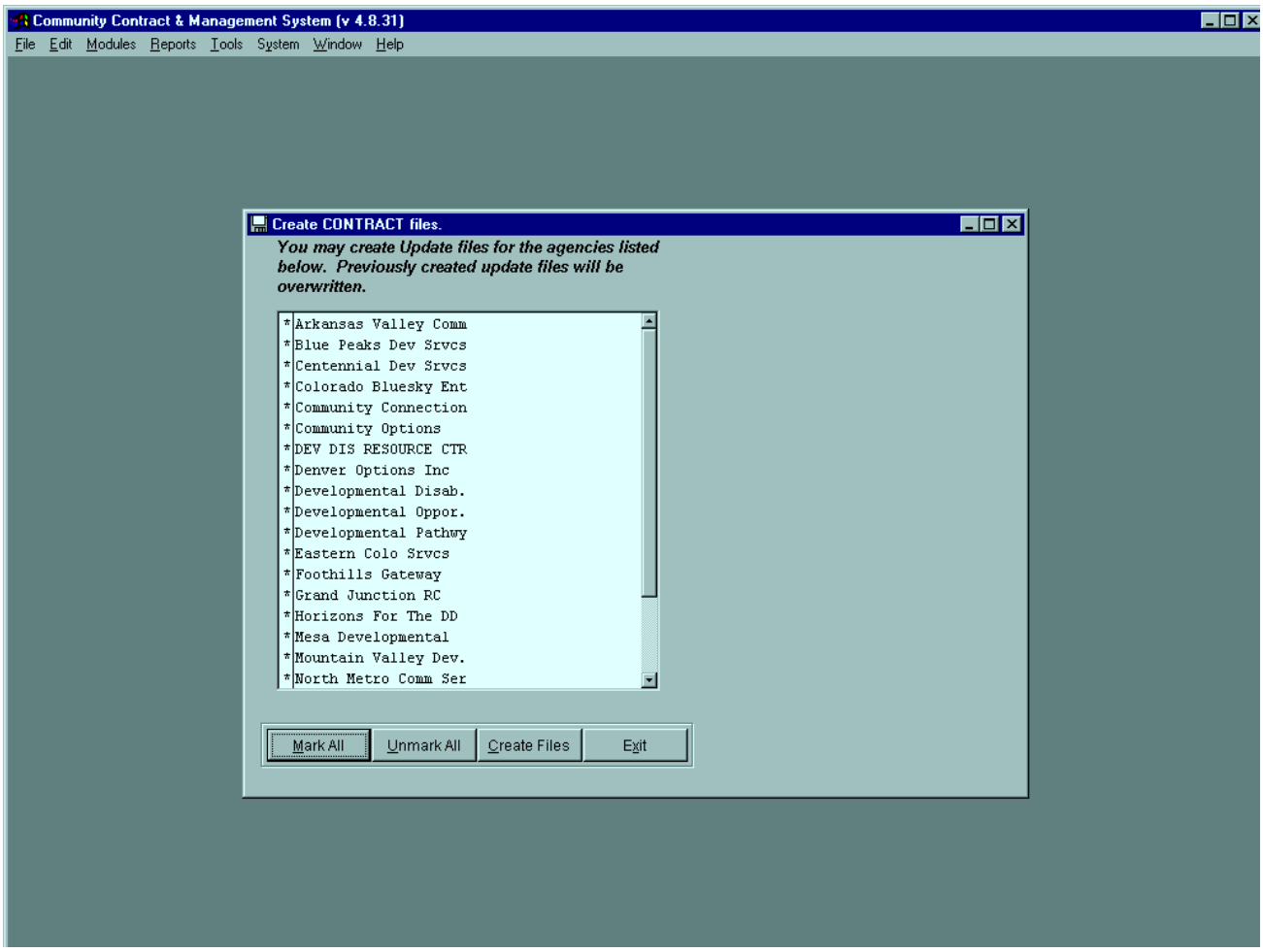
If the provider record is for a residential provider, the **Program and Location codes** must also be entered. If it is for a group home, the **License number** assigned by the Department of Health must also be entered. DDD defines and assigns the location codes. They must be entered in the CCMS Table file before they can be used on this screen.

**The DDD provider record is an Agency's authorization to bill for the Medicaid service or program reflected in the record. Agencies are not allowed to enter or update DDD provider records**. DDD provider records are entered at DDD and transmitted to the Agency at the beginning of the billing month along with other DDD updates.

Press the **Edit button** to open this provider record for editing. The Edit button is only available at DDD. The **Repeat button** is used to repeat the values on this screen to create a new provider record and is also only available at DDD.

The **Save, Revert and Delete buttons** are initially disabled or dimmed and will become enabled when you have made any changes to record. Any changes you have made will not actually be saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made. The **Revert button** will discard all changes made since the last time you saved changes.

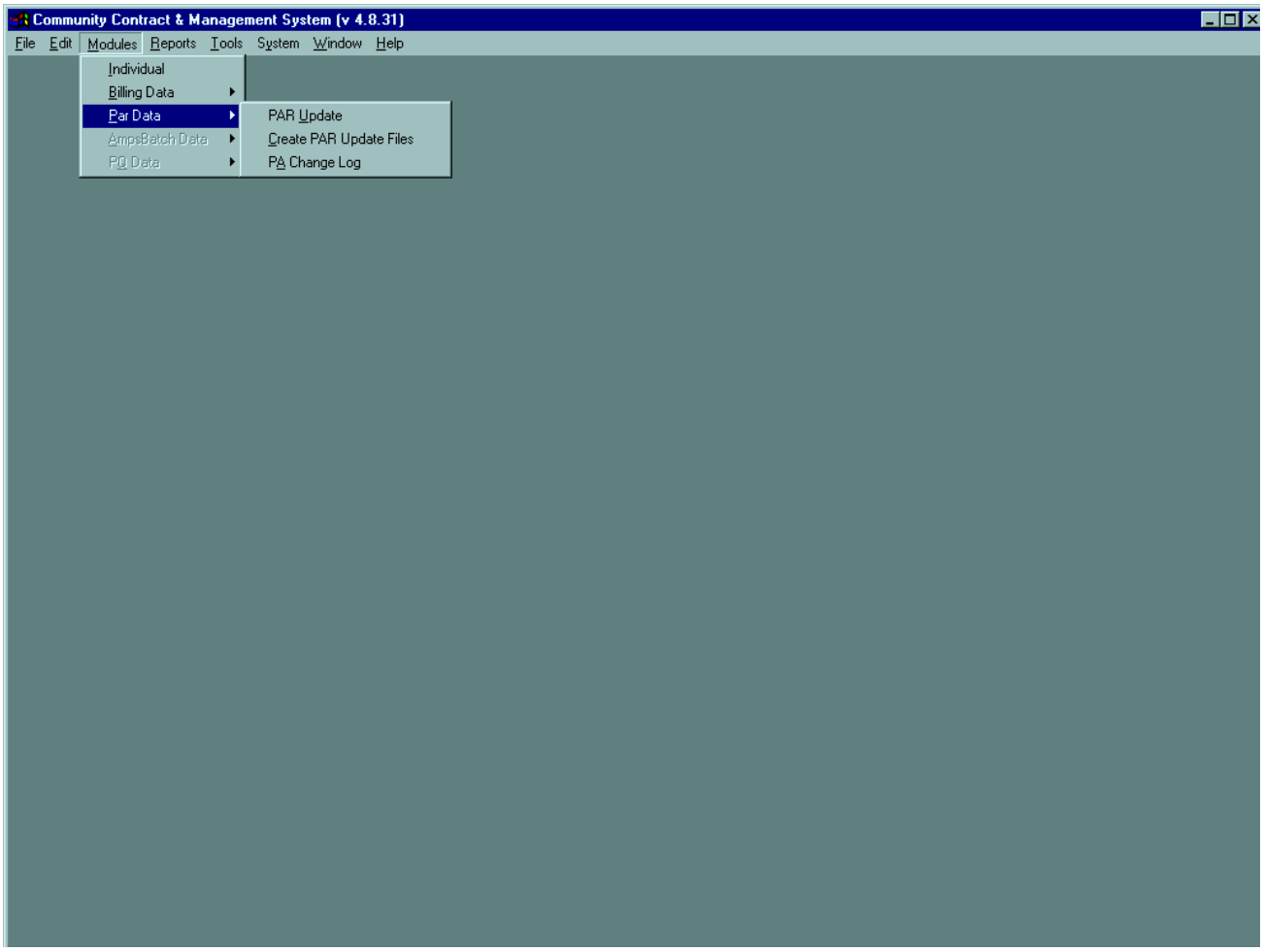
**Press the Delete button** to delete a provider record. Do not delete a provider record if an Agency is currently billing for the provider or it will not be able to submit billing in future billing months.




## This screen is only available at DDD

**The Create Contract Files and Create Provider Files screens** are used by DDD to write out contract updates, contract adjustment updates, rate updates and provider updates for Agencies. You reach the screen by **selecting Billing Data from the CCMS Modules drop down menu** and then either **Create Contract Update Files or Create Provider/Rate Update Files** from the Billing Data side menu.

All Agencies are automatically marked with an asterisk when you first enter this screen. Any Agency that is marked will have update files created when you select the **Create Files** button. Press the **Unmark All** button to unmark all Agencies. Then you may individually mark Agencies by **double clicking on the Agency name in the window**. Double click on marked Agency names to unmark them. Press the **Mark All** button to mark all of the Agencies. Press the **Create Files** button to create update files for all marked Agencies. These files are sent to Agencies at the beginning of the month with the DDD Update file.

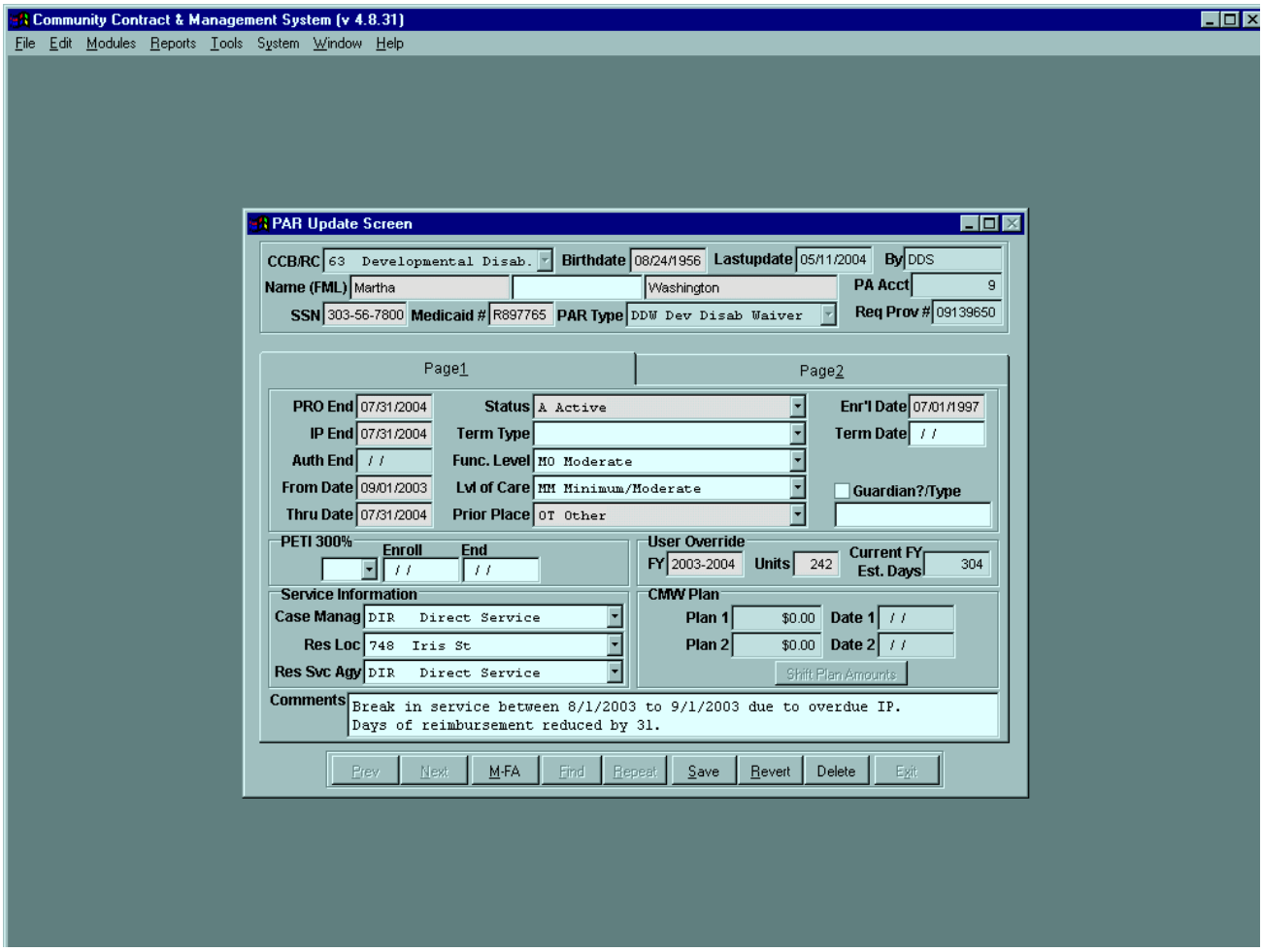



The **PAR Data menu** is used to select the functions that may be performed in the PAR module. You reach the PAR Data menu by **selecting PAR Data from the CCMS Modules drop down menu**. Click on the PAR Data menu item with the mouse pointer to get a drop down menu that displays selections for the PAR module. Your ability to select the items on the PAR Data menu is determined by the security level that has been assigned to you. If you do not have security rights to a PAR Data function, you will not be able to select that item from the menu.

The **PAR Update** menu choice allows you to view and update **Medicaid Prior Authorization Records (PAR).** PAR records provide authorization for an Agency to bill the Medicaid Fiscal Agent for authorized Medicaid services.

The **Create PAR Update Files** menu choice is only available to DDD and is used to write out copies of updated PAR records. These updates are sent to each Agency monthly to provide updated billing prior authorization information.

The **PA Change Log** menu choice is only available to DDD and is used to determine which updates should be sent to the Fiscal Agent for the current billing month.




The **PAR Update screen** is used to view or enter or update Prior Authorization (PAR) records for persons funded under Medicaid. You reach the PAR Update screen by **selecting PAR Data from the CCMS Modules drop down menu** and then **selecting PAR Update** from the PAR Data side menu

The PAR screen contains two **Pages**. The first page presents the main data in the PAR record. The second page presents optional and historical data. You can only display and update one PAR record at a time.

PAR records can be entered and updated only at the DDD site. Staff at Agency sites may only view the records on the screen. For DDD staff, your **security level** will determine whether you have the ability to **enter data** on this screen or may only **view the data** on the screen. If you have been given rights for viewing data only, the fields will appear dimmed and you will not be able to move the cursor to them to enter data. **The Repeat, Add, Edit, Revert and Save buttons** will also be disabled if you do not have rights to enter data.

Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

**Press the Add button** to add a new record. You must enter the **CCB/RC (Community Centered Board/Regional Center), Social Security Number, Medicaid Number, Birthdate, Name, PAR Type, Date of Enrollment, From Date, Through Date and PAR Status** at a minimum on this screen in order to enter a new record. Prior Placement, IP (Individualized Plan) End Date and PRO (Peer Review Organization) End Date are required as well depending upon the type of PAR record being entered.

**The information entered into the PAR record is sent monthly to the Medicaid Fiscal Agent** in a batch file in order to update the Prior Authorization files used in the Medicaid Management Information System (MMIS) to authorize payment for Medicaid Waiver and some State Medicaid Plan services. Prior Authorization is the responsibility of the Division for Developmental Disabilities central office. It is provided after review and approval of required enrollment documents submitted by the case management agency. Generally authorization is given for one year at a time and yearly updates of Individualized Plans Coversheets, Electronic ULTC-100.2 reviews and other documentation must be submitted, as required, to continue authorization on a yearly basis.

The CCB/RC field is used to record the Agency through which the person is currently authorized to receive services. **A copy of the updated PAR file is sent to each Agency at the beginning of every month with the DDD updates**. Only the records for which the Agency is identified as the authorized Agency (in the CCB/RC field) are included in that Agency's copy of the PAR file. The latest copy of the PAR file is accessed by the CCMS Billing module to determine if the person is authorized for the services being billed. Billing transactions will be rejected at posting if the PAR file does not contain a PAR record for an individual or if the billing service dates do not fall within the PAR authorization dates. The CCMS Billing module will check for the existence of a PAR record based on social security number match, **so if the social security number in the PAR record is not the same as the social security number being used in the billing transaction, the system will not find a PAR match.** Discrepancies in social security numbers must be resolved prior to the next time DDD updates are sent to an Agency in order to affect the next month's billing.

The **PAR Type field** identifies the type of PAR record displayed. This field cannot be changed on existing PAR records. If a person is no longer authorized for services for the PAR Type shown in this field, the record must be terminated and a new PAR record may be entered with a different PAR Type. A person may have more than one PAR record with different PAR Types, but only one PAR Type may be active at a given time, with the exception of Medicaid State Plan Targeted Case Management (TCM), which is authorized in conjunction with DD, SLS and CES Waivers and for children enrolled in Early Intervention Services.

**You may not change the CCB/RC field or PAR Type field on this screen for existing records.** If a person moves to another service area that is handled by a different Agency, the existing PAR record must be terminated and a new PAR record must be entered for the new Agency. Also, if a person receives short term comprehensive services for a limited time from a Regional Center, the existing DD Waiver PAR record for the CCB must be terminated and another DD Waiver PAR record must be entered under the Regional Center, to authorize comprehensive services for the short term placement span. When the short term placement ends, the Regional Center record must be terminated and a new record must be entered under the CCB showing the date that the person returned to the CCB placement.

The **From Date and Thru Date fields** show the latest period of eligibility for this PAR record. These dates provide the time spans used by the CCMS Billing module and MMIS to determine if a person was authorized for services during the time period billed. When the PRO End or IP End fields are updated, the system will automatically change the Thru Date to the earliest of these two fields, since authorization for services may not extend past the date when updated PRO or IP documentation is required. You may override the automatic update to manually enter a different date into the Thru Date field. **The Thru Date field may be left blank for TCM PAR records until the record is terminated.** TCM does not require annual submission of an Individualized Plan or Electronic ULTC-100.2, and remains authorized until a termination occurs. Termination paperwork must be submitted from the case management agency to DDD for a TCM PAR to be terminated**.**

A **Termination Type and the Termination Date** must be entered if the status is terminated. **Functioning Level and Level of Care fields** are informational only and do not have to be entered.

The **PETI 300% fields** show the latest period of Medicaid eligibility based on the Medicaid 300% rule. This eligibility determination will identify those persons who must contribute a portion of their income towards the cost of services provided. **DDD requires that 300% eligibility be marked "yes" or "no" on the printed IP Coversheet. Otherwise, Medicaid staff will not update the IP End Date on the CCMS PAR screen.**

The **Service Information section** is used to record the current service agency for Case Management services and Residential Services. If the service is being provided by the Agency shown in the CCB/RC field, enter DIR - Direct Service into the service agency field. This will always be true for the case management (CM) service agency field. The **Residential Location field** is used to record the location code assigned to the residential group home or individual setting where the person is residing. **In order for DDD to update the CCMS PAR screen with residential location changes, the case management agency must submit an IP Coversheet reflecting, the change with the correct location code.**

The **User Override section** is used to display and change the number of authorized days of Comprehensive services for DD Waiver PAR records. **The Current Fiscal Year Estimated Days is displayed** and is a calculation for the current fiscal year based on the span of days contained in the From and Thru dates of service. Comprehensive services are authorized for a maximum number of days in the fiscal year. If the maximum number of days is equaled or exceeded in the span of the From and Thru dates which falls within the current fiscal year, the estimated days will be equal to the

allowed maximum. If the span of days has not yet reached the maximum, the estimated days will be equal to the span of days.

The Estimated Days can be overridden by an entry into the **User Override FY and Units fields.** If a person has been transferred from another Agency during the course of the fiscal year, the number of authorized days must be based on an evaluation of the days available in the span of service for the current Agency PAR record and the number of days already billed by the previous Agency. DDD will make this determination and enter a different number of authorized days (Units) and the fiscal year (FY) to which it applies. DDD may also enter a different number of authorized days if a break in service eligibility has occurred. For example, in the PAR Update screen above, the estimated days is 242 days because this is the number of days allowable after a break in service penalty was assessed.

The **Comments** field at the bottom of the screen can be used for reminders or information about this PAR record. Information about how the number of days was determined for User Override of Estimated Days should be entered into this field.

The **CMW Plan section** is obsolete and displays only historical information about the Children's Medical Waiver program for records belonging to that Waiver type. This Waiver is no longer administered by DDD.

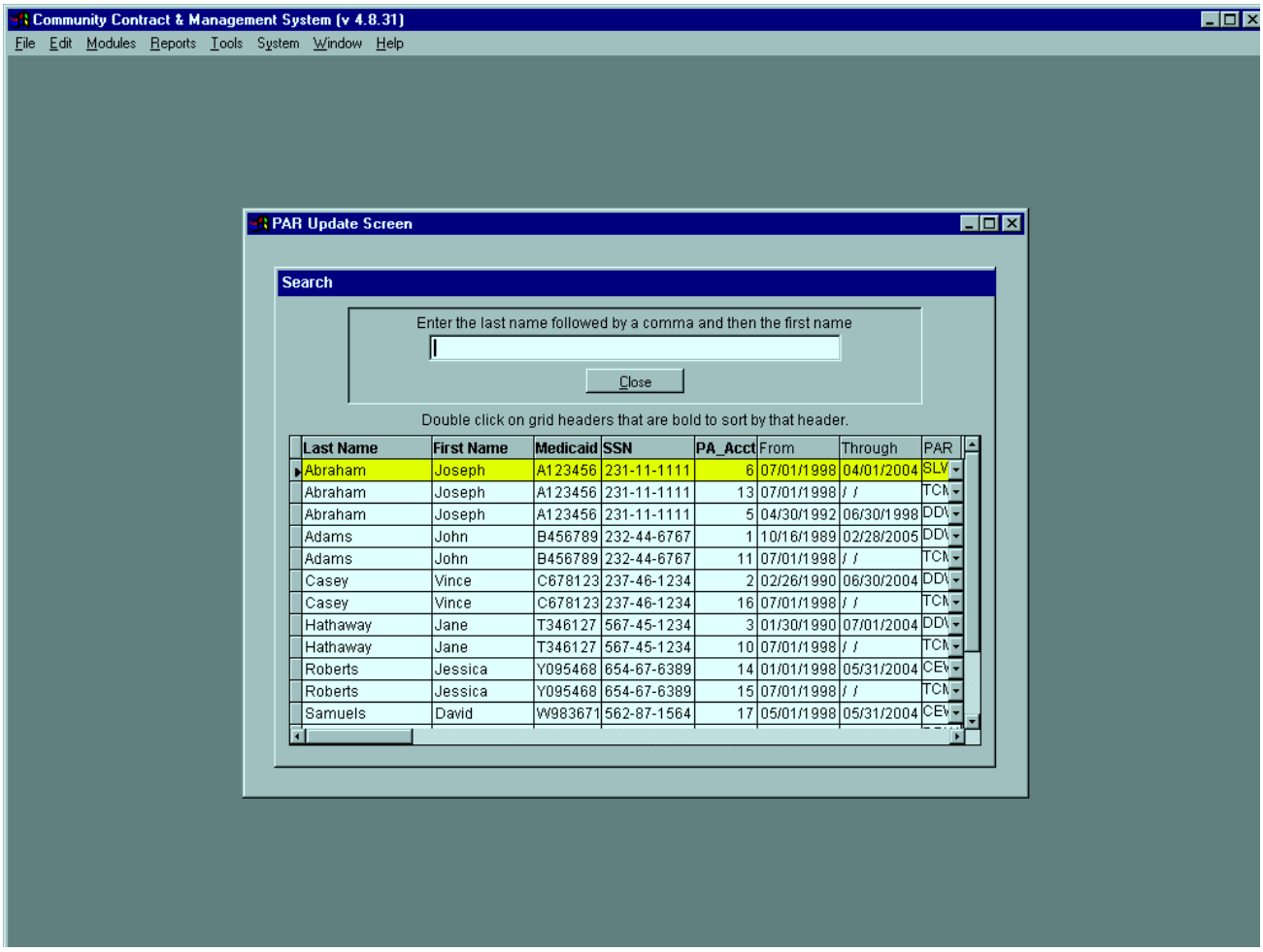
The **M-FA button** will take you to a Browse window in which the MMIS PAR lines are displayed. The M-FA button is only available to DDD.

Press the **Find button** to find another individual's record(s). Use the **Prev and Next buttons or Top and Bottom buttons** at the bottom of the screen to move backward and forward through the records in the file.

Press the **Edit button** to open the selected PAR record for editing. The **Save, Revert** and **Delete buttons** are initially disabled or dimmed and will become enabled when you have made any changes to the PAR record. Any changes you have made will not actually be saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made. The **Revert button** will discard all changes made since the last time you saved changes.

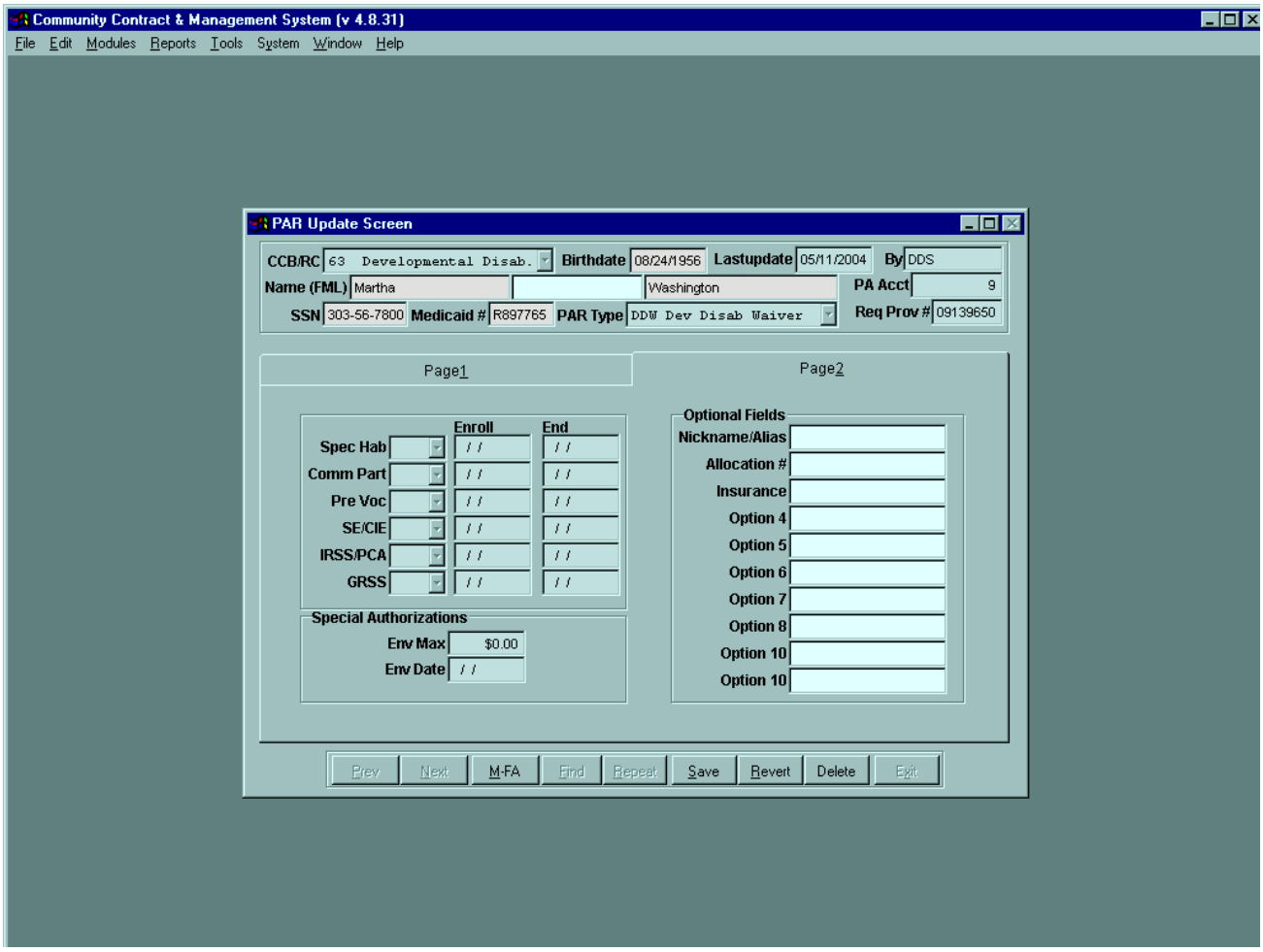
When you **press the Save button for a new record**, the system will automatically create a matching TCM (Targeted Case Management) PAR record when the PAR type is one of the other Waiver types. The From Date and Enrollment Dates in the TCM PAR record are automatically filled in to match the dates in the original record.

Press the **Delete button** to delete a PAR record. The corresponding deletion or inactivation must also take place in the MMIS. These deletions must be done on-line using the current fiscal agent's MMIS software.




The **Search screen** is displayed when the **Find button** is pressed on the PAR Update screen.

The **Search screen** allows you to identify a PAR record to view or update. Refer to Section II for further information about the **Search screen**. You can scroll through a list of records or type a search value on the screen and then **press the Close button** to bring up the selected record on the screen. You should search for an individual by name, social security number and Medicaid number to ensure you identify an existing record before adding a new record.



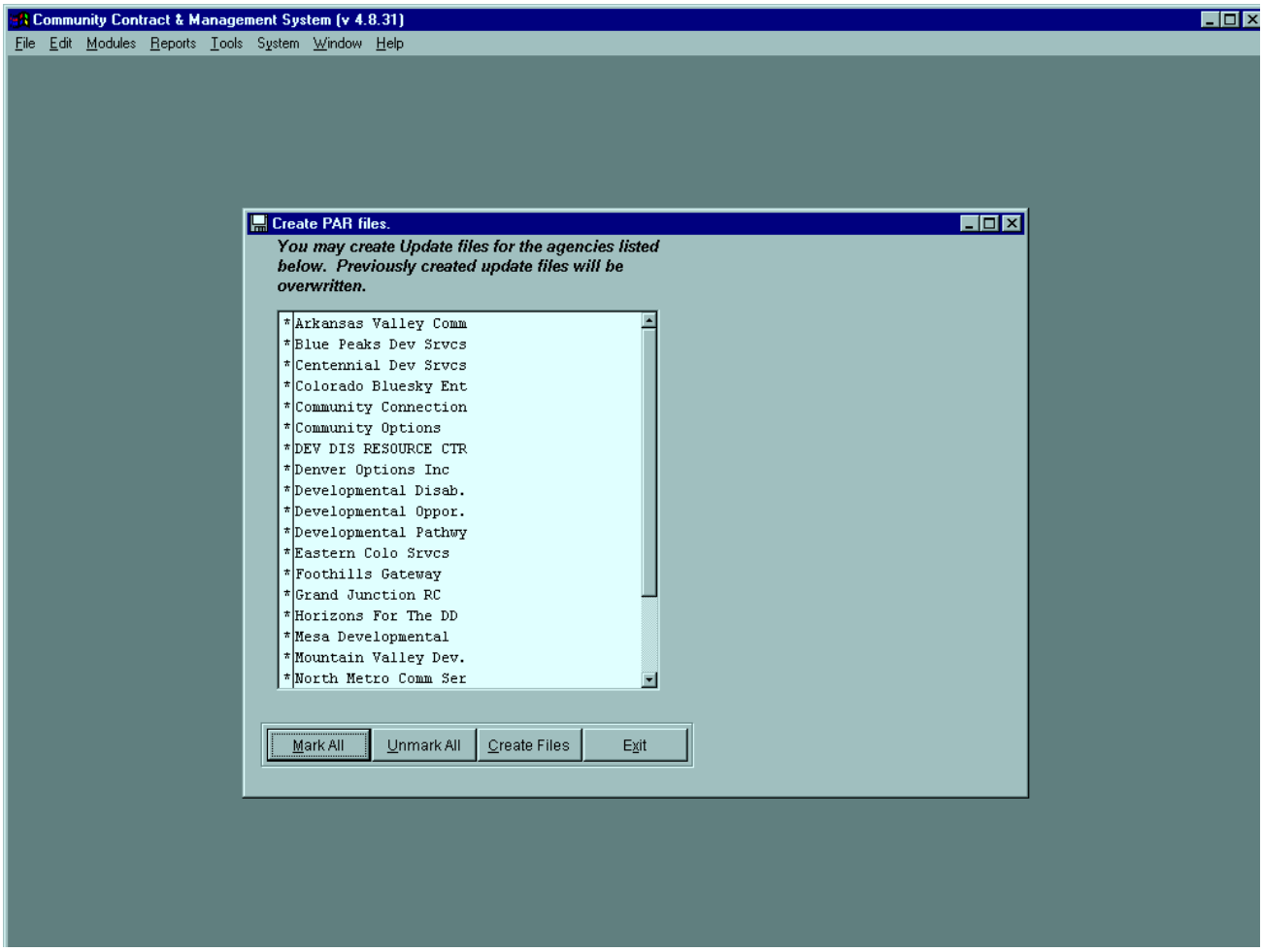

The **Page 2 screen** is displayed when you **press the Page 2 tab** from the PAR Update screen. It is used to enter additional information for a PAR record.

**The section, which was used to enter Enroll and End** dates for several different programs (i.e. Pre Voc, SE/CIE, etc.), is obsolete and was used to authorize specific services for the DD Waiver prior to 7/1/1999 dates of service.

The **Optional Fields section** is used to record additional data. The use of the PAR optional fields is defined by DDD staff based on specific needs identified for collection of additional information not displayed on the main PAR screen. Each optional field is 20 characters in length and any kind of data (characters, numbers, special characters) can be entered into each field. Once it is decided to use an optional field to record a certain type of information, **that field must be used ONLY to record that type of information**. This ensures consistent reporting and record selection based on data contained in the field.

The **Special Authorizations section** is used to enter approvals for billing in excess of pre-established maximums. If an amount above the standard Environmental Engineering maximum for CES Waiver

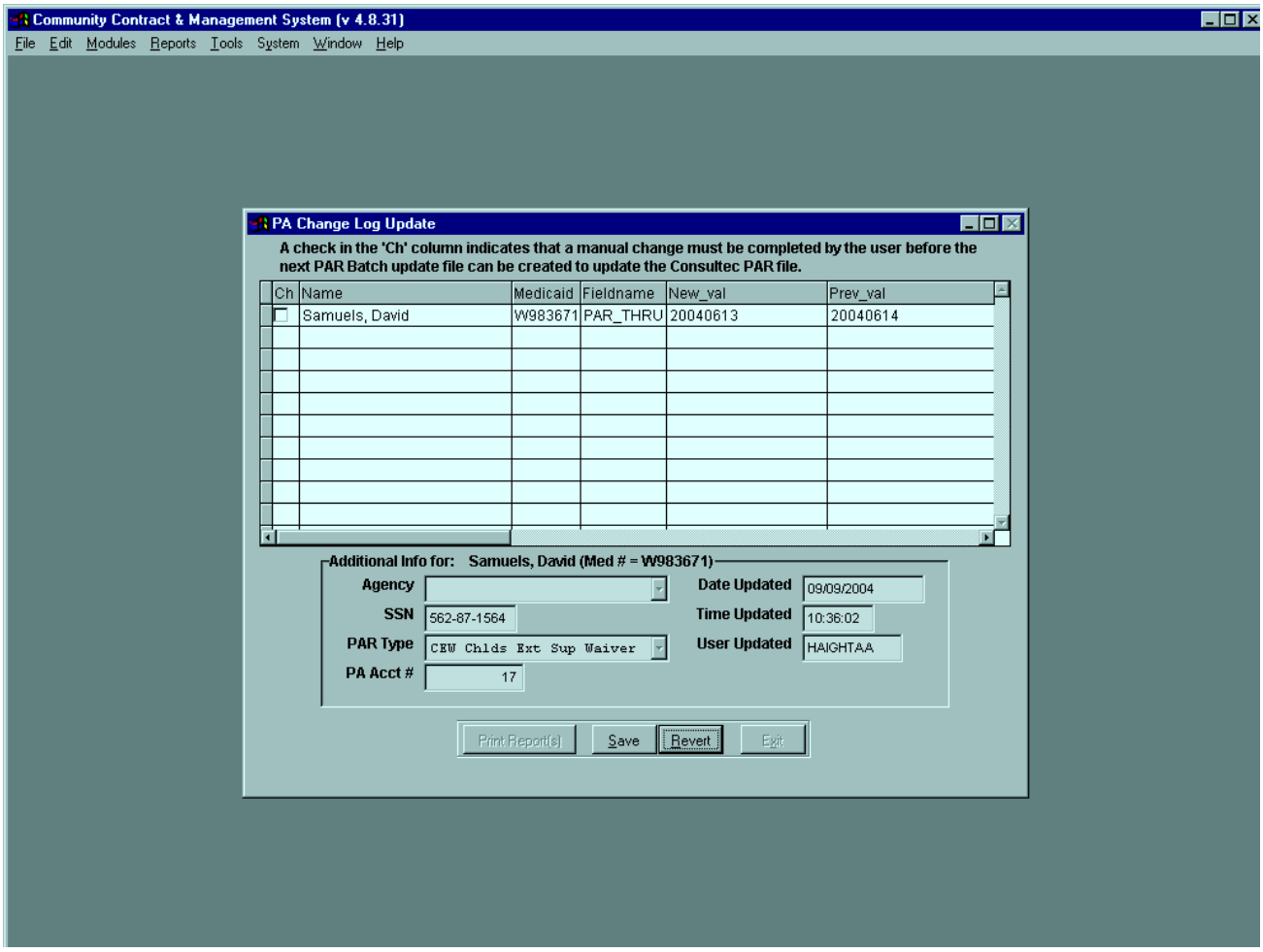
has been approved for billing, enter the total amount approved and ending date of the authorization for that amount into the Env Max/End Date fields. These fields are only available for the CES Waiver program. The Billing module will access these fields to allow billings above the maximums for CES Waiver.




## This screen is only available at DDD

**The Create PAR Update File screen** is used by DDD to write out PAR updates for Agencies. You reach the screen by **selecting PAR Data from the CCMS Modules drop down menu** and then **Create PAR Update Files** from the PAR Data side menu.

All Agencies are automatically marked with an asterisk when you first enter this screen. Any Agency that is marked will have update files created when you select the **Create Files** button. Press the **Unmark All** button to unmark all Agencies. Then you may individually mark Agencies by **double clicking on the Agency name in the window**. Double click on marked Agency names to unmark them. Press the **Mark All** button to mark all of the Agencies. Press the **Create Files** button to create update files for all marked Agencies. These files are sent to Agencies at the beginning of the month with the DDD Update file.




## This screen is only available at DDD

The **PA Change Log Update screen** is used to identify user required changes to the Medicaid Fiscal Agent PAR file that haven't been transmitted to the MMIS as yet. You reach the PA Change Log Update screen by **selecting PAR Data from the CCMS Modules drop down menu** and then **selecting PA Change Log** from the PAR Data side menu.

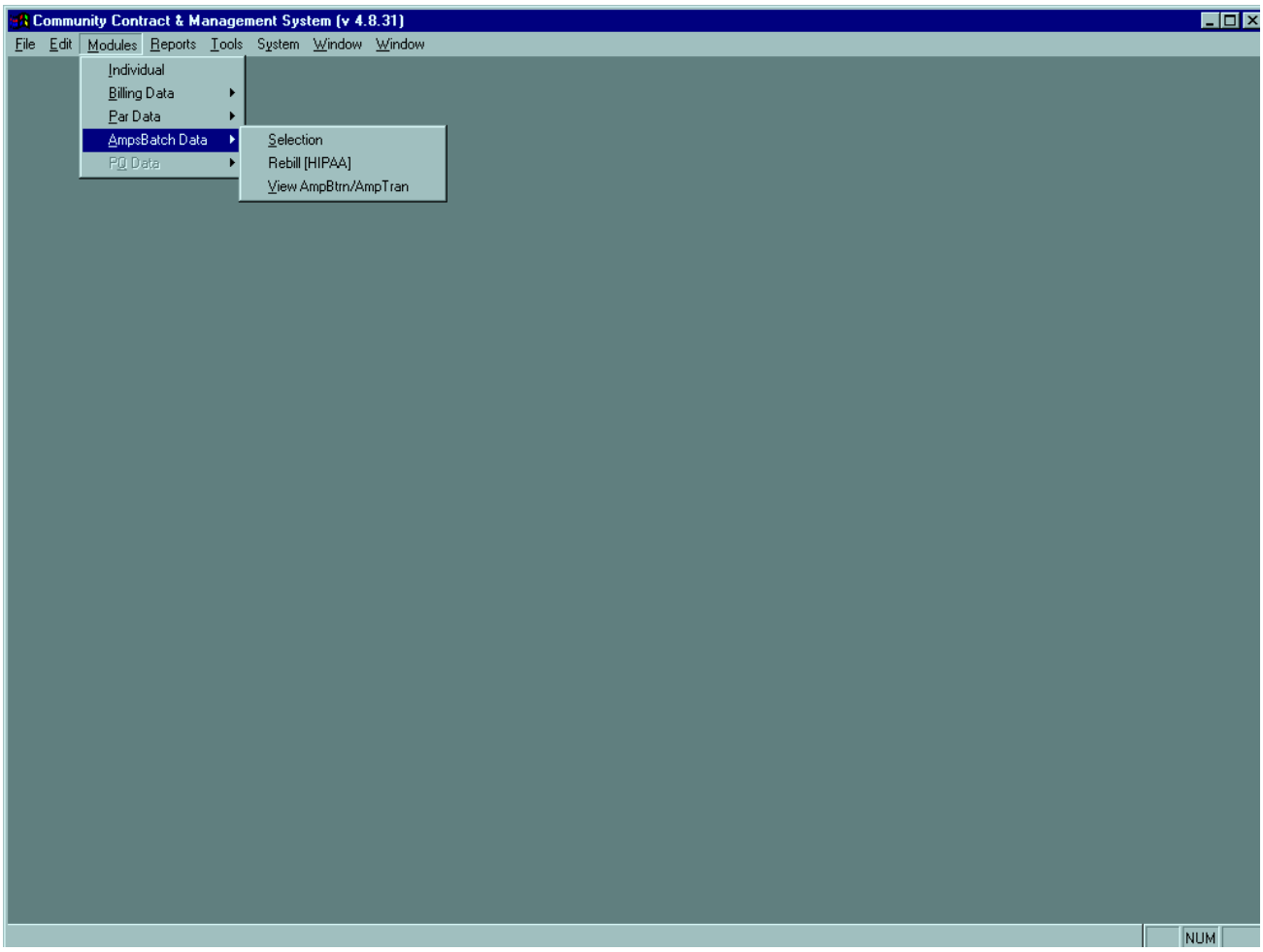
**Certain changes to CCMS PAR records cannot be transmitted via the batch update and require on-line update in the Medicaid Management Information System (MMIS)**. For example, in the screen displayed above, the From date of authorization was changed on a Children's Extensive Support Medicaid Waiver PAR record. Because the From date is part of the key for the PAR batch update program to find a matching record in the MMIS, the date must be changed on-line in the MMIS before the CCMS PAR batch process will be able to match to the record for future updates.

All changes that require manual intervention before transmission to the fiscal agent will NOT have a check mark in the beginning of the line. You must manually perform the update in the MMIS and then return to this screen and **check the box** prior to the next PAR batch update creation.

Press the **Edit button** to open the list of PAR updates for editing. The **Save, Revert and Delete buttons** are initially disabled or dimmed and will become enabled when you have made any changes to the list of PAR updates. Any changes you have made will not actually be saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made. The **Revert button** will discard all changes made since the last time you saved changes.

Press the **Delete button** to delete a PAR update record. A record may need to be deleted because an incorrect Medicaid number was entered, for example. Deleting the record before it is sent in a PAR batch transmission will prevent a rejection from the MMIS.

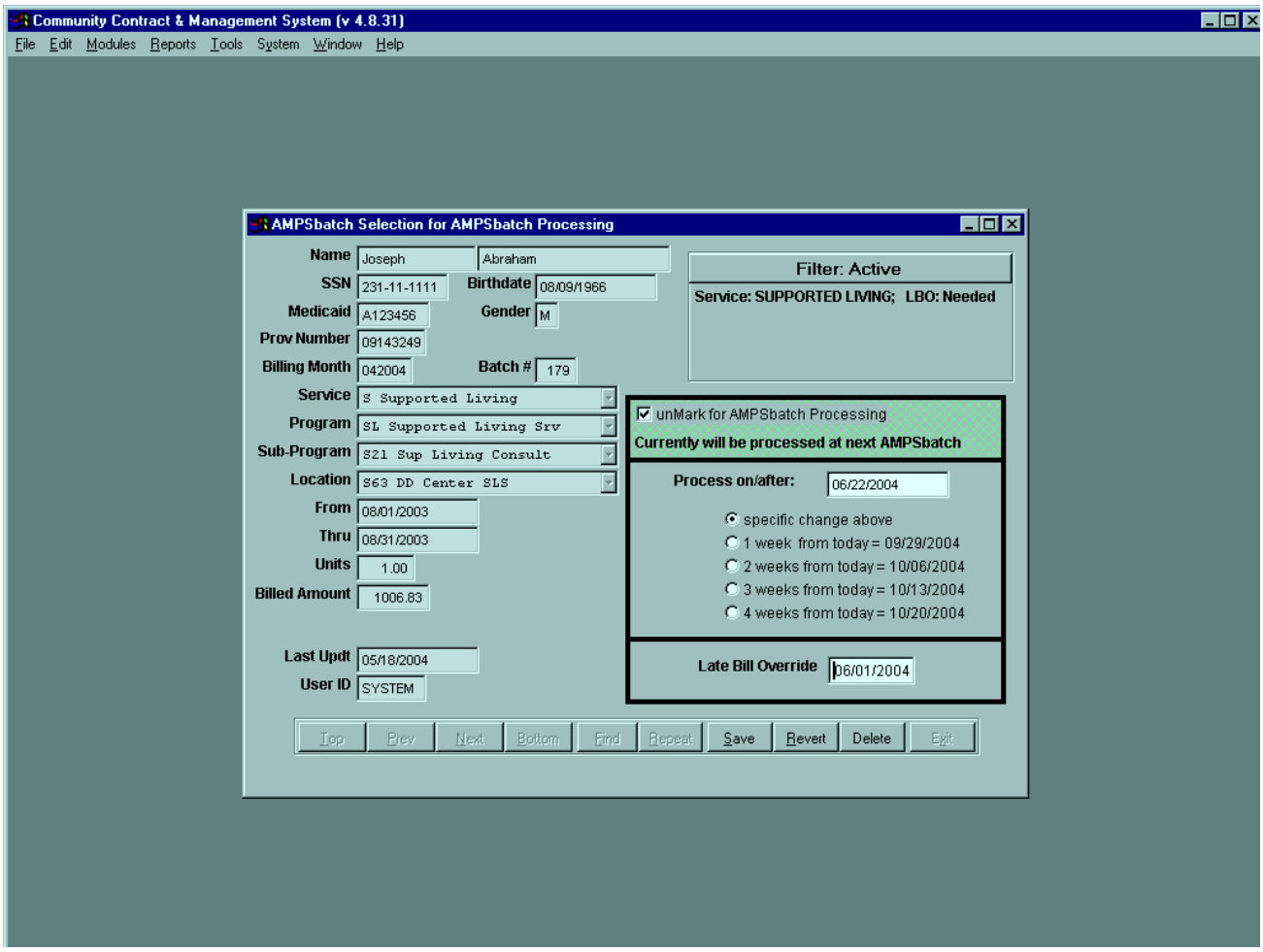
Press the **Print Report(s) button** to get a printed copy of the changes made in the PA Change log file.




The **AmpsBatch Data menu** is used to select the functions that may be performed in the AMPSbatch module. You reach the AmpsBatch Data menu by **selecting AmpsBatch Data from the CCMS Modules drop down menu**. Click on the AmpsBatch Data menu item with the mouse pointer to get a drop down menu that displays selections for the AMPSbatch module. Your ability to select the items on the AmpsBatch Data menu is determined by the security level that has been assigned to you. If you do not have security rights to an AMPSbatch function, you will not be able to select that item from the menu.

The **Selection** menu choice allows Agencies to mark or unmark transactions posted by the Billing module prior to claim creation. This menu choice is not available at the DDD site because claims are not billed by DDD.

The **Rebill (HIPAA)** menu choice allows Agencies to rebill claims that have been submitted to the Medicaid Fiscal agent, but have been rejected or denied. This menu choice is not available at the DDD site because claims are not billed by DDD.




The **AMPSbatch Selection for AMPSbatch Processing screen** is used to mark or unmark AMPSbatch Billing Transaction records for claim generation. You reach the AMPSbatch Selection screen by **selecting AmpsBatch Data from the CCMS Modules drop down menu** and then **Selection** from the AmpsBatch Data side menu.

Your **security level** will determine whether you have the ability to **enter data** on this screen or may only **view the data** on the screen. If you have been given rights for viewing data only, the fields will appear dimmed and you will not be able to move the cursor to them to enter data. **The Edit, Revert and Save buttons** will also be disabled if you do not have rights to enter data.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

All Medicaid funded billing transactions must be submitted as Medicaid claims through the Medicaid Fiscal Agent's Automated Medicaid Payment System (AMPS) in either a batch mode or in an interactive mode. **The AMPSbatch Selection screen is used to mark or unmark transactions from the AMPSbatch Billing transaction file that will be sent to the Medicaid Fiscal Agent in a**

**batch mode.** The records that are contained in the AMPSbatch Billing Transaction file are generated during posting of billing transactions. Only those transactions that were identified during the posting session as being appropriate for claim batch submission, and which have not yet had a claim generated for batch submission, will be available for selection in this file.

If a Medicaid Billing transaction was not written to the AMPSbatch Billing Transaction file during posting, no batch claim can be created for it. In that case you will need to determine whether it is appropriate to submit the claim using the Medicaid Fiscal Agent's interactive on-line claim entry software. Generally the reason that a transaction was not written to the AMPSbatch Billing Transaction file will be one of the two reasons below:

1. The transaction did not meet editing criteria and was rejected during posting. In this case, you need to correct the reason for the rejection and re-enter the transaction at next month's billing as an adjustment to the previous month. Once the transaction has been accepted, it should be automatically submitted to the Medicaid Fiscal Agent with the next AMPSbatch submission. **If the transaction was rejected at the end of the fiscal year, you will not be able to enter it as an adjustment transaction in the next billing month because the Billing module will not accept transactions for a previous fiscal year. In this case you will have to submit the claim through the Medicaid Fiscal Agent on-line claim entry software once the problem has been corrected.**

2. The transaction was an adjustment for a period of time for which a claim had previously been submitted. **In this case, you will have to submit an adjustment through the Medicaid Fiscal Agent on-line software to adjust the original claim.**

**When transactions are written to the AMPSbatch Billing Transaction file, they are automatically marked to send for AMPSbatch processing on or after the date of posting.** If you want to generate claims for all transactions, you do not have to make any changes on this screen. If you want to hold any transactions for claim generation or if you need to enter a late billing override date on any transactions, you will need to make those entries on this screen.

The fields displayed on the left side of the AMPSbatch Selection screen cannot be updated. The information in these fields was produced from the posted billing transactions and provides the detail billing information that will be used to generate the Medicaid claims.

The Filter information displayed under the **Filter button** at the top of the screen is based on the last filter set for the AMPSbatch Billing Transaction file.

**The Mark for AMPSbatch processing check box along with the Process on/after date field** is used to **mark or unmark a transaction** for AMPSbatch processing. All transactions are marked for processing initially and must be unmarked to hold them. To hold a transaction from processing, click on the checkbox. The message "Currently will NOT be processed at the next AMPSbatch" will appear below the box. To hold the transaction for a specified period of time, only **change the date in the Process on/after date field**. You may click on the buttons below the date field to have the

system automatically calculate a date for you which is one, two, three or four weeks from the current date. When you create an AMPSbatch transmission file **on or after the date you have marked in the Process on/after date field**, the transaction will automatically be included in the processing.

There will be very few times that you would want or need to hold any transactions from AMPSbatch processing. Some examples might be: a) holding a transaction until a Prior Authorization (PAR) record update/correction has been entered in the MMIS, or b) holding a group of transactions until a Rate update/correction has been entered in the MMIS or c) holding a transaction until an issue over Medicaid eligibility could be resolved (generally through the county social service department).

**The Late Bill Override field** must be completed for any transaction for which the last date of service is beyond the State of Colorado Medicaid timely filing deadline. You **MUST** enter a late bill override date in order for this transaction to be accepted for AMPSbatch processing. The late bill override date permits you to bill beyond the normal timely filing deadline without having to submit paper documentation to the Medicaid Fiscal Agent. Documentation for using the Late Bill Override Date can found on the Department of Health Care Policy & Financing website in the Medicaid provider billing manual. You **MUST** have the documentation on file that supports your entry of a late bill override date based on the information listed in the Medicaid provider billing manual. The following are examples for using a Late Bill Override Date listed in the Medicaid provider billing manual:

1. The claim was rejected or denied **within the past 60 days**. The date the claim was previously rejected during AMPSbatch submission or denied by MMIS is the date to be entered in the Late Bill Override field. (This is only applicable after a claim has been created and submitted to the Medicaid Fiscal Agent.)

2. You have been awaiting third party information. The date the claim was processed by other insurance or Medicare is the date to be entered in the Late Bill Override field. (This is currently not applicable to DDD claims.)

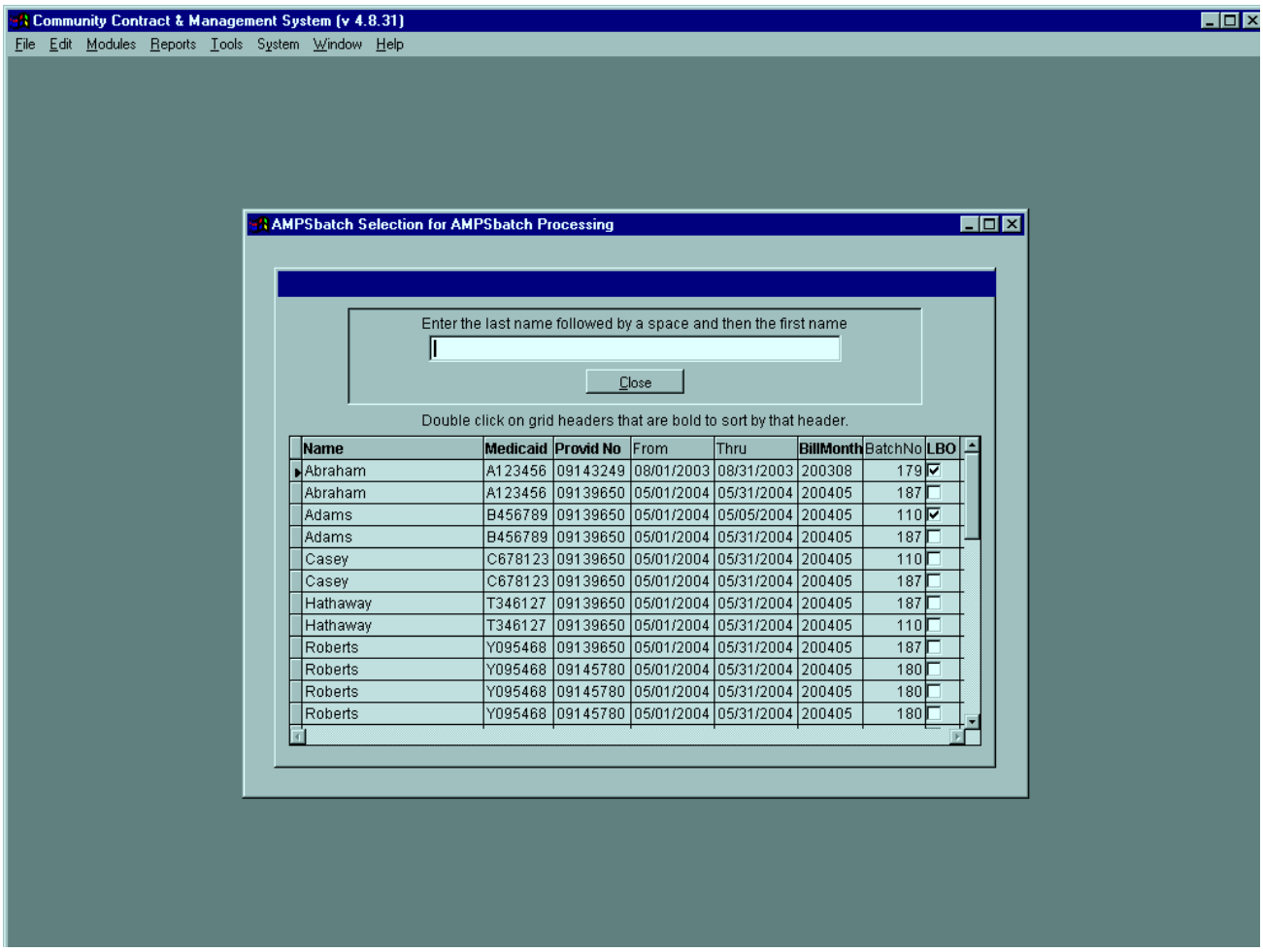
3. You are submitting the claim in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific client, claim, services, or circumstances (Correspondence authorization). You must keep the authorization from the Colorado Medical Assistance Program in your records.

**If you entered and posted a transaction that was beyond the timely filing period and you do not have a valid reason for entering a late billing override date, you will have to hold the transaction indefinitely from AMPSbatch processing or delete it.**

Press the **Edit button** to edit the transaction displayed on the screen in order to mark or unmark it for processing and enter a date of processing, if needed. Use the **Prev and Next buttons** at the bottom of the screen to move backward and forward through the records in the file. Use the **Filter button** to set a filter so only specified records are displayed (see the explanation on the Filter screen).

The **Save, Revert and Delete buttons** are initially disabled or dimmed and will become enabled when you have made any changes to the AMPSbatch processing section. Any changes you have made will not actually be saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made. The **Revert button** will discard all changes made since the last time you saved changes.

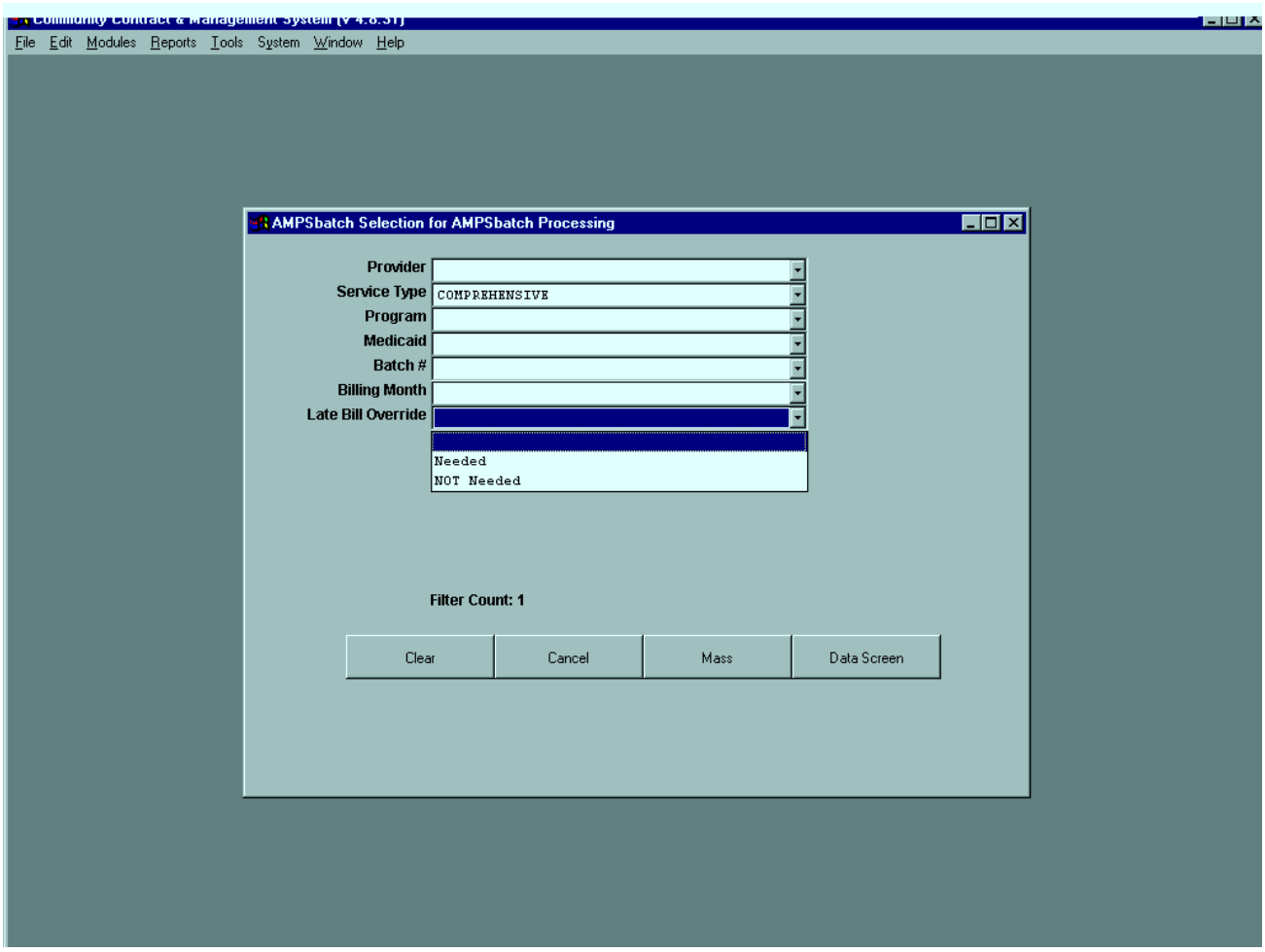
Press the **Delete button** to delete the transaction displayed on the screen. You will be asked to confirm the deletion and then the message "Make sure you enter a billing adjustment in CCMS if appropriate" is displayed and you will be able to print a copy of the transaction that was deleted. **Transactions that have posted to the Billing module must either be adjusted or deleted if they were entered incorrectly.**




The **Search screen** is displayed when the **Find button** is pressed on the AMPSbatch Selection for AMPSbatch Processing screen.

The **Search screen** allows you to identify a transaction to view or update. Refer to Section II for further information about the **Search screen**. You can scroll through a list of records or type a search value on the screen and then **press the Close button** to bring up the selected record on the screen.

Note the checkbox for **LBO** on the right side of the screen. When checked, it identifies transactions where a Late Bill Override (LBO) date must be entered. The evaluation of the need for a Late Bill Override date is based on the current rules for how many days are allowed to bill a Medicaid claim before it is past the timely filing deadline.

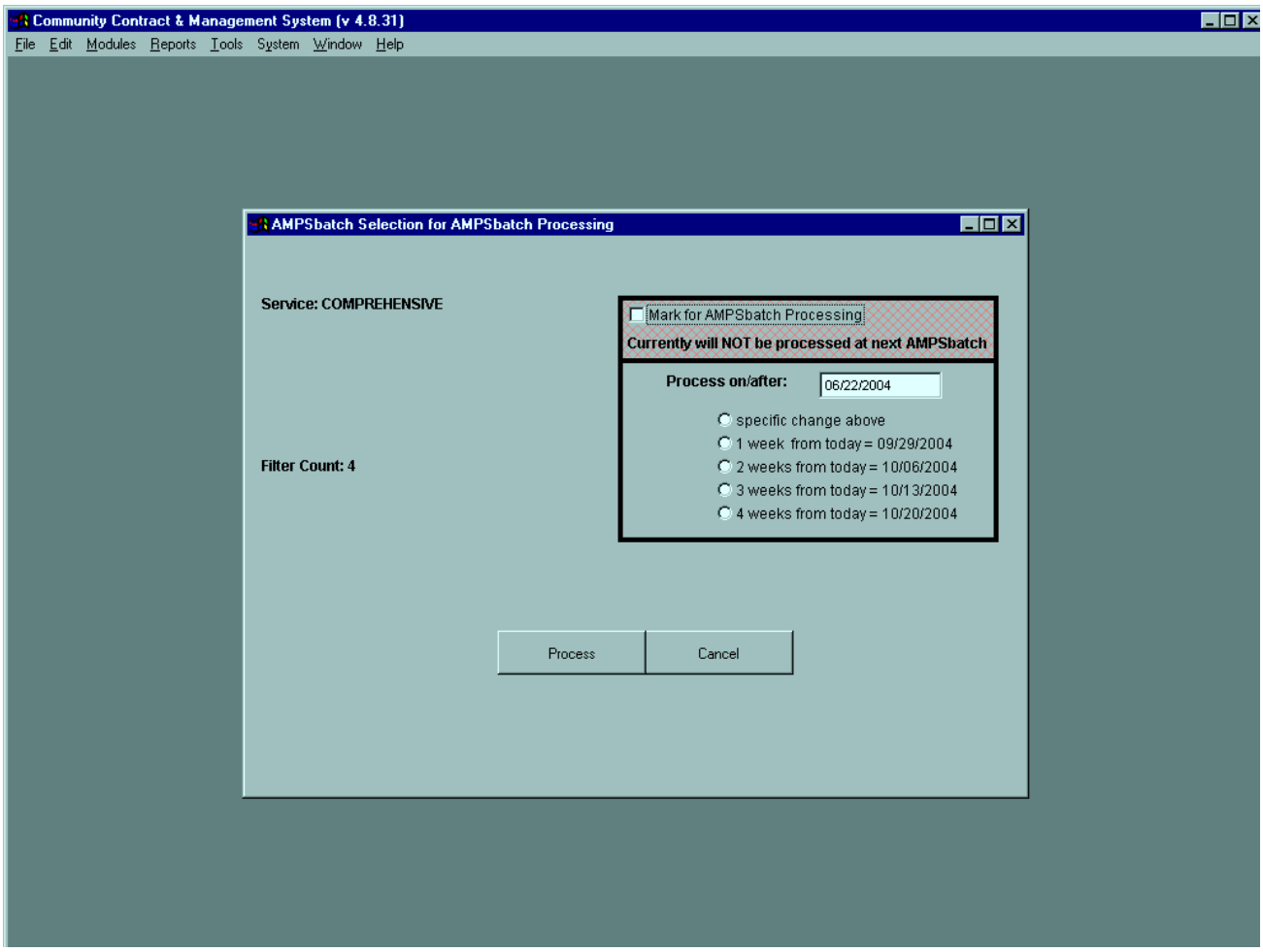



The **Filter screen** is displayed when you press the **Filter button** from the AMPSbatch Selection for AMPSbatch Processing screen. It provides you with several selection criteria from which you may choose in order to limit the records that will be displayed for viewing and updating. The last selected filter criteria will be displayed on the screen as well as the number of records that match the filter.

**Click on the down arrows to the right of the selection criteria fields to get a listing of the possible values by which you may limit the records**. Only those values that are contained in the current AMPSbatch Billing Transaction records will be available for selection. For example, if you just finished posting Comprehensive services for the billing month, but have not posted any other services, only Comprehensive service will be available on the Service Type list and only Comprehensive values will be available on the other lists. **The Late Bill Override filter is either Needed or NOT Needed. Set the filter to Needed to easily display all the records for which you must enter a late billing override date.**

Press the **Clear button** to clear an existing filter so that ALL records in the AMPSbatch Billing Transaction file will be available for display and update. Press the **Cancel button** to cancel any changes you have made and return to the previous filter, if any. Press the **Mass button** to perform a

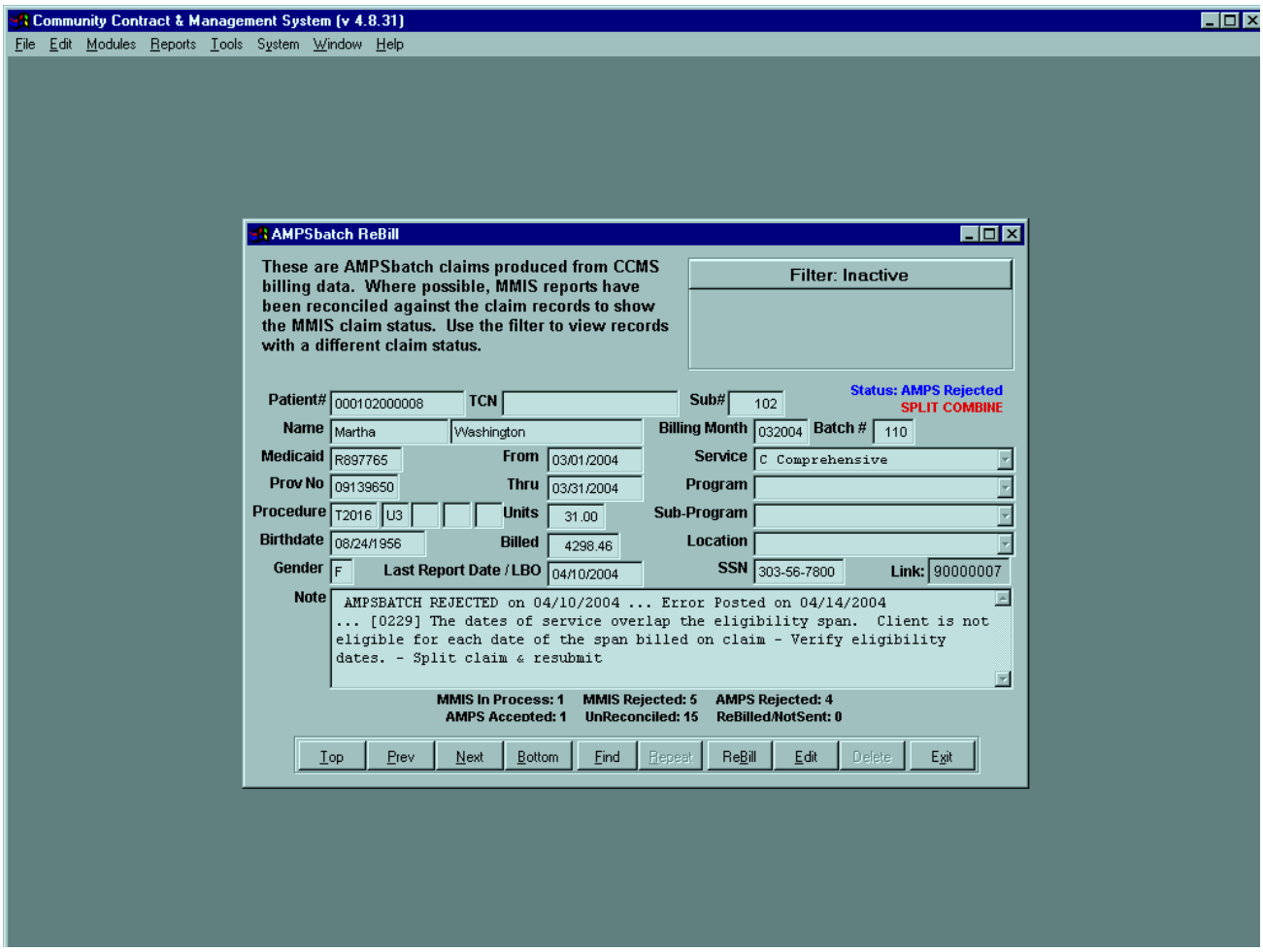
mass AMPSbatch marking or unmarking of records to process (see the explanation on the Mass Change screen). Press the **Data Screen button** to return to the AMPSbatch Selection screen. The records available for display and update will be based on the last filter set in the Filter screen.




The **Mass Change screen** is displayed when you press the **Mass button** from the Filter screen. It provides you with the ability to mark or unmark multiple records for AMPSbatch processing based on the filter criteria specified on the Filter screen.

The filter criteria is displayed again on the Mass Change screen for your information. The number of records that match the filter criteria and are currently marked for processing is also displayed for your information. Refer to the instructions on the AMPSbatch Selection screen for marking and unmarking records and entering the Process on/after date to understand how transactions are marked.

Press the **Process button** to process the selections against all records that meet the filter criteria. Press the **Cancel button** to return to the Filter screen without processing any changes.




The **AMPSbatch Rebill screen** is used to rebill rejected or denied claim lines. You reach the AMPSbatch Rebill screen by **selecting AMPSbatch Data from the CCMS Modules drop down menu** and then **Rebill** from the AmpsBatch Data side menu.

Your **security level** will determine whether you have the ability to **enter data** on this screen or may only **view the data** on the screen. If you have been given rights for viewing data only, the fields will appear dimmed and you will not be able to move the cursor to them to enter data. **The ReBill, Edit, Revert and Save buttons** will also be disabled if you do not have rights to enter data.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

When you retrieve Batch Submission Claim Acceptance/Rejection Reports or MMIS Provider Payment Reports from the Medicaid Fiscal Agent, the system will automatically perform a reconciliation of those reports against the claims that were submitted. The reconciliation process will compare the submitted claims against the report of whether the claims were accepted, rejected or paid and determine which detail line(s) are in error on rejected claims. Any claims which contained errors

will be marked as rejected with an explanation for the rejection so they may be easily viewed, corrected if necessary, and rebilled on this screen. **If you canceled the reconciliation process or it was aborted by the system when you retrieved your reports, you will need to manually start the reconciliation process for the affected reports in order to easily identify claims that need to be rebilled (refer to instructions on the AMPSbatch Report Retrieval screen in Section VIII).**

At the bottom of the screen is a display of the possible claim statuses and the number of claims that match each status. Following is an explanation of claim statuses:

1. MMIS in Process – claims for this status have been accepted for processing by the Medicaid Fiscal Agent, but the claim has not been paid or denied pending further action or research. A transaction control number is assigned in the MMIS to track the claim.

2. MMIS Rejected – claims for this status have been accepted for processing by the Medicaid Fiscal Agent, and the claim has been formally denied in the MMIS. A transaction control number is assigned in the MMIS to track the claim.

3. AMPS Rejected – claims for this status have been rejected for processing by the Medicaid Fiscal Agent. Generally these claims are rejected for processing because pre-processing edits for validity of the information or the existence of an approved provider or prior authorization record could not be substantiated.

4. AMPS Accepted – claims for this status have been accepted for processing by the Medicaid Fiscal Agent, but no report of action taken on the claims will be available until after a processing cycle has been completed. A transaction control number is assigned in the MMIS to track the claim.

5. Unreconciled – claims for this status have not yet been sent to the Medicaid Fiscal Agent, or no report has been retrieved from the fiscal agent to update the status of the claims. These claims were created from the transactions posted in the Billing module or rebilled claims from the AMPSbatch Rebill screen.

6. ReBilled/Not Sent-– claims for this status have not yet been sent to the Medicaid Fiscal Agent, or no report has been retrieved from the fiscal agent to update the status of the claims. These claims were created from rebilled claims from the AMPSbatch Rebill screen

Each claim line that has been MMIS Rejected or AMPS Rejected must be reviewed to determine whether it should be rebilled. Claims that were submitted with incorrect information should be corrected and rebilled. Claims that were submitted in error, should be deleted.

Claims that were denied during MMIS processing cannot always be reconciled by the system. You will have to identify those claims by filtering for Accepted claims that have not been marked as paid after retrieving reports from the Medicaid Fiscal Agent (refer to the Filter screen for instructions). Review your printed MMIS Provider Payment Reports to verify each of the denied claims that needs

to be rebilled. Claims in suspension (MMIS In Process) generally do not need to be rebilled and will be either paid or denied after further review by the Medicaid Fiscal Agent.

The AMPSbatch Rebill screen will display all of the pertinent information about one claim detail line at a time. **The status of a claim line will be displayed on the same line as the Patient# and TCN number. The Sub# field** identifies the batch submission number of the batch that was created to be sent to the Medicaid Fiscal Agent.

**Refer to the Patient # and TCN number to match each claim line to the printed line on the Medicaid Fiscal Agent reports**. The Patient Account Number is a unique number assigned by the system to each claim to identify it for AMPSbatch processing. It will be listed as the Patient Account Number on AMPS Accepted/Rejected reports and as the Invoice Number on MMIS Provider Payment reports. The Transaction Control Number (TCN) is assigned to AMPS accepted claims by the Medicaid Fiscal Agent and will only show up on AMPSbatch claim lines that had been reconciled against the AMPS report. **If you do not reconcile reports against submitted claims, the system will not be able to match the Transaction Control Number to the submitted claim and display it on the screen for your reference.**

The Filter information displayed under the **Filter button** at the top of the screen is based on the last filter set for the AMPSbatch Claim file.

**Press the ReBill button** to rebill a claim. Any of the fields that are enabled in the ReBill mode may be changed. **This allows you to correct data in error** before rebilling a claim. **The Note area** at the bottom of the screen will contain the error number(s) and error message(s) related to the rejection of the claim line (if the reconciliation process identified the claim as a rejected claim). You may also type additional notes into this field. When you select to rebill a claim line, the system will automatically enter a message into this Memo field to indicate that the line was rebilled, the date it was rebilled and the user ID of the person who rebilled the claim. All notes entered into this field will carry over to the new claim for historical reference. If a claim was not reconciled automatically by the system, you may want to type in the reason for rejection or denial in this area. You may also want to type in steps that were taken to ensure that the rebilled claim would not be rejected or denied again (e.g. sending in an overdue Individualized Plan to update the PAR record). **Even an unreconciled claim can be rebilled. This may be necessary if no report of status of the claim was received from the Medicaid Fiscal Agent.**

The process of rebilling a claim creates a new claim record. Once you have selected to rebill a claim line, it will no longer be available for display on this screen. **You must create another batch file before the rebilled claim lines can be sent to the Medicaid Fiscal Agent.**

**You must enter a date in the Last Report Date / LBO field before a claim can be rebilled if the dates of service are past the timely filing period allowed.** This date will have been automatically entered by the system from the AMPS Acceptance/Rejection report if the claim was reconciled automatically. Otherwise you must enter the date of the report that shows the **latest** rejection or denial of the claim. This date will be used as the Late Billing Override date for any claims that are

past the timely filing deadline for Medicaid claims. You may change the date, if necessary, to reflect a more appropriate Late Bill Override date based on other factors (e.g. correspondence received from county social service department).

The late bill override date permits you to bill beyond the normal timely filing deadline without having to submit paper documentation to the Medicaid Fiscal Agent. Documentation for using the Late Bill Override Date can found on the Department of Health Care Policy & Financing website in the Medicaid provider billing manual. You **MUST** have the documentation on file that supports your entry of a late bill override date based on the information listed in the Medicaid provider billing manual. The following are examples for using a Late Bill Override Date listed in the Medicaid provider billing manual:

1. The claim was rejected or denied **within the past 60 days**. The date the claim was previously rejected during AMPSbatch submission or denied by MMIS is the date to be entered in the Late Bill Override field. **You must ensure that rejected or denied AMPSbatch claims get rebilled at least every 60 days in order to protect timely filing.**

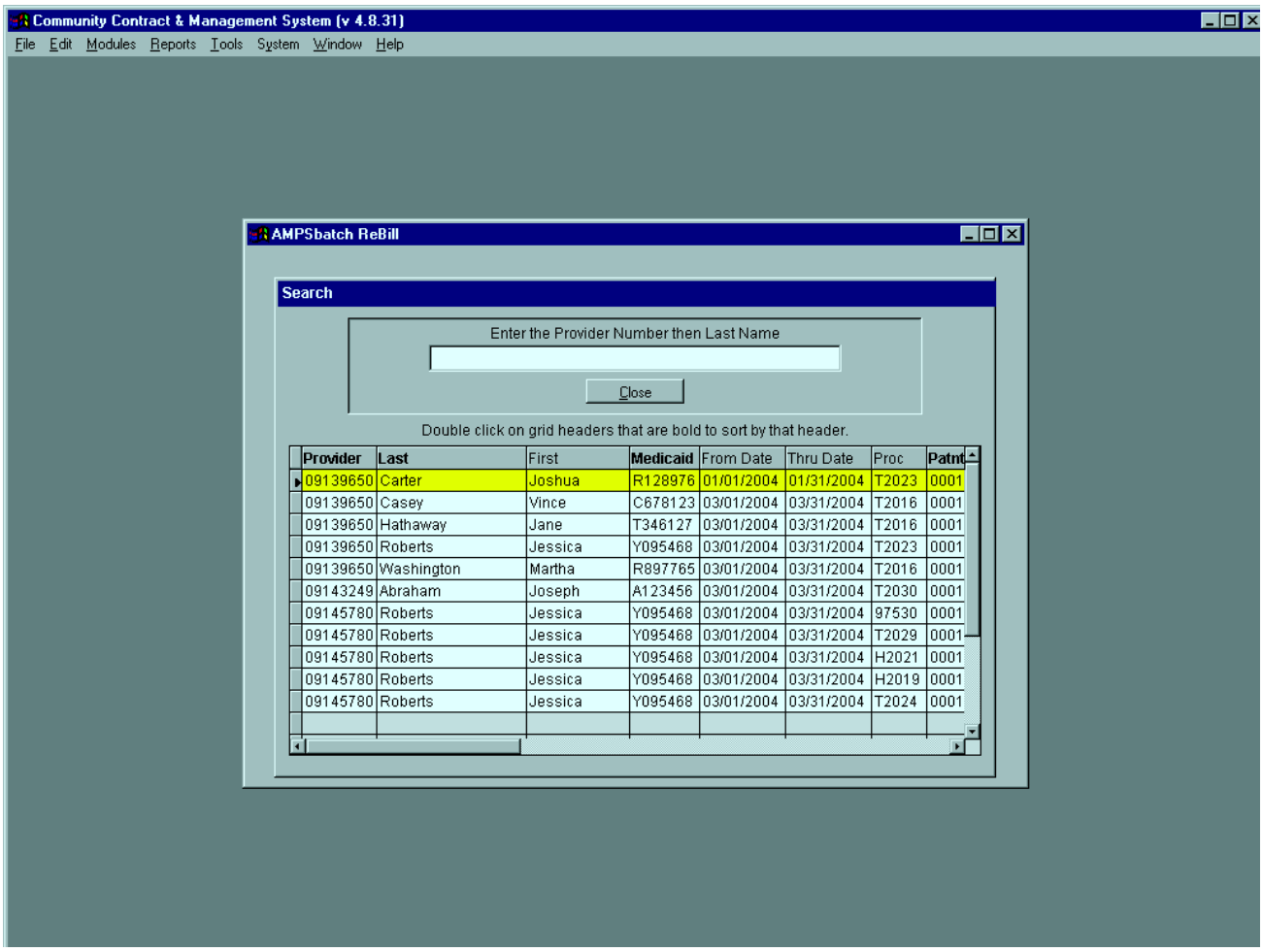
2. You have been awaiting third party information. The date the claim was processed by other insurance or Medicare is the date to be entered in the Late Bill Override field. (This is currently not applicable to DDD claims.)

3. You are submitting the claim in accordance with instructions (authorization) from the Colorado Medical Assistance Program for a 60 day filing extension for a specific client, claim, services, or circumstances (Correspondence authorization). You must keep the authorization from the Colorado Medical Assistance Program in your records.

Press the **Edit button** to enter a note in the Memo field without rebilling the claim. If further research on your part is required before rebilling the claim, that information can be entered for later follow-up. Use the **Prev and Next buttons** at the bottom of the screen to move backward and forward through the records in the file. Use the **Filter button** to set a filter so only specified records are displayed (see the explanation on the Filter screen.

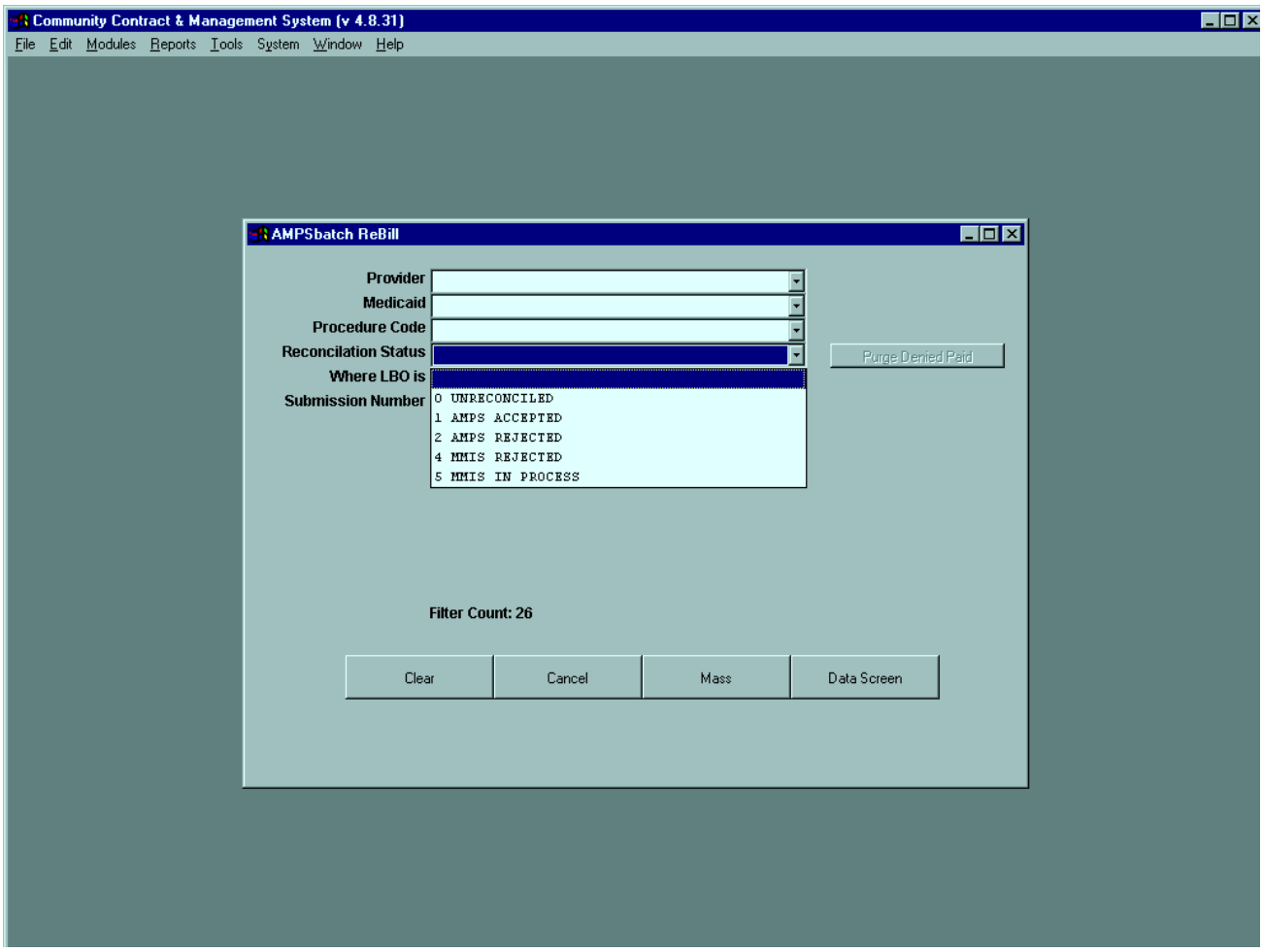
The **Done, Revert and Delete buttons** are initially disabled or dimmed and will become enabled when you have pressed the Rebill button. A claim will not be rebilled until you press the **Done button**. Use the **Revert button** to discard changes you have made. The **Revert button** will discard all changes made since the last time you saved changes.

Press the **Delete button** to delete the claim displayed on the screen. You will be asked to confirm the deletion and then the message “Make sure you enter a billing adjustment in CCMS if appropriate” is displayed and you will be able to print a copy of the transaction was deleted. **Transactions that have posted to the Billing module must either be adjusted or deleted if they were entered incorrectly.**




The **Search screen** is displayed when the **Find button** is pressed on the AMPSbatch ReBill screen.

The **Search screen** allows you to identify a claim to view or rebill. Refer to Section II for further information about the **Search screen**. You can scroll through a list of records or type a search value on the screen and then **press the Close button** to bring up the selected record on the screen.



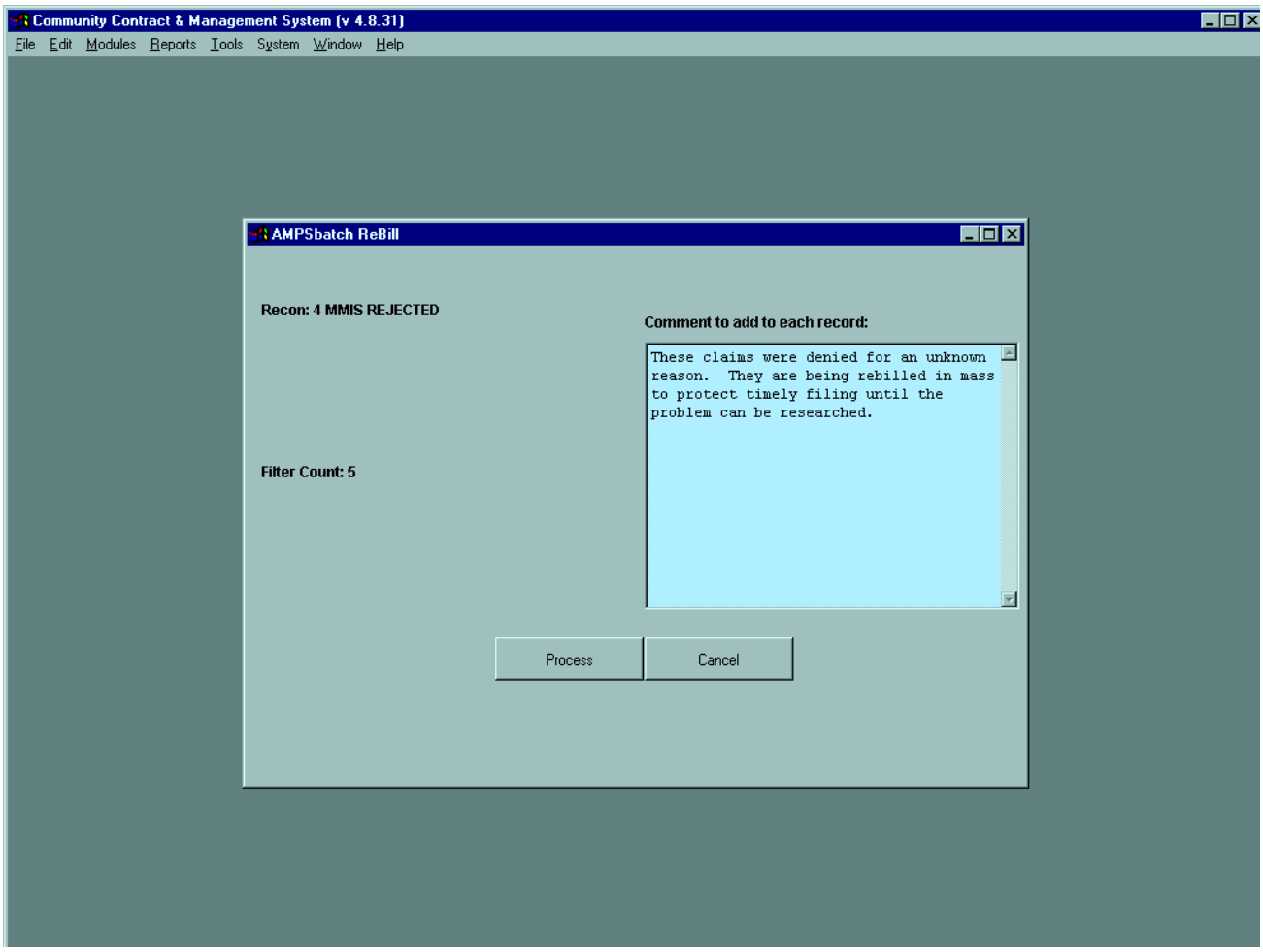

The **Filter screen** is displayed when you press the **Filter button** from the AMPSbatch ReBill screen. It provides you with several selection criteria from which you may choose in order to limit the records that will be displayed for viewing and updating. The last selected filter criteria will be displayed on the screen as well as the number of records that match the filter.

**Click on the down arrows to the right of the selection criteria fields to get a listing of the possible values by which you may limit the records**. Only those values that are contained in the current AMPSbatch Claim records will be available for selection. For example, only those claim statuses that were found in the reports from the Medicaid Fiscal Agent would be available for selection.

**Purge Denied Paid button** – this button will only become active when the filter for "Reconciliation Status" is set to "4 MMIS REJECTED" and the comment of a rebill transaction contains the specific information relating to a "already paid" item. If this button is accessible and you press it – **ALL "already paid"** items under the specific filter that is set will be purged and can no longer be rebilled through CCMS AMPSbatch (they could still be rebilled through the Medicaid Fiscal Agent's on-line claim software).

Press the **Clear button** to clear an existing filter so that ALL records in the AMPSbatch Claim file will be available for display and update. Press the **Cancel button** to cancel any changes you have made and return to the previous filter, if any. Press the **Mass button** to perform a mass AMPSbatch rebill (see the explanation on the Mass Change screen). Press the **Data Screen button** to return to the AMPSbatch ReBill screen. The records available for display and update will be based on the last filter set in the Filter screen.

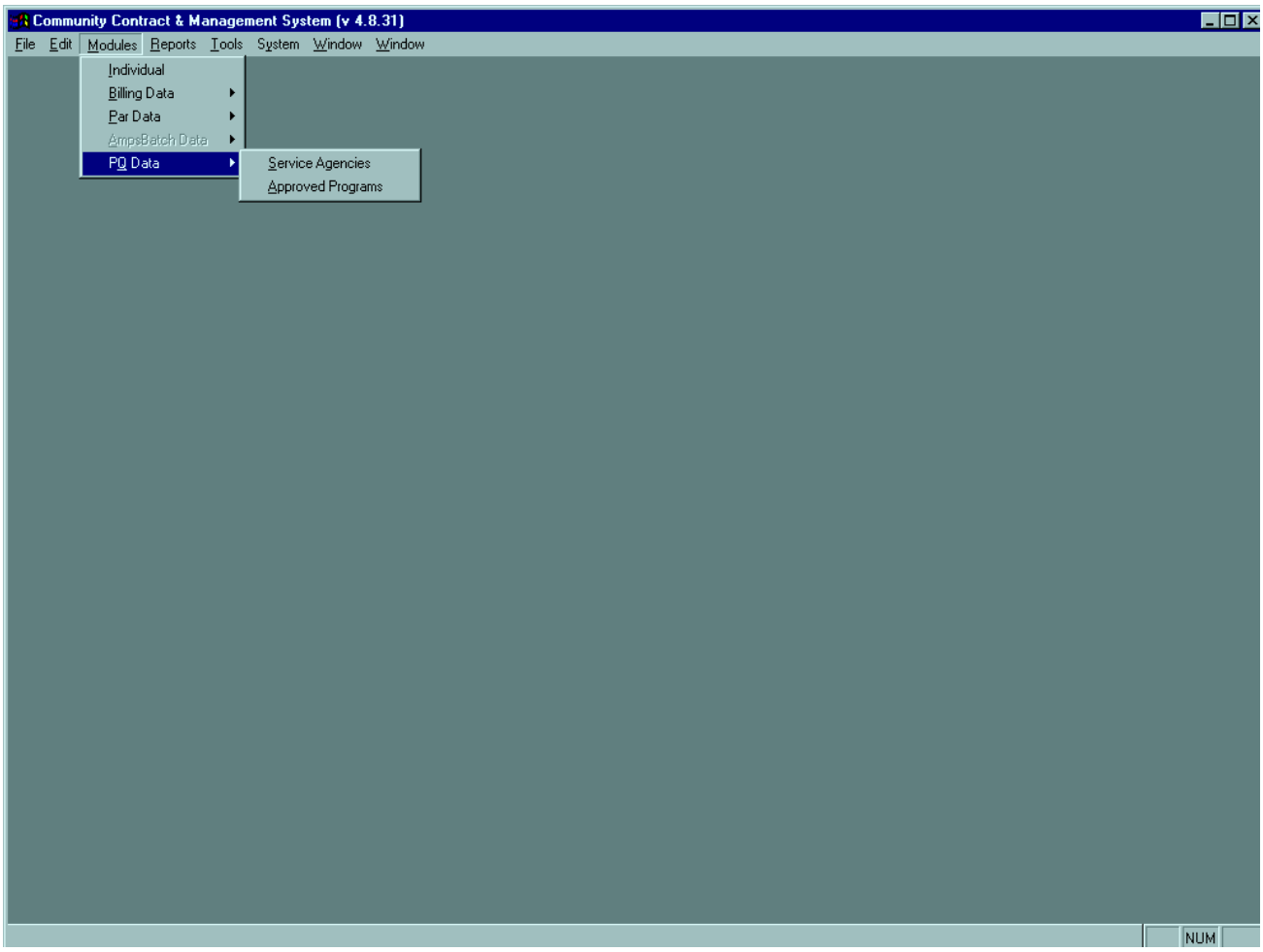
MMIS denials may not have been identified through the reconciliation process, so you will need to change the filter to identify AMPSbatch accepted claims that have not been marked as paid in order to filter for the possible MMIS denials that need rebilling. There may also be times where AMPS Accepted/Rejected reports or MMIS Provider Payment reports have not been received or were inadvertently deleted before they could be reconciled. In these cases, you will need to filter for claims which were not reconciled at all (unreconciled) or which were reconciled only through the AMPS Accepted/Rejected reports.




The **Mass Rebill screen** is displayed when you press the **Mass button** from the Filter screen. It provides you with the ability to rebill multiple claims based on the filter criteria specified on the Filter screen.

For example, if you wanted to rebill all denied claims without having to process them one at a time, the mass rebill would allow you to do that. The filter criteria is displayed again on the Mass Rebill screen for your information. The number of records that match the filter criteria and are currently marked for rebilling is also displayed for your information. Refer to the instructions on the AMPSbatch ReBill screen for rebilling individual claims to understand how the claims will be included in the next claim batch.

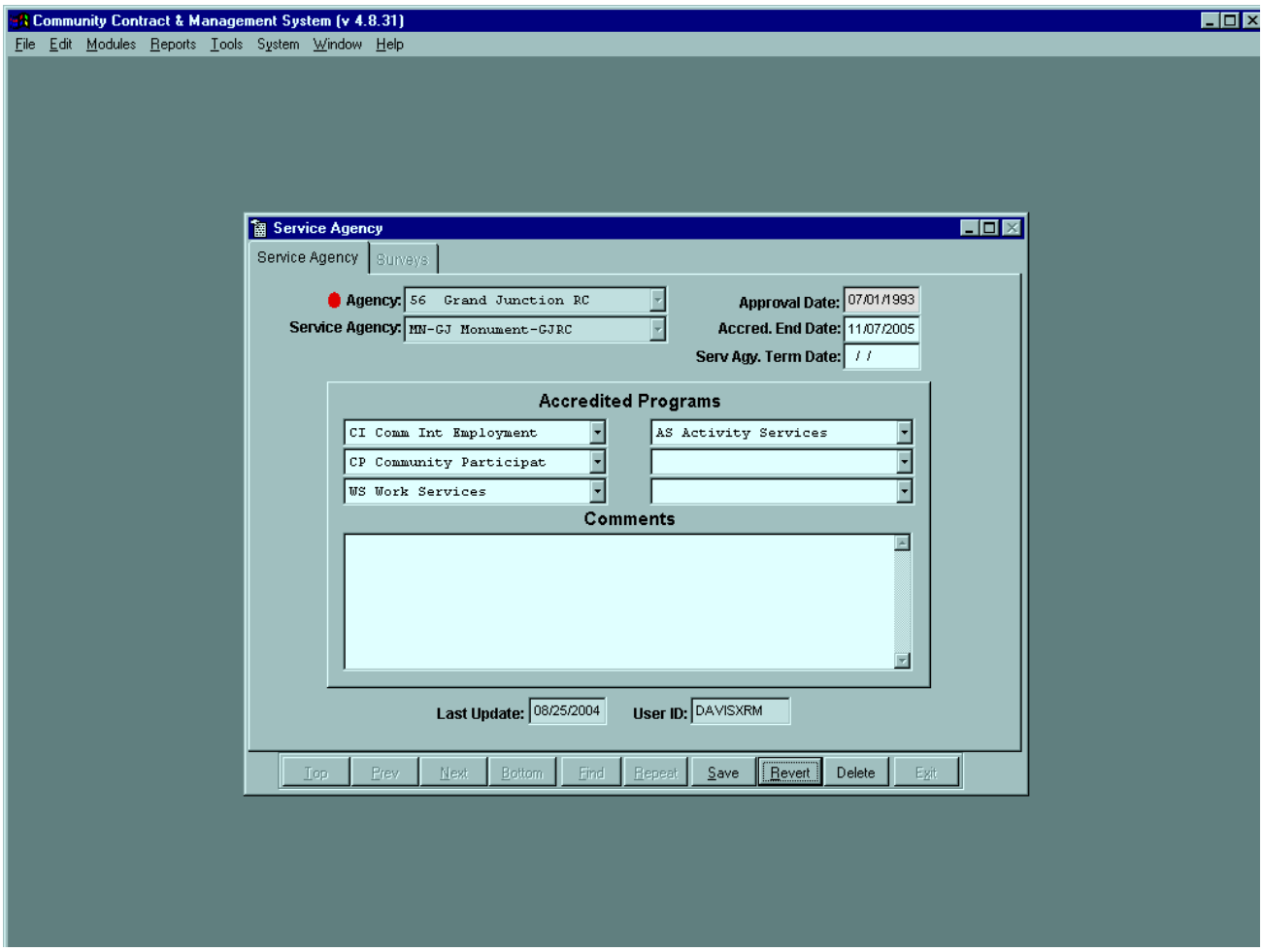
Press the **Process button** to rebill all the claims that meet the filter criteria. Press the **Cancel button** to return to the Filter screen without rebilling the claims.




The **PQ Data menu** is used to select the functions that may be performed in the PQ (Program Quality) module. You reach the PQ Data menu by **selecting PQ Data from the CCMS Modules drop down menu**. Click on the PQ Data menu item with the mouse pointer to get a drop down menu that displays selections for the PQ module. Your ability to select the items on the PQ Data menu is determined by the security level that has been assigned to you. If you do not have security rights to a PQ Data function, you will not be able to select that item from the menu. **Only DDD has security rights to select items from the PQ Data menu.**

The **Service Agencies** menu choice allows you to view and update **Service agency records.** Service agency records track service agencies, funded by DDD, that provide services to individuals with developmental disabilities.

The **Approved Programs** menu choice allows you to view and update **Approved program records.** Approved program records track the programs that service agencies have been approved to provide.




## This Screen is only Available at DDD

The **Service Agency screen** is used to enter or update service agency records. You reach the Service Agency screen by **selecting PQ Data from the CCMS Modules drop down menu** and then **selecting Service Agencies from** the PQ Data side menu**.**

The Service Agency screen contains two **Tabs**. The first tab presents the main service agency record. The second tab allows you to view and update survey records associated with the service agency displayed on the Service Agency screen.

Your **security level** will determine whether you have the ability to **enter data** on this screen or may only **view the data** on the screen. If you have been given rights for viewing data only, the fields will appear dimmed and you will not be able to move the cursor to them to enter data. **The Add, Edit, Revert and Save buttons** will also be disabled if you do not have rights to enter data.

Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

**Press the Add button** to add a new record. You must enter the **Agency, Service Agency and Approval Date** at a minimum on this screen in order to enter a new record. No program approval or survey records may be entered for a service agency program unless a service agency record has been entered first.

The Agency field is used to record the CCB/RC service area in which this agency provides services. The Service Agency field identifies the specific service provider. A separate service agency record must be entered for each service area in which the agency provides service. A CCB or RC is also considered a service agency and must have a service agency record entered. **If the record identifies the CCB or RC itself, enter DIR - Direct Service for the Service Agency.**

The **Service Agency Termination Date** identifies the date a service agency was terminated.

**Up to six Accredited Programs can be entered** for service agencies that are surveyed by an accrediting agency separate from DDD. The accredited programs are defined based on DDD criteria in order to determine for which programs DDD survey requirements can be met via the outside accreditation. **Use the Accreditation End Date field to enter the date the accreditation expires. This date will be used to identify the need for future accreditation.**

Comments related to this service agency record may be in the **Comments** at the bottom of the screen.

The **Last Update and User ID fields** are automatically completed based on the last user that updated the record.

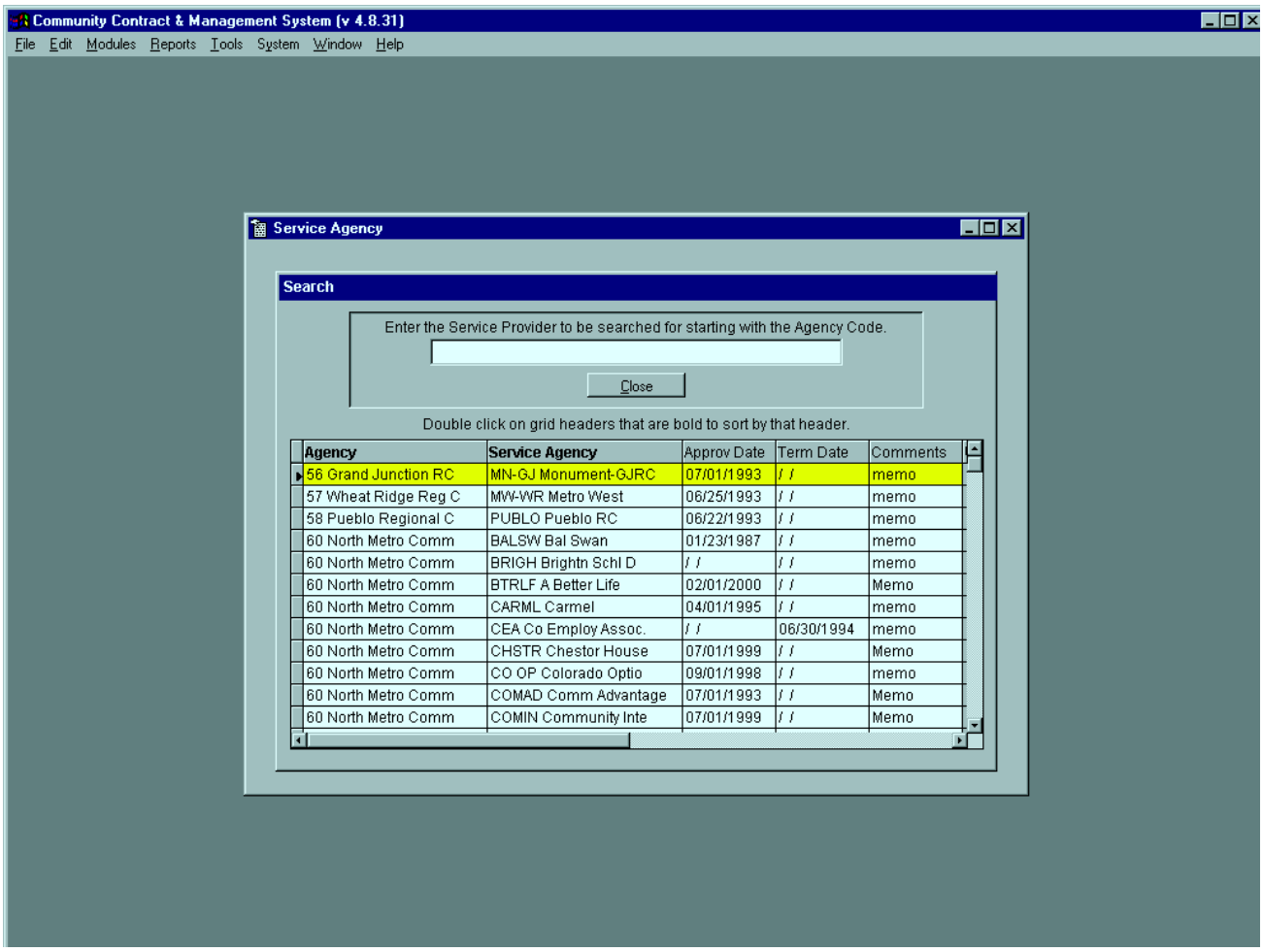
Press the **Find button** to find another service agency record(s). Use the **Prev and Next buttons or Top and Bottom buttons** at the bottom of the screen to move backward and forward through the records in the file.

**The Save, Revert and Delete buttons** are initially disabled or dimmed and will become enabled when you have chosen the **Edit button** to make changes to the selected service agency record. Any changes you have made will not actually be saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made to the record. The **Revert button** will discard all changes made to the record since the last time you saved changes. Use the **Exit button** to exit from this data entry screen.

Press the **Delete button** to delete a service agency record. When you select to delete a service agency record you will be asked to confirm your action. The system will check the Program

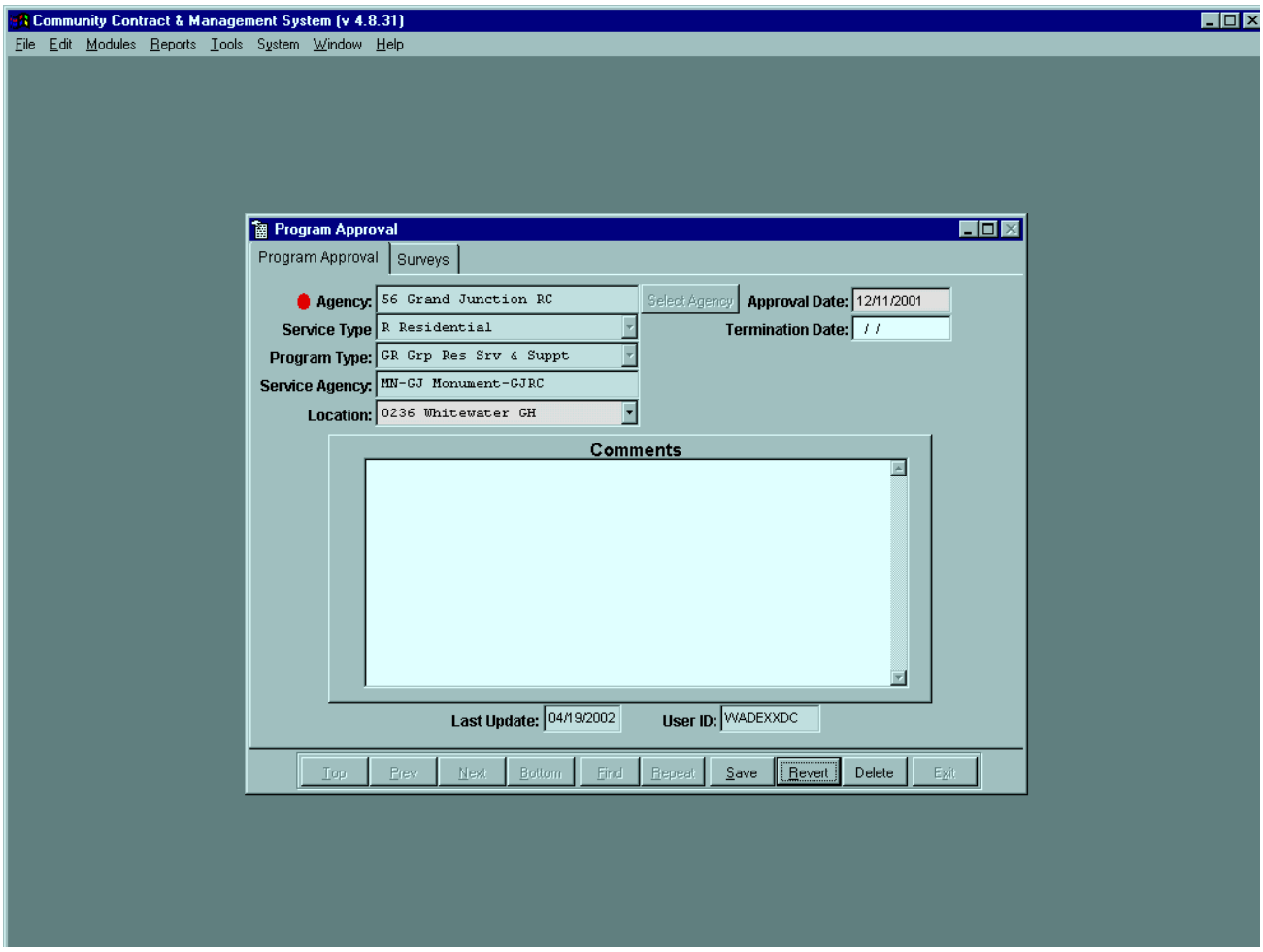
Approval and Surveys files to see if any program approval or survey records have been entered related to this service agency, and will not allow you to delete the service agency record if any are found.

Press the **Survey tab** to view and update the records that track the surveys for this service agency. If any survey records have been previously entered for this service agency, a **red dot will appear in front of the Agency label for your information**. All surveys, with exception of Group Residential Services and Supports (GRSS) surveys, are accessed from the service agency record. The GRSS surveys are accessed from the Program Approval screen. There are multiple group homes within each service agency that require individual approval from the Department of Health, as well as DDD, so the system tracks individual program approval and survey records for these homes under the Program Approval screen where the specific group home can be identified. (See the explanation of the Survey Screen after the Program Approval screen.)




The **Search screen** is displayed when the **Find button** is pressed on the Service Agency screen.

The **Search screen** allows you to identify a service agency record to view or update. Refer to Section II for further information about the **Search screen**. You can scroll through a list of records or type a search value on the screen and then **press the Close button** to bring up the selected record on the screen.




## This Screen is only Available at DDD

The **Program Approval screen** is used to enter or update program approval records. You reach the Program Approval screen by **selecting PQ Data from the CCMS Modules drop down menu** and then **selecting Program Approval from** the PQ Data side menu**.**

The Program Approval screen contains two **Tabs**. The first tab presents the main program approval record. The second tab allows you to view and update survey records associated with the approved program displayed on the Program Approval screen.

Your **security level** will determine whether you have the ability to **enter data** on this screen or may only **view the data** on the screen. If you have been given rights for viewing data only, the fields will appear dimmed and you will not be able to move the cursor to them to enter data. **The Add, Edit, Revert and Save buttons** will also be disabled if you do not have rights to enter data.

Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

To add a new program approval record, first **press the Add button** at the bottom of the screen and then press the **Select Agency button** to select a service agency record that this program approval record is related to. No program approval record may be entered for a service agency program unless a service agency record has been entered first. A list of the existing service agency records, sorted by CCB/RC will be presented at the bottom of the screen for selection.

You must enter the **Agency, Service Type, and Program Type** at a minimum on this screen in order to enter a new record. In addition, the **Location must be entered for Group Residential Services and Supports** (GRSS) programs in order to identify the specific group home for which program approval has been given.

Enter a **Termination Date** if the agency or program approval has been terminated.

Comments related to this service agency record may be in the **Comments** at the bottom of the screen.

The **Last Update and User ID fields** are automatically completed based on the last user that updated the record.

Press the **Find button** to find another program approval record. Use the **Prev and Next buttons or Top and Bottom buttons** at the bottom of the screen to move backward and forward through the records in the file.

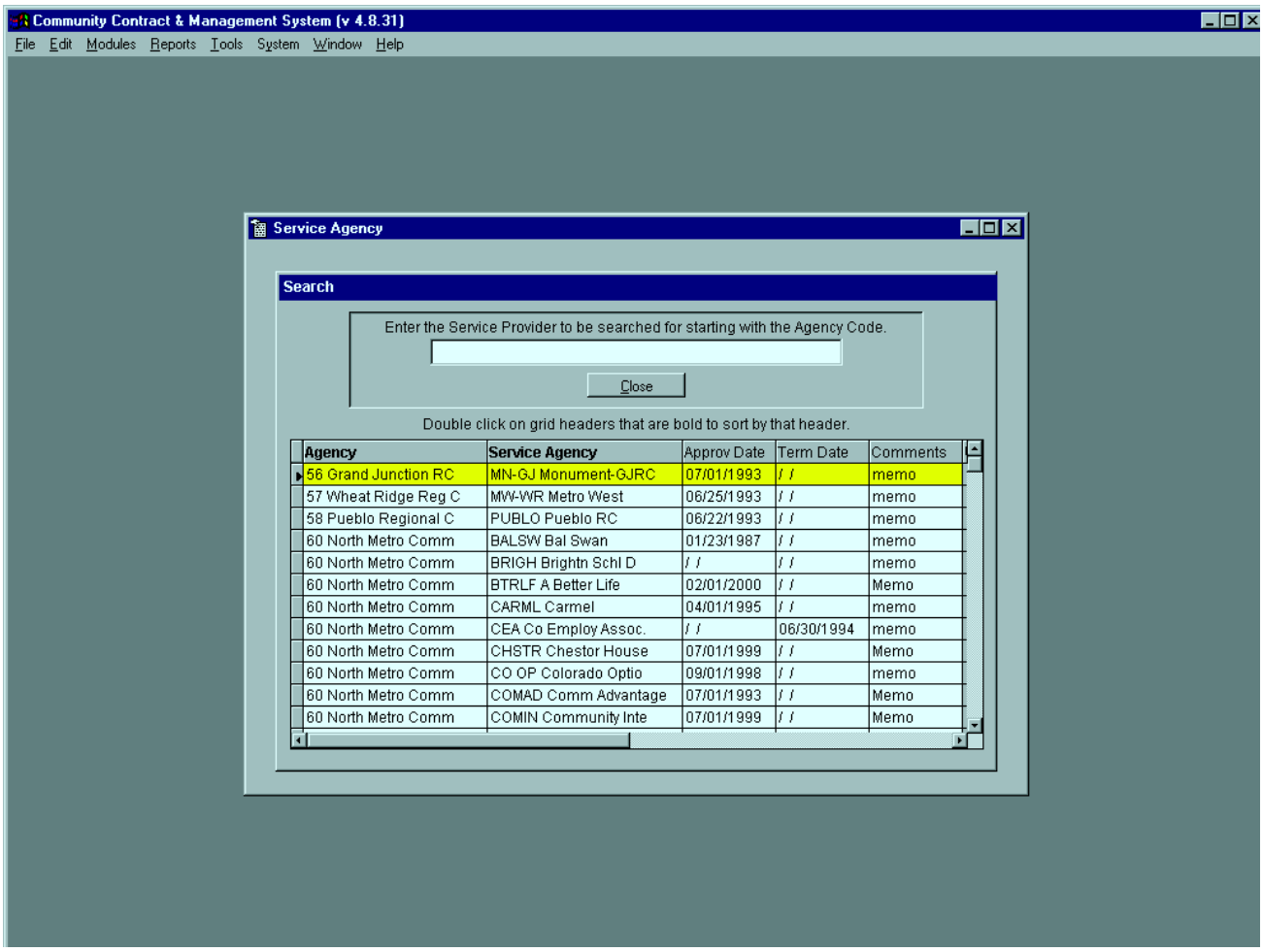
**The Save, Revert and Delete buttons** are initially disabled or dimmed and will become enabled when you have chosen the **Edit button** to make changes to the selected program approval record. Any changes you have made will not actually be saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made to the record. The **Revert button** will discard all changes made to the record since the last time you saved changes. Use the **Exit button** to exit from this data entry screen.

Press the **Delete button** to delete a program approval record. When you select to delete a program approval record you will be asked to confirm your action. The system will check the Surveys file to see if any survey records have been entered related to this program approval and will not allow you to delete the program approval record if any are found.

Press the **Survey tab** to view and update the records that track the surveys for the group home identified on the Program Approval Screen. **The Survey tab will only be enabled when the displayed program approval record is for GRSS.** Individual program approvals and surveys must

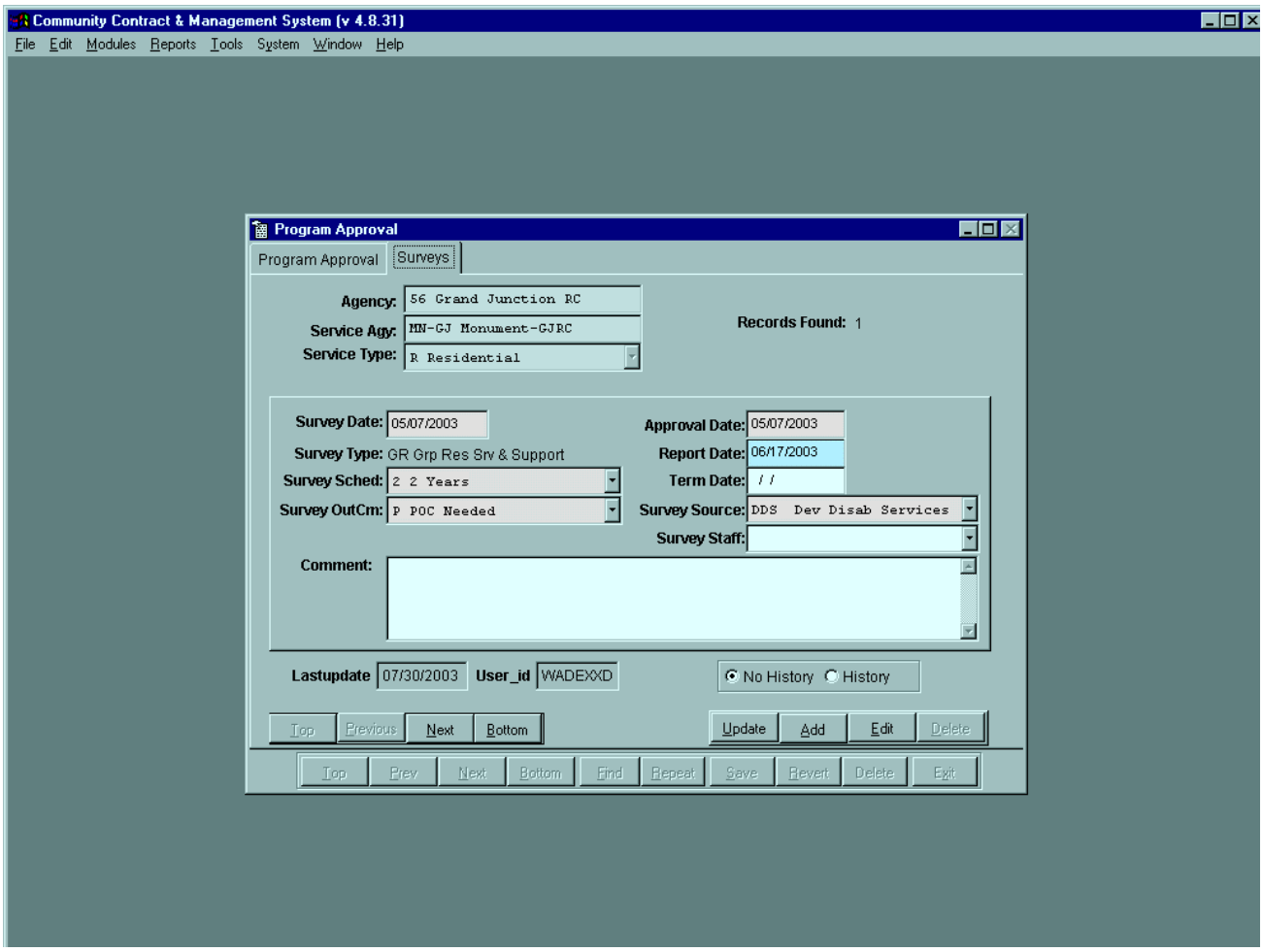
be done for each group home, so those surveys are entered and accessed from the Program Approval screen. To view other types of surveys for a service agency, use the Surveys tab from the Service Agency screen.

If any survey records have been previously entered for this group home, a **red dot will appear in front of the Agency label for your information**.




The **Search screen** is displayed when the **Find button** is pressed on the Program Approval screen.

The **Search screen** allows you to identify an approved program to view or update. Refer to Section II for further information about the **Search screen**. You can scroll through a list of records or type a search value on the screen and then **press the Close button** to bring up the selected record on the screen.




## This Screen is only Available at DDD

The **Surveys screen** is used to enter or update Survey records for Service Agency surveys and Group Residential Services and Supports (GRSS) surveys. You reach the Surveys screen from either the **Service Agency or Program Approval screen by selecting the Survey tab from one of those screens.**

Your **security level** will determine whether you have the ability to **enter data** on this screen or may only **view the data** on the screen. If you have been given rights for viewing data only, the fields will appear dimmed and you will not be able to move the cursor to them to enter data. **The Add, Edit, Revert and Save buttons** will also be disabled if you do not have rights to enter data.

Valid selections for data entry are presented in the form of **drop down lists** for those fields that have codes assigned to the data. You must choose from one of the valid codes in the list in order to enter information in the field. Click on the arrow to the right side of the field to access the list.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

Only survey records related to the Service Agency or Program Approval screen from which the Survey button was selected will be available for viewing on this screen.

**Press the Add button** to add a new record. You must enter the **Survey Date, Service Type, Survey Schedule, Survey Source and Survey Outcome** at a minimum on this screen in order to enter a new record. The **Agency and Service Agency are entered for you automatically** based on the value of these fields from the Service Agency or Program Approval screen from which the Survey screen was reached.

If the survey record is being entered from the Program Approval screen, the Service Type and Survey Type will be automatically completed for you to identify the survey as **a group home survey**, and you will be unable to change those fields.

The **Survey Date field** represents the latest survey conducted for this service agency and survey type. When a new survey is conducted for this same service agency and survey type, **press the Update button** to create a new survey record. You must enter the new survey date and approval date and change other fields as needed to record the new survey. The previous survey record is marked as **History**.

The **Survey Staff** field must be completed if the Survey Source field indicates this is a DDD conducted survey. The entry for this field will be based upon a list of users in CCMS, so each surveyor must have a login for CCMS that provides them with at least a read only level access to PQ module. If the Survey Source is other than DDD, no entry is required into the Survey Staff field.

Enter a **Termination Date** if the agency or program approval has been terminated.

Comments related to this service agency record may be in the **Comments** at the bottom of the screen.

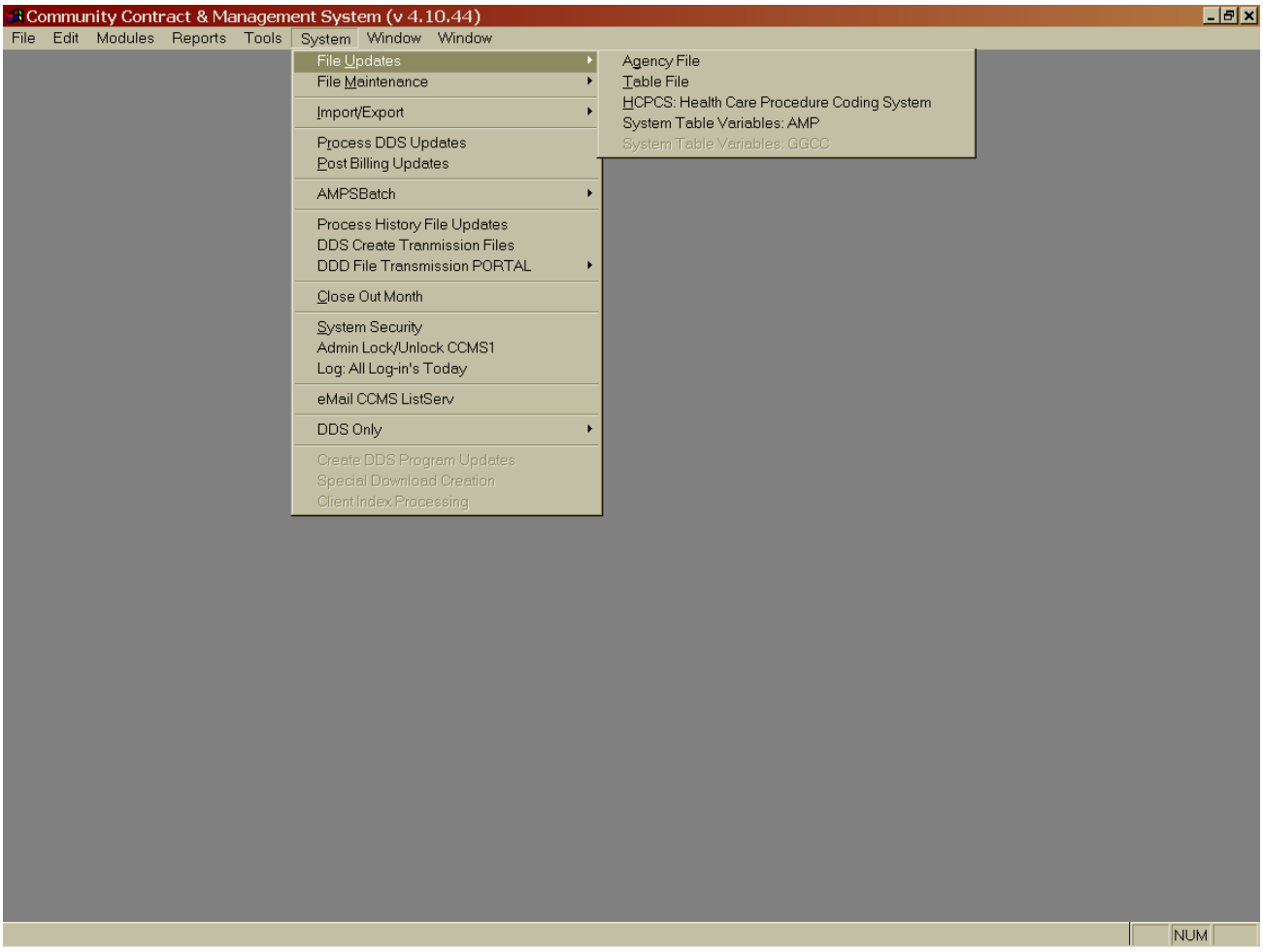
The **Last Update and User ID fields** are automatically completed based on the last user that updated the record.

The Survey file contains multiple records showing all the historical surveys that have occurred for a service agency or group home. The **History radio buttons** at the bottom of the screen allow you to look at the historical records as well as the current survey record. Click with the mouse pointer on the **History** button to see all of the survey records. As you move though the records **using the Prev or Next button to display the records**, you will see all the records for that service agency or group home grouped together. Select **No History** to return to the display of only current survey record. The number of survey records for a service agency or group home is displayed at the top of the screen with the label **Records Found**.

Use the **Prev and Next buttons or Top and Bottom buttons** at the bottom of the screen to move backward and forward through the records in the file.

**The Save, Revert and Delete buttons** are initially disabled or dimmed and will become enabled when you have chosen the **Edit button** to make changes to the selected survey record. Any changes you have made will not actually be saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made to the record. The **Revert button** will discard all changes made to the since the last time you saved changes. Use the **Exit button** to exit from this data entry screen.

Press the **Delete button** to delete a survey record. You should not delete a History record unless it was entered incorrectly. The History records track the previous surveys for this program or group home and must be maintained for historical reference.



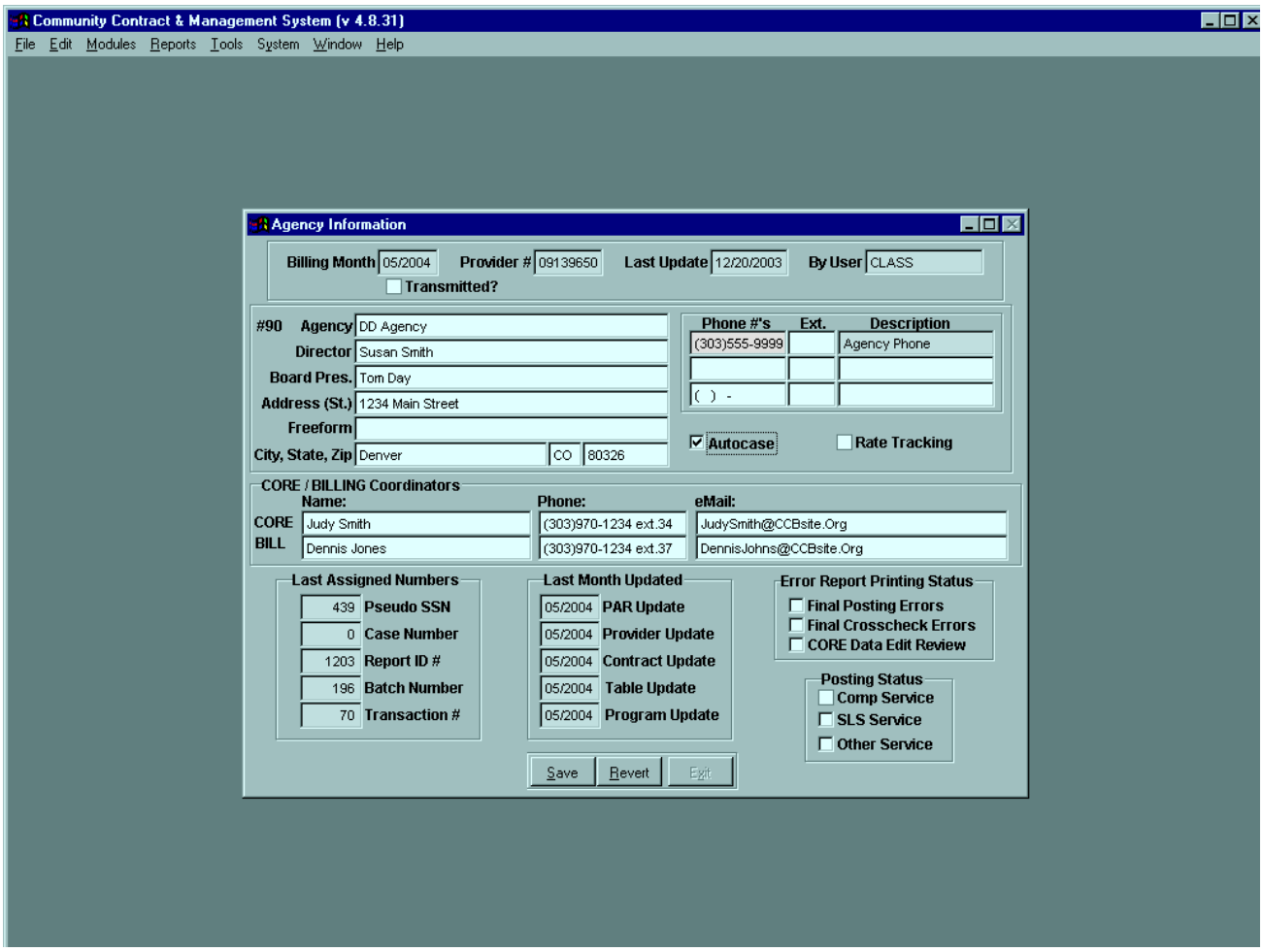

The **File Updates menu** is used to perform several types of CCMS file updates which are either not related to a specific module or which require special access at a system level. You reach the File Updates menu by **selecting File Updates from the CCMS System drop down menu**. Click on the File Updates menu item with the mouse pointer to get a drop down menu that displays selections for the File Updates menu. Your ability to select the File Updates menu is determined by the security level that has been assigned to you. If you do not have security rights to the CCMS System menu, you will not be able to get to this menu choice.

The **Agency File** menu choice allows you to view and update information in the Agency file for your Agency.

The **Table File** menu choice allows you to view and update codes used throughout the system.

The **HCPCS Health Care Procedure Coding System** menu choice allows you to view and update Medicaid procedure codes used in Medicaid claims.

The **System Table Variables AMP_SYS** menu choice allows you to view and update the variables needed to submit an AMPSBatch file to the Medicaid Fiscal Agent.




The **Agency File screen** allows display and entry of information specific to your Agency. You reach this screen by **selecting File Updates from the CCMS System drop down menu** and then **Agency File** from the File Updates side menu.

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for System Functions, you will be able to update the Agency file.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

Enter the legal name of your Agency in the **Agency field.** The Director and Board President, although not required, but should be entered for information purposes. Enter the mailing address of your Agency in the **Address, City, State and Zip fields**. Enter the telephone number for your Agency in the **first Phone Number field**. The Agency name, address and telephone number are used when Medicaid claims are created and submitted to the Medicaid Fiscal Agent **and must be entered and updated in a timely manner**. The first phone number description is **pre-defined as Agency**

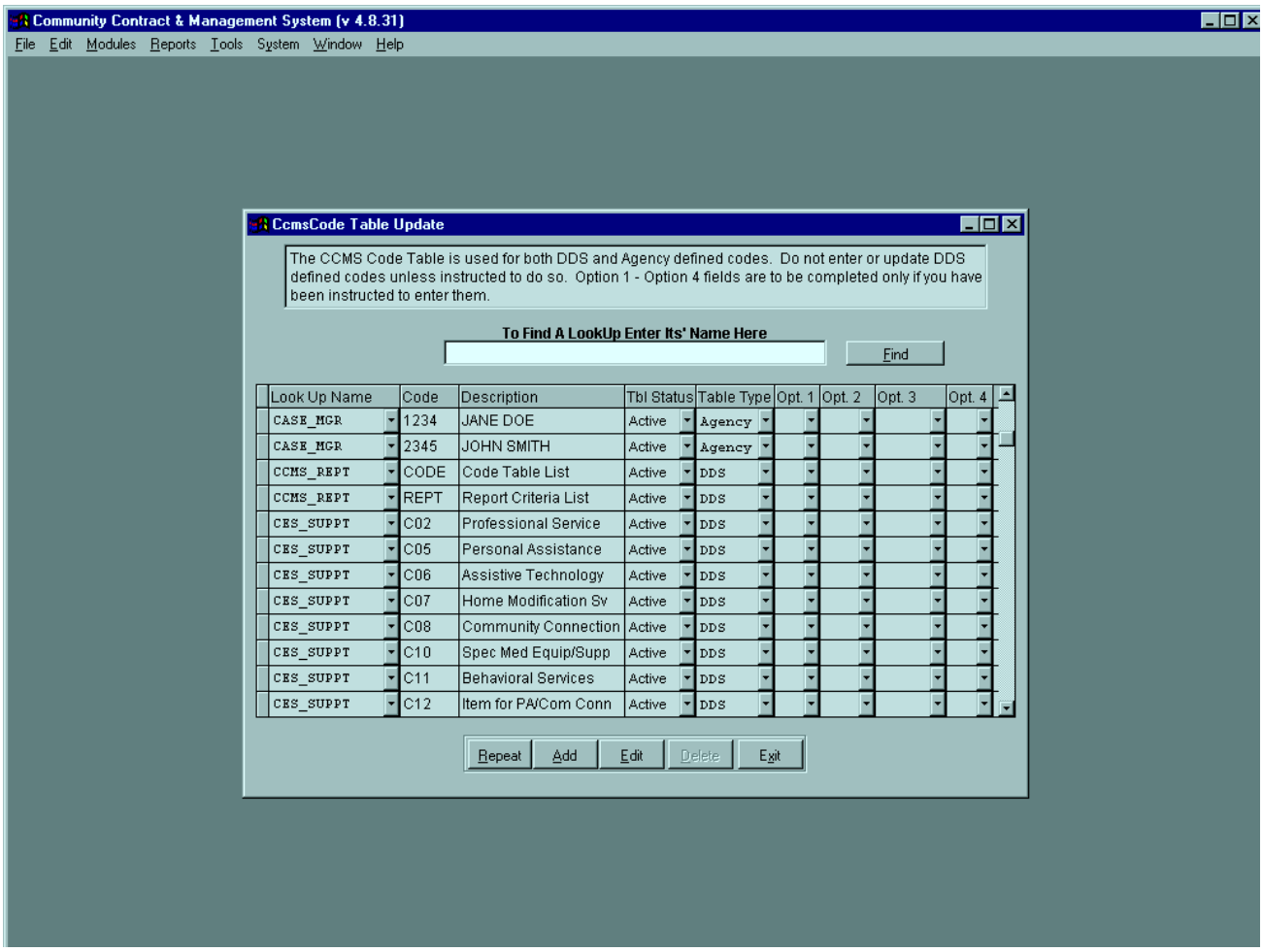
**Phone** so the telephone number for your Agency can always be accessed for claim production from the first phone number field. Additional phone numbers can be entered and defined by you.

Click the **checkbox for Auto Case number** assignment if you want the system to assign sequential case numbers to the records you enter in the CORE mandatory file. Case number assignment will begin with the next number after the number displayed in the **Case Number field** under the Last Assigned Numbers section.

Enter the **Name, Phone number (along with extension, if applicable) and email address** of the CORE and Billing coordinators for your Agency. This information allows DDD to identify the correct individual to contact with questions or issues about the data in your Agency. **This information must be updated as soon as it changes so DDD has the most recent information in the files that are transmitted monthly.**

Most of the information on this screen is for display rather than update. The Agency file is used to keep track of several system statuses. **Look at the Agency file to determine statuses such as: current billing month, which services have been posted, which error reports have been printed, etc.**

Press the **Edit button** to open the record for editing. The **Save and Revert buttons** are initially disabled or dimmed and will become enabled when you have made any changes to the record. Any changes you have made will not actually be saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made. The **Revert button** will discard all changes made since the last time you saved changes.




The **Code Table Update screen** is used to enter and update codes used in CCMS. You reach this screen by **selecting File Updates from the CCMS System drop down menu** and then **Table File** from the File Updates side menu.

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for System Functions, you will be able to update the Table file.

**Refer to Appendix A for definitions of the codes and data requirements for each field on this screen. Refer to Section II for common screen elements and pop-up screens.**

Codes are used throughout CCMS to standardize the entry, reporting and analysis of data. For example, standard codes have been assigned for residential facilities, day program locations and supported living services providers. These codes can then be used in all the files in CCMS that need to track this information and the codes will identify the same information from file to file. Most codes are defined and assigned by DDD. **DO NOT make up your own codes for DDD assigned code types.** You can determine if a code is a DDD defined code by looking at the **Table Type column to**

**see if it is D - DDD or A - Agency.** When you need a new DDD assigned code for day, residential or supported living service locations/providers, contact DDD to get the code.

All codes must be entered under a Look Up Name that identifies to the system what this code is used for. Each code is related to a Look Up Name. Look Up Name codes are all related to specific data field(s). **Look Up Names have been pre-defined for all files except the Optional file**. Each Agency can define the structure of its optional file to fit its needs. At the same time that you define the Optional file structure, you assign Look Up Names for the coded fields that have been defined in the structure. You must use this screen to enter the codes and descriptions for the coded fields you have defined for your Optional file, using the Look Up Names you assigned for those fields.

**Press the Add or Repeat button** to create new code records for a Look Up Name. The Repeat button will repeat the values from the currently selected record for the new record you are entering, so this ensures that you have the correct Look Up Name for the new code. When adding a new record with the Add button, choose the **correct Look Up Name from the drop down list in the Look Up Name column**.

Enter the new code in the **Code field**. The system will force the entry to an uppercase display for all codes, except for those associated with Street direction and type. Enter the description of this code, up to twenty characters long, in the **Description field**. Enter a **Table Status** of A - Active to indicate that the new code is an active code. The status should be changed to I - Inactive when a code is no longer used. Enter a **Table Type** of D - DDD if the code is a DDD assigned code or A - Agency if the code is an Agency assigned code. The Option 1 through Option 4 fields should be completed only if you have received instructions from DDD to complete them.

Press the **Edit button** to edit an existing code record. The Look Up Name and Code cannot be changed for an existing code. If the code was entered in correctly, delete the invalid code and enter a new code record. The **Description of codes assigned by DDD cannot be changed at Agency sites** except for the description of residential, day program and support services providers. Allowing the Agency to change descriptions for these codes identifies the service provider on screens and reports under the common name used by Agency staff. Refer to the table below for descriptions that can be changed by the Agency when editing in a code record.

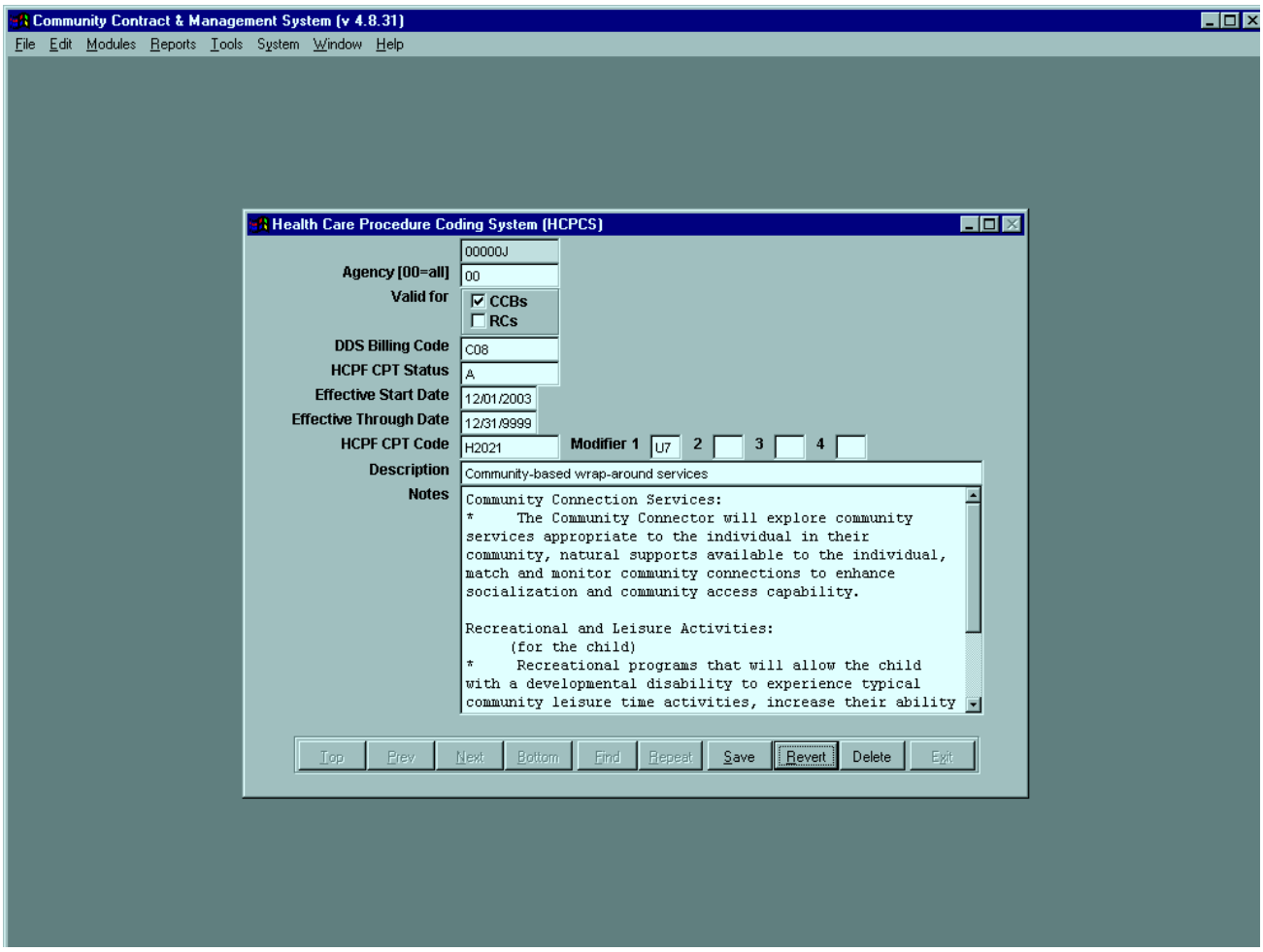
The **Save, Revert and Delete buttons** are initially disabled or dimmed and will become enabled when you have made any changes to the records in the Table file. Any changes you have made will not actually be saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made. The **Revert button** will discard all changes made since the last time you saved changes.

Press the **Delete button** to delete a code record. When you select to delete a code record you will be asked to confirm your action. **Do not delete code records for codes that are still valid in old records.** For example, if a residential facility has closed, the code for this facility is probably contained in terminated records in your CORE mandatory file. The code needs to remain identified in

your Code Table file for historical reference. In this case, **just change the Code Status to I - Inactive**.

Refer to the table below for a list of Look Up Names for which code descriptions can be changed or for which the Agency must enter an Agency defined code record. The Use column describes how the code is used. An Agency may change the description of any code assigned under an optional Look Up Name, as well as those listed in the table below:

| Look Up Name | Use | Comments |
|---|---|---|
| AGY_STAT | CORE Agency Status and Regional Center Admission Type | DDD records entered for RC Admission codes<br>Codes are Agency defined for other statuses |
| A_DAYPROG | CORE Agency Defined Day Program | Codes are all Agency defined |
| BILL_OPT | Billing Optional Code | Codes are all Agency defined |
| CASE_MGR | CORE Case Manager | Codes are all Agency defined |
| DAY_COORD | CORE Day Coordinator | Codes are all Agency defined |
| DAY_LOC | CCMS Day Program Location/Prov | Codes are DDD defined, but Agency can enter its own description |
| MAILCODE | Address File Mailing Code | Codes are all Agency defined |
| RELATION | Address File Relationship | DDD record entered for S - Self code<br>Codes are Agency defined for other relationships |
| RES_COORD | CORE Residential Coordinator | Codes are all Agency defined |
| RES_FACIL | CCMS Residential Facility/Prov | Codes are DDD defined, but Agency can enter its own description |
| SLS_CONSLT | CORE SLS Consultant | Codes are all Agency defined |
| SLS_PROV | CCMS SLS Provider | Codes are DDD defined, but Agency can enter its own description |
| SUBCONTRCT | Billing Subcontractor | DDD records entered for DDD and Direct Service contracts<br>Codes are Agency defined for other subcontracts |




The **Health Care Procedure Coding System (HCPCS) screen** is used to view or update CCMS HCPCS records that identify the procedure codes used in the Medicaid Management Information System (MMIS). You reach this screen by **selecting File Updates from the CCMS System drop down menu** and then **HCPCS** from the File Updates side menu.

**The CCMS HCPCS records can only be entered and updated by DDD staff**. Staff at Agency sites may only view the records on the screen. Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for System Functions, you will be able to view the HCPCS file.

**Press the Add button** to add a new record. You must enter the **Agency number or '00' to designate whether the entry applies to only a specific Agency or to all agencies.**

Check the appropriate boxes to indicate whether the procedure code is used by Community Centered Boards (CCBs), Regional Centers (RCs), or both. Enter the CCMS billing code that corresponds to the billing procedure code used in the MMIS in the **DDD Billing Code field.** Enter a status of **A - Active** in the **HCPF CPT Status field** to designate a code that is currently active. **Enter the Start**

**and Through** date to identify the spans of service when the code was valid for billing. These dates are used by the Billing and AMPSBatch modules to select the correct procedure code for claim creation.

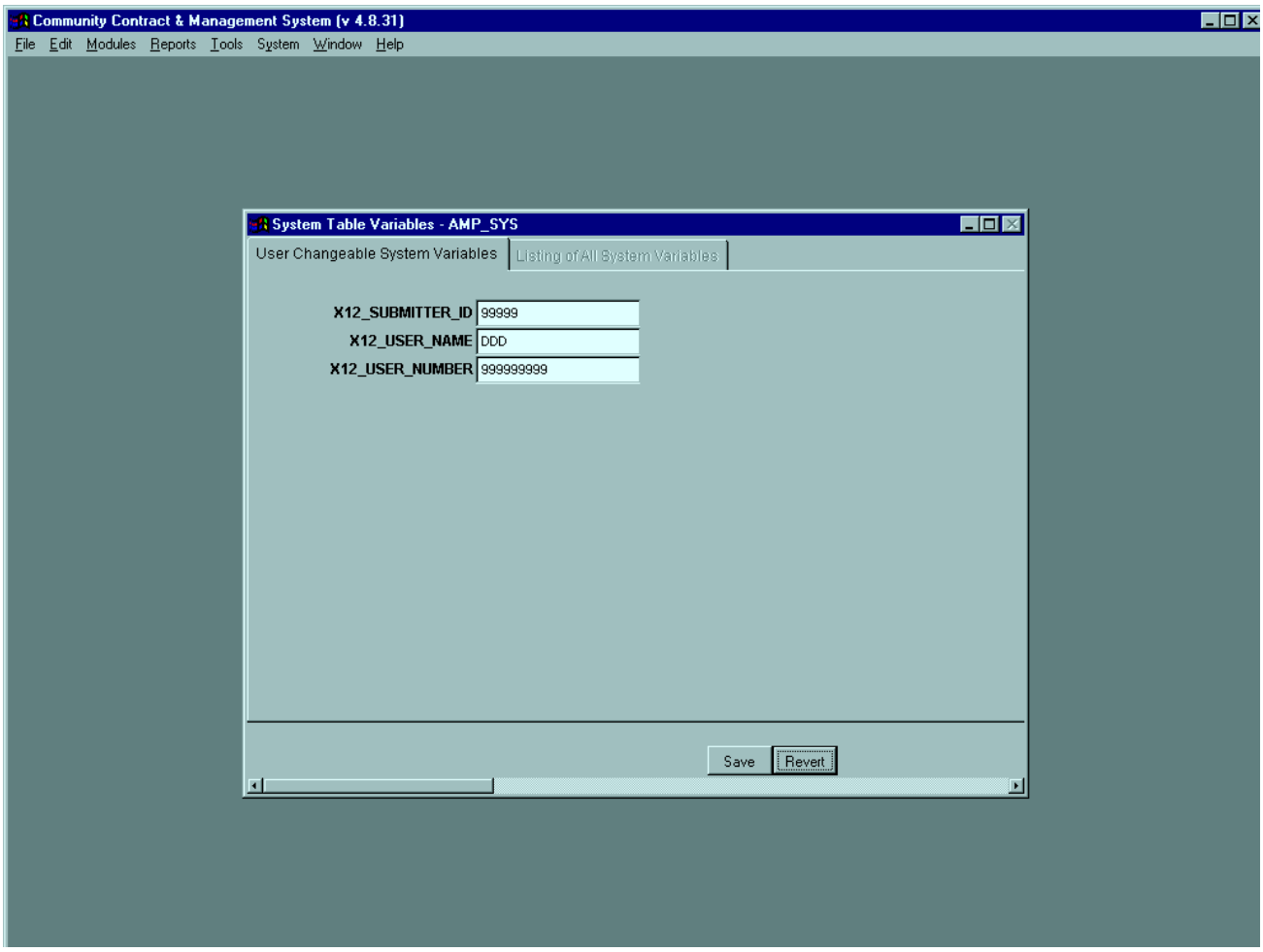
Enter the **HCPF CPT code** (procedure code) that should be used to create claims for this span of service dates. If the procedure code requires an additional modifier, **enter the appropriate Modifier** code(s) in the Modifier 1, 2, 3 or 4 fields.

**Enter the Description used in the MMIS** to describe the procedure. Enter an expanded explanation in the Notes field, if desired.

Press the **Find button** to find another HCPCS record(s). Use the **Prev and Next buttons or Top and Bottom buttons** at the bottom of the screen to move backward and forward through the records in the file.

Press the **Edit button** to open the selected HCPCS record for editing. The **Save, Revert** and **Delete buttons** are initially disabled or dimmed and will become enabled when you have made any changes to the HCPCS record. Any changes you have made will not actually be saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made. The **Revert button** will discard all changes made since the last time you saved changes.

Press the **Delete button** to delete a HCPCS record. **Do NOT delete a record if the procedure code can still be billed in the MMIS.** Instead, enter a Through date, so any claims prior to that date can identify the correct procedure code for that period of time.



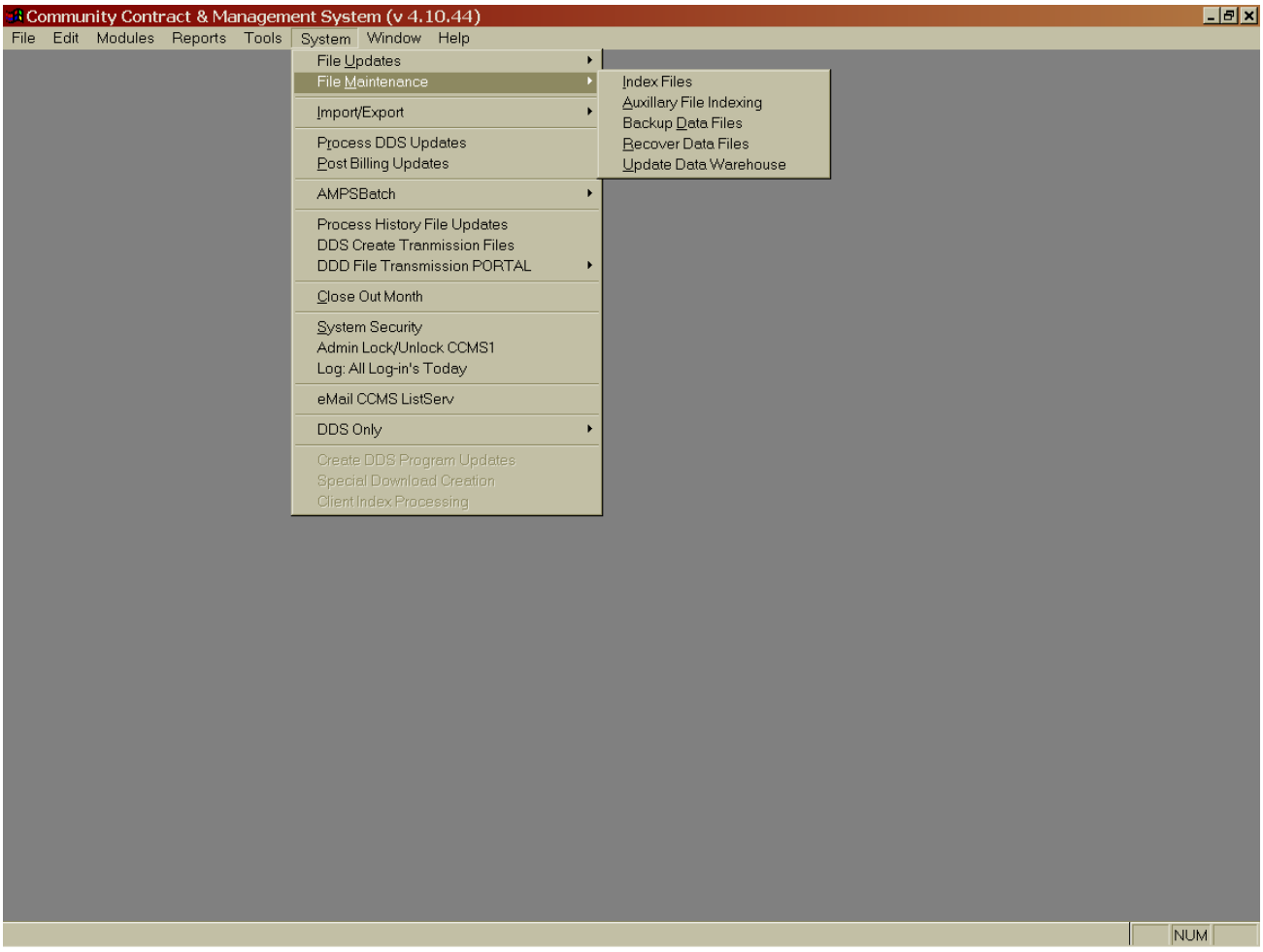

The **System Table Variables AMP_SYS screen** is used to view or update the variables used by the AMPSBatch module to create a batch file to send to the Fiscal Agent. You reach this screen by **selecting File Updates from the CCMS System drop down menu** and then **System Table Variables** from the File Updates side menu.

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for System Functions, you will be able to view and update the System Table Variables AMP_SYS file.

**Press the Edit button** to update the record. Enter the correct values for **the Submitter ID, User Name and User Number.** If you do not know these values, you will have to contact the Medicaid Fiscal agent to obtain them. **These values must be entered and updated as needed, or AMPSBatch submission files cannot be accepted by the Medicaid Fiscal Agent.**

The **Save and Revert buttons** are initially disabled or dimmed and will become enabled when you have made any changes to the record. Any changes you have made will not actually be saved to the

file until you press the **Save button**. Use the **Revert button** to discard changes you have made. The **Revert button** will discard all changes made since the last time you saved changes.




The **File Maintenance menu** is used to perform CCMS system maintenance functions that require execution at a system level. You reach the File Maintenance menu by **selecting File Maintenance from the CCMS System drop down menu**. Click on the File Maintenance menu item with the mouse pointer to get a drop down menu that displays selections for the File Maintenance menu. Your ability to select the File Maintenance menu is determined by the security level that has been assigned to you. If you do not have security rights to the CCMS System menu, you will not be able to get to this menu choice.

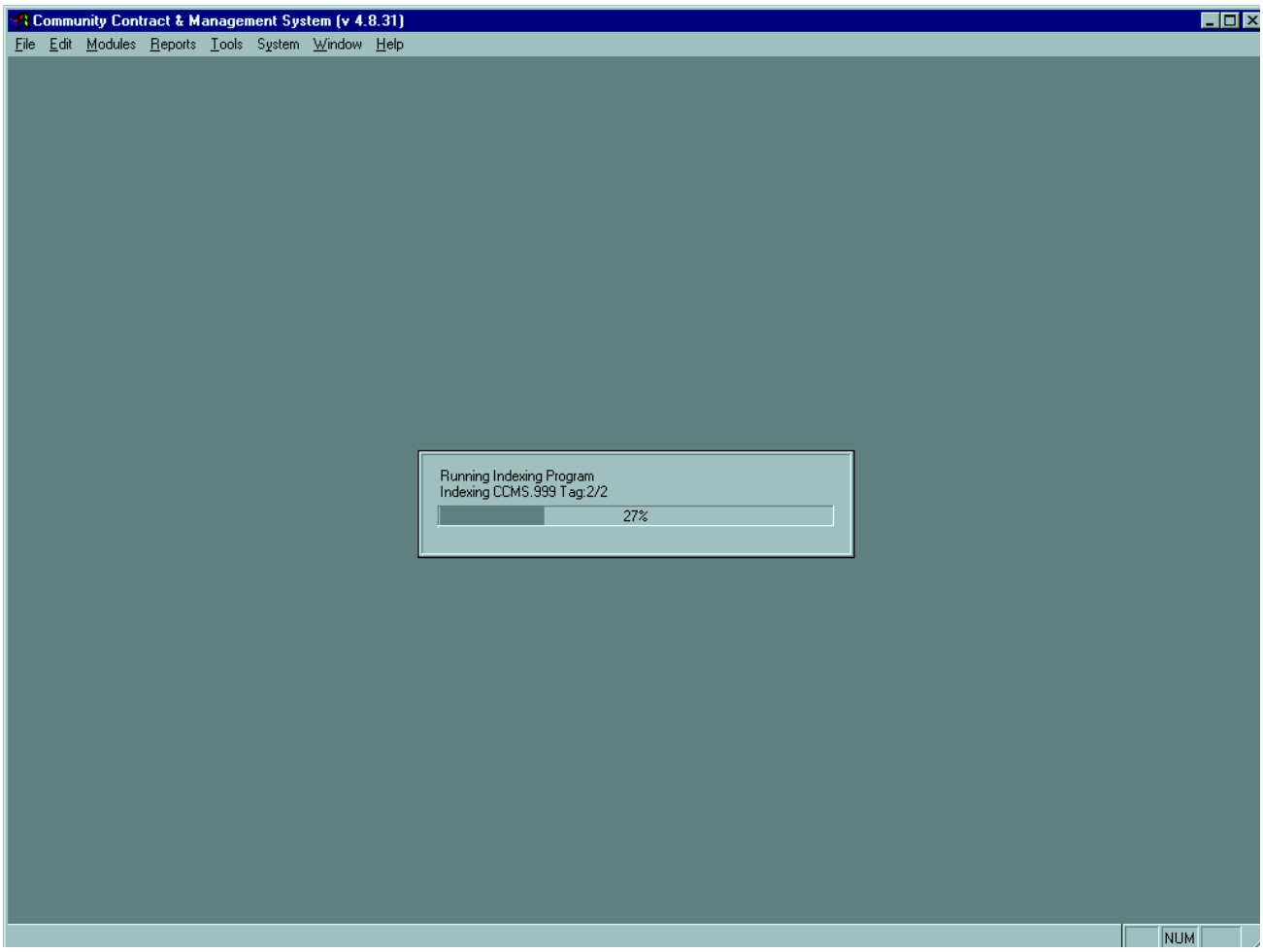
The **Index Files** menu choice allows you to perform an index of the main files in the system.

The **Auxiliary File Indexing** menu choice allows you to choose the files to index.

The **Backup Data Files** menu choice allows you to perform an elective backup of your data files to a special directory on the hard disk.

The **Recover Data Files** menu choice allows you to perform an elective recovery of your data files from a special directory on the hard disk.

The **Update Data Warehouse** menu choice allows you to perform an update of files created specifically for report printing.



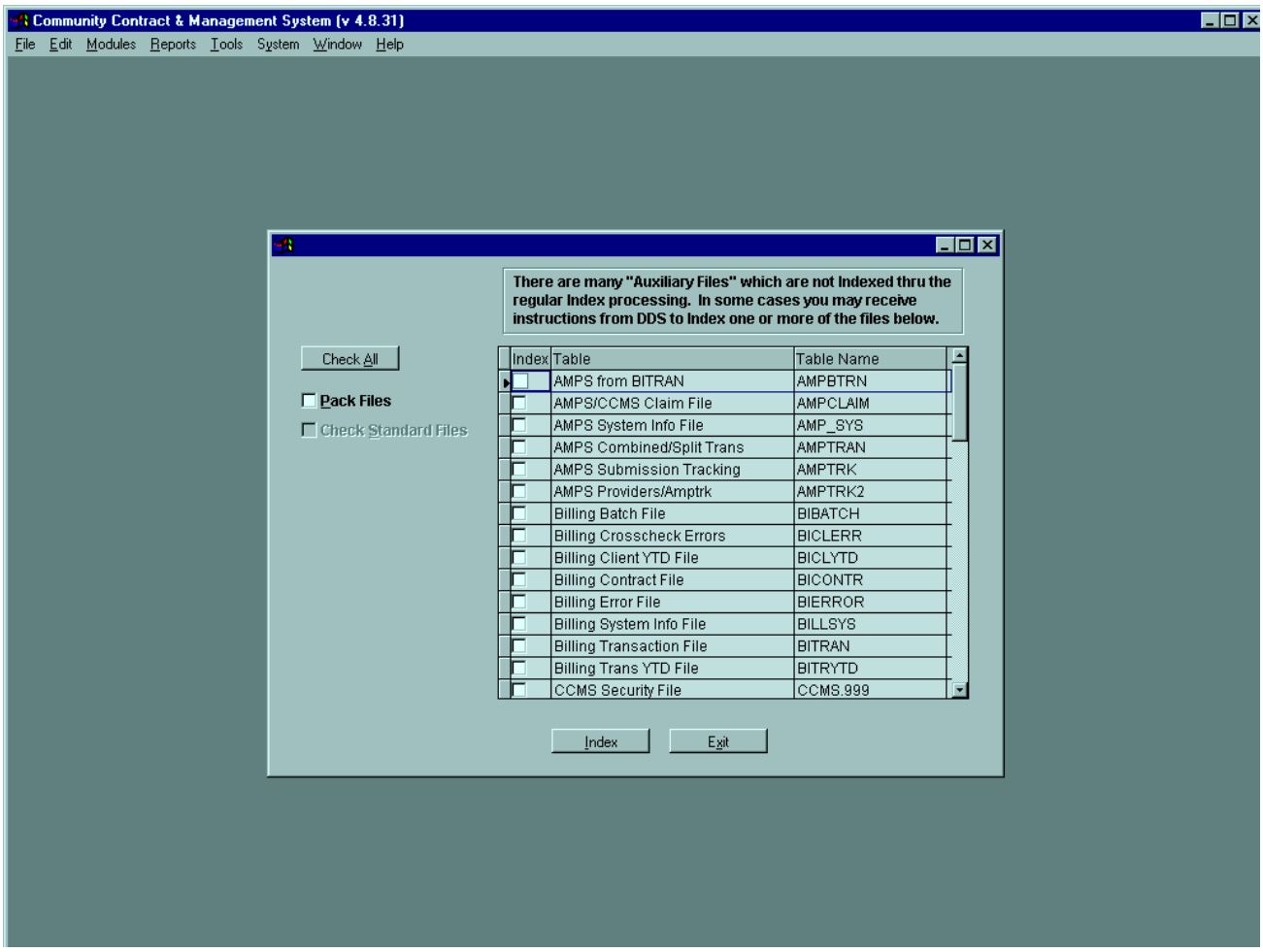

The **Index Files** function is used to re-create the indices for all of the critical files in CCMS. You reach this function by **selecting File Maintenance from the CCMS System drop down menu** and then **Index Files** from the File Maintenance side menu.

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for System Functions, you will be able to index files.

**This function requires that no other users be in CCMS.** The program will check to make sure that no other users are in the system in a network environment. If there are other users in the system, you will receive a notification and you will not be allowed to proceed.

**You should index your files anytime there has been abnormal interruption during data entry, e.g. a power outage. network error, etc.** You should also choose this function if you are receiving unanticipated output on reports. Index files are used to order the data in your CCMS database files to allow sorting of reports and quick access of information. If index files get out of synchronization with the database, the system may not be able to find the actual data records that are contained in the database file.

**If you find yourself unable to locate a record that you know was in the system previously, or accessing incorrect related data (such as billing rates), or finding incorrect or inconsistent information on printed reports, immediately index your files and then return to the screen or report to see if the data is now correct. If it still is not, submit a Help Desk ticket and wait for assistance from the Information Technology staff.**




The **Auxiliary File Indexing** function is used to re-create the indices for auxiliary files containing system. You reach this function by **selecting File Maintenance from the CCMS System drop down menu** and then **Auxiliary File Indexing** from the File Maintenance side menu.

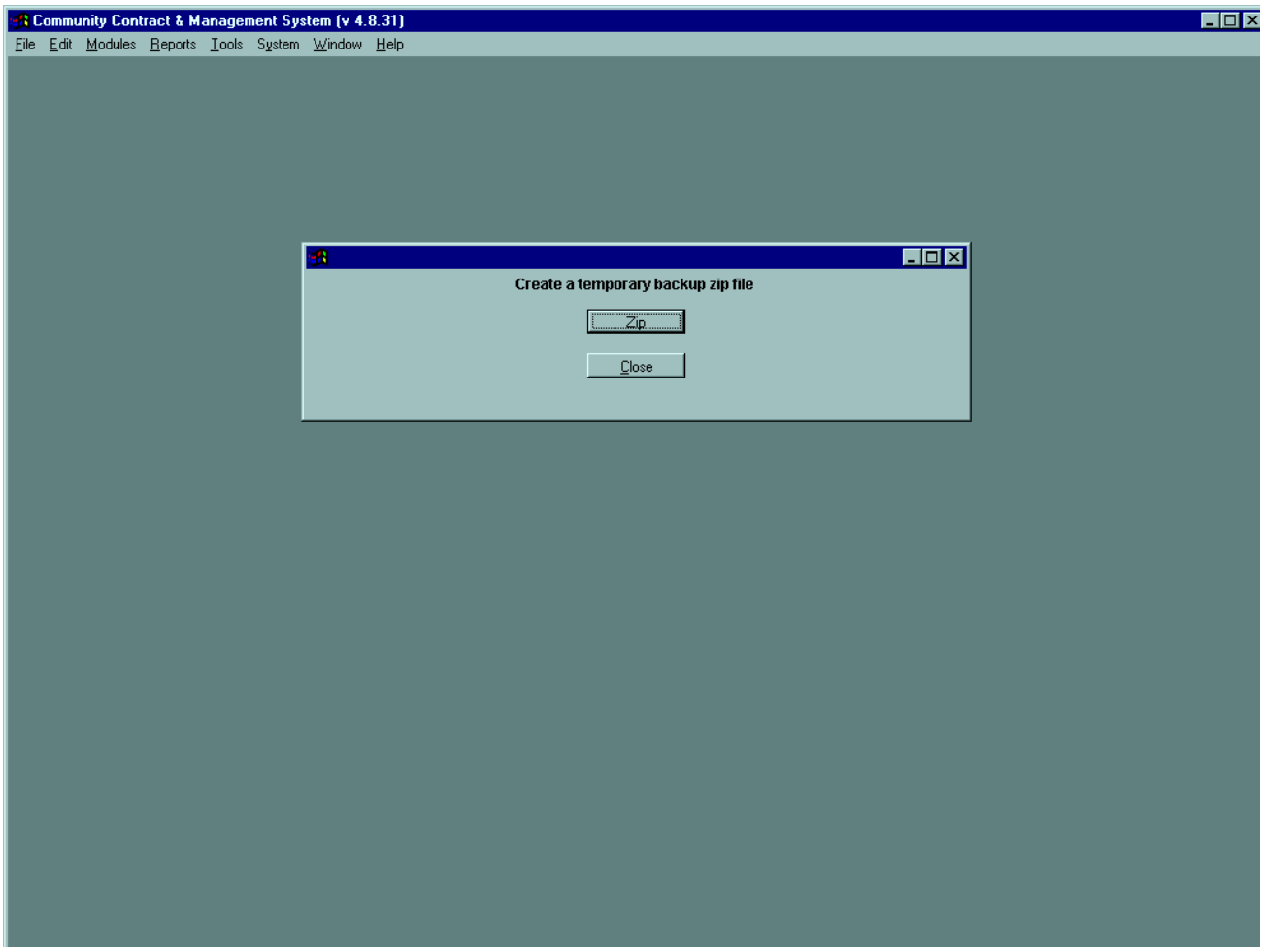
Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for System Functions, you will be able to index auxiliary files.

**This function requires that no other users be in CCMS.** The program will check to make sure that no other users are in the system in a network environment. If there are other users in the system, you will receive a notification and you will not be allowed to proceed.

Generally you will only perform this function when you have been asked to do so by DDD. It may be necessary to re-create index files if one or more auxiliary files appears to have a problem with finding existing records or adding new records to the file. The possible auxiliary files that may be indexed will be displayed in a list format as shown on the screen above. No files will be marked for indexing when you first display this screen. **Click on the box before each file name to mark or unmark it for indexing. Press the Check All button** on the left side of the screen to mark all files for indexing.

This screen may also be used to **Pack Files by clicking on the Pack Files check box displayed on the left side of the screen**. Packing files gets rid of records that have been marked for deletion by the system. When the Pack Files check box is marked, any files that are indexed will also be packed. **Do not select to Pack Files unless instructed to do so by DDD support staff.**

**Press the Index button to perform the actual indexing**. Very large files, such as the History file (Clhist.dbf) and the Billing Transaction Year to Date file (Bitrytd.dbf) may take several minutes to index.



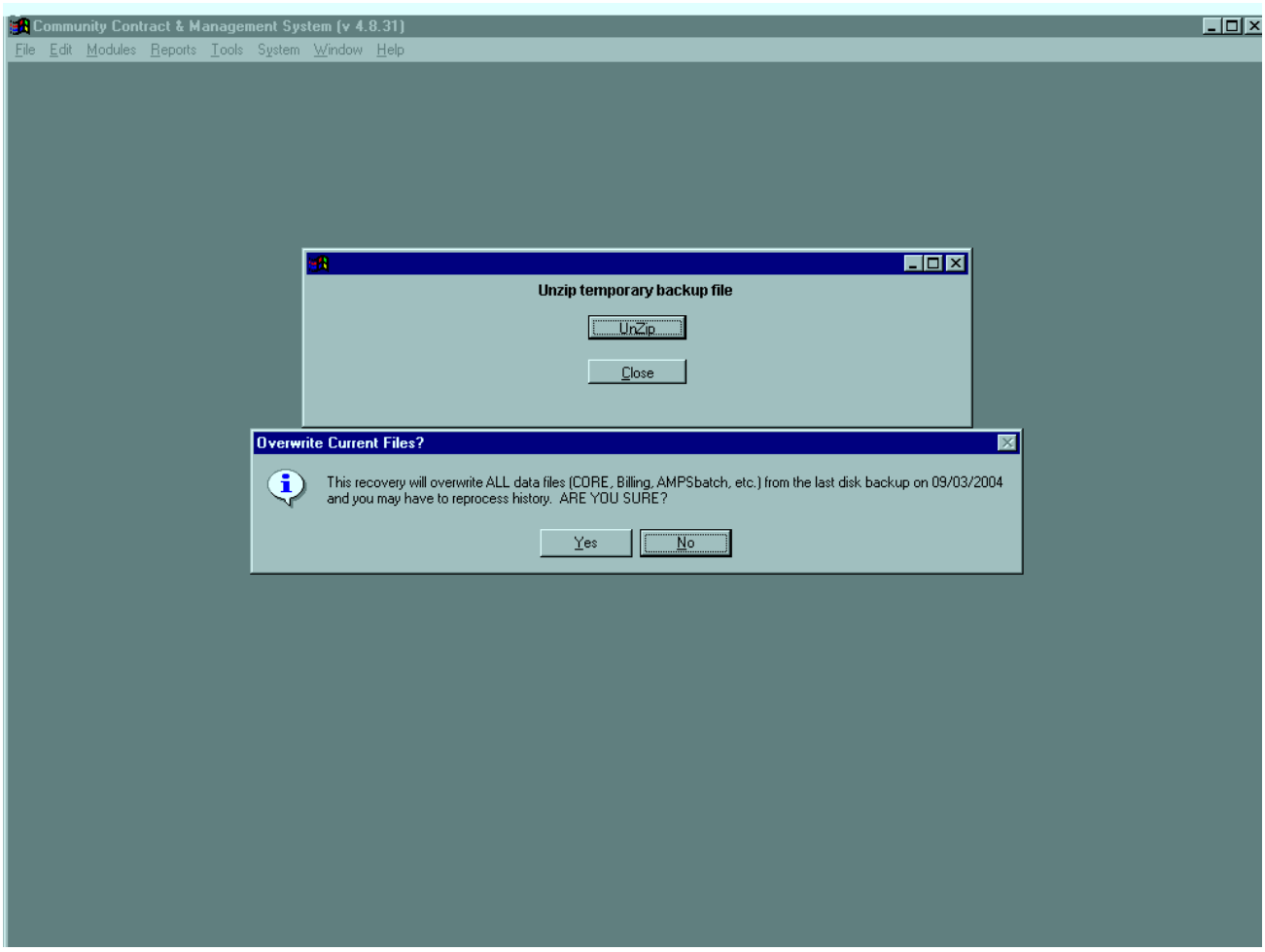

The **Backup Data Files** function is used to make a backup copy of your data files to a tempback subdirectory under the CCMS directory on the hard drive of your computer or on the file server if you are operating in a network environment. You reach this function by **selecting File Maintenance from the CCMS System drop down menu** and then **Backup Data Files** from the File Maintenance side menu**.**

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for System Functions, you will be able to backup files.

**This function requires that no other users be in CCMS.** The program will check to make sure that no other users are in the system in a network environment. If there are other users in the system, you will receive a notification and you will not be allowed to proceed.

This function will copy **ALL** of your database files, CORE, Billing, PAR and AMPS files. It is not possible to selectively back up files.

**This "temporary" backup is not meant to take the place of routine backups to tape or some other medium.** You may wish to perform this backup during the day when you have been making extensive entries into your data files and you want to ensure that you have a good copy of the files to recover from in case they are damaged by a power failure, power surge or other unusual occurrence. Temporary backups also occur under system control prior to critical functions such as posting billing files, creating AMPS Batch files, creating DDD Transmission files, etc.



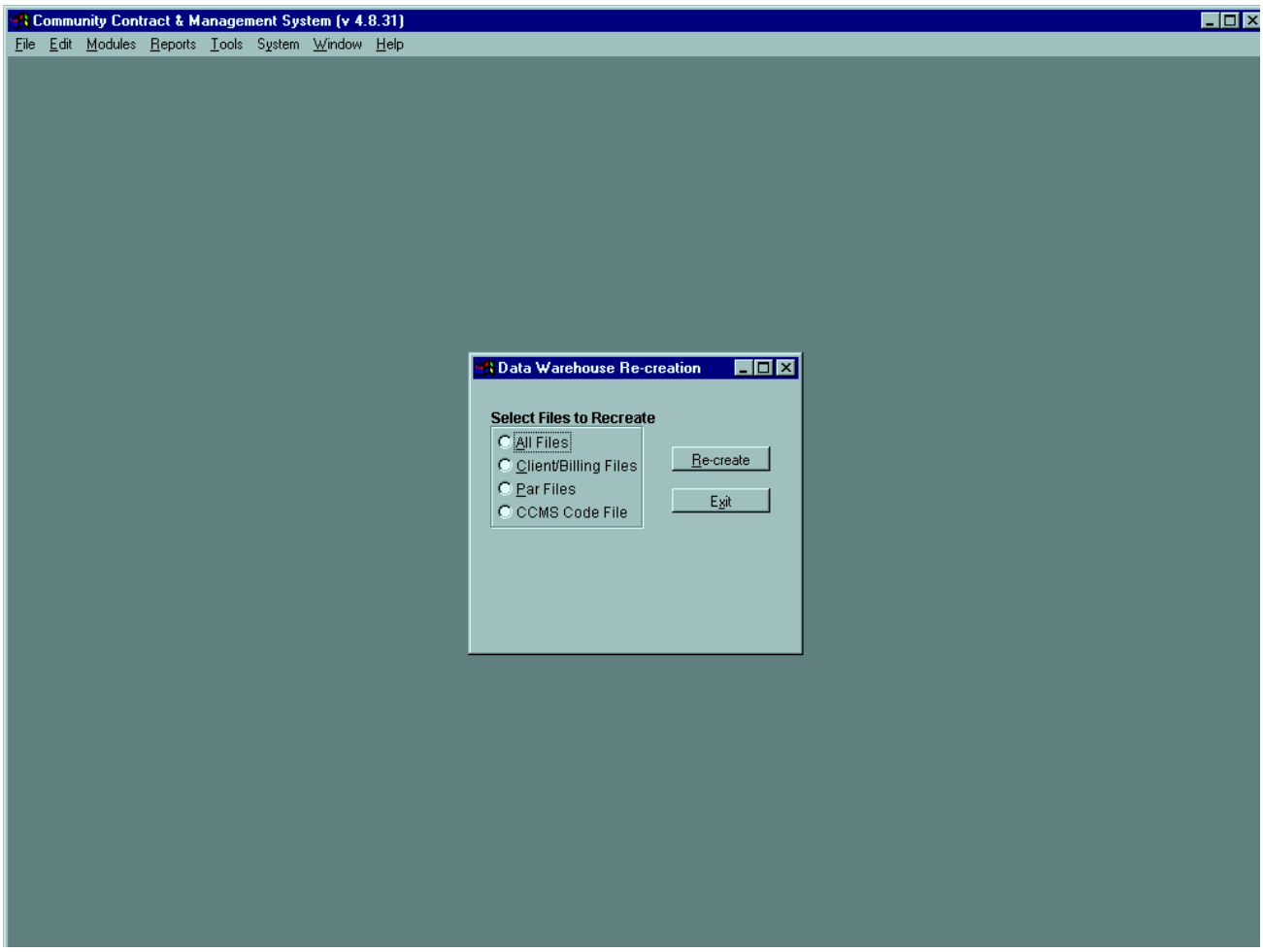

The **Recover Data Files** function is used to restore the files on the tempback subdirectory over the current working files. You reach this function by **selecting File Maintenance from the CCMS System drop down menu** and then **selecting Recover Data Files** from the File Maintenance side menu**.**

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for System Functions, you will be able to recover files.

**This function requires that no other users be in CCMS.** The program will check to make sure that no other users are in the system in a network environment. If there are other users in the system, you will receive a notification and you will not be allowed to proceed.

You will receive the **Confirm screen** as displayed above when you select this function. This function will recover **ALL** of your database files, CORE, Billing, PAR and AMPS files. It is not possible to selectively recover files. You need to make sure that the recovery is appropriate for all system users. If the CORE coordinator has made several updates to files in the Individual Module since the date of the last backup shown on the Confirm Screen, it would be inappropriate for the Billing coordinator to

recover files from the temporary backup completed prior to the last posting, because the recovery will overwrite the files that the CORE coordinator has updated as well as the billing files. **Click on the Yes button** with the mouse pointer to proceed with the recovery or on the **No button** to cancel and return to the menu.




The **Update Data Warehouse** function is used to update files used in printing reports under the previous Foxpro 2.6 version of CCMS. You reach this function by **selecting File Maintenance from the CCMS System drop down menu** and then **selecting Update Data Warehouse** from the File Maintenance side menu**.**

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for System Functions, you will be able to update the data warehouse.

The data warehouse is a set of Foxpro 2.6 version of CCMS data files. These files are needed to generate several different business reports that have not yet been converted to Crystal Reports versions. Until all business reports have been converted to the Crystal Reports software, the data warehouse must be used to generate the old reports.

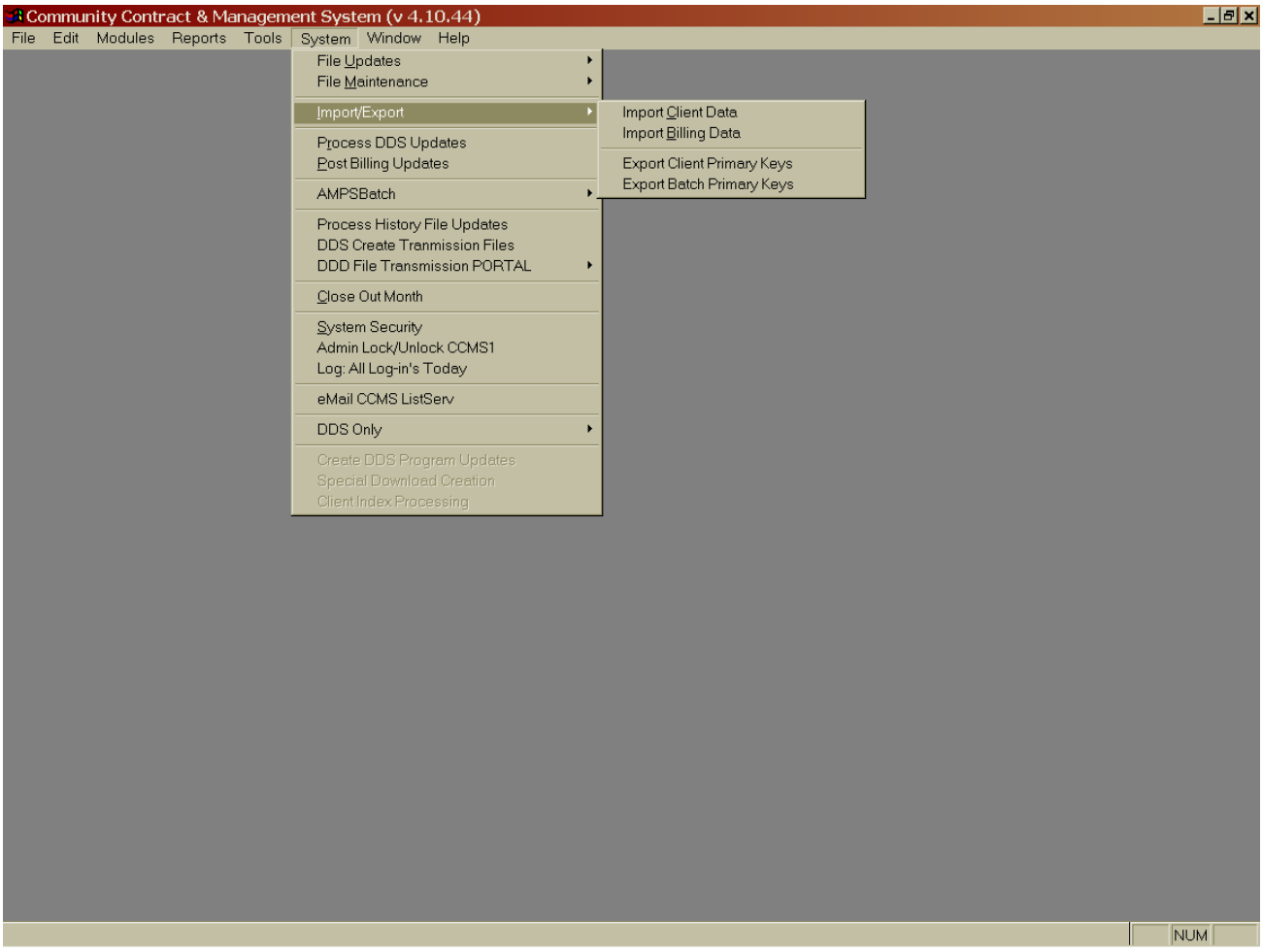
The data warehouse files are automatically updated during data entry and during several system level functions that take place during the month (e.g. close of month). If any of these functions get interrupted or do not complete properly, the data warehouse files will not reflect all of the current

data and reports will not print accurate data. Use the Data Warehouse Re-creation screen to update the data warehouse files manually.

**Check the box in front of All Files** to re-create the Foxpro 2.6 files for all CCMS files that require report printing in the old format. Check boxes are provided to only re-create some of the data files to reduce the time needed to re-create the complete data warehouse. **For example, if you only needed to print a PAR report, check the box in front of the PAR Files selection.**

Once all reports have been converted to Crystal Reports versions, this function will no longer be available.

IMPORT / EXPORT




The **Import/Export menu** is used to import demographic/billing information and export cross-reference primary keys to/from the CCMS tables. You reach the Import/Export menu by **selecting Import/Export from the CCMS System drop down menu**. Click on the Import/Export menu item with the mouse pointer to get a side menu that displays selections for the File Corrections menu. Your ability to select the Import/Export menu is determined by the security level that has been assigned to you. If you do not have security rights to the CCMS System menu, you will not be able to get to this menu choice.

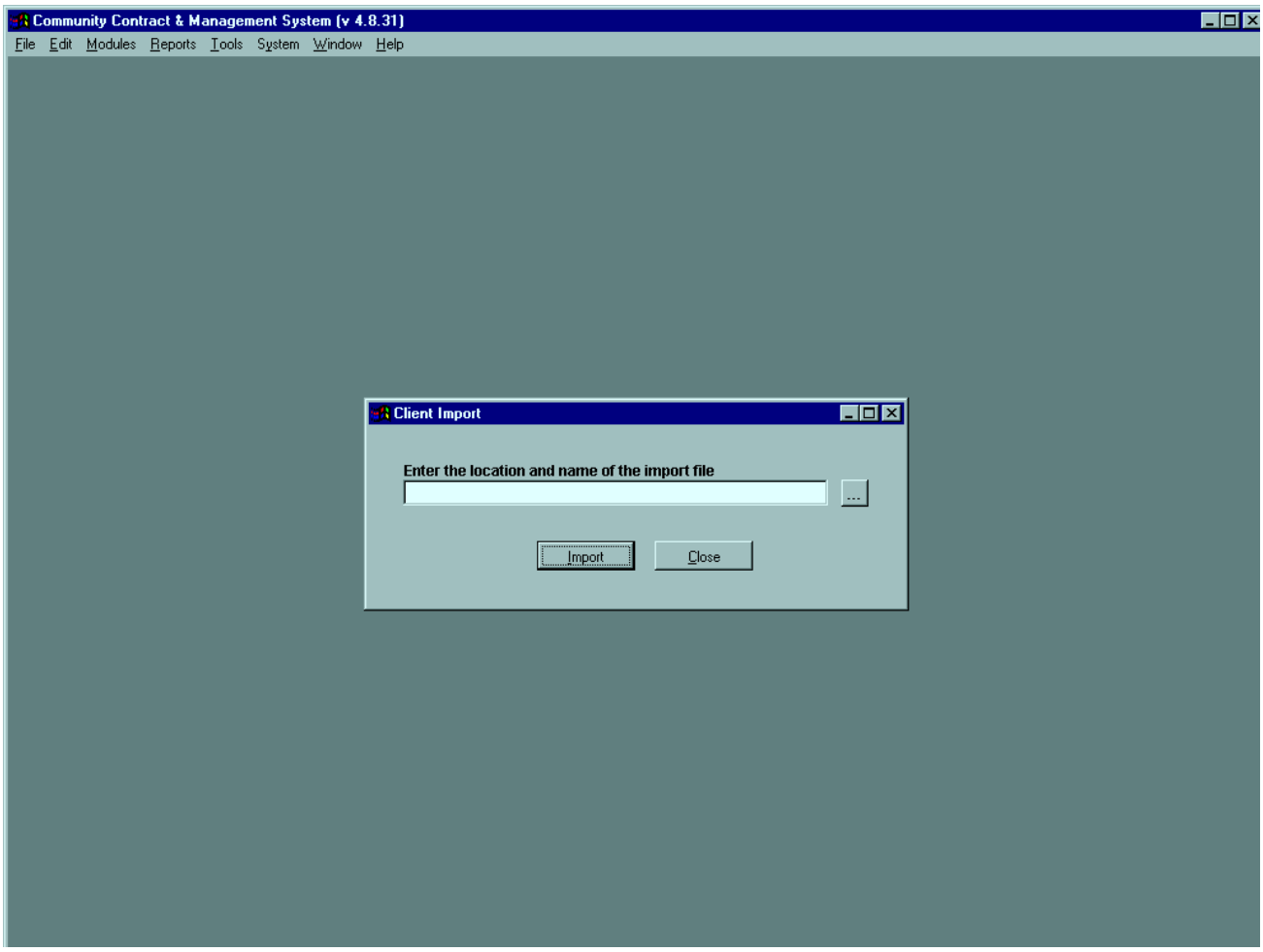
The **Import Client Data** menu choice allows you to import Client data provided by another system.

The **Import Billing Data** menu choice allows you to import Billing data provided by another system.

The **Export Client Data** menu choice exports keys for records in the Consumer files so another data system can match them for creating import data.

The **Export Billing Data** menu choice exports keys for records in the Billing files so another data system can match them for creating import data.

IMPORT CLIENT DATA:



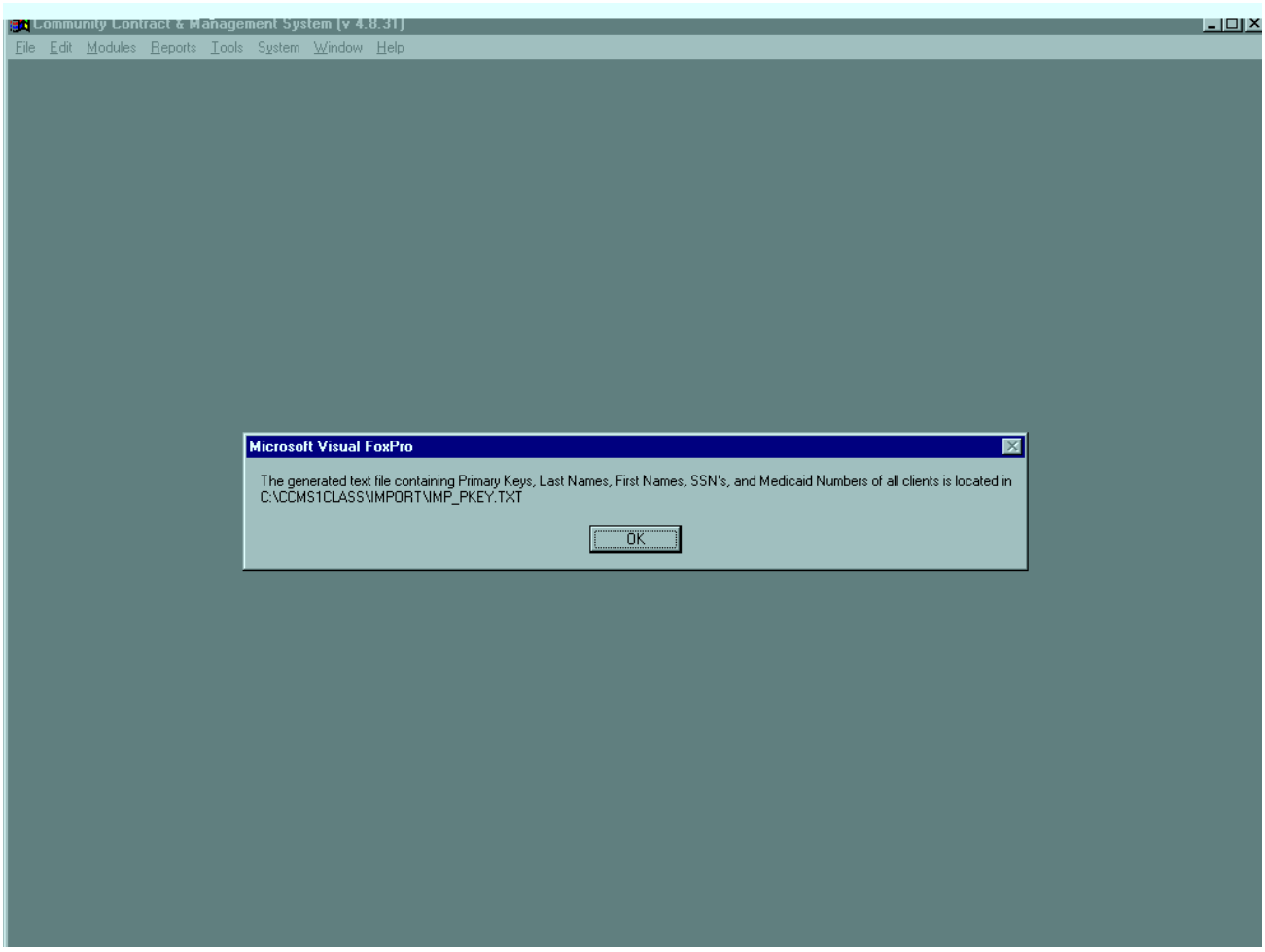

The **Import Client Data** function is used to import data from a text file in order to update the demographic data files in CCMS. You reach this function by **selecting File Maintenance from the CCMS System drop down menu** and then **selecting Import Client Data** from the File Maintenance side menu**.**

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for System Functions, you can import or export files.

The import function reduces the amount of duplicate entry your Agency must perform in order to synchronize the data in your own systems with the data in CCMS. Import functionality is provided for certain types of updates, for both the Consumer and Billing data.

For more information on Import/Export requirements and procedures see the Import - Export Specifications.pdf. This document contains the technical specifications and requirements for importing data into CCMS.

**As of October 1, 2004, this function has not yet been fully tested. Before you can use this function to import data, your Agency must submit sample data for testing and receive a vendor certification number. Contact the Help Desk to request the technical specifications and to request testing and certification.**




The **Export Client Data** function is used to export identifying information from CCMS to be used by another data system for the purposes of matching information to create an import file. You reach this function by **selecting File Maintenance from the CCMS System drop down menu** and then **selecting Export Client Primary Keys** from the File Maintenance side menu**.**

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for System Functions, you can import or export files.

This function can be used to test the ability of another software program to successfully match data to the CCMS data files prior to requesting certification to import data into CCMS. After a software program has been certified, use this function to integrate new CCMS identifying information into your Agency's data system.

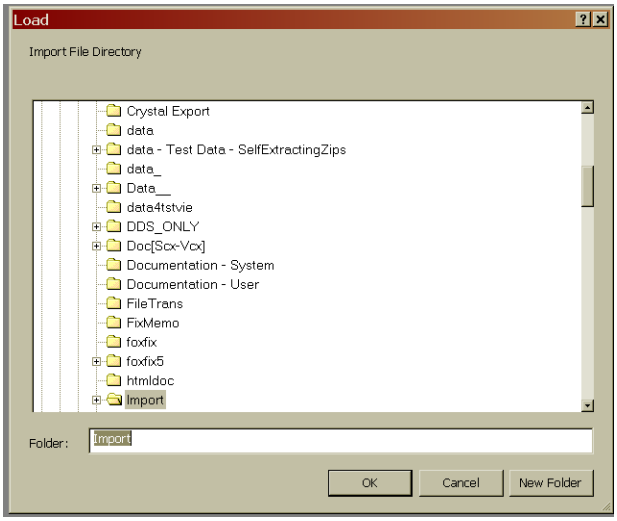
IMPORT BILLING DATA:

The **Import Billing Data** function is used to import data from a text file in order to update the Billing Transaction data files in CCMS. You reach this function by **selecting File Maintenance from the CCMS System drop down menu** and then **selecting Import Billing Data** from the File Maintenance side menu**.**

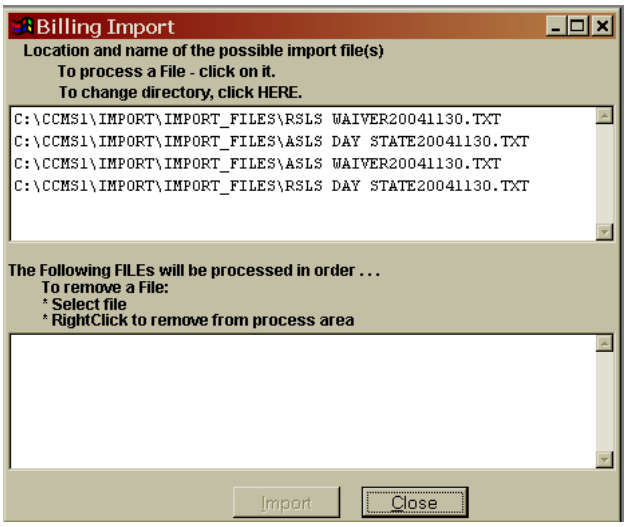
Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for System Functions, you can import or export files.

The import function reduces the amount of duplicate entry your Agency must perform in order to synchronize the data in your own systems with the data in CCMS. Import functionality is provided for certain types of updates, for both the Consumer and Billing data.

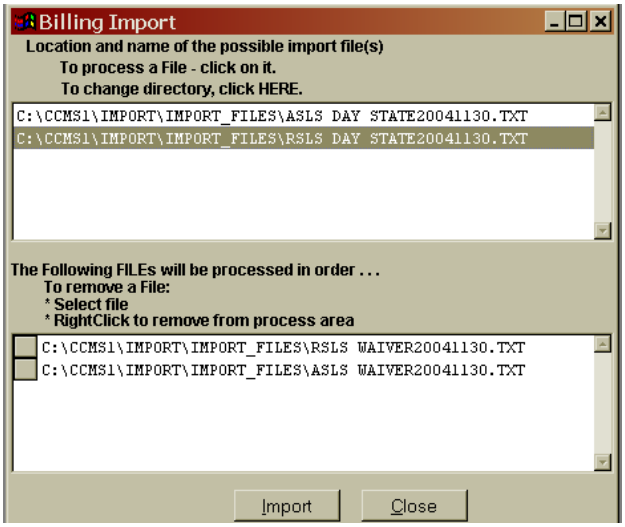
For more information on Import/Export requirements and procedures see the Import – Export Specifications.pdf. This document contains the technical specifications and requirements for importing data into CCMS.



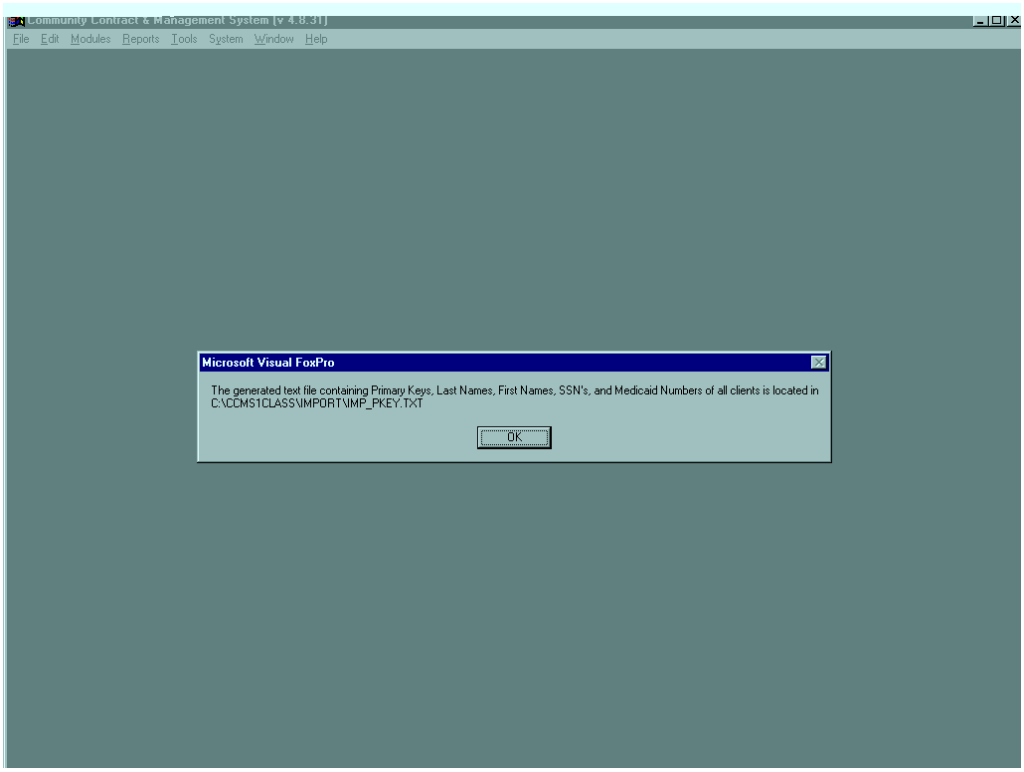

After starting the **Billing Import**, the user is presented with a directory selection choice screen. Find the directory where the billing import files are stored, highlight it, and then press ok. The **Billing Import** program will remember where the last selected *Import Directory* was and default to that directory the next time the **Billing Import** is selected.




After the directory is selected all files with the extension of TXT will be displayed



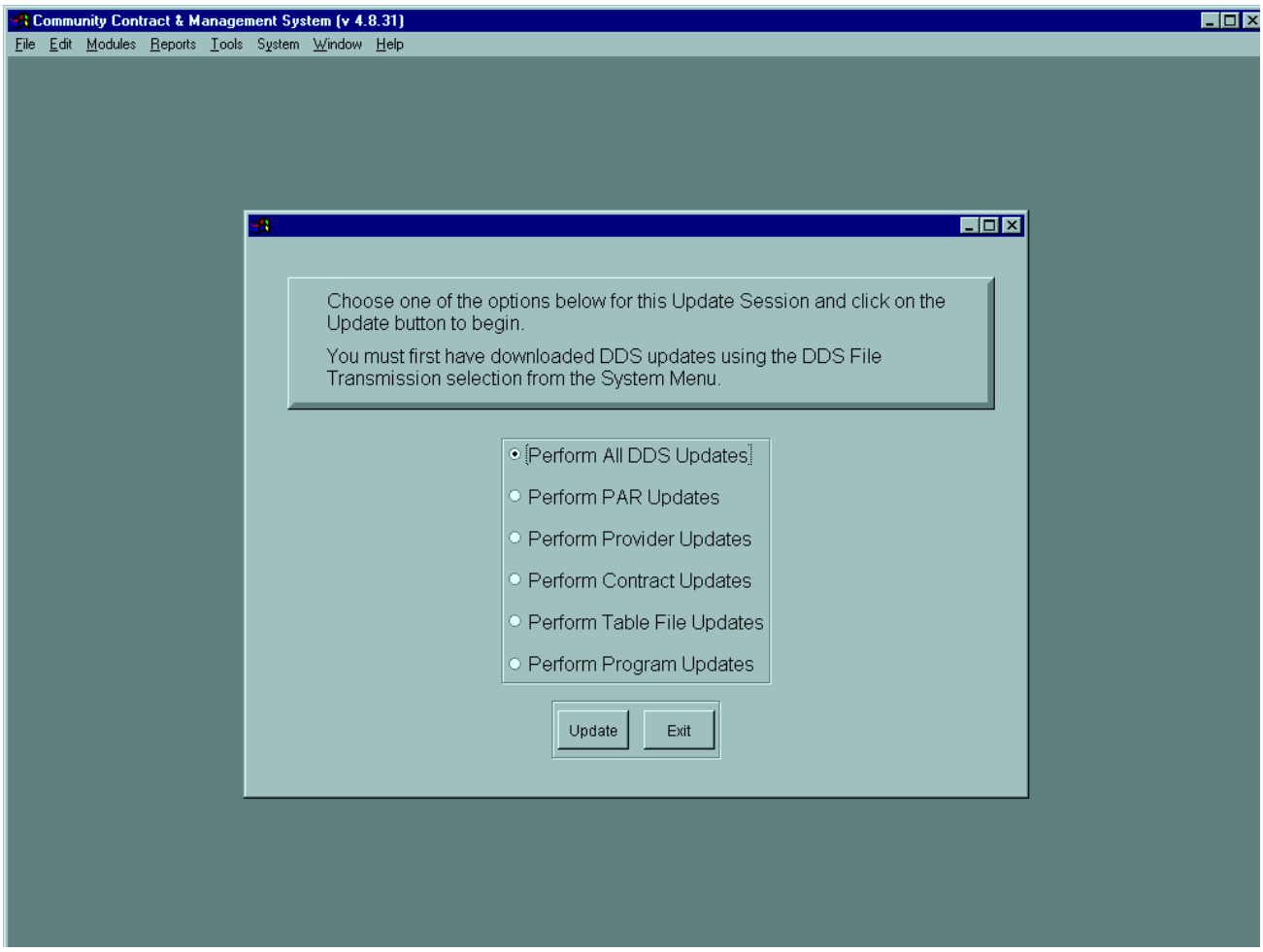

From this point, pressing the IMPORT button will cause the program to begin.
First, a validation process is preformed on all files selected to be imported, if this passes then…
Second, a temporary back will be preformed.
Third, the files will be imported and process messages will be shown to the user.




The **Export Batch Primary Data** function is used to export identifying information from CCMS to be used by another data system for the purposes of matching information to create an import file. You reach this function by **selecting File Maintenance from the CCMS System drop down menu** and then **selecting Export Batch Primary Keys** from the File Maintenance side menu**.**

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for System Functions, you will be import or export files.

This function can be used to test the ability of another software program to successfully match data to the CCMS data files prior to requesting certification to import data into CCMS. After a software program has been certified, use this function to integrate new CCMS identifying information into your Agency's data system.




The **DDD Update screen** is used by Agency sites to process updates received from DDD. You reach this screen by **selecting Process DDD Updates from the CCMS System drop down menu.**

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for the **second level** of System Functions, you will be able to process DDD updates.

**This function requires that no other users be in CCMS.** The program will check to make sure that no other users are in the system in a network environment. If there are other users in the system, you will receive a notification and you will not be allowed to proceed.

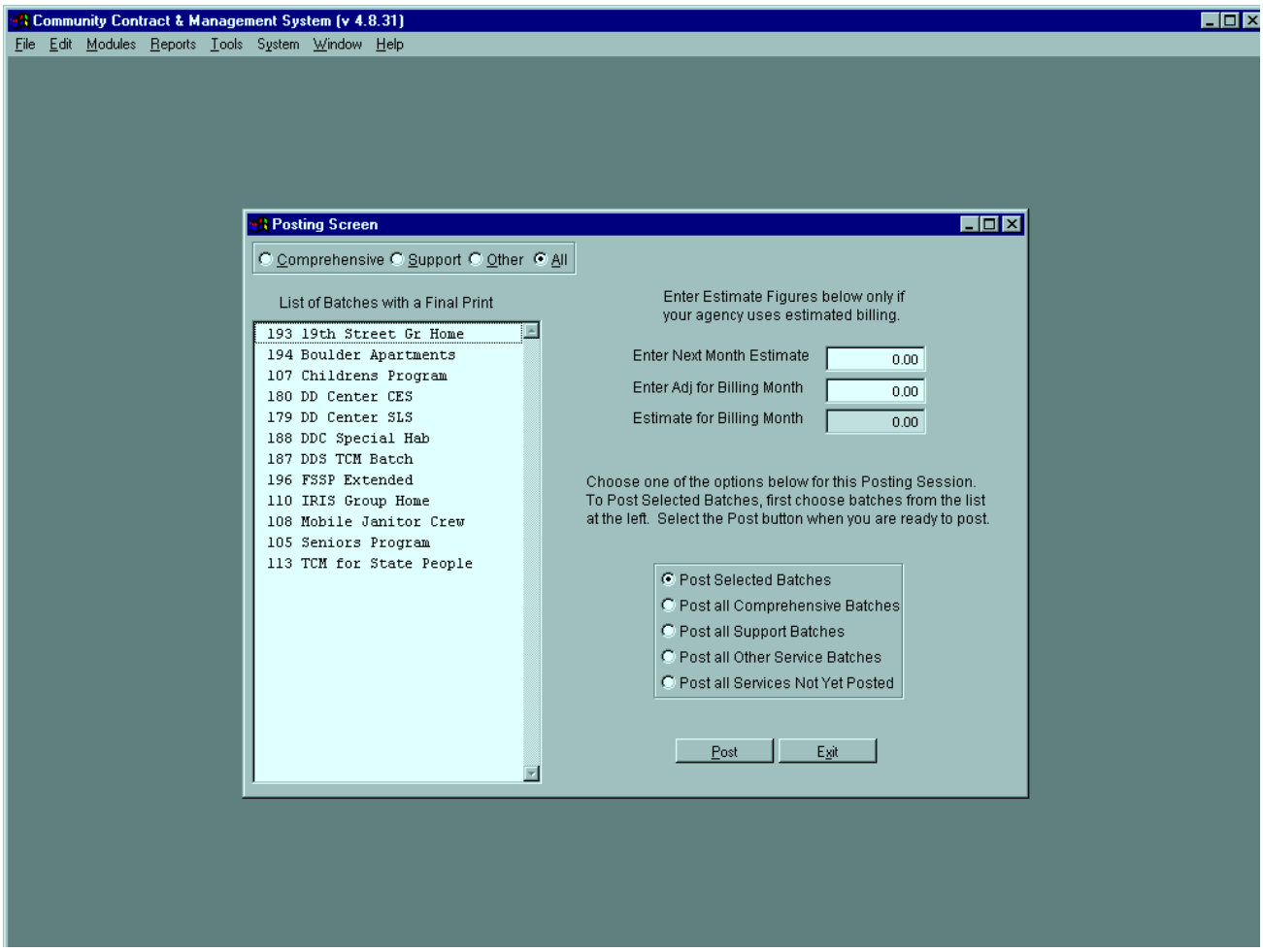
**You must first have downloaded your DDD updates before you can process them.** DDD updates are downloaded from the DDD File Transmission screen. If you attempt to process DDD updates for the current billing month without first having downloaded them, you will receive an error message that the updates are not for the current billing month, and will be unable to proceed.

**At a minimum each month, you will receive a PAR Update** from DDD. Provider Updates must be sent if new provider records have been added or updated for your Agency. Contract Updates will be sent if there has been a change or addition to your contract file or if there are DDD contract adjustment entries that must be posted to your contract records to correct year-to-date fields that are in error. Table File and Program updates will be sent by DDD as needed to perform corrections, changes or enhancements to the system.

**Generally you should perform all updates at one time**. When you first enter this screen, **the radio button next to Perform ALL DDD Updates is highlighted**. When you process all DDD updates and there are no Provider Updates or Contract Updates, you will be provided with a warning message and asked to confirm that you wish to continue with processing all other updates during the Update process. This message will alert you to the absence of those updates, so if you were expecting Provider or Contract changes, you need to check with DDD to determine why they were not sent. If a special PAR, Provider, etc. update has been created for your Agency sometime during the month, you would just perform that update individually. To select to perform updates individually, click with the mouse pointer on the radio button in front of the update you wish to perform.

**Press the Update button to process the updates**. The system will first perform a temporary backup of the files. This ensures that files can be recovered as they were just prior to the updates if you lose power during the updates or if any errors occur during the program execution.

Select **Exit to exit this screen** after the updates have completed processing.




The **Posting screen** is used to post billing transactions to year-to-date fields and to post special monthly billed contracts with the amount to be billed for the billing month. You reach this screen by **selecting Post Billing Files from the CCMS System drop down menu.**

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for the **second level** of System Functions, you will be able to post billing entries.

**This function requires that no other users be in CCMS.** The program will check to make sure that no other users are in the system in a network environment. If there are other users in the system, you will receive a notification and you will not be allowed to proceed.

The Posting screen allows you to post batches of billing transactions individually, select a service to post in its entirety (Comprehensive, Supported Living or Other) or select to post all services at once. When you first enter this screen, **the radio button next to the Post Selected Batches is highlighted**. When you post only selected batches, only a partial posting is taking place for the service types within which the selected batches fall. **If you select to post a service completely, all**

**batches within that service type are posted as well as any specially billed contract records within that service type.** For example, the Family Support Services Program contract is a monthly billed contract which posts 1/12th of the contract amount each month for payment. When you post all of Supported Living Services, this contract will also be posted to reflect the amount due for the current month based on 1/12th of the contract amount.

The list of batches on the left side of the screen are the batches that have had a **Final Print** and are ready to post. **If a batch does not show up in the list, you will have to exit this screen and go to the Batch Report screen to perform the final print first before it can be posted.**

Select from the list to post individual batches. **Press the Shift key** and arrow down from the top to select all batches in the list. **Press the Control key** and click on individual batches to select individual batches in the list. The list is disabled and you cannot select from it if you have chosen one of the radio buttons for posting a service type or to post all services.

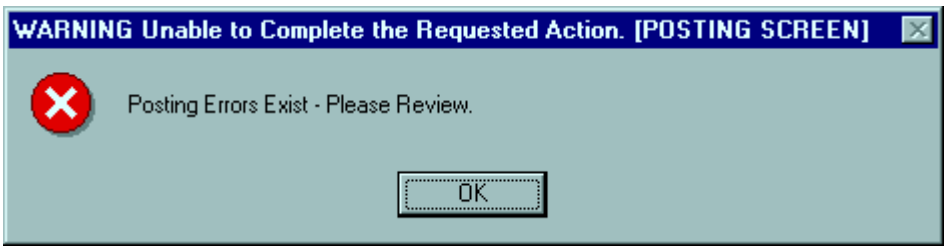
Once you have made all of your selections on this screen, **press the Post button to proceed with posting**.

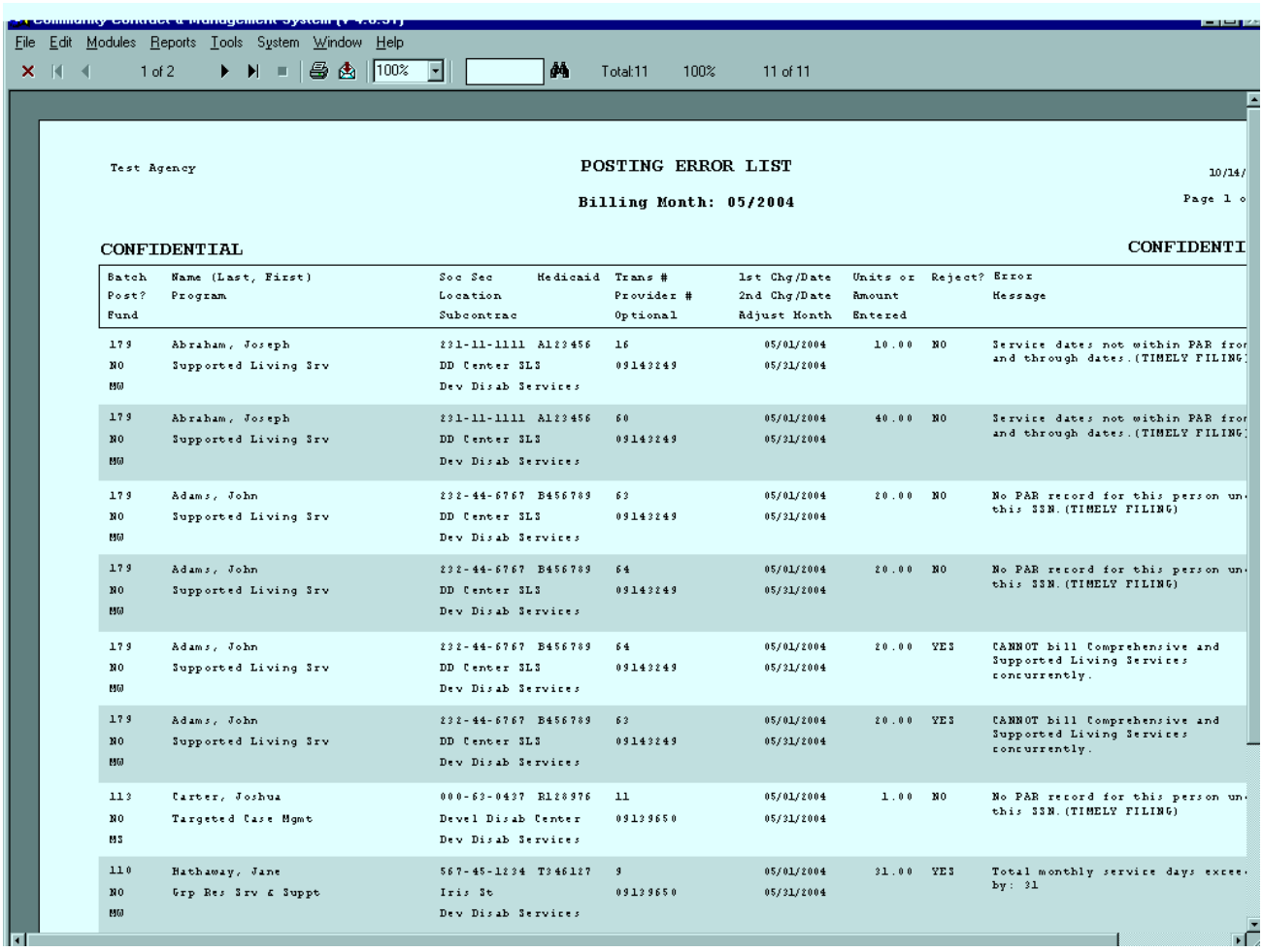
When you press the Post button and posting proceeds, the system will first perform a temporary backup of the files. This ensures that files can be recovered as they were just prior to the posting if you lose power during posting, if any errors occur during the program execution or if you decide that you need to recover to correct errors and make additional entries. There are several steps involved in posting. As each posting process occurs, a message will be displayed on the screen telling you what is occurring. **When posting is completed, you will receive a message telling you posting has completed successfully.**

This screen is also used to enter estimates for State Funded Services. If your Agency uses the Estimated billing method, you must enter the estimate each month on this screen in order for the figures to print on the Summary bills. **Use the Enter Estimate for Next Month field** to enter your estimated billing. If your estimate on the last billing was adjusted by DDD, use the **Enter Adjustment for Billing Month field** to enter the adjustment that was made, either positive or negative. The **Estimate for Billing Month field** will be displayed for your information and cannot be updated. It is the estimate figure you entered in the previous month. You may enter estimate figures on this screen without selecting any batches to post and you may change them as often as you like, up until the files have been transmitted to DDD. If you change the figures after printing your Summary bills, remember to reprint the bills. When you select the **Exit button** the entries will be saved.

When you select the **Post** button and begin the posting process, the system will perform several edits to check for errors such as lack of prior authorization, billing beyond allowable monthly units, cross over or duplication of service, etc. If there are errors in the billing transactions being posted, you will receive a message notifying you that there are errors and requiring a review of those errors. A report will be displayed on the screen for you to review (and print if desired). See the **WARNING message**

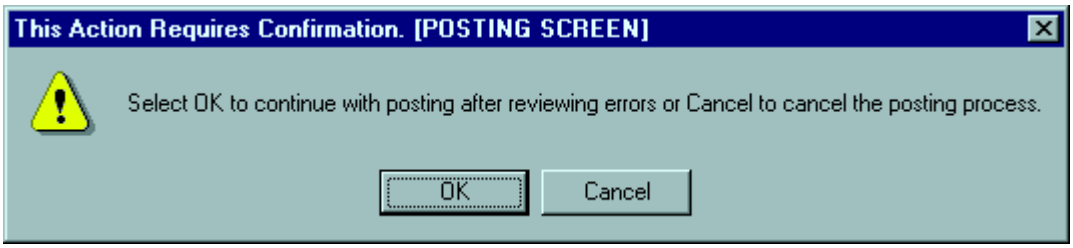
**and Posting Error List report** below. If the Reject? column on the report displays 'Yes', it means that the error is serious enough to cause rejection of the transaction in error if posting continues.



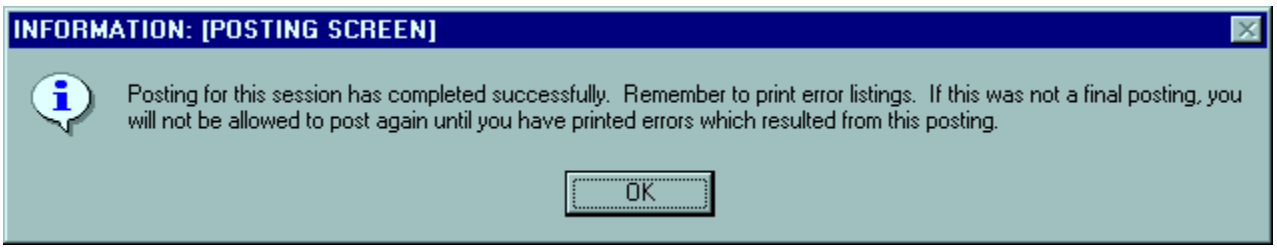

| Batch Post? Fund | Name (Last, First) Program | Soc Sec Location Subcontrac | Medicaid | Trans # Provider # Optional | 1st Chg/Date 2nd Chg/Date Adjust Month | Units or Amount Entered | Reject? | Error Message |
|---|---|---|---|---|---|---|---|---|
| 179 NO MW | Abraham, Joseph Supported Living Srv | 231-11-1111 DD Center SLS Dev Disab Services | Al23456 | 16 09143249 | 05/01/2004 05/31/2004 | 10.00 | NO | Service dates not within PAR fro and through dates.(TIMELY FILING) |
| 179 NO MW | Abraham, Joseph Supported Living Srv | 231-11-1111 DD Center SLS Dev Disab Services | Al23456 | 60 09143249 | 05/01/2004 05/31/2004 | 40.00 | NO | Service dates not within PAR fro and through dates.(TIMELY FILING) |
| 179 NO MW | Adams, John Supported Living Srv | 232-44-6767 DD Center SLS Dev Disab Services | B456789 | 63 09143249 | 05/01/2004 05/31/2004 | 20.00 | NO | No PAR record for this person un this SSN.(TIMELY FILING) |
| 179 NO MW | Adams, John Supported Living Srv | 232-44-6767 DD Center SLS Dev Disab Services | B456789 | 64 09143249 | 05/01/2004 05/31/2004 | 20.00 | NO | No PAR record for this person un this SSN.(TIMELY FILING) |
| 179 NO MW | Adams, John Supported Living Srv | 232-44-6767 DD Center SLS Dev Disab Services | B456789 | 64 09143249 | 05/01/2004 05/31/2004 | 20.00 | YES | CANNOT bill Comprehensive and Supported Living Services concurrently. |
| 179 NO MW | Adams, John Supported Living Srv | 232-44-6767 DD Center SLS Dev Disab Services | B456789 | 63 09143249 | 05/01/2004 05/31/2004 | 20.00 | YES | CANNOT bill Comprehensive and Supported Living Services concurrently. |
| 113 NO MS | Carter, Joshua Targeted Case Mgmt | 000-63-0437 Devel Disab Center Dev Disab Services | Rl28976 | 11 09139650 | 05/01/2004 05/31/2004 | 1.00 | NO | No PAR record for this person un this SSN.(TIMELY FILING) |
| 110 NO MW | Hathaway, Jane Grp Res Srv & Suppt | 567-45-1234 Iris St Dev Disab Services | T346127 | 9 09139650 | 05/01/2004 05/31/2004 | 31.00 | YES | Total monthly service days excee by: 31 |

After you have reviewed the errors, close the Posting Error List report to return to the Posting screen and the Confirmation message below will be displayed. **Select OK to continue the posting process or to select Cancel to cancel this posting session.**

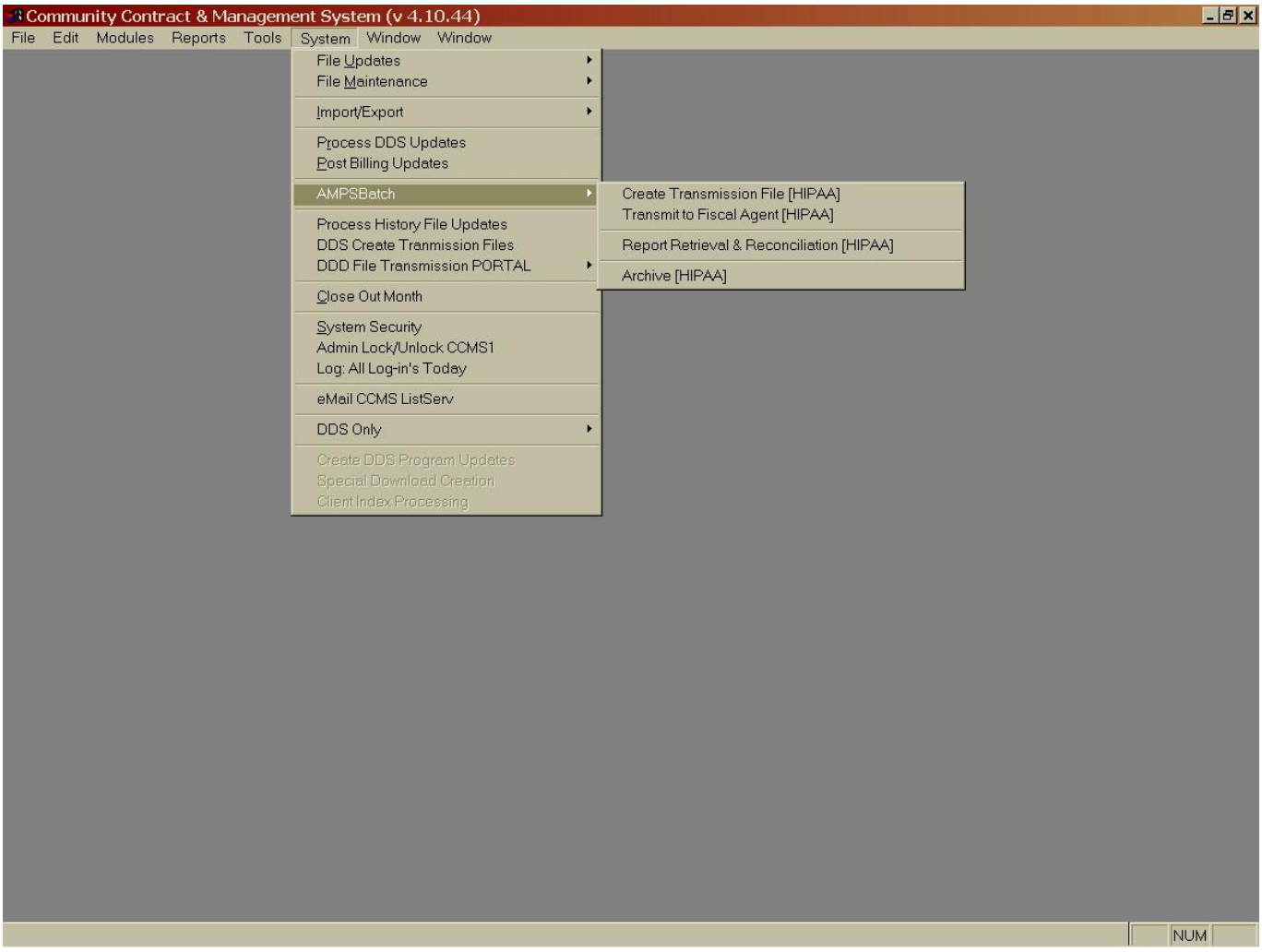



You may cancel the session, go to the appropriate batches to correct any errors that can be corrected, print the updated batches and then return to the Posting screen to post again. However, many errors cannot be corrected during the current billing cycle; for example if action is required from a case manager in order to update prior authorization files. Errors that cannot be corrected immediately will cause rejection of the transaction in error. **However, do not delete transactions just because they will reject at posting. The rejections on the posting error list will serve as your reminder that you must re-enter the transaction the following and will also track the actual service provision information for analysis by DDD staff.**

You may post multiple times during a billing month, depending on how you schedule entry of your billing data. A final posting must be done by selecting the radio button next to **Post all Services Not Yet Posted,** when you are ready to close out data entry for the billing month. At the end of the posting process, the reminder message below will be displayed to remind you that posting errors must be printed after each posting session.




Select **Exit to exit this screen** after the posting has completed processing.



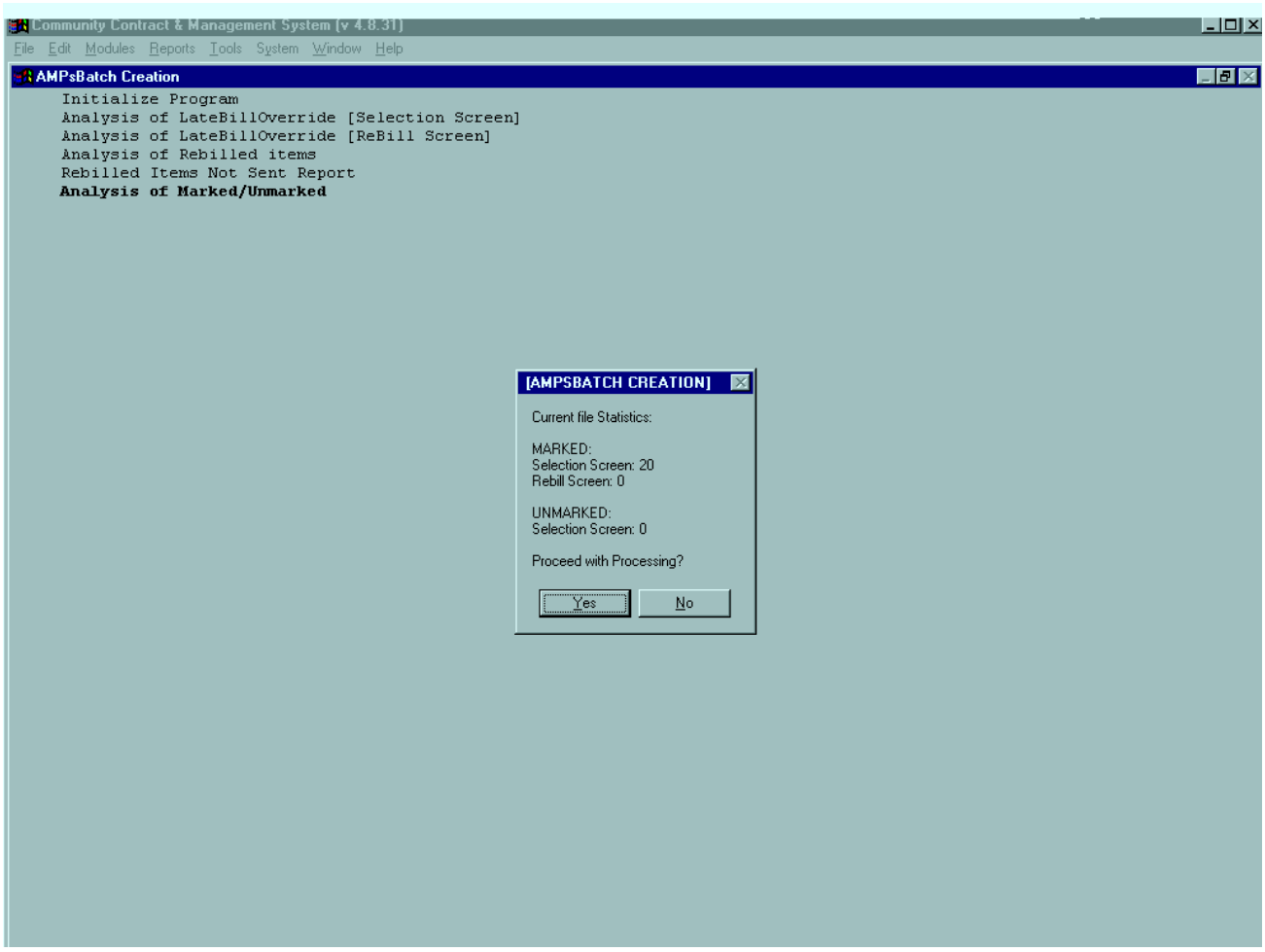

The **AMPSBatch menu** is used to perform several types of AMPSBatch functions relating to Medicaid claim creation and transmission. You reach the AMPSBatch menu by **selecting AMPSBatch from the CCMS System drop down menu**. Click on the AMPSBatch menu item with the mouse pointer to get a side menu that displays selections for the AMPSBatch menu. Your ability to select the AMPSBatch menu is determined by the security level that has been assigned to you. If you do not have the **second level** of security rights to AMPSBatch functions, you will not be able to select any items from the AMPSBatch menu.

The **Create Transmission File** menu choice allows you to create Medicaid batch files to be sent to the Medicaid Fiscal Agent in the proper format for Medicaid claim processing.

The **Transmit to Fiscal Agent** menu choice allows you to transmit the Medicaid claim batch files created from the Create Transmission File process.

The **Report Retrieval and Reconciliation** menu takes you to a screen where you perform processes to get reports from the Fiscal Agent or reconcile those reports to the CCMS data files.

The **Archive** menu choice takes you to a screen where you select Medicaid claim batch files to archive.



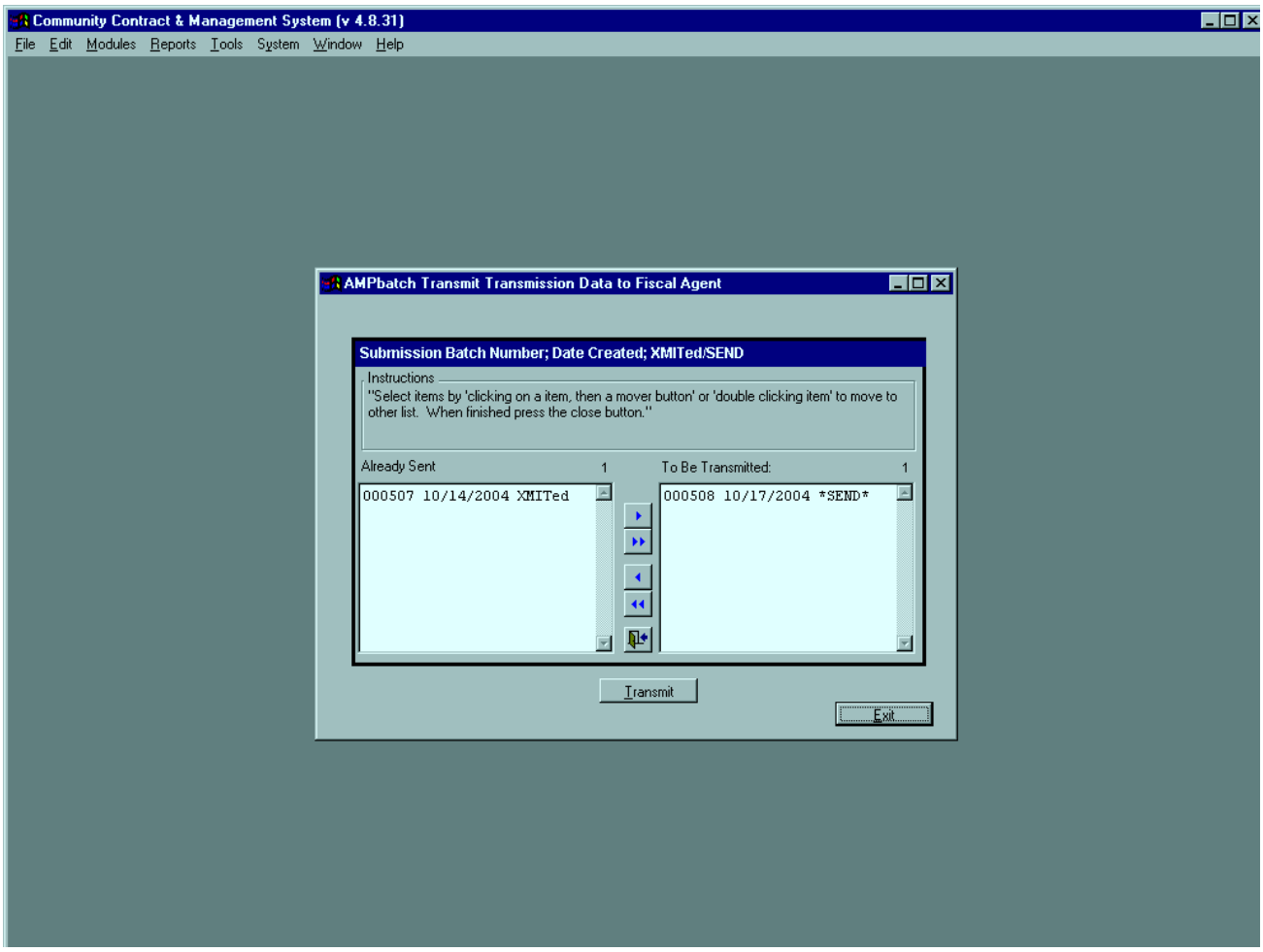

The **AMPSBatch Creation screen** is used to create Medicaid claim batch files (AMPSBatch submission files) that will be sent to the Medicaid Fiscal Agent. You reach this screen by **selecting AMPSBatch from the CCMS System drop down menu** and then **Create Transmission File** from the AMPSBatch side menu.

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for the **second level** of AMPSBatch Functions, you will be able to create AMPSBatch Transmission files.

**Before you may create an AMPSBatch transmission file, you must have posted some Medicaid services for the billing month (or marked previously posted and billed claims to be rebilled).** When you post billing transactions, the posting program creates an interim file of posted Medicaid transactions and marks them for AMPSBatch processing. You can unmark transactions for AMPSBatch processing on the AMPSBatch Selection screen. **Any transactions that have been marked for AMPSBatch processing will be entered into the AMPSBatch transmission file created during this session.** If there are any transactions which are past the timely filing deadline as of the current date, and you have not entered a late billing override date on the transaction, the system

will give you a warning message and will not proceed. You must go to the AMPSBatch Selection or Rebill screen to enter the late billing override date on the transaction(s) before you may return to the AMPSBatch transmission function to produce a transmission file. (Refer to the instructions in Section VI for the Selection screen and the Rebill screen for further information.)

Several steps are involved in creation of transmission files. As each process occurs, a message will be displayed on the screen telling you what is occurring**. When creation of the transmission file is completed, a report will be printed which contains statistical information about the batch that was created.** Keep these reports and file them. If there is a problem with a batch that was created, the report will be useful in determining what happened to cause the problem.



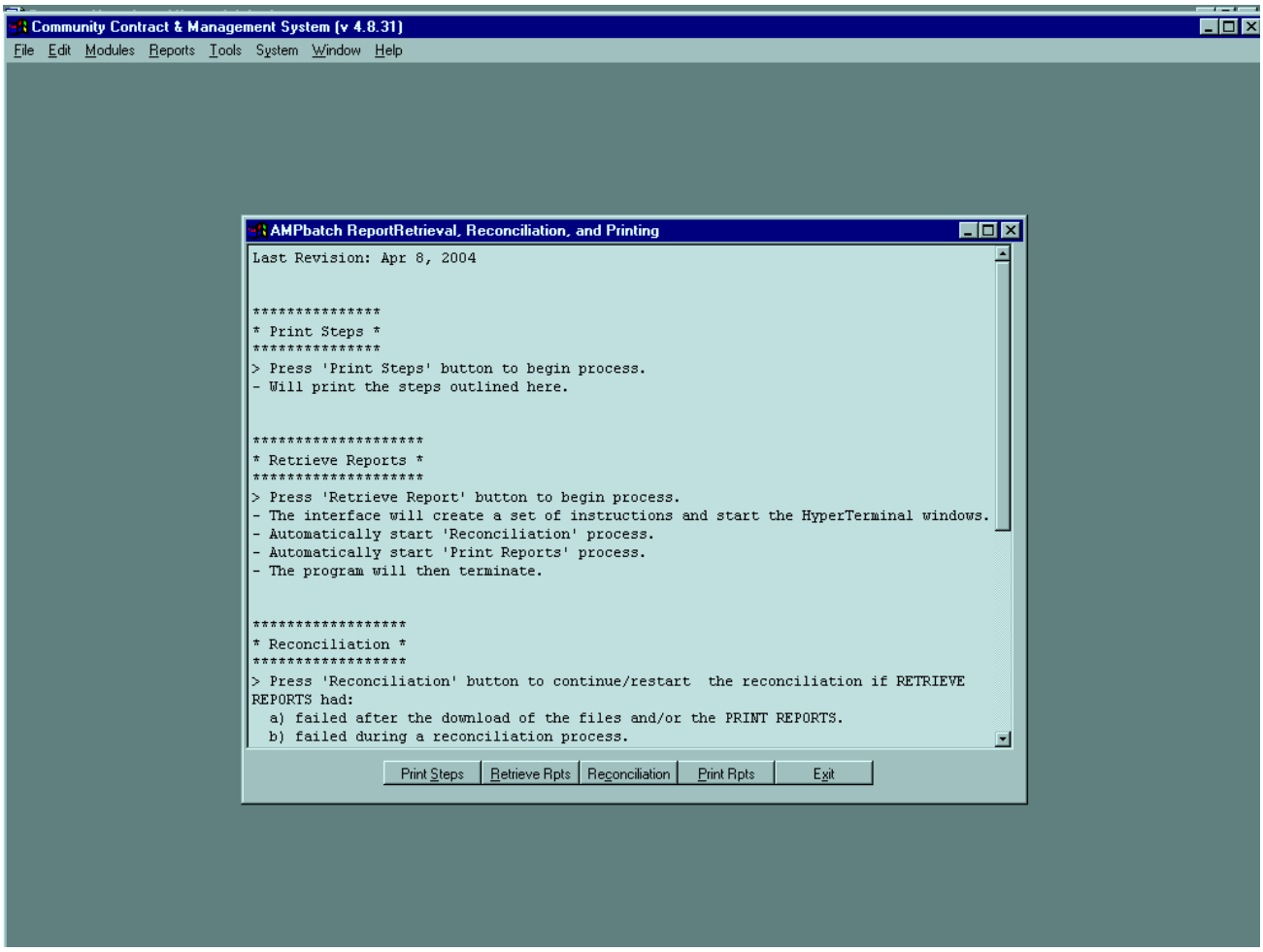

The **AMPSBatch Transmit Data to Fiscal Agent screen** is used to transmit the Medicaid claim batch files to the Medicaid Fiscal Agent. You reach this screen by **selecting AMPSBatch from the CCMS System drop down menu** and then **Transmit to Fiscal Agent** from the AMPSBatch side menu.

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for the **second level** of AMPSBatch Functions, you will be able to create AMPSBatch Transmission files.

Before you can transmit any files, you must have created them by selecting the Create Transmission file menu choice from the AMPSBatch menu. Any AMPSBatch submission files that have not yet been transmitted will be displayed on the right side of the AMPSBatch Transmit Data to Fiscal Agent screen under the **To Be Transmitted column** with a status of ***Send***. Those files previously transmitted will appear on the left side of the screen under the **Already Sent column** with a status of ***XMITed*.**

Files under the **Already Sent column** can be re-transmitted if necessary. You may need to re-transmit files if you are notified by the Medicaid Fiscal Agent that a batch file was unreadable or if there was an interruption in the previous transmission process before the file could be transmitted successfully. Use the arrows in the middle of the screen to move transmission files from the Already Sent column to the To Be Transmitted column as needed. **Do not re-transmit files that were received and processed by the Medicaid Fiscal Agent successfully.** If you do, already paid claims will be denied as duplicates.

**Press the Transmit button** to send the batches listed under the **To Be Transmitted column**. Actual transmission of the file will be completed using the current authorized communication software program. This software changes based on requirements of the CCMS system and the Medicaid Fiscal Agent. Contact the Help Desk for further instructions.




The **AMPSBatch Report Retrieval, Reconciliation and Printing screen** is used to retrieve, print and reconcile reports from the Medicaid Fiscal Agent. You reach this screen by **selecting AMPSBatch from the CCMS System drop down menu** and then **Report Retrieval and Reconciliation** from the AMPSBatch side menu.

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for the **second level** of AMPSBatch Functions, you will be able to retrieve and reconcile the Medicaid Fiscal Agent report files.

Before you can retrieve any reports, you must have transmitted files to the Medicaid Fiscal Agent. The reports you retrieve will include Medicaid Management Information System (MMIS) **Acceptance/Rejection Reports and Provider Payment Reports**. Acceptance/Rejection Reports notify you which claims were accepted for actual processing in the MMIS. Those claims that were rejected will not be processed for payment or denial in the MMIS and will need to be re-billed once the problem that caused the rejection is resolved. Acceptance/Rejection Reports should be available within 24 hours of the file transmission, although they may be ready much earlier depending upon what time of day you transmitted the files. Provider Payment Reports will be available on the

Monday following the weekend processing cycle that formally adjudicated the claims for payment or denial.

The MMIS reports must be downloaded to your Agency before they can be accessed by CCMS for reconciliation. After downloading reports, the system will a) automatically proceed into the reconciliation process and reconcile the information in the MMIS files against the claims that were submitted by CCMS; b) automatically pop open the WINDOWS EXPLORER window containing a listing of the MMIS downloaded reports. You will need to load these report files into your word processing software to view and print them.

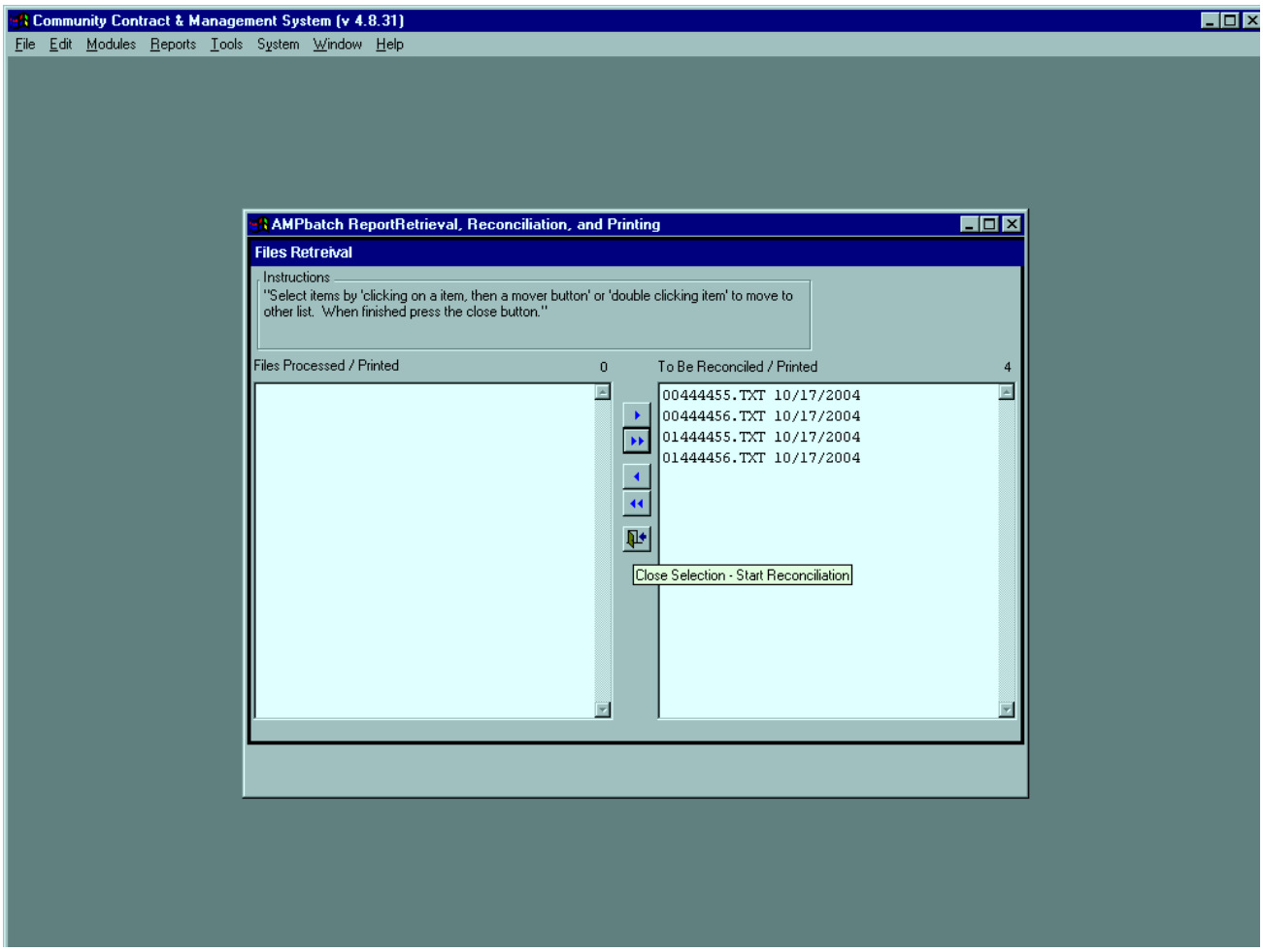
Press the **Print Steps button** to get a listing of the steps to follow to Retrieve, Reconcile and Print MMIS reports.

Press the **Retrieve Rpts button** to get new MMIS reports. Actual retrieval of the reports will be completed using the current authorized communication software program. This software changes based on requirements of the CCMS system and the Medicaid Fiscal Agent. Contact the Help Desk for further instructions.

Press the **Reconciliation button** to reconcile the MMIS reports that have been retrieved against the AMPSBatch claim records that were created. This process will update the claim records with the current status (accepted, rejected, denied, paid, etc.). If the reconciliation process does not take place automatically when MMIS reports are downloaded, **you must start the reconciliation process by pressing this button.**

Press the **Print Rpts button** to display a list of the MMIS reports that have been retrieved and are ready to be printed.

***Note***: A Microsoft Word Visual Basic Macro has been created by DDD to assist users of Microsoft Word in printing MMIS reports. Refer to the information in the printed report after selecting the **Print Steps** button.




The **Reconciliation list** is displayed when you press the Reconciliation button from the AMPSBatch Report Retrieval, Reconciliation and Printing screen. Reports will need to be reconciled if you did not continue with the reconciliation process at the last MMIS report retrieval or if there was an interruption of the reconciliation process.

Any MMIS reports that have not yet been reconciled and printed will be displayed on the right side of the screen under the column **To Be Reconciled / Printed column**. Those MMIS reports previously reconciled will appear on the left side of the screen under the **Files Processed / Printed column**.

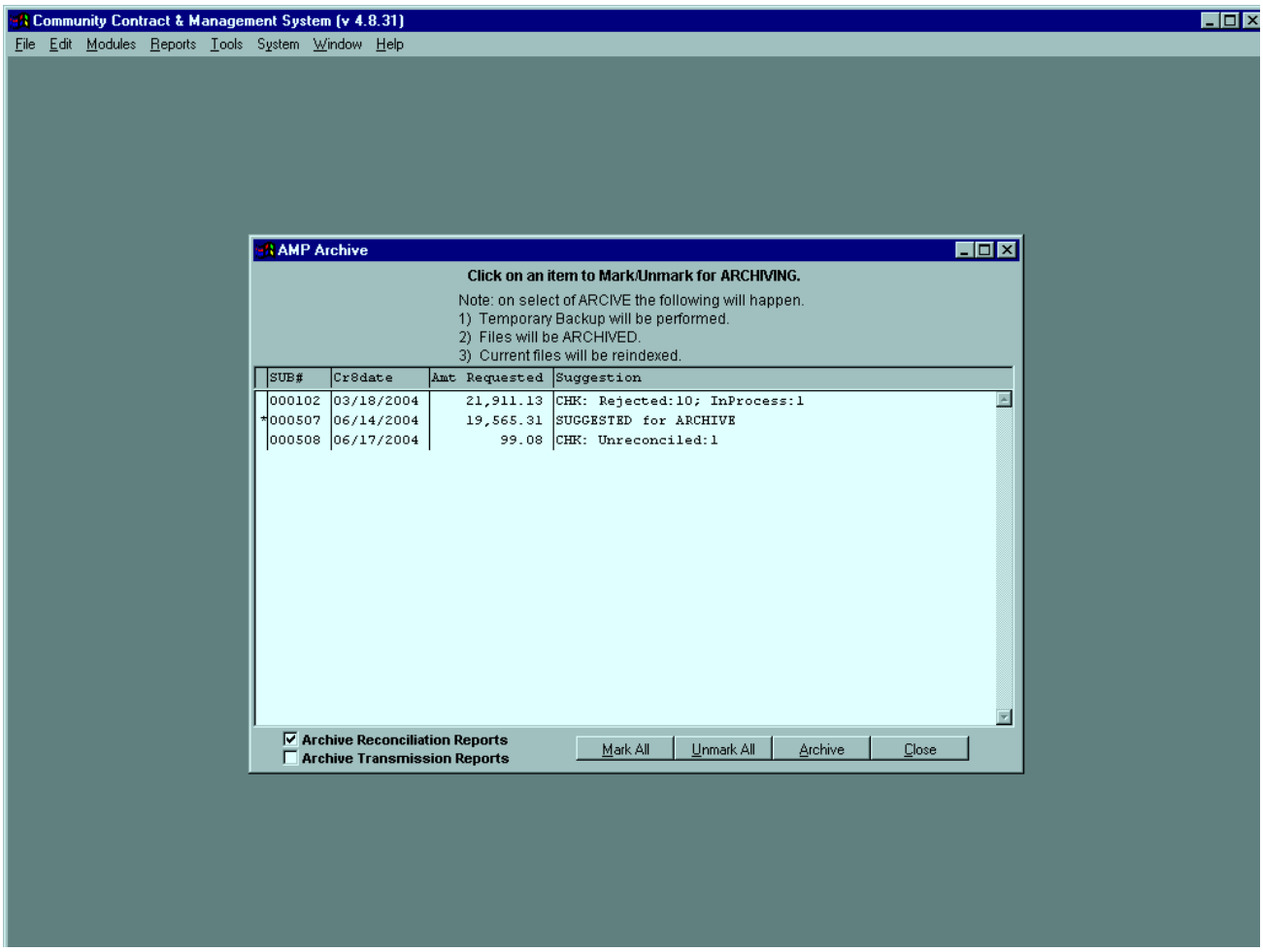
Files under the **Files Processed / Printed column** can be reconciled again if necessary. You may need to reconcile files again if there was an interruption in the previous reconciliation process. Use the arrows in the middle of the screen to move MMIS report files from the Files Processed / Printed Column to the To Be Reconciled / Printed column.

**Press the button at the bottom of the selection arrows in the middle of the screen** to begin the reconciliation process. The system will attempt to reconcile all of the MMIS reports in the To Be Reconciled column against the AMPSBatch claims that were created

**MMIS Accepted/Rejected reports will be reconciled against AMPSBatch claim records to mark them as accepted or rejected. MMIS Provider Payment reports will be reconciled against AMPSBatch claim records to mark them as paid or denied.** The reconciliation process will assist you to identify which claims need to be rebilled in the AMPSBatch ReBill screen (refer to Section VI for an explanation of the AMPSBatch ReBill screen).

If you do not perform the reconciliation process for each report, the system will not be able to automatically identify the claims that were rejected or denied. **Reconciling a previously reconciled MMIS report file will NOT affect the correct analysis of the status of the claim**. The system will evaluate whether the claim record has previously been updated with a status that marked it as accepted, rejected, paid or denied. At the end of a reconciliation process, the system will produce a printed report showing the number of claims reconciled broken down by the reconciliation status.

**It will not always be possible for the system to identify the status of every claim**. The system is attempting to read a report file that is composed of columns of text. Sometimes reports cannot be read properly because columns of information have become offset during creation of the report or transmission of the data. If the Medicaid Fiscal Agent changes the format of a report and DDD is not notified of the change, the system may no longer be able to find the correct columns of information to determine a claim status. Also, if a report is not downloaded from the Medicaid Fiscal Agent for any reason, there will be no MMIS report for the system to reconcile against. **Regardless of whether a report has been received or correctly reconciled against the AMPSBatch claim records, your Agency is responsible to ensure that all claims have been accounted for and to rebill claims within the required timely filing period.**




The **AMPSBatch Archive screen** is used to copy old AMPSBatch claim records to a compressed archive file in order to reduce file sizes and speed up access to the current AMPSBatch claim files. You reach this screen by **selecting AMPSBatch from the CCMS System drop down menu** and then **Archive** from the AMPSBatch side menu.

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for the **second level** of AMPSBatch Functions, you will be able to archive AMPSBatch files.

**All AMPSBatch submission files created more than 60 days prior to the current date, and which have not yet been archived, will be listed on the screen. Those in which ALL the AMPSBatch claims have been marked as paid, purged or rebilled will be identified with an asterisk to the left and SUGGESTED for ARCHIVE.** These are the submission files for which you should not have to perform any additional reporting or rebilling of claims, because all claims have been identified as properly paid or inappropriate for additional rebilling. Once you archive an AMPSBatch submission file, you will no longer have access to the information in that file from the

CCMS AMPSBatch functions, so you need to be sure that you have printed any reports you wish to keep on file for that AMPSBatch submission file.

Any AMPSBatch submission file that is not SUGGESTED for ARCHIVE will list the current number of UnReconciled, Rejected or In Process claims which it contains to help you make a decision about archiving the data. The following criteria are used to determine the status of the claim records:

1. UnReconciled
   UnReconciled claim records are those that have been marked as Accepted but not yet paid by the Medicaid Management Information System (MMIS), or have not been marked at all because they were never reconciled against an MMIS report. Since it is sometimes difficult for the system to identify an MMIS denial, some of the claims that were initially accepted for MMIS processing, may now actually be MMIS denials (which you must identify from the printed MMIS report). If you can determine that an UnReconciled claim has been paid or denied, you should select to delete it on the AMPSBatch ReBill screen so it is no longer identified as an UnReconciled claim.

2. Rejected
   Rejected claim records are those that were rejected for MMIS processing or were denied during MMIS processing. If you do not plan to rebill a claim that has been rejected or denied, you should select to delete it on the AMPSBatch ReBill screen so it is no longer identified as a rejected claim.

3. In Process
   In Process claim records are those that have been accepted by the MMIS for processing, but have not yet been paid because they require further follow-up. You should receive a Provider Payment Report notifying of the final action on the claim and the claim should be marked as either paid or denied at that point. If you can determine that an In Process claim has been paid or denied, you should select to delete it on the AMPSBatch ReBill screen so it is no longer identified as an In Process claim.

Once you have evaluated each AMPSBatch submission file to determine whether to archive it, you can **mark and unmark submission files by double clicking with the mouse pointer** on the file line. You may also use the **Mark All and Unmark All buttons** to mark or unmark all of the submission files at once.

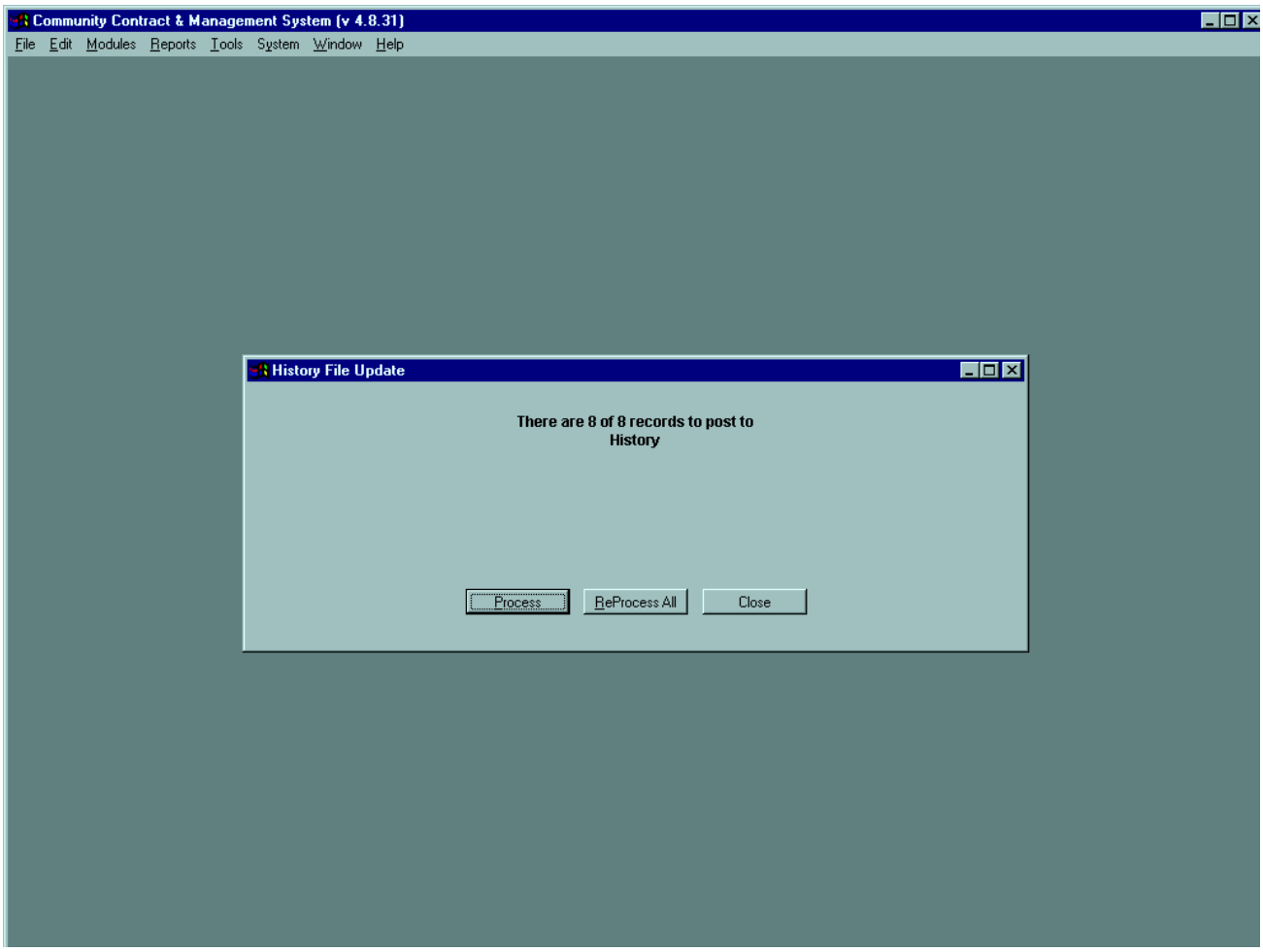
The **Archive Reconciliation Reports check box at the bottom left side of the screen can be checked if you wish to also archive the reports received from the Medicaid Fiscal Agent**. If you do select to Archive Reconciliation Reports from this screen, the system will archive any reports that are older than 60 days along with the AMPSBatch submission files that are archived.

**Press the Archive button** to begin the archiving process for each marked submission file. Any AMPSBatch submission files that were not SUGGESTED for ARCHIVE require confirmation to

archive. A confirmation screen will be displayed on which you must click on the Yes button to archive or the No button to remove the file from the archive list.

At the end of the archiving process, the system will produce a printed report showing the AMPSBatch submission files that were archived and the number of records archived. Refer to this report to determine which AMPSBatch submission files are contained in each archive file. The archive file is a compressed file containing several AMPSBatch files that hold the records related to each AMPSBatch submission file. Archive files are named with the current date in the format century/month/year. (e.g. 20041017). **Because the files are named using the current date, you cannot create more than one archive file per day**. The archive files are written to the \ccms1\data\amparchv directory.

**Archiving your old AMPSBatch claim records is an important task to perform on a regular basis**. The AMPSBatch claim files become large and cumbersome over time and will slow down AMPSBatch functions as well as any CCMS functions that must access the AMPSBatch files. Archiving and zipping the files will typically reduce their size by at least 90 %. If you later find you need to access information contained in an archive file, contact the Help Desk for assistance.




The **History File Update screen** is used to update the CCMS history file, which contains previously entered historical data related to the CORE consumer file. You reach this screen by **selecting Process History File Updates from the CCMS System drop down menu.**

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for the **second level** of System Functions, you will be able to process history updates.

DDD has defined certain fields of information collected in the CORE consumer file (Clmand.dbf) as history fields. Generally this includes consumer identifying information and all information related to program services (date of service, program type, funding type, level of service, location of service) that have either been received or for which the individual has been on a waiting list. When information is updated or a new record is created in the CORE consumer file, the system writes out an update transaction to a transaction file. The information in the transaction file is transmitted to DDD monthly to update the aggregated CORE consumer file at the DDD site and to also update the aggregated consumer history file at the DDD site. In order to update the consumer history file at each Agency site, the Process History File Updates process must be run at least once a month.

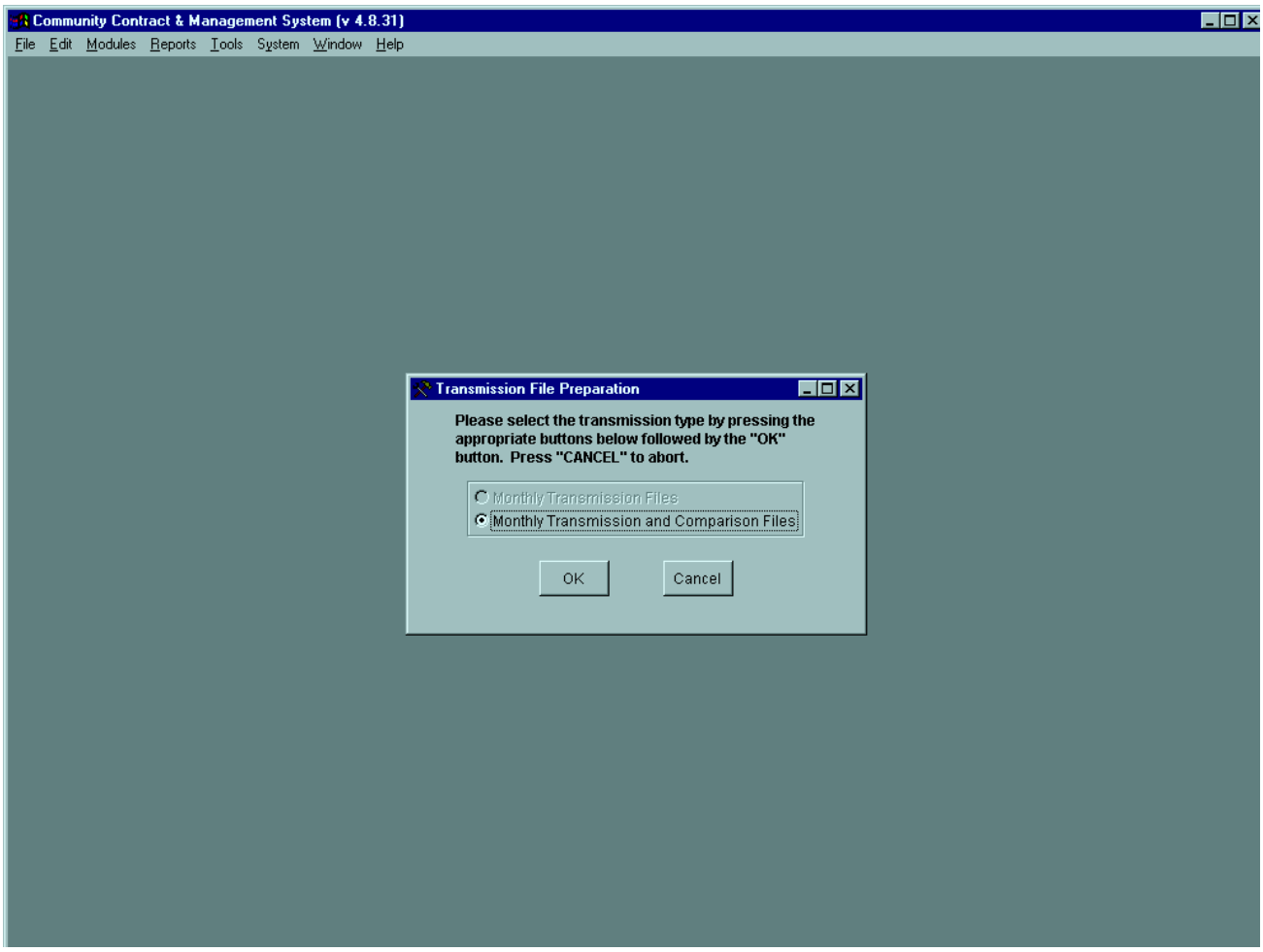
Although you are only required to post to the consumer history file once each month prior to creation of DDD transmission files, you may wish to post more often in order to obtain reports from the consumer history file which contain the most recent information. Newly entered consumer updates will NOT appear in the history file until the Process History File Updates function has been run.

**When you select DDD Create Transmission Files from the CCMS System menu**, the system will check to see if all transactions in the transaction file have been posted against the consumer history file. If not, you will not be allowed to proceed until history file updates have been processed. The same screen (shown above) that is displayed when you choose to Process History File Updates will be displayed at that point, so that you may proceed with updating the history file.

The system will display the number of records that have not yet been posted to history. This number reflects the total number of transactions in the consumer transaction file, and does not necessarily represent the number of records that will actually be written to the history file. Many of the transactions have been written out in order to update non-history fields at DDD (e.g. IP date, case manager, etc.). However, each transaction must be evaluated for possible history file updating, written to the history file if appropriate and marked as "posted".

If the number of records not yet posted is equal to the number of transactions currently contained in the consumer transaction file, the system assumes that you have not yet posted any history for the current month and only the Process button is available. **Press the Process button to process history updates.**

If the number of records not yet posted is different than the number of transactions currently contained in the consumer transaction file, the system assumes that you have posted some history for the current month and provides the option to either Process or ReProcess All. If a previous attempt to post to the history file failed, **choose the ReProcess All button to start from the beginning of the transaction entries for the month to ensure that history file data is accurate.** The system maintains a "zipped" or compressed copy of the history file that is refreshed each month when DDD transmission files are created, and will recover back to this copy of the file when you select to ReProcess All. If no problems occurred on a previous attempt to process history, just select to Process.




The **Transmission File Preparation screen** is used to create the monthly transmission files that will be sent to DDD. You reach this function by **selecting DDD Create Transmission Files from the CCMS System drop down menu.**

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for the **second level** of System Functions, you will be able to create DDD transmission files.

**This function requires that no other users be in CCMS.** The program will check to make sure that no other users are in the system in a network environment. If there are other users in the system, you will receive a notification and you will not be allowed to proceed.

**Before you may create transmission files, all billing services must be posted and all error reports must be printed.** If any of these functions have not been completed, you will receive an error message and will not be allowed to proceed. You will have to complete the missing functions before you may return to this screen and create transmission files. The system will also check to see if all history file updating has been completed. If not, you will not be allowed to proceed until history

file updates have been processed. You will be presented with a screen where you may choose to process history updates before proceeding.

Generally the **Monthly Transmission Files radio button** will be automatically selected by the system. Periodically, DDD needs a complete copy of the CORE Consumer Mandatory file and the History file in order to perform a comparison of the data in your files with the data in the DDD centralized files. The system will automatically mark the **Monthly Transmission and Comparison Files radio button** when your Agency is due for a comparison of data files. DDD may ask your Agency to send comparison files if there is reason to believe data between the Agency site and the DDD site is not in sync and it is necessary to identify data that needs to be corrected.

**Press the OK button to proceed** with creation of DDD transmission files. The system will first perform a temporary backup of the files. This ensures that files can be recovered as they were just prior to the file creation if you lose power during the process or if any errors occur during the program execution. Several steps are involved in creation of transmission files. As each transmission process occurs, a message will be displayed on the screen telling you what is occurring. **When creation of transmission files is completed, a message will be displayed to confirm it was successful**.


The **DDD File Transmission Portal process** is used to receive the monthly DDD updates, send the monthly DDD transmission files and to upload or download special file updates. You reach this function by **selecting DDD File Transmission from the CCMS System drop down menu.**

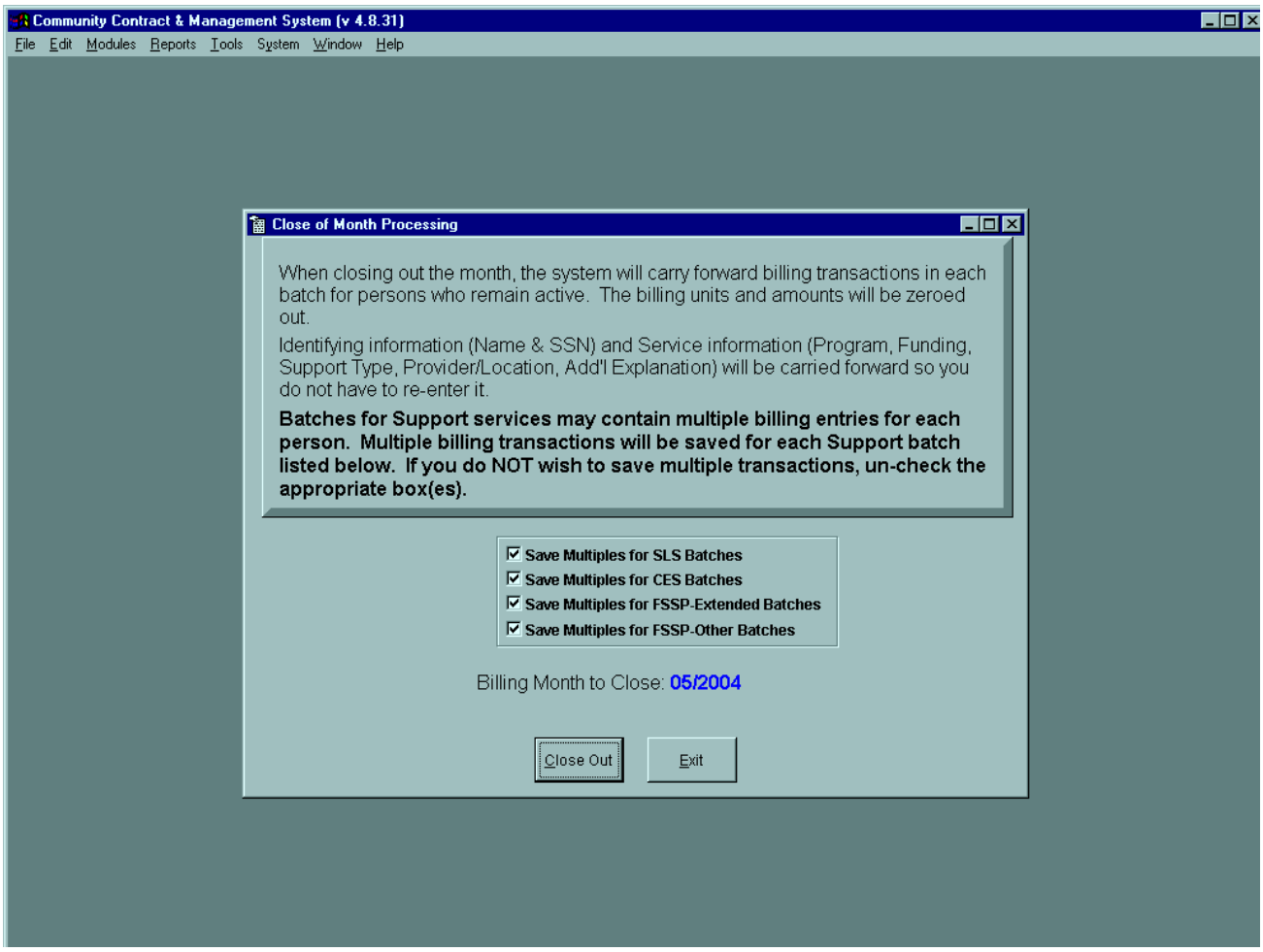
Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for the **second level** of System Functions, you will be able to transmit and receive DDD transmission files.

A common interface screen is presented for uploading and downloading CCMS files. The screen above is an example of the screen that is presented when you choose to **Send files** to DDD. A similar screen is presented when you choose to **Receive files** from DDD. Select the appropriate menu choice from the DDD File Transmission menu to either Send or Receive files.

**Click on the Connect button** to send your monthly transmission files to DDD or receive monthly updates from DDD. The monthly DDD updates are generally ready by the third working day of the month. **Transmission files are generally due on the 20th calendar day of each month.** Before

you can transmit your files, you must have created them by selecting the DDD Create Transmission files menu choice from the System menu.

You will be notified in the monthly CCMS Broadcast Message of the specific date transmission files must be received at DDD. Your Agency will be notified each month via email when the monthly DDD updates are available.




The **Close of Month Processing screen** is used to increment the billing month and clear out all current month billing figures in preparation for the next billing month. You reach this function by **selecting Close Out Month from the CCMS System drop down menu.**

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for the **second level** of System Functions, you will be able to close out the month.

**This function requires that no other users be in CCMS.** The program will check to make sure that no other users are in the system in a network environment. If there are other users in the system, you will receive a notification and you will not be allowed to proceed.

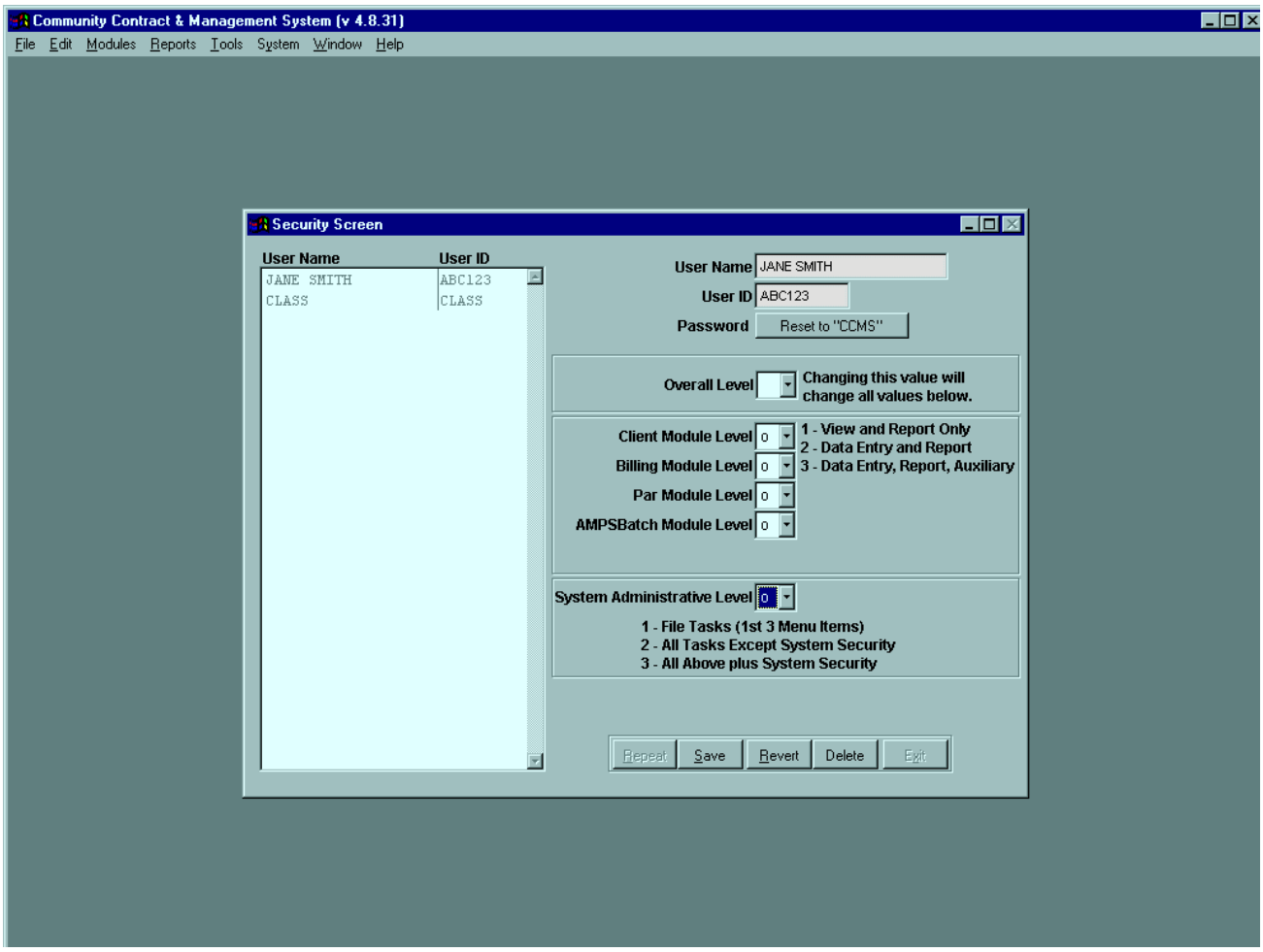
Before you may close out the month, files must have been transmitted to DDD for the current billing month. **If files have not been transmitted, you will not be allowed to proceed.** You will have to transmit files before you may return to this screen and close out the month. Once you have closed out the month, the billing figures for the month you are closing out will not be available for printing

on current month billing reports. Make sure you have printed all of the reports you need before you close out the month.

The **Save Multiples checkbox** for each supported living service program type is initially checked on. You may un-check boxes for each program for which you do not wish to save multiple transactions for the following billing month. Saving multiple billing transactions may reduce data entry requirements for following months provided persons generally receive the same Support Types every month.

**Press the Close Out button to proceed** with close of the month. The system will first perform a temporary backup of the files. This ensures that files can be recovered as they were just prior to close of month if you lose power during the close of month or if any errors occur during the program execution.

Several steps are involved in closing out the month. As each close of month process occurs, a message will be displayed on the screen telling you what is occurring. **When close of month is completed, you will receive a message telling you close of month has completed successfully.**




The **System Security screen** is used to enter passwords and security levels for users of the system. You reach this screen by **selecting System Security from the CCMS System drop down menu.**

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for the **third level** of System Functions, you will be able to enter and update security records.

**Use the Add or Repeat buttons** to create new security records. You must enter a User Name and User ID for each record.

**Enter the User Name up to 25 characters long in the User Name field.** The Name will automatically be converted to upper case. Each user must have a unique ID, which can be the same as the user's network ID if you are running CCMS on a network. The User ID must conform to DOS file naming conventions, because it is used to create various temporary files throughout the system. **Enter an ID up to eight characters long in the User ID field.** The ID will automatically be converted to upper case.

The user must also have a password assigned to him that he will have to enter on the System Startup screen when he first comes into the system. **The system will automatically generate a password for a new user.** The automatically generated password is displayed on the screen. This password must be given to the new user and he will be prompted to change it the first time he enters the system.

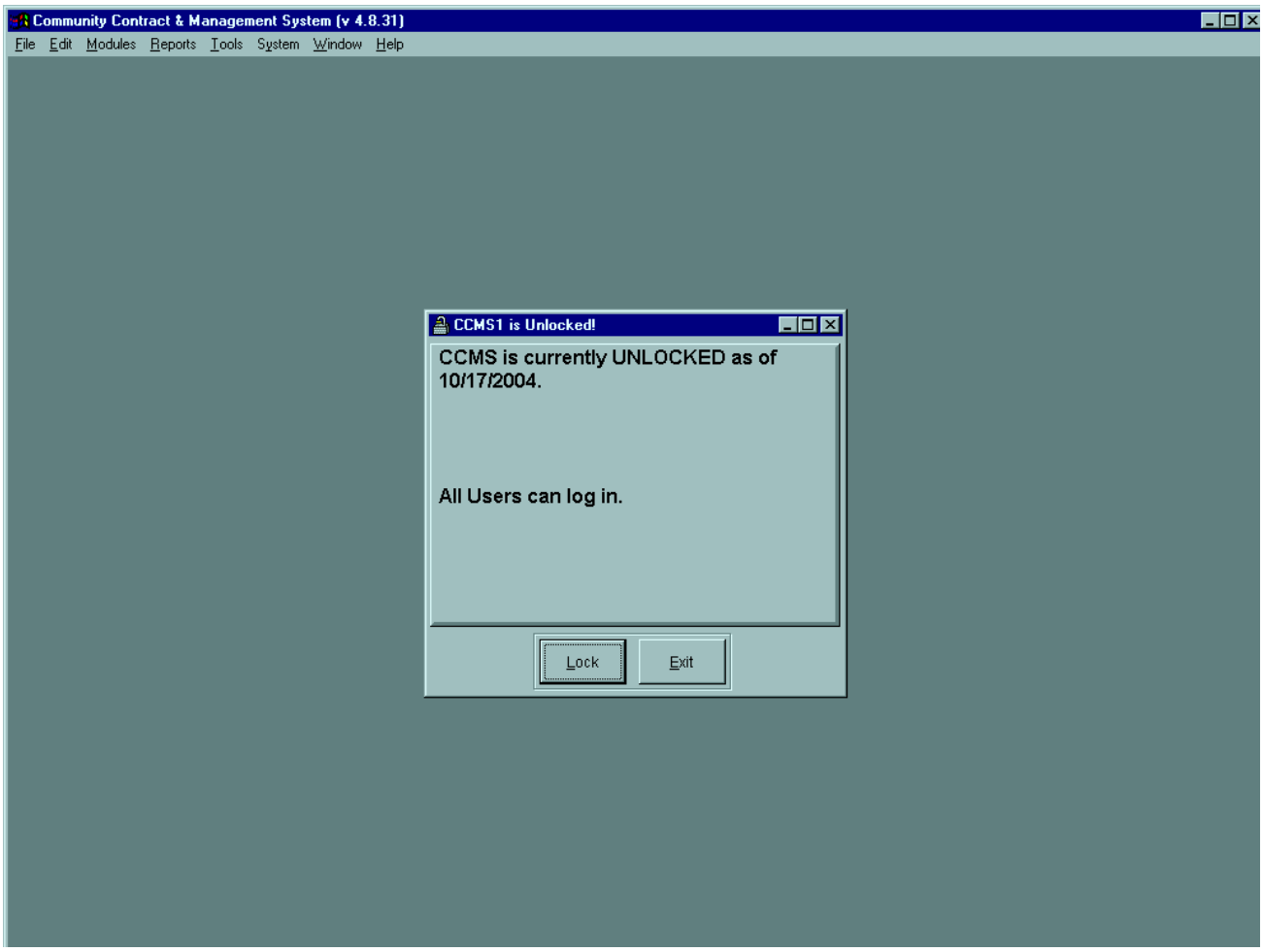

Enter a level of security for the user based on the modules and functions he needs to have available to him for viewing, updating or processing. You may either **enter a level of 1 through 3 in the Overall CCMS Level field** and the system will automatically complete the other module levels for you, or you may enter individual level numbers in the level fields for each module. If you leave a level at Zero for one of the modules, a user will not have access to that module at all.

**Press the Edit button** to edit an existing security record. **You may make changes to a user's security level at any time**. However, if the user is currently logged into CCMS at the time you make the changes, they will not become effective immediately. The user must exit and re-enter CCMS before the security level changes will take place.

**Press the Reset to "CCMS" button** in Edit mode, to reset a user's password. If a user has forgotten his password and can no longer log into the system, the password must be reset to allow him to log in. The new password will be displayed on the screen as soon as you press the **Reset button**. He must log in with the new password, and then change his password again when prompted to do so.

The **Save, Revert and Delete buttons** are initially disabled or dimmed and will become enabled when you have made any changes to the security record. Any changes you have made will not actually be saved to the file until you press the **Save button**. Use the **Revert button** to discard changes you have made. The **Revert button** will discard all changes made since the last time you saved changes.

Press the **Delete button** to delete a security record. You cannot delete a security record for a user currently in the system.



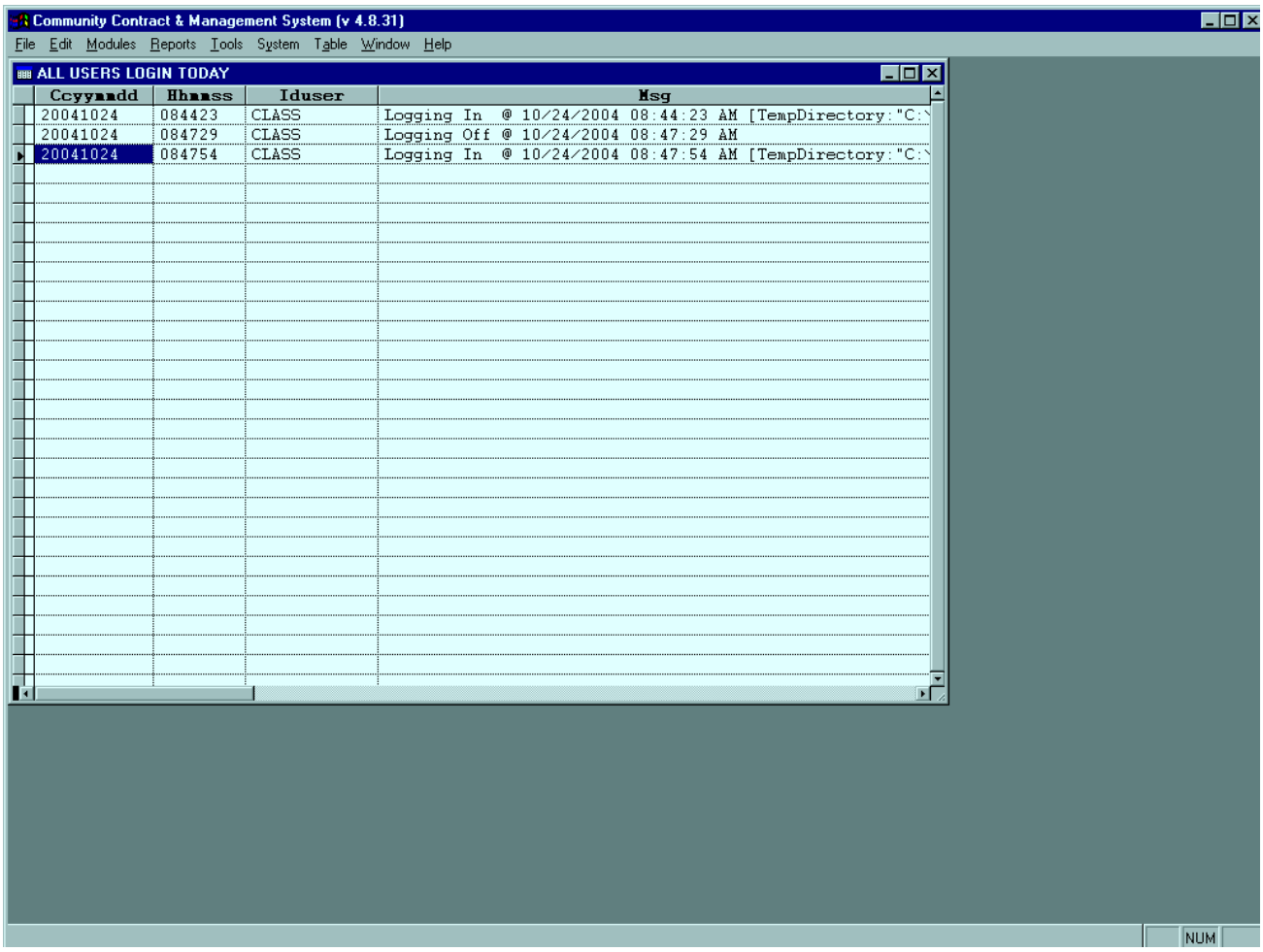

The **System Lock function** is used by the System Administrator to lock and unlock entry into CCMS. You reach this function by **selecting Admin Lock / Unlock CCMS1 from the CCMS System drop down menu.**

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for the **third level** of System Functions, you will be able to lock the CCMS system.

This lock can be set before critical functions such as Posting, Creation of Transmission files and Close of Month take place. Once the lock is in place, no users will be able to enter CCMS until the System Administrator unlocks the system. **Press the Lock button** to lock the system. When finished with system tasks, **press the Unlock button to release the system** for other users to access.

Another tool for the System administrator is available from the **Log: All Log-in's Today** menu choice from the CCMS System menu. The menu choice allows the System Administrator access to a list of log-ins for the day. This allows identification of users who were logged in before the system

lock took place. Those users need to be notified to log out of the system before proceeding with system tasks.




The **Log: All Log-In's Today** is used by the System Administrator to determine what users have logged into the system during the day. You reach this function by **selecting Log: All Log-In's Today from the CCMS System drop down menu.**

Your **security level** will determine whether you have the ability to get to this screen at all. If you have been given rights for the **third level** of System Functions, you will be able to view CCMS log-ins.

This function allows you to view a list of users who have logged into the system on the current date. The log also tracks when the user logs out, so you can determine whether users are currently in the system. Use this function, along with System Lock Function, to prevent users from getting into the system and identifying users who are currently in the system and need to be notified to log out.

# APPENDIX A

## Field Definitions and Minimum Reporting Criteria

The Agency file is used to record identifying information for each Agency operating the system. The Agency record for each Agency contains a pre-assigned agency number that identifies the Agency uniquely in the CCMS statewide data files. It also contains the name, address and telephone number of the Agency, which are used in creation of AMPSbatch submission files that are transmitted to the Medicaid Fiscal Agent monthly, so this information must be updated by the Agency in a timely manner if it changes. The Agency file is used to track automatic assignment of various sequential numbers, system indicators for functions such as posting and transmission, latest update and billing months and production of monthly error reports. Fields that track this information are updated automatically as various functions occur within the system.

Refer to Section VIII (System Functions) for the data entry screen and additional information about updating this file. Refer to Appendix E for file structure and field names.

BILLING MONTH - Mandatory and Automatically Updated

The current billing month in MMYYYY format. You cannot enter or update this date. It is updated by CCMS.

TRANSMITTED? - Mandatory and Automatically Updated

The flag setting that indicates whether or not the information for the billing month displayed above has been transmitted to DDD. This is automatically updated by the system. You cannot enter or change this field.

PROVIDER NUMBER - Mandatory

The HCB-DD Waiver Provider Number for this Agency. This number was entered during initial configuration of the system for this Agency, and it cannot be changed or deleted.

LAST UPDATE - Mandatory and Automatically Updated

The date this record was last changed. Update is automatic when any field is changed; the date is taken from the computer's system date. You cannot enter or change this information.

BY USER - Mandatory and Automatically Updated

The name of the user that matches the user ID automatically, entered when this record was last updated. You cannot enter or change this information.

AGENCY NAME - Required

Enter the name of your Agency as you want to see it appear on AMPSbatch submissions and on printed reports; use upper and lower case letters if desired. You have 40 characters available, so you will probably need to abbreviate

DIRECTOR - Optional

Enter the full name of your CCB Executive Director/Coordinator or RC Superintendent here. Type it as you would like it to appear on reports, using upper and lower case letters if desired.

BOARD PRESIDENT - Optional

Enter the full name of your board's president as you would like it to be printed on reports, using upper and lower cases letters if desired. Regional Centers may choose to enter a different name here.

ADDRESS - Required

Enter your Agency's street address as it should appear on mailing lists and on the AMPSbatch submission file. You may extend the address into the Freeform field described below.

FREEFORM ADDRESS - Optional

This freeform field may be used to extend the street address defined above. The AMPSbatch module uses only the first 35 characters, so try to limit your entry to 35 characters for accuracy in the AMPSbatch submission file.

CITY, STATE, ZIP - Required

The name of the city and state, and the zip code for this Agency address. These fields are used by the AMPSbatch module in creating the AMPSbatch submission file. The zip code format includes the extended four numbers, you must enter at least the usual first five numbers.

AGENCY PHONE NUMBERS (1st line) - Required (2nd & 3rd) - Optional

Enter the Area Code and number, and an extension if appropriate.

The first number listed must be the main number for your Agency because it is used by the AMPSbatch module when creating batches for submission to the Medicaid Fiscal Agent.

The second and third numbers may be other numbers, and you are given 20 characters to describe these numbers.

AUTO CASE - Optional

This flag indicates to the system whether or not your Agency wants the computer to automatically generate case numbers for each record as they are entered into the CORE file. If you have used this option in the past and then discontinued it, you should check with CCMS support staff before you start using it again, or you may end up with duplicate case numbers.

A check in the box means that automatic case numbering is taking place.

RATE TRACKING

This field is obsolete. It was used in a previous version of the system.

CORE/BILLING COORDINATORS – Required

CORE COORDINATOR NAME
Enter the name of the current CORE coordinator. Update this field as soon as a new coordinator takes over. This field provides the CCMS support staff information on who to contact.

CORE COORDINATOR PHONE
Enter the Area Code and number, and an extension if appropriate.

CORE COORDINATOR eMAIL
Enter the individual email address of the coordinator. If the coordinator does not have an individual email address, enter the email address of your Agency. This address will be used to send questions or respond to issues about your Agency's CORE data.

BILLING COORDINATOR NAME
Enter the name of the current Billing coordinator. Update this field as soon as a new coordinator takes over. This field provides the CCMS support staff information on who to contact.

BILLING COORDINATOR PHONE
Enter the Area Code and number, and an extension if appropriate.

BILLING COORDINATOR eMAIL
Enter the individual email address of the coordinator. If the coordinator does not have an individual email address, enter the email address of your Agency. This address will be used to send questions or respond to issues about your Agency's Billing data.

LAST ASSIGNED NUMBERS - Mandatory and Automatically Updated

PSEUDO SOCIAL SECURITY NUMBER
This is the last four digits of the last pseudo social security number assigned by the system. Pseudo SSNs may be used temporarily for persons until real numbers can be obtained. Pseudo SSNs are made up of "000" plus your Agency's number plus a sequential four-digit number. Pseudo SSNs are automatically generated by the computer. This field is incremented automatically by CCMS each time a new record is entered with a Pseudo SSN. You cannot update this number or change it. If this field is not accurate you must contact CCMS support staff to change it.

CASE NUMBER
If you have chosen to have CCMS automatically assign case numbers (see 'Auto Case?' above), this is the last case number assigned by the system. It is incremented automatically each time a new record is entered. You cannot update this number or change it. If this field is not accurate you must contact CCMS support staff to change it.

REPORT ID NUMBER
This field is obsolete. It displays the last report number assigned in a previous version of the system.

BATCH NUMBER
The batch number of the last billing batch record created. You cannot update this number or change it. If this field is not accurate you must contact CCMS support staff to change it.

TRANSACTION NUMBER
The number of the last billing transaction entered. You cannot update this number or change it. If this field is not accurate you must contact CCMS support staff to change it.

LAST BILLING MONTH UPDATED - Mandatory and Automatically Updated

PAR UPDATE
The billing month of the last update of the Prior Authorization File from DDD. You cannot enter or update this date. This date in MMYYYY format is automatically updated at the time the file is updated. You cannot post until this file has been processed.

PROVIDER UPDATE
The billing month of the last update of the Provider and Rate Files from DDD. You cannot enter or update this date. This date in MMYYYY format is automatically updated at the time the files are updated.

CONTRACT UPDATE
The billing month of the last update of the Billing Contract File from DDD. You cannot enter or update this date. This date in MMYYYY format is automatically updated at the time the file is updated.

TABLE UPDATE
The billing month of the last update of the CCMS Table (Code) File from DDD. You cannot enter or update this date. This date in MMYYYY format is automatically updated at the time the file is updated.

PROGRAM UPDATE
The billing month of the last update of the CCMS Program Files from DDD. You cannot enter or update this date. This date in MMYYYY format is automatically updated at the time the file is updated.

ERROR REPORT PRINTING STATUS - Mandatory and Automatically Updated

FINAL POSTING ERRORS
The flag setting that indicates whether or not ALL final Posting Error Reports have been printed. This includes reports for Comprehensive, Support and Other Services. It is automatically updated by the system. You cannot enter or change this field.

FINAL CROSSCHECK ERRORS

The flag setting that indicates whether or not the final Client/Billing Crosscheck Report has been printed after all posting has been completed. It is automatically updated by the system. You cannot enter or change this field.

CORE DATA EDIT REVIEW

The flag setting that indicates whether or not the CORE Data Edit Review has been printed after all posting has been completed. It is automatically updated by the system. You cannot enter or change this field.

POSTING STATUS - Mandatory and Automatically Updated

COMP SERVICE

Has the comprehensive service posting been completed for the billing month shown at the top left of the screen? You cannot change this, it is automatically updated by the system.

SLS SERVICE

Has the support service posting been completed for the billing month shown at the top left of the screen? You cannot change this, it is automatically updated by the system.

OTH SERVICE

Has posting been completed for other services for the billing month shown at the top left of the screen? You cannot change this, it is automatically updated by the system.

FIELDS NOT SHOWN ON THE SCREEN

There are fields in this file which do not appear on the data entry screen that are for tracking State billing estimates (which are entered on the Posting screen), and tracking dates of system functions. Refer to Appendix E for a short description of these fields.

The CORE Consumer Mandatory file is the CORE file of the system because it contains the basic information about individuals served by the Agency. Records cannot be entered into any other files for an individual until the CORE record has been entered. The CORE record contains demographic information and information about the services needed and provided to persons who have been determined developmentally disabled. The record contains only the current information for each individual. Historical information is kept in a separate history file.

Refer to Section III (Individual Module) for the data entry screens and additional information about updating this file. Refer to Appendix E for file structure and field names.

LEGAL FIRST NAME - Required

The person's legal first or given name. This must be the legal name. You will have an opportunity to enter an 'alias' or nick name in other fields.

Enter the first name as you want to see it on your printed output. Keep in mind that it is possible to use CCMS data in word processing files. You may want to be sure that you enter the name with both upper and lower case.

LEGAL MIDDLE NAME - Required

The person's legal middle name. This must be the legal name. You will have an opportunity to enter an 'alias' or nick name in other fields. If there is no legal middle name, leave this field blank.

Enter the middle name as you want to see it on your printed output. Keep in mind that it is possible to use CCMS data in word processing files. You may want to be sure that you enter the name with both upper and lower case.

LEGAL LAST NAME - Mandatory

The person's legal last name or surname. This must be the legal name. You will have an opportunity to enter an 'alias' in other fields.

Enter the last name as you want to see it on your printed output. Keep in mind that it is possible to use CCMS data in word processing files. You may want to be sure that you enter the name with both upper and lower case. You must enter a last name of at least two characters, or the record will not be added to the file.

LEGAL TITLE - Required

The person's legal title if is part of the legal name. The choices are Jr., Sr. and I – V.

ALTERNATE FIRST NAME - Optional

Enter an alternate first name for this person if appropriate (different from the legal first name).

Possible uses: Nicknames or middle name if that is the name the person uses.

ALTERNATE LAST NAME - Optional

Enter an alternate last name for this person if appropriate (different from the legal last name).

Possible uses: A foster parent's name or maiden name if a woman is married.

SOCIAL SECURITY NUMBER - Mandatory

This number must be the person's Social Security Number, NOT the number of a relative or a number under which the person receives benefits. You must enter a social security number or the record will not be added to the file.

When entering the consumer information for the first time, if the Social Security Number is unknown, or the person does not have one, click on the 'ASSN PSEUDO' button on the screen, and the computer will automatically generate a temporary "pseudo" number. The first three numbers will be 000 and the second two numbers will be your two-digit agency code. The final four digits will be used in sequence. The pseudo number should only be used until a real number can be found or applied for through the appropriate Social Security office. Do not use the same pseudo number more than once, even if a real number has been obtained for a previously used pseudo number, or history files at DDD will be hopelessly confused.

This number will be used for identification of records in other files in the system for this person.

MEDICAID NUMBER - Required if the person receives Medicaid funded services

This State ID number is assigned to the recipients of Medicaid and other state services by the Colorado Department of Health Care, Policy and Financing (HCPF). This number must be this person's, not a relative's. It is required only for those persons receiving Medicaid funded services (including Waiver and State Plan Medicaid). It is optional for all other persons; however, it is strongly recommended that you enter the Medicaid Number if you know it.

It must begin with an uppercase letter followed by six digits. This number cannot be used for or by other people.

CASE NUMBER - Optional

The identification number (any combination of letters and/or numbers) assigned by your Agency for case management.

If you enter this case number, it will be used in an index so you can recall records by case number for review or update. You have seven spaces available for this number; any number entered will be left justified. Do not use a number more than once.

You can choose to have the computer automatically generate this number for you. You must indicate your Agency's desire for automatic case numbering in the Agency file (refer to that section for further instructions). If you choose automatic generation of case numbers, the numbers can only be numeric

(you will not be able to include any alphabetic characters) and you must let the computer generate the number for you.

DD OVERALL CASE STATUS AND DATE - Mandatory

These fields reflect the person's status and date of status with regard to the Division for Developmental Disabilities. You must enter an overall status and date or a new record will not be added to the file. An existing record cannot be saved without this information. Enter the appropriate code and enter the date on which the overall status became effective. If the only service being received is Family Support Services Program (FSSP), enter the date that the person became eligible for FSSP funding as indicated by a commitment of funds in the Family Support Plan (FSP).

The status date should change every time the status changes unless an incorrect status is being corrected or a Regional Center discharge and admission are occurring on the same day. Data entry edits will require that the date be entered when status is entered or updated.

Status updates must follow a logically consistent order so the history file maintains proper chronological information:

Case Management Only must go to Active or Terminated;
Active must go to Terminated;
Terminated may go to any status;
Non-DD funded, Other Agency Case Management and Waiting List without Case Management must go to Case Management or Active.

If this is a new record, the system will auto-fill the Day Service, Comprehensive (Residential) and Support status fields with “N” - Non-DD funded if this status is “C” - Case Management Only, “W” - Waiting List without Case Management or “N” - Non-DD funded. If this status is “A” - Active, either the Comprehensive (Residential) or Support status must be “A”. If this status is not “A” - Active, none of the other three statuses can be “A” - Active. The status date cannot be a future date, and cannot be prior to the person's birthdate.

When you update the overall status and date fields on an existing CCMS record, you will be asked for "M/U" for each field before saving the record to indicate a correction of a mistake (M) or an update of valid data (U). If both the status and date of status are changed, both fields must have matching change types (e.g. "M" as the change type for both status and date of status). However, you may correct just one of the fields with an "M" if you need to correct invalid data which was entered in that field. If you update one field with a "U", the program will require you to enter data into the other field. (A valid update affects both the status and date of status). The Date of Status will serve as the Date of Change. You will be able to enter logically inconsistent status changes if you are making a mistake change rather than an update. DO NOT use the mistake change type to change a status to one that is not logically consistent with the previous status unless it really is a mistake correction.

A Active DD - This status applies to a person who is receiving case management and comprehensive services and supports funded by DDD, or is enrolled in FSSP as indicated by a commitment of funding in the FSP, or who is enrolled in other DD funded support services, or who resides in a Regional Center. All Regional Center residents must be recorded as active on the Regional Center CORE record. All persons with an overall status of active must have

already been determined to be eligible or have a developmental disability according to DDD eligibility criteria. When the person discontinues all DD or RC funded services, the record's overall status must be changed to "T" - Terminated. If the person continues to receive only case management, the status must then be updated to "C" - Case Management only.

C Case Management Only - This person is receiving only case management services. He or she is not active in a DD funded comprehensive service or FSSP, or other DD funded support services. This person should also be shown on the waiting list unless he or she is not appropriate for a DD funded comprehensive service or FSSP, or other DD funded support services. All persons with an overall status of case management only must have already been determined to be eligible or have a developmental disability according to DDD eligibility criteria. If the person enters comprehensive services funded by DD or enrolls in FSSP or other DD funded support services, the record is changed to "A" - Active DD. If the person discontinues case management services, the record is changed to "T" - Terminated.

All persons residing in a nursing home and determined to have a developmental disability according to DDD eligibility criteria, must initially have this status recorded in the CORE record. If the person declines case management services, then the status must be changed to "T" - Terminated with a Termination Type of “CD” - Case Management Declined.

O Other Agency Case Management - This person is receiving Children’s Medical Waiver case management from an agency other than your CCB and is NOT receiving any other services from the CCB. The person must have already been determined to be eligible or have a developmental disability according to DDD eligibility criteria. If the person enters comprehensive services funded by DD or enrolls for FSSP or other DD funded support service in your service area, the record is changed to "A" - Active DD. If the person discontinues Children’s Medical Waiver case management services with the other agency, you must delete the record or change the status to "N" - Non-DD funded. You cannot terminate a person from this status.

T Terminated - This person no longer receives any DD or RC funded services. This status can only be entered if the record was one of the above statuses. You cannot terminate a Non-DD funded status. You must terminate one of the above statuses before changing the status to Non-DD funded.

When a person is terminated, in addition to changing DD Overall Status to "T", also update the following fields:

DD Status Date (Ostat_Date)
show date of termination
Termination Type (Term_Type)
enter the appropriate termination code
** WARNING ** - RCS ONLY All emergency and respite care admissions MUST be terminated in Overall Status and on your Monthly Census reporting to DDD before they can be admitted under another status (such as ILD).
Comprehensive (Residential) Status (Res_Stat)
if "A", change to "T"
Comprehensive (Residential) Status Date (Rstat_Date)

if Comprehensive Status changed to "T", then change this field to the date of termination (this date must be earlier than or equal to the date of overall status)

Current Living Arrangement Type (Res_Set)
for CCBs, leave setting unchanged;
for RCs, enter the code that reflects the new community placement

Provider (Res_Facil)
for CCBs, leave provider/facility code unchanged;
for RCs, update the code to reflect the community facility or provider placed to (Caution, make sure that this code is in your code file)

Day Service Status (Day_Stat)
if "S" or "C", change to "T"

Day Service Status Date (Dstat_Date)
if Day Service Status changed to "T", then change this date to the date of termination (this date must be earlier than or equal to the date of overall status)

Support Status (SL_Stat)
if "A", change to "T"

Support Status Date (Sstat_Date)
if Support Services Status changed to "T", then change this date to the date of termination (this date must be earlier than or equal to the date of overall status)

W Waiting List without Case Management - This person is on a waiting list for a DD funded comprehensive service or FSSP, or other DD funded support services in your service area. However, the person does not reside in your service area and case management is being provided by another CCB. The person must have already been determined to be eligible or have a developmental disability according to DDD eligibility criteria. If the person enters comprehensive services funded by DD or enrolls for FSSP or other DD funded support service in your service area, the record is changed to "A" - Active DD. If the person is removed from the waiting list without being placed, you must delete the record or change the status to "N" - Non-DD funded. You cannot terminate a person from this status.

N Non-DD funded - This person is not funded by DD, is not enrolled in FSSP or other DD funded support service and does not reside in a Regional Center, but you do want to enter a CCMS record. Use the Agency Status Field to record the status as it pertains to your Agency. You cannot change this status to terminated when the person leaves your Agency; you must delete the record, or change only your Agency Status Field to terminated. You can change this status to any of the statuses above, but DO NOT do it to get the record to a terminated status. That would distort the history file that is used for tracking and other management reports.

AGENCY STATUS AND DATE (CCBs ONLY) - Optional

This is the agency status as defined by your Agency. See your CORE Coordinator for a list of codes for your Agency. These codes must have been defined by your Agency and entered into the CCMS Table file. This field cannot be blank if the agency status date is not blank.

The date cannot remain the same when the agency status is changed, unless the agency status change is a mistake correction.

The date cannot be an earlier date than the current agency status date, unless this is a mistake correction.

The date cannot be a future date or prior to the birthdate.

AGENCY STATUS AND DATE (RCs ONLY) - Required (Date is Optional)

The Agency Status field is used to record the RC admission type for Regional Centers. If Regional Centers also wish to record a separate agency status, they must use the Optional File to do so. This is the legal status of the person's admission to the Regional Center. Pick the appropriate one-character code from the list below.

I Imposition of Legal Disability - The person has been admitted as a result of a court order determining that the person's needs would best be met in the Regional Center. An IP (Individualized Plan) must be developed.

R Respite Care - The person has been admitted solely for respite care services. This placement is short-term and cannot exceed a cumulative total of 28 days in any fiscal year. No IP is required.

E Emergency - The person was admitted under one of the following emergency circumstances: imminent danger to self, behavior which presents a danger to others, no available shelter, inappropriate or potentially harmful setting where abuse may be evidenced, health care which does not preclude involvement in programming and health conditions are stabilized plus all existing alternative residential resources have been exhausted. A transitional IP must be developed. This placement is temporary and cannot exceed ninety (90) days. All emergency placements must be reviewed by the DDD office prior to placement.

Inactive codes -

C Criminal - The adult person has been admitted as a result of a court order stemming from criminal activity on the part of the person. This admission must have occurred before July 1, 1985. An IP must be developed.

J Juvenile - The juvenile person has been admitted as a result of a court order stemming from criminal activity on the part of the person. This admission must have occurred before July 1, 1985. An IP must be developed.

V Voluntary - This person has been admitted voluntarily to the Regional Center. This admission must have occurred before July 1, 1985. An IP must be developed.

TERMINATION TYPE - Required

The type or reason for termination from services. Pick the appropriate type from the list.

This field should be completed only for an overall status of terminated, and left blank if the overall status is active. You will be reminded that this field should be completed for records with a termination date after 4/30/1994.

Regional Centers must use a termination code appropriate to the admission type in Agency Status.

CCB Termination Types

CD Case Management Declined - This individual, who is residing in a nursing home, has declined all services offered by the CCB. This includes active treatment as well as case management. An Annual Resident Review must still be completed for this person and this code identifies the individual for purposes of tracking that the review is completed as required.

CH Individual or Parent or Guardian Choice - One of these individuals has made the choice to discontinue all services.

CP Completed Program - The individual has completed the program of service and is no longer in need of further services.

DE Deceased

DS Dissatisfaction - The person or family is dissatisfied with the services received.

IR Inappropriate Referral - This person was inappropriately referred to your Agency for services.

LF Loss of Funding - The funding source for this person's services is no longer available.

MA More Appropriate Program - The person has transferred to a more appropriate program that is not funded by DD through your Agency.

MS Moved from the Service Area - The person has moved from the area in which your Agency provides services although they are still in Colorado. (See Below)

NA No Appropriate Program - Your Agency does not provide the type of program most appropriate for this person.

OS Moved Out of State - The person has moved out of Colorado.

OT Other - A termination reason not listed here.

UK Unknown - The termination reason is unknown.

Regional Center Termination Types

DI Direct Discharge (only valid prior to 3/1/92) - All long-term active individuals who are discharged at their request or guardian request. Do not include discharges of short-term (emergency or respite care) here.

PP Planned Placement (only valid prior to 3/1/92) - All active individuals put on placement status whose placement was planned by the Placement Committee. May include individuals admitted as long-term or on emergency status. All placements must be taken off the census on the day of placement, although they are carried on the enrollment until discharged or until 60 days pass (whichever comes first). All planned placements must be shown as discharged within 60 days of placement.

PL Placements - Individuals who were on long-term status but who are now moving out of the Regional Center as a direct discharge or planned placement for reasons other than transfer to another DHS institution or death. Do not include temporary leaves to hospitals or other temporary placements. Do not include discharges of short-term (emergency or respite care).

ED Emergency Discharge - Discharge of an individual who had been admitted for emergency care (except due to death). Note that emergency care cannot exceed 90 days. If the individual is first admitted as emergency and then admitted ILD, he/she must first be discharged from emergency and then be shown as a long-term admission.

RD Respite Care Discharge - Discharge of an individual who had been admitted for respite care. Note that respite care cannot exceed 28 days. If the individual is first admitted as respite and then admitted ILD, he/she must first be discharged from respite and then be shown as a long-term admission.

TR Transfer to other DHS - All active individuals who have been discharged from this center for transfer to another facility operated by the Department of Human Services (i.e. other regional center, state mental health hospital, or Office of Youth Services' facility). May include individuals admitted as long-term or on emergency status.

DE, DR, DO - Deceased

DE Deceased (only used prior to 6/30/87)
DR Deceased on RC Property or while under RC care
DO Deceased off RC Property, but before being discharged

Use these codes for all active individuals who have died, regardless of location (i.e. even if on temporary leave). All deaths reported on incident reports to the Department of Human Services must also be reported through CCMS.

LAST UPDATE - Mandatory and Automatically Updated

The date this record was last changed. Update is automatic when any field is changed; the date is taken from the computer's system date. You cannot enter or change this entry.

INTAKE DATE - Optional

Enter the date of the initial contact as contact is defined by your Agency.

The date cannot be a future date, and cannot be prior to the date of birth.

ORIGINAL ENTRY DATE - Optional

Enter the date of the original entry into services provided by your Agency.

The date cannot be a future date, and cannot be prior to the date of birth.

COUNTY OF RESIDENCE - Required

The county where this person resides. Enter the appropriate Colorado County or pick the appropriate code from the list.

COUNTY OF CCB CASE MANAGEMENT RESPONSIBILITY - Required

The community centered board responsible for providing ongoing case management services is the one in whose designated service area the person receiving services resides, except when the following conditions apply:

If the person receiving services is reasonably expected to reside in a designated service area for ninety (90) days or less and was previously receiving case management services from another community centered board, the community centered board of origin shall retain case management responsibility for the person;

If the person receiving services is placed into a state operated program for ninety days or fewer under short term emergency or respite care status, the community centered board of placement origin shall retain case management responsibility for the person;

If the person receiving services is placed into a privately operated Intermediate Care Facility for the Mentally Retarded (ICF/MR) after July 1, 1990, the community centered board of placement origin shall retain case management responsibility for the person, unless the community centered board where the ICF/MR is located accepts case management responsibility; or,

For purposes of transition, if a person is receiving residential services funded by the Department of Human Services, Division of Child Welfare Services, the person (if over eighteen (18) years of age), parent(s) of a minor, or legal guardian, as appropriate, shall have the option of choosing either the designated service area where the person receiving services currently resides for continuity of service provision or the designated service area of placement origin from the county department of social services.
(R & R 5.1.6 October 1, 1995)

Enter the appropriate Colorado County or pick the correct county from the displayed list.

COUNTY OF ORIGIN - Required

The county in which the person resided when he or she applied for eligibility determination and/or services. Enter the appropriate Colorado County or pick the correct county from the list.

CASE MANAGER - Required

Enter the name of this person's case manager or pick the name from the list.

Your Agency must have assigned codes to case manager names and entered them into the CCMS Table file.

LAST IP/REVIEW DATE - Required

The date that the last annual interdisciplinary review of the Individualized Plan (IP) was held.

Also use this field to record the date of the last Annual Resident Review for individuals who are residing in a nursing home and have declined active treatment and case management services (overall status will be terminated). Annual Resident Reviews must be conducted yearly for nursing home residents regardless of whether the individual is receiving any other services.

ADDRESS - Required

This is the person's current physical address, not that of a relative or guardian or contact. If the person lives in a residential facility funded by DD, enter the address of the facility. Enter the actual address if the person is in an individual residential setting or actually living with a relative or guardian. Enter contact or relative names and addresses for persons not residing at this address in the CCMS Address file.

The street address can be blank only if a freeform address is appropriate: the address is a Post Office Box or Rural Route Number. Please enter the street address in this order to facilitate data entry.

HOUSE NUMBER - Required
The number of the structure on the street - as in the '123' of '123 Elm Street'.

STREET DIRECTION
The direction of the street - as in the 'North' of '123 North Elm Street'.

STREET NAME - Required
The name of the street - as in the 'Elm' of '123 Elm Street'.

STREET TYPE - Required
The type of the street - as in the 'Street' of '123 Elm Street'.

ENDING STREET DIRECTION
The ending street direction - as in the 'SW' of '123 Elm Street SW'.

FREEFORM ADDRESS - Required if no street address
A freeform address that does not fit the format; as in 'P.O. Box' or General Delivery, Etc. Also use this field for apartment number, suite number, etc.
Must be completed is there is no other street address.

CITY - Required
The name of the city for this person's address.

STATE - Required
The state where this person lives.

ZIP CODE - Required
The zip code for this person's address. The format includes the extended four numbers, you must enter at least the usual first five numbers.

BIRTHDATE - Required

Enter the person's date of birth. This date cannot be a future date.

GENDER - Required

Pick the appropriate code:
M Male
F Female

LEVEL OF FUNCTIONING - Required

Pick a level of functioning as assessed using the guidelines of the American Association on Mental Deficiencies (AAMD) and using nationally recognized assessment tools. You must use the standards for administration contained in the instruction manual for the tools your Agency selects to use. Documentation of these assessments must be contained in the person's record.

Use the following guidelines to complete the level of functioning code. These guidelines were taken from the AAMD 1983 Revision of Classification in Mental Retardation.:

> "IQ is an important component of the definition of mental retardation and determination of IQ is a salient clinical step; but both the definition of mental retardation and diagnostic practice go beyond IQ. The posture of the American Association on Mental Deficiency has always been that diagnosis is made in a thorough clinical assessment of the person, which should include appraisal of adaptive behavior, review of information secured from informed people such as teachers, parents, and family physician; and direct observation of the behavior."

The narrow band at each end of each level listed below, was used to indicate that clinical judgment about all information, including the IQs, adaptive behavior scales and other information about intellectual functioning is necessary to determine level.
NO Normal - IQ of above 70-75.
MI Mild - IQ range of 50-55 to approximately 70.
MO Moderate- IQ range of 35-40 to 50-55.
SE Severe - IQ range of 20-25 to 35-40.
PF Profound - IQ range of below 20 or 25.

The following codes may be used if the level of functioning cannot be entered for the reasons defined.

UD Undetermined - due to age (under 5 years old) or condition.

UK Unknown - Assessment of level of functioning has been made by an agency other than yours, and the information has not been made available to your Agency.

IQ SCORE - Optional

Record the actual IQ score. If the score is greater than 100, record 99. If the score is undetermined due to age (under 5 years old) or condition, then enter 'UD' in this field. If an IQ score has been determined by some other agency but has not been made available to your Agency, then enter 'UK' for unknown.

If an IQ test has been applied, but the individual's performance is not scoreable on the Intelligence Scale used, then enter 'NS' in this field. Individuals who have had an IQ test applied but are in an unscoreable range can generally be assumed to be in the profound range of mental retardation with an IQ of less than 20. (Source: Jerry Treadway, Psychologist, Wheatridge Regional Center)

ETHNICITY - Required

The racial/ethnic origins of the person. The definitions of the codes below were taken from Federal guidelines. Pick the appropriate entry from the list.

W White - A person with origins in any of the original peoples of Europe, North Africa, or the Middle East who is not of Hispanic origin.

H Hispanic - A person of Mexican, Puerto Rican, Cuban, South American, or other Spanish culture or origin, regardless of race.

B Black - A person with origins in any of the black racial groups of Africa who is also not of Hispanic origin.

A Asian or Pacific Islander - A person with origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Republic, and Samoa.

I American Indian or Alaskan Native - A person with origins in any of the original peoples of North America and who maintains cultural identification through tribal affiliation or community recognition.

U Unknown - The individual's origin is unknown or unavailable.

SCHOOL DISTRICT OF FINANCIAL RESPONSIBILITY - Optional

Pick the school district where the person is or may be counted for purposes of receiving funds under the School Finance Act (also referred to as Per Pupil Operating Revenue (PPOR), previously known as ARB). If the person will be less than 21 years of age on or after September 15 of the current year, you must complete this field. Note that CCMS School District codes do not correspond to Department of Education codes.

DISABILITIES - Required

A limiting condition or continuing handicap that contributes to the need for special programming or other services. To be recorded on CCMS, these disabilities must either be medically determined, based

on the results of a recognized evaluation tool, or have an IP/IPP objective aimed at addressing them. The person's file must contain proper documentation.

Pick the appropriate disability type from the list. You may enter up to eight disabilities, but do not use a code more than once.

The primary developmental disabilities categories (mental retardation, cerebral palsy, seizure disorder, autism, other neurological condition, developmental delay, and at-risk) are defined in the uniform eligibility criteria. Any changes to the eligibility criteria will overrule definitions given here.

MR Mental Retardation - Significant subaverage general intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior and manifested during the developmental years (prior to age 18). Both the intellectual level and adaptive behavior level will be considered in making classifications. Only those individuals who demonstrate deficits in both measured intelligence and adaptive behavior are classified as being mentally retarded. This condition must be documented in the person's file by a medical diagnosis.

Significantly subaverage is defined as an IQ of 70 or below on standardized measures of intelligence. This upper limit is intended as a guideline; it could be extended upward through IQ 75 or more, depending on the reliability of the intelligence test used.

Impairments in adaptive behavior are defined as significant limitations in an individual's effectiveness in meeting the standards of maturation, learning, personal independence and/or social responsibility that are expected of his or her age level and cultural group, as determined by clinical assessment and, usually standardized scales. Since these expectations vary for different age groups, deficits in adaptive behavior will vary at different ages. Behaviors contributing to a total adaptation to the environment are reflected in the following developmental areas:

- Sensory development
- Motor skills development
- Communication skills (including speech and language)
- Self-help skills
- Social/Emotional development
- Cognitive development
- Application of appropriate reasoning and judgment in mastery of the environment
- Vocational skills

(AAMR Definition)

CP Cerebral Palsy - A disorder dating from birth or early infancy, non-progressive, characterized by examples of aberrations of motor function (paralysis, weakness, incoordination) and often other manifestations of organic brain damage such as sensory disorders, seizures, mental retardation, learning difficulty and behavioral disorders. This condition must be documented in the person's file by a medical diagnosis.

SD Seizure Disorder/Epilepsy - A clinical disorder characterized by single or recurring attacks of loss of consciousness, convulsive movements, or disturbances of feeling or behavior. These transient episodes are associated with excessive neuronal discharges occurring diffusely or

focally in the brain. The sites of neuronal discharge determine the clinical manifestations of the seizure. This condition must be documented in the person's file by a medical diagnosis.

AU Autism - A rare condition characterized by severe problems in communication and behavior and an inability to relate to people in a normal manner. This condition must be documented in the person's file by a medical diagnosis.

ON Other Neurological Conditions - These include brain damage (excluding traumatic brain injury), spina bifida, muscular dystrophy and other sensory handicaps.

- Brain Damage - Brain damaged persons are those who have suffered injury to intact brain cells through any process or event other than traumatic brain injury which occurs after conception and which either destroys or permanently disorganizes functioning cell systems in the brain. A diagnosis requires a documented history of damage or neurologic symptoms of such a nature that they furnish certain evidence that damage has taken place. Mental retardation is a frequent but not invariable symptom of brain damage. This condition must be documented in the person's file by a medical diagnosis. If the brain damage is the result of a Traumatic Brain Injury (TBI), record the disability only under the BI category.
- Spina Bifida - is a developmental anomaly characterized by a defect in the bony encasement of the spinal cord, causing motor damage, muscle weakness or brain damage. This condition must be documented in the person's file by a medical diagnosis.
- Muscular Dystrophy - is an inherited degenerative muscle disease causing progressive deterioration of muscle size and strength. This condition must be documented in the person's file by a medical diagnosis

DD Developmental Delay - means that a child -meets one or more of the following:

A child less than five (5) years of age who is significantly delayed in development in one or more of the following areas:

- Communication,
- Adaptive behavior,
- Social-emotional,
- Motor,
- Sensory, or
- Cognition.

(DDD Rules, Section 16.120, February 2001)

AR At Risk - A child who is less than five (5) years of age at risk of having a developmental disability because of the presence of one or more of the following:

- Chromosomal conditions associated with delays in development,
- Congenital syndromes and conditions associated with delays in development,
- Sensory impairments associated with delays in development,
- Metabolic disorders associated with delays in development,
- Prenatal and perinatal infections and significant medical problems associated with delays in development,
- Low birth weight infants weighting less than 1200 grams, or
- Postnatal acquired problems resulting in delays in development.

Or, A child less than three (3) years of age who lives with one or both parents who have a developmental disability.
(DDD Rules, Section 16.120, February 2001)

SH Significant Hearing Impairment/Deaf - A deficiency in hearing acuity as demonstrated by reduced threshold of auditory sensitivity to pure tones or speech, sufficient to affect the ability to communicate with others, where, even with the help of amplification, the person requires supplementary assistance or modification of instructional methods and materials in order to communicate, function and learn. Sufficient deficiency is generally considered to be an average hearing loss of 20 decibels or greater in the better ear in the speech range. The hearing deficit must be documented in the person's file by an appropriate screening test, assessment or physical administered by a qualified professional and must have been applied within accepted current practice, and must be addressed within the IP.

SV Significant Vision Impairment/Blind - A deficiency in vision acuity where, even with the use of lenses or corrective devices, the person requires modification or adaptation of instructional methods and materials or supplementary assistance in order to function and learn. The vision deficit must be documented in the person's file by an appropriate screening test, assessment or physical administered by a qualified professional and must have been applied within accepted current practice, and must be addressed within the IP.

SS Significant Speech Impairment/Non-Verbal - A deficiency in the ability to verbally express oneself which requires articulation or communication therapy. The speech deficit must be documented in the person's file by an appropriate screening test, assessment or physical administered by a qualified professional and must have been applied within accepted current practice, and must be addressed within the IP.

MB Maladaptive Behavior Requiring Intervention - Behaviors which require intervention documented in an IP/ISSP objective and which are dangerous to self and/or others or which interfere with and/or disrupt programming. The person must have demonstrated one or more of the following behaviors taken from the Behavior Rating Scale at a level judged to be "frequently, many or often":

- inappropriate hugging, kissing, clinging, or other inappropriate attention demanding behavior
- inappropriate yelling, screaming, swearing, or other inappropriate verbal behavior
- threats of spitting, pushing, shoving, or other threats of mild aggressive behavior
- spitting, pushing, shoving, or other mild aggressive behavior
- threats of hitting, kicking, biting, scratching, hair pulling, or other threats of intense aggressive behavior
- hitting, kicking, biting, scratching, hair pulling, or other intense aggressive behavior
- furniture shoving, chair tipping, object throwing, or other similarly disruptive behavior
- clothes tearing, window breaking, fire setting, or other similarly destructive behavior
- mild hair pulling, body slapping, sore picking, arm/hand biting, head banging, or other mild self-abusive behavior
- intense hair pulling, body slapping, sore picking, arm/hand biting, head banging, or other intense self-abusive behavior

- restlessness, running, jumping, pacing, or other hyperactive behaviors
- body rocking, head rolling, arm/hand waving, or other stereotypic behaviors
- excessive laughing, talking to self, repeating phrase over and over, or other bizarre speech or noises
- sitting, standing, or moving self away from others/activities or other withdrawn behaviors
- pica (ate inappropriate, non-nutritive substances) or inappropriate mouthing of object
- inappropriate masturbation, body part fondling or other sexual behavior toward self
- inappropriate gestures, touching/fondling or other sexual behavior toward others
- the taking of others' belongings or other stealing behavior
- inappropriate removal of clothing, shoes or other stripping behavior

MI Developmental Disability/Mental Illness Co-Occurring Diagnosis- The individual has a psychiatric diagnosis that is current within a two-year period of the date of entry into the CCMS system and which is fully documented in the person's record. Individuals with longstanding diagnoses of chronic and ongoing psychiatric conditions should have these diagnoses reflected and confirmed in their current medical records. The person should be receiving current treatment for the condition or they should be eligible for treatment but unable to access services (e.g., on a waiting list, etc.).

DSM-IV categories should be used to describe the psychiatric condition. Some of the most common classifications include, but are not limited to:

- Schizophrenia and Other Psychotic Disorders;
- Mood Disorders;
- Anxiety Disorders (Note: among other disorders, this category includes obsessive compulsive disorder and posttraumatic stress disorder);
- Impulse-Control Disorders Not Elsewhere Classified; and
- Personality Disorders

*Clarification: Because of the difficulty in discriminating between behavioral and psychiatric causes for some symptoms displayed by persons with developmental disabilities, it is typically harder to arrive at a conclusive diagnosis of Impulse-Control Disorder or Personality Disorder.*

Although both autism and attention deficit disorders have DSM-IV classification codes, these conditions are captured as separate categories in the CCMS data fields and should not be reflected under MI. Any other disability not specifically listed in the CCMS definitions should be included in the Other category.

In order for an individual to remain classified as MI in the CCMS system, the CCB will need to confirm that the record of the individual reflects current psychiatric diagnosis

(Guidelines for Use of MI Category in CCMS – memo from Cami Learned 12/23/2003)

NA Non-Ambulatory - The inability to move from place to place without the assistance of a physical device. (CORE PAC)

NM Non-Mobile - The inability to move from place to place without the assistance of another person. (CORE PAC)

MF Medically Fragile - The individual is either ambulatory or nonambulatory and:

- is in need of continuous supervision;
- is in need of intermittent medical/nursing care;
- may require recurrent skilled nursing intervention.

The individual will generally exhibit one or more of the following:

- Massive sensory deprivation;
- Severe motor dysfunction;
- Neurological or degenerative disease with associated medical/nursing needs;
- Congenital anomalies or genetic disorders requiring medical/nursing supervision;
- Uncontrolled seizure disorders;
- Respiratory distress syndrome with resultant and recurrent apnea;
- Immature survival reflexes requiring life support;
- Profound brain damage resulting from near drowning or other trauma;
- Failure-to-thrive syndrome with physiological developmental delay.

The individual will require procedures including but not limited to the following:

- Tube insertion and/or feeding (nasogastric, lavage, gastrostomy, etc.);
- Suctioning (nasal or tracheal);
- Oxygen therapy;
- Intermittent positive pressure breathing (IPPB);
- Wound irrigation, drainage and dressing;
- Catheterization and catheter care;
- Apnea monitoring;
- Positioning and skin care;
- Special diets.

(Colorado Dept. of Public Health and Environment)

BI Brain Injury - The individual has suffered an insult to the brain, not of a degenerative or congenital nature, caused by an external physical force. That force or blow may produce a diminished or altered state of consciousness, which results in dysfunction of cognitive abilities and/or physical functioning. These impairments may be either temporary or permanent and cause partial or total functional disability or psychosocial maladjustment. This condition must be documented in the person's file by a medical diagnosis. Enter this disability in the CORE record only if it is a current or permanent condition.
(Traumatic Brain Injury and Vocational Rehabilitation, The Research and Training Center, University of Wisconsin-Stout)

DS Down Syndrome - The individual has been diagnosed by a qualified professional with the chromosomal abnormality called Down Syndrome.
This is a syndrome in which the majority of affected individuals are trisomic for chromosome number 21: clinical manifestations include epcanthal folds, oblique palpebral fissures, broad

bridge of the nose, protruding tongue, open mouth, square-shaped ears, muscular hypotonia, often congenital heard disease, and varying degrees of mental retardation.
(Classification in Mental Retardation, AAMD, 1983)

FX Fragile X Syndrome - The individual has been diagnosed by a qualified professional with the chromosomal abnormality called Fragile X Syndrome.
"The fragile X syndrome may account for a large number of persons who have been described as having mild familial MR, estimated to affect 1/1000 births. Males are affected more often than females. Associated physical features include normal to increased head size, macro-orchidism, a prominent jaw, and protruding ears."
The X chromosome has a constriction near the end of the long arm, resulting in what looks like a small knob separated from the main portion of the chromosome by a thin stalk. The thin stalk is referred to as a fragile site.
(The Merc Manual, Chapters 191 and 206, 1992

AD Attention Deficit Disorder - The individual has been diagnosed by a qualified professional with this disorder.
"The essential feature of Attention-Deficit/Hyperactivity Disorder is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than is typically observed in individuals at a comparable level of development (Criterion A). Some hyperactive-impulsive or inattentive symptoms that cause impairment must have been present before age 7 years, although many individuals are diagnosed after the symptoms have been present for a number of years (Criterion B). Some impairment from the symptoms must be present in at least two settings (e.g., at home and at school or work) (Criterion C). There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning (Criterion D). The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and is not better accounted for by another mental disorder (e.g., a Mood Disorder, Anxiety Disorder, Dissociative Disorder, or Personality Disorder) (Criterion E)."
(Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, 1994

OT Other - The individual has a disability that does not fall within any of the items listed above. It must, however, be significant enough that an IP/IPP objective exists to address the problem.

COMMENT FIELD - Optional

This is a free-form field your Agency can use to record any comments appropriate for this record.

DAY SERVICE STATUS AND DATE - Mandatory

This field reflects the person's status and date of status with regard to Day Service. You must enter a day service status and date or a new record will not be added to the file. An existing record cannot be saved without this information. Enter the appropriate status from the list and enter the date on which the day service status became effective.

The status date should change every time the day service status changes unless an incorrect status is being corrected or a Regional Center discharge and admission are occurring on the same day. Data entry edits will require that the date be entered when a status is entered.

When you update the day service status and date fields on an existing CCMS record, you will be asked for "M/U" to indicate a correction of a mistake (M) or an update of valid data (U). If both the status and date of status are changed, both fields must have matching change types (e.g. "M" as the change type for both status and date of status). However, you may correct just one of the fields with an "M" if you need to correct invalid data which was entered in that field. If you update one field with a "U", the program will require you to enter into the other field. (A valid update affects both the status and date of status). The Date of Status will serve as the Date of Change. You will be able to enter logically inconsistent status changes if you are making a mistake change rather than an update. DO NOT use the mistake change type to change a status to one that is not logically consistent with the previous status unless it really is a mistake correction.

C Comprehensive – This status applies to a person who is currently receiving day services as part of Comprehensive Services or who resides in a Regional Center. The day service must be specifically listed in the Comprehensive Individualized Plan. When the person discontinues Comprehensive Services or the day service is removed from the plan, the status must be changed to "T" - Terminated.

S SLS Program - This status applies to a person who is currently receiving day services as part of DD Supported Living Services. The day service must be specifically listed in the Individualized Plan. When the person discontinues Supported Living Services or the day service is removed from the plan, the status must be changed to "T" - Terminated.

T Terminated - This person was previously receiving DD or RC funded day services and is no longer.

N Non-DD funded or No Service - This person is not receiving a DD funded day service, is receiving a day service not funded through your agency or is not receiving any day service.

CURRENT DAY SERVICES - Optional

The setting(s) that best describe the person's current day services. Each of four sets of fields (Day Service Type, Funding, Provider/Location, Level of Service and Date of Change) is considered to be one set of information for the CCMS History file. When data entry is completed, the Date of Change will be used for all fields in the set. Therefore, if the information changes with multiple dates, the form or face sheet must be completed to indicate which fields changed on which date. You cannot correct a Mistake and Update a field on the same date. Correction of a Mistake must use the previous date of change so that the update programs can change the correct history record. Make all Mistake corrections first, save the record, then make Updates. If you have multiple dates of change, make the changes associated with the earliest date first, save the record, then make changes for each subsequent date, saving the record between each date.

Enter as many sets of information as the person receives day service types. This information is optional because DDD does not require it with the implementation of Comprehensive Services effective July 1, 1999. However, if you do enter any information in these sets, edits for missing data, logical consistency and mistake/update consistency will be applied for each set you enter.

DAY SERVICE TYPE - Optional
The service type currently attended by the person. All persons enrolled in DD funded services must meet the DDD eligibility criteria. Whenever a change is made to this field, be sure to check the accuracy of data in location, date, funding and level of service. When a day service is updated, the Date of Change must change, unless you are correcting a mistake.

DD Funded Services

IA Integrated Activities - State or Waiver Funded
Integrated Activities are typical activities and functions of community life that are desired and chosen by the general population, including community education or training, and retirement activities. Integrated Activities provide a wide variety of opportunities to facilitate, build relationships and natural supports in the community, along with utilizing the community as a learning environment to provide instruction when identified in the Individualized Plan.

NA Non-Integrated Activities - State or Waiver Funded
Non-Integrated Activities are training or day activities (i.e. non-paid work or activities) which are primarily habilitative in nature with an emphasis on skill development and focus on generalizing those skills. Non-Integrated Activities are provided in sheltered/ segregated settings in which the majority of people have a disability or the primary purpose of the agency/business is to provide training or day activities for persons with disabilities (e.g. facility-based day program site).

IW Integrated Work - State or Waiver Funded
Integrated Work is work a person performs in a community job setting and support provided by paid staff to develop or maintain the community job.

NW Non-Integrated Work - State or Waiver Funded
Non-Integrated Work is paid work (no matter the rate of pay) in a sheltered/ segregated setting. Non-integrated Work (i.e. Sheltered Work Services) typically includes contract and/or subcontract work and prime manufacturing in a setting/business in which the majority of workers have a disability or the primary purpose of the agency/business is to provide work for persons with disabilities (e.g. facility-based sheltered workshop).

Other Services/Employment - Not DD Funded

CE Competitive Employment without Support - A job in which a person with developmental disabilities is a member of a firm's or organization's regular work force, is paid wages at minimum wage or better, is entitled to benefits on the same basis as non-disabled workers, and constitutes at least 20 hours of work each week. Maintenance services are not required on a regular basis. This is not an Integrated Work service funded through DD.

PP Private Preschool - A regular or special education service for preschool aged children that is not part of the public school system or DD system.

PU Public School - A regular or special education program of the public school system.

DR Division of Vocational Rehabilitation - A service funded by the Colorado Division of Vocational Rehabilitation

MH Mental Health Services - A service funded by Colorado Mental Health Services or the Department of Health Care Policy and Financing capitated Mental Health plan

YS Office of Youth Services - A service funded by the Colorado Division of Youth Services

SS Social Services - A service funded directly by other Colorado Department of Human Services (CDHS) offices.

OT Other - The individual is receiving a service not listed above and which is not funded by DD.

NO None - The individual is receiving no established day service at this time.

DAY SERVICE FUNDING - Optional
Pick the code that corresponds to the funding for the day service type indicated in this 'day service set'.

S State - This service is funded through State DD funds, and the person receives day service funds through DD.

OS OBRA Community State - This service is funded through State DD funds, and the person receives day service funds through DD that have been targeted for individuals who have moved out of a nursing facility.

ON OBRA Nursing Home State - This funding is for persons residing in a nursing facility who are receiving day services as part of an SLS program through State DD funding.

HW HCB-DD Waiver - This service is certified for Medicaid and the person does, in fact, receive funds through the HCB-DD Waiver. (i.e. Comprehensive Services)

OW OBRA Waiver - This service is certified for Medicaid and the person does, in fact, receive funds through the OBRA Waiver. The person must have moved out of a nursing facility. As of 9/30/95 this Waiver is part of the 'regular' HCB-DD Waiver, but for purposes of tracking the original allocation source, the funding must be identified as OBRA.

MS Medicaid State Plan - The person is receiving State Plan Medicaid funds, not HCB-DD or OBRA Waiver funds. These persons will normally reside in a Nursing Facility, Regional Center Campus, or ICF/MR >15 facility where day program is provided by the facility staff. This funding type has been known in the past as Title XIX.

SL SLS Waiver - This service is certified for Medicaid and the person does, in fact, receive funds through the SLS Waiver.

SS SLS State - This service is funded through State Support Block funds, and the person receives day service funds through DD.

PP Private Pay - The person may be enrolled in a program whose services are normally funded through DD, but they are funding these services with private payment.

O Other - The person receives funding other than through DD State, DD Waiver, or State Plan Medicaid even though he or she may be enrolled in a service normally funded by one of these funding bases.

ED Department of Education - This service is funded with Department of Education or local school district funds.

N None - The person receives no funding for day services.

DAY SERVICE PROVIDER/LOCATION - Optional
Enter the name of the facility where this day service is located, or the name of the service provider. You must enter a location code for each DD funded day service. If the individual is enrolled in more than one service at the same location, you will enter the same code more than once.

These codes are assigned by the DDD Central Office; you may NOT assign these codes. Location codes are only required for DD funded services. DO NOT enter school district codes here.

DAY SERVICE LEVEL OF SERVICE - Optional
Indicates the level of service provided. Prior to 7/1/99, allocations were assigned by DDD to day program services and the level codes were based on DDD definitions of the funding levels. Your Agency may continue to use these funding level codes as they apply to your own allocation process for day program services.

Pick the appropriate type from the list.

F Flat Rate - This person is not receiving a rate higher than the usual rate for this program.
E Enhanced Rate - The person is receiving an enhanced rate for this program.
H High Need - This person is receiving a high need rate.
N Negotiated - This person is receiving a negotiated rate.
R REF - This person is receiving an enhanced rate through a Rate Enhancement Funding process.

DATE OF CHANGE - Optional
This date will change any time information in any one of the fields in the 'Day Service Set' is updated. These fields are:

Day Service Type
Day Service Funding
Day Service Provider/Location
Day Service Level of Service

It will be stored in the history file to indicate the date the information changed.

It cannot be blank if the day service type field is not blank.

It must change when an update is made, but may remain the same if all changes are indicated as mistake corrections. However, do NOT change this date if only the optional Agency Day Service Type is updated. The Agency Day Service Type is for internal use and does not affect tracking of DDD defined historical data.

If this is not a new record entry, it cannot be earlier than the date currently on the file unless this is a mistake correction.

It cannot be a future date and cannot be prior to the date of birth.

AGENCY DAY SERVICE TYPE - Optional

The name your Agency uses to refer to this service. These names and codes must be assigned and entered into the CCMS Table file by your Agency.

DAY SERVICE COORDINATOR - Optional

This code is determined by your Agency and refers to the staff person who coordinates the day service services for this person.

Enter the name of the coordinator or pick the appropriate name from the list.

You must have entered the codes and names into the CCMS Table file.

COMPREHENSIVE (RESIDENTIAL) STATUS AND DATE - Mandatory

These fields reflect the person's status and date of status with regard to Comprehensive Services. You must enter a comprehensive status and date or a new record will not be added to the file. An existing record cannot be saved without this information. Enter the appropriate status from the list below and enter the date on which the comprehensive status became effective.

The status date should change every time the comprehensive status changes unless an incorrect status is being corrected or a Regional Center discharge and admission are occurring on the same day. Data entry edits will require that the date be entered when the status is entered or updated.

When you update the comprehensive status and date fields on an existing CCMS record, you will be asked for "M/U" to indicate a correction of a mistake (M) or an update of valid data (U). If both the status and date of status are changed, both fields must have matching change types (e.g. "M" as the change type for both status and date of status). However, you may correct just one of the fields, however, with an "M" if you need to correct invalid data which was entered in that field. If you update one field with a "U", the program will require you to enter into the other field. (A valid update affects both the status and date of status). The Date of Status will serve as the Date of Change. You will be able to enter logically inconsistent status changes if you are making a mistake change rather than an update. DO NOT use the mistake change type to change a status to one that is not logically consistent with the previous status unless it really is a mistake correction.

A Active DD - This status applies to a person who is currently receiving comprehensive services funded through DD or who resides in a Regional Center. When the person discontinues DD or RC funded services, the status must be changed to "T" - Terminated.

T Terminated - The person was previously receiving comprehensive services funded through DD, or was in a Regional Center and is no longer receiving any of these services and supports.

N Non-DD funded or No Service - The person is living at home, is living in a non-DD funded setting or is living in a setting not funded through your Agency.

CURRENT LIVING ARRANGEMENT - Required

The setting that best describes the person's current living arrangement. This set of fields (Setting Type, Funding, Provider, Level of Service and Date of Change) are considered to be one set of information for the CCMS History file. When data entry is completed, the Date of Change will be used for all fields in the set. Therefore, if the information changes with multiple dates, the form or face sheet must be completed to indicate which fields changed on which date. You cannot correct a Mistake and Update a field on the same date. Correction of a Mistake must use the previous date of change so that the update programs can change the correct history record. Make all Mistake corrections first, save the record, then make Updates. If you have multiple dates of change, make the changes associated with the earliest date first, save the record, then make changes for each subsequent date, saving the record between each date.

RESIDENTIAL TYPE - Required
The current residential setting for the person. All persons enrolled in DD funded services must meet the DDD eligibility criteria. Whenever a change is made to this field, be sure to check the accuracy of data in provider, date, funding and level of service. When a residential setting is updated, the Date of Change must change, unless you are correcting a mistake.

DD Funded Settings

IR Individual Residential Services & Supports (IRSS) - State or Waiver Funded
Individual Residential Services and Supports (IRSS) use a variety of living arrangements individually designed to meet the unique needs for support, guidance and habilitation of each person receiving services. The service agency has the responsibility for the living environment and persons may live in a home owned or leased by the agency, their own home or a Host Home. Services are generally provided to no more than two persons receiving services per setting. (R & R 12.3.1 October 1, 1995)

This service includes the services previously identified as Host Homes, Apartments, and Personal Care Alternatives.

GR Group Residential Services & Supports (GRSS) - State or Waiver Funded
Group Residential Services and Supports (GRSS) encompass group living environments of four or more persons receiving services. (R & R 12.4.1 October 1, 1995)

This service includes the services previously identified as State Group Homes, Intensive ARS, Moderate Supervision and Specialized Group Homes, including Regional Center Satellite Group Homes.

Other Settings - Not DD Funded

IC ICF/MR > 15 - A Medicaid licensed Intermediate Care Facility for more than 15 residents. The facility provides supervision, training and necessary medical and/or physical care.

RC Regional Center - Campus - On-campus residency in a state institution providing residential and training services to persons with developmental disabilities.

NH Nursing Care Facility - A health institution planned, organized, operated and maintained to provide facilities and health services with related social care to in-patients who require regular medical care and 24-hour nursing services for illness, injury, or disability. Each patient shall be under the care of a physician licensed to practice medicine in the State of Colorado. The nursing services shall be organized and maintained to provide 24-hour nursing services under the direction of a registered professional nurse employed full-time. (Directory of Colorado Health Facilities, January, 1992, Colorado Department of Public Health and Environment)

CH RCCF or Other Children's Group Home - A residential facility for 5 or more children ages 3 through 21 years and funded through the Department of Human Services Office of Children, Youth and Families Programs.

FF Family Foster Care - A private family residential service for no more than 4 children, new born (0) through 21 years and funded through the Department of Human Services Office of Children, Youth and Families Programs.

PR Parent/Relative/Guardian's Home - Person resides with his natural or adoptive family, other relatives or legal guardian in a private home.

IH Independent Home or Apartment - Person is living independent of supervision.

BH Boarding Home - A living situation that primarily provides beds and meals. Most are unsupervised. A Personal Care Boarding Home means a residential facility that provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services, and social care but do not require regular 24-hour medical or nursing care. (Directory of Colorado Health Facilities, January, 1992, Colorado Department of Public Health and Environment)

OT Other - Residential facility does not fall within any of the items listed above.

RESIDENTIAL FUNDING - Required

Pick the code that corresponds to the funding for the residential setting indicated. These funding sources are mutually exclusive; a person cannot be receiving both Waiver and State funds, or both State and State Plan Medicaid funds.

S State - The person receives comprehensive services funded through State DD funds.

HW HCB-DD Waiver - The person receives comprehensive services certified for Medicaid and the person does, in fact, receive funds through the HCB-DD Waiver.

OW OBRA Waiver - The person receives comprehensive services certified for Medicaid and the person does, in fact, receive funds through the OBRA Waiver. The person must have moved out of a nursing facility. As of 9/30/95 this Waiver is part of the 'regular' HCB-DD Waiver, but for purposes of tracking the original allocation source, the funding must be identified as OBRA.

MS Medicaid State Plan - The person receives comprehensive services funded by regular State Plan Medicaid funds, not HCB-DD or OBRA Waiver funds. These persons will normally reside in a Nursing Facility, Regional Center Campus, or ICF/MR >15 facility. This funding type has been known in the past as Title XIX.

PP Private Pay - The person may be receiving comprehensive services in a program whose services are normally funded through DD, but they are funding these services with private payment such as family payment.

O Other - The person receives funding other than through DD State, DD Waiver, or State Plan Medicaid even though he or she may be receiving comprehensive services normally funded by one of these funding bases.

N None - The person receives no funding for comprehensive services.

RESIDENTIAL PROVIDER - Required
The provider of services or name of the residential facility indicated in Residential Setting Type. You must enter a provider or location code for DD funded residential settings.

Enter the name or pick the appropriate type from the list provided.

Codes are available for GRSS, IRSS and larger facilities (e.g. RCs and Nursing Homes). Individual homes (e.g. a particular Host Home or Family Foster Care home) are not coded.

These codes MUST be assigned by the DDD Central Office; you may NOT assign these codes.

RESIDENTIAL LEVEL OF SERVICE - Optional
Indicates the level of service provided.

Pick the appropriate level of service from the list.

L Low
M Moderate
S Specialized
E Enhanced Rate
H High Need Rate
N Negotiated
R Receives Rate Enhancement Funds (REF)

DATE OF CHANGE - Required
This date will change any time information in any one of the fields in the 'Residential Set' is updated. These fields are:

Residential Setting Type
Residential Funding
Residential Facility or Provider
Residential Level of Service

It will be stored in the history file to indicate the date the information changed.

It cannot be blank if the residential type field is not blank.

It must change when an update is made, but may remain the same if all changes are indicated as mistake corrections.

If this is not a new record entry, it cannot be earlier than the date currently on the file unless this is a mistake correction.

It cannot be a future date and cannot be prior to the date of birth.

RESIDENTIAL SERVICE COORDINATOR - Optional

This is the staff person who coordinates the residential services and supports for this person.

Enter the Coordinator's name or pick the appropriate name from the list.

You must have entered the codes and names into the CCMS Table file.

RESIDENTIAL SETTING DATE - Optional

Your Agency may use this date to record either the date the individual entered the residential setting type listed above or the date the person moved into the group home listed above.

COMMUNITY SAFETY RISK – Required if the individual presents a risk to the community
The reason a secure setting is required for the individual.

C Convicted - any individual currently in DD funded SLS or Comprehensive Services
Who has been found guilty through the criminal justice system of a criminal action involving harm to another person or arson,

**AND**

Whose behavior severity due to security/community safety issues currently requires either:

- a specially controlled environment that limits the person's ability to leave the setting unsupervised and/or
- 24-hour direct supervision.
- Individuals in this group will have Rights Restrictions in place through the DD system, parole or probation requirements, or a court order that restricts their rights.

**NOTE:** A person must meet both parts of the above definition. Therefore, if a person has a criminal conviction in the past but is currently determined **not** to pose a threat and does not require a secure environment/24 hour supervision, then they should not be identified and tracked.

N Non-Convicted – an individual currently in DD funded Comprehensive Services
Whose behavior severity due to security/community safety issues currently requires either:

- a specially controlled environment that limits the person's ability to leave the setting unsupervised and/or,
- 24-hour direct supervision.
- Individuals in this group will have Rights Restrictions in place through the DD system or a court order that restricts their rights.

**Exclusion – this applies to both Convicted and Non-Convicted**

Do not classify someone as presenting a potential public safety risk based on being a danger to themselves, rather than being a danger to others. While such factors may also require 24-hour direct supervision, they do not by themselves pose a safety risk to the public.

(Memo from Kerry Stern of June 13, 2003 "State Auditor's Recommendation #19 – Criteria for Identifying and Tracking People with High-Risk Behaviors")

COMMUNITY SAFETY REVIEW DATE – Required if the individual presents a risk to the community

The date that the last review of this individual's risk to the community was reviewed.

CASE MANAGEMENT FUNDING - Required.

The type of funding for Case Management Services. Pick the appropriate type from the list.

S State - The person's case management is funded through State DD funds. This person will typically be receiving State funded services and is not in the Waiver. The case management funds are not billed individually, but are part of a CCB's contract amount.

OS OBRA Community State - The person's case management is funded through State DD funds that have been targeted for individuals moving out of a nursing home. This person will typically be receiving State funded services and is not in the Waiver. The case management funds are not billed individually, but are part of a CCB's contract amount.

ON OBRA Nursing Home State - This person is receiving services funded by OBRA Nursing Home State, and case management funds are part of a CCB's contract amount.

MS Medicaid State Plan - The person's case management is funded with State Plan Medicaid funds. These persons will normally be receiving Targeted Case Management.

CW Children's Medical Waiver - The person's case management is provided through the Children's Medical Waiver.

PP Private Pay - The person's case management if funded with private payment.

O Other - The person's case management funding is other than listed above.

N None - The person receives no funding for case management services.

DD ELIGIBILITY DATE - Required

DD Eligibility Date - This is the date that eligibility for DD services was determined in accordance with DDD rules. Also refer to the Revised Waiting List Guidelines published by DDD in August, 1999 for relationship of this date to the waiting list date.

The date cannot be a future date or prior to the birthdate.

If this is a new record, or the overall status is being updated to Active, Case Management, or Waiting List without Case Management, there will be a screen reminder that this date is required.

ORDER OF SELECTION DATE - Required if waiting for services

Order of selection for Waiting List placement - This is the date that will be used for prioritizing on the State-wide waiting list as described in the Revised Waiting List Guidelines published by DDD in August, 1999. This will usually be the DD Eligibility Date. However, since a child cannot be on a waiting list for adult services (IRSS, GRSS, or Supported Living Services) until the age of fourteen, the waiting list date for adult services may be no earlier than the child's 14th birthday. The following excerpt from the Waiting List Guidelines is included here for reference. You **must** refer to the Waiting List Guidelines for additional specifics and situations. Also refer to CCMS correspondence.

**Date of Placement on Waiting Lists for Persons Residing in Colorado**

*Adult Services*: The date used to establish a persons' placement on a waiting list for adult services is:

- The date when eligibility for the developmental disabilities system was originally established; or,

- The person's fourteenth (14) birth date if s/he was determined eligible prior to age 14. (This age was chosen to be synchronous with the age in the Individuals with Disabilities Education Act at which transition planning for adult services is encouraged.) A child can not be on the waiting list for adult services prior to the age of 14.

- If the exact date when eligibility was initially established can not be identified, the date when the person first started services will be used. These situations, however should be exceptions and only occur when a person has been in the system for a long time.

The original date of eligibility or a child's 14 birth date, when applicable, will be used for placement on the waiting list for all persons and types of service. These dates will also be used when a person is

placed on the waiting list in another service area; i.e., the placement date is "portable". The person will maintain his/her date for placement on a waiting list as long as s/he continues to be eligible for services in the developmental disabilities system.

The following are some examples of the above:

1. Tom was determined eligible for developmental disabilities services December 5, 1998 when he was 25. The date used to establish placement on the waiting list is December 5, 1998, the original date of eligibility.

2. Jennifer who is 15 wants to be placed on the waiting list for comprehensive services. She was determined eligible for the developmental disabilities system when she was 12. The date used to establish her placement on the waiting list is her 14 birth date.

3. Emily is also 15 and wants to be placed on the waiting list for SLS services. She was not determined eligible until she was 15; her date for placement on the waiting list will be the date of eligibility determination.

4. Michael has an eligibility date of March 15, 1996. He wants to move and be placed on the waiting list in another service area. His date of placement for the waiting list in the other service area will be March 15, 1996 (the original eligibility date).

*Children's Services*: As with adults, the date when a child is determined to meet the eligibility criteria for services in the developmental disabilities system will be used to determine placement on a waiting list for children's services.

Children determined eligible prior to the age of five (children with a developmental delay) need to have their eligibility re-determined at the age of five since different eligibility criteria set in at that time (children need to be determined to have a developmental disability). If a child is still determined eligible at age five, the original date of eligibility will be used for him/her for purpose of placement on the waiting list for children's services. For example, a child is determined to have a developmental delay and eligible for Early Intervention services August 1, 1995; at the age of five he is determined to have a developmental disability and therefore eligible to continue to receive services. The date used for his placement on the waiting list for children's services (i.e. FSSP) will be August 1, 1995.

*Children's Extensive Support Waiver(CES)* - The waiting list for CES is a statewide waiting list and is maintained by the Colorado Foundation for Medical Care (CFMC). The Order of Selection date is determined by CFMC and you must enter it as it was provided.

WAITING LIST REFERRAL REASON - Required if waiting for services after January 1, 2000

This information is helpful in tracking the growth of the waiting list and the reasons people are waiting for services.

Pick the appropriate code from the list.

A Recent move to Colorado
B Available Services – services became available
C Transition - aging out of foster care, schools, etc. and referred to the CCB to seek transition/on-going services).
D Other Agency referral - was referred by Social Services, Health, Schools, Mental Health or other service agency
E Emergency - there was a recent change in circumstances which resulted in seeking services at this time.
F Phone/Word of mouth - friends, neighbors, others in DDD programs or phone book entry.
G Advertisement - via some advertisement or printed materials
Z Other

BENEFITS - Optional

The description of the benefit received. Pick the appropriate benefit from the list. These codes must have been entered into your Agency's CCMS Table file. The codes must be assigned by DDD. DO NOT ADD CODES WITHOUT CONTACTING DDD.

| | |
|---|---|
| TANF | Temporary Aid to Needy Families |
| CHRP | Children's Habilitation Residential Program Waiver |
| CMW | Children's Medicaid Waiver |
| EBD | Elderly, Blind and Disabled Waiver |
| EPSD | Early and Periodic Screening Diagnosis and Treatment |
| FS | Food Stamps |
| HCA | Home Care Allowance |
| HCBS | HCBS Children's Waiver |
| HCP | Health Care Program for Children with Special Needs |
| HUD | Housing & Urban Development |
| MDCD | Medicaid |
| MDCR | Medicare |
| OAA | Older Americans Act |
| PASS | PASS/IRWE |
| PC | Part C |
| PLWA | Persons Living with Aids |
| PPOR | Per Pupil Operating Revenue |
| REP | Representative Payee |
| RR | Railroad Retirement Benefits |
| SSDI | Social Security Disability Insurance |
| SSI | Supplemental Security Income |
| VA | Veterans Administration Benefits |
| WIC | Women Infants & Children |
| NO | None |

BENEFIT RECEIPT - Optional

Is this benefit currently received, needed, or received but needed in a larger amount?

Pick the appropriate type from the list.

R Received
N Needed
B Both - received, but the person needs a larger amount.

BENEFIT AMOUNT - Optional

Enter the amount of benefit received or needed if appropriate.

SUPPORT STATUS AND DATE - Mandatory

These fields reflect the person's status and date of status with regard to Support Services. You must enter a support status and date or a new record will not be added to the file. An existing record cannot be saved without this information. Enter the appropriate status from the list and enter the date on which the support status became effective.

The status date should change every time the support status changes unless an incorrect status is being corrected or a Regional Center discharge and admission are occurring on the same day. Data entry edits will require that the date be entered when a status is entered.

When you update the support service status and date fields on an existing CCMS record, you will be asked for "M/U" to indicate a correction of a mistake (M) or an update of valid data (U). If both the status and date of status are changed, both fields must have matching change types (e.g. "M" as the change type for both status and date of status). However, you may correct just one of the fields, however, with an "M" if you need to correct invalid data which was entered in that field. If you update one field with a "U", the program will require you to enter into the other field. (A valid update affects both the status and date of status). The Date of Status will serve as the Date of Change. You will be able to enter logically inconsistent status changes if you are making a mistake change rather than an update. DO NOT use the mistake change type to change a status to one that is not logically consistent with the previous status unless it really is a mistake correction.

A Active DD - This status applies to a person who is currently receiving support services funded by DD. When the person discontinues DD funded support services, the status must be changed to "T" - Terminated.

T Terminated - This person was previously receiving DD funded support services and is no longer receiving DD funded support services.

N Non-DD funded or No Service - This person is not receiving a DD funded support service, is receiving a support service not funded through your Agency or is not receiving any support service.

L Local NO Match – This person is receiving Early Intervention or Family Support Services Program services through local funds only, that are not matched by any DD funds.

CURRENT SUPPORT SERVICES - Required

The settings that best describe the person's support services. Each of three sets of fields (Support Service Type, Funding, Provider, Level of Service and Date of Change) is considered to be one set of information for the CCMS History file. When data entry is completed, the Date of Change will be used for all fields in the set. Therefore, if the information changes with multiple dates, the form or face sheet must be completed to indicate which fields changed on which date. You cannot correct a Mistake and Update a field on the same date. Correction of a Mistake must use the previous date of change so that the update programs can change the correct history record. Make all Mistake corrections first, save the record, then make Updates. If you have multiple dates of change, make the changes associated with the earliest date first, save the record, then make changes for each subsequent date, saving the record between each date.

SUPPORT SERVICE TYPE - Required
The service type currently received by the person. All persons enrolled in DD funded services must meet the DDD eligibility criteria. Whenever a change is made to this field, be sure to check the accuracy of data in provider, date, funding and level of service. When a support service is updated, the Date of Change must change, unless you are correcting a mistake.

Family Support Services Program
The Family Support Services Program (FSSP) offers assistance to a family who chooses or desires to maintain a family member with a developmental disability at home. The family member who is generating the program eligibility for the Family Support Services Program must meet the following program criteria:

- The person, regardless of his/her age, has been determined to have a developmental disability by a CCB, pursuant to C.R.S. 27-10.5-102(11); and
- The person with a developmental disability lives with a family.

Once a specific person meets the eligibility criteria, the entire family living in the household becomes eligible to receive services and supports which are directly related to the person's disability and are necessary to maintain the family member with a developmental disability at home. (FSSP Implementation Guidelines 9/97)

FE FSSP Extended Support - State Funded
Family Support Extended is defined as a category of FSSP in which a family is enrolled in a prioritized fashion based upon the intensity of need of the family (i.e. they meet the Families Most in Need criteria) and the on-going level of services and supports that are necessary to meet the needs of the family. The Community Centered Board, through the Family Support Plan (FSP), must make an on-going (i.e. at least annual) commitment of funding and support which could be expected to continue into the next fiscal year unless changes in the needs of the family occur. Funding which is reviewed or re-approved monthly, quarterly, or semi-annually does not qualify as on-going.
(FSSP Implementation Guidelines 9/97 and Families Most in Need criteria 7/04)

FO FSSP Other Supports - State Funded
Family Support Other is defined as any FSSP enrollment for which an ongoing commitment of funding and support is not made (i.e. they only meet the funding criteria for emergency or short-term funding).
(FSSP Implementation Guidelines 9/97 and Families Most in Need criteria 7/04)

Other DD Funded Support Services

EI Early Intervention - State Funded.
Early Intervention Services and Supports shall include eligible children birth through age two. Early Intervention Services and Supports are designed to meet the developmental needs of infants and toddlers within the context of the family. (R & R 13.1.1 October 1, 1995)

Early Intervention Services and Supports are provided in a variety of home and/or community settings typical for children of that age without special needs and appropriate to meet the individual developmental needs of the infant/toddler and their family. Parent(s) or guardian preference should receive primary consideration regarding the provision of home, and/or community based services. (R & R 13.2.1 October 1, 1995)

SL Supported Living Services (SLS) - State or Waiver Funded
Supported Living Services are services and supports which are available to assist persons with developmental disabilities to live in the person's own home, apartment, family home. SLS differs from traditional community residential services in that it does not offer “full package” 24-hour supervision services.

CS Children’s Extensive Support Services (CES) - Waiver Funded
Children’s Extensive Support Services are available to assist children under the age of 18, living in the family home, who require significant supervision or attention. The child must be enrolled in the Children’s Extensive Support Waiver before he can access these services.

NO None - The individual is receiving no established support service at this time.

SUPPORT SERVICE FUNDING - Required
Pick the code that corresponds to the funding for the support type indicated in this 'set'.

S State - The person is receiving services funded through State DD funds, and receives funds through DD.

ON OBRA Nursing Home State - This funding is for persons residing in a nursing facility who are receiving day services as part of an SLS program through State DD funding.

SL SLS Waiver - The person is receiving services certified for Medicaid and the person does, in fact, receive funds through the SLS Waiver.

CS CES Waiver - The person is receiving services certified for Medicaid and the person does, in fact, receive funds through the CES Waiver.

PP Private Pay - The person may be receiving services normally funded through DD, but they are funding these services with private payment.

O Other - The person receives services funded with other than DD State, DD Waiver, or State Plan Medicaid even though he or she may be enrolled in a program normally funded by one of these funding sources.

N None - The person receives no funding for support services.

LN Local Funds NO Match - The person is receiving EI or FSSP services and being funded through local funds and NOT State or Medicaid funds.

SUPPORT SERVICE PROVIDER - Required
Enter the name of the provider providing the services if appropriate. You must enter a provider for each DD funded service, with the exception of Family Support Services for which the CCB is always the provider. If the individual is enrolled in more than one support type provided by the same provider, you will enter the same code more than once.

These codes are assigned by the DDD Central Office; you may NOT assign these codes. Provider codes are only required for DD funded services.

SUPPORT SERVICE LEVEL - Optional
Level of service provided for this support service. These levels have not yet been defined by DDD. You may enter a level of service based on the codes below; however when the codes are defined, you may have to change them based on the DDD definitions.

L Low
M Moderate
H High

DATE OF CHANGE - Required
This date will change any time information in any one of the fields in the 'Support Service Set' is updated. These fields are:

Support Services Type
Support Services Funding
Support Services Provider
Support Services Level

It will be stored in the history file to indicate the date the information changed.

It cannot be blank if the support service type field is not blank.

It must change when an update is made, but may remain the same if all changes are indicated as mistake corrections.

If this is not a new record entry, it cannot be earlier than the date currently on the file unless this is a mistake correction.

It cannot be a future date and cannot be prior to the date of birth.

SUPPORTED LIVING CONSULTANT/COORDINATOR - Optional

This code is determined by your Agency and refers to the staff person who coordinates this support service for this person.

Enter the name or pick the appropriate name from the list.

You must have entered the codes and names into the CCMS Table file.

**FIELDS NOT ON THE DATA FORM OR SCREEN**

The following fields also exist in the data base although they may not appear on the form or the screen.

STATE IDENTIFICATION NUMBER - Required

This number is assigned by the State of Colorado Department of Human Services State Identifier Module and is entered automatically by CCMS.

AGENCY - Mandatory

The number assigned to your Agency by DDD for identification in the CCMS data systems. This number is entered by the CCMS software.

The Waiting List Registry file is used to track the need for additional resources for persons who either are receiving no services funded through DDD or who need a different type of resource than they are currently receiving. The file may also be used to track internal management needs for persons who need more of the same resource type or some change in how their current service is delivered (such as an individualized residential setting rather than a group home). Multiple waiting list records for an individual can be entered into the file in order to identify each service the person might be willing to accept.

A CORE consumer record must be entered before a waiting list record can be entered.

Refer to Section III (Individual Module) for the data entry screens and additional information about updating this file. Refer to Appendix E for file structure and field names.

NEEDED PROGRAM - Mandatory

The type of program needed. Pick the appropriate program from the list. For a description of these services, refer to the definitions in the preceding Consumer Mandatory section. Remember that some programs have age requirements, and you cannot enter a waiting list record if the person is not eligible for the program due to age (for example, Children's Extensive Support is only available to children under 18 years old). You cannot change this field on an existing record.

C Comprehensive Services (requires a supervised residential setting)
SL Supported Living Services
FS Family Support Services Program
EI Early Intervention Services
CS Children's Extensive Support Services
IC ICF/MR

NEEDED LEVEL – Conditional

The level of service that you expect this person will need for Comprehensive or Family Support Services Program (FSSP) services. This field cannot be completed for any other programs.

For Comprehensive services, pick the appropriate level of service from the list based on the rate level of the resource that is needed.

Comprehensive Level
IA Intensive ARS
MO Moderate
SP Specialized
ENH Enhanced
MID Mid Range Enhancement
HN High Need

For FSSP, pick the appropriate level of service from the list based on the level of commitment of funding and support that is needed.

FSSP Level
FE – FSSP Extended
FO – FSSP Other

NEEDED FUND - Mandatory

The presumed funding type for the program needed. Pick the type of funding for which it is anticipated the person will be eligible and for which this program is eligible.

M Medicaid
S State

NEEDED TIMELINE - Mandatory

The timeline within which this program is needed. Pick the appropriate timeline from the list.

A As Soon As Available – The service is needed right now and would be accepted as soon as it is available.
S Safety Net – The person does not want the service currently, but will if current supports are lost or otherwise change (e.g. loss of primary caregiver, change in medical status, etc.).
D See Date – a projected date at which it is known the service will be needed.

DATE NEEDED - Conditional

If the timeline entered was "See Date", enter the date it is anticipated the person will need the service.

OPTION 1 - Optional

An optional field used by your Agency to further define the need this waiting list record identifies.

This field can be used as your Agency chooses to indicate information such as: residential setting type preferred, need for a higher rate, preferred provider, etc. It is available for sort/selection criteria in report generation. You must have entered the code and its interpretation in the CCMS Table file before it can be entered in a waiting list record.

OPTION 2 – Optional

An optional field used by your Agency to further define the need this waiting list record identifies.

This field can be used as your Agency chooses to indicate information such as: residential setting type preferred, need for a higher rate, preferred provider, etc. It is available for sort/selection criteria in report generation. You must have entered the code and its interpretation in the CCMS Table file before it can be entered in a waiting list record.

TEXT OPTION - Optional

This is a 40 character freeform field that can be used for brief comments about this waiting list record.

STATUS - Mandatory

Enter the current status for this waiting list record from the list.

Y Yes – Waiting
This status is used to track needs for a person who is either receiving no services funded through DDD or who needs a different type of resource than is currently being received. There can be only one waiting list record per needed program for a person at any time with this status. For example, a person may have both a Comprehensive and a Supported Living Services waiting list record with a status of "Y", but he/she may not have two Comprehensive waiting list records with a status of "Y".

R Removed
This status is used to track needs for a person who was waiting for a new resource but has since been removed from the waiting list for that service. Only a record with a status of "Y" can be changed to this status. There may be multiple records with a status of "R" if a person has been waiting for the same program during different time spans. You cannot change this status back to "Y" on an existing record unless you are correcting an error. If the person has a later need for the program identified in this record, you must enter a new record.

I Internal Management
This status is used to track needs for a person who needs more of the same resource type or needs some change in how their current service is delivered (such as an individualized residential setting rather than a group home). This status is used at your Agency's option, to track needs that require internal management decisions to shift or revise resource assignment. As with the "Y" status, there can be only one waiting list record per needed program for a person at any time with this status.

X Internal Management Removed
This status is used to track needs for a person who was waiting for an internal management change in resources but has since been removed from the internal management list for this service. Only a record with a status of "I" can be changed to this status. There may be multiple records with a status of "X" if a person has been waiting for internal management decisions for the same program during different time spans. You cannot change this status back to "I" on an existing record unless you are correcting an error. If the person has a later need for an internal management decision for the program identified in this record, you must enter a new record.

DATE IDENTIFIED - Mandatory

Enter the date this need was identified. The date cannot be a future date. This date should be changed only if correcting an incorrect entry. If a person was removed from the waiting list or from your Agency's internal management list, the original record must be updated to a removed status (R or X), showing the date removed and the reason removed. A new record should be entered for the new identified need showing the date that the new need was identified.

DATE REMOVED - Conditional

If the status of a record is changed to a removed status (R or X), enter the date the person was removed from the waiting list or from your Agency's internal management list for this program. The date cannot be a future date. Note that a person may be removed from the list for one program, such as SLS, and still remain waiting for another program, such as Comprehensive.

REMOVAL REASON - Conditional

If the status of a record is changed to a removed status (R or X), enter the reason the person was removed from the list.

E Enrolled in Service - The person was enrolled into the service type for which he/she was waiting.

C Changed Service Need – The person no longer needs this particular service for which he/she has been waiting.

N No Annual Contact – The Agency was unsuccessful in attempting to contact the person for the annual review.

A Not Age Eligible – The person is no longer eligible for the program for which he/she was waiting due to the age eligibility requirements for the program. This only applies to Early Intervention Services, for which the person must be under the age of three, and Children's Extensive Support Services, for which the person must be under the age of 18.

T Term Overall Status – The person has been terminated from all DD funded services provided by your Agency, including case management services. If the DD Overall status on the Main data screen is changed to "T – Terminated", the system will automatically update any waiting list records with a status of "Y" to "R - Removed" and a status of "I" to "X – Internal Management Removed", effective the same date as the DD Overall status change. This code will automatically be entered as the removal reason at the same time.

The Consumer Address file contains records which track the contacts and addresses of persons associated with an individual. As many records as needed can be entered into the file for each individual. The system automatically creates or updates a "Self" address record (which identifies the individual's address) when a CORE record is created or updated for the individual.

Refer to Section III (Individual Module) for the data entry screen and additional information about updating this file. Refer to Appendix E for file structure and field names.

RELATIONSHIP - 1st is Mandatory, 2nd & 3rd are Optional

The relationship of this contact to the person (or the agency). These fields, if properly coded, can be used as selection criteria for producing limited lists or labels. Codes will apply to all three relationship fields.

The relationship code of 'S' for Self has already been assigned and used in programming to identify the address record of the person receiving services as opposed to records of other individuals associated with consumers. It is used in the 1st Relationship field of a "self" address record automatically created by the system when the CORE record is entered. You cannot enter the 'S' relationship code in the 1st Relationship field of any other address record. However, you can enter it in the 2nd and 3rd Relationship fields. Your Agency must assign other relationship codes, but YOU CANNOT CHANGE the interpretation of 'S'. The codes must first be entered in your CCMS Table file before you can enter them in an address record.

CONTACT NAME (First, Last) - Optional

The first name(s), then the last name of the person whose address this is. Remember to consider how this entry will appear on labels, lists and letters. When the "self" address record is created, the consumer name is automatically entered into these fields. You may change the contact name as needed (e.g. to the parent's name(s) if the person lives with his parents).

TITLE - Optional

The professional title (if any) of this contact person.

AGENCY - Optional

The agency of which this contact person is a member (if applicable).

STREET ADDRESS - Optional

Enter the street address for this contact person as it should appear on labels and letters. If this is a "self" address record, this field can only be updated by changing it in the CORE record. The new information will be automatically transferred to the address record.

FREEFORM - Optional

Enter freeform address information (e.g. P.O. Boxes) or a continuation of the street address for this contact person as it should appear on labels and letters. If this is a "self" address record, this field can only be updated by changing it in the CORE record. The new information will be automatically transferred to the address record.

CITY, STATE, ZIP - Optional

Enter the city, state and zip code for this contact person as it should appear on labels and letters. The zip code provides space for the nine-digit zip code. If this is a "self" address record, these fields can only be updated by changing them in the CORE record. The new information will be automatically transferred to the address record.

EMERGENCY CONTACT? - Optional

This is a checkbox to indicate whether or not this person is to be contacted in case of an emergency.

LAST UPDATE - Mandatory and Automatically Updated

The date this record was last changed. Update is automatic when any field is changed; the date is taken from the computer's system date. You cannot enter or change this field.

PHONE NUMBERS - Optional

You have room for five phone numbers for this contact person, each with the area code, prefix, number, extension and a 20 character description. Examples of phone numbers you may wish to enter are home, work, cell-phone, fax, etc.

MAILING CODES - Optional

Use these mailing codes to describe the type of mailing to be made to this contact person. Examples might be newsletters, IP staffing notices, or meeting notices.

This field, if properly coded, could be used as selection criteria for producing limited lists or labels. Remember that you can assign a code only once. Your Agency is responsible for determining the codes to be used and for entering them into your CCMS Table file.

COMMENTS - Optional

This is a memo field that can be used for more extensive comments about this contact record.

The Billing Batch file contains records which are used to batch billing transactions according to common characteristics. As many records as needed can be entered into the file according to how each Agency groups billing attendance or expense information. Batch records and billing transactions associated with them are saved and re-initialized from month to month to reduce data entry. Only new batch records for new programs or new billing transactions for new persons in program need to be entered in subsequent months.

Refer to Section IV (Billing Module) for the data entry screen and additional information about updating this file. Refer to Appendix E for file structure and field names.

BATCH NAME - Required

The description for this batch. This description of the batch should be entered when you create the batch to help identify batches for selection, update, printing and posting.

STATUS - Optional

The current billing status of this billing batch. If you wish to keep batch records after you have terminated all the transactions in the batch, the terminated status will alert you and the system that nothing is to be entered for the batch.

A Active - the transactions in this batch are currently active and should be updated each month.
I Inactive - the transactions in this batch are not currently active, but will be used in the future.
T Terminated - all of the transactions in this batch were terminated. Use this batch only when you need to enter adjustments to previously entered transactions.

LAST UPDATE - Mandatory and Automatically Updated

The date this record was last changed. Update is automatic when any field is changed; the date is taken from the computer's system date. You cannot enter or change this information.

BILLING MONTH - Mandatory and Automatically Entered

The current billing month for this batch. This field is automatically completed by the system. You cannot enter or change it.

BATCH NUMBER - Mandatory and Automatically Entered

The number of this billing batch. You cannot enter this number; these numbers are assigned automatically by the system as you enter batches.

BY USER - Mandatory and Automatically Updated

The name of the user that matches the user ID automatically entered when this record was last updated. You cannot enter or change this information.

POSTED - Mandatory and Automatically Updated

The checkbox indicates whether the batch has been posted. This is automatically updated by the system. You cannot enter or change it.

FINAL PRINT - Mandatory and Automatically Updated

The checkbox indicates whether the batch has had a final print (control and actual totals matched when the batch report was printed). This is automatically updated by the system. You cannot enter or change it.

SERVICE - Mandatory and Automatically Entered

The service type for this batch. The description of the service type that was automatically entered based on the service type you selected from the radio buttons for the service type. You cannot change this field. Service types are:

C Comprehensive
O Other
S Support

FUNDING - Mandatory

The type of funding for this batch. You must enter this information on new batches by selecting a matching contract record with the appropriate funding type. You cannot change it on existing batches.

ST State
MS Medicaid State Plan
MW Medicaid Waiver

PROGRAM - Conditional

The program type for this batch. You must enter this information on new batches unless the batch is an Hours Reporting Only batch for Comprehensive services. You cannot change it on existing batches. The following billing program codes, which relate to the program codes in the matching contract record, are to be used to enter into this field:

Comprehensive Service Codes (Residential Reporting)
IR Individual Residential Services & Supports
GR Group Residential Services & Supports

Other Service Codes
TC Targeted Case Management

Supported Living Service Codes

C3 Children's Extensive Support Waiver
FE FSSP Extended
FO FSSP Other
SL Supported Living Services
EI Early Intervention Services

SUBCONTRACTOR - Mandatory

The subcontract/cost center code used to link this batch to a subcontract record. If no subcontract record has been entered for this batch, then the code for DDD contract records must be entered here. You must enter this information on new batches. You may change it on existing batches if you wish to begin linking to a subcontract record, link to a different subcontract record or discontinue the link to a subcontract record.

This code is used to identify the contract record(s) against which these billings will be posted. If the subcontract code is the one assigned to DDD, only the matching DDD contract record will be posted. Any other entry will cause the system to post to both the DDD contract record and to the subcontract record that matches to the subcontract code. You must first have assigned and entered a subcontract code in your CCMS Table file AND entered a matching subcontract record in the contract file before you may enter any code other than the code assigned for DDD contract records in this field.

LOCATION - Conditional

The location/provider of services for this batch. You must enter this information on new batches with the exception of FSSP, which has no assigned location codes. You cannot change it on existing batches.

These codes must have been entered into your Agency's CCMS Table file and must have been assigned by DDD. DO NOT ASSIGN THESE CODES. Call DDD for codes your Agency does not have.

OPTIONAL - Optional

An optional field used by your Agency to further define batch characteristics.

This field can be used as your Agency chooses to indicate information such as: in-house program description, case manager, contact person, etc. It is available for sort/selection criteria in report generation. You must have entered the code and its interpretation in the CCMS Table file before it can be entered in a batch record.

DEFAULT PRIMARY DAY AGENCY/SERVICE AGENCY - Conditional

For Comprehensive services, this field is used to identify the primary day provider, and entry is optional. For Support services and Other services this field is used to identify the service agency providing the support services, and entry is optional. You may change this field on existing batches.

These codes must have been entered into your Agency's CCMS Table file and must have been assigned by DDD. DO NOT ASSIGN THESE CODES. Call DDD for codes your Agency does not have.

DDD RATE - Mandatory and Automatically Entered

The DDD billing rate for this batch. This field is automatically filled through a lookup to the related contract record for programs that are billed at a unit rate (programs that are billed by bundled rate or have multiple different rates do not display a rate on the Billing Batch screen). You cannot enter or change this field.

SUBCONTRACT RATE – Optional (only for "Other" batches)

The subcontract rate for this batch if your Agency uses this feature. A subcontract rate can only be specified for Other service programs. This field is automatically filled through a lookup to the related subcontract record entered by your Agency. You cannot enter or change this field. Any change your Agency makes in a subcontract rate must be entered in the subcontract record.

PROVIDER NUMBER - Mandatory if Medicaid funded and Automatically Entered

The Provider Number for this batch. This field is automatically filled through a lookup to the related provider record. You cannot enter or change this field.

The Provider Number will be blank for batches that are not funded by Medicaid or Hours Only Reporting Only batches.

COMMON BILLING HOURS/DAYS/UNITS/AMOUNTS - Optional

The common hour, day, unit or dollar entry to be entered for most transactions in this batch. This information will automatically be transferred to transactions in the batch and you may later change individual figures as needed in the transactions. The common entry is different based on program as listed below:

Comprehensive Service Common Entry

| | |
|---|---|
| Residential Reporting | Enter Calendar Days in Residence |
| Residential Reporting | Enter Absent Days |

Supported Living Service Common Entry

| | |
|---|---|
| All FSSP | Enter Amounts |
| CES Waiver | N/A (both hours and units must be entered in individual transactions) |
| SLS Waiver | N/A (both hours and units must be entered in individual transactions) |
| Early Intervention | Enter Common Hours in the categories below: |

- Center Based Hours
- Community Based Hours
- Home Based Hours

Other Service Common Entry

| | |
|---|---|
| Targeted Case Mgmt | Enter 1 Unit |

BATCH CONTROL - Conditional

This is the sum of all service units or dollar amounts being billed in this batch. This figure is entered as a control check. The computer will sum the units/amounts for each transaction entered within the batch (including any adjustment entries made for prior month services) and compare the final total with this control total. If they do not match, it will require you to either correct the entries or the control total before producing a final batch print and allowing you to post the batch. The figures to be summed are different based on funding and program as listed below:

Comprehensive Service Control Total

| | |
|---|---|
| Residential Reporting | Sum Calendar Days |
| Hours Reporting Only | N/A – no Batch Total is required |

Supported Living Service Control Total

| | |
|---|---|
| All FSSP | Sum Amounts |
| CES Waiver | Sum Amounts |
| SLS Waiver | Sum Amounts |
| Early Intervention | N/A – no Batch Total is required |

Other Service Control Total

| | |
|---|---|
| Targeted Case Mgmt | Sum Units |

ACTUAL TOTAL - Mandatory and Automatically Calculated

The total calculated by the system for this batch for comparison to the entered Batch Control Total. You cannot enter or change this field.

COMMENTS - Optional

Enter any comments related to this batch and batch entry.

The Billing Transaction file contains the individual billing transaction records that identify the specific billing services and amounts being submitted for payment or encounter reporting for each person receiving services. Refer to the description of the Billing Batch file for the fields that contain the common characteristics of each transaction (i.e. service type, funding type, etc.).

Each month, when the Agency closes out the current billing month in preparation for the next month, the transactions from the Billing Transaction file are added to a Billing Transaction Year-to-Date file (Bitrytd.dbf). Transactions are accumulated in the Billing Transaction Year-to-Date file for one full fiscal year before being cleared out.

Refer to Section IV (Billing Module) for the data entry screens and additional information about updating this file. Refer to Appendix E for file structure and field names.

**Fields that appear on all billing transaction data entry screens are listed first. Then fields that are unique to Comprehensive, Support and Other Services screens are listed under sections specifically devoted to those screens.**

NAME AND SOCIAL SECURITY NUMBER - Mandatory and Automatically Entered

The ID fields are displayed from the matching CORE record after it has been identified. No billing transactions may be entered if a CORE record has not first been entered for the person. New transactions must first have the CORE record identified before the fields can be displayed. Existing transactions will display the information and the ID fields will not be available for data entry.

When you add a new billing transaction, the system will display a Search for selecting the matching CORE record for the individual. If a matching CORE record cannot be located, you must cancel the addition of a new transaction.

1ST CHANGE AND DATE - Date is Mandatory and Automatically Entered, Change is Conditional

These fields are used to record the beginning date of service and any change to the person's status.

The date field is automatically filled with the first day of the billing month by the system. You may change it to reflect the actual beginning date of service for the month if it is different. This date will be used as the first date of service on the Medicaid claim if the transaction is for a Medicaid funded service. Only enter a code into the change code field if this person had a status change. Only “admission” or “from inactive” codes are allowed in this field. If a person terminated, or went inactive during the month, that status change must be recorded in the second change field in order to correctly reflect the last date of service.

Additional transactions must be used to report adjustments to previous month’s billing information. After adding a new transaction, change the dates of service to reflect the period of service that requires adjustment. In order to accurately reflect the corrected billing figures, you must first enter a transaction reversing the previously reported figures. Then enter a second transaction correctly reporting the billing figures.

2ND CHANGE AND DATE - Date is Mandatory and Automatically Entered, Change is Conditional

These fields are used to record the ending date of service and any change to the person's status.

The date field is automatically filled with the last day of the billing month by the system. You may change it to reflect the actual ending date of service for the month if it is different. This date will be used as the last date of service on the Medicaid claim if the transaction is for a Medicaid funded service. Only enter a code into the change code field if this person had a status change. Only "termination" or "discharge" codes are allowed in this field. If a person enrolled or came back from inactive during the month, that status change must be recorded in the first change field in order to correctly reflect the first date of service.

Additional transactions must be used to report adjustments to previous month's billing information. After adding a new transaction, change the dates of service to reflect the period of service that requires adjustment. In order to accurately reflect the corrected billing figures, you must first enter a transaction reversing the previously reported figures. Then enter a second transaction correctly reporting the billing figures.

DDD RATE - Conditional and Automatically Entered

The DDD billing rate for this transaction. Only Comprehensive and Other Service billing transactions have a DDD billing rate associated with them. It is automatically transferred from the batch record. You cannot enter or change this field, unless the transaction is for a service period prior to the current billing month. The system will attempt to identify the correct rate for the previous service period, but you may change it if necessary.

PROVIDER NUMBER - Mandatory if Medicaid Funded and Automatically Entered

The Provider Number for this transaction if it is Medicaid funded. It is automatically transferred from the batch record. You cannot enter or change this field

OPTIONAL - Optional

An optional field used by your Agency to further define this billing transaction. It is automatically transferred from the batch record, but you can change it on individual transactions as needed.

This field can be used as your Agency chooses to indicate information such as: in-house program description, case manager, contact person, etc. It is available for sort/selection criteria in report generation. You must have entered the code and its interpretation in the CCMS Table file before it can be entered in a transaction.

**COMPREHENSIVE SERVICES SCREENS**

DAYS SERVED - Conditional

The total number of days of service provided this month for Residential Reporting transactions. Days are automatically transferred from the batch record if you entered common days, but you can change

them on individual transactions as needed. You will also need to change the 1st and 2nd Date fields to reflect the correct "from" and "to" dates. Enter the total number of billable days the individual was physically present in the residence.

If the individual was absent because he was in another Medicaid funded facility at any time during the month (e.g. in the hospital), multiple transactions must be created to report the span of days to be billed to the Medicaid residential facility. Create a transaction to report each span of service and change the 1st and 2nd Date fields to reflect the correct "from" and "to" dates of service for each span.

ABSENT DAYS - Conditional

The number of allowable absent days this month for Residential Reporting transactions. Absent days are automatically transferred from the batch record if you entered common absences, but you can change them on individual transactions as needed. Enter the number of allowable absent days the person was absent from the residential program during the month. The total of the Days Served and Absent Days may not exceed the total number of days in the span of service being reported (the days from the 1st Date through the 2nd Date).

If the individual was absent because he was in another Medicaid funded facility at any time during the month (e.g. in the hospital), multiple transactions must be created to report the span of absent days. Create a transaction to report each span of service and change the 1st and 2nd Date fields to reflect the correct "from" and "to" dates of service for each span.

RESIDENTIAL DESCRIPTION - Optional

Enter the address or other description of the residential living arrangement for Residential Reporting transactions.

PRIMARY DAY AGENCY – Conditional

The provider of Supported Day Program Hours reported for this transaction. It is automatically transferred from the batch record, but you can change it on individual transactions as needed. The information must be entered ONLY if you are reporting any Day Program Supported Hours in this transaction.

These codes must have been entered into your Agency's CCMS Table file and must have been assigned by DDD. DO NOT ASSIGN THESE CODES. Call DDD for codes your Agency does not have. Two special codes have been assigned to identify cases where the Supported Hours are not being provided by a formally approved day program agency as follows:

RESDAY – Residential Day Provider
The residential provider is also providing Supported Hours for typical day services.
GEND – Generic Day Provider
The Supported Hours are being provided by a generic agency that does not require formal day program approval.

COMPREHENSIVE HOURS/OCCURENCES REPORTING - Conditional

Report the units of service as either hours or occurrences for the support types listed below:

**Day Program Integrated Job Hours**
Enter the number of hours a person worked at a job for pay in a community integrated setting, whether supported or not. Enter the hours by the categories described below:

- Integrated Group Job Hours
- Integrated Individual Job Hours

**Day Program Supported Hours**
Enter the number of supported hours of day services provided to persons in Comprehensive services. Enter the hours by the categories described below:

- Support Integrated Work Hours
- Support Non-Integrated Work Hours
- Support Integrated Activity Hours
- Support Non-Integrated Activity Hours

**Residential Encounter Reporting – (NOT required for State Comprehensive services)**
Enter specific services that were provided during the month while residing in a group home or individual residential setting. Enter the units by the categories described below:

- Skilled Nursing – enters of hours of service
- Transportation – enter occurrences of services
- Specialized Medical Equipment and Supplies – enter occurrences of services
- Behavioral Services – enter hours of service
- Occupational Therapy – enter hours of service
- Physical Therapy – enter hours of service
- Dental – enter occurrences of service
- Vision – enter occurrences of service

COMPREHENSIVE SERVICE COST- Optional

This field is used to enter the actual cost of services. Enter the total dollar amount expended for this category of support.

PERSONAL NEEDS - Conditional and Automatically Entered (only applies to State Comprehensive)

The computer will automatically complete this field based on the usual personal needs amount for Residential Reporting transactions for State funded persons. You may alter the information if necessary. You must zero this field out if personal needs should not be allowed for the person in this transaction. Otherwise, the system will use the personal needs figure in calculating total amount due for this transaction. This field only needs to be completed for state funded persons.

MEDICAL DEDUCTION - Conditional (only applies to State Comprehensive)

If there are medical costs not covered by Medicaid, Medicare or private insurance, they may be deducted from the consumer's income for the month. Enter the amount of the medical costs in this field for Residential Reporting transactions for State funded persons.

SSI AMOUNT- Conditional (only applies to State Comprehensive)

List all SSI payments received during this billing period for this person. This field only needs to be completed for Residential Reporting transactions for State funded persons.

SSA AMOUNT - Conditional (only applies to State Comprehensive)

List all OASDI payments received during this billing period for this person. This field only needs to be completed for Residential Reporting transactions for State funded persons.

AND/OAP AMOUNT - Conditional (only applies to State Comprehensive)

List all AND or OAP payments received during this billing period for this person. This field only needs to be completed for Residential Reporting transactions for State funded persons.

VA AMOUNT - Conditional (only applies to State Comprehensive)

List all VA payments received during this billing period for this person. This field only needs to be completed for Residential Reporting transactions for State funded persons.

WAGES - Conditional (only applies to State Comprehensive)

Enter the total amount of earned wages as follows: gross wages less involuntary deductions of FICA, federal, state and local income taxes and health insurance premiums. This field only needs to be completed for Residential Reporting transactions for State funded persons.

** NOTE ** An entry into this field is assumed to be for one month's earned income and the system will apply the calculations for applicable income based on that assumption. If an adjustment needs to be made to wages previously reported, you will have to perform the calculation to determine the difference between what the system previously calculated and what should have been calculated and enter the figure you calculated (positive or negative) in the OTHER INCOME field.

OTHER INCOME AND EXPLANATION - Conditional (only applies to State Comprehensive)

List any other income in excess of $30.00 per month and explain its source. Other income should be determined in accordance with SSI guidelines. Examples are: interest income, veterans benefits and family contributions. This field only needs to be completed for Residential Reporting transactions for State funded persons.

## SUPPORTED LIVING SERVICES SCREEN

SUPPORT TYPE - Mandatory

This field is used to enter the category of Supported Living Services support. The support types are listed below:

SLS Supports

| | | | |
|---|---|---|---|
| S02 | Professional Service | S23 | Transportation |
| S05 | Personal Assistance | S26 | Day Habilitation |
| S15 | Supported Employment/CIE | S28 | Item for Non-Professional Service |
| S18 | Dental/Vision/Hearing | S29 | Item for Professional/Behavioral |
| S21 | Supported Living Consultation | S30 | Env Engineering |

ADDITIONAL EXPLANATION - Conditional

This field is required if the Support Type reported is S30 – Environmental Engineering. Enter an explanation of the expenditure reported under this support type. It is also required if the Support Type is S15 – Supported Employment/CIE and the Outcome Payment Indicator is O – Outcome. In that case, enter the expected outcome in this field.

DAY SERVICE HOURS REPORTING - Conditional

Report the hours of day program service for the day service support types listed below:

**Supported Employment Hours**
These fields are required if the Support Type reported is S15 – Supported Employment/CIE. The number of hours entered into the Integrated Work Hours fields will automatically transfer to the Support Hours field as the number of hours of support provided for the Service Cost being reported in this transaction. The number of Non-supported hours is informational only. Enter the hours by the categories described below:

- Integrated Group Job Hours (Non-supported)
- Integrated Individual Job Hours (Non-supported)
- Integrated Work Hours (Supported)

**Supported Day Habilitation Hours**
These fields are required if the Support Type reported is S26 – Day Habilitation. The sum of the hours entered into these fields will automatically transfer to the Support Hours field as the number of hours of support provided for the Service Cost being reported in this transaction. Enter the hours by the categories described below:

- Non-Integrated Work Hours
- Integrated Activity Hours
- Non-Integrated Activity Hours

HOURS/OCCURRENCES - Conditional

This field is required if a service cost has been entered. Enter the number of hours or occurrences of service provided under this category of support. If you entered Supported Hours for Supported Employment or Day Habilitation services, the Support Hours will have already been calculated and entered for you.

SERVICE COST - Optional

This field is used to enter the actual cost of services. Enter the total dollar amount expended for this category of support.

PRIMARY DAY AGENCY – Conditional

The provider of Supported Hours when the Support Type for this transaction is S15 – Supported Employment/CIE or S26 – Day Habilitation. The information must be entered if you are reporting any Supported Hours in this transaction.

These codes must have been entered into your Agency's CCMS Table file and must have been assigned by DDD. DO NOT ASSIGN THESE CODES. Call DDD for codes your Agency does not have. A special code have been assigned to identify cases where the Supported Hours are not being provided by a formally approved day program agency as follows:

GEND – Generic Day Provider
The Supported Hours are being provided by a generic agency which does not require formal day program approval.

OUTCOME PAYMENT INDICATOR - Conditional

This field is used if the Support Type reported is S15 – Supported Employment/CIE, and the provider of service is being paid on the basis of an expected outcome. If you enter O - Outcome in this field, you must enter information about the expected outcome in the Additional Explanation field.

## CHILDREN'S EXTENSIVE SUPPORT SCREEN

SUPPORT TYPE - Mandatory

This field is used to enter the category of Children's Extensive Support Services (CES) Waiver support. The support types are listed below:

CES Waiver Supports

| | |
|---|---|
| C02 | Professional Services |
| C05 | Personal Assistance |
| C06 | Assistive Technology |
| C07 | Home Modification Services |
| C08 | Community Connections |
| C10 | Specialized Medical Equip/Supplies |
| C11 | Behavioral Services |
| C13 | Item for Professional/Behavioral |
| C14 | Personal Care Item |
| C15 | Waiver Service (Not Otherwise Specified) |

ADDITIONAL EXPLANATION - Conditional

This field is required for the CES Waiver if the Support Type reported is C06 - Assistive Technology, C07 - Home Modification Services, C10 – Specialized Medical Equipment/Supplies, C13 – Item for Professional/Behavioral, C14 – Personal Care Item or C15 – Waiver Service (Not Otherwise Specified). Enter an explanation of the expenditure reported under this support type.

HOURS/OCCURRENCES - Conditional

This field is required for the CES Waiver, if the Support Type reported is one for which hours of service can be reported. Enter the number of hours of service provided under this category of support. Hours of service cannot be entered if the Support Type reported is C06 - Assistive Technology, C07 - Home Modification Services, C10 – Specialized Medical Equipment/Supplies, C13 – Item for Professional/Behavioral, C14 – Personal Care Item or C15 – Waiver Service (Not Otherwise Specified).

SERVICE COST - Required

This field is used to enter the actual cost of services. Enter the total dollar amount expended for this category of support.

## EARLY INTERVENTION SCREEN

EARLY INTERVENTION HOURS OF SERVICE - Required

The number of hours of service provided to persons in the children's Early Intervention program. Hours are automatically transferred from the batch record if you entered figures in the common hours fields, but you can change them on individual transactions as needed. Enter the hours by the categories described below:

- Center Based Hours
- Community Based Hours
- Home Based Hours

TERMINATION REASON - Conditional

This field must be completed if this transaction has been terminated. Enter one of the termination codes listed below:

A Service is no Longer Needed
B Transfer to Other Specialized Services
C Left Service Area
D Refused Service
E Deceased
F Other

## FAMILY SUPPORT SERVICES SCREEN

SUPPORT TYPE - Mandatory

This field is used to enter the category of Family Support Services Program (FSSP) support. The support types are listed below:

FSSP Supports

| | | | |
|---|---|---|---|
| F01 | Respite Care | F05 | Other Individual Services |
| F02 | Professional Services | F06 | Assistive Technology |
| F03 | Medical & Dental Services | F07 | Home Modification Services |
| F04 | Transportation Services | F08 | Family Related Services |

AMOUNT - Required

This field is used to enter the actual cost of services. Enter the total dollar amount expended for this category of support.

TERMINATION REASON - Optional

This field must be completed if this transaction has been terminated. Enter one of the termination codes listed below:

A Service is no Longer Needed
B Transfer to Other Specialized Services
C Left Service Area
D Refused Service
E Deceased
F Other

## OTHER SERVICES SCREEN (TARGETED CASE MANAGEMENT)

CASE MANAGEMENT UNITS – Required
Enter the number of units of service to be billed in this transaction.

SUBCONTRACT RATE - Optional

The subcontract billing rate for this transaction, if your Agency uses this feature. Only Other Service billing transactions can have a subcontract billing rate associated with them. It is automatically transferred from the batch record. You cannot enter or change this field, unless the transaction is for a service period prior to the current billing month. The system will attempt to identify the correct rate for the previous service period, but you may change it if necessary.

The Billing Contract file contains a record for every program and funding combination for which an Agency is authorized to bill. In addition to authorizing billing for services, the contract records aggregate billing information in order to track how much has been billed for each program, both for the current month and year-to-date. Summary bills and Contract status reports are produced from the aggregated information in the contract records. Agencies may enter subcontract records to perform these same functions for their subcontractors or cost centers they have defined within their own direct service programs.

Refer to Section IV (Billing Module) for the data entry screen and additional information about updating this file. Refer to Appendix E for file structure and field names.

EXHIBIT ORDER – Automatic

When this radio button is selected, the contract records are presented in the order in which they appear on the Contract Exhibit for each CCB. This allows DDD to perform data entry more efficiently and allows the Agencies to scroll through their contract records in exhibit order on the Contract update screen.

MAIN ORDER – Automatic

When this radio button is selected, the contract records are presented sorted by the Main index tag described for the contract file in Appendix E. Refer to Appendix E for the current order of the fields included in this index tag.

FISCAL YEAR- Display Only

This field contains the current fiscal year based on the current billing month. The billing month is accessed from the Agency file. You cannot enter or change this field.

BILLING MONTH - Display Only

The current billing month. This field is automatically completed by the system. You cannot enter or change it.

POSTED?- Mandatory and Automatically Updated

Has this contract record been posted? This field is automatically updated by the system. You cannot enter or change it.

| | |
|---|---|
| Y | Yes - some posting has occurred against this record for the current billing month |
| N | No - no posting has occurred against this record for the current billing month |
| F | Final - all posting has been completed for the current billing month and figures in the contract record are final |

LAST UPDATE - Mandatory and Automatically Updated

The date this record was last changed. Update is automatic when any field is changed; the date is taken from the computer's system date. You cannot enter or change this information.

BY USER - Mandatory and Automatically Updated

The name of the user that matches the user ID automatically entered when this record was last updated. You cannot enter or change this information.

SERVICE - Mandatory

The service type for this contract. You must enter this information on new contract records. You cannot change it on existing contract records. Service types are:

C Comprehensive
O Other
S Support

FUNDING - Mandatory

The type of funding for this contract. You must enter this information on new contract records. You cannot change it on existing contract records. Funding types are:

ST State
MS Medicaid State Plan
MW Medicaid Waiver

PROGRAM - Mandatory

The program type for this contract. You must enter this information on new contract records. You cannot change it on existing contract records.

Contract program types generally match to the contract lines in your Agency's written contract with DDD. The following contract program codes are to be used to enter into this field:

Comprehensive Service Codes
C Comprehensive Services (includes IRSS and GRSS)

Supported Living Service Codes
C3 Children's Extensive Support Waiver
FM Family Support Services Direct (includes FSSP Extended and FSSP Other)
SL Supported Living Services
EI Early Intervention Services

Other Service Codes
AD Administration
CM Case Management
MF Management Fee
TC Targeted Case Management
C4 Children's Management Fee

SUBCONTRACTOR - Mandatory

The code used to identify whether this is a DDD contract record or a subcontract/cost center contract record. You must enter this information on new contract records. You cannot change it on existing contract records. DDD contract records can only be entered at the DDD site.

This subcontract/cost center code is used to link billing batches to contract records so that billing transactions within the batch will be posted against the matching subcontract record. You must first have assigned and entered a subcontract code in your CCMS Table file before you may use it in the contract record. Then you must enter the subcontract code in the billing batch record for the batch of transactions you wish to have posted to the contract record you have entered.

BILLING METHOD - Mandatory

The code for the method of billing used for this contract. You must enter this information on new contract records. You may change it on existing contract records if the billing method changes during the year.

The code entered in this field will determine how billings are generated for this contract. For the monthly billing method, the bill will be calculated by dividing the amount remaining in the contract by the number of periods remaining in the fiscal year. Other billing methods aggregate monthly billing transactions for individuals by day, unit or amount, to determine the units and/or amount to be billed for the month.

The following Billing Methodology Codes are to be used to enter into this field:

M 1/12 (per Month)
$ Dollar Amount
D Daily
U Unit of Service

AMENDMENT DATE - Optional

Enter the effective date of the last contract amendment, or the initial date of the contract if this is a new contract record.

1ST PROGRAM TYPE - Conditional

This field is used to record the billing program type for the first program that can be billed under this contract, when the contract program is different from the billing program. Entry of a billing program

type into this field provides authorization for your Agency to enter billing batches for this program for either a DDD or a subcontract/cost center contract record. If the billing program type is not entered, you will not be able to enter batches for that program type.

Enter one of the billing program types from the list below if the contract program is one of the underlined programs:

Comprehensive Services
IR Individual Residential Services & Supports
GR Group Residential Services & Supports

Family Support Services Direct
FE FSSP Extended
FO FSSP Other

2ND PROGRAM TYPE - Conditional

This field is used to record the billing program type for the second program that can be billed under this contract, when the contract program is different from the billing program. Entry of a billing program type into this field provides authorization for your Agency to enter billing batches for this program for either a DDD or a subcontract/cost center contract record. If the billing program type is not entered, you will not be able to enter batches for that program type.

Enter one of the program types from the list provided under 1st Program Type above if the contract program is one of the underlined programs AND a second billing program type must be authorized.

BILLING RATE - Conditional

Enter the billing rate for this contract, if applicable. Contracts that are billed periodically (i.e. monthly), do not require a rate to be entered. Contracts that are billed by units or days of service must have an entry in this field in order for the system to calculate an amount due for each transaction. The Medicaid Supported Living Services bundled service rate must be entered in this field to identify the rate for the bundled service claim. The system will automatically access this field to enter the correct DDD rate or subcontract rate into associated billing batches at data entry time, so it is important that you update this field if the rate changes.

MAXIMUM INDIVIDUAL UNITS/AMOUNT - Conditional

Enter the individual maximum units or days if an individual maximum has been set for this program. The system will access this field in the DDD contract record at the time of posting, to determine if a person has exceeded the individual maximum allowed for this program and funding type. The individual maximum for Comprehensive and Other services is based on the number of days or units entered into this field. Days or other service units above the individual maximum will not be included in the bill. Therefore, it is extremely important that the information in this field is correct so that transaction entries are billed or disallowed appropriately for this program and funding type.

TOTAL UNITS - Conditional

Enter the total contracted units effective as of the last amendment for contracts that are allocated by units of service.

TOTAL AMOUNT - Required

Enter the total dollar amount contracted effective as of the last amendment. If this is a state funded contract/subcontract record, the system will access this field at posting to determine if total amount billable exceeds total contracted amount, and disallow part or all of the current month's billable amount if so. If the contract is later amended to increase total dollar amount , the system will reevaluate the year-to-date amount billed versus the year-to-date amount billable and rebill amounts previously disallowed, if appropriate.

If this is a Medicaid funded contract/subcontract record, the system will not make any adjustments for billable amount in excess of contract amount, so this field may be left blank. However, the contract status report which is produced for the contract record will show negative contract balances and will not be as useful as it could be for contract utilization management information.

BEGINNING MINIMUM NUMBER - Conditional

Enter the minimum number of people to be served as established at the beginning of the fiscal year for this contract. This figure will be used for contract utilization review.

ADDITIONAL MINIMUM NUMBER - Conditional

Enter the additions to the minimum number of people to be served as the contract is amended during the fiscal year. This figure is the greatest addition of the number of people served during the contract period and is not necessarily the difference of the Beginning Minimum Number and the Current Minimum Number. This figure is not reduced by subsequent amendments but may be increased. This figure will be used for contract utilization review.

CURRENT MINIMUM NUMBER - Conditional

Enter the current minimum number of people to be served as it changes throughout the fiscal year for this contract. This will not necessarily be the total of the Beginning Minimum number and Additional Minimum number, because resources added during the year may be pulled back for various reasons. This figure will be used for contract utilization review.

BEGINNING MEMBER NUMBER - Conditional

Enter the member months or days to be served as established at the beginning of the fiscal year for this contract. This figure will be used for contract utilization review.

ADDITIONAL MEMBER NUMBER - Conditional

Enter the additions to the member months or days to be served as the contract is amended during the fiscal year. This figure is the greatest addition of the number of people served during the contract period and is not necessarily the difference of the Beginning Minimum Number and the Current Minimum Number. This figure is not reduced by subsequent amendments but may be increased. This figure will be used for contract utilization review.

CURRENT MEMBER NUMBER - Conditional

Enter the current member months or days to be served as it changes throughout the fiscal year for this contract. This will not necessarily be the total of the Beginning Member number and Additional Member number, because resources added during the year may be pulled back for various reasons. This figure will be used for contract utilization review.

UNITS ENROLLED YTD - Display Only

The enrolled units that have been posted year-to-date against this contract record. This field is automatically completed by the system for contracts that are billed by units or days. The enrolled units or days in individual transactions are aggregated against this field during posting. You cannot enter or change it. Check the Billing Month and Posted? fields to determine the current billing month and whether this contract has had a final posting yet. If not, these figures may reflect only partial billing for the month.

UNITS BILLABLE YTD - Display Only

The billable units that have been posted year-to-date against this contract record. This field is automatically completed by the system for contracts that are billed by units or days. The enrolled units or days in individual transactions that are not in excess of the individual maximum are aggregated against this field during posting. You cannot enter or change it. Check the Billing Month and Posted? fields to determine the current billing month and whether this contract has had a final posting yet. If not, these figures may reflect only partial billing for the month.

UNITS BILLED YTD - Display Only

The billed units that have been posted year-to-date against this contract record. This field is automatically completed by the system for contracts that are billed by units or days. The aggregated billable units or days that are not in excess of the contract maximum are entered into this field during posting. You cannot enter or change it. Check the Billing Month and Posted? fields to determine the current billing month and whether this contract has had a final posting yet. If not, these figures may reflect only partial billing for the month.

AMOUNT ENROLLED YTD - Display Only

The enrolled amount that has been posted year-to-date against this contract record. This field is automatically completed by the system. The enrolled amounts in individual transactions are aggregated against this field during posting for contracts that are billed by transaction entry. You cannot enter or

change it. Check the Billing Month and Posted? fields to determine the current billing month and whether this contract has had a final posting yet. If not, these figures may reflect only partial billing for the month.

AMOUNT BILLABLE YTD - Display Only

The billable amount that has been posted year-to-date against this contract record. This field is automatically completed by the system. The enrolled amount in individual transactions that is not in excess of the individual maximum is aggregated against this field during posting for contracts that are billed by transaction entry. The per month portion of the contract amount is entered into this field for contracts that are billed monthly. You cannot enter or change it. Check the Billing Month and Posted? fields to determine the current billing month and whether this contract has had a final posting yet. If not, these figures may reflect only partial billing for the month.

AMOUNT BILLED YTD - Display Only

The billed amount that has been posted year-to-date against this contract record. This field is automatically completed by the system. The aggregated billable amount that is not in excess of the contract maximum is entered into this field during posting for contracts that are billed by transaction entry. The per month portion of the contract amount is entered into this field for contracts that are billed monthly. You cannot enter or change it. Check the Billing Month and Posted? fields to determine the current billing month and whether this contract has had a final posting yet. If not, these figures may reflect only partial billing for the month.

MEMBER NUMBER YTD - Display Only

The number of member months posted year-to-date against this contract record. This field is automatically completed by the system. The aggregated number of individuals or days (depending on the type of program) is entered into this field during posting for contracts that are billed by transaction entry. You cannot enter or change it. Check the Billing Month and Posted? fields to determine the current billing month and whether this contract has had a final posting yet. If not, these figures may reflect only partial billing for the month.

BUNDLED NUMBER YTD - Display Only

The number of SLS Waiver bundled billings months posted year-to-date against this contract record. This field is automatically completed by the system. The aggregated number of individuals billed for SLS Waiver is entered into this field during posting. You cannot enter or change it. Check the Billing Month and Posted? fields to determine the current billing month and whether this contract has had a final posting yet. If not, these figures may reflect only partial billing for the month.

The Billing Rate file is used to enter maximum allowable billing rates for Children's Extensive Support Waiver hourly billing services. The rates to be entered are the same rates entered into the Medicaid Management Information System. Agencies may also enter records in the file to establish a lower rate for their Agency. A copy of the Billing Rate file is sent to each Agency monthly to be used by the Billing module to disallow entries that are above the maximum authorized rates.

This file also contains historical rates for Supported Living Services Waiver. The SLS Waiver is currently billed under a bundled rate methodology, so maximum rates no longer apply.

Refer to Section IV (Billing Module) for the data entry screen and additional information about updating this file. Refer to Appendix E for file structure and field names.

AGENCY - Mandatory

Enter the Agency code for the CCB this rate applies to. At the Agency site, only your own Agency code is available to you. At the DDD site, a list of codes will appear in the drop down list. This code will be used by the system when creating the monthly DDD update files to determine which records should be sent to each Agency.

RATE TYPE- Mandatory

Enter the type of rate. At the Agency site, this field will automatically default to 'Agency'. At the DDD site, this field will automatically default to 'DDD'. This field identifies whether the rate was established by DDD or the Agency.

PROGRAM - Mandatory

Enter the program this rate applies using the appropriate codes below:

C3 Children's Extensive Support Waiver
SL Supported Living Services Waiver

SUPPORT TYPE - Mandatory

Enter the support type this rate applies to using the appropriate codes below:

CES Waiver Supports
C02 Professional Services
C05 Personal Assistance
C08 Community Connections
C11 Behavioral Services

SLS Waiver Supports
S02 Professional Service (historical rate only)
S05 Personal Assistance (historical rate only)

EFFECTIVE DATE - Mandatory

Enter the effective date for the rate.

The Billing module will access this date to determine whether an entered billing transaction falls within the date span covered by this rate record. Multiple rate records can be entered that establish different rates for different periods of time.

LOW RATE - Optional

Enter the lowest rate that is allowed for an entered billing transaction.

This is an optional field that allows Agencies to establish a rate check to ensure that billings are not entered for less than the established rate at the Agency.

HIGH RATE - Mandatory

Enter the highest rate that is allowed for an entered billing transaction.

If this record is an Agency record, this rate record will be accessed during billing entry to ensure that billings are not entered for more than the established rate at the Agency. If this record is a DDD record, this rate record will be accessed during billing entry to ensure that billings are not entered for more than the established rate in the MMIS. If the Agency entered rate record contains a rate higher than the rate in the DDD rate, the rate in the DDD record will be used to limit the billing rate.

The Provider file is used to enter Provider records for Medicaid providers certified by DDD. A record must be entered into the Provider file before an Agency can bill for Medicaid services under that provider and service type. Provider certification is the responsibility of the DDD central office, so Provider records can only be entered and updated at the DDD site. A copy of the Provider file is sent to each Agency monthly to be used by the Billing module to accept or reject entry of Medicaid billing transactions for a provider.

Refer to Section IV (Billing Module) for the data entry screen and additional information about updating this file. Refer to Appendix E for file structure and field names.

PROVIDER NUMBER - Mandatory

Enter the provider number assigned to this provider/program or group home by the Medicaid Fiscal Agent, with the exception of day and residential providers approved after June 30, 1999. For day and residential providers with an effective date of 7/1/99 or later, a special DDD assigned provider number will be automatically generated by the system.

PROVIDER NAME - Mandatory

Enter the name of the provider/program or group home to which this provider record applies. Each group home requires its own provider record. In the case of a group home provider record entry, the Provider Name field must contain the name of the group home and the actual provider name will be contained in the Owner field and/or identified in the Service Agency field. For provider records that identify providers other than group homes, the name may be a combination of the CCB/RC, service agency and program, depending on how the information will be used for reporting.

PROVIDER ADDRESS - Required

Enter the street address of the provider/program or group home. For provider records that identify providers other than group homes, either the CCB/RC address or service agency address may be entered here, depending on how the information will be used for reporting.

FREEFORM - Optional

Enter additional components of the address if needed (e.g. Suite #, Post Office box, etc.)

CITY, STATE AND ZIP - Required

Enter the City, State and Zip code of the provider/program or group home. For provider records that identify providers other than group homes, either the CCB/RC city, state and zip or service agency city, state and zip may be entered here, depending on how the information will be used for reporting.

OWNER - Required

Enter the LEGAL name of the owner of this provider/program or group home.

OWNER'S PHONE - Optional

Enter the telephone number of the owner of this provider/program or group home.

CCB/RC - Mandatory

Enter the agency code for the CCB or RC through which this provider is certified. This code will be used by the system when creating the monthly DDD update files to determine which records should be sent to each Agency.

SERVICE AGENCY - Conditional

Enter the service agency code that identifies the purchase of service agency, or DIR for Direct Service. Codes are assigned to DD purchase of service agencies by DDD staff.

This field MUST be completed in order for the correct provider record to be located at the Agency site if the Service Type is Day Program or Other.

SERVICE TYPE - Mandatory

Enter the service type of this provider record.

Service types are:

D Day Program
O Other
S Supported Living Services
R Residential

PROGRAM - Conditional

This field is not available for day program provider records but must be entered for other service types using the appropriate codes below:

RESIDENTIAL PROGRAMS
IR Individual Residential Service and Supports
GR Group Residential Service and Supports

SUPPORTED LIVING SERVICE PROGRAMS
C3 Children's Extensive Support Waiver
SL Supported Living Services Waiver

LOCATION - Conditional

This field is not available for day program or other service provider records but must be entered for residential and supported living services records. Location codes are assigned to by DDD staff.

This field MUST be completed in order for the correct provider record to be located at the Agency site if the Service Type is Residential or Supported Living Services.

STATUS - Mandatory

Enter the current status of this provider record from the list below:

A Active
I Inactive
T Terminated

LICENSE # - Conditional

This field is applicable to residential group home provider records only.

Enter the license number assigned to this group home by the Department of Public Health and Environment.

LICENSE DATE - Conditional

This field is applicable to residential group home provider records only.

Enter the starting date of the current license for this group home by the Department of Public Health and Environment.

LICENSE RENEWAL - Conditional

This field is applicable to residential group home provider records only.

Enter the renewal (or expiration) date of the current license for this group home by the Department of Public Health and Environment.

ORIGINAL CERTIFICATION DATE - Mandatory

Enter the original Medicaid certification date for this provider. No billings may be submitted for this provider/program or group home prior to the original certification date.

CERTIFICATION START DATE - Required

Enter the Department of Public Health and Environment Certification and Transmittal beginning date for group home providers. Enter the most recent beginning date of Medicaid re-certification for other providers.

CERTIFICATION END DATE - Required

Enter the Department of Public Health and Environment Certification and Transmittal ending date for group home providers. Enter the most recent ending date of Medicaid re-certification for other providers.

TERMINATION DATE - Conditional

If the Status of this provider record is Terminated, enter the date of termination. No billings may be submitted for this provider/program or group home past the date of termination.

LICENSED BEDS - Conditional

This field is applicable to residential group home provider records only.

Enter the number of licensed beds based on Department of Public Health and Environment licensing and DDD program approval for this group home.

FUNDED BEDS - Conditional

This field is applicable to residential group home provider records only.

Enter the number of beds funded by DDD for this group home. No billings may be submitted for more than the number of funded beds in a group home

COMMENTS - Optional

This is a free-form field that can be used to record any comments appropriate for this record.

The Prior Authorization (PAR) file is used to enter service authorization information for persons enrolled in Medicaid funded Waiver programs or Targeted Case Management (TCM). PAR updates are transmitted to the Medicaid Fiscal Agent to be entered into the Medicaid Management Information System (MMIS) to authorize payment of claims. Authorization is the responsibility of the DDD central office, so PAR records can only be entered and updated at the DDD site. A copy of the PAR file is sent to each Agency monthly to be used by the Billing module to accept or reject billing transactions at the time of posting.

Refer to Section V (PAR Module) for the data entry screen and additional information about updating this file. Refer to Appendix E for file structure and field names.

CCB/RC - Mandatory

Enter the agency code for the CCB or RC through which the person is currently receiving services. This code will be used by the system when creating the monthly DDD update files to determine which records should be sent to each Agency.

BIRTHDATE - Mandatory

Enter the person's date of birth. The date of birth is used in conjunction with the name and Medicaid number to identify this person in the State of Colorado Medicaid eligibility file.

LAST UPDATE - Mandatory and Automatically Updated

The date this record was last changed. Update is automatic when any field is changed; the date is taken from the computer’s system date. You cannot enter or change this information.

BY USER - Mandatory and Automatically Updated

The name of the user that matches the user ID automatically entered when this record was last updated. You cannot enter or change this information.

SOCIAL SECURITY NUMBER - Mandatory

This number must be the person's Social Security Number, NOT the number of a relative or a number under which the person receives benefits. You must enter a social security number or the record will not be added to the file.

MEDICAID NUMBER - Mandatory

Enter the Medicaid number. It must begin with an uppercase letter followed by six digits. This State ID number is assigned to the recipients of Medicaid and other state services by the Colorado Department of Health Care, Policy and Financing (HCPF). This number must be this person's, not a relative's. If it is entered incorrectly, Medicaid Waiver claims submitted for this person will be rejected because no match will be found in the State of Colorado Medicaid eligibility file.

FIRST NAME - Mandatory

The person's legal first or given name. This must be the legal name.

Enter the first name as you want to see it on your printed output. Keep in mind that it is possible to use CCMS data in word processing files. You may want to be sure that you enter the name with both upper and lower case.

MIDDLE NAME - Required

The person's legal middle name. This must be the legal name. If there is no legal middle name, leave this field blank.

Enter the middle name as you want to see it on your printed output. Keep in mind that it is possible to use CCMS data in word processing files. You may want to be sure that you enter the name with both upper and lower case.

LAST NAME - Mandatory

The person's legal last name or surname. This must be the legal name.

Enter the last name as you want to see it on your printed output. Keep in mind that it is possible to use CCMS data in word processing files. You may want to be sure that you enter the name with both upper and lower case.

PA ACCOUNT NUMBER – Mandatory and Automatically Entered

This is a number assigned by the system to uniquely identify this PAR record when batch updates are sent to the Medicaid Management Information System (MMIS). The number is used to match updates to the correct record to the correct record in the MMIS.

PAR TYPE - Mandatory

The type of PAR record. You must enter this information on new records. You cannot change it on existing records. There are several Medicaid Waivers administered by DDD for persons with developmental disabilities. In addition, Medicaid State plan programs may also be administered by DDD (e.g. Targeted Case Management) and require a PAR record entry in order to track prior authorization dates and services.

Enter the appropriate PAR type from the list below:

CEW Children's Extensive Support Waiver
DDW Developmental Disabilities Waiver
SLW Supported Living Service Waiver
TCM Targeted Case Management

REQUESTING PROVIDER NUMBER – Mandatory and Automatically Entered

This is the main provider number of the CCB/RC case management agency. This number identifies the provider to the MMIS when new batch PAR records are submitted.

PRO END DATE - Conditional

Enter the date that a re-certification from the Peer Review Organization (PRO) is due for this person in order to continue Medicaid Waiver eligibility. An Electronic ULTC-100.2 form must be submitted before this field can be updated. This field must be entered for all Medicaid Waiver records, but is not applicable to a Medicaid State Plan record.

IP END DATE - Conditional

Enter the date that an updated Individualized Plan (IP) is due for this person in order to continue Medicaid Waiver eligibility. An Individualized Plan Coversheet must be submitted before this field can be updated. This field must be entered for all Medicaid Waiver records, but is not applicable to a Medicaid State Plan record.

AUTHORIZED PLAN END DATE - Obsolete

This field is obsolete. It was used to display the ending date of an authorized plan for the Children's Medical Waiver.

ELIGIBLE FROM DATE - Mandatory

Enter the date eligibility began as of the latest enrollment for this PAR record.

ELIGIBLE THRU DATE - Conditional

For an active Medicaid Waiver record, enter the date that eligibility will expire without documentation of continued eligibility (it will be the earliest of the PRO end date, IP end date or the authorized plan end date). For a terminated record, enter the date of termination. This field may be left blank for Targeted Case Management Medicaid State Plan records unless the record is terminated.

STATUS - Mandatory

This is the person's current status for this Medicaid Waiver type or Medicaid State Plan program. Enter the one of the following statuses:
A – Active
S – Short Term Placement
T - Terminated

TERMINATION TYPE - Conditional

This code indicates the reason for termination of a PAR record. This field is used by DDD for informational purposes only.

Enter the appropriate termination type from the list below if the PAR status is 'T' - Terminated.

| | |
|---|---|
| AH | At Home |
| BREAK | Break in Service |
| CH | Client Choice |
| D | Deceased |
| H | Hospitalized |
| HCB | To HCB-DD |
| NH | Nursing Home |
| O | Other |
| OS | Out of State |
| RES | Residential Program |
| SLS | Support Living Services |
| STRC | Short Term RC Stay |
| TRANS | Transfer to New Agency |
| V | Vocational Program |
| JAIL | Jail/incarceration |
| MHI | Mental Health Instit |
| LME | Lost Medicaid Elgibil |
| SFS | State Funded Service |
| OSA | Out of Service Area |
| AO | Aged Out |
| DDM | DDM Denial |

TERMINATION DATE - Conditional

Enter the termination date if the PAR status is 'T' - Terminated.

FUNCTIONING LEVEL - Conditional

The person's overall level of functioning. This field must be entered for all Medicaid Waiver records, but is not applicable to a Medicaid State Plan record.

Enter the functioning level from the list below:

| | |
|---|---|
| MI | Mild |
| MO | Moderate |
| SE | Severe |
| PF | Profound |

LEVEL OF CARE – Optional

The person's level of care required. This field is not applicable to a Medicaid State Plan record.

Enter the level of care from the list below:

| | |
|---|---|
| MM | Minimum/Moderate |
| SI | Specialized Intensive |
| MP | Medical/Psychosocial |

PRIOR PLACEMENT - Conditional

This code indicates the person's placement prior to entering a Medicaid Waiver program. This field must be entered for all Medicaid Waiver records, but is not applicable to a Medicaid State Plan record.

Enter the prior placement from the list below:

| | |
|---|---|
| DI | Deinstitutionalized |
| NH | Nursing Home |
| OT | Other |

ENROLLMENT DATE - Mandatory

Enter the date of enrollment for this PAR record. If a person has in interruption in service due to a Short Term Regional Center placement or a break in eligibility, a new PAR record must be established with a new enrollment date.

GUARDIAN?/TYPE - Optional

Check the box to indicate if the person has a guardian. Use the 20 character freeform field to indicate the type of guardian (e.g. legal, medical, power of attorney, etc.) or other important information.

PETI 300% - Conditional

Enter "Y" – Yes or "N" – No to indicate if the person is eligible for Medicaid Waiver under the 300% treatment of income rule and the date he was enrolled under that rule. When the person is no longer eligible under the 300% rule, enter "N" – No and enter an ending date of enrollment.

SERVICE AGENCIES - Conditional

CASE MANAGEMENT SERVICE AGENCY - The service agency providing case management services. Use DIR for direct service by the CCB/RC or enter the code for the specific service agency. These codes are assigned by DDD program support staff and must have been entered into the CCMS Table file before you can use them in this record.

RESIDENTAL LOCATION - The location code of the residential group home or individual residential program. These codes are assigned by DDD program support staff and must have been entered into the CCMS Table file before you can use them in this record.

RESIDENTIAL SERVICE AGENCY - The service agency providing residential services. Use DIR for direct service by the CCB/RC or enter the code for the specific service agency. These codes are assigned by DDD program support staff and must have been entered into the CCMS Table file before you can use them in this record.

USER OVERRIDE - Conditional

The user override fields are used to override the estimated number of authorized days for DD Waiver Comprehensive services. DDD will determine the correct number of authorized days to enter when an individual has transferred from one CCB to another or when a break in service eligibility has occurred for Comprehensive services.

FY - Enter the fiscal year to which the override applies.

UNITS - Enter the number of units (days) that should be authorized for Comprehensive services for this PAR record.

CURRENT FY ESTIMATED DAYS – This field is a display field only. It is a calculation for the current fiscal year based on the span of days contained in the From and Thru dates of service, provided no fiscal year override units had been entered and up to the current maximum days for Comprehensive services.

CMW PLAN FIGURES - Obsolete

These fields are obsolete. They were used to display the amounts and dates of the Children's Medical Waiver plans.

PLAN 1 - annual plan total for the first authorized plan.

DATE 1 - beginning date of the first authorized plan.

PLAN 2 - annual plan total for the second authorized plan.

DATE 2 - beginning date of the second authorized plan.

COMMENTS - Optional

This is a free-form field that can be used to record any comments appropriate for this record.

**The following fields appear on the second PAR data entry screen.**

ENROLL/END DATES - Obsolete

These fields apply only to the Developmental Disabilities Waiver (DDW) PAR type and only for the period of time prior to 7/1/99. The information is kept for historical reference.

SPECIALIZED HABILITATION - Enter 'Y' - Yes if the person has been authorized for Specialized Habilitation services and the date of enrollment into those services. When the person is no longer authorized, enter 'N' - No and an ending date of enrollment. This indicator and the dates were used by the Billing module to determine if Community Participation services could be billed for this person prior to 7/1/99.

COMMUNITY PARTICIPATION - Enter 'Y' - Yes if the person has been authorized for Community Participation services and the date of enrollment into those services. When the person is no longer authorized, enter 'N' - No and an ending date of enrollment. This indicator and the dates were used by the Billing module to determine if Community Participation services could be billed for this person prior to 7/1/99.

PRE-VOCATIONAL - Enter 'Y' - Yes if the person has been authorized for Pre-Vocational services and the date of enrollment into those services. When the person is no longer authorized, enter 'N' - No and an ending date of enrollment. This indicator and the dates were used by the Billing module to determine if Pre-Vocational services could be billed for this person prior to 7/1/99.

SUPPORTED EMPLOYMENT/CIE - Enter 'Y' - Yes if the person has been authorized for Supported Employment services and the date of enrollment into those services. When the person is no longer authorized, enter 'N' - No and an ending date of enrollment. This indicator and the dates were used by the Billing module to determine if Supported Employment services could be billed for this person prior to 7/1/99.

IRSS/PCA - Enter 'Y' - Yes if the person has been authorized for Individual Residential Services and Supports/Personal Care Alternative services and the date of enrollment into those services. When the person is no longer authorized, enter 'N' - No and an ending date of enrollment. This indicator and the dates were used by the Billing module to determine if IRSS/PCA services could be billed for this person prior to 7/1/99.

GRSS - Enter 'Y' - Yes if the person has been authorized for Group Residential Services and Supports and the date of enrollment into those services. When the person is no longer authorized, enter 'N' - No and an ending date of enrollment. This indicator and the dates were used by the Billing module to determine if GRSS could be billed for this person prior to 7/1/99.

SPECIAL AUTHORIZATIONS - Conditional

These fields are used to record authorization for an amount in excess of the standard for Children's Extensive Support Waiver environmental engineering.

ENVIRONMENTAL ENGINEERING MAXIMUM - Enter the maximum amount that can be billed for this person for CES Waiver environmental engineering services.

END DATE
Enter the ending date of this authorization.

OPTIONAL FIELDS 1-10 - These fields are used by DDD to record additional information as needed.

The AMP (Automated Medicaid Payment) Billing Transaction file is created when billing records are posted in the Billing module, to serve as the interim file used by the AMPSbatch module from which to create claims. This file is used by the "AMPSbatch Selection Screen" to identify records to hold, release or delete for claims processing.

Refer to Section VI (AMPSbatch Module) for the data entry screen and additional information about updating this file. Refer to Appendix E for file structure and field names.

Most of the fields on the AMPSbatch Selection Screen are display fields only. The data contained in the fields was entered into the posted billing transactions that were used to create this file. You cannot enter or update the billing information on this screen. If it was incorrectly entered into the CCMS Billing module, you will have to enter an adjustment billing transaction in a subsequent billing month to correct the information that was posted to the billing transaction.

MARK FOR AMPSBATCH PROCESSING – Required and Automatically Entered

All posted billing transactions are initially marked for AMPSbatch processing. All marked transactions will be processed into Medicaid claims at the next creation of an AMPSbatch claim file. If you wish to hold this transaction from claims processing, unmark this field and the transaction will be held.

PROCESS ON/AFTER - Required and Automatically Entered

All posted billing transactions are initially set to process for claims processing as of the date they were posted. If you wish to hold this transaction from claims processing until a specified date, enter the specific date in this field, or mark one of the radio buttons on the screen for a specified time period, and the system will automatically enter the date for you.

LATE BILL OVERRIDE - Conditional

If the current system date is more than 119 days from the last date of service on an AMP billing transaction record, the system will require that a Late Bill Override date be entered before the transaction can be processed as a claim. The late billing override date permits you to bill beyond the timely filing deadline without having to submit paper documentation for claims. However, you **MUST** have the documentation on file that one of the following late billing override dates is appropriate:

1. The date the claim was previously rejected during AMPSbatch submission or denied by MMIS

2. The date the claim was processed by other insurance or Medicare (not applicable to DD claims)

3. The date correspondence was received from the Medicaid Fiscal Agent, the state Medicaid program or county agencies

The AMP (Automated Medicaid Payment) Transaction file contains specific billing services and amounts used to create detailed lines of a claim submitted to Medicaid. The AMPTRAN file is used by the "AMPSbatch Rebill Screen" to rebill claims previously submitted.

Refer to Section VI (AMPSbatch Module) for the data entry screen and additional information about updating this file. Refer to Appendix E for file structure and field names.

Most of the fields on the AMPSbatch Rebill Screen are display fields only. The data contained in the fields was entered into the record when claims were created from the AMP Billing Transaction file. You can only update selected fields on the screen to correct information for the next claim submission.

NAME (FL) - Mandatory

Enter the corrected first and last name of this person if the claim was originally submitted under the wrong name or spelling and has been rejected or denied for some reason. Although the correctness of this information will not affect whether the claim is paid, it will help you to identify the person correctly on the AMPSbatch Rebill screen and AMPSbatch reports.

MEDICAID - Mandatory

Enter the corrected Medicaid ID number if the claim was originally submitted under the wrong number. The claim will not process for payment in the MMIS until it has been rebilled with the proper Medicaid ID number.

BIRTHDATE - Mandatory

Enter the corrected birth date if the claim was originally submitted under the wrong date of birth and was rejected or denied for that reason. The claim will not process for payment in the MMIS until it has been rebilled with the proper birth date.

GENDER - Mandatory

Enter the corrected gender if the claim was originally submitted under the wrong gender and was rejected or denied for that reason. The claim will not process for payment in the MMIS until it has been rebilled with the proper gender.

FROM - Mandatory

Enter the corrected From date of service if the claim was originally submitted under the wrong beginning date of service and was rejected or denied for that reason. The claim will not process for payment in the MMIS until it has been rebilled with the proper From date.

THRU - Mandatory

Enter the corrected Thru date of service if the claim was originally submitted under the wrong ending date of service and was rejected or denied for that reason. The claim will not process for payment in the MMIS until it has been rebilled with the proper Thru date.

UNITS - Mandatory

Enter the corrected number of units if the claim was originally submitted with the wrong number of units.

BILLED AMOUNT - Mandatory

Enter the corrected billing amount. The billing amount must be recalculated based on the rate per unit of service.

LAST REPORT DATE / LBO – Conditional and Automatically Entered

Enter the last report date of the report that showed this claim was denied or rejected. The system will automatically enter this date for you if it was able to retrieve this information from an electronic report downloaded from the Medicaid Fiscal Agent. If the current system date is more than 119 days from the last date of service on the claim, you MUST enter either a Last Report Date which is within 60 days from current system date, or a late billing override (LBO) date given to you by the State to authorize billing past the timely filing deadline.

NOTES – Optional and Automatically Entered

Enter any information that will be helpful for identifying the reasons for claim rejection or denial, and actions taken to resolve the problem. The system will automatically enter the latest rejection reason if it was able to retrieve this information from an electronic report downloaded from the Medicaid Fiscal Agent. This information will be appended to the record if the claim continues to be denied or rejected, so you can see a history of the actions on the claim.

The PQ (Program Quality) Service Agency file is used to enter records identifying service agencies. Each service agency that provides services to persons with developmental disabilities funded through the Division for Developmental Disabilities, must be monitored by DDD for program administration, service and support planning and specific program standards. The Service Agency record identifies the date the agency first became approved to provide services within a service area. No program approval records or survey records can be entered for a service agency until this main record is entered.

Refer to Section VII (Program Quality Module) for the data entry screen and additional information about updating this file. Refer to Appendix E for file structure and field names.

AGENCY - Mandatory

Enter the agency code for the CCB or RC for the service area in which the service agency is providing services.

SERVICE AGENCY - Mandatory

The service agency providing services. Use DIR for direct service to identify the CCB or RC as the service agency or enter the code for the specific service agency.

APPROVAL DATE - Required

Enter the date that the service agency was first approved to provide services in the service area that this record identifies.

ACCREDITATION END DATE - Conditional

If this service agency has received accreditation from an outside agency, enter the date that the accreditation expires.

SERVICE AGENCY TERM DATE - Conditional

If this service agency is no longer providing services in the service area this record identifies, enter the date that the service agency discontinued providing services.

ACCREDITED PROGRAMS - Conditional

If this service agency has received accreditation from an outside agency, enter the programs for which accreditation was provided. These program codes have been defined to match DDD program codes, so it can be determined if accreditation can replace surveys which would otherwise have to be completed by DDD staff.

AS Activity Services
CI Community Integrated Employment/Supported Employment
CP Community Participation/Accessibility
WS Work Services

COMMENTS - Optional

Enter any comments related to this service agency that you would like to record for future use or understanding.

LAST UPDATE - Mandatory and Automatically Updated

The date this record was last changed. Update is automatic when any field is changed; the date is taken from the computer's system date. You cannot enter or change this information.

BY USER - Mandatory and Automatically Updated

The ID of the user who last updated this record. Update is automatic when any field is changed. You cannot enter or change this information.

The PQ (Program Quality) Program Approval file is used to enter records identifying programs which have been approved for DDD service agencies. A service agency may not bill for programs until they have been reviewed and approved based on DDD requirements.

Refer to Section VII (Program Quality Module) for the data entry screen and additional information about updating this file. Refer to Appendix E for file structure and field names.

AGENCY - Mandatory

Enter the agency code for the CCB or RC for the service area in which the service agency is providing services.

SERVICE TYPE - Mandatory

The major service type for this program. The service type is used to identify and group records that belong together, e.g. R - Residential service type identifies records for both IRSS and GRSS programs. Service types are:

D Day Program
O Other
R Residential
S Supported Living

PROGRAM TYPE - Mandatory

The approved program. Approved programs must be entered within appropriate Service types. Approved programs grouped by Service type are:

**D Day Program**
CI - Community Integrated Employment/Supported Employment
CP - Community Participation/Accessibility
EI - Early Intervention
NI - Non-Integrated Adult

**O Other**
TR - Transportation

**R Residential**
GR - Group Residential Services and Supports
IR - Individual Residential Services and Supports

**S Supported Living**
CS - Children's Extensive Support
FS - Family Support Services
SL - Supported Living Services

SERVICE AGENCY - Mandatory

The service agency providing services. Use DIR for direct service to identify the CCB or RC as the service agency or enter the code for the specific service agency.

LOCATION - Conditional

The location code assigned to a GRSS provider. This code must be entered for all program approval records for group home services. It uniquely identifies the group home for which approval has been given and for which surveys must be conducted.

APPROVAL DATE - Required

Enter the date that the service agency was first approved to provide this program in the service area that this record identifies.

TERM DATE - Conditional

If this service agency is no longer providing this program in the service area this record identifies, enter the date that the service agency discontinued providing services.

COMMENTS - Optional

Enter any comments related to this program approval that you would like to record for future use or understanding.

LAST UPDATE - Mandatory and Automatically Updated

The date this record was last changed. Update is automatic when any field is changed; the date is taken from the computer's system date. You cannot enter or change this information.

BY USER - Mandatory and Automatically Updated

The ID of the user who last updated this record. Update is automatic when any field is changed. You cannot enter or change this information.

The PQ (Program Quality) Survey file is used to enter records identifying surveys that have been conducted for DD service agencies and group homes. This file contains multiple records so that both current and past surveys may be tracked.

Refer to Section VII (Program Quality Module) for the data entry screen and additional information about updating this file. Refer to Appendix E for file structure and field names.

AGENCY - Mandatory

The agency code for the CCB or RC for the service area in which the service agency is providing services. The system automatically enters this field for you based on the information in the matching service agency or program approval record.

SERVICE AGENCY - Mandatory

The service agency providing services. The system automatically enters this field for you based on the information in the matching service agency or program approval record.

SERVICE TYPE - Mandatory

The major service type for this program. The service type is used to identify and group records that belong together, e.g. R - Residential service type identifies records for both IRSS and GRSS surveys. The system automatically enters this field for you when entering GRSS survey records. Service types are:

D Day Program
O Other
R Residential
S Supported Living

SURVEY DATE - Mandatory

Enter the date of the survey.

SURVEY TYPE - Mandatory

The type of survey conducted. Survey types must be entered within appropriate Service types. The system automatically enters this field for you when entering GRSS survey records. Survey types grouped by Service type are:

**D Day Program**
AC - Accreditation Surveys
D - Day Program

**O Other**
AD - Administration
CM - Case Management

**R Residential**
GR - Group Residential Services and Supports
IR - Individual Residential Services and Supports

**S Supported Living**
CS - Children's Extensive Support
FS - Family Support Services
SF - Supported Living Services/Follow Along

SURVEY SCHEDULE - Conditional

Enter the code that identifies the schedule for the next survey of this type to be conducted for this service agency. Survey schedules are:

1 1 Year
2 2 Years
3 3 Years
N No Schedule

SURVEY OUTCOME - Mandatory

The outcome of this survey based on the three outcome possibilities listed below:

C Critical Standards Not Met
N No Plan of Correction Needed
P Plan of Correction Needed

APPROVAL DATE - Required

Enter the date that approval was given to continue provision of service as a result of the survey.

REPORT DATE - Required

Enter the date that the survey report was completed.

SURVEY SOURCE - Mandatory

Enter the agency from which the survey originated from the list below:

AC Accreditation Council
ADS Agency Directed Survey
CARF Commission on Accreditation of Rehabilitation Facilities
DDD Division for Developmental Disabilities
JCAH Joint Commission on Accreditation of Health Care Organizations
O Other

SURVEY STAFF - Conditional

Enter the user ID of the person at DDD who conducted the survey, if the survey source is DDD.

COMMENTS - Optional

Enter any comments related to this survey that you would like to record for future use or understanding.

LAST UPDATE - Mandatory and Automatically Updated

The date this record was last changed. Update is automatic when any field is changed; the date is taken from the computer's system date. You cannot enter or change this information.

BY USER - Mandatory and Automatically Updated

The ID of the user who last updated this record. Update is automatic when any field is changed. You cannot enter or change this information.

The Code Table file is used to track all of the valid codes used throughout the system. Each code is related to a Look Up Name. Look Up Name codes are all related to specific data field(s). For example, codes entered under the Look Up Name of ETHNICITY identify valid entries for the Ethnicity field entry on the Individual Data screen.

Codes are also marked as Active or Inactive. A code marked Inactive will generate a reminder message that the code should not be used in the current (non-historical) records. Codes should be marked as Inactive when they are no longer current. For example, when a residential group home is closed.

Refer to Section VIII for the data entry screen and additional information about updating this file. Refer to Appendix E for file structure and field names.

LOOK UP NAME - Mandatory

The Look Up Name identifies where this code will be used in the system. Each Look Up Name is tied to coded field(s) on data entry screens in which the associated code may be a valid entry. Look Up Names are assigned by DDD for DDD defined coded fields. Agencies must assign their own Look Up Names for coded fields in their consumer optional file.

Listed below are the valid Look Up Names defined by DDD, and the names of the data entry screens on which they are used. The Table file code records that are entered under each Look Up Name are usually assigned by DDD. However, some Look Up Names allow assignment of codes by the Agency in order to define Agency specific information. Where it is appropriate for an Agency to define codes under a Look Up Name, it is noted in the description of the Look Up Name.

ACRED_PROG - Accredited program to be used on the Program Quality Service Agency screen.

ADLT_HOURS – The type of hours for Comprehensive or Supported Living Services to be used for printing Billing reports for these programs.

ADLT_HOURS_C – The type of hours for Comprehensive Services to be used on the Billing Browse Transaction screen.

ADLT_HOURS_S – The type of hours for Supported Living Services to be used on the Billing Browse Transaction screen.

ADULT_REM – Reason for removal code to be used on the Waiting List Registry screen for Adult waiting list records.

AGENCY - The Agency code assigned by DDD for each Community Centered Board (CCB) or Regional Center (RC) to be used on several screens and in several files throughout the system.

AGY_STAT - The Agency Status to be used on the Individual Data screen. For CCBs the codes to be entered under this Look Up Name are defined by their Agency. For RCs the codes are pre-defined by DDD to capture the Regional Center admission type.

AMP_RECON - AMPSbatch reconciliation code as displayed on the AMPSbatch Rebill screen.

A_DAYPROG - Agency Day program type defined by each Agency to be used on the Current Day Programs Individual Data screen.

APPRV_DAY - Approved day program to be used on the Program Quality Program Approval screen.

APPRV_OTH - Approved ancillary program to be used on the Program Quality Program Approval screen.

APPRV_RES - Approved residential program to be used on the Program Quality Program Approval screen.

APPRV_SLS - Approved supported living service program to be used on the Program Quality Program Approval screen.

BATCH_STAT - The Status of a billing batch record to be used on Billing Batch screens.

BENEFIT - Benefit code to be used on the Individual Data screen.

BILL_CHNGE - Billing change code to be used on Billing Browse Transaction screens.

BILL_FUND - Billing funding code to be used on Billing Contract screen.

BILL_METH - Billing methodology code to be used on Billing Contract screens.

BILL_OPT - Billing optional code defined by each Agency to be used on Billing Batch and Billing Browse Transaction screens.

BILL_PROG - Billing program code to be used on Billing Rate, Billing Contract and Provider screens.

BILL_TERM - Termination type to be used on the Billing Browse Transaction screens.

CASE_MGR - Case Manager code defined by each Agency to be used on the Individual Data screen.

CES_SUPPT - CES Waiver support type to be used on Billing Browse Transaction screens.

CHILD_REM - Reason for removal code to be used on the Waiting List Registry screen for Children's waiting list records.

CHLD_HOURS - The type of hours for Early Intervention Services to be used on the Billing Browse Transaction screen.

CM_FUND - Case Management funding code to be used on the Individual Data screen.

COMP_BILL – Program types that apply to Comprehensive Services to be used on Billing Contract screens.

COMP_LEVEL – Level of Comprehensive services needed code to be used on the Waiting List Registry Screen.

COUNTY - County code to be used on the Individual Data screen.

DAY_COORD - Day Program coordinator code defined by each Agency to be used on the Current Day Programs Individual Data screen.

DAY_FUND - Day Program funding code to be used on Current Day Programs Individual Data screen.

DAY_LEVEL - Day Program level code to be used on Current Day Programs Individual Data screen.

DAY_LOC - Day Program location code to be used on Current Day Programs Individual Data screen.

DAY_PROG - Day Program type to be used on Current Day Programs Individual Data screen.

DAY_STAT - Day Program Status to be used on Current Day Programs Individual Data screen.

DIRECTION - Direction preceding or following a street address to be used on the Individual Data screen.

DISABILITY - Disability code to be used on the Individual Data screen.

ETHNICITY - Ethnicity code to be used on the Individual Data screen.

FSSP_LEVEL - Level of FSSP needed code to be used on the Waiting List Registry Screen.

FSSP_SUPPT - FSSP support type to be used on Billing Browse Transaction screens.

GENDER – Gender code to be used on the Individual Data screen.

MAILCODE - Mailing list code defined by each Agency to be used on the Address screen.

OFUNC_LVL - Overall Functioning level to be used on the Individual Data screen.

OTH_BILL – Program types that apply to Case Management, Administration and Management Fee Services to be used on Billing Contract screens.

O_ALL_STAT - Overall Status to be used on the Individual Data screen.

PAR_LEVEL - Level of service to be used on the PAR screen.

PAR_STATUS - The Status of a PAR record to be used on the PAR screen.

PAR_TERM - Termination type to be used on the PAR screen.

PAR_TYPE - The Waiver type of a PAR record to be used on the PAR screen.

PLACE_TIME - Placement time period to be used on the Individualized Plan screen.

PRIOR_PLAC - Prior placement indicator to be used on the PAR screen.

PROV_STAT - The Status of a Provider record to be used on the Provider screen.

PROV_TYPE - Provider type code to be used on the Billing SLS Services Screen.

PYMT_TYPE - Payment type code to be used on the Billing SLS Services Screen.

REF_REASON – The waiting list referral reason code used on the Current Living Arrangement Individual Data screen.

RELATION - Relationship code defined by each Agency to be used on the Address screen. The S - Self code is pre-defined by DDD and cannot be changed.

RES_COORD - Residential coordinator code defined by each Agency to be used on the Current Living Arrangement Individual Data screen.

RES_FACIL - Residential facility or provider/program code to be used on the Current Living Arrangement Individual Data.

RES_FUND - Residential funding code to be used on the Current Living Arrangement Individual Data screen.

RES_LEVEL - Residential level code to be used on the Current Living Arrangement Individual Data screen.

RES_SET - Residential Setting code to be used on Current Living Arrangement Individual Data screen.

RES_STAT - Residential Status to be used Current Living Arrangement Individual Data screen.

SAFETYRISK – Safety risk code to be used Current Living Arrangement Individual Data screen to identify a consumer that may pose a danger to the community.

SCHL_DIST - School District code to be used on the Individual Data screen.

SERVICE - Main Service type to be used on several screens throughout the system to identify whether a service is being provided under Day, Residential, SLS or some other major category.

SERV_AGY - The Purchase of Service agency (or DIR for Direct) providing service to be used on Billing Batch, PAR and Provider screens.

SLS_CONSLT - Supported Living Service consultant code defined by each Agency to be used on Current Supported Living Services Individual Data screen.

SLS_BILL - Program types that apply to Support Services to be used on Billing Contract screens.

SLS_FUND - Supported Living Service funding code to be used on Current Supported Living Services Individual Data screen.

SLS_LEVEL - Supported Living Service level code to be used on Current Supported Living Services Individual Data screen.

SLS_PROV - Supported Living Service provider/program code to be used on the Current Supported Living Services Individual Data screen.

SLS_STAT - Supported Living Service Status to be used on the Current Supported Living Services Individual Data screen.

SLS_TYPE - Supported Living Service type to be used on the Current Supported Living Services Individual Data screen.

SL_SUPPT - Waiver Supported Living support type to be used on Billing Browse Transaction Screens.

STATE - State code to be used on the Individual Data screen and Address screen.

SUBCONTRCT - Subcontract code defined by each Agency to be used on the Billing Contract Screen. The DDD - Dev Disabil Services code is pre-defined by DDD and cannot be changed.

SURVY_DAY - Day Survey type code to be used on the Program Quality Survey Screen.

SURVY_OTH - Ancillary Survey type code to be used on the Program Quality Survey Screen.

SURVY_RES - Residential Survey type code to be used on the Program Quality Survey Screen.

SURVY_SLS - Supported living services Survey type code to be used on the Program Quality Survey Screen.

SURV_OUTCOM - Survey outcome code to be used on the Program Quality Survey Screen.

SURV_SCHED - Survey schedule code to be used on the Program Quality Survey Screen.

SURV_SRC - Survey source code to be used on the Program Quality Survey Screen.

TERM_TYPE - Termination type to be used on the Individual Data screen.

TITLE – Jr., Sr. or roman numerals that are part of a person’s legal last name to be used on the Individual Data screen.

TYPE - Type (Street, Blvd, etc.) following a numbered address to be used on the Individual Data screen.

WL_FUND - Waiting list funding code to be used on the Waiting List Registry screen.

WL_OPTION – Waiting list optional code, assigned by the Agency and to be used on the Waiting List Registry screen.

WL_PROG – Needed waiting list program code to be used on the Waiting List Registry screen.

WL_STAT - Waiting list status code to be used on the Waiting List Registry screen.

WL_TIMELN - Waiting timeline code to be used on the Waiting List Registry screen.

CODE - Mandatory

Enter the code you wish to assign. Codes can contain letters, numbers and special characters. The system will force all code entries to upper case. Codes can be up to five characters long; however, some of the fields in which codes are entered are less than five characters so you must assign codes which are only as long as the field in which the code will be entered. Refer to Appendix E for field sizes of DDD defined fields.

Note that all coded fields which an Agency defines for the optional file are automatically set to five characters long, so that you may enter codes up to five characters long for all of your optional file coded fields.

DESCRIPTION - Mandatory

Enter the description of this code as you want to see it on screens and printed output. Keep in mind that it is possible to use CCMS data in word processing files. You may want to be sure that you enter the description with both upper and lower case.

TABLE STATUS - Mandatory

Enter the Status of this code as either A - Active or I - Inactive. Codes which are no longer used should be kept in the file and marked as Inactive. DO NOT DELETE CODES WHICH HAD PREVIOUSLY BEEN USED. These codes and their descriptions must be kept for historical reference because they may still be contained in terminated or archived records.

TABLE TYPE - Mandatory

Enter D - DDD if this is a DDD defined code or A - Agency if this is an Agency defined code.

OPTION 1 - Conditional

Enter a value in this field only if instructed to do so by DDD. This option is used to identify the CCB/RC service area for certain codes.

OPTION 2 - Conditional

Enter a value in this field only if instructed to do so by DDD. This option is used to identify the type of provider (purchase of service, direct, etc.) for certain codes.

OPTION 3 - Conditional

Enter a value in this field only if instructed to do so by DDD. This option is used to identify the purchase of service agency for certain codes.

OPTION 4 - Conditional

Enter a value in this field only if instructed to do so by DDD. This option is used to identify the setting/program type for certain codes.

OPTION 5 - Conditional and Automatically Updated

This field will be updated automatically for certain codes to identify the previous setting/program type.

**FIELDS NOT ON THE DATA FORM OR SCREEN**

The following field also exists although it does not appear on the form or the screen.

AGENCY - Mandatory

The number assigned to each Agency by DDD for identification in the CCMS data systems.

This number is entered by the CCMS software. Monthly, the CCMS Table file is transmitted to DDD so DDD has a copy of the codes in each Agency's Table file.

# APPENDIX B

# Billing Methodologies

**COMMUNITY CONTRACT AND MANAGEMENT SYSTEM**
**BILLING METHODOLOGIES**
**APPENDIX B**

The billing and reimbursement methodologies for DD funded services vary based on the type of service being provided and the funding for the service, either Medicaid or State General Fund. Many services are reimbursed based on a monthly portion of the total contract. Other services are reimbursed based on service units reported in monthly billing transactions, which are multiplied by an established rate to arrive at a billable amount for each transaction. Still other services are reimbursed based on the actual cost of the service reported in billing transactions.

Various system adjustments may be applied against reported service information to affect the reimbursement amount for billing transactions. Adjustments are made to reduce reimbursement amounts when an individual has exceeded an established individual maximum for a program, or if the total reimbursement for services exceeds an established contract amount. System adjustments or user entered adjustments may also be applied to correct billings previously reported incorrectly.

## I. System Wide Definitions

**Unit** - a specified quantity by which a service is reported and may also be reimbursed. The measurement scale represented by a unit varies by reporting requirements for each program.

**Enrolled Units** - these are the number of units of service actually provided to an individual for the current billing month. Enrolled units are the units that must be entered into the billing transactions throughout the fiscal year regardless of whether individual maximums have been exceeded.

**Adjustment Units** - these are enrolled units that were provided in a month prior to the current billing month. These may be negative or positive, dependent on whether you are reporting units that were not reported previously or reversing units that were reported incorrectly. You enter these units on the same billing entry screen used to enter monthly enrolled units, but you must enter a separate billing transaction for each reversal and correction or a separate billing transaction or previously unreported billing. The dates of service on the billing transaction must reflect the dates of service for which the adjustment is being submitted.

**Billable Units** - these are the number of enrolled units that do not exceed individual maximums for services which are reimbursed by unit and for which a maximum number of reimbursement units has been established by DDD. This number may be equal to or less than the number of enrolled units. For example, the maximum number of units billable for Comprehensive Services is currently 304 days in a fiscal year. The system will determine when an individual maximum is exceeded and it will calculate billable units accordingly.

**Enrolled Amount** – this is the dollar amount of service actually provided to an individual for the current billing month. This figure will be calculated automatically for those programs that have an established unit rate by which services are reimbursed. For other services that require entry of the cost of service, you must enter the dollar amount manually.

**Adjustment Amount** – this is the dollar amount of service that was provided in a month prior to the current billing month. This figure may be negative or positive, dependent on whether you are reporting a service amount that was not reported previously or reversing a service amount that was reported incorrectly. You enter this amount, along with units of services if appropriate, on the same billing entry screen used to enter monthly billing information, but you must enter a separate billing transaction for each reversal and correction or a separate billing transaction or previously unreported billing. The dates of service on the billing transaction must reflect the dates of service for which the adjustment is being submitted.

**Billable Amount** – this is the dollar amount of service that does not exceed individual maximums. Individual maximums may be exceeded when the number of units of service billed reaches an individual unit maximum, or when the dollar amount of service billed reaches an individual dollar amount maximum. In either case, the system will determine when an individual maximum is exceeded and it will calculate billable amount accordingly.

**System Adjustment to Units or Amount** - there are four types of adjustments that the system will make automatically to billable units or amounts.

1. Over-service adjustments due to exceeding the maximum set by DDD on units or amount billable for a single person in a fiscal year for a given program type. The system does continue to store total cumulative units and amount enrolled, but it will never allow billings to be generated for the amount that exceeds the individual maximum. Billing transactions that exceed the individual maximum will be flagged with the message "Overserved" on billing transaction reports.

2. Over-service adjustments due to exceeding the total State funded contract for a program. The system does continue to store total cumulative contract units and amount, but it will not generate a billing for the amount that exceeds the contract maximum. If a contract amendment is later made to increase the contract amount, the disallowed amount will be automatically billed. The column on the State Funded Summary Billing titled "Amount in Excess of State Contract" will reflect the amount disallowed because it was over the contract amount.

3. Correction of billable figures when an individual maximum is increased. If any units or dollar amounts have been disallowed, and an increase occurs in the individual maximum for a program during the fiscal year, any previously disallowed units or amount within the new individual maximum will be considered billable. The system will automatically calculate the billable figures and will create a special system adjustment transaction to show the additional billable units and/or dollars. The message "System Adjustment to fix Billable" will appear for that transaction on the Posting Error List to alert you that an adjustment has occurred. If the system adjustment is for State funded services, the system will automatically add the additional billable amount to the State Funded Summary Billing.

If the system adjustment is for Medicaid funded services, you must submit adjustments to the Medicaid Fiscal Agent for previously paid Medicaid claims.

4. Room and Board for State Comprehensive Services. A calculation of room and board is performed against income reported for persons in State funded Comprehensive Services. The resulting figure is subtracted from the amount determined billable, after checking individual maximums, to arrive at an adjusted billable amount.

   The calculation for room and board amount is: Total Unearned Income + Applicable Wages – Personal Needs – Medical Deductions.
   - Total Unearned Income = SSI + Social Security + Veterans Benefits + Aid to the Needy + any other unearned income in excess of $30.
   - Applicable Wages = Earned income - Disregard. The portion of the income to be disregard is based on comparing the level of earnings for the month to the minimum wage for a month. The monthly minimum wage is calculated by multiplying average work hours in a month (40 * 52)/12 times the current hourly minimum wage of $5.15 (currently)
     If earnings are below minimum wage - disregard the first $85.00 plus ½ of the remainder of total earned income
     If earnings are above minimum wage – disregard ½ of total earned income
   - Personal Needs = $34 (currently)
   - Medical Deductions = Any uncovered costs for medical, dental, eyeglasses, etc.

**Contract Adjustment Amounts** - these are billable amounts that are added to or subtracted from contract records via a special contract adjustment entry made by DDD. (Refer to Section IV – Contract Adjustment/Special Billing Entry.) In general, the only time adjustment amounts can be entered in this way will be when a rate adjustment must be made across persons due to a retroactive rate change or use of an incorrect rate in previously posted billing month(s). If the adjustment is for a State funded contract record, the amount to be added or subtracted will appear on the next State Funded Summary Billing report. If the adjustment is for a Medicaid funded contract record, DDD will initiate a mass adjustment in the Medicaid Management Information System (MMIS) to add or subtract from the next Medicaid payment.

## II. Encounter Data Reporting

Encounter data is the service information reported in monthly billing transactions for individuals served by your Agency. Encounter data generates actual reimbursement for some programs and serves as supporting information for programs that are reimbursed at a portion of the contract amount.

Encounter data varies by program, but at a minimum each billing transaction must report the person being served, the type of service provided and the dates of service. Depending on the program additional encounter data may include:

- Service provider
- Hours, units or occurrences of service
- Days in residence
- Number of absent days
- Cost of service
- Additional description of service

For specific reporting requirements for each program, refer to the DDD Data Collection/Reporting Definitions in Appendix C.

The encounter data is required by DDD in order to document billings and support the amount of contracted funds. The data is used to evaluate contract performance standards, which are criteria used to determine if the contractor is in compliance with the terms of the contract. Regardless of whether encounter data produces an actual reimbursement amount; it is critical that encounter data be reported in an accurate and timely manner for ongoing monitoring of standards such as minimum number served, member months, member days, etc. For further details about contract performance standards refer to your Agency's contract with DDD.

## III. Reimbursement Methods

Reimbursement methods vary based on the program and funding being received. Reimbursement for Medicaid funded services occurs through the Medicaid Fiscal Agent. The system creates Medicaid claim records from the billing transactions that are successfully posted each month. These claims are transmitted to the Medicaid Fiscal Agent in a batch file for payment. Reimbursement for State funded services occurs through DDD. The system creates a monthly billing report that contains the amount of State funds payable.

**State funded billing** – the system aggregates the billable amounts across individual billing transactions to arrive at the amount to be billed for those services reimbursed on the basis of individual service information. Only billing transactions that are posted successfully will be included in the aggregation. The amount to be billed for programs which are reimbursed based on a portion of the contract (identified by a Billing Methodology code of M – Monthly in the contract record) is calculated monthly based on the balance of the contract divided by the number of months left to pay. The monthly State Funded Summary Billing serves as the actual billing report from which payment is generated, and includes both individual billing aggregated amounts and portion of the contract billing amounts.

**COMMUNITY CONTRACT AND MANAGEMENT SYSTEM**
**BILLING METHODOLOGIES**
**APPENDIX B**

The following reimbursement methods apply to State funded billing.

1. Comprehensive Services
   Reimbursement amount is the number of days in residence multiplied by the daily State Comprehensive rate less individual overservice amount and less the calculated room and board. The individual maximum for this program is 304 days per fiscal year effective 7/1/99.

   Payment is based on the total of billable amounts aggregated across posted State Comprehensive billing transactions for the month.

2. Supported Living Services
   Paid at $1/12^{th}$ of the contract

3. Family Support Services Program
   Paid at $1/12^{th}$ of the contract

4. Early Intervention Services
   Paid at $1/12^{th}$ of the contract

5. Administration
   Paid at $1/12^{th}$ of the contract

6. Case Management
   Paid at $1/12^{th}$ of the contract

7. Management Fee
   Paid at $1/12^{th}$ of the contract

8. Children's Management Fee
   Paid at $1/12^{th}$ of the contract

**Medicaid funded billing** – the system generates individual Medicaid claim records to bill Medicaid funded services to the Medicaid Management Information System (MMIS) for those services reimbursed on the basis of individual service information. Only billing transactions that are posted successfully will generate a Medicaid claim. Actual payment does not occur until the claim has been processed by the Medicaid Fiscal Agent. The amount to be billed for programs which are reimbursed based on a portion of the contract (identified by a Billing Methodology code of M – Monthly in the contract record) is calculated monthly based on the balance of the contract divided by the number of months left to pay. DDD generates a financial transaction to the MMIS for payment of non-individual billings.

The following reimbursement methods apply to Medicaid funded billing.

1. Comprehensive Services - DD Waiver

   Reimbursement amount is the number of days in residence multiplied by the daily Medicaid Comprehensive rate less individual overservice amount. The individual maximum for this program is 304 days per fiscal year effective 7/1/99.

   Payment is based on individual claims submitted to the Medicaid Fiscal Agent as follows:

| Proc Code | Mod Code(s) | Description of Service | Units to bill | Amount to bill |
|---|---|---|---|---|
| T2016 | U3 | CCB Comprehensive | Days in residence | Comprehensive Rate * Units |
| T2016 | U3 and TG | RC Comprehensive | Days in residence | Comprehensive Rate * Units |

2. Supported Living Services Waiver

   A Bundled Rate billing is generated for each month in which any service was received for the service types included in the bundled rate (see below). The individual maximum for this program is $35,000 per fiscal year effective 7/1/99.

   Payment is based on individual claims submitted to the Medicaid Fiscal Agent as follows:

| Proc Code | Mod Code(s) | Description of Service | Units to bill | Amount to bill |
|---|---|---|---|---|
| T2030 | U8 | Supported Living Services Bundled** | 1 unit per month | SLS Rate * Units |

   **A bundled rate claim is generated for any month in which any of the following services are received:

   S02 – Professional Service
   S05 – Personal Assistance
   S15 – Supported Employment
   S18 – Dental/Vision/Hearing
   S21 – Supported Living Consultation
   S23 – Transportation
   S26 – Day Habilitation
   S28 – Item for Bundled Service
   S29 – Item for Behavioral/Professional Service
   S30 – Environmental Engineering

3. Children's Extensive Support Services Waiver

Reimbursement amount is based on the actual cost of service. The individual maximum for this program is $35,000 per fiscal year effective 7/1/99.

Payment is based on individual claims submitted to the Medicaid Fiscal Agent as follows:

| Proc Code | Mod Code(s) | Description of Service | Units to bill | Amount to bill |
|---|---|---|---|---|
| T1019 | U7 | C05 - Personal Assistance | Hours | Cost of service (Cost/Hours cannot exceed maximum rate set in the MMIS) |
| 97530 | U7 | C02 - Professional Services | Hours | Cost of service (Cost/Hours cannot exceed maximum rate set in the MMIS) |
| T2029 | U7 | C06 - Assistive Technology | Same as amount | Cost of service (rate is set at $1/unit) |
| S5165 | U7 | C07 - Home Modification | Same as amount | Cost of service (rate is set at $1/unit) |
| H2021 | U7 | C08 – Community Connections | Hours | Cost of service (Cost/Hours cannot exceed maximum rate set in the MMIS) |
| T2028 | U7 | C10 – Specialized Medical Equipment/Supplies | Same as amount | Cost of service (rate is set at $1/unit) |
| H2019 | U7 | C11 - Behavioral Services | Hours | Cost of service (Cost/Hours cannot exceed maximum rate set in the MMIS) |

| Proc Code | Mod Code(s) | Description of Service | Units to bill | Amount to bill |
|---|---|---|---|---|
| T2024 | U7 | C13 - Item for Professional / Behavioral Services | Same as amount | Cost of service (rate is set at $1/unit) |
| S5199 | U7 | C14– Personal care item, Not Otherwise Specified | Same as amount | Cost of service (rate is set at $1/unit) |
| T2025 | U7 | C15– Waiver services, Not Otherwise Specified | Same as amount | Cost of service (rate is set at $1/unit) |

4. Targeted Case Management
Reimbursement amount is based on a set rate per unit at one unit per month (individual maximum of 12 units per year)

Payment is based on individual claims submitted to the Medicaid Fiscal Agent as follows:

| Proc Code | Mod Code(s) | Description of Service | Units to bill | Amount to bill |
|---|---|---|---|---|
| T2023 | U4 | CCB Targeted Case Management | 1 unit per month | TCM Rate * Units |
| T2023 | U4 TG | RC Targeted Case Management | 1 unit per month | TCM Rate * Units |

5. Administration
Paid at $1/12^{th}$ of the contract

6. Management Fee
Paid at $1/12^{th}$ of the contract

7. Children's Management Fee
Paid at $1/12^{th}$ of the contract

# APPENDIX C

# Billing Reporting Requirements

# APPENDIX D

# Error Messages

**COMMUNITY CONTRACT AND MANAGEMENT SYSTEM**
**APPENDIX D - ERROR MESSAGES**

Following is a summary of the types of error messages that are produced in the Community Contract and Management System. Refer to the appropriate section in this appendix for details about the actual error messages themselves and how to correct them.

**The error messages are listed alphabetically in each section for easy identification.**

I. Data Entry Error Messages

These messages are produced during entry and update of information on data entry screens and are usually displayed in a warning box on the data entry screen. Some of the messages merely require a confirmation, while others require that you change the data you have entered or enter missing required data before you may proceed.

II. Posting Error Messages

These messages are produced while posting billing transactions and are displayed in a screen report during the Billing posting process and by printing the Posting Error List after posting. Some of the messages are informational while others will cause billing transactions to be rejected.

III. Crosscheck Error Messages

These messages are produced by edits which take place when cross checking data entered in individual CORE records with billing transactions entered, and are printed on the Billing to CORE Crosscheck Errors report and CORE to Billing Crosscheck Errors report. An additional report titled Year To Date Crosschecks, evaluates prior month billing transaction records to find incidences of over or under reporting. These messages are used to calculate an error rate percentage to check the accuracy of an agency's data.

IV. Data Edit Review Error Messages

These messages are produced by edits which take place when reviewing data entered in individual CORE records and Waiting List Registry records and are printed on the Individual Data Edit Review List report. These messages are used to calculate an error rate percentage to check the accuracy of an agency's data.

## I. DATA ENTRY ERROR MESSAGES

Following is a list of data entry error messages with an explanation of each one and the process for correcting it, if applicable. The messages are listed alphabetically within the module where they occur. If a message applies to more than one module, it is listed under each module to which it applies. **This listing is not an attempt to be all inclusive.** It should, however, provide you with the most common data entry messages and help you resolve them.

Usually you will just make the appropriate correction to a field in error to get out of the error message loop. Sometimes you may find that you need to cancel a new record entry or the changes you have made to an existing record in order to fix the problem. Usually selecting the Revert button on a data entry screen will allow you to cancel the entry you have made and start fresh. However, at times, you may have to enter something into a field which will pass the edit and get you out of the field level edit before you can Revert your entry.

### Individual Module Data Entry Error Messages

In the Individual Module, you must enter an "update" or "mistake" indicator for certain historical field changes to indicate whether the change made to the field is in fact a sequential change from the existing information, or if it is a correction of information previously entered in error. Many of the Individual Module data entry error messages are related to incorrect use of the U/M (update/mistake) indicator. Error messages that apply to the Mistake/Update screen are followed by "(m/u error)". Follow the instructions listed under the error message for correction of the problem and if you do not understand them, call DDD for assistance (you may Revert your entry and come back to it when someone can assist you). **Do not change the indicator to M - mistake just to get out of the edit. This will affect historical information kept on file for each record.**

1st (2nd, 3rd, 4th) Day Fund. Code Has Been Updated - Date Must Be Updated For History (u/m error).
1st (2nd, 3rd, 4th) Day Level Code Has Been Updated - Date Must Be Updated For History (u/m error).
1st (2nd, 3rd, 4th) Day Loc. Code Has Been Updated - Date Must Be Updated For History (u/m error).
1st (2nd, 3rd, 4th) Day Program Code Has Been Updated - Date Must Be Updated For History (u/m error).
You have changed the funding, level, provider/location or program for one of the four day program sets and reported it as an "update" change without changing the date associated with the day program set. An update change requires that the associated date be changed to show when the update occurred. You must either change the associated date to show when the update occurred, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will not be required to change the date.

1st (2nd, 3rd, 4th) Day Program Date Cannot Be Prior To Previous Date For An Update (u/m error).
You have changed the program date for one of the four day program sets to an earlier date than was previously reported, and reported it as an "update" change. An update change requires that the associated date be sequentially later than the previous date. You must either change the associated date to a later date than was previously entered, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will be able to use the earlier date.

1st (2nd, 3rd) SLS Funding Code Has Been Updated - Date Must Be Updated For History (u/m error).
1st (2nd, 3rd) SLS Level Code Has Been Updated - Date Must Be Updated For History (u/m error).
1st (2nd, 3rd) SLS Program Code Has Been Updated - Date Must Be Updated For History (u/m error).
1st (2nd, 3rd) SLS Prov. Code Has Been Updated - Date Must Be Updated For History (u/m error).
You have changed the funding, level, program or provider/location for one of the three support sets and reported it as an "update" change without changing the date associated with the support set. An update change requires that the associated date be changed to show when the update occurred. You must either change the associated date to show when the update occurred, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will not be required to change the date.

1st (2nd, 3rd) Support Program Date Cannot Be Prior To Previous Date For An Update (u/m error).
You have changed the program date for one of the three support sets to an earlier date than was previously reported, and reported it as an "update" change. An update change requires that the associated date be sequentially later than the previous date. You must either change the associated date to a later date than was previously entered, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will be able to use the earlier date.

A Birthdate must be entered.
You have attempted to save a CORE record without a date of birth. You must enter the birth date on the Individual Main Data screen before you will be able to save the record.

A Comp Status must be entered.
A Comp Status date must be entered.
You have attempted to save a new record without entering a Comprehensive (residential) status or Comprehensive (residential) status date. This status and date are part of the minimum eligibility information required for a record and cannot be blank. You must enter the status and date before you will be able to save the record.

A "Date ID" must be entered for the Needed Program on the Waiting List.
You have attempted to save a waiting list record without entering a date the need was identified. This date is part of the minimum information required for a record and cannot be blank. You must enter the date the need was identified before you will be able to save the record.

A Date must be entered for the SLS Program Type 1 (2, 3).
A support set contains program information but no associated date. You must either enter the date associated with this set or blank out the program information as a "mistake" change before you will be able to save the record.

A "Date Needed" value is required when a Time Line of "See Date" is selected for the <program> Needed Program on the Waiting List.
You have selected "See Date" as the timeline for placement for a waiting list record, but have not entered a projected date of placement in the Date Needed field. You must enter a timeline date before you will be able to save the record.

A "Date Removed" is required when either "Int Mgmt Removed" or "Removed" program statuses are selected for the <program> Needed Program on the Waiting List.

You have entered a status for a waiting list record indicating that the person has been removed from this waiting list (R or X), but have not entered a date the person was removed. You must enter a removal date before you will be able to save the record.

A Day Status Code must be entered.
A Day Status Date must be entered.

You have attempted to save a new record without entering a day program status or day program status date. This status and date are part of the minimum eligibility information required for a record and cannot be blank. You must enter the status and date before you will be able to save the record.

A DD Status must be entered.
A DD Status Date must be entered.

You have attempted to save a new record without entering a DD overall status or DD overall status date. This status and date are part of the minimum eligibility information required for a record and cannot be blank. You must enter the status and date before you will be able to save the record.

A "Fund" must be entered for the <program> Needed Program on the Waiting List.

You have attempted to save a waiting list record without entering a presumed funding for the program needed. Fund is part of the minimum information required for a record and cannot be blank. You must enter the presumed funding before you will be able to save the record.

A gender must be entered.

You have attempted to save a new record without selecting a gender. The gender is part of the identifying information for a record and cannot be blank. You must select a gender before you will be able to save the record.

A Legal Last Name must be entered.

You have attempted to save a new record without entering a last name. The last name is part of the identifying information for a record and cannot be blank. You must enter the last name before you will be able to save the record.

A "Level" is required when "Comprehensive" or "Family Support Services (FSSP)" are entered on the Waiting List.

You have attempted to save a waiting list record for either Comprehensive Services or Family Support Services without entering a level of need. Each of these programs requires that a level be identified so the proper level of resource can be requested. You must enter the level of need before you will be able to save the record.

A "Needed Program" must be entered for each Waiting List record.

You have attempted to save a waiting list record without entering a needed program. The program is part of the minimum information required for a record and cannot be blank. You must enter the needed program before you will be able to save the record.

A person cannot be "Active" in "Child. Ext. Support" or "Supported Living Services" while waiting for "Child. Ext. Support" on the Waiting List

You have attempted to save a waiting list record for Children's Extended Support Services (CES) with a status of "Y – Yes –Waiting" and the CORE record indicates that the individual is already receiving funding for CES from DDD. This status is reserved for cases where the individual is not receiving any DDD funded CES Services. If the Support status on the Support Screen shows the person as Active and incorrectly shows the Support type as CES or SLS, you may correct the Support status and/or Support type fields and then return to the waiting list record after you have saved your changes. If you wish to track a need for a change in the amount of the CES Services provided or a change in the way they are provided, you may enter a waiting list record with a status of "I – Internal Management". You must either change the Support status and/or Support type of the CORE record or the status of the waiting list record before you will be able to save the record.

A person cannot be "Active" in "Comprehensive Services" while waiting for "Comprehensive Services" on the Waiting List.

You have attempted to save a waiting list record for Comprehensive Services with a status of "Y – Yes – Waiting" and the CORE record indicates that the individual is already receiving funding for Comprehensive Services from DDD. This status is reserved for cases where the individual is not receiving any DDD funded Comprehensive Services. If the Comprehensive status on the Current Living Arrangement Screen incorrectly shows the person as Active, you may correct the status and then return to the waiting list record after you have saved your changes. If you wish to track a need for a change in the amount of the Comprehensive Services provided or a change in the way they are provided, you may enter a waiting list record with a status of "I – Internal Management". You must either change the Comprehensive status of the CORE record or the status of the waiting list record before you will be able to save the record.

A person cannot be "Active" in "Comprehensive Services" while waiting for "Supported Living Services" on the Waiting List.

You have attempted to save a waiting list record for Supported Living Services with a status of "Y – Yes – Waiting" and the CORE record indicates that the individual is receiving funding for Comprehensive services from DDD. Waiting List guidelines require that an individual not be receiving a Comprehensive service in order to be on the waiting list for SLS services. If the Comprehensive status on the Current Living Arrangement Screen incorrectly shows the person as Active, you may correct the status and then return to the waiting list record after you have saved your changes. If you wish to record a need for a change from Comprehensive Services to SLS for internal management, you may enter a waiting list record with a status of "I – Internal Management". You must either change the Comprehensive status of the CORE record or the status of the waiting list record before you will be able to save the record.

A person cannot be "Active" in "Early Intervention Services" while waiting for "Early Intervention Services" on the Waiting List.

You have attempted to save a waiting list record for Early Intervention Services (EI) with a status of "Y – Yes –Waiting" and the CORE record indicates that the individual is already receiving funding for EI from DDD. This status is reserved for cases where the individual is not receiving any DDD funded EI Services. If the Support status on the Support Screen shows the person as Active and incorrectly shows the Support type as EI, you may correct the Support status and/or Support type fields and then return to the waiting list record after you have saved your changes. If you wish to track a need for a change in the amount of the EI Services provided or a change in the way they are provided, you may enter a waiting list record with a status of "I – Internal Management". You must either change the Support status and/or Support type of the CORE record or the status of the waiting list record before you will be able to save the record.

A person cannot be "Active" in "Family Support Services (FSSP) - Extended Level" while waiting for "Family Support Services (FSSP) - Extended Level" on the Waiting List

You have attempted to save a waiting list record for Family Support Services Program (FSSP) with a level of FSSP-Extended and with a status of "Y – Yes –Waiting", and the CORE record indicates that the individual is already receiving funding for FSSP-Extended services from DDD. This status is reserved for cases where the individual is not receiving any DDD funded FSSP-Extended services. If the Support status on the Support Screen shows the person as Active and incorrectly shows the Support type as FSSP-Extended, you may correct the Support status and/or Support type fields and then return to the waiting list record after you have saved your changes. If you wish to track a need for a change in the amount of the FSSP-Extended Services provided or a change in the way they are provided, you may enter a waiting list record with a status of "I – Internal Management". You must either change the Support status and/or Support type of the CORE record or the status of the waiting list record before you will be able to save the record.

A person cannot be "Active" in "Family Support Services (FSSP)" while waiting for "Family Support Services (FSSP) - Other Level" on the Waiting List.'

You have attempted to save a waiting list record for Family Support Services Program (FSSP) with a level of FSSP-Other and with a status of "Y – Yes –Waiting", and the CORE record indicates that the individual is already receiving funding for FSSP-Extended or FSSP-Other services from DDD. This status is reserved for cases where the individual is not receiving any DDD funded FSSP services. If the Support status on the Support Screen shows the person as Active and incorrectly shows the Support type as FSSP-Extended or FSSP-Other, you may correct the Support status and/or Support type fields and then return to the waiting list record after you have saved your changes. If you wish to track a need for a change in the amount of the FSSP services provided or a change in the way they are provided, you may enter a waiting list record with a status of "I – Internal Management". You must either change the Support status and/or Support type of the CORE record or the status of the waiting list record before you will be able to save the record.

A person cannot be "Active" in "Supported Living Services" while waiting for "Supported Living Services" on the Waiting List.

You have attempted to save a waiting list record for Supported Living Services (SLS) with a status of "Y – Yes –Waiting", and the CORE record indicates that the individual is already receiving funding for SLS from DDD. This status is reserved for cases where the individual is not receiving any DDD funded SLS. If the Support status on the Support Screen shows the person as Active and incorrectly shows the Support type as SLS, you may correct the Support status and/or Support type fields and then return to the waiting list record after you have saved your changes. If you wish to track a need for a change in the amount of the SLS provided or a change in the way they are provided, you may enter a waiting list record with a status of "I – Internal Management". You must either change the Support status and/or Support type of the CORE record or the status of the waiting list record before you will be able to save the record.

A person must be 14 years old for "Supported Living Services" to be selected as a Needed Program on the Waiting List

You have attempted to save a waiting list record for Supported Living Services with a status of "Y – Yes – Waiting" and the birth date in the CORE record indicates that the individual is under 14 years old. Waiting List guidelines require that an individual must be at least 14 years of age in order to be on the waiting list for SLS. If the birth date is incorrect in the CORE record, you may correct it on the Individual Main Data screen and return to the waiting list record after you have saved your changes. If you wish to track this need earlier than the person's 14th birthday for internal management purposes, you may enter a waiting list record with a status of "I – Internal Management". You must either change the birth date or the waiting list status before you will be able to save the record.

A person must be at least 14 years old for "Comprehensive Services" to be selected as a Needed Program on the Waiting List.

You have attempted to save a waiting list record for Comprehensive Services with a status of "Y – Yes – Waiting" and the birth date in the CORE record indicates that the individual is under 14 years old. Waiting List guidelines require that an individual must be at least 14 years of age in order to be on the waiting list for Comprehensive services. If the birth date is incorrect in the CORE record, you may correct it on the Individual Main Data screen and return to the waiting list record after you have saved your changes. If you wish to track this need earlier than the person's 14th birthday for internal management purposes, you may enter a waiting list record with a status of "I – Internal Management". You must either change the birth date or the waiting list status before you will be able to save the record.

A person must be younger than 3 years of age for "Early Intervention Services" to be selected as a "Needed Program" on the Waiting List.

You have attempted to save a waiting list record for Early Intervention Services with a status of "Y – Yes – Waiting" and the birth date in the CORE record indicates that the individual is 3 years old or older. Eligibility for this program includes an age requirement that the person be under 3 years old. If the birth date is incorrect in the CORE record, you may correct it on the Individual Main Data screen and return to the waiting list record after you have saved your changes. If you wish to track this need for a person 3 years old or older for internal management purposes, you may enter a waiting list record with a status of "I – Internal Management". You must either change the birth date or the waiting list status before you will be able to save the record.

A person must be younger than 18 years of age for "Child. Ext. Support" to be selected as a Needed Program on the Waiting List.

You have attempted to save a waiting list record for Children's Extended Support Services (CES) and the birth date in the CORE record indicates that the individual is 18 years old or older. Eligibility for this program includes an age requirement that the person be under 18 years old. If the birth date is incorrect in the CORE record, you may correct it on the Individual Main Data screen and return to the waiting list record after you have saved your changes. You must either change the birth date in order to save the record or cancel the record entry.

A Social Security Number (SSN) is required.

You have attempted to save a new record without entering a social security number. The social security number is part of the identifying information for a record and cannot be blank. You must enter the social security number before you will be able to save the record. If the social security number is unknown or one has not yet been received, you can have the system assign a pseudo social security number for this record.

A "Status" must be entered for the <program> Needed Program on the Waiting List.

You have attempted to save a waiting list record without entering a status for the record. The status is part of the minimum information required for a record and cannot be blank. You must enter the status before you will be able to save the record.

A Residential Date of Change must be entered.
A residential set contains program information but no associated date. You must either enter the date associated with this set or blank out the program information as a "mistake" change before you will be able to save the record.

A Residential Type must be entered for the Residential Date of Change.
A residential set contains a date but no associated program information. You must either enter the program information associated with this set or blank out the date as a "mistake" change before you will be able to save the record.

A "Termination Type" is required when "DD Status" is "Terminated."
Any records terminated after 7/1/94 must also contain a termination type. You must enter the termination type before you will be able to save the record.

A "Time Line" must be entered for the <program> Needed Program on the Waiting List
You have attempted to save a waiting list record without entering a timeline for placement. The timeline is part of the minimum information required for a record and cannot be blank. You must enter the timeline before you will be able to save the record.

A Support Services Status Code must be entered.
A Support Services Status Date must be entered.
You have attempted to save a new record without entering a Support status or Support status date. This status and date are part of the minimum eligibility information required for a record and cannot be blank. You must enter the status and date before you will be able to save the record.

A "Yes - Waiting" Status for the <program> Needed Program on the Waiting List cannot be entered with DD Statuses of "Terminated" or "Non DDD Funded Only".
You have attempted to enter a waiting list record with a status of "Y - Yes – Waiting" for a person whose DD Overall status in the CORE record is Terminated or Non-DD. This waiting list status is not appropriate for an individual who is terminated from all services or is receiving only Non-DD funded services. The individual must have a DD Overall status of: Active, Case Management Only, Other Agency Case Management or Waiting List without Case Management order to enter a waiting list record with a status of "Y - Yes – Waiting".

Active RC or RS setting is only valid for Regional Centers.
The Regional Center and Regional Center Satellite settings only apply to Regional Center agencies actively serving the individual, and your CCB agency is attempting to enter one of those setting codes in a CORE record with a Comprehensive (residential) status of Active. You must determine the correct setting and enter it into the setting field before you will be able to save the record.

Active Residential in Regional Setting can only have Funding Code of MS.
Your Regional Center agency is entering a funding code other than MS – Medicaid State Plan in a record with an Active Comprehensive (residential) status. You must correct the funding type field before you will be able to save the record.

Active Residential Status requires a funding code of S, HW, OW, or MS.
The Comprehensive block of services can only fund specific settings and funding types under the Active Comprehensive (residential) status. You must determine the correct funding and enter it into the funding field before you will be able to save the record.

Active Residential Status requires a Setting code of IR, GR, RC, or RS.
The Comprehensive block of services can only fund specific settings and funding types under the Active Comprehensive (residential) status. You must determine the correct setting and enter it into the setting field before you will be able to save the record.

Agency Status Code is required if Agency Status Date is entered.
The agency status date field contains a date, but the agency status is blank. You must either blank out the date in the status date field as a "mistake" change or enter an agency status before you will be able to save the record.

Agency Status Date Cannot Be Prior To Previous Date For An Update (u/m error).
You have changed the agency status date to an earlier date than was previously reported, and reported it as an "update" change. An update change requires that the agency status date be sequentially later than the previous date. You must either change the agency status date to a later date than was previously entered, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will be able to use the earlier date.

Agency Status Date is Required if Agency Status is entered.
The agency status field contains data, but the agency status date is blank. You must either blank out the information in the agency status field as a "mistake" change or enter an agency status date before you will be able to save the record.

Agency Status Date must be after the Birthdate.
The agency status date is earlier than the date of birth reported in this record. You cannot enter dates for a time before the individual was born. You must either correct the date to be later or equal to the birthdate, or correct the birthdate if it is incorrect, before you will be able to save the record.

Agency Status Date Must Be Updated Whenever Agency Status Is Updated (u/m error).
Agency Status Must Be Updated Whenever Agency Status Date Is Updated (u/m error).
You have changed the agency status or agency status date and reported it as an "update" change without changing the related field. An update change requires that both the status and the date be changed. You must either change both fields, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will not be required to change the related field.

All Changes To The 1st (2nd, 3rd, 4th) Day Program Transaction Set Must Be The Same Type (u/m error).
All Changes To The 1st (2nd, 3rd) SLS Program Transaction Set Must Be The Same Type (u/m error).
All Changes To The Residential Transaction Set Must Be The Same Type (u/m error).
Changes to any of the historical fields that are part of a set of related fields must be made in a logical order in order to track the sequential history of the changes. When more than one field in the set is changed at the same time, each of the field changes must be effective on the same date and they must all be either "mistake" changes or "update" changes.
For example, if a person moved to a new day program with a new funding, the program type, funding and date of change would all be changed at the same time and reported as "update" changes. However, if there was

erroneous data in the record that needed to be corrected, you would need to make that change first. For example: if the provider/location field was blank, but the person had been served all along at the same provider/location, you would first enter the provider/location information and save the record as a "mistake" change without changing the date so the history would reflect that he was served by that some provider for the previous program. Then you would change the program type, funding and date of change and save the record as "update" changes.

All Changes To The Agency Status Transaction Set Must Be The Same Type (u/m error).
All Changes To The Day Status Transaction Set Must Be The Same Type (u/m error).
All Changes To The DD (Overall) Status Transaction Set Must Be The Same Type (u/m error).
All Changes To The Residential Status Transaction Set Must Be The Same Type (u/m error).
All Changes To The SLS Status Transaction Set Must Be The Same Type (u/m error).
Changes to any of the historical fields that are part of a set of related fields must be made in a logical order in order to track the sequential history of the changes. When more than one field in the set is changed at the same time, each of the field changes must be effective on the same date and they must all be either "mistake" changes or "update" changes.
For example, if a person was Terminated from all support services on 10/01/2004, the date of change for the Support status should reflect that date. However, if the previous Support status date was in error and needed to be corrected, you would need to make that change first. For example: if the previous Support status date should have been 01/01/2004, you would change the Support status date on the data entry screen and save the record as a "mistake" change without changing the Support status to Terminated, so the history would reflect the correct date he became active in Support services. Then, you would change the Support status to Terminated and enter the date of 10/01/2004 and save the record as "update" changes.

All "U/M"values and "Chg Dates" must be entered (u/m error)
You must enter U or M (Update or Mistake) in the U/M column on the Update/Mistake screen for each field listed on the screen. This information is used to determine how to update the historical information for this record.
You must enter a date of change on the Update/Mistake screen for any historical field changes that do not already have a date of change displayed on the screen. Many field changes do not require entry of a date of change because the date is entered on the data entry screen (e.g. day program status and date). However, fields that have no date of change associated with them on the data entry screen (e.g. county of residence, county of origin) require entry of a date of change on the Update/Mistake screen for historical purposes. Enter the actual date the information was effective, NOT the current calendar date.

An "Internal Management" Status for the <program> Needed Program on the Waiting List cannot be entered with DD Status of "Terminated"
You have attempted to save a waiting list record with a status of "I" for a person whose DD Overall status in the CORE record is Terminated. This waiting list status is not appropriate for an individual who is terminated from all services. The individual must have a DD Overall status of: Active, Case Management Only, Other Agency Case Management, Waiting List without Case Management or Non-DD in order to enter a waiting list record with a status of "I".

Another First (Second, Third, Fourth) Day Program History Field Must Be Changed, Date Was Updated (u/m error).
Another First (Second, Third) SL Service History Field Must Be Changed, Date Was Updated (u/m error).
Another Residential History Field Must Be Changed, Date Was Updated (u/m error).
You have changed the date associated with a support, day program or residential set and reported it as an "update" without changing any fields within the set. An update change to a date field that is associated with other fields requires that one of the associated fields be changed to show the new information. You must either change one of the associated fields to show the new information, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will not be required to change the information in the associated fields.

"BABY, NONE, GIRL, BOY, N/A, NA" and numeric values are not allowed as a First Name.
"BABY, NONE, GIRL, BOY, N/A, NA" and numeric values are not allowed as a Last Name.
"BABY, NONE, GIRL, BOY, N/A, NA, NO MIDDLE NAME, NMN" is not allowed as a Middle Name.
Only legal names are allowable in the first, middle and last name fields. If an individual has a title or Jr., Sr., I, II, III, IV or V, enter it in the Title field. If the individual has no middle name, leave the middle name field blank.

Cannot be Active in both COMP and Support at the same time.
The Comprehensive block and the Support block are mutually exclusive. A person cannot be Active under both blocks the same time. You must determine which status is being reported incorrectly and correct it before you will be able to save the record.

City, State, and Zip are mandatory fields when Medicaid ID is entered.
A valid address is required data for all CORE records that have a status of Active, Case Management or Waiting List W/o Case Management. The address can temporarily be left blank, except if the individual has a Medicaid number. The address is mandatory for creation of Medicaid claims sent by the AMPSBatch system, so the address fields become mandatory data when you enter a new record or update an existing record. You must enter the full correct address before you will be able to save the record.

Comp Status date must be after the Birthdate.
The Comprehensive (residential) status date is earlier than the date of birth reported in this record. You cannot enter dates for a time before the individual was born. You must either correct the date to be later or equal to the birthdate, or correct the birthdate if it is incorrect, before you will be able to save the record.

Comp Status date must be after the DD Status Date.
When entering a new record, the date entered for the Comprehensive (residential) status may not be earlier than the date entered for the DD overall status. You must either correct the residential status date or the overall status date before you will be able to save the record.

Comprehensive and Support Status cannot be 'Active' if DD Status isn't 'Active'.
Comprehensive or Support Status must be 'Active' if DD Status = 'Active'.
The different statuses maintained in the record must be logically consistent with each other. If the DD overall status is Active, it means that program funding is being provided, so either the Comprehensive (residential) or Support status must also be Active to reflect under what major service area the program services are funded. Conversely, if the DD overall status is not Active, neither of the other two statuses may be active. You must determine which status(es) are being reported incorrectly and correct them before you will be able to save the record.

Date cannot be in the future
The date entered in the field being edited is later than the current calendar date as reported by your computer system. You cannot enter future dates in any field except for the IP Date field. You must correct the date to be earlier or equal to the computer's system date in order to get out of this field level edit. If the problem is with the system date on your computer being reported incorrectly, you will have to correct it before you may enter the proper date in this field.

Day Prog. Status Date Must Be Updated When Status Is Updated (u/m error).
Day Prog. Status Must Be Updated When Day Prog. Status Date Is Updated (u/m error).
You have changed the day program status or day program status date and reported it as an "update" change without changing the related field. An update change requires that both the status and the date be changed. You must either change both fields, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will not be required to change the related field.

Day Program Date 1 (2, 3, 4) must be entered.
A day program set contains program information but no associated date. You must either enter the date associated with this set or blank out the program information as a "mistake" change before you will be able to save the record.

Day Program Type 1 (2, 3, 4) must be entered (since a 'Date of Change' was entered).
A day program set contains a date but no associated program information. You must either enter the program information associated with this set or blank out the date as a "mistake" change before you will be able to save the record.

Day Status Code Cannot Be Changed From Non-DD to Terminated As An Update (u/m error).
You have entered a status change and reported it as an "update' but it is not a logical change from the previous status. Logical sequences must be followed when updating statuses in order to accurately reflect historical information. A day program status of SLS Program or Comprehensive may be changed to Terminated to reflect termination of day program funding. However, a day program status of Non-DD cannot be changed to Terminated because the previous status was not a funded status. You must either change the status to reflect a logical sequence, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will be able to use the inconsistent status.

Day Status Date Cannot Be Prior To Previous Date For An Update (u/m error).
You have changed the date for day program status to an earlier date than was previously reported, and reported it as an "update" change. An update change requires that the associated date be sequentially later than the previous date. You must either change the associated date to a later date than was previously entered, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will be able to use the earlier date.

Day Status Date must be after the Birthdate.
The day program status date is earlier than the date of birth reported in this record. You cannot enter dates for a time before the individual was born. You must either correct the date to be later or equal to the birthdate, or correct the birthdate if it is incorrect, before you will be able to save the record.

Day Status Date must be after the DD Status Date.

When entering a new record, the date entered for the day program status may not be earlier than the date entered for the DD overall status. You must either correct the day program status date or the overall status date before you will be able to save the record.

DD Eligibility Date must be after the Birthdate.
The eligibility date is earlier than the date of birth reported in this record. You cannot enter dates for a time before the individual was born. You must either correct the date to be later or equal to the birthdate, or correct the birthdate if it is incorrect, before you will be able to save the record.

DD Status cannot be "Case Management Only" for a Regional Center.
The DD overall status of C - Case Management Only is not appropriate for a Regional Center because program services of some kind are always provided to a person residing at a Regional Center. You must correct the overall status to reflect Active if the services are DD funded or Non-DD if the services are funded in some other way before you will be able to save the record.

DD Status Date must be after the Birthdate.
The DD overall status date is earlier than the date of birth reported in this record. You cannot enter dates for a time before the individual was born. You must either correct the date to be later or equal to the birthdate, or correct the birthdate if it is incorrect, before you will be able to save the record.

DD Status Date Must Be Updated Whenever DD Status Is Updated (u/m error).
DD Status Must Be Updated Whenever DD Status Date Is Updated (u/m error).
You have changed the DD overall status or DD overall status date and reported it as an “update” change without changing the related field. An update change requires that both the status and the date be changed. You must either change both fields, or if this was actually a correction of mistaken data, you must report it as a “mistake” change and you will not be required to change the related field.

First (Second, Third, Fourth) Day Program Date must be after the Birthdate.
The day program date is earlier than the date of birth reported in this record. You cannot enter dates for a time before the individual was born. You must either correct the date to be later or equal to the birthdate, or correct the birthdate if it is incorrect, before you will be able to save the record.

First (Second, Third) Support Services Date must be after the Birthdate.
The support services program date is earlier than the date of birth reported in this record. You cannot enter dates for a time before the individual was born. You must either correct the date to be later or equal to the birthdate, or correct the birthdate if it is incorrect, before you will be able to save the record.

Funding for "Child. Ext. Support" program must be "Medicaid" funding on the Waiting List
You have attempted to enter a waiting list record with a needed program of Children’s Extended Support Services with a funding of State. The only funding type available for Children’s Extended Support Services is Medicaid funding.

Intake Date must be after the Birthdate.
The intake date is earlier than the date of birth reported in this record. You cannot enter dates for a time before the individual was born. You must either correct the date to be later or equal to the birthdate, or correct the birthdate if it is incorrect, before you will be able to save the record.

IP Date must be after the Birthdate.
The IP date is earlier than the date of birth reported in this record. You cannot enter dates for a time before the individual was born. You must either correct the date to be later or equal to the birthdate, or correct the birthdate if it is incorrect, before you will be able to save the record.

IQ score must be numeric or have a value of "UK", "UD", or "NS"
An entry in the IQ field must either be a positive integer or UD - Undetermined, UK - Unknown or NS - Not scorable. You must either enter one of these valid options or leave the IQ score blank until you can determine the correct information to enter into the field before you will be able to save the record.

Original Entry Date must be after the Birthdate.
The original entry date is earlier than the date of birth reported in this record. You cannot enter dates for a time before the individual was born. You must either correct the date to be later or equal to the birthdate, or correct the birthdate if it is incorrect, before you will be able to save the record.

Over-All Status Code Can Only Be Changed From Active to Any Other Status than Terminated As An Update (u/m error).
Over-All Status Cannot Be Changed From Non-DD to Terminated As An Update (u/m error).
Over-All Status Cannot Be Changed From Wait List W/o CM to Terminated As An Update (u/m error).
You have entered a status change and reported it as an "update' but it is not a logical change from the previous status. Logical sequences must be followed when updating statuses in order to accurately reflect historical information. A DD overall status of Active may be changed to Terminated to reflect termination of all funding. However, a DD overall status of Non-DD, Other Agy Case Mgmt or Waiting-No Case Mgt cannot be changed to Terminated because the previous status was not a funded status. An "update" change to DD overall status of Case Management Only can only go to Terminated or Active. You must either change the status to reflect a logical sequence, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will be able to use the inconsistent status.

Over-All Status Date Cannot Be Prior To Previous Date For An Update (u/m error).
You have changed the date for DD overall status to an earlier date than was previously reported, and reported it as an "update" change. An update change requires that the associated date be sequentially later than the previous date. You must either change the associated date to a later date than was previously entered, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will be able to use the earlier date.

Res. Status Date Must Be Updated Whenever Res. Status Is Updated (u/m error).
Res. Status Must Be Updated Whenever Res. Status Date Is Updated (u/m error).
You have changed the Comprehensive (residential) status or Comprehensive (residential) status date and reported it as an "update" change without changing the related field. An update change requires that both the status and the date be changed. You must either change both fields, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will not be required to change the related field.

Resid. Change Date Cannot Be Prior To Previous Date For An Update (u/m error).

You have changed the date for the residential set to an earlier date than was previously reported, and reported it as an "update" change. An update change requires that the associated date be sequentially later than the previous date. You must either change the associated date to a later date than was previously entered, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will be able to use the earlier date.

Resid. Facility Code Has Been Updated - Date Must Be Updated For History (u/m error).
Resid. Funding Code Has Been Updated - Date Must Be Updated For History (u/m error).
Resid. Level Code Has Been Updated - Date Must Be Updated For History (u/m error).
Resid. Setting Code Has Been Updated - Date Must Be Updated For History (u/m error).'
You have changed the facility, funding, level or residential setting and reported it as an "update" change without changing the date associated with the residential set. An update change requires that the associated date be changed to show when the update occurred. You must either change the associated date to show when the update occurred, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will not be required to change the date.

Resid. Status Code Can Only Be Changed From Active to Any Other Status than Terminated As An Update (u/m error).
Resid. Status Code Cannot Be Changed From Non-DD to Terminated As An Update (u/m error).
You have entered a status change and reported it as an "update' but it is not a logical change from the previous status. Logical sequences must be followed when updating statuses in order to accurately reflect historical information. A Comprehensive (residential) status of Active may be changed to Terminated to reflect termination of residential funding. However, a Comprehensive (residential) status of Non-DD cannot be changed to Terminated because the previous status was not a funded status. You must either change the status to reflect a logical sequence, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will be able to use the inconsistent status.

Residential Setting can not be 'None' or Blank
This record has a status that indicates the person is currently receiving services from your agency or is on your agency's waiting list, but the residential setting field has been left blank or is reported as None. All individuals receiving services or on waiting list have a known residential setting. You must determine the correct setting and enter it before you may save changes to this record.

SafetyRisk: Comprehensive or Support Status must be ACTIVE for Convicted.
An individual who has been convicted of a crime that poses a risk to the community, must be identified only if he is in Active in Comprehensive or Supported Living Services. Neither the Comprehensive or Support statuses are Active. You must update the appropriate status before you will be able to save the record.

SafetyRisk: Comprehensive Status must be ACTIVE for Non-Convicted.
An individual who has been determined to be a risk to the community, but not convicted of a crime, must be identified only if he is in Active in Comprehensive Services. The Comprehensive status is not Active. You must update the status before you will be able to save the record.

SafetyRiskDate: Date required when SAFETY RISK contains a value.
A review of the Community Safety Risk must be completed yearly for an individual who has been identified as a risk to the community. The date of the next review must be entered before you will be able to save the record.

SafetyRiskDate: Must be greater than Birthdate.

The Safety Risk review date is earlier than the date of birth reported in this record. You cannot enter dates for a time before the individual was born. You must either correct the date to be later or equal to the birthdate, or correct the birthdate if it is incorrect, before you will be able to save the record.

SLS Program Type 1 (2, 3) must be entered (since a 'Date of Change' was entered).
A support set contains a date but no associated program information. You must either enter the program information associated with this set or blank out the date as a "mistake" change before you will be able to save the record.

SLS Status Code Can Only Be Changed From Active to Terminated As An Update (u/m error).
SLS Status Code Cannot Be Changed From Non-DD to Terminated As An Update (u/m error).
You have entered a status change and reported it as an "update' but it is not a logical change from the previous status. Logical sequences must be followed when updating statuses in order to accurately reflect historical information. A Support status of Active may be changed to Terminated to reflect termination of Support funding. However, a Support status of Non-DD cannot be changed to Terminated because the previous status was not a funded status. You must either change the status to reflect a logical sequence, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will be able to use the inconsistent status.

SLS Status Date Cannot Be Prior To Previous Date For An Update (u/m error).
You have changed the date for Support status to an earlier date than was previously reported, and reported it as an "update" change. An update change requires that the associated date be sequentially later than the previous date. You must either change the associated date to a later date than was previously entered, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will be able to use the earlier date.

SLS Status Date Must Be Updated Whenever SLS Status Is Updated (u/m error)
SLS Status Must Be Updated Whenever SLS Status Date Is Updated (u/m error)
You have changed the Support status or Support status date and reported it as an "update" change without changing the related field. An update change requires that both the status and the date be changed. You must either change both fields, or if this was actually a correction of mistaken data, you must report it as a "mistake" change and you will not be required to change the related field.

Support Services Status Date must be after the Birthdate.
The Support status date is earlier than the date of birth reported in this record. You cannot enter dates for a time before the individual was born. You must either correct the date to be later or equal to the birthdate, or correct the birthdate if it is incorrect, before you will be able to save the record.

Support Services Status Date must be after the DD Status Date.
When entering a new record, the date entered for the Support status may not be earlier than the date entered for the DD overall status. You must either correct the Support status date or the overall status date before you will be able to save the record.

Termination Code must be "ED Emergency Discharge" if Agency Status = "E Emergency."
Termination Code must be "RD Respite Care Discharge" if Agency Status = "R Respite Care".
These messages apply to Regional Centers and ensure accurate status information and history for Regional Center admissions (which are recorded in the agency status field) and discharges (which are recorded in the termination field). An Emergency Admission must be terminated as an Emergency Discharge. A Respite Admission must be terminated as a Respite Discharge. You must either change the termination code or the agency status so the admission and discharge are consistent before you will be able to save the record.

The "Date ID'd" for the <program> Needed Program cannot be after the date Removed on the Waiting List.
The Removal Date on this Waiting List record is earlier than the Date ID'd. Each Waiting List record is its own history and must record the date the individual was originally waiting for the program identified in the record. When the individual is removed from the waiting list for that program, the removal date must be entered and the original Date ID'd must be retained. If the individual must goes on a waiting list for the same program in the future, add a new waiting list record with the most recent Date ID'd.

The "Date ID" for the new <program> Needed Program must be after the "Date ID" for all pre-existing Needed Programs.
The Date ID'd for this new waiting list record, is earlier than a previous record for the same program. Each Waiting List record is its own history and must record the date the individual was originally waiting for the program identified in the record. When the individual is removed from the waiting list for that program, the removal date must be entered and the original Date ID'd must be retained. If the individual goes on a waiting list for the same program in the future, the new waiting list record must have a Date ID'd later than all previous records for that program.

The first "Relationship" in an Address record cannot be blank.
You have attempted to save an Address record without entering a relationship code in the 1st relationship field. The 1st relationship is the minimum identifying information required for an Address record. You must enter a 1st relationship code before you will be able to save the record.

The Medicaid Number is invalid.
Medicaid numbers have a pre-determined format that begins with a capital letter and ends with 6 numbers. If the Medicaid number you entered does not meet this format, you must correct it before you will be able to save the record.

The "Needed Program" of "Supported Living Services" on the Waiting List is not valid with the current Residential Setting.
You have attempted to save a waiting list record for Supported Living Services with a status of "Y – Yes – Waiting" and the CORE record indicates that the individual is in a residential setting of ICF/MR, Regional Center, Regional Center Satellite, Nursing Home, Family Foster Care or Children's Group Home. Waiting List guidelines require that an individual not be residing in any of these settings in order to be on the waiting list for SLS services. If the residential setting on the Current Living Arrangement Screen incorrectly shows the person in one of these settings, you may correct the setting and then return to the waiting list record after you have saved your changes. If you wish to record a need for a change from one of these settings to SLS for internal management, you may enter a waiting list record with a status of "I – Internal Management". You must either change the residential setting of the CORE record or the status of the waiting list record before you will be able to save the record.

The "Removal Reason" must be entered when the status is "Removed" or "Int Mgmt Removed" for the <program> Needed Program on the Waiting List

You have entered a status for a waiting list record indicating that the person has been removed from this waiting list (R or X), but have not entered a reason for the removal. You must enter a removal reason before you will be able to save the record.

The "Self" relationship is only allowed for the first "Relationship" in an Address record.'

You have entered a relationship code of S - Self in the 1st Relationship field of an address record. This code is entered into the 1st Relationship field by the system when it automatically creates a "self" address record from the address in the main file. You may update the "self" address record that was created by the system, but you may not create another address record with S - Self in the 1st Relationship field. You must change the 1st Relationship code to any other valid code before you will be able to save the record.

The STATUS 'I - Internal Management', can not be used with Needed Program Code 'IC - ICF-MR'.
The STATUS 'X - Int Mgmt Removed', can not be used with Needed Program Code 'IC - ICF-MR'.

Regional Centers must track individuals who are awaiting entry into the RC's Institutional services. DDD requires this information, for planning so only "Y" Yes - Waiting and "R" Removed statuses are the only ones allowed in this case.

The "Time Line" must be before the 18th birthday when "Child. Ext. Support" is selected as a Needed Program on the Waiting List

You have attempted to save a waiting list record for Children's Extended Support Services (CES) and the birth date in the CORE record indicates that the individual will be 18 years old or older on the date entered as the projected placement date. Eligibility for this program includes an age requirement that the person be under 18 years old. If the birth date is incorrect in the CORE record, you may correct it on the Individual Main Data screen and return to the waiting list record after you have saved your changes. You must either change the birth date in order to save the record or cancel the record entry.

The "Time Line" must be on or after the 18th birthday when "Comprehensive Services" is selected as a Needed Program on the Waiting List

You have attempted to save a waiting list record for Comprehensive Services with a status of "Y – Yes – Waiting" and the birth date in the CORE record indicates that the individual will be under 18 years old on the date entered as the projected placement date. Waiting List guidelines require that an individual must be 18 years old in order to receive Comprehensive services. If the birth date is incorrect in the CORE record, you may correct it on the Individual Main Data screen and return to the waiting list record after you have saved your changes. If you wish to project placement for this need earlier than the person's 18th birthday for internal management purposes, you may enter a waiting list record with a status of "I – Internal Management". You must either change the birth date or the waiting list status before you will be able to save the record.

The "Time Line" must be on or after the 18th birthday when "Supported Living Services" is selected as a Needed Program on the Waiting List

You have attempted to save a waiting list record for Supported Living Services with a status of "Y – Yes – Waiting" and the birth date in the CORE record indicates that the individual will be under 18 years old on the date entered as the projected placement date. Eligibility for this program includes an age requirement that the person be 18 years old or older. If the birth date is incorrect in the CORE record, you may correct it on the Individual Main Data screen and return to the waiting list record after you have saved your changes. If you wish to project placement for this need before 18 years of age for internal management purposes, you may enter

a waiting list record with a status of “I – Internal Management”. You must either change the birth date or the waiting list status before you will be able to save the record.

The "Time Line" must be on or before the 3rd birthday when "Early Intervention Services" is selected as a Needed Program on the Waiting List.

You have attempted to save a waiting list record for Early Intervention Services with a status of “Y – Yes – Waiting” and the birth date in the CORE record indicates that the individual will be 3 years old or older on the date entered as the projected placement date. Eligibility for this program includes an age requirement that the person be under 3 years old. If the birth date is incorrect in the CORE record, you may correct it on the Individual Main Data screen and return to the waiting list record after you have saved your changes. If you wish to project placement for this need after 3 years of age for internal management purposes, you may enter a waiting list record with a status of “I – Internal Management”. You must either change the birth date or the waiting list status before you will be able to save the record.

The Waiting List status cannot be changed from "Int Mgmt Removed" to "Internal Management" for the <program> program unless you are correcting a mistake. If you are not correcting a mistake you must enter a new program.

Each Waiting List record is its own history and must record the date the individual was originally waiting for the program identified in the record, and the date he was removed from the waiting list for that program. You cannot change the status back to “I - Internal Management”, unless you are correcting a mistake. When you receive the message “The following error is only allowed if you are correcting a mistake. Are you correcting a mistake?”, answer “Yes” and you will be allowed to proceed with the change; answer “No” and you will not be allowed to make the change.

The Waiting List status cannot be changed from "Removed" to "Yes - Waiting" for the <program> program unless you are correcting a mistake. If you are not correcting a mistake you must enter a new program.

Each Waiting List record is its own history and must record the date the individual was originally waiting for the program identified in the record, and the date he was removed from the waiting list for that program. You cannot change the status back to “Y – Yes – Waiting”, unless you are correcting a mistake. When you receive the message “The following error is only allowed if you are correcting a mistake. Are you correcting a mistake?”, answer “Yes” and you will be allowed to proceed with the change; answer “No” and you will not be allowed to make the change.

Waiting List Date must be after the Birthdate.

The waiting list date (Order of Selection Date) is earlier than the date of birth reported in the CORE record. You cannot enter dates for a time before the individual was born. You must either correct the date to be later or equal to the birth date, or correct the birth date if it is incorrect, before you will be able to save the record.

Zip code must be a valid "5" or "5+4" postal format.

The zip code on this Active, Case Management or Waiting List W/o Case Management record does not meet the national zip code standards. You must enter the correct zip code before you will be able to save the record.

## Billing Module Data Entry Error Messages

A Day Agency is required.
You have reported hours of support in a billing transaction for Comprehensive or SLS Day services without entering a primary day agency code. The primary day agency code identifies who is the provider of supported day services. This information is needed by DDD for purposes of verifying program approval and identifying persons who should be included in surveys of approved day services agencies, where appropriate. If the primary day provider is not an approved service agency, you may choose the code that indicates the provider is a generic day provider. You must enter the code for the primary day provider before you will be able to save the record.

A Medicaid Number needs to be entered in the Individual screen before you can enter a transaction for this person.
There is no Medicaid number entered in the CORE record for this billing transaction. You cannot enter a billing until the Medicaid number has been entered into the CORE record.

A provider matching the Day Agency you've selected doesn't exist. Modify this to match those of known providers.
The entry for SLS or Comprehensive day program service agency does not match to a Medicaid certified day program provider. You must determine whether the provider record has not been entered yet or has been entered incorrectly, and take steps to have the record entered or corrected, if so. It is probable that the correction can not be made until the following month. You will have to revert this entry until you can resolve the problem.

A Support Hour entry is required if Service Costs have been entered.
If Service Costs have been entered for the SLS program and the service type is one that is reported by hour, Support Hours must be entered. You must enter hours of service before you will be able to save the record.

A Support Type is required.
For the SLS, CES and FSSP programs, a support type must be reported. The support type identifies the type of service being provided. You must select a support type before you will be able to save the record.

A Termination Reason is required.
You have entered a termination/discharge code in either the 1st change or 2nd change field but the termination reason field is blank and the billing is for a program that requires entry of a termination reason. You must either enter a code in the termination reason field or blank out the termination/discharge code in the 1st or 2nd change field before you will be able to save the record.

Absent Days cannot be negative for current month entries.
Current month billing transactions must be used to report billing information for that month only. If it is necessary to correct erroneous information submitted for a previous billing month, an adjustment billing transaction must be entered containing the reversal figures and the dates of service to which it applies. You must correct the negative figure(s) before you will be able to save the record.

Amounts cannot be negative for current month entries.
Current month billing transactions must be used to report billing information for that month only. If it is necessary to correct erroneous information submitted for a previous billing month, an adjustment billing transaction must be entered containing the reversal figures and the dates of service to which it applies. You must correct the negative figure(s) before you will be able to save the record.

An Additional Explanation is required.
For CES Waiver services which must be reported as an "item" because it is only appropriate to report the dollar amount of the service (e.g. purchase of an item or a one-time cost of service), an explanation of the item(s) or service(s) purchased must be provided. This allows evaluation of the appropriateness of the item purchased. You must enter an explanation of the item purchased or the service provided before you will be able to save the record.
For Medicaid Waiver and State SLS services, you need only provide an explanation for Environmental Engineering.

An Occurrence entry is required if Service Costs have been entered.
If Service Costs have been entered for the SLS program and the service type is one that is reported by occurrence, Occurrences must be entered. You must enter occurrences before you will be able to save the record.

An 'Other Income Explanation' must be entered.
The other income field is used to record 'other' income for persons in State funded comprehensive services. You must enter an explanation of the income being reported before you will be able to save the record.

Hours cannot be negative for current month entries.
Current month billing transactions must be used to report billing information for that month only. If it is necessary to correct erroneous information submitted for a previous billing month, an adjustment billing transaction must be entered containing the reversal figures and the dates of service to which it applies. You must correct the negative figure(s) before you will be able to save the record.

Support Hours cannot be entered.
Hours of service cannot be entered for CES Waiver services that must be billed or reported as an "item" or one-time service cost. Only the cost of the service is to be reported regardless of the number of items or events included in the service cost. If more than one item or event needs to be reported, enter separate billing transactions for each item with different dates of service, or explain each item in the Additional Explanation field. You must zero out the hours before you will be able to save the record.

'Sprt Hrs' and 'Srvc Cst' must both have the same sign (positive or negative).
When adjusting previously reported SLS or CES services, a billing transaction reversing the incorrect figures must first be entered and then a billing transaction reporting the correct figures must be entered. You cannot combine adjustments together or enter partial adjustment that could result in both positive and negative figures in these fields.

Support hours are required.
For CES Waiver services which must be billed by hours, the hours to be billed must be reported. You must enter the hours of service before you will be able to save the record.

The "1st Date" cannot be after the billing month.
The "2nd Date" cannot be after the billing month.
The 1st and 2nd date fields cannot contain dates that are later than the ending date of the current billing month. You must correct the date(s) of service before you will be able to save the record.

The "1st Date" cannot be empty.
The "2nd Date" cannot be empty.
The 1st and 2nd date fields are used to show the dates of enrollment for the program being billed and to complete the from and through dates of service for Medicaid claims. You must enter both the 1st date and 2nd date before you will be able to save the record.

The "1st Date" cannot be in a prior fiscal year.
No billing transactions entries are allowed for prior fiscal year units of service or status changes. You must correct the dates of service date before you will be able to save the record.

The "1st Date" cannot be later than the 2nd Date.
The date entered in the 1st date field is later than the date entered in the 2nd date field. You must correct the dates of service before you will be able to save the record.

The 1st Date is before the provider certification date.
The provider certification date in the provider record for this billing transaction is later than the date(s) of service in the billing transaction. You cannot enter a billing for this provider prior to the effective date of certification. You must either correct the dates of service in the billing transaction to be equal to or later than the certification date, or resolve any discrepancies with DDD Medicaid staff and try billing again after the provider record has been corrected.

The "1st and 2nd Dates" must be in the same month.
The dates entered in the 1st and 2nd date fields must fall within the same month of service. Each billing transaction must reflect no more than one month of billing information. You must correct the dates of service before you will be able to save the record.

The 2nd Date is after the provider termination date.
The provider record for this billing transaction has been terminated and the termination date in the provider record is earlier than the date(s) of service in the billing transaction. You cannot enter a billing for this provider beyond the effective date of termination. You must either correct the dates of service in the billing transaction to be equal to or earlier than the termination date, or resolve any discrepancies with DDD Medicaid staff and try billing again after the provider record has been corrected.

The following Additional Explanations are not allowed: 'stuff', 'things', and 'misc'.
For CES and SLS services that require an additional explanation, the generic explanations above are not allowed. You must enter an explanation that provides more detail before you will be able to save the record.

The 'Service Cost' divided by the 'Support Hours' exceeds the DDD maximum allowable billable rate as entered in the bill_rate table.
All CES services that report hours of support cannot exceed a maximum hourly rate established by DDD. If the cost of the service divided by the hours exceeds that rate, you will not be allowed to save the record. You must reduce the service cost before you will be able to save the record.

The Service Cost is required.
All CES services reported by hours of support must have a cost associated with those hours. You must enter the cost of the service before you will be able to save the record.

The sum of 'Days Served' and 'Absent Days' cannot be greater than the difference between the 1st and 2nd 'Dates'.
The number of days of service entered into the billing transaction exceeds the number of days in the billing month. You must correct the number of days before you will be able to save the record.

Units cannot be negative for current month entries.
Current month billing transactions must be used to report billing information for that month only. If it is necessary to correct erroneous information submitted for a previous billing month, an adjustment billing transaction must be entered containing the reversal figures and the dates of service to which it applies. You must correct the negative figure(s) before you will be able to save the record.

Units must be -1 through 1 after 11/30/03.
No more than one unit of Targeted Case Management may be billed per person per month. You must correct the number of units entered before you will be able to save the record.

## PAR Module Date Entry Error Messages

A Birthdate must be entered
You have attempted to save a new PAR record without entering a date of birth. The birthdate is part of the identifying information for a record and cannot be blank. You must enter the birthdate before you will be able to save the record.

A First name must be entered.
You have attempted to save a new PAR record without entering a first name. The first name is part of the identifying information for a record and cannot be blank. You must enter the first name before you will be able to save the record.

A Legal Last Name must be entered.
You have attempted to save a new PAR record without entering a last name. The last name is part of the identifying information for a record and cannot be blank. You must enter the last name before you will be able to save the record.

A 'Medicaid' # must be entered.
You have attempted to save a new PAR record without entering a Medicaid number. The Medicaid number is part of the identifying information for a record and cannot be blank. You must enter the Medicaid number before you will be able to save the record.

A PAR record already exists for the entered time period (between the 'From' and 'Thru' Dates) for this PAR type, Agency and SSN.
A PAR record must contain a unique authorization span for a person for a specific PAR type within an Agency. You have attempted to enter a new PAR record within the same Agency for a person that overlaps an authorization span for an existing PAR record of this type, and the duplication will not be allowed.

A 'PAR Status' must be entered.
You have attempted to save a new PAR record without entering a status code. The status is part of the critical information for a record and cannot be blank. You must enter the status before you will be able to save the record.

A PAR type must be entered.
You have attempted to save a new PAR record without entering a PAR type code. The PAR type is part of the identifying information for a record and cannot be blank. You must enter the PAR type before you will be able to save the record.

A 'Prior Placement' must be entered.
You have attempted to save a new PAR record without entering a prior placement code. The prior placement is part of the critical information for a record and cannot be blank. You must enter the prior placement before you will be able to save the record.

A 'PRO End Date' must be entered.
You have attempted to save a new Waiver PAR record without entering a PRO (Peer Review Organization) end date. The PRO end date is part of the critical information for a record and cannot be blank. You must enter the PRO end date before you will be able to save the record.

A Social Security Number (SSN) must be entered.
You have attempted to save a new PAR record without entering a social security number. The social security number is part of the identifying information for a record and cannot be blank. You must enter the social security number before you will be able to save the record.

A 'Termination Date' must be entered.
The status of this PAR record is terminated, but the Termination Date field has been left blank. You must enter both the type and date of termination before you will be able to save the record.

A 'Termination Type' must be entered
The status of this PAR record is terminated, but the Termination Type field has been left blank. You must enter both the type and date of termination before you will be able to save the record.

A 'Thru Date' must be entered.
You have attempted to save a new PAR record without entering the current ending date of authorization or Thru date. This date is critical information accessed by the Billing module to ensure that billings are not submitted beyond the date the person is authorized for Waiver services. You must enter the Thru date before you will be able to save the record.

An 'Env Max End Date' is required if 'Env Max' is entered.
An Environment Engineering Maximum has been entered for the Children's Extensive Support Waiver without and Environmental Engineering Ending date. These fields are related and both fields must be completed or left blank. The Ending Date is required in order for the Billing module to allow billing at the increased maximum for a limited period of time.

An 'Env Max' is required if 'Env Max End Date' is entered.
An Environment Engineering Ending Date has been entered for the Children's Extensive Support Waiver without an Environmental Engineering Maximum. These fields are related and both fields must be completed or left blank. The Environmental Engineering Maximum is required in order for the Billing module to allow billing at the increased maximum for a limited period of time.

An 'IP End Date' is must be entered.
You have attempted to save a new Waiver PAR record without entering an IP (individualized plan) end date. The IP end date is part of the critical information for a record and cannot be blank. You must enter the IP end date before you will be able to save the record.

From Date must be entered.
You have attempted to save a new PAR record without entering the current beginning date of authorization or From date. This date is critical information accessed by the Billing module to ensure that billings are not submitted before the date the person is authorized for Waiver services. You must enter the From date before you will be able to save the record.

Only TCM PARs can have SSNs beginning with '000' or '999' as these numbers are reserved for pseudo SSN's
You have entered a social security number in this PAR record beginning with '000' or '999'. These numbers are reserved for use in "pseudo" social security numbers that are assigned until the real social security number is known. All PAR record entries, with the exception of TCM PAR records, must use only a valid social security number. You cannot enter the Waiver PAR record until the social security number is known.

The 'Enroll Date' must be earlier than the 'End Date' for 'PETI 300%'
An End date has been entered for the PETI 300% indicator that is earlier than the Enroll date. It is not logically consistent to have the End date prior to the Enroll date. You must correct the date(s) before you will be able to save the record.

The enroll date must be entered.
You have attempted to save a new PAR record without entering an original enrollment date. The enrollment date is part of the critical information for a record and cannot be blank. You must enter the enrollment date before you will be able to save the record.

The PAR 'Thru Date' cannot be less than the 'From Date'.
A Thru date has been entered for this PAR record which is earlier than the From date. It is not logically consistent to have the Thru date prior to the From date. You must correct the date(s) before you will be able to save the record.

The 'Termination Date' must be blank unless the 'PAR Status' is 'Terminated'.
The status of this PAR record is NOT terminated, but the Termination Date field contains data. You must remove both the type and date of termination before you will be able to save the record.

The 'Termination Type' must be blank unless the 'PAR Status' is 'Terminated'.
The status of this PAR record is NOT terminated, but the Termination Type field contains data. You must remove both the type and date of termination before you will be able to save the record.

The 'Thru Date' and the 'Termination Date' must be the same.
The status of this PAR record is terminated but the Termination Date field is not the same as the Thru Date. The Termination date must be the same date as the date the prior authorization ends.

'User Override' 'Units' cannot be entered if the 'User Override' Fiscal Year ('FY') is blank
You have attempted to enter a number of units in the units override field without indicating the fiscal year to which the override applies. The fiscal year is required in order for the system to determine for which fiscal year the standard number of authorized units should be overridden. You must enter the Fiscal Year before you will be able to save the record.

'User Override' 'Fiscal Year (FY)' must be in the format 'YYYY-YYYY' where the second year must be one greater than the first year
You have attempted to a Fiscal Year value that is not valid. The Fiscal Year entry must be the beginning fiscal year and the subsequent fiscal year, e.g. 2004-2005.

## AMPSbatch Module Data Entry Error Messages

Late Bill Override date must be greater than THRU DATE of <date>.
You have entered a late billing override date in an AMPSbatch billing transaction record which is earlier or equal to the through date of service in the record. A late billing override date applies to an event which occurred subsequent to the date(s) the service was provided, and is used to record a date in which authorization was provided to bill later than the timely filing deadline for Medicaid claims. You must correct the late billing override date to reflect the date of that authorization, or unmark the transaction for AMPsBatch processing if you do not have a valid authorization and cannot provide a valid late billing override date.

No AMPsBatch Selection Records Exist.
You chose the Selection menu item from the AMPSbatch Data menu but there are currently no AMPsBatch billing transaction records to select. The only times that records are available for selection are: 1) after billing transactions have been posted and before you have created AMPsBatch claims from them and 2) if they were previously unmarked for AMPsBatch processing in the Selection screen and remain unmarked.

You must enter either 'M' or 'F' for gender.
The gender code for the AMPSbatch claim you are rebilling is not valid. You must enter a valid gender code before you will be able to rebill the claim.

From Date cannot be blank.
The From date of service for the AMPSbatch claim you are rebilling is blank. You must enter a From date before you will be able to rebill the claim.

Thru Date cannot be blank.
The Thru date of service for the AMPSbatch claim you are rebilling is blank. You must enter a Thru date before you will be able to rebill the claim.

From Date cannot be greater than Thru Date.
A From date has been entered for this AMPSbatch claim you are rebilling which is later than the Thru date. It is not logically consistent to have the From date later than the Thru date. You must correct the date(s) before you will be able to rebill the claim.

Late Bill Override Date Invalid – LBO DATE greater than the 60 days allowed.
The Last Report Date / LBO date must be no more than 60 days from the current date, if the last date of service on the claim record is past the timely filing deadline. You must enter a date that is within the 60 days allowed before you will be able to rebill the claim.

**Note: Be sure to have documentation for the date you chose to use**

## II. POSTING ERROR MESSAGES

Following is a list of posting error messages with an explanation of each one and the process for correcting it, if applicable. The messages are listed alphabetically. **Many posting error messages will result in rejection of the billing transaction in error. For easier identification of those critical messages, they are preceded by two asterisks.** Some posting error messages do not cause rejection of a transaction but do require that you follow up to determine if it is in fact an error which requires correction. Some posting error messages are merely informational to alert you to a system adjustment or a potential problem that may occur as the result of a particular billing entry.

Rejected transactions will be marked with a 'YES' in the Reject? column on the Posting Error List report. **These transactions must be re-entered as prior month reporting transactions in the following month after the problem that caused the rejection has been corrected.** In some cases, Medicaid funded transactions that would normally be rejected will be accepted by the system in order to ensure that timely filing requirements for Medicaid claims are met. Medicaid funded transactions for which the last date of service is 90 days or more previous to the current date will be accepted and posted. However, the error message will still be printed on the Posting Error List report followed by the words **TIMELY FILING**. The Reject? column will contain a 'NO'. It is likely that this claim will be rejected at the Medicaid Fiscal Agent, but submission of the claim within the 120 day timely filing deadline ensures that the claim can be rebilled and paid when the problem which caused the rejection is resolved. **Additionally, most Medicaid funded transactions are accepted for posting in the June billing month, as it is the last billing month of the fiscal year**. This ensures that the transactions will be available for end of year contract monitoring by DDD and can be rebilled to the Medicaid Fiscal Agent using the AMPSBatch rebill screen.

During the posting process, you will be allowed an opportunity to view the posting errors before proceeding to post the billing figures. If you find errors that appear to be correctable during the current billing cycle, you may elect to cancel the posting process so you can correct those errors and then select to post again. Many errors cannot be corrected during the current billing cycle because they involve updates that must be made to files maintained at the DDD Central Office. The PAR and Provider files, for example, must be entered and updated by DDD Medicaid staff and an updated copy is prepared monthly for each agency at the beginning of the billing cycle. If necessary paperwork has not been received by DDD Medicaid staff several days prior to the current billing cycle, the updates will have to wait until the following billing month in most cases.

### Posting Errors – no allowable error rate established

Where possible, the errors listed below should be corrected prior to re-posting billing transactions.

0 Hours of service - will not count in performance evaluation.

This Early Intervention billing transaction does not contain any hours of service. Performance evaluations are done for the purpose of determining if contractual requirements have been met for a minimum number of persons to be served. Since this billing transaction does not record that any service was provided to the person, it will not be included in a count of persons served for the month. If service was provided to the person, it is important that you either cancel the posting process to enter the hours of service prior to posting again, or enter the hours in an adjustment transaction in the next billing month.

Bundled rate being backed out. YOU MUST SUBMIT MMIS ADJUSTMENT.

You have reversed all SLS Waiver "bundled service" billing entries for a person for a month in which one of the previous entries generated a claim to the MMIS. Since all of these "bundled services" were reversed, there

is no longer a "bundled rate" due for the person in that month and you must reverse the claim in the MMIS as well.

**CANNOT bill Comprehensive and Supported Living Services concurrently
Programs within the Residential comprehensive block may not be received in conjunction with Supported Living Services. If dates of service overlap between mutually exclusive programs, one of the transactions will be rejected. You must correct the dates of service in the billing transaction(s) so that the dates do not overlap.

**Cross service with other Medicaid Waiver program - <program>.
Programs within each type of Medicaid Waiver may not be received in conjunction with programs within another type of Medicaid Waiver. If dates of service overlap between mutually exclusive Medicaid Waiver programs, one of the transactions will be rejected. You must correct the dates of service in the billing transaction(s) so that the dates do not overlap.

**Exceeds authorized Env Eng maximum - Adjust the billed amount or get add'l authorization.
This CES Waiver billing transaction contains an amount for environmental engineering which, when added to the total billed so far, exceeds the 'life of the waiver' limit for this person. An increase in the limit must be requested of DDD Medicaid staff and entered in the PAR record, if approved. The PAR record update cannot be made until the following month. Unless the request for increase is granted, you may not bill in excess of the waiver limit and will need to reduce the amount billed.

**Exceeds authorized program maximum - the billed amount must be adjusted.
This CES Waiver billing transaction contains an amount which, when added to the total billed so far, exceeds the annual maximum allowed for the program. You may not bill in excess of the annual maximum and will need to reduce the amount billed.

**Medicaid # mismatch between PAR and CORE - must be resolved before billing.
The Medicaid number entered in the CORE record for this Medicaid billing transaction does not match the Medicaid number entered in the PAR record. You must determine which information is correct, and take steps to have either the CORE or the PAR record corrected. The PAR record update cannot be made until the following month.

**No PAR record for this person under this SSN.
There is no matching PAR record under the social security number contained in the billing transaction. You must determine whether a PAR record has not been entered at all for this person or whether it has been entered with an incorrect social security number, and take steps to have the PAR record entered or corrected. The PAR record correction cannot be made until the following month.

**Not enough service dates to produce multiple claim lines to cover total units.
Only 999 units per claim line may be submitted on Medicaid claims. If a billing transaction produces units in excess of this amount, there must be enough service days between the 1st and 2nd dates to allow billing of multiple claim lines for different dates of service (e.g. 999 units from 1/1/2004 through 1/1/2004 and 2 units from 1/2/2004 through 1/2/2004). You must change the 1st or 2nd date to allow enough service days to bill the total number of units in increments of 999 per claim line.

**Program cross service dates with same service program - <program>.

Programs within each major service area (Comprehensive, Other Services and Support Services) may not generally be received in conjunction with programs within the same major service area. If dates of service overlap between mutually exclusive programs, one of the transactions will be rejected. You must correct the dates of service in the billing transaction(s) so that the dates do not overlap.

**Service dates not within PAR from and through dates.

The authorized service dates in the PAR record do not include the date(s) of service in the billing transaction. You must either correct the dates of service in the billing transaction to be within the PAR authorization dates or take steps to have the PAR record updated, if needed. The PAR record update cannot be made until the following month.

System Adjustment to fix Billable.

A special adjustment transaction was created during the posting process to correct a previous over or under payment for an individual. This may occur if the annual rate for a program had been entered incorrectly and was then corrected for the current billing month. For example: a maximum program annual amount was entered incorrectly at $8,000 and it was exceeded by $500 in the previous billing month. The $500 would not have been counted as billable in that month. The annual amount was then increased to $11,000 for the current billing month. In addition to allowing the billing for the current month, the system would perform an adjustment to bill the previously non-billable $500.

**Total monthly Case Management units exceeded by: <number>.

No more than one unit of Targeted Case Management may be billed per person per month. More than one billing transaction was entered for the month and the combination of the transactions contain more than one unit. You must correct or delete the transaction in error or the system will reject one of the transactions.

**Total monthly service days exceeded by: <number>.

The number of days of service entered into two or more billing transactions for a program billed by calendar day, exceeds the number of days in the billing month. You must correct or delete the transaction in error or the system will reject one of the transactions.

**Total yearly calendar days exceeded by: <number>.

This billing transaction contains a number days which, when added to the total number of days billed for this person so far, exceeds the number of days in the calendar year. You must correct the number of days entered in the transaction or the system will reject the transaction. If the excessive days of billing is caused by a previously incorrect billing entry, an adjustment transaction must be submitted to reverse the incorrect days previously billed before this transaction will be accepted.

## III. CROSSCHECK ERROR MESSAGES

Following is a list of crosscheck error messages with an explanation of each one. The messages are listed alphabetically within the report where they occur. **The process for correcting the errors requires cooperation among CORE coordinators, Billing coordinators, case managers and program directors.** Each error points out an inconsistency between information about the services being billed and information in the CORE client record about services being provided. Determining why the information is inconsistent may require input from several people.

Sometimes the inconsistency occurs because of information that has not been entered or updated in other files. For example, if a Medicaid number had not yet been assigned for a person reported as being enrolled in SLS Waiver services, you would not be able to enter a billing transaction for that person and there would not be a matching billing for the services reported in the CORE record. Other times the inconsistency may be due to a misunderstanding or miscommunication about what services are actually being received versus the services that are being reported on billing attendance reports. These discrepancies must be resolved among all parties that report information about service provision. **Do not change CORE or billing information just to make the information match without verifying which information is correct.**

The Billing to CORE and CORE to Billing crosscheck reports must be generated and printed at least once monthly, or more often if you wish. However, you must generate and print them AFTER all posting has been completed for the month in order for the reports to be considered "final" reports. You cannot transmit your files to DDD unless a final generation and printing of these reports has taken place. Generation of the reports updates an error table that contains a calculation of the error percentage rate for each report. When you transmit your files to DDD, you are also transmitting this error table that will be used to monitor the status of error rates for your agency. **You should correct as many errors as possible on each report and then re-generate and re-print the final reports before transmitting your files.**

### Billing to CORE Crosscheck - 1% allowable error rate

This report counts errors for billing information that does not match to the CORE record. If the CORE record contains dates that indicate the CORE status or program information is future to the current billing month, the edits are skipped for that service type or program for the month. Since billing is always a month behind, it is not expected that your CORE and billing data will always be synchronized. If the information does not match appropriately, it will be flagged in the next billing month. The program, funding and location/provider code **in each non-terminated billing transaction which contains enrolled units or amounts for the current billing month** is checked against the CORE program, funding and location/provider code for that service type in the CORE record. The billing status of each billing transaction, regardless of whether it contains enrolled units or amounts, is also compared to the CORE status where it can be expected that they should match. If an appropriate match is not found for any of these four elements, an error message is printed and is added to the error count.

As each of the four elements in the billing transaction is edited, a counter of the number of fields against which edits were performed is increased by one. For each error that is encountered, a counter of the number of errors is increased by one. At the end of the error generation, the program calculates what percentage of the total fields edited had errors and reports this as the error rate.

Billing case management funding does not match CORE case management funding.
The funding type in this case management billing transaction does not match the case management funding type recorded in the CORE record for this person. If one of the allowable matches shown in the table below is not found an error will result.

| **Billing Fund** | **Allowable CORE Fund Match** |
|---|---|
| Medicaid State Plan | Medicaid State Plan |

Billing residential facility/location does not match to CORE residential facility/location
The location in this residential billing transaction does not match the residential facility/location contained in the CORE record for this person. There must be an exact match or an error will result.

Billing residential funding does not match to CORE residential funding.
The funding type in this residential billing transaction does not match the residential funding type contained in the CORE record for this person. If one of the allowable matches shown in the table below is not found an error will result.

| **Billing Fund** | **Allowable CORE Fund Match** |
|---|---|
| Medicaid Waiver | HCB-DD Waiver<br>OBRA Waiver |
| State General Fund | OBRA State<br>State |

Billing residential program does not match to CORE residential setting.
The program in this residential program billing transaction does not match the residential setting contained in the CORE record for this person. If one of the allowable matches shown in the table below is not found an error will result.

| **Billing Program** | **Allowable CORE Program Match** |
|---|---|
| Individual Residential Services and Supports | Individual Residential Services and Supports |
| Group Residential Services and Supports | Group Residential Services and Supports |

Billing SLS funding does not match to any CORE SLS funding types.
The funding type in this Support billing transaction does not match the Support funding type(s) contained in the CORE record for this person. There are three different Support sets contained in the CORE record and the system checks each one for a match. If one of the allowable matches shown in the table below is not found an error will result.

| **Billing Fund** | **Allowable CORE Fund Match** |
|---|---|
| Medicaid Waiver | SLS Waiver<br>CES Waiver |
| State General Fund | OBRA State<br>State |

Billing SLS program type does not match to any CORE SLS program types

The program in this Support billing transaction does not match the Support program(s) contained in the CORE record for this person. There are three different Support sets contained in the CORE record and the system checks each one for a match. If one of the allowable matches shown in the table below is not found an error will result.

| **Billing Program** | **Allowable CORE Program Match** |
|---|---|
| Children's Extensive Support | Children's Extensive Support |
| FSSP Extended | FSSP Extended |
| FSSP Other | FSSP Other |
| Supported Living Services | Supported Living Services |
| Early Intervention | Early Intervention |

Final Billing residential status does not match CORE record residential status.

Final Billing SLS status does not match CORE record Supported Living Service status.

The latest billing status in a billing transaction within Comprehensive (residential) or Support services does not match the status recorded on CORE for that service type. The system checks the change field associated with the latest date of service in each billing transaction (if there are multiple transactions it will use the transaction with the latest date of service and if there is more than one transaction with the same date of service, it will use the last transaction found with that date of service). If the change field is blank, the status is assumed to be active because no billing status change has been reported. If the change field contains a code, it is evaluated to determine if the status is active or terminated. If the status does not match to the CORE status for this service, an error will result.

This error may occur when a person has terminated from one billing program/provider/funding and enrolled into another, but attendance has not yet been received for the new program or the transaction for the new program could not be entered because other files (e.g. PAR file) were not updated prior to the current billing month. DO NOT terminate a CORE status for a service type just because a person terminated from a billing program, if the person has been enrolled into another program for that service type. The CORE status must remain active for as long as the person continues to receive funding within that service type.

## CORE to Billing Crosscheck - 1% allowable error rate

This report counts errors for CORE program information for which there is no matching billing transaction. If the CORE record contains dates that indicate the CORE status or program information is future to the current billing month, the edits are skipped for that service type or program for the month. Since billing is always a month behind, it is not expected that your CORE and billing data will always be synchronized. If the information does not match appropriately, it will be flagged in the next billing month.

The program, funding and location/provider code for each active DDD program type in the CORE record is used to look for a matching billing transaction for the current billing month **which may or may not contain enrolled units or amounts. You must still enter a monthly billing transaction for someone who had no service for the month due to illness or absence or for whom billings are sporadic (e.g. FSSP services) as long as they are still enrolled in the program, so the system can find a matching billing.**

The system also checks rejected billing transaction for the current month to look for a match. If a billing transaction has been rejected for any reason, but matches the services under the same program, funding and location/provider as what is recorded in the CORE record, it is considered a match. If an appropriate match is not found, an error message is printed and is added to the error count.

As each program is edited, a counter of the number of programs against which edits were performed is increased by one. For each error that is encountered, a counter of the number of errors is increased by one. At the end of the error generation, the program calculates what percentage of the total programs edited had errors and reports this as the error rate.

No matching case management billing for this CORE case management funding.
This edit occurs only when the DD Overall status is Active.
The case management funding type in the CORE record is one for which there should be a monthly billing. If a billing transaction for the required match shown in the table below is not found an error will result.

| CORE Fund | Required Billing Program Match |
|---|---|
| Medicaid State Plan | Targeted Case Management |

No matching residential billing for this CORE setting, funding, location combination.
This edit occurs only when the Comprehensive (residential) status is Active.
The DDD residential setting recorded in the CORE record does not have a matching billing for the month. The search for a match is based on the program, funding and facility/location code. The facility/location match to the billing record must be an exact match, but the funding and program matches are based upon the tables below. The system will look for a match based on all possible allowable program and funding matches and if none is found an error will result.

| CORE Fund | Allowable Billing Fund Match |
|---|---|
| HCB-DD Waiver | Medicaid Waiver |
| OBRA State | State General Fund |
| OBRA Waiver | Medicaid Waiver |
| State | State General Fund |

| CORE Program | Allowable Billing Program Match |
|---|---|
| Individual Residential Services and Supports | Individual Residential Services and Supports |
| Group Residential Services and Supports | Group Residential Services and Supports |

No matching Support billing for this CORE support service and funding combination.
This edit occurs only when the Support status is Active.
The DDD Support program recorded in one of the three Support sets contained in the CORE record does not have a matching billing for the month. The search for a match is based on the program and funding codes in each Support set. The funding and program matches are based upon the tables below. The system will look for a match based on all possible allowable program and funding matches and if none is found an error will result.

| CORE Fund | Allowable Billing Fund Match |
|---|---|
| OBRA State | State General Fund |
| SLS Waiver | Medicaid Waiver |
| State | State General Fund |

| CORE Program | Allowable Billing Program Match |
|---|---|
| Children's Extensive Support | Children's Extensive Support |
| FSSP Extended | FSSP Extended |
| Supported Living Services | Supported Living Services |
| Early Intervention | Early Intervention |

***Note - no attempt is made to find a matching billing for the FSSP Other program because these billings may be submitted as seldom as once per year.

## Year To Date Crosschecks – 1% allowable error rate

This report counts errors for billing transactions entered in the current billing month that have resulted in over-reported or under-reported billing or encounter information during the fiscal year. An aggregated total for each individual is evaluated to determine whether the year to date figures that were reported exceed a monthly maximum or report less than zero for the month.

Prior month adjustments cannot exceed the allowable maximums and should not reverse or adjust prior reported figures with a net result of less than zero. If an aggregated total for any individual finds this to be the case, an error message is printed and is added to the error count.

As each billing transaction is edited, a counter of the number of records against which edits were performed is increased by one. At the end of the error generation, the program calculates what percentage of the total records edited had errors and reports this as the error rate.

Reported enrolled amount for SLS (Medicaid and State) is less than zero for the <month> service month..
The aggregated reporting figures for Supported Living Services program are less than zero for a service month. Both State and Medicaid transactions are evaluated to reflect a total aggregation for an individual that has transferred from one funding to another. Either a current month or previous month billing transaction has under reported the actual amount of service. This is probably the result of reversing too much from a previous transaction.

Reported enrolled amount for FSSP (Extended and Other) is less than zero for the <month> service month.
The aggregated reporting figures for the Family Services Support program are less than zero for a service month. Either a current month or previous month billing transaction has under reported the actual amount of service. This is probably the result of reversing too much from a previous transaction.

Reported enrolled amount for CES is less than zero for the <month> service month.
The aggregated reporting figures for the Children's Extensive Waiver program are less than zero for a service month. Either a current month or previous month billing transaction has under reported the actual amount of service. This is probably the result of reversing too much from a previous transaction.

Reported case management units for TCM (Targeted Case Management) is less than zero for the <month> service month.
The aggregated reporting figures for the Targeted Case Management program are less than zero for a service month. Either a current month or previous month billing transaction has under reported the actual amount of service. This is probably the result of reversing too much from a previous transaction.

Reported days of Residential Services is less than zero for the <month> service month.
The aggregated reporting figures for Residential Services are less than zero for a service month. Both IRSS and GRSS transactions are evaluated to reflect a total aggregation for an individual that has transferred from one program to another. Either a current month or previous month billing transaction has under reported the actual days of service. This is probably the result of reversing too much from a previous transaction.

Reported days of Residential Service is greater than the days in the month for the <month> service month.
The aggregated reporting figures for Residential Services are more than the days in the month for a service month. Both IRSS and GRSS transactions are evaluated to reflect a total aggregation for an individual that has transferred from one program to another. Either a current month or previous month billing transaction has over

reported the days of service. The over reporting is probably due a duplicate transaction or reporting too many days for a prior month adjustment.

Reported case management units for TCM is more than the 1 unit billable for the <month> service month.
The aggregated reporting figures for Targeted Case Management are more than the units allowed in a month for a service month. Either a current month or previous month billing transaction has over reported the units of service. The over reporting is probably due a duplicate transaction or reporting too many units for a prior month adjustment.

## IV. DATA EDIT REVIEW ERROR MESSAGES

Following is a list of data edit review error messages with an explanation of each one. The messages are listed alphabetically. Each error points out missing, invalid or inconsistent data in a CORE client record or a Waiting List Registry record. Errors are either considered critical, and add to the error rate, or informational, and do not add to the error rate. **For easier identification of critical error messages they are preceded by two asterisks.** Determining what the missing or correct information should be will require the assistance of the case manager who is assigned to the person to whom the record belongs.

The Individual Data Edit Review List report must be generated and printed at least once monthly, or more often if you wish. However, you must generate and print it AFTER all posting has been completed for the month in order for the report to be considered a "final" report. You cannot transmit your files to DDD unless a final generation and printing of this report has taken place. Generation of the report updates an error table that contains a calculation of the error percentage rate for the report. When you transmit your files to DDD, you are also transmitting this error table that will be used to monitor the status of error rates for your agency. **You should correct as many errors as possible on the report and then re-generate and re-print the final report before transmitting your files.**

### Individual Data Edit Review - 1% allowable error rate

This report counts errors for missing data, invalid data or data that is out of date (e.g. IP date) for records in the CORE mandatory file and the Waiting List Registry file. Most missing data and out of date edits take place only for those CORE records which have an overall status of Active, Case Management or Waiting List, so Non-DD and Terminated records don't generally add to the error counts. However, certain mandatory fields that require data regardless of the overall status will be flagged and added to the error counts. They are identified with the message "Mandatory missing data". Invalid data will be flagged regardless of overall status, but may or may not add to the error counts depending upon the type of invalid data.

As each field in a CORE or Waiting List Registry record is edited, a counter of the number of fields against which edits were performed is increased by one. For each critical error that is encountered, a counter of the number of errors is increased by one. At the end of the error generation, the program calculates what percentage of the total fields edited had critical errors and reports this as the error rate.

**Community Safety Risk date review overdue: it has been <number> days since the last review was done

A review of the Community Safety Risk must be completed yearly for an individual who has been identified as a risk to the community. The Community Safety Risk review date for this Active CORE record is more than 395 days prior to the current date, indicating that the review is overdue.

**Date cannot be future to system date

The date entered in the field being edited is later than the current calendar date as reported by your computer system. No future dates are allowed in any date fields with the exception of the IP Date field. If the problem is with the system date on your computer being reported incorrectly, you will have to correct it and re-generate the report to eliminate this message. If the system date on your computer had previously been incorrect so it was possible to enter a future date during data entry, you must correct the date in the CORE or Waiting List Registry record so it is no longer future to the real calendar date.

**Inactive Code - this record must contain only current information.
The code entered in the field being edited has been marked as inactive in your code table file. This Active, Case Management or Waiting List CORE record must contain ONLY current information. If the code is incorrectly marked as inactive, you must correct the inactive status in the code table file and re-generate the report to eliminate this message.

**Invalid Data - Must be a valid date.
The date contained in the date field being edited is not a valid date. Since dates are validated during data entry by Foxpro itself, this error would most likely be caused by corruption of the file. If there is only one date or very few dates for which this message appears, attempt to correct them yourself. If there are a large number of date fields that are in error, it may require that a good copy of the file be recovered from a backup. **Contact the Help Desk to report a high incidence of this error so Information Technology staff can verify the validity of your data files.**

**IP out of date - it has been <number> days since the last IP was done.
An individualized plan (IP) must be completed when a person is initially determined eligible and put on the waiting list or enrolled in services. The IP must be updated yearly thereafter. The IP date for this Active or Case Management CORE record is more than 395 days prior to the current date, indicating that the IP update is overdue.

Logical Inconsistency – this same type service recorded as currently received.
There is a logical inconsistency between one or more fields in this Active, Case Management or Waiting List CORE record or in a Waiting List Registry record. The Waiting List Registry record is for a service already being received.

Logical Inconsistency – funding is not consistent with setting.
There is a logical inconsistency between the funding type and one or more of the status fields in this Active CORE record. Check the funding for the field in question to determine whether it is appropriate.

**Mandatory Missing Data
The data contained in a mandatory field is blank. All CORE and Waiting List Registry records, regardless of status, require data in mandatory fields.

**Missing Data
The data contained in a required field is blank. This Active, Case Management or Waiting List CORE record or Waiting List Registry record requires data in this field in order to record current information. Requirements for entry of data in specific fields are sometimes dependent upon the status of the CORE or Waiting List Registry record and the services being received or needed. Where further explanation of these requirements seems necessary, an additional message is added to clarify the need.
**Note** - the Middle Name field is reported as missing data if it is blank, but it does NOT add to the error count. It will continue to flag even though the person does not have a middle name for you to enter in the field. Do NOT enter 'None', 'N/A', etc. in this field.

**PASSAR out of date
A Pre-Admission Screening and Review (PASSAR) is required on a yearly basis for persons residing in a nursing home, regardless of whether case management is being provided. The IP date field is used to record the PASSAR date. The PASSAR date for this nursing home resident is more than 395 days prior to the current date, indicating that the PASSAR is overdue.

Pseudo SSN - Please update when real social security number is known.
This Active, Case Management or Waiting List CORE record contains a pseudo social security number that has been assigned by the system. When the real social security number is known, it must be entered into the CORE record.

Recheck functioning level - Level is recorded as Normal.
The overall level of functioning recorded in this Active, Case Management or Waiting List CORE record is Normal. This is not logically consistent for a person with developmental disabilities.

**The Waiting List Status cannot be 'Y – Yes Waiting' if the Overall Status is not A,C,O,W.
The status of this Waiting List Registry record is "Y – Waiting" but the CORE status is not a status that allows an individual to be considered for a resource allocation.

This disability determination is not appropriate for persons over the age of 6.
The disability code of AR - At Risk or DD - Developmental Delay is recorded in this Active, Case Management or Waiting List CORE record for a person over the age of 6 years. These disabilities are not appropriate for persons who are school age or older, because an assessment should have been completed which would have identified the ongoing disabilities.

**Too old to be eligible for the WL Program: <name of program>
The status of this Waiting List Registry record is "Y – Yes Waiting" but the individual is no longer age eligible for the program. The status of the record must be changed to "R – Removed" and the Date Removed must reflect that date the individual was no longer age eligible.

**Timeline placement is earlier than the eligible age for the WL Program: <name of program>
The status of this Waiting List Registry record is "Y – Yes Waiting" but the timeline for placement is earlier than the date the individual is age eligible for the program. The Date Needed must be changed to the date the individual is eligible for the program he is waiting for.

Undetermined functioning level - Persons over age 6 should have a level determined.
The overall functioning level of UD - Undetermined is recorded in this Active, Case Management or Waiting List CORE record for a person over the age of 6 years. This functioning level is not appropriate for persons who are school age or older, because an assessment should have been completed to determine the actual functioning level.

Unknown code - Check validity of code and enter into CCMS code file for historical data.
The data contained in the field being edited is a code that is not contained in your code table file. Although this CORE record does not contain an Active, Case Management or Waiting List status, the code should still be checked for validity and corrected, if needed. If the code is an historical code that has been deleted from your code table file, you should re-enter it for historical purposes.

# APPENDIX E

## File Structure and Field Names

| | |
|---|---|
| **FILE NAME** | **Ccmsagcy.dbf** |
| **INDEX TAGS** | **Agency** Agency |
| **FILE DESCRIPTION** | **Agency Table**<br><br>The Agency file is used to record identifying information for each agency operating the system. The Agency record for each agency contains a pre-assigned agency number that identifies the agency uniquely in the CCMS statewide data files. It also contains the name, address and telephone number of the agency that are used in creation of AMPSbatch submission files that are transmitted to the Medicaid Fiscal Agent monthly, so this information must be updated by the agency in a timely manner if it changes. The Agency file is used to track automatic assignment of various sequential numbers, system indicators for functions such as posting and transmission, latest update and billing months and production of monthly error reports. Fields that track this information are updated automatically as various functions occur within the system. |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | AGENCY | Char | 2 | XX | Mandatory | Agency Code | Will have been entered as part of initial configuration for an agency. |
| 2 | HCBPRV_NR | Char | 8 | X(8) | Mandatory | Agency HCB-DD Waiver Provider Number – the main provider number assigned to the agency for Medicaid Waiver billing. This number is used to identify the provider as the case management "requesting agency" for prior authorization and to bill the Comprehensive service claims. | Will have been entered as part of initial configuration for an agency. |
| 3 | AG_NAME | Char | 40 | X(40) | Required | Agency Name<br>Required for Medicaid Claim creation under HIPAA X12 transaction sets. | Manual |
| 4 | BOARD_PRES | Char | 45 | X(45) | Optional | Board President's Name | Manual |
| 5 | DIRECTOR | Char | 45 | X(45) | Optional | Name of Agency Director | Manual |
| 6 | ADDRESS | Char | 48 | X(48) | Required | Street address<br>Required for Medicaid Claim creation under HIPAA X12 transaction sets. | Manual |
| 7 | FREEFORM | Char | 35 | X(35) | Optional | Freeform address (Box number, etc.)<br>IF "Street Address" is blank - Required for Medicaid Claim creation under HIPAA X12 transaction sets. | Manual |
| 8 | CITY | Char | 25 | X(25) | Required | City<br>Required for Medicaid Claim creation under HIPAA X12 transaction sets. | Manual |
| 9 | STATE | Char | 2 | XX | Required | State<br>Required for Medicaid Claim creation under HIPAA X12 transaction sets. | Manual |
| 10 | ZIP | Char | 10 | 99999-9999 | Required | Zip Code<br>Required for Medicaid Claim creation under HIPAA X12 transaction sets. | Manual |
| 11 | AG_PHONE_1 | Char | 13 | (999)999-9999 | Required | Agency Phone Number<br>Required for Medicaid Claim creation under HIPAA X12 transaction sets. | Manual |
| 12 | AG_EXT_1 | Char | 5 | 99999 | Optional | 1st Phone Extension | Manual |
| 13 | AG_PDESC_1 | Char | 20 | X(20) | Required | Pre-defined as "Agency Phone" for this field because this number must be used by the AMPSbatch module to record the phone number of the submitter. | Will have been entered as part of initial configuration for an agency. |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 14 | AG_PHONE_2 | Char | 13 | (999)999-9999 | Optional | 2nd Phone Number | Manual |
| 15 | AG_EXT_2 | Char | 5 | 99999 | Optional | 2nd Phone Extension | Manual |
| 16 | AG_PDESC_2 | Char | 20 | X(20) | Optional | 2nd Phone Description | Manual |
| 17 | AG_PHONE_3 | Char | 13 | (999)999-9999 | Optional | 3rd Phone Number | Manual |
| 18 | AG_EXT_3 | Char | 5 | 99999 | Optional | 3rd Phone Extension | Manual |
| 19 | AG_PDESC_3 | Char | 20 | X(20) | Optional | 3rd Phone Description | Manual |
| 20 | LAST_PSEUD | Num | 4 | 9999 | Mandatory | Last Pseudo Social Security Number Assigned | Automatic |
| 21 | AUTO_CASE | Logical | 1 | T/F | Optional | Auto Case Number assignment flag - if “True” the system will automatically assign the next sequential case number when a new CORE record is created. | Manual |
| 22 | LAST_CASE | Num | 7 | 9999999 | Optional | Last Case Number Assigned | Automatic |
| 23 | LAST_REPT | Num | 5 | 99999 | Obsolete (eff. 10/00) | Last Report Number Assigned | Automatic |
| 24 | LAST_BATCH | Num | 4 | 9999 | Mandatory | Last Billing Batch Number Assigned | Automatic |
| 25 | LAST_TRAN | Num | 5 | 99999 | Mandatory | Last Billing Transaction Number Assigned | Automatic |
| 26 | BILL_MONTH | Char | 6 | MMCCYY | Mandatory | Current Billing Month | Automatic |
| 27 | EST_OLD | Num | 9 | 999999.99 | Optional | Current Month’s Billing Estimate | Automatic (updated from “new” estimate at close of month) |
| 28 | EST_ADJ | Num | 10 | 9999999.99 | Optional | Adjustment to Estimate | Manual |
| 29 | EST_NEW | Num | 9 | 999999.99 | Optional | Next Month’s Billing Estimate | Manual |
| 30 | COMP_POST | Logical | 1 | T/F | Mandatory | Comprehensive posting completed? | Automatic |
| 31 | SLS_POST | Logical | 1 | T/F | Mandatory | Support Service posting completed? | Automatic |
| 32 | OTH_POST | Logical | 1 | T/F | Mandatory | Other Services posting completed? | Automatic |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 33 | COMP_PRINT | Logical | 1 | T/F | Mandatory | Final Comprehensive Posting Error Report Printed? | Automatic |
| 34 | SLS_PRINT | Logical | 1 | T/F | Mandatory | Final Support Service Error Report Printed? | Automatic |
| 35 | OTH_PRINT | Logical | 1 | T/F | Mandatory | Final Other Services Posting Error Report Printed? | Automatic |
| 36 | EDIT_PRINT | Logical | 1 | T/F | Mandatory | Data Edit review report printed during this billing month? | Automatic |
| 37 | CROS_PRINT | Logical | 1 | T/F | Mandatory | Final Consumer/Billing cross-check report printed after all posting has been completed? | Automatic |
| 38 | PAR_UPDATE | Char | 6 | MMCCYY | Mandatory | Billing month of last DDD PAR update | Automatic |
| 39 | PRV_UPDATE | Char | 6 | MMCCYY | Mandatory | Billing month of last DDD Provider update | Automatic |
| 40 | CNT_UPDATE | Char | 6 | MMCCYY | Mandatory | Billing month of last DDD Contract update | Automatic |
| 41 | TBL_UPDATE | Char | 6 | MMCCYY | Mandatory | Billing month of last DDD Table file update | Automatic |
| 42 | PRG_UPDATE | Char | 6 | MMCCYY | Mandatory | Billing month of last DDD Program file update | Automatic |
| 43 | SYS_UPDATE | Date | 8 | MM/DD/CCYY | Mandatory | System date of last DDD Program file update | Automatic |
| 44 | TEMP_BACK | Date | 8 | MM/DD/CCYY | Mandatory | Date of last temporary backup to hard disk | Automatic |
| 45 | CRIT_FUNC | Char | 10 | X(10) | Mandatory | Critical function interruption indicator | Automatic |
| 46 | TRANSMIT | Logical | 1 | T/F | Mandatory | Transmission completed for this billing month? | Automatic |
| 47 | LASTUPDATE | Date | 8 | MM/DD/CCYY | Mandatory | Date this record was updated last by a user | Automatic |
| 48 | USER_ID | Char | 8 | X(8) | Mandatory | ID of the last user who updated this record | Automatic |
| 49 | VERSION | Char | 7 | X(7) | Mandatory | Latest version of the CCMS software | Automatic |
| 50 | VER_DATE | Date | 8 | MM/DD/CCYY | Mandatory | Latest version date of the CCMS software | Automatic |
| 51 | RATE_OPT | Logical | 1 | T/F | Never used | Never Used | Never Used |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 52 | PAR_LOCK | Logical | 1 | T/F | Automatic | DDD only: used by the Prior Authorization System during **Prior Auth Batch Processing** | Automatic |
| 53 | ADD_UPDATE | Date | 8 | MM/DD/CCYY | Never used | Never used | Never used |
| 54 | DW_TABLES | Char | 150 | X(150) | Automatic | Contains list of tables currently being processed into the DataWareHouse (old ccms). | Automatic |
| 55 | CORENAME | Char | 40 | X(40) | Required | Name of current CORE coordinator | Manual |
| 56 | COREPHONE | Char | 20 | X(20) (999)999-9999x999999 | Required | Phone # of current CORE coordinator | Manual |
| 57 | COREEMAIL | Char | 200 | X(200) | Required | Email address of current CORE coordinator | Manual |
| 58 | BILLNAME | Char | 40 | X(40) | Required | Name of current Billing coordinator | Manual |
| 59 | BILLPHONE | Char | 20 | X(20) (999)999-9999x999999 | Required | Phone # of current Billing coordinator | Manual |
| 60 | BILLEMAIL | Char | 200 | X(200) | Required | Email address of current Billing coordinator | Manual |

| | | |
|---|---|---|
| **FILE NAME** | **Clmand.dbf**<br>**Clmand.fpt** | |
| **INDEX TAGS** | **Pkey** | Pkey (primary key for this table) |
| | **Name** | Upper(alltrim(lastname)+" "+firstname) |
| | **Namecomma** | Upper(alltrim(lastname)+","+firstname) |
| | **Ssn** | Ssn |
| | **Medicaid** | Medicaid |
| | **Case_no** | Case_no |
| | **Agencyssn** | Agency+ssn |
| | **Deleted** | .Not.deleted() |
| | **Zipcode** | Substr(zip,1,5) |
| | **City** | Upper(city) |
| | **Birthdate** | Dtos(birthdate) |
| **FILE DESCRIPTION** | **CORE Consumer Mandatory Table**<br><br>The CORE Consumer Mandatory file is the CORE file of the system because it contains the basic information about individuals served by the agency. Records cannot be entered into any other files for an individual until the CORE record has been entered. The CORE record contains demographic information and information about the services provided to persons who have been determined developmentally disabled. The record contains only the current information for each individual. Historical information is kept in a separate history file. | |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PKEY | Char | 6 | X(6) | Mandatory | Primary key assigned by the system | Automatic |
| 2 | STATE_ID | Char | 7 | X(7) | None | State Identifier assigned by the CDHS State Identifier Module (SIDMOD) | Automatic |
| 3 | AGENCY | Char | 2 | XX | Mandatory | Agency Number | Automatic |
| 4 | LASTNAME | Char | 25 | X(25) | Mandatory | Legal Last Name | Manual |
| 5 | FIRSTNAME | Char | 15 | X(15) | Required | Legal First Name | Manual |
| 6 | MIDDLE | Char | 15 | X(15) | Required | Legal Middle Name | Manual |
| 7 | LN_TITLE | Char | 4 | XXXX | Required | Legal Title (Jr, Sr, III, etc.) | Manual |
| 8 | ALTLNAME | Char | 25 | X(25) | Optional | Alternate Last Name (if different from Legal Last Name) | Manual |
| 9 | ALTFNAME | Char | 15 | X(15) | Optional | Alternate First Name & Initial (if different from Legal First Name & Initial) | Manual |
| 10 | SSN | Char | 11 | 999-99-9999 | Mandatory | Social Security Number | Manual<br>(Automatic if Pseudo SSN assigned by the system) |
| 11 | MEDICAID | Char | 7 | A999999 | Conditional | Medicaid Number - Required if individual is receiving Medicaid funding | Manual |
| 12 | CASE_NO | Char | 7 | X(7) | Optional | Case Number | Manual<br>(Automatic if agency chooses Automatic case numbering) |
| 13 | OSTAT_CODE | Char | 1 | X | Mandatory | DDD Overall Status Code | Code Table Pick List |
| 14 | OSTAT_DATE | Date | 8 | MM/DD/CCYY | Mandatory | Overall Status Date | Manual |
| 15 | ASTAT_CODE | Char | 1 | X | Required/Optional | Regional Center Admission Type Code - Required for Regional Centers<br>CCB Agency status - Optional for CCBs | Code Table Pick List |
| 16 | ASTAT_DATE | Date | 8 | MM/DD/CCYY | Required/Optional | Regional Center Admission Date - Required for RCs<br>Agency status date - Optional for CCBs | Manual |
| 17 | TERM_CODE | Char | 2 | XX | Conditional | Termination Type Code - Required if terminated after 4/30/94 | Code Table Pick List |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 18 | INTAKE | Date | 8 | MM/DD/CCYY | Optional | Intake Date -Date of initial contact as defined by each agency | Manual |
| 19 | ORIG_DATE | Date | 8 | MM/DD/CCYY | Optional | Original Entry Date - Date of original entry into agency services | Manual |
| 20 | RCNTY_CODE | Char | 3 | XXX | Required | County of Residence Code | Code Table Pick List |
| 21 | CCNTY_CODE | Char | 3 | XXX | Required | County of Case Management Responsibility Code | Code Table Pick List |
| 22 | OCNTY_CODE | Char | 3 | XXX | Required | County of Origin Code | Code Table Pick List |
| 23 | CASE_CODE | Char | 4 | XXXX | Required | Case Manager Code | Code Table Pick List |
| 24 | IP_DATE | Date | 8 | MM/DD/CCYY | Required | Date of Last Individualized Plan | Manual |
| 25 | NUMBER | Char | 6 | X(6) | Required | Individual's Address - Street Number (may leave blank if only a freeform address is appropriate) | Manual |
| 26 | DIRECTION | Char | 2 | XX | Required | Individual's Address - Street Direction (may leave blank if only a freeform address is appropriate) | Code Table Pick List |
| 27 | STREET | Char | 30 | X(30) | Required | Individual's Address - Street Name (may leave blank if only a freeform address is appropriate) | Manual |
| 28 | TYPE | Char | 4 | XXXX | Required | Individual's Address - Street Type (e.g. St, Ave, Blvd)<br>(may leave blank if only a freeform address is appropriate) | Code Table Pick List |
| 29 | END_DIREC | Char | 2 | XX | Required | Individual's Address - Ending Street Direction (may leave blank if only a freeform address is appropriate) | Code Table Pick List |
| 30 | FREEFORM | Char | 35 | X(35) | Conditional | Individual's Address - Freeform portion of address (e.g. Apt. #, PO Box, General Delivery)<br>(Required if there is no other address) | Manual |
| 31 | CITY | Char | 25 | X(25) | Required | Individual's Address - City | Manual |
| 32 | STATE | Char | 2 | XX | Required | Individual's Address - State | Manual |
| 33 | ZIP | Char | 10 | 99999-9999 | Required | Individual's Address - Zipcode | Manual |
| 34 | BIRTHDATE | Date | 8 | MM/DD/CCYY | Required | Date of Birth | Manual |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 35 | GENDER | Char | 1 | X | Required | Gender | Spinner (M,F) |
| 36 | ETH_CODE | Char | 1 | X | Required | Ethnic Group Code | Code Table Pick List |
| 37 | OFUNC_CODE | Char | 2 | XX | Required | Overall Functioning Level Code | Code Table Pick List |
| 38 | IQ_SCORE | Char | 2 | XX | Optional | I. Q. Score | Manual |
| 39 | SCHL_CODE | Char | 3 | XXX | Optional | Responsible School District Code | Code Table Pick List |
| 40 | DISBCODE_1 | Char | 2 | XX | Required | 1st Disability Code | Code Table Pick List |
| 41 | DISBCODE_2 | Char | 2 | XX | Conditional | 2nd Disability Code | Code Table Pick List |
| 42 | DISBCODE_3 | Char | 2 | XX | Conditional | 3rd Disability Code | Code Table Pick List |
| 43 | DISBCODE_4 | Char | 2 | XX | Conditional | 4th Disability Code | Code Table Pick List |
| 44 | DISBCODE_5 | Char | 2 | XX | Conditional | 5th Disability Code | Code Table Pick List |
| 45 | DISBCODE_6 | Char | 2 | XX | Conditional | 6th Disability Code | Code Table Pick List |
| 46 | DISBCODE_7 | Char | 2 | XX | Conditional | 7th Disability Code | Code Table Pick List |
| 47 | DISBCODE_8 | Char | 2 | XX | Conditional | 8th Disability Code | Code Table Pick List |
| 48 | RSTAT_CODE | Char | 1 | X | Mandatory | Comprehensive (residential) Status Code | Code Table Pick List |
| 49 | RSTAT_DATE | Date | 8 | MM/DD/CCYY | Mandatory | Comprehensive (residential) Status Date | Manual |
| 50 | RSET_CODE | Char | 2 | XX | Required | Residential Setting Type Code | Code Table Pick List |
| 51 | RES_DATE | Date | 8 | MM/DD/CCYY | Required | Residential Date of Change | Manual |
| 52 | R_FUNDCODE | Char | 2 | XX | Conditional | Residential Funding Type | Code Table Pick List |
| 53 | RFAC_CODE | Char | 4 | XXXX | Conditional | Residential Facility Code | Code Table Pick List |
| 54 | RESLVLCODE | Char | 1 | X | Conditional | Residential Program Provided Level Code | Code Table Pick List |
| 55 | R_COORCODE | Char | 5 | XXXX | Optional | Residential Program Coordinator Code | Code Table Pick List |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 56 | RESSET_DAY | Date | 8 | MM/DD/CCYY | Optional | Residential Setting Date | Manual |
| 57 | DSTAT_CODE | Char | 1 | X | Mandatory | Day Program Status Code | Code Table Pick List |
| 58 | DSTAT_DATE | Date | 8 | MM/DD/CCYY | Mandatory | Day Program Status Date | Manual |
| 59 | DP_1_CODE | Char | 2 | XX | Optional | 1st Day Program Type Code | Code Table Pick List |
| 60 | DPDATE_1 | Date | 8 | MM/DD/CCYY | Optional | 1st Day Program Date of Change | Manual |
| 61 | DF_1_CODE | Char | 2 | XX | Optional | 1st Day Program Funding Type Code | Code Table Pick List |
| 62 | DL_1_CODE | Char | 4 | XXXX | Optional | 1st Day Program Location Code | Code Table Pick List |
| 63 | DLVLCODE1 | Char | 1 | X | Optional | 1st Day Program Level Code | Code Table Pick List |
| 64 | DP_2_CODE | Char | 2 | XX | Optional | 2nd Day Program Type Code | Code Table Pick List |
| 65 | DPDATE_2 | Date | 8 | MM/DD/CCYY | Optional | 2nd Day Program Date of Change | Manual |
| 66 | DF_2_CODE | Char | 2 | XX | Optional | 2nd Day Program Funding Type Code | Code Table Pick List |
| 67 | DL_2_CODE | Char | 4 | XXXX | Optional | 2nd Day Program Location Code | Code Table Pick List |
| 68 | DLVLCODE2 | Char | 1 | X | Optional | 2nd Day Program Level Code | Code Table Pick List |
| 69 | DP_3_CODE | Char | 2 | XX | Optional | 3rd Day Program Type Code | Code Table Pick List |
| 70 | DPDATE_3 | Date | 8 | MM/DD/CCYY | Optional | 3rd Day Program Date of Change | Manual |
| 71 | DF_3_CODE | Char | 2 | XX | Optional | 3rd Day Program Funding Type Code | Code Table Pick List |
| 72 | DL_3_CODE | Char | 4 | XXXX | Optional | 3rd Day Program Location Code | Code Table Pick List |
| 73 | DLVLCODE3 | Char | 1 | X | Optional | 3rd Day Program Level Code | Code Table Pick List |
| 74 | DP_4_CODE | Char | 2 | XX | Optional | 4th Day Program Type Code | Code Table Pick List |
| 75 | DPDATE_4 | Date | 8 | MM/DD/CCYY | Optional | 4th Day Program Date of Change | Manual |
| 76 | DF_4_CODE | Char | 2 | XX | Optional | 4th Day Program Funding Type Code | Code Table Pick List |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 77 | DL_4_CODE | Char | 4 | XXXX | Optional | 4th Day Program Location Code | Code Table Pick List |
| 78 | DLVLCODE4 | Char | 1 | X | Optional | 4th Day Program Level Code | Code Table Pick List |
| 79 | ADP_1_CODE | Char | 2 | XX | Optional | 1st Agency Day Program Type Code | Code Table Pick List |
| 80 | D_CORCODE1 | Char | 4 | XXXX | Optional | First Day Program Coordinator Code | Code Table Pick List |
| 81 | ADP_2_CODE | Char | 2 | XX | Optional | 2nd Agency Day Program Type Code | Code Table Pick List |
| 82 | D_CORCODE2 | Char | 4 | XXXX | Optional | Second Day Program Coordinator Code | Code Table Pick List |
| 83 | SSTAT_CODE | Char | 1 | X | Mandatory | Support Service Status Code | Code Table Pick List |
| 84 | SSTAT_DATE | Date | 8 | MM/DD/CCYY | Mandatory | Support Service Status Date | Manual |
| 85 | SL_1_CODE | Char | 2 | XX | Conditional | 1st Support Service Type Code | Code Table Pick List |
| 86 | SUPDATE_1 | Date | 8 | MM/DD/CCYY | Conditional | 1st Support Service Date of Change | Manual |
| 87 | SF_1_CODE | Char | 2 | XX | Conditional | 1st Support Service Funding Type Code | Code Table Pick List |
| 88 | SP_1_CODE | Char | 4 | XXXX | Conditional | 1st Support Service Provider Code<br>(Blank if Support Service type is Family Support) | Code Table Pick List |
| 89 | SLVLCODE1 | Char | 1 | X | Not used yet | 1st Support Service Level Code | Code Table Pick List |
| 90 | SLC_CODE1 | Char | 4 | XXXX | Optional | 1st Support Service Consultant/Coordinator Code | Code Table Pick List |
| 91 | SL_2_CODE | Char | 2 | XX | Conditional | 2nd Support Service Type Code | Code Table Pick List |
| 92 | SUPDATE_2 | Date | 8 | MM/DD/CCYY | Conditional | 2nd Support Service Date of Change | Manual |
| 93 | SF_2_CODE | Char | 2 | XX | Conditional | 2nd Support Service Funding Type Code | Code Table Pick List |
| 94 | SP_2_CODE | Char | 4 | XXXX | Conditional | 2nd Support Service Provider Code<br>(Blank if Support Service type is Family Support) | Code Table Pick List |
| 95 | SLVLCODE2 | Char | 1 | X | Not used yet | 2nd Support Service Level Code | Code Table Pick List |
| 96 | SLC_CODE2 | Char | 4 | XXXX | Optional | 2nd Support Service Consultant/Coordinator Code | Code Table Pick List |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 97 | SL_3_CODE | Char | 2 | XX | Conditional | 3rd Support Service Type Code | Code Table Pick List |
| 98 | SUPDATE_3 | Date | 8 | MM/DD/CCYY | Conditional | 3rd Support Service Date of Change | Manual |
| 99 | SF_3_CODE | Char | 2 | XX | Conditional | 3rd Support Funding Type Code | Code Table Pick List |
| 100 | SP_3_CODE | Char | 4 | XXXX | Conditional | 3rd Support Living Service Provider Code<br>(Blank if Support Service type is Family Support) | Code Table Pick List |
| 101 | SLVLCODE3 | Char | 1 | X | Not used yet | 3rd Support Service Level Code | Code Table Pick List |
| 102 | SLC_CODE3 | Char | 4 | XXXX | Optional | 3rd Support Service Consultant/Coordinator Code | Code Table Pick List |
| 103 | BEN_CODE1 | Char | 4 | X | Optional | 1st Benefit Code | Code Table Pick List |
| 104 | BEN_REC1 | Char | 4 | XXXX | Optional | 1st Benefit Receipt | Spinner (RECD, NEED, BOTH) |
| 105 | BEN_AMT1 | Num | 7 | 9999.99 | Optional | 1st Benefit Amount | Manual |
| 106 | BEN_CODE2 | Char | 4 | X | Optional | 2nd Benefit Code | Code Table Pick List |
| 107 | BEN_REC2 | Char | 4 | XXXX | Optional | 2nd Benefit Receipt | Spinner (RECD, NEED, BOTH) |
| 108 | BEN_AMT2 | Num | 7 | 9999.99 | Optional | 2nd Benefit Amount | Manual |
| 109 | BEN_CODE3 | Char | 4 | X | Optional | 3rd Benefit Code | Code Table Pick List |
| 110 | BEN_REC3 | Char | 4 | XXXX | Optional | 3rd Benefit Receipt | Spinner (RECD, NEED, BOTH) |
| 111 | BEN_AMT3 | Num | 7 | 9999.99 | Optional | 3rd Benefit Amount | Manual |
| 112 | BEN_CODE4 | Char | 4 | X | Optional | 4th Benefit Code | Code Table Pick List |
| 113 | BEN_REC4 | Char | 4 | XXXX | Optional | 4th Benefit Receipt | Spinner (RECD, NEED, BOTH) |
| 114 | BEN_AMT4 | Num | 7 | 9999.99 | Optional | 4th Benefit Amount | Manual |
| 115 | BEN_CODE5 | Char | 4 | X | Optional | 5th Benefit Code | Code Table Pick List |
| 116 | BEN_REC5 | Char | 4 | XXXX | Optional | 5th Benefit Receipt | Spinner (RECD, NEED, BOTH) |
| 117 | BEN_AMT5 | Num | 7 | 9999.99 | Optional | 5th Benefit Amount | Manual |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 118 | BEN_CODE6 | Char | 4 | X | Optional | 6th Benefit Code | Code Table Pick List |
| 119 | BEN_REC6 | Char | 4 | XXXX | Optional | 6th Benefit Receipt | Spinner (RECD, NEED, BOTH) |
| 120 | BEN_AMT6 | Num | 7 | 9999.99 | Optional | 6th Benefit Amount | Manual |
| 121 | BEN_CODE7 | Char | 4 | X | Optional | 7th Benefit Code | Code Table Pick List |
| 122 | BEN_REC7 | Char | 4 | XXXX | Optional | 7th Benefit Receipt | Spinner (RECD, NEED, BOTH) |
| 123 | BEN_AMT7 | Num | 7 | 9999.99 | Optional | 7th Benefit Amount | Manual |
| 124 | BEN_CODE8 | Char | 4 | X | Optional | 8th Benefit Code | Code Table Pick List |
| 125 | BEN_REC8 | Char | 4 | XXXX | Optional | 8th Benefit Receipt | Spinner (RECD, NEED, BOTH) |
| 126 | BEN_AMT8 | Num | 7 | 9999.99 | Optional | 8th Benefit Amount | Manual |
| 127 | BEN_CODE9 | Char | 4 | X | Optional | 9th Benefit Code | Code Table Pick List |
| 128 | BEN_REC9 | Char | 4 | XXXX | Optional | 9th Benefit Receipt | Spinner (RECD, NEED, BOTH) |
| 129 | BEN_AMT9 | Num | 7 | 9999.99 | Optional | 9th Benefit Amount | Manual |
| 130 | BEN_CODE10 | Char | 4 | X | Optional | 10th Benefit Code | Code Table Pick List |
| 131 | BEN_REC10 | Char | 4 | XXXX | Optional | 10th Benefit Receipt | Spinner (RECD, NEED, BOTH) |
| 132 | BEN_AMT10 | Num | | 9999.99 | Optional | 10th Benefit Amount | Manual |
| 133 | DDDELIDATE | Date | 8 | MM/DD/CCYY | Required | DDD Eligibility Date | Manual |
| 134 | CMFUN_CODE | Char | 2 | XX | Conditional | Case Management Funding Code | Code Table Pick List |
| 135 | WREF_CODE | Char | 2 | XX | Conditional | Waiting List Referral/Reason Code | Code Table Pick List |
| 136 | LASTUPDATE | Date | 8 | MM/DD/CCYY | Mandatory | Date this record was updated last - Changed when any field is changed | Automatic |
| 137 | DDDWDATE | Date | 8 | MM/DD/CCYY | Required | DDD Waiting List Date:<br>Beginning date for DDD State-wide waiting list.<br>Also known as the Order of Selection Date. | Manual |
| 138 | COMMENT | Memo | 4 | MEMO | Optional | Memo field for comments | Manual |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 139 | PICT | General | 4 | .BMP or .TIF | Not Currently Used | General field for storing picture of individual | Not Currently Used |
| 140 | CSRCODE | Char | 2 | XX | Conditional | Community Safety Risk Code | Code Table Pick List |
| 141 | CSRDATE | Date | 8 | MM/DD/CCYY | Conditional | Last Date Community Safety Risk was reviewed | Manual |

| | |
|---|---|
| **FILE NAME** | **Claddr.dbf**<br>**Claddr.fpt** |
| **INDEX TAGS** | **Pkey** Pkey (primary key for this table)<br>**Pkey_clmand** Pkey_clmand |
| **FILE DESCRIPTION** | **Consumer Address Table**<br><br>The Consumer Address file contains records which track the contacts and addresses of persons associated with an individual. As many records as are needed can be entered into the file for each individual. The system automatically creates or updates a "Self" address record (which identifies the individual's address) when a CORE record is created or updated for the individual. The use of this file is optional. |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PKEY | Char | 6 | X(6) | Mandatory | Primary key assigned by the system | Automatic |
| 2 | PKEY_CLMAND | Char | 6 | X(6) | Mandatory | Pkey for the Matching Consumer Record in CLMAND | Link to the Consumer Table |
| 3 | AGENCY | Char | 2 | XX | Mandatory | Agency Number | Automatic |
| 4 | CONT_LNAME | Char | 25 | X(25) | Optional | Contact Person's Last Name | Manual |
| 5 | CONT_FNAME | Char | 20 | X(20) | Optional | Contact Person's First Name<br>Note - the standard first name size is 15 characters, but an additional 5 characters is added to allow entry of a title (Dr., Mrs., etc.) | Manual |
| 6 | REL_1_CODE | Char | 1 | X | Mandatory | 1st Relationship Code | Code Table Pick List |
| 7 | REL_2_CODE | Char | 1 | X | Optional | 2nd Relationship Code | Code Table Pick List |
| 8 | REL_3_CODE | Char | 1 | X | Optional | 3rd Relationship Code | Code Table Pick List |
| 9 | TITLE | Char | 40 | X(40) | Optional | Agency Title | Manual |
| 10 | AG_NAME | Char | 40 | X(40) | Optional | Agency Name | Manual |
| 11 | ADDRESS | Char | 48 | X(48) | Optional | Complete Street Address | Manual |
| 12 | FREEFORM | Char | 35 | X(35) | Optional | Freeform Address (e.g. General Delivery, Route, PO Box, etc.) | Manual |
| 13 | CITY | Char | 25 | X(25) | Optional | City | Manual |
| 14 | STATE | Char | 2 | XX | Optional | State | Manual |
| 15 | ZIP | Char | 10 | 99999-9999 | Optional | Zip Code | Manual |
| 16 | PHONE_1 | Char | 13 | (999) 999-9999 | Optional | 1st Phone Number | Manual |
| 17 | EXT_1 | Char | 5 | 99999 | Optional | 1st Phone Number Extension | Manual |
| 18 | PHNDESC_1 | Char | 20 | X(20) | Optional | 1st Phone Number Description | Manual |
| 19 | PHONE_2 | Char | 13 | (999) 999-9999 | Optional | 2nd Phone Number | Manual |
| 20 | EXT_2 | Char | 5 | 99999 | Optional | 2nd Phone Number Extension | Manual |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 21 | PHNDESC_2 | Char | 20 | X(20) | Optional | 2nd Phone Number Description | Manual |
| 22 | PHONE_3 | Char | 13 | (999) 999-9999 | Optional | 3rd Phone Number | Manual |
| 23 | EXT_3 | Char | 5 | 99999 | Optional | 3rd Phone Number Extension | Manual |
| 24 | PHNDESC_3 | Char | 20 | X(20) | Optional | 3rd Phone Number Description | Manual |
| 25 | PHONE_4 | Char | 13 | (999) 999-9999 | Optional | 4th Phone Number | Manual |
| 26 | EXT_4 | Char | 5 | 99999 | Optional | 4th Phone Number Extension | Manual |
| 27 | PHNDESC_4 | Char | 20 | X(20) | Optional | 4th Phone Number Description | Manual |
| 28 | PHONE_5 | Char | 13 | (999) 999-9999 | Optional | 5th Phone Number | Manual |
| 29 | EXT_5 | Char | 5 | 99999 | Optional | 5th Phone Number Extension | Manual |
| 30 | PHNDESC_5 | Char | 20 | X(20) | Optional | 5th Phone Number Description | Manual |
| 31 | EMERGENCY | Logical | 1 | T/F | Optional | Emergency Contact | Spinner (T/F) |
| 32 | MAILCODE_1 | Char | 1 | X | Optional | 1st Mailing Code | Automatic |
| 33 | MAILCODE_2 | Char | 1 | X | Optional | 2nd Mailing Code | Code Table Pick List |
| 34 | MAILCODE_3 | Char | 1 | X | Optional | 3rd Mailing Code | Code Table Pick List |
| 35 | COMMENT | Memo | 4 | MEMO | Optional | Memo field for comments | Manual |
| 36 | LASTUPDATE | Date | 8 | MM/DD/CCYY | Mandatory | Date this record was updated last - Changed when any fields are changed | Automatic |

| | |
|---|---|
| **FILE NAME** | **Clwait.dbf** |
| **INDEX TAGS** | **Pkey** Pkey (primary key for this table)<br>**Pkey_clmand** Pkey_clmand<br>**Wprog_code** Wprog_code *(descending)*<br>**Histdelete** Pkey_clmand+agency+wprog_code+TRANSFORM(history) *(descending)*<br>**Wdate_id** Pkey_clmand+DTOS(wdate_id) *(descending)*<br>**Wdate_idyr** Pkey_clmand+wprog_code+DTOS(wdate_id) FOR wstat_code$"YR" *(descending)*<br>**Wdate_idix** Pkey_clmand+wprog_code+DTOS(wdate_id) FOR wstat_code$"IX" *(descending)* |
| **FILE DESCRIPTION** | **Consumer Waiting List Registry Table**<br><br>The Waiting List Registry file is used to track the need for additional resources for persons who either are receiving no services funded through DDD or who need a different type of resource than they are currently receiving. The file may also be used to track internal management needs for persons who need more of the same resource type or some change in how their current service is delivered (such as an individualized residential setting rather than a group home). Multiple waiting list records for an individual can be entered into the file in order to identify each service the person might be willing to accept.<br><br>The latest waiting list record for a person for a particular service type is considered the current waiting list record for that program. Previous waiting list records for the same program are marked as historical records so they may be filtered out during data entry and printing. |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PKEY | Char | 6 | X(6) | Mandatory | Primary key assigned by the system | Automatic |
| 2 | PKEY_CLMAND | Char | 6 | X(6) | Mandatory | Pkey for the Matching Consumer Record in CLMAND | Link to the Consumer File |
| 3 | AGENCY | Char | 2 | XX | Mandatory | Agency Number | Automatic |
| 4 | WPROG_CODE | Char | 2 | XX | Mandatory | Waiting List Program Code | Code Table Pick List |
| 5 | WSTAT_CODE | Char | 1 | X | Mandatory | Waiting List Status Code | Code Table Pick List |
| 6 | WDATE_ID | Date | 8 | MM/DD/CCYY | Mandatory | Date Need Identified | Manual |
| 7 | WDATE_REM | Date | 8 | MM/DD/CCYY | Conditional | Date Removed from this Waiting List | Manual |
| 8 | WLVL_CODE | Char | 3 | XXX | Conditional | Waiting List Level Code | Code Table Pick List |
| 9 | WFUND_CODE | Char | 1 | X | Mandatory | Waiting List Presumed Funding Code | Code Table Pick List |
| 10 | WTIME_CODE | Char | 1 | X | Mandatory | Waiting List Timeline Code | Code Table Pick List |
| 11 | WTIME_DATE | Date | 8 | MM/DD/CCYY | Conditional | Waiting List Timeline Date | Manual |
| 12 | WREMV_CODE | Char | 1 | X | Conditional | Waiting List Reason for Removal Code | Code Table Pick List |
| 13 | WOPT1_CODE | Char | 2 | XX | Optional | 1st Waiting List Option Code - defined by the Agency | Code Table Pick List |
| 14 | WOPT2_CODE | Char | 2 | XX | Optional | 2ndt Waiting List Option Code - defined by the Agency | Code Table Pick List |
| 15 | WL_COMMENT | Char | 40 | X(40) | Optional | Freeform field for additional information | Manual |
| 16 | HISTORY | Logical | 1 | T/F | Mandatory | Indicates whether the record is current or a previous Waiting List need. Begins as False and changed to True ONLY WHEN A NEW RECORD OF THE SAME TYPE IS ADDED. | Automatic |
| 17 | LASTUPDATE | Date | 8 | X | Mandatory | Date record was last updated | Automatic |
| 18 | USER_ID | Char | 8 | X(8) | Mandatory | User ID of Last User who Updated this Batch | Automatic via a Lookup to the Security Table |
| 19 | CR8_STAMP | Char | 12 | X(12) | Mandatory | Date and Time this record was created | Automatic |

| | | |
|---|---|---|
| **FILE NAME** | **Clhist.dbf** | |
| **INDEX TAGS** | **Pkey** | Pkey (primary key for this table) |
| | **Pkey_clmand** | Pkey_clmand |
| | **Mp_main** | Pkey_clmand+data_numb+trans_mo+sequence |
| | **Mp_main2** | Pkey_clmand+data_numb+trans_mo+sequence *(descending)* |
| | **Del_td** | Deleted() |
| | **Agency** | Agency |
| | **Trans_mo** | Trans_mo |
| | **Data_numb** | Data_numb |
| | **Rec_type** | Rec_type |
| | **Ssn** | Substr(new_data,63,11) FOR data_numb="001" |
| **FILE DESCRIPTION** | **Consumer History Table**<br><br>The Consumer History file contains historical data for individuals who have been served by an agency. Certain historical fields are written to the history file so the individual's dates and types of service can be tracked over a period of time. | |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PKEY | Char | 6 | X(6) | Mandatory | Primary key assigned by the system | Automatic |
| 2 | PKEY_CLMAND | Char | 6 | X(6) | Mandatory | Pkey for the Matching Consumer Record in CLMAND | Link to the Consumer Table |
| 3 | AGENCY | Char | 2 | XX | Mandatory | Agency Number | Automatic |
| 4 | DATA_NUMB | Char | 3 | XXX | Mandatory | Number to identify the CLMAND field (s) being tracked | Automatic |
| 5 | TRANS_MO | Char | 6 | MMCCYY | Mandatory | Data transmission month when the historical data was written to History | Automatic |
| 6 | SEQUENCE | Char | 5 | X(5) | Mandatory | Distinguishes between multiple changes for the same consumer record data set updated in the same transaction month. | Automatic |
| 7 | DATA_NAME | Char | 10 | X(10) | Mandatory | Name to identify the set of CLMAND field (s) being tracked | Automatic |
| 8 | REC_TYPE | Char | 1 | X | Mandatory | Original (O) or Update (U) | Automatic |
| 9 | NEW_DATA | Char | 151 | X(151) | Mandatory | Data tracked for this set of fields, including descriptions of coded fields | Automatic |

| | | |
|---|---|---|
| **FILE NAME** | **Bibatch.dbf**<br>**Bibatch.fpt** | |
| **INDEX TAGS** | **Pkey** | Pkey (primary key for this table) |
| | **Pkey_bipro** | Pkey_biprov |
| | **Pkey_bicon** | Pkey_bicontr |
| | **Batch_name** | Alltrim(batch_name) |
| | **Batch_nr** | Batch_nr |
| | **Pksfp** | Pkey+serv_code+fund_code+prog_code |
| | **Srvcde_agc** | Srv_code+agency |
| | **Agcy_bchnr** | Agency+str(batch_nr) |
| | **Deleted** | Deleted() |
| **FILE DESCRIPTION** | **Billing Batch Table**<br><br>The Billing Batch file contains records that are used to batch billing transactions according to common characteristics. As many records as are needed can be entered into the file according to how each agency groups billing attendance or expense information. Batch records and billing transactions associated with them are saved and re-initialized from month to month to reduce data entry. Only new batch records for new programs or new billing transactions for new persons in program need to be entered in subsequent months. | |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PKEY | Char | 6 | X(6) | Mandatory | Primary Key | Automatic generation |
| 2 | PKEY_BIPROV | Char | 6 | X(6) | Mandatory | Pkey for Matching Provider Record in BIPROV | Link to the Medicaid Provider Table |
| 3 | PKEY_BICONTR | Char | 6 | X(6) | Mandatory | Pkey for Matching Contract Record in BICONTR | Link to the Contract Table |
| 4 | AGENCY | Char | 2 | XX | Mandatory | Agency Number | Automatic via a Lookup to the Agency Table |
| 5 | BILL_MONTH | Char | 6 | MMCCYY | Mandatory | Current Billing Month | Automatic via a Lookup to the Agency Table |
| 6 | BATCH_NR | Num | 4 | 9999 | Mandatory | Batch Number | Automatic update based on the last number assigned in the Agency Table |
| 7 | BATCH_NAME | Char | 20 | X(20) | Required | Batch Name | Manual |
| 8 | BSTAT_CODE | Char | 1 | X | Optional | Batch Status Code | Code Table Pick List |
| 9 | SERV_CODE | Char | 1 | X | Mandatory | Service Type Code | Automatic via a Lookup to the Contract Table |
| 10 | FUND_CODE | Char | 2 | XX | Mandatory | Funding Code | Automatic via a Lookup to the Contract Table |
| 11 | PROG_CODE | Char | 2 | XX | Conditional | Program Code<br>(blank if Comprehensive Day Program Hours Reporting Only) | Automatic via a Lookup to the Contract Table |
| 12 | SUB_P_CODE | Char | 3 | XXX | Not Currently Used | Sub-Program Code | Not Currently Used |
| 13 | LOC_CODE | Char | 4 | X(4) | Mandatory | Location/Provider Code<br>(blank if Support Service type is Family Support)) | Code Table Pick List |
| 14 | LOCATION | Char | 20 | X(20) | Mandatory | Location/Provider Description<br>(blank if Support Service type is Family Support)) | Automatic via a Lookup to the Code Table |
| 15 | SUBC_CODE | Char | 5 | X(5) | Mandatory | Subcontractor Code | Automatic via a Lookup to the Contract Table |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 16 | OPT_CODE | Char | 5 | X(5) | Optional | Optional Code<br>(assigned and defined by the Agency) | Code Table Pick List |
| 17 | SA_CODE | Char | 5 | X(5) | Optional | Service Agency Code<br>(if Comprehensive, used to identify the Primary Day Agency) | Code Table Pick List |
| 18 | PROVID_NR | Char | 8 | X(8) | Conditional | Medicaid Provider Number<br>(blank if State funded program only) | Automatic via a Lookup to the Medicaid Provider Table |
| 19 | DDD_RATE | Num | 8 | 99999.99 | Mandatory | DDD Billing Rate<br>(must be a positive number) | Automatic via a Lookup to the Contract Table |
| 20 | SUBC_RATE | Num | 8 | 99999.99 | Optional | Subcontract Billing Rate<br>(must be a positive number) | Automatic via a Lookup to the Contract Table |
| 21 | COMM_ENTRY | Num | 6 | 999.99 | Optional | Common Unit or Dollar Entry for Most Entries in this Batch<br>(varies by program type) | Manual |
| 22 | BA_HOURS_1 | Num | 6 | 999.99 | Obsolete (eff. 7/04) | Common Hours of Service for Category 1 for Most Entries in this Batch<br>(applies only to Comprehensive Day Program Hours Reporting Only) | Manual |
| 23 | BA_HOURS_2 | Num | 6 | 999.99 | Obsolete (eff. 7/04) | Common Hours of Service for Category 2 for Most Entries in this Batch<br>(applies only to Comprehensive Day Program Hours Reporting Only) | Manual |
| 24 | BA_HOURS_3 | Num | 6 | 999.99 | Obsolete (eff. 7/04) | Common Hours of Service for Category 3 for Most Entries in this Batch<br>(applies only to Comprehensive Day Program Hours Reporting Only) | Manual |
| 25 | BA_HOURS_4 | Num | 6 | 999.99 | Obsolete (eff. 7/04) | Common Hours of Service for Category 4 for Most Entries in this Batch<br>(applies only to Comprehensive Day Program Hours Reporting Only) | Manual |
| 26 | BA_HOURS_5 | Num | 6 | 999.99 | Obsolete (eff. 7/04) | Common Hours of Service for Category 5 for Most Entries in this Batch<br>(applies only to Comprehensive Day Program Hours Reporting Only) | Manual |
| 27 | BA_ABSENT | Num | 5 | 99.99 | Optional | Common Number of Absent Days for Most Entries in this Batch<br>(applies only to Comprehensive Residential Reporting) | Manual |
| 28 | CTRL_HRS_1 | Num | 6 | 2 | Not Currently Used | Control Total of the Hours of Service for Category 1 to be Entered Into this Batch | Not Currently Used |
| 29 | CTRL_HRS_2 | Num | 6 | 2 | Not Currently Used | Control Total of the Hours of Service for Category 2 to be Entered Into this Batch | Not Currently Used |
| 30 | CTRL_HRS_3 | Num | 6 | 2 | Not Currently Used | Control Total of the Hours of Service for Category 3 to be Entered Into this Batch | Not Currently Used |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 31 | CTRL_HRS_4 | Num | 6 | 2 | Not Currently Used | Control Total of the Hours of Service for Category 4 to be Entered Into this Batch | Not Currently Used |
| 32 | CTRL_HRS_5 | Num | 6 | 2 | Not Currently Used | Control Total of the Hours of Service for Category 5 to be Entered Into this Batch | Not Currently Used |
| 33 | CONTRL_TOT | Num | 9 | 999999.99 | Conditional | Control Total of Entries Into this Batch (varies by program type) | Manual |
| 34 | ACTUAL_TOT | Num | 9 | 999999.99 | Conditional | Actual Total of Entries into this Batch (varies by program type) | Automatic update from the Data Entry function |
| 35 | PRINT_IND | Logical | 1 | T/F | Mandatory | Has a Final Print been Done? | Automatic update from the Batch Printing function |
| 36 | POST_IND | Logical | 1 | T/F | Mandatory | Has this Batch Been Posted? | Automatic update from the Posting function |
| 37 | LASTUPDATE | Date | 8 | MM/DD/CCYY | Mandatory | Date of Last Update to this Batch | Automatic based on the System Date |
| 38 | USER_ID | Char | 8 | X(8) | Mandatory | User ID of Last User who Updated this Batch | Automatic via a Lookup to the Security Table |
| 39 | COMMENT | Memo | 4 | MEMO | Optional | Memo field for comments | Manual |

| | |
|---|---|
| **FILE NAME** | **Bitran.dbf** |
| **INDEX TAGS** | **Bitran tags**<br>**Pkey** Pkey (primary key for this table)<br>**Pkey_clman** Pkey_clmand<br>**Pkey_bibat** Pkey_bibatch<br>**Pkey_bicon** Pkey_bicontr<br>**Pkbcnotmt** Timestamp FOR .not.empty(pkey_bicontr) *(descending)*<br>**Tran_nr** Tran_nr<br>**Bill_month** Bill_month |
| **FILE DESCRIPTION** | **Billing Transaction Table**<br><br>The Billing Transaction file contains the individual billing transaction records that identify the specific billing services and amounts being submitted for payment for each person receiving services. No billing transactions can be entered for an individual unless a record has been entered for the person in the Consumer file. Each billing transaction is linked to a batch record. Most of the program and funding identification fields contained in the billing transaction record are automatically completed based on the information entered into the batch record. |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PKEY | Char | 6 | X(6) | Mandatory | Primary Key | Automatic generation |
| 2 | PKEY_CLMAND | Char | 6 | X(6) | Mandatory | Pkey for the Matching Consumer Record in CLMAND | Link to the Consumer Table |
| 3 | PKEY_BIBATCH | Char | 6 | X(6) | Mandatory | Pkey for Matching Batch Record in BIBATCH | Link to the Batch Table |
| 4 | PKEY_BICONTR | Char | 6 | X(6) | Mandatory | Pkey for Matching Contract Record in BICONTR | Link to the Contract Table |
| 5 | TIMESTAMP | Date / Time | 8 | 99999999 | Mandatory | Date and Time of Last Update to this Transaction | Automatic based on the System Date and Time |
| 6 | TRAN_NR | Num | 5 | 99999 | Mandatory | Transaction Number<br>(assigned Sequentially within each Billing Month) | Automatic update based on the last number recorded in the Agency Table |
| 7 | AGENCY | Char | 2 | XX | Mandatory | Agency Number | Automatic via a Lookup to the Agency Table |
| 8 | SUB_F_CODE | Char | 2 | XX | Not Currently Used | Sub-funding Code | Not Currently Used |
| 9 | SUB_P_CODE | Char | 3 | XXX | Conditional | Sub-Program Code<br>(used to identify service category for service or encounter reporting) | Code Table Pick List |
| 10 | OPT_CODE | Char | 5 | XXXXX | Optional | Optional Code<br>(assigned and defined by the Agency) | Code Table Pick List |
| 11 | DAYSA_CODE | Char | 5 | XXXXX | Conditional | Primary Day Agency Code<br>(used to identify the Primary Day Program provider for day services) | Code Table Pick List |
| 12 | DDD_RATE | Num | 8 | 99999.99 | Mandatory | DDD Billing Rate<br>(must be a positive number) | Automatic via a Lookup to the Contract Table |
| 13 | SUBC_RATE | Num | 8 | 99999.99 | Optional | Subcontract Billing Rate<br>(must be a positive number) | Automatic via a Lookup to the Contract Table |
| 14 | NEGOT_IND | Char | 1 | X | Not Currently Used | Negotiated/Individualized Day Rate? (Y/N) | Not Currently Used |
| 15 | PROVID_NR | Char | 8 | X(8) | Conditional | Medicaid Provider Number<br>(blank if State funded) | Automatic via a Lookup to the Medicaid Provider Table |
| 16 | ENR_UNIT | Num | 7 | 9999.99 | Conditional | Number of Enrolled Units (before calculation of individual overservice) | Manual/Calculated |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 17 | ABSENT_NR | Num | 6 | 999.99 | Conditional | Number of Absent Days<br>(used to report absent days for Comprehensive Residential) | Manual |
| 18 | WAIVED_NR | Num | 6 | 999.99 | Not Currently Used | Number of Waived Absent Days | Not Currently Used |
| 19 | HOURS_1 | Num | 7 | 9999.99 | Conditional | Hours of Service or Occurrences for Category 1<br>(varies by program)<br>*Children's Extensive Support* (Prog_code = C3)<br>Hours of support related to the service reported in the Sub_p_code field (may be Zero if services are not billed by hour)<br>*Supported Living Services* (Prog_code = SL)<br>Hours or occurrences of support related to the service reported in the Sub_p_code field | Manual |
| 20 | SRV_1_CODE | Char | 1 | X | Conditional | 1st Special Service Code<br>(used to record an Outcome payment type for SLS Supported Employment) | Code Table Pick List |
| 21 | SRV_2_CODE | Char | 1 | X | Not Currently Used | 2nd Special Service Code | Not Currently Used |
| 22 | SRV_3_CODE | Char | 1 | X | Not Currently Used | 3rd Special Service Code | Not Currently Used |
| 23 | SRV_4_CODE | Char | 1 | X | Not Currently Used | 4th Special Service Code | Not Currently Used |
| 24 | SRV_5_CODE | Char | 1 | X | Not Currently Used | 5th Special Service Code | Not Currently Used |
| 25 | SRV_6_CODE | Char | 1 | X | Not Currently Used | 6th Special Service Code | Not Currently Used |
| 26 | SRV_7_CODE | Char | 1 | X | Not Currently Used | 7th Special Service Code | Not Currently Used |
| 27 | BTRM_CODE | Char | 1 | X | Conditional | Billing Termination Code<br>(used to report termination reason from EI and FSSP) | Code Table Pick List |
| 28 | CHG_CODE_1 | Char | 2 | XX | Conditional | 1st Change code<br>(required if a person is new to the program) | Code Table Pick List |
| 29 | CHG_DATE_1 | Date | 8 | MM/DD/CCYY | Mandatory | 1st Date of Service (From Date) | Manual |
| 30 | CHG_CODE_2 | Char | 2 | XX | Conditional | 2nd Change Code<br>(required if a person is terminated from the program) | Code Table Pick List |
| 31 | CHG_DATE_2 | Date | 8 | MM/DD/CCYY | Mandatory | 2nd Date of Service (Through Date) | Manual |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 32 | ADJ_MONTH | Char | 6 | MMCCYY | Conditional | Adjustment Month and Year<br>(required if this is an adjustment entry) | Manual |
| 33 | RES_DESC | Char | 20 | X(20) | Optional | Description of Residential Living Arrangement (e.g. Apt. Address) | Manual |
| 34 | SSI_INCOME | Num | 8 | 99999.99 | Conditional | Income from SSI<br>(if this is a State Comprehensive transaction) | Manual |
| 35 | SSA_INCOME | Num | 8 | 99999.99 | Conditional | Income from Social Security other than SSI<br>(if this is a State Comprehensive transaction) | Manual |
| 36 | AND_OAP | Num | 8 | 99999.99 | Conditional | Income from Aid to the Needy and/or Old Age Pension<br>(if this is a State Comprehensive transaction) | Manual |
| 37 | VA_INCOME | Num | 8 | 99999.99 | Conditional | Income from Veteran's Administration<br>(if this is a State Comprehensive transaction) | Manual |
| 38 | WAGES | Num | 8 | 99999.99 | Conditional | Net Income from Wages<br>(if this is a State Comprehensive transaction) | Manual |
| 39 | OTH_INCOME | Num | 8 | 99999.99 | Conditional | Income from Other Sources<br>(if this is a State Comprehensive transaction) | Manual |
| 40 | OTH_INC_EXP | Char | 20 | X(20) | Conditional | Explanation of Income from Other Sources<br>(if this is a State Comprehensive transaction) | Manual |
| 41 | SPOUSE_DED | Num | 8 | 99999.99 | Not Currently Used | Income Deduction to Apply to Spouse for PETI calculation | Not Currently Used |
| 42 | FAMILY_DED | Num | 8 | 99999.99 | Not Currently Used | Income Deduction to Apply to Family for PETI calculation | Not Currently Used |
| 43 | MED_DED | Num | 8 | 99999.99 | Conditional | Income Deduction for Allowable Medical Expenses<br>( if this is a State Comprehensive transaction) | Manual |
| 44 | PERS_NEEDS | Num | 6 | 999.99 | Conditional | Standard Personal Needs Amount<br>(if this is a State Comprehensive transaction) | Automatic via a Lookup to the Contract Table |
| 45 | AMOUNT_1 | Num | 8 | 99999.99 | Not Currently Used | Amount for Category 1 (dependent on program type) | Not Currently Used |
| 46 | AMOUNT_2 | Num | 8 | 99999.99 | Not Currently Used | Amount for Category 2 (dependent on program type) | Not Currently Used |
| 47 | AMOUNT_3 | Num | 8 | 99999.99 | Not Currently Used | Amount for Category 3 (dependent on program type) | Not Currently Used |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 48 | APP_WAGES | Num | 8 | 99999.99 | Conditional | Wages which must be applied toward Room and Board<br>(if this is a State Comprehensive transaction) | Calculated |
| 49 | RMBD_CALC | Num | 9 | 999999.99 | Conditional | Total income which must be applied to Room and Board<br>(if this is a State Comprehensive transaction) | Calculated |
| 50 | SL_ENR_AMT | Num | 9 | 999999.99 | Conditional | Enrolled Amount for Support Service Programs | Manual |
| 51 | SL_ENR_UNT | Num | 8 | 99999.99 | Mandatory | Enrolled Units for Medicaid funded Support Service Programs (before calculation of individual overservice) | Calculated |
| 52 | SL_BIL_UNT | Num | 8 | 99999.99 | Mandatory | Billable Units for Medicaid funded Support Service Programs (after calculation of individual overservice) | Calculated |
| 53 | BILBL_UNIT | Num | 7 | 9999.99 | Mandatory | Billable Units (after calculation of individual overservice)<br>(varies by program) | Calculated |
| 54 | ENR_AMTDUE | Num | 9 | 999999.99 | Mandatory | Enrolled Amount Due (before calculation of individual overservice) | Calculated |
| 55 | BIL_AMTDUE | Num | 9 | 999999.99 | Mandatory | Billable Amount Due (after calculation of individual overservice) | Calculated |
| 56 | CM_ENR_UNT | Num | 2 | 99 | Not Currently Used | Enrolled units for Case Management Associated with this Transaction | Not Currently Used |
| 57 | TR_ENR_UNT | Num | 3 | 999 | Not Currently Used | Enrolled units for Transportation Associated with this Transaction | Not Currently Used |
| 58 | MEDICAID | Char | 7 | A999999 | Conditional | Medicaid Number for this Person<br>(may be blank if State funded) | Automatic via a Lookup to the Consumer Table |
| 59 | MED_R_CODE | Char | 1 | X | Mandatory | Medicaid Reconciliation Code | Automatic update from the Posting function |
| 60 | DENY_CODE | Char | 5 | XXXXX | Not Currently Used | MMIS Denial Code | Not Currently Used |
| 61 | CHECK_NR | Char | 15 | X(15) | Not Currently Used | Check or Voucher Number Associated with this Transaction | Not Currently Used |
| 62 | POST_IND | Char | 1 | X | Mandatory | Has this Transaction Been Posted? (Y/N) | Automatic update from the Posting function |
| 63 | FREEFORM | Char | 35 | X(35) | Conditional | Reason for Adjustment on Contract Adjustment Entries<br>Reason for System Adjustment During Posting<br>Reason for Special Billing on Special Billing Entries | Manual or Automatic update from the Posting function |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 64 | ADD_EXPLAN | Char | 40 | X(40) | Conditional | Additional Explanation of Service/Cost for Support Services | Manual |
| 65 | SORT_MONTH | Char | 6 | CCYYMM | Mandatory | Entered by the system to use as a sorting field to sort transactions together that apply to the same month (regardless of when the billing was actually entered) | Automatic update from the Data Entry program |
| 66 | DATA_SRC | Char | 1 | X | Mandatory | If entered, identifies a record that came from an import file | Automatic update from the Import function |
| 67 | BILL_MONTH | Char | 6 | MMCCYY | Mandatory | Current Billing Month | Automatic via a Lookup to the Agency Table |
| 68 | HCPCS_UNITS | Num | 12 | 999999999.99 | Conditional | Medicaid Units to be billed to the MMIS (varies by program) | Automatic update from the Data Entry and Posting programs |

| | |
|---|---|
| **FILE NAME** | **Bihours.dbf** |
| **INDEX TAGS** | **Pkey_bitra** Pkey_Bitran<br>**Pk_bitcode** Pkey_bitran+hours_code<br>**Pk_bitcdhr** Pkey_bitran FOR hours_code$"IA,IW,NA,NW".and.hours#0<br>**Pk_code2** Pkey_bitran FOR hours_code$"IA,NA,NW"<br>**Pk_code5** Pkey_bitran FOR hours_code$"DH,IA,NA,NW"<br>**Pk_code6** Pkey_bitran FOR hours_code$"IJ,IW"<br>**Pk_code4** Pkey_bitran FOR hours_code="IW".and..not.empty(hours)<br>**Pk_codeneg** Pkey_bitran FOR hours<0 |
| **FILE DESCRIPTION** | **Billing Hours Table**<br><br>The Billing Hours file contains records associated with hours of service for Supported Living Services, Comprehensive Services and Early Intervention Services. The Comprehensive hours reported include both day program hours and residential hours. |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PKEY_BITRAN | Char | 6 | X(6) | Mandatory | Pkey for the Matching Transaction Record in BITRAN | Link to the Billing Transaction Table |
| 2 | AGENCY | Char | 2 | XX | Mandatory | Agency Number | Automatic via a Lookup to the Agency Table |
| 3 | HOURS_CODE | Char | 2 | XX | Mandatory | Type of Hours | Code Table Pick List |
| 4 | HOURS | Num | 7 | 9999.99 | Mandatory | Number of Hours | Manual |
| 5 | SERVICE_COST | Num | 8 | 99999.99 | Optional | Cost of Service | Manual |

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|---|---|
| **FILE NAME** | **Biclytd.dbf** |
| **INDEX TAGS** | **Pkey** Pkey (primary key for this table)<br>**Pkey_clman** Pkey_clmand<br>**Pksrvfprg** Pkey_clmand+serv_code+fund_code+prog_code+sub_p_code |
| **FILE DESCRIPTION** | **Billing Client Year-to-Date Table**<br><br>The Billing Client Year-to-Date file contains one record for each program and funding combination for which a person has been billed during the fiscal year. (For Support Services billed by service category, there is one record per service category or sub-program.) This record aggregates the total enrolled and billable figures for each person within that program and funding combination in order to monitor individual maximums so that no one person can exceed the individual maximum allowed. |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PKEY | Char | 6 | X(6) | Mandatory | Primary Key | Automatic generation |
| 2 | PKEY_CLMAND | Char | 6 | X(6) | Mandatory | Pkey for the Matching Consumer Record in CLMAND | Link to the Consumer Table |
| 3 | AGENCY | Char | 2 | XX | Mandatory | Agency Number | Automatic |
| 4 | SERV_CODE | Char | 1 | X | Mandatory | Service Type Code | Automatic |
| 5 | FUND_CODE | Char | 2 | XX | Mandatory | Funding Code | Automatic |
| 6 | PROG_CODE | Char | 2 | XX | Mandatory | Program Code | Automatic |
| 7 | SUB_P_CODE | Char | 3 | XXX | Conditional | Sub-program Code<br>(Mandatory for Support Service programs billed by service categories) | Automatic |
| 8 | U_ENRL_YTD | Nun | 8 | 99999.99 | Mandatory | Units Enrolled Year-to-Date | Calculated |
| 9 | U_BLBL_YTD | Num | 8 | 99999.99 | Mandatory | Units Billable Year-to-Date | Calculated |
| 10 | A_ENRL_YTD | Num | 9 | 999999.99 | Mandatory | Amount Enrolled Year-to-Date | Calculated |
| 11 | A_BLBL_YTD | Num | 9 | 999999.99 | Mandatory | Amount Billable Year-to-Date | Calculated |
| 12 | ABSENT_YTD | Num | 6 | 999.99 | Mandatory | Absences Year-to-Date | Calculated |
| 13 | LAST_BILL | Char | 8 | MMCCYY | Mandatory | Last month billed for this program | Automatic |

| | | |
|---|---|---|
| **FILE NAME** | **Bicontr.dbf** | |
| **INDEX TAGS** | **Pkey** | Pkey (primary key for this table) |
| | **Agency** | Agency |
| | **Main** | Serv_code+subc_code+fund_code+prog_code |
| | **Agy_main** | Agency+serv_code+subc_code+fund_code+prog_code |
| **FILE DESCRIPTION** | **Billing Contract Table**<br><br>The Billing Contract file contains a record for every program and funding combination for which an agency is authorized to bill. In addition to authorizing billing for services, the contract records aggregate billing information in order to track how much has been billed for each program both for the current month and year-to-date. Agencies may enter subcontract records to perform these same functions for their subcontractors or cost centers they have defined within their own direct service programs. | |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PKEY | Char | 6 | X(6) | Mandatory | Primary Key | Automatic generation |
| 2 | AGENCY | Char | 2 | XX | Mandatory | Agency Number | Automatic |
| 3 | SERV_CODE | Char | 1 | X | Mandatory | Service Type Code | Code Table Pick List |
| 4 | FUND_CODE | Char | 2 | XX | Mandatory | Funding Code | Code Table Pick List |
| 5 | PROG_CODE | Char | 2 | XX | Mandatory | Program Code of the main contract allocation line | Code Table Pick List |
| 6 | SUBP1_CODE | Char | 2 | XX | Conditional | 1st Sub-program Code - 1st Authorized Billing Type<br>( must be entered if Program Code is different from the authorized billing type) | Code Table Pick List |
| 7 | SUBP2_CODE | Char | 2 | XX | Conditional | 2nd Sub-program Code - 2nd authorized billing type | Code Table Pick List |
| 8 | SUBC_CODE | Char | 5 | XXXXX | Mandatory | Subcontract Code | Code Table Pick List |
| 9 | METH_CODE | Char | 1 | X | Mandatory | Billing Methodology Code | Code Table Pick List |
| 10 | LASTUPDATE | Date | 8 | MM/DD/CCYY | Mandatory | Date this Record was Last Updated | Automatic |
| 11 | USER_ID | Char | 8 | X(8) | Mandatory | Last User who Updated this Record | Automatic |
| 12 | POST_IND | Char | 1 | X | Mandatory | Posted this billing month? Yes/No/Final (Y/N/F) | Automatic |
| 13 | AMEND_DATE | Date | 8 | MM/DD/CCYY | Optional | Effective Date of Last Amendment | Manual |
| 14 | BILL_RATE | Num | 8 | 99999.99 | Conditional | Current Billing Rate | Manual |
| 15 | TOT_UNITS | Num | 11 | 99999999.99 | Conditional | Total Contracted Units | Manual |
| 16 | TOT_FPE | Num | 7 | 9999.99 | Obsolete (eff. 7/99) | Total Number of Full Allocations | Manual |
| 17 | TOT_AMOUNT | Num | 11 | 99999999.99 | Required | Total Dollar Amount | Manual |
| 18 | MAX_UNITS | Num | 8 | 99999.99 | Conditional | Maximum Number of Units/Dollar Amount per Individual | Manual |
| 19 | MAX_ABSENT | Num | 6 | 999.99 | Obsolete (eff. 7/99) | Maximum Number of Paid Absences Allowable per Individual | Manual |
| 20 | BEG_MIN_NR | Num | 7 | 9999.99 | Conditional | Beginning Minimum Number to be Served for the current FY | Manual |
| 21 | ADD_MIN_NR | Num | 6 | 999.99 | Conditional | Additional Minimum Number to be Served for the current FY | Manual |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 22 | CUR_MIN_NR | Num | 7 | 9999.99 | Conditional | Current Minimum Number to be Served for the current FY | Manual |
| 23 | BEG_MEM_NR | Num | 9 | 999999.99 | Conditional | Beginning Member Months or Days to be Served for the current FY | Manual |
| 24 | ADD_MEM_NR | Num | 8 | 99999.99 | Conditional | Additional Member Months or Days to be Served for the current FY | Manual |
| 25 | CUR_MEM_NR | Num | 9 | 999999.99 | Conditional | Current Member Months or Days to be Served for the current FY | Manual |
| 26 | YTD_MEMBER | Num | 9 | 999999.99 | Conditional | Year to Date Member Months Billed for the current FY | Manual |
| 27 | YTD_BNDLED | Num | 9 | 999999.99 | Conditional | Year to Date Bundled Months Billed for the current FY | Manual |
| 28 | U_ENRL_TOT | Num | 11 | 99999999.99 | Conditional | Units Enrolled Year-to-Date | Calculated |
| 29 | U_BLBL_TOT | Num | 11 | 99999999.99 | Conditional | Units Billable Year-to-Date | Calculated |
| 30 | U_BLLD_TOT | Num | 11 | 99999999.99 | Conditional | Units Billed Year-to-Date | Calculated |
| 31 | A_ENRL_TOT | Num | 11 | 99999999.99 | Conditional | Amount Enrolled Year-to-Date | Calculated |
| 32 | A_BLBL_TOT | Num | 11 | 99999999.99 | Mandatory | Amount Billable Year-to-Date | Calculated |
| 33 | A_BLLD_TOT | Num | 11 | 99999999.99 | Mandatory | Amount Billed Year-to-Date | Calculated |
| 34 | RMBD_TOT | Num | 10 | 9999999.99 | Conditional | Room and Board Accrued Year-to-Date | Calculated |
| 35 | UNT_ADJ_MO | Num | 10 | 9999999.99 | Conditional | Adjustment Units this Month | Calculated |
| 36 | UNT_BIL_MO | Num | 10 | 9999999.99 | Conditional | Billed Units this Month (including adjustment units) | Calculated |
| 37 | AMT_ADJ_MO | Num | 10 | 9999999.99 | Conditional | Adjustment Amount this Month | Calculated |
| 38 | AMT_BIL_MO | Num | 10 | 9999999.99 | Conditional | Billed Amount this Month (including adjustment amount) | Calculated |
| 39 | UNT_OVR_MO | Num | 10 | 9999999.99 | Conditional | Units Over Contract Service this Month (may be negative if previous over-service is being paid due to a contract amendment) | Calculated |
| 40 | AMT_OVR_MO | Num | 10 | 9999999.99 | Conditional | Amount over Contract Service this Month (may be negative if previous over-service is being paid due to a contract amendment) | Calculated |

Field Numbers 41 - 47 are repeated for all twelve months of the year. The definition is the same for each set of fields within each month so they are only described once below.

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 41 | UNT_ENR_## | Num | 10 | 9999999.99 | Conditional | Units Enrolled for the Month (specified by ##) | Calculated |
| 42 | UNT_BLB_## | Num | 10 | 9999999.99 | Conditional | Units Billable for the Month (specified by ##) | Calculated |
| 43 | AMT_ENR_## | Num | 10 | 9999999.99 | Conditional | Amount Enrolled for the Month (specified by ##) | Calculated |
| 44 | AMT_BLB_## | Num | 10 | 9999999.99 | Mandatory | Amount Billable for the Month (specified by ##) | Calculated |
| 45 | RMBD_## | Num | 10 | 9999999.99 | Conditional | Room and Board Applied for the Month (specified by ##) | Calculated |
| 46 | PERSONS_## | Num | 4 | 9999 | Conditional | Persons Billed for the Month (specified by ##) | Calculated |
| 47 | RATE_## | Num | 8 | 99999.99 | Conditional | Billing Rate for the Month (specified by ##) | Transferred from Bill_rate field when it is updated for the current Billing month |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 125 | FISCAL_YR | Char | 9 | MMCCYY-MMCCYY | Mandatory | Current Fiscal Year of this contract record | Automatic |

| | |
|---|---|
| **FILE NAME** | **Biprov.dbf**<br>**Biprov.fpt** |
| **INDEX TAGS** | **Pkey** Pkey (primary key for this table)<br>**Provider** Upper(provider)<br>**Provid_nr** Provid_nr<br>**Servlocprg** Serv_code+loc_code+prog_code<br>**Serv_sa** Serv_code+sa_code<br>**Servsaprog** Serv_code+sa_code+prog_code |
| **FILE DESCRIPTION** | **Medicaid Provider Table**<br><br>The Medicaid Provider file is used to enter service authorization information for Medicaid providers. Billing provider numbers are assigned by the Medicaid Fiscal Agent and then manually entered at DDD. An updated copy of the Medicaid Provider file is sent to each agency monthly to be used by the Billing module to determine whether a provider has been authorized to provide the services being billed. |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PKEY | Char | 6 | X(6) | Mandatory | Primary Key | Automatic generation |
| 2 | PROVID_NR | Char | 8 | X(8) | Mandatory | Medicaid Provider Number | Manual |
| 3 | PROVIDER | Char | 45 | X(45) | Mandatory | Medicaid Provider Name | Manual |
| 4 | ADDRESS | Char | X(48) | 48(9) | Required | Street Address | Manual |
| 5 | OWNR_PHONE | Char | 13 | X(13) | Required | Phone number of Owner | Manual |
| 6 | OPTION4 | Char | 20 | X(20) | Optional | Optional Field (not currently used) | Manual |
| 7 | FREE_FORM | Char | 35 | X(35) | Optional | Freeform Address (Box Number, etc.) | Manual |
| 8 | CITY | Char | 25 | X(25) | Required | City | Manual |
| 9 | STATE | Char | 2 | X(2) | Required | State | Manual |
| 10 | ZIP | Char | 10 | X(10) | Required | Zip Code | Manual |
| 11 | CNTY_CODE | Char | 3 | X(3) | Optional | Provider's Contract County Code | Code Table Pick list |
| 12 | OWNER | Char | 65 | X(65) | Optional | Owner's Name | Manual |
| 13 | AGENCY | Char | 2 | XX | Mandatory | CCB/RC Agency Code | Code Table Pick list |
| 14 | SERV_CODE | Char | 1 | X | Mandatory | Service Type Code | Code Table Pick list |
| 15 | PROG_CODE | Char | 2 | X(2) | Conditional | Program Type Code<br>(Mandatory for Residential, Support Service and Other Service Types) | Code Table Pick list |
| 16 | LOC_CODE | Char | 4 | X(4) | Conditional | Location/Provider Code<br>(Mandatory for Residential and Support Service Types) | Code Table Pick list |
| 17 | SA_CODE | Char | 5 | X(5) | Conditional | Service Agency Code<br>(Mandatory for Day Program and Other Service Types) | Code Table Pick list |
| 18 | CERTDATE | Date | 8 | MM/DD/CCYY | Mandatory | Original Date of Certification | Manual |
| 19 | CERTEDDATE | Date | 8 | MM/DD/CCYY | Required | Ending Certification Date (for the current cycle) | Manual |
| 20 | CERTSTDATE | Date | 8 | MM/DD/CCYY | Required | Beginning Certification Date (for the current cycle.) | Manual |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 21 | LICENSE_NO | X | 4 | X(4) | Required | Department of Health License Number (Group Homes only) | Manual |
| 22 | LIC_DATE | Date | 8 | MM/DD/CCYY | Required | Date of Licensing by DOH (Group Homes only) | Manual |
| 23 | LIC_RENEW | Date | 8 | MM/DD/CCYY | Required | Renewal Date for Re-licensing by DOH (Group Homes only) | Manual/Automatic |
| 24 | LIC_BEDS | Num | 3 | 999 | Required | Number of Licensed Beds (Residential only) | Manual |
| 25 | FUND_BEDS | Num | 3 | 999 | Required | Number of Beds Funded by DDD (Residential only) | Manual |
| 26 | PRSTATCODE | Char | 1 | X | Mandatory | Provider Status Code | Code Table Pick list |
| 27 | TERM_DATE | Date | 8 | MM/DD/CCYY | Conditional | Date for Termination of the Provider Number (Mandatory if the Status is terminated) | Manual |
| 28 | COMMENT | Memo | 4 | MEMO | Optional | Memo Field for Comments | Manual |

| | |
|---|---|
| **FILE NAME** | **Bil_rate.dbf** |
| **INDEX TAGS** | **Main** Agency+prog_code+sub_p_code+rate_type+dtos(eff_date) *(descending)*<br>**Display** Agency+rate_type+prog_code+sub_p_code+dtos(eff_date) |
| **FILE DESCRIPTION** | **Billing Rate Table**<br><br>The Billing Rate file contains maximum rates for Children's Extensive Support Waiver and Supported Living Services hourly billing services. Because Supported Living Services Waiver billing was changed to a bundled rate in 7/01, the rates are merely historical information for that Waiver. These rates are determined by DDD. Agencies may enter additional rate records to identify their own lower rates. |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | AGENCY | Char | 2 | XX | Mandatory | Agency Number | Automatic |
| 2 | RATE_TYPE | Char | 1 | X | Mandatory | DDD or Agency rate | Automatic (depending on the site entering the record) |
| 3 | PROG_CODE | Char | 2 | XX | Mandatory | Program Code | Code Table Pick list |
| 4 | SUB_P_CODE | Char | 3 | XXX | Mandatory | Service Code | Code Table Pick list |
| 5 | EFF_DATE | Date | 8 | MMDDCCYY | Mandatory | Effective Date of this Rate | Manual |
| 6 | HIGH_RATE | Num | 9 | 999999.99 | Mandatory | Highest allowable Billing Rate for this service | Manual |
| 7 | LOW_RATE | Num | 9 | 999999.99 | Optional | Lowest allowable Billing Rate for this service | Manual |

| | | |
|---|---|---|
| **FILE NAME** | **PAR.dbf**<br>**PAR.fpt** | |
| **INDEX TAGS** | **Pkey** | Pkey (primary key for this table) |
| | **Ssn** | Ssn |
| | **Medicaid** | Medicaid |
| | **Name** | Upper(alltrim(lastname)+" "+firstname) |
| | **Birthdate** | Dtos(birthdate) |
| | **Par_span** | Ssn+par_code+dtos(par_from) *(descending)* |
| | **Med_span** | Medicaid+par_code+dtos(par_from) |
| | **Medsearch** | Medicaid+par_st_cod+par_code |
| | **Namesearch** | Upper(alltrim(lastname)+","+firstname)+par_st_cod+par_code |
| | **Sssnsearch** | Ssn+par_st_cod+par_code |
| | **Pa_acct** | Pa_acct |
| **FILE DESCRIPTION** | **Prior Authorization Table**<br><br>The Prior Authorization (PAR) file is used to enter service authorization information for persons enrolled in Medicaid funded Waiver programs and some Medicaid State Plan programs. PAR updates are transmitted to the Medicaid Fiscal Agent to be entered into the Medicaid Management Information System (MMIS) to authorize payment of claims. Authorization is the responsibility of the DDD central office, so PAR records can only be entered and updated at the DDD site. A copy of the PAR file is sent to each agency monthly to be used by the Billing module to accept or reject billing transactions at the time of posting. | |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PKEY | Char | 6 | X(6) | Mandatory | Primary Key | Automatic generation |
| 2 | AGENCY | Char | 2 | XX | Mandatory | Agency Number | Code Table Pick List |
| 3 | LASTNAME | Char | 25 | X(25) | Mandatory | Legal Last Name | Manual |
| 4 | FIRSTNAME | Char | 15 | X(15) | Mandatory | Legal First Name | Manual |
| 5 | MIDDLE | Char | 15 | X(15) | Required | Legal Middle Name | Manual |
| 6 | LN_TITLE | Char | 4 | XXX | Conditional | | Manual |
| 7 | MEDICAID | Char | 7 | A999999 | Mandatory | Medicaid Number | Manual |
| 8 | SSN | Char | 11 | 999-99-9999 | Mandatory | Social Security Number - Key Identifier Field For Linking to Other Databases | Manual |
| 9 | BIRTHDATE | Date | 8 | MM/DD/CCYY | Mandatory | Date of Birth | Manual |
| 10 | PAR_ENROLL | Date | 8 | MM/DD/CCYY | Mandatory | Date of Enrollment OR Re-Enrollment into the Waiver or CSLA | Manual |
| 11 | PAR_FROM | Date | 8 | MM/DD/CCYY | Mandatory | Beginning date of eligibility for this eligibility span | Manual |
| 12 | PAR_THRU | Date | 8 | MM/DD/CCYY | Mandatory | Ending date of eligibility for this eligibility span. | Manual |
| 13 | PAR_CODE | Char | 3 | XXX | Mandatory | PAR Type Indicator Code | Code Table Pick List |
| 14 | PRIOR_CODE | Char | 2 | XX | Required | Prior Placement Indicator Code | Code Table Pick List |
| 15 | PARLVL_COD | Char | 2 | XX | Required | Level of Care Code | Code Table Pick List |
| 16 | OFUNC_CODE | Char | 2 | XX | Required | Overall Functioning Level Code | Code Table Pick List |
| 17 | PRO_END | Date | 8 | MM/DD/CCYY | Required | Ending Date of PRO Certification | Manual |
| 18 | IP_END | Date | 8 | MM/DD/CCYY | Required | Ending Date of Last Individualized Plan | Manual |
| 19 | PLAN_END | Date | 8 | MM/DD/CCYY | Required | Ending Date of Plan Authorization for waivers requiring yearly plans in addition to the IP | Manual |
| 20 | PAR_ST_CO | Char | 1 | X | Mandatory | PAR Status Code | Code Table Pick List |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 21 | PAR_TRM_CO | Char | 5 | X(5) | Required | Termination Type Code | Code Table Pick List |
| 22 | PAR_TRM_DT | Date | 8 | MM/DD/CCYY | Required | Termination Date | Manual |
| 23 | PV_IND | Char | 1 | X | Not Currently Used | Pre-Vocational Indicator | Not Currently Used |
| 24 | PV_ENROLL | Date | 8 | MM/DD/CCYY | Not Currently Used | Beginning Date of Pre-Vocational Enrollment | Not Currently Used |
| 25 | PV_END | Date | 8 | MM/DD/CCYY | Not Currently Used | Ending Date of Pre-Vocational Enrollment | Not Currently Used |
| 26 | SE_CI_IND | Char | 1 | X | Not Currently Used | Supported Employment/CIE Indicator | Not Currently Used |
| 27 | SE_CI_ENRL | Date | 8 | MM/DD/CCYY | Not Currently Used | Beginning Date of Supported Employment/CIE Enrollment | Not Currently Used |
| 28 | SE_CI_END | Date | 8 | MM/DD/CCYY | Not Currently Used | Ending Date of Supported Employment/CIE Enrollment | Not Currently Used |
| 29 | CP_IND | Char | 1 | X | Not Currently Used | Community Participation Indicator | Not Currently Used |
| 30 | CP_ENROLL | Date | 8 | MM/DD/CCYY | Not Currently Used | Beginning Date of Community Participation Enrollment | Not Currently Used |
| 31 | CP_END | Date | 8 | MM/DD/CCYY | Not Currently Used | Ending Date of Community Participation Enrollment | Not Currently Used |
| 32 | SH_IND | Char | 1 | X | Not Currently Used | Specialized Habilitation Indicator | Not Currently Used |
| 33 | SH_ENROLL | Date | 8 | MM/DD/CCYY | Not Currently Used | Beginning Date of Specialized Habilitation Enrollment | Not Currently Used |
| 34 | SH_END | Date | 8 | MM/DD/CCYY | Not Currently Used | Ending Date of Specialized Habilitation Enrollment | Not Currently Used |
| 35 | PCA_IND | Char | 1 | X | Not Currently Used | IRSS/PCA Indicator | Not Currently Used |
| 36 | PCA_ENROLL | Date | 8 | MM/DD/CCYY | Not Currently Used | Beginning Date of IRSS/PCA Enrollment | Not Currently Used |
| 37 | PCA_END | Date | 8 | MM/DD/CCYY | Not Currently Used | Ending Date of IRSS/PCA Enrollment | Not Currently Used |
| 38 | GR_IND | Char | 1 | X | Not Currently Used | GRSS Indicator | Not Currently Used |
| 39 | GR_ENROLL | Date | 8 | MM/DD/CCYY | Not Currently Used | Beginning Date of GRSS Enrollment | Not Currently Used |
| 40 | GR_END | Date | 8 | MM/DD/CCYY | Not Currently Used | Ending Date of GRSS Enrollment | Not Currently Used |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 41 | GUARDIAN | Logical | 1 | T/F | Required | Guardian? | Manual |
| 42 | GUAR_COMM | Char | 20 | X(20) | Conditional | Type of Guardian Comment | Code Table Pick List |
| 43 | CM_SA_CODE | Char | 5 | X(5) | Required | Case Management Service Agency Code | Code Table Pick List |
| 44 | DAY_SA_COD | Char | 5 | X(5) | Obsolete (7/01) | Day Program Service Agency Code | Code Table Pick List |
| 45 | RES_SA_COD | Char | 5 | X(5) | Conditional | Residential/Support Services Service Agency Code | Code Table Pick List |
| 46 | PAR_300 | Char | 1 | X | Required | 300 % Rule Eligibility Indicator (Y/N) | Manual |
| 47 | START_300 | Date | 8 | MM/DD/CCYY | Required | Date of Eligibility Under the 300 % Rule | Manual |
| 48 | END_300 | Date | 8 | MM/DD/CCYY | Required | Date Eligibility Ended Under the 300 % Rule | Manual |
| 49 | NURFAC_IND | Logical | 1 | T/F | Not Currently Used | Used to indicate whether this SLS Waiver PAR record is for a person who has met the Nursing Facility level of care screening | Not Currently Used |
| 50 | HST_TOT | Num | 9 | 999999.99 | Not Currently Used | Total historical plan amount (transferred from first plan field when plan amounts are shifted) | Not Currently Used |
| 51 | HST_DATE | Date | 8 | MM/DD/CCYY | Not Currently Used | Historical plan date (transferred from first plan field when plan amounts are shifted) | Not Currently Used |
| 52 | PLAN1_TOT | Num | 9 | 999999.99 | Not Currently Used | Plan 1 Total plan amount | Not Currently Used |
| 53 | PLAN1_DATE | Date | 8 | MM/DD/CCYY | Not Currently Used | Plan 1 plan date | Not Currently Used |
| 54 | PLAN2_TOT | Num | 9 | 999999.99 | Not Currently Used | Plan 2 Total plan amount | Not Currently Used |
| 55 | PLAN2_DATE | Date | 8 | MM/DD/CCYY | Not Currently Used | Plan 2 plan date | Not Currently Used |
| 56 | SLSMAX_OVR | Num | 9 | 999999.99 | Obsolete (7/01) | Total amount approved for SLS maximum when total expenditures across SLS Waiver and State funded programs will exceed the standard maximum | Manual |
| 57 | SLSMAX_END | Date | 8 | MM/DD/CCYY | Obsolete (7/01) | Ending date of SLS excess maximum approval | Manual |
| 58 | ENVMAX_OVR | Num | 9 | 999999.99 | Conditional | Total amount approved for Environmental Engineering when total expenditures will exceed the standard maximum | Manual |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 59 | ENVMAX_END | Date | 8 | MM/DD/CCYY | Conditional | Ending date of Environmental Engineering excess maximum approval | Manual |
| 60 | PAR_OPT1 | Char | 20 | X(20) | Optional | Optional Field to be Used as Needed | Manual |
| 61 | PAR_OPT2 | Char | 20 | X(20) | Optional | Optional Field to be Used as Needed | Manual |
| 62 | PAR_OPT3 | Char | 20 | X(20) | Optional | Optional Field to be Used as Needed | Manual |
| 63 | PAR_OPT4 | Char | 20 | X(20) | Optional | Optional Field to be Used as Needed | Manual |
| 64 | PAR_OPT5 | Char | 20 | X(20) | Optional | Optional Field to be Used as Needed | Manual |
| 65 | PAR_OPT6 | Char | 20 | X(20) | Optional | Optional Field to be Used as Needed | Manual |
| 66 | PAR_OPT7 | Char | 20 | X(20) | Optional | Optional Field to be Used as Needed | Manual |
| 67 | PAR_OPT8 | Char | 20 | X(20) | Optional | Optional Field to be Used as Needed | Manual |
| 68 | PAR_OPT9 | Char | 20 | X(20) | Optional | Optional Field to be Used as Needed | Manual |
| 69 | PAR_OPT10 | Char | 20 | X(20) | Optional | Optional Field to be Used as Needed | Manual |
| 70 | COMMENT | Memo | 4 | MEMO | Optional | Memo Field for Comments | Manual |
| 71 | LASTUPDATE | Date | 8 | MM/DD/CCYY | Mandatory | Date This Record Was Last Updated | Automatic |
| 72 | USER_ID | Char | 8 | X(8) | Mandatory | ID of the Last User Who Updated This Record | Automatic |
| 73 | PA_ACCT | Num | 12 | 9999 | Mandatory | Assigned by the system to uniquely identify a PAR record | Automatic |
| 74 | RPROVID_NR | Char | 8 | 99999999 | Mandatory | The Requesting provider number to be transmitted to the Medicaid Fiscal Agent | Automatic |
| 75 | PA_CHNG | Logical | 1 | T/F | Conditional | Set by the system to indicate if a change has been made which must be transmitted to the Medicaid Fiscal Agent | Automatic |
| 76 | USROV_UNT | Num | 4 | 9999 | Conditional | User Override # of Authorized Units (days) | Manual |
| 77 | USROV_FY | Char | 9 | 9999-9999 | Conditional | Fiscal Year to which the override applies | Manual |
| 78 | USROV_AMT | Num | 8 | 99999.99 | Not Used Yet | User Override Authorized Amount | Manual |
| 79 | RES_LOC | Char | 5 | X(5) | Conditional | Residential Location Code | Code Table Pick List |

| | | |
|---|---|---|
| **FILE NAME** | **AMPBTRN.DBF** | |
| **INDEX TAGS** | **Pkey** | Pkey_ampbtrn |
| | **P_clmand** | Pkey_clmand |
| | **Amps_prov** | Agency+upper(provid_nr)+upper(medicaid) |
| | **Agencyssn** | Agency+ssn |
| | **Lastname** | Upper(lastname) |
| | **Medicaid** | Medicaid |
| | **Provid_nr** | Provid_nr |
| | **F_tran** | F_tran |
| | **F_cr8** | F_cr8 |
| | **F_cr8date** | F_cr8date |
| | **No_del** | Pkey_clmand FOR f_tran=.F. |
| | **Frmslct00** | Upper(lastname)+" "+upper(firstname) FOR f_tran=.F..AND.extprov=.F. |
| | **Frmslct01** | Medicaid FOR f_tran=.F..AND.extprov=.F. |
| | **Frmslct02** | Provid_nr FOR f_tran=.F..AND.extprov=.F. |
| | **Frmslct03** | Batch_nr FOR f_tran=.F..AND.extprov=.F. |
| | **Frmslct04** | Sort_month FOR f_tran=.F..AND.extprov=.F. |
| | **Frmsltc05** | IIF(amp_lbo_nd=.T.,"T","F") FOR f_tran=.F..AND.extprov=.F. |
| **FILE DESCRIPTION** | **AMPSbatch Billing System Transaction Interface Table**<br><br>This file is updated by the Billing posting program. An AMPBTRN record is created for each billing transaction that the system determines is appropriate for claim generation. The AMPBTRN records are used to create the subsequent claims that are transmitted to the Medicaid Fiscal Agent. Some records may be split into multiple claims while others are combined to make fewer claims. This AMPBTRN file is used by the "AMPSbatch Selection Screen" to identify records to hold, release or delete for claims processing. | |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PKEY_AMPBTRN | Char | 8 | X(8) | Mandatory | Primary Key | Automatic generation |
| 2 | PKEY_CLMAND | Char | 6 | X(6) | Entered By System | Pkey for the Matching Consumer Record in CLMAND | Transferred from Posted Billing Transaction |
| 3 | PKEY_BIPROV | Char | 6 | X(6) | Entered By System | Pkey for Matching Provider Record in BIPROVR | Transferred from Posted Billing Transaction |
| 4 | TRAN_NR | Num | 5 | 99999 | Entered By System | Transaction Number | Transferred from Posted Billing Transaction |
| 5 | AGENCY | Char | 2 | XX | Entered By System | Agency number | Transferred from Posted Billing Transaction |
| 6 | LASTNAME | Char | 25 | X(25) | Entered By System | Last Name | Transferred from Posted Billing Transaction |
| 7 | FIRSTNAME | Char | 15 | X(15) | Entered By System | First Name | Transferred from Posted Billing Transaction |
| 8 | SSN | Char | 11 | 999-99-9999 | Entered By System | Social Security Number | Transferred from Posted Billing Transaction |
| 9 | BILL_MONTH | Char | 6 | MMCCYY | Entered By System | Billing Month of this Transaction | Transferred from Posted Billing Transaction |
| 10 | BATCH_NR | Num | 4 | 9999 | Entered By System | Batch Number | Transferred from Posted Billing Transaction |
| 11 | SERV_CODE | Char | 1 | X | Entered By System | Service Type Code | Transferred from Posted Billing Transaction |
| 12 | PROG_CODE | Char | 2 | XX | Entered By System | Program Code | Transferred from Posted Billing Transaction |
| 13 | SUB_P_CODE | Char | 3 | XXX | Entered By System | Sub-Program Code (used for Support programs billed by service category) | Transferred from Posted Billing Transaction |
| 14 | PROVID_NR | Char | 8 | 99999999 | Entered By System | Medicaid Provider Number | Transferred from Posted Billing Transaction |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 15 | CHG_DATE_1 | Date | 8 | MM/DD/CCYY | Entered By System | 1st Date of Service (From Date) | Transferred from Posted Billing Transaction |
| 16 | CHG_DATE_2 | Date | 8 | MM/DD/CCYY | Entered By System | 2nd Date of Service (To Date) | Transferred from Posted Billing Transaction |
| 17 | BIL_AMTDUE | Num | 9 | 999999.99 | Entered By System | Billable Amount Due | Transferred from Posted Billing Transaction |
| 18 | MEDICAID | Char | 7 | A999999 | Entered By System | Medicaid Number for this Person | Transferred from Posted Billing Transaction |
| 19 | SORT_MONTH | Char | 6 | CCYYMM | Entered By System | Sorting field to sort transactions together that apply to the same month | Transferred from Posted Billing Transaction |
| 20 | AMP_UNIT | Num | 7 | 9999.99 | Entered By System | AMPSbatch Units of Service to bill | Computed from Posted Billing Transaction |
| 21 | AMP_PROG | Char | 2 | XX | Entered By System | AMPSbatch Special Program Indicator | Computed from Posted Billing Transaction |
| 22 | AMP_PROC | Char | 5 | X(5) | Entered By System | AMPSbatch HCPCS Procedure Code | Computed from Posted Billing Transaction |
| 23 | BIRTHDATE | Date | 8 | MM/DD/CCYY | Entered By System | Birth Date | Transferred from PAR or Consumer Record |
| 24 | GENDER | Char | 1 | X | Entered By System | Gender | Transferred from Consumer Record |
| 25 | LOC_CODE | Char | 4 | XXXX | Entered By System | Location / Provider Code | Transferred from Posted Billing Transaction |
| 26 | F_CR8 | Logical | 1 | T/F | Mandatory | Flag: If true: AMPBTRN transaction marked for processing.<br>Set from Posted Billing Transaction to "True".<br>May be changed on the AMPSbatch Selection screen from MARKED (True) to UNMARKED (False).<br>A transaction with (F_CR8 true and F_CR8DATE is on or before the current system date) is ready to be processed into a claim the next time the AMPSbatch Claim Creation process is run. | Automatic/Manual |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 27 | F_CR8DATE | Date | 8 | MM/DD/CCYY | Conditional | Transaction may be processed on or after this date (Mandatory if F_CR8 = True)<br>Set from Posted Billing Transaction to the System Date.<br>May be changed on the AMPSbatch Selection screen to a different date. | Automatic/Manual |
| 28 | F_TRAN | Logical | 1 | T/F | Entered By System | Flag: AMPBTRN transaction posted to AMPTRAN file for processing?<br>Set to true when a transaction is posted to AMPTRAN or deleted. | Automatic |
| 29 | AMPBTRN_CL | Logical | 1 | T/F | Entered By System | Flag: AMPSbatch combine transaction with other transaction to make 1 AMPTRAN transaction? | Automatic |
| 30 | AMPBTRN_SL | Logical | 1 | T/F | Entered By System | Flag: AMPSbatch split transaction to make multiple AMPTRAN transactions? | Automatic |
| 31 | EXTPROV | Logical | 1 | T/F | Entered By System | External Provider Flag (currently not used) | Automatic |
| 32 | LASTUPDATE | Date | 8 | MM/DD/CCYY | Entered By System | Date this record was updated last - Changed when any fields are changed | Automatic |
| 33 | USER_ID | Char | 8 | X(8) | Entered By System | User ID who last updated this record - Changed when any fields are changed | Automatic |
| 34 | AMP_LBO | Date | 8 | MM/DD/CCYY | Conditional | AMPSbatch Late Bill Override Date (Mandatory if AMP_LBO_ND is True) | Manual |
| 35 | AMP_LBO_ND | Logical | 1 | T/F | Entered By System | Flag: AMPSbatch Late Bill Override Need Flag ? (True = needed)<br>Computed based on the system date and the allowable timely filing period for Medicaid claims. If the "To" date of service is beyond timely filing, a Late Bill Override Date is needed. | Automatic |
| 36 | AMP_MOD1 | Char | 2 | XX | Entered By System | 1st Claim Modifier | Automatic |
| 37 | AMP_MOD2 | Char | 2 | XX | Entered By System | 2nd Claim Modifier | Automatic |
| 38 | AMP_MOD3 | Char | 2 | XX | Entered By System | 3rd Claim Modifier | Automatic |
| 39 | AMP_MOD4 | Char | 2 | XX | Entered By System | 4th Claim Modifier | Automatic |

| | | |
|---|---|---|
| **FILE NAME** | **AMPTRAN.DBF**<br>**AMPTRAN.FPT** | |
| **INDEX TAGS** | **Pkey** | Pkey_amptran |
| | **P_ampbtrn** | Pkey_ampbtrn |
| | **P_clmand** | Pkey_clmand |
| | **P_biprov** | Pkey_biprov |
| | **No_del** | Pkey_clmand FOR (ISNULL(amp_recon)).OR.(.NOT.INLIST(amp_recon,"3","6","7")) |
| | **Deleted** | Deleted() |
| | **Rbill_scrn** | Rbill_scrn |
| | **Amp_recon** | Amp_recon |
| | **Patntcntrl** | Patntcntrl |
| | **Sub_numb** | Sub_Numb |
| | **Last_upd** | Patntcntrl+dtos(lastupdate) |
| | **Rbill_0** | Provid_nr+upper(lastname+firstname) FOR rbill_scrn=.T. |
| | **Rbill_1** | Upper(lastname+firstname)+provid_nr FOR rbill_scrn=.T. |
| | **Rbill_2** | Medicaid+provid_nr FOR rbill_scrn=.T. |
| | **Rbill_3** | Patntcntrl FOR rbill_scrn=.T. |
| **FILE DESCRIPTION** | **AMPSbatch Transaction Table**<br><br>This file contains specific billing services and amounts used to create detailed lines of a claim submitted to Medicaid. Each transaction is linked back to records in the AMPBTRN file through the PKEY_AMPBTRN field and forward to the AMPCLAIM file with the PATNTCNTRL field. The AMPTRAN file is used by the "AMPSbatch Rebill Screen" to rebill transactions in for which claims were previously submitted. | |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PKEY_AMPTRAN | Char | 8 | X(8) | Mandatory | Primary Key | Automatic generation |
| 2 | PATNTCNTRL | Char | 15 | X(15) | Entered By System | Patient control number assigned in "AMPSbatch Create Transmission File". program. This identifying number is used to match AMPS and MMIS claim reports back to the original claims submitted. | Automatic |
| 3 | PKEY_AMPBTRN | Char | 8 | X(8) | Mandatory | Pkey for the Matching Record in AMPBTRN | Link to the AMPBTRN Table |
| 4 | PKEY_CLMAND | Char | 6 | X(6) | Entered By System | Pkey for the Matching Consumer Record in CLMAND | Transferred from AMPBTRN Transaction |
| 5 | PKEY_BIPROV | Char | 6 | X(6) | Entered By System | Pkey for Matching Provider Record in BIPROVR | Transferred from AMPBTRN Transaction |
| 6 | TRAN_NR | Num | 5 | 99999 | Entered By System | Transaction Number | Transferred from AMPBTRN Transaction |
| 7 | AGENCY | Char | 2 | XX | Entered By System | Agency number | Transferred from AMPBTRN Transaction |
| 8 | LASTNAME | Char | 25 | X(25) | Entered By System | Last Name (may be manually changed when rebilling) | Transferred from AMPBTRN Transaction |
| 9 | FIRSTNAME | Char | 15 | X(15) | Entered By System | First Name (may be manually changed when rebilling) | Transferred from AMPBTRN Transaction |
| 10 | SSN | Char | 11 | 999-99-9999 | Entered By System | Social Security Number | Transferred from AMPBTRN Transaction |
| 11 | BILL_MONTH | Char | 6 | MMCCYY | Entered By System | Billing Month | Transferred from AMPBTRN Transaction |
| 12 | BATCH_NR | Num | 4 | 9999 | Entered By System | Batch Number | Transferred from AMPBTRN Transaction |
| 13 | SERV_CODE | Char | 1 | X | Entered By System | Service Type Code | Transferred from AMPBTRN Transaction |
| 14 | PROG_CODE | Char | 2 | XX | Entered By System | Program Code | Transferred from AMPBTRN Transaction |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 15 | SUB_P_CODE | Char | 3 | XXX | Entered By System | Sub-Program Code (used for Support programs billed by service category) | Transferred from AMPBTRN Transaction |
| 16 | PROVID_NR | Char | 8 | 99999999 | Entered By System | Medicaid Provider Number | Transferred from AMPBTRN Transaction |
| 17 | CHG_DATE_1 | Date | 8 | MM/DD/CCYY | Entered By System | 1st Date of Service (From Date)<br>(may be manually changed when rebilling) | Transferred from AMPBTRN Transaction |
| 18 | CHG_DATE_2 | Date | 8 | MM/DD/CCYY | Entered By System | 2nd Date of Service (To Date)<br>(may be manually changed when rebilling) | Transferred from AMPBTRN Transaction |
| 19 | BIL_AMTDUE | Num | 9 | 999999.99 | Entered By System | Billable Amount Due | Transferred from AMPBTRN Transaction |
| 20 | MEDICAID | Char | 7 | X999999 | Entered By System | Medicaid Number for this Person<br>(may be manually changed when rebilling) | Transferred from AMPBTRN Transaction |
| 21 | SORT_MONTH | Char | 6 | CCYYMM | Entered By System | Sorting field to sort transactions together that apply to the same month | Transferred from AMPBTRN Transaction |
| 22 | AMP_UNIT | Num | 7 | 9999.99 | Entered By System | AMPSbatch Units of Service | Transferred from AMPBTRN Transaction |
| 23 | AMP_PROG | Char | 2 | XX | Entered By System | AMPSbatch Special Program Indicator | Transferred from AMPBTRN Transaction |
| 24 | AMP_PROC | Char | 5 | XXXXX | Entered By System | AMPSbatch HCPCS Procedure Code | Transferred from AMPBTRN Transaction |
| 25 | BIRTHDATE | Date | 8 | MM/DD/CCYY | Entered By System | Birth Date<br>(may be manually changed when rebilling) | Transferred from AMPBTRN Transaction |
| 26 | GENDER | Char | 1 | X | Entered By System | Gender<br>(may be manually changed when rebilling) | Transferred from AMPBTRN Transaction |
| 27 | LOC_CODE | Char | 4 | XXXX | Entered By System | Location / Provider Code | Transferred from AMPBTRN Transaction |
| 28 | AMPBTRN_CL | Logical | 1 | T/F | Entered By System | Flag: AMPSbatch combine transaction with other transactions to make 1 AMPTRAN transaction.? | Automatic |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 29 | AMPBTRN_CN | Num | 4 | 9999 | Entered By System | Number of records combined from AMPBTRN to create this transaction in AMPTRAN.<br>(NOTE - An AMPBTRN record may be combined with other AMPBTRN records to create a transaction which will have to be split creating multiple transactions in the AMPTRAN file) | Computed |
| 30 | AMPBTRN_SL | Logical | 1 | T/F | Entered By System | Flag: AMPSbatch split transaction to make multiple AMPTRAN transactions ? (due to field limitation of 3 integers for units billed) | Automatic |
| 31 | AMPBTRN_SN | Num | 4 | 9999 | Entered By System | Number of records created in AMPTRAN from the transaction record in AMPBTRN.<br>(NOTE - An AMPBTRN record may be combined with other AMPBTRN records to create a transaction which will have to be split creating multiple transactions in the AMPTRAN file). | Computed |
| 32 | F_320DONE | Logical | 1 | T/F | Entered By System | If F_320DONE is false, this tansaction may be ready to be processed into a claim. | Automatic |
| 33 | AMP_LBO_ON | Logical | 1 | T/F | Entered By System | Flag: AMPSbatch Late Bill Override Need Flag ? (True = needed)<br>Computed based on the system date and the allowable timely filing period for Medicaid claims. If the "To" date of service is beyond timely filing, a Late Bill Override Date is needed. | Automatic |
| 34 | AMP_LBO | Date | 8 | MM/DD/CCYY | Conditional | AMPSbatch Late Bill Override Date (Mandatory if AMP_LBO_ND is True) | Manual or Automatic |
| 35 | AMP_RECON | Char | 1 | X | Entered By System | AMPSbatch Reconciliation Flag | Automatic |
| 36 | AMP_RDATE | Date | 8 | MM/DD/CCYY | Entered By System | AMPSbatch Reconciliation Report Date | Automatic |
| 37 | AMP_TCN | Char | 17 | X(17) | Entered By System | AMPSbatch MMIS Transaction Control Number | Automatic |
| 38 | AMP_REASON | Memo | 4 | MEMO | Conditional | Memo field containing system messages (Any error from fiscal agent or "Automatic Rebill" or "Rebilled on ...") and/or user notes. User notes are entered by the user to record actions taken to resolve a problem, date of corrections, etc. | Automatic/Manual |
| 39 | RBILL_SCRN | Logical | 1 | T/F | Entered By System | If RBILL_SCRN is true, this transaction will be shown in the rebill screen. | Automatic |
| 40 | REBILLALLOWED | Logical | 1 | T/F | Entered By System | If REBILLALLOWED is true, the user is allowed to rebill this transaction. | Automatic |
| 41 | LASTUPDATE | Date | 8 | MM/DD/CCYY | Entered By System | Date This Record Was Last Updated | Automatic |
| 42 | USER_ID | Char | 8 | X(8) | Entered By System | User ID who last updated this record - Changed when any fields are changed | Automatic |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 43 | SUB_NUMB | Num | 6 | 999999 | Entered By System | Submission File Number | Automatic |
| 44 | AMP_MOD1 | Char | 2 | XX | Entered By System | 1st Claim Modifier | Automatic |
| 45 | AMP_MOD2 | Char | 2 | XX | Entered By System | 2nd Claim Modifier | Automatic |
| 46 | AMP_MOD3 | Char | 2 | XX | Entered By System | 3rd Claim Modifier | Automatic |
| 47 | AMP_MOD4 | Char | 2 | XX | Entered By System | 4th Claim Modifier | Automatic |
| 48 | CLAIM_PD | Num | 10 | 9999999.99 | Entered By System | Actual payment on this claim by the MMIS | Automatic |

| | |
|---|---|
| **FILE NAME** | **AMPCLAIM.DBF**<br>**AMPCLAIM.FPT** |
| **INDEX TAGS** | **Patntcntrl** Patntcntrl<br>**Main** Agency + Patntcntrl<br>**Sub_numb** Sub_numb |
| **FILE DESCRIPTION** | **AMPSbatch Claim Table**<br><br>This file contains all of the information that must be transferred into the MMIS claim format (not described in this appendix). It also contains fields to record error information received from the AMPS rejected and MMIS denial reports. The PATNTCNTRL key field links this file back to the AMPTRAN file for display and rebill of rejected and denied claims on the "AMPSbatch Rebill Screen". |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PATNTCNTRL | Char | 15 | X(15) | Entered by the System | Patient control number assigned in "AMPSbatch Create Transmission File". program. This identifying number is used to match AMPS and MMIS claim reports back to the original claims submitted. | Automatic |
| 2 | AGENCY | Char | 2 | XX | Entered by the System | Agency number | Transferred from AMPTRAN Transaction |
| 3 | SUB_NUMB | Num | 6 | 999999 | Entered by the System | Submission File Number | Automatic |
| 4 | BA0SEQNUM | Num | 4 | 9999 | Entered by the System | Batch Sequence Number within this Submission File Number | Automatic |
| 5 | CA0SEQNUM | Num | 5 | 99999 | Entered by the System | Claim Sequence Number within this Batch Sequence Number | Automatic |
| 6 | LASTNAME | Char | 25 | X(25) | Entered by the System | Last Name | Transferred from AMPTRAN Transaction |
| 7 | FIRSTNAME | Char | 15 | X(15) | Entered by the System | First Name | Transferred from AMPTRAN Transaction |
| 8 | SSN | Char | 11 | 999-99-9999 | Entered by the System | Social Security Number | Transferred from AMPTRAN Transaction |
| 9 | PROVID_NR | Char | 8 | 99999999 | Entered by the System | Medicaid Provider Number | Transferred from AMPTRAN Transaction |
| 10 | MEDICAID | Char | 7 | X999999 | Entered by the System | Medicaid Number for this Person | Transferred from AMPTRAN Transaction |
| 11 | CLAIM_REQ | Num | 9 | 999999.99 | Entered by the System | Requested dollar amount for this claim | Transferred from AMPTRAN Transaction |
| 12 | CLAIM_PD | Num | 9 | 999999.99 | Entered by the System | Dollar amount paid for this claim | Automatic |
| 13 | AMP_TCN | Char | 17 | X(17) | Entered by the System | AMPS/MMIS Transaction Control Number | Automatic |
| 14 | AMP_RECON | Char | 1 | X | Entered by the System | Reconciliation Status Code | Automatic |
| 15 | AMP_RDATE | Date | 8 | MM/DD/CCYY | Entered by the System | Reconciliation Date (Report Date) | Automatic |
| 16 | ERR_LINE_1 | Char | 2 | XX | Entered by the System | 1st Claim Line In Error | Automatic |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 16 | ERR_LINE_2 | Char | 2 | XX | Entered by the System | 2nd Claim Line In Error | Automatic |
| 18 | ERR_LINE_3 | Char | 2 | XX | Entered by the System | 3rd Claim Line In Error | Automatic |
| 19 | ERR_LINE_4 | Char | 2 | XX | Entered by the System | 4th Claim Line In Error | Automatic |
| 20 | ERR_LINE_5 | Char | 2 | XX | Entered by the System | 5th Claim Line In Error | Automatic |
| 21 | ERR_LINE_6 | Char | 2 | XX | Entered by the System | 6th Claim Line In Error | Automatic |
| 22 | ERR_LINE_7 | Char | 2 | XX | Entered by the System | 7th Claim Line In Error | Automatic |
| 23 | ERR_LINE_8 | Char | 2 | XX | Entered by the System | 8th Claim Line In Error | Automatic |
| 24 | ERR_LINE_9 | Char | 2 | XX | Entered by the System | 9th Claim Line In Error | Automatic |
| 25 | ERR_CODE_1 | Char | 4 | XXXX | Entered by the System | 1st Claim Line Error Code | Automatic |
| 26 | ERR_CODE_2 | Char | 4 | XXXX | Entered by the System | 2nd Claim Line Error Code | Automatic |
| 27 | ERR_CODE_3 | Char | 4 | XXXX | Entered by the System | 3rd Claim Line Error Code | Automatic |
| 28 | ERR_CODE_4 | Char | 4 | XXXX | Entered by the System | 4th Claim Line Error Code | Automatic |
| 29 | ERR_CODE_5 | Char | 4 | XXXX | Entered by the System | 5th Claim Line Error Code | Automatic |
| 30 | ERR_CODE_6 | Char | 4 | XXXX | Entered by the System | 6th Claim Line Error Code | Automatic |
| 31 | ERR_CODE_7 | Char | 4 | XXXX | Entered by the System | 7th Claim Line Error Code | Automatic |
| 32 | ERR_CODE_8 | Char | 4 | XXXX | Entered by the System | 8th Claim Line Error Code | Automatic |
| 33 | ERR_CODE_9 | Char | 4 | XXXX | Entered by the System | 9th Claim Line Error Code | Automatic |
| 34 | AMP_REASON | Memo | 4 | MEMO | Entered by the System | Memo field providing the error message for each error identified in the 1st through the 9th error codes, by the claim line in error. | Automatic |
| 35 | B_PRINTED | Logical | 1 | T/F | Entered by the System | Flag – Printed? | Automatic |
| 36 | R010_DT | Date | 8 | MM/DD/CCYY | Entered by the System | Date the R010 report was printed | Automatic |

| | |
|---|---|
| **FILE NAME** | **Pqsagy.dbf**<br>**Pqsagy.fpt** |
| **INDEX TAGS** | **Pkey** Pkey<br>**Main** **A**gency + upper(Sa_code)<br>**Main_agy** Agency+upper(sa_code)<br>**Sa_code** Upper(sa_code)<br>**Del_td** Deleted() |
| **FILE DESCRIPTION** | **Program Quality Service Agency Table**<br><br>The Service Agency file contains records that identify service agencies approved to provide services and receive funding from DDD for persons with developmental disabilities. A service agency record must be entered before program approval records or survey records can be entered for a service agency. |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PKEY | Char | 6 | X(6) | Mandatory | Primary Key | Automatic generation |
| 2 | AGENCY | Char | 2 | XX | Mandatory | Agency Number | Code Table Pick List |
| 3 | SA_CODE | Char | 5 | X(5) | Mandatory | Service Agency Code | Code Table Pick List |
| 4 | APROV_DATE | Date | 8 | MM/DD/CCYY | Required | Approval Date for this Service Agency | Manual |
| 5 | SA_TRMDATE | Date | 8 | MM/DD/CCYY | Conditional | Termination Date for this Service Agency | Manual |
| 6 | ACRD_EDATE | Date | 8 | MM/DD/CCYY | Conditional | Accreditation Ending Date (if accredited) | Manual |
| 7 | ACR_PCODE1 | Char | 2 | XX | Conditional | 1st Accredited Program Code | Code Table Pick List |
| 8 | ACR_PCODE2 | Char | 2 | XX | Conditional | 2nd Accredited Program Code | Code Table Pick List |
| 9 | ACR_PCODE3 | Char | 2 | XX | Conditional | 3rd Accredited Program Code | Code Table Pick List |
| 10 | ACR_PCODE4 | Char | 2 | XX | Conditional | 4th Accredited Program Code | Code Table Pick List |
| 11 | ACR_PCODE5 | Char | 2 | XX | Conditional | 5th Accredited Program Code | Code Table Pick List |
| 12 | ACR_PCODE6 | Char | 2 | XX | Conditional | 6th Accredited Program Code | Code Table Pick List |
| 13 | COMMENT | Memo | 4 | MEMO | Optional | Memo field for comments | Manual |
| 14 | USER_ID | Char | 8 | X(8) | Mandatory | User ID of Last User who Updated this Record | Automatic |
| 15 | LASTUPDATE | Date | 8 | MM/DD/CCYY | Mandatory | Date of Last Update to this Record | Automatic |

| | |
|---|---|
| **FILE NAME** | **Pqprog.dbf**<br>**Pqprog.fpt** |
| **INDEX TAGS** | **Pkey** Pkey<br>**Pkey_pqsagy** Pkey_pqsagy<br>**Main** Agency+upper(sa_code)+uperr(serv_code)+upper(appr_pcode)+upper(loc_code)<br>**Agy_sagy** Agency+sa_code<br>**Servagy** Upper(sa_code)<br>**Main_prog** Agency+upper(sa_code)+upper(serv_code)+upper(appr_pcode)+upper(loc_code)<br>**Main_prg** Agency+upper(sa_code)+upper(serv_code)+upper(appr_pcode)+upper(loc_code) |
| **FILE DESCRIPTION** | **Program Quality Program Approval File**<br><br>The Program Approval file contains records that identify programs that service agencies have been approved to provide. It also contains records for group homes which have been approved for Group Residential Services and Supports within each service agency. A program approval record must be entered before survey records can be entered for a group home. |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PKEY | Char | 6 | X(6) | Mandatory | Primary Key | Automatic generation |
| 2 | PKEY_PQSAGY | Char | 6 | X(6) | Mandatory | Pkey for the Matching Record in PQSAGY | Link to the PQSAGY Table |
| 3 | AGENCY | Char | 2 | XX | Mandatory | Agency Number | Code Table Pick List |
| 4 | SA_CODE | Char | 5 | X(5) | Mandatory | Service Agency Code | Code Table Pick List |
| 5 | SERV_CODE | Char | 1 | X | Mandatory | Service Type Code | Code Table Pick List |
| 6 | APPR_PCODE | Char | 2 | XX | Mandatory | Approved Program Code | Code Table Pick List |
| 7 | LOC_CODE | Char | 4 | XXXX | Conditional | Location Code for a Group Home | Code Table Pick List |
| 8 | APROV_DATE | Date | 8 | MM/DD/CCYY | Required | Approval Date for this Program or Group Home | Manual |
| 9 | PRG_TDATE | Date | 8 | MM/DD/CCYY | Conditional | Termination Date for this Program or Group Home | Manual |
| 10 | COMMENT | Memo | 4 | MEMO | Optional | Memo field for comments | Manual |
| 11 | USER_ID | Char | 8 | X(8) | Mandatory | User ID of Last User who Updated this Record | Automatic |
| 12 | LASTUPDATE | Date | 8 | MM/DD/CCYY | Mandatory | Date of Last Update to this Record | Automatic |

| | |
|---|---|
| **FILE NAME** | **Pqsurvey.dbf**<br>**Pqsurvey.fpt** |
| **INDEX TAGS** | **Pkey** Pkey<br>**Pkey_pqsagy** Pkey_pqsagy<br>**Pkey_pqprog** Pkey_pqprog<br>**Main** Agency+upper(sa_code)+upper(srvy_code)+dtos(srvy_date)<br>**Sa_code** Upper(sa_code)<br>**Loc_code** Upper(loc_code)<br>**Surdate** Dtos(srvy_date)+ agency + upper(sa_code)<br>**Main_prg** Pkey_pqsagy+upper(srvy_code)+dtos(srvy_date)<br>**Main_agy** Pkey_pqsagy+upper(serv_code)+upper(srvy_code)+dtos(srvy_date)<br>**Del_td** Deleted() |
| **FILE DESCRIPTION** | **Program Quality Survey Table**<br><br>The Survey file contains records that identify surveys that have been conducted for service agencies or group homes. The latest survey record for a service agency survey type or for a group home is considered the current survey record. Previous surveys are marked as historical records so they may be filtered out on data entry screens and displayed only if the user chooses to do so. |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | PKEY | Char | 6 | X(6) | Mandatory | Primary Key | Automatic generation |
| 2 | PKEY_PQSAGY | Char | 6 | X(6) | Mandatory | Pkey for the Matching Record in PQSAGY | Link to the PQSAGY Table |
| 3 | PKEY_PQPROG | Char | 6 | X(6) | Mandatory | Pkey for the Matching Record in PQPROG | Link to the PQPROG Table |
| 4 | AGENCY | Char | 2 | XX | Mandatory | Agency Number | Automatic |
| 5 | SA_CODE | Char | 5 | X(5) | Mandatory | Service Agency Code | Automatic |
| 6 | LOC_CODE | Char | 4 | XXXX | Conditional | Location Code for a Group Home | Automatic |
| 7 | SERV_CODE | Char | 1 | X | Mandatory | Service Type Code | Code Table Pick List (Automatic for Group Homes) |
| 8 | SRVY_CODE | Char | 2 | XX | Mandatory | Survey Type Code | Code Table Pick List (Automatic for Group Homes) |
| 9 | SRVY_DATE | Date | 8 | MM/DD/CCYY | Mandatory | Date of this Survey | Manual |
| 10 | APROV_DATE | Date | 8 | MM/DD/CCYY | Conditional | Approval Date for this Survey | Manual |
| 11 | RPT_DATE | Date | 8 | MM/DD/CCYY | Conditional | Date the Survey Report was Completed | Manual |
| 12 | SRVY_SCHED | Char | 1 | XX | Mandatory | Survey Schedule Code | Code Table Pick List |
| 13 | SRVY_OCODE | Char | 1 | X | Mandatory | Survey Outcome Code | Code Table Pick List |
| 14 | SRC_CODE | Char | 4 | XXXX | Mandatory | Survey Source Code | Code Table Pick List |
| 15 | SRV_STAFID | Char | 8 | X(8) | Conditional | User ID of DDD Staff Conducting the Survey (if DDD Survey) | Code Table Pick List |
| 16 | SRV_NAME | Char | 25 | X(25) | Conditional | Name of DDD Staff Conducting the Survey (if DDD Survey) | Code Table Pick List |
| 17 | COMMENT | Memo | 4 | MEMO | Optional | Memo field for comments | Manual |
| 18 | USER_ID | Char | 8 | X(8) | Mandatory | User ID of Last User who Updated this Record | Automatic |
| 19 | LASTUPDATE | Date | 8 | MM/DD/CCYY | Mandatory | Date of Last Update to this Record | Automatic |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 20 | PQFILE | Char | 8 | X(8) | Obsolete | Linking Field for PQ File | Obsolete |
| 21 | HISTORY | Logical | 1 | T/F | Mandatory | Indicates if this is a History Record<br>This flag is set to TRUE when a survey record is updated with a new survey date to indicate a new survey has occurred. The current record becomes a history record and a new current survey record is created containing the updates. | Automatic |
| 22 | TERM_DATE | Date | 8 | MM/DD/CCYY` | Conditional | Termination date of the service agency associated with this survey record | Automatic |

| | |
|---|---|
| **FILE NAME** | **Ccmscode.dbf** |
| **INDEX TAGS** | **Agency** Agency<br>**Code** Code<br>**Look_up** Look_up<br>**Lookupdesc** Look_up+descript<br>**Lookupcode** look_up+code<br>**Candidate** Agency+look_up+code<br>**Lk_com_des** Trim(look_up)+","+upper(descript)<br>**Deleted** Deleted() |
| **FILE DESCRIPTION** | **CCMS Code Table Table**<br><br>The CCMS Code file contains a record for each valid code used throughout the system. It is used to validate codes entered into data entry screens by providing lists of valid codes to choose from on data entry screens. |

| FIELD NUMB | FIELD NAME | FIELD TYPE | FIELD SIZE | FIELD FORMAT | FIELD REQUIREMENTS | DESCRIPTION OF FIELD USE | DATA ENTRY TYPE |
|---|---|---|---|---|---|---|---|
| 1 | AGENCY | Char | 2 | XX | Mandatory | Agency Number | Automatic |
| 2 | LOOK_UP | Char | 10 | X(10) | Mandatory | The Look Up Name under which the code is entered | Code Table Pick List |
| 3 | CODE | Char | 5 | X(5) | Mandatory | The code to be used in data entry coded fields | Manual |
| 4 | DESCRIPT | Char | 20 | X(20) | Mandatory | The description to be used in data entry description fields | Manual |
| 5 | TBL_STATUS | Char | 1 | X | Mandatory | Current status of this code (Active or Inactive) | Spinner (A,I) |
| 6 | TBL_TYPE | Char | 1 | X | Mandatory | Code type (DDD or Agency) | Spinner (D,A) |
| 7 | OPTION1 | Char | 5 | X(5) | Conditional | Agency code of the service area associated with this code for day, residential and Support provider/location codes | Manual |
| 8 | OPTION2 | Char | 5 | X(5) | Conditional | Type of provider (Purchase of Service, Direct Service, etc.) for day, residential and Support provider/location codes | Manual |
| 9 | OPTION3 | Char | 5 | X(5) | Conditional | Service Agency code of Purchase of Service provider for day, residential and support provider/location codes | Manual |
| 10 | OPTION4 | Char | 5 | X(5) | Conditional | Type of program or residential setting for residential facility/location codes | Manual |
| 11 | OPTION5 | Char | 5 | X(5) | Conditional | Special use by DDD as needed | Manual |
| 12 | OPTION6 | Char | 5 | X(5) | Conditional | Special use by DDD as needed | Manual |