Georgia Department of Community Health
Georgia Families - Care Management Organization (CMO)
Obstetrical Delivery Payment (DVP) Process

File Submission Instructions (as 7/23/14)
Process for Obstetrical Delivery Payment (DVP)
Data Submission and Verification

File Layout:

• Data Elements:

No.	Data Element	Description	Type	Size
1	CMO Enterprise ID	CMO Enterprise ID.	Alphanumeric	15
2	TCN Number/Claim Number	TCN or claim number assigned to claim by CMO.	Alphanumeric	20
3	Member Medicaid/PCK ID	Member's Medicaid ID (this is the mother's ID).	Alphanumeric	12
4	Member Last Name	Mother's last name as appears on eligibility file.	Alphanumeric	25
5	Member First Name	Mother's first name as appears on eligibility file.	Alphanumeric	13
6	Procedure	A valid Procedure is required. (However, the CMO can use a valid diagnosis code in # 16 below instead if appropriate.)	Alphanumeric	5
7	Admission Date to Hospital	Date of admission: CCYYMMDD.	Numeric	8
8	Delivery Date	Delivery date related to this service: CCYYMMDD.	Numeric	8
9	Billing Provider Last Name	Last name of billing provider.	Alphanumeric	25
10	Billing Provider First Name	First name of billing provider.	Alphanumeric	35
11	Billing Provider Medicaid Number	Billing provider's Medicaid number	Alphanumeric	12
12	Paid Date	Date claim was paid by CMO: CCYYMMDD.	Numeric	8
13	Paid Amount	Amount paid to the provider in dollars: 999999.99	Numeric	9
14	Capitated or FFS Service	If service is capitated or FFS (C or F).	Alphanumeric	1
15	Infant Member ID	Infant Medicaid ID, optional. It is optional in the sense that it can be blank, but there should still be a column reserved for it.	Alphanumeric	12
16	Diagnosis	A code from the List of Valid Diagnosis Codes is required. No decimal point should be included (However, a valid procedure code can be used instead above in #6 if appropriate.)	Alphanumeric	7
17	MMIS Response Code	"X" on inbound request file. Will be filled in and returned to CMO as a success or reject code on the outbound response file.	Alphanumeric	3

Note: **All fields are required** with the exception of the "Infant Member ID" & "MMIS Response Code Field"

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Data Submission

The Care Management Organization (CMO) can submit monthly inbound flat files, using this proprietary file format sent via SFTP to the HP server. However, the files will only be processed once per month. The response file will be placed in the same folder into which the CMO deposits the inbound file. Files will be distinguished by date, sequence number, and CMO ID. See naming standards below for details.

- **Protocol and Frequency for Submission by the Plans**
  The CMO can submit multiple DVP request files monthly. The submission deadline varies each month depending upon when the monthly capitation cycle runs.

  Those files NOT uploaded by the given deadline will be processed by DCH during the next monthly processing cycle.

  DCH will validate the submitted files utilizing a set of edits and audits. Those records on the

  CMO submitted file that fail to pass these edits and audits will be rejected back to the CMO on a response file during that cycle. If the CMO is able to correct the information on the rejected records, they can be resubmitted in the next cycle. On a regular basis, DCH will audit encounter data to validate the submitted data.

- **Media for Submission by the Plans**
  The file will be submitted via SFTP to HP

- **Naming Convention for the Inbound Submitted File**

  The file name should follow the naming convention specified:
  (Case-sensitive, use all caps):

  YYYYMMDD.TTTTTTTTTTTTTTT.DELIVERY_REQUEST.SSSS.TDF.txt

  YYYYMMDD = The date the file was created by the source system

  TTTTTTTTTTTTTTT   = Trading Partner ID for the Payee of the submitting CMO (T_TP.ID_ISA_IDENTIFIER)

  DELIVERY_REQUEST = The name identifying the file as DVP request

  SSSS = Sequence number as defined by the CMO

- **Naming Convention for the Outbound Response File**

  The file name should follow the naming convention specified:

(Case-sensitive, use all caps):

YYYYMMDD.TTTTTTTTTTTTTTT.DELIVERY_RESPONSE.SSSS.TDF.txt

YYYYMMDD = The date the file was created by the source system

TTTTTTTTTTTTTTT   = DCH if 3 chars and trading partner if 15 (see note below)

DELIVERY_RESPONSE = The name identifying the file as DVP response

SSSS = Sequence number. This will be the HP gdg version number

Note: (TTTTTTTTTTTTTTT is variable length depending on outbound or inbound file (3 chars if DCH, 15 if a trading partner)

Data Verification:

1. **Missing Data Elements**
   The DVP process will reject records with missing or incomplete required data elements that are needed to verify and validate the delivery.

2. **Member Verification**
   The DVP process will validate the submitted delivery files against the member eligibility file. This file will be compared against the delivery reports submitted by the health plans in order to verify client identity. The system will check the Medicaid/PCK ID. The verification will consider all merged IDs.

3. **Plan Affiliation for Georgia Families**
   This will validate plan affiliation for the enrolled member on the date of admission. The plan code must be the CMO plan code for Georgia Families that the member was enrolled in on the date of admission.

4. **Delivery Date Verifications**
   The admission date must be equal to or prior to the Delivery date.

5. **Procedure Code Check Edit**
   This will check that the procedure code submitted is a valid delivery related procedure code. Either the procedure code or diagnosis code are required. Both may be submitted and at least one must be valid.

   The list of valid procedure codes will be stored on a Reference table, which can be updated as needed. As of November 1, 2010 the list of valid procedure codes are:

   59400, 59409, 59410, 59412, 59414, 59430, 59510, 59514, 59515, 59525, 59610, 59612, 59614, 59618, 59620, 59622

6. **Diagnosis Code Edit**
   This will check that the diagnosis code submitted is a valid delivery related diagnosis code. Either the diagnosis code or procedure code are required. Both may be submitted and at least one must be valid.

   If an ICD9 diagnosis code is received, the delivery date must be less than or equal to the ICD9 end date denoted in the system when ICD9 codes are still valid. If an ICD10 diagnosis code is received, the delivery date must be greater than or equal to the ICD10 begin date denoted in the system when ICD10 codes become valid.

   The list of valid diagnosis codes will be stored on a Reference table, which can be updated as needed.

   As of June 6, 2011 the list of valid ICD-9 diagnosis codes are:

```
64001, 64081, 64091, 64101, 64111, 64121, 64131, 64181, 64191, 64201, 64202,
64211, 64212, 64221, 64222, 64231, 64232, 6424,  64241, 64242, 64251, 64252,
64261, 64262, 64271, 64272, 64291, 64292, 64301, 64311, 64321, 64381, 64391,
64421, 64501, 64511, 64521, 64601, 64611, 64612, 64621, 64622, 64631, 64641,
64642, 64651, 64652, 64661, 64662, 64671, 6468,  64681, 64682, 64691, 64701,
64702, 64711, 64712, 64721, 64722, 64731, 64732, 64741, 64742, 64751, 64752,
64761, 64762, 64781, 64782, 64791, 64792, 64801, 64802, 64811, 64812, 64821,
64822, 64831, 64832, 64841, 64842, 64851, 64852, 64861, 64862, 64871, 64872,
64881, 64882, 64891, 64892, 64901, 64902, 64911, 64912, 64921, 64922, 64931,
64932, 64941, 64942, 64951, 64961, 64962, 64971, 650,   65101, 65111, 65121,
65131, 65141, 65151, 65161, 65181, 65191, 65201, 65211, 65221, 65231, 65241,
65251, 65261, 65271, 65281, 65291, 65301, 65311, 65321, 65331, 65341, 65351,
65361, 65371, 65381, 65391, 65401, 65402, 65411, 65412, 6542,  65421, 65431,
65432, 65441, 65442, 65451, 65452, 65461, 65462, 65471, 65472, 65481, 65482,
65491, 65492, 65501, 65511, 65521, 65531, 65541, 65551, 65561, 65571, 65581,
65591, 65601, 65611, 65621, 65631, 65641, 65651, 65661, 65671, 65681, 65691,
65701, 65801, 65811, 65821, 65831, 65841, 65881, 65891, 65901, 65911, 65921,
65931, 65941, 65951, 65961, 65971, 65981, 65991, 66001, 66011, 66021, 66031,
66041, 66051, 66061, 66071, 66081, 66091, 66101, 66111, 66121, 66131, 66141,
66191, 66201, 66211, 66221, 66231, 66301, 66311, 66321, 66331, 66341, 66351,
66361, 66381, 66391, 66401, 66411, 66421, 66431, 66441, 66451, 66461, 66481,
66491, 66501, 66511, 66512, 66522, 66531, 66541, 66551, 66561, 66571, 66572,
66581, 66582, 66591, 66592, 66602, 66612, 66622, 66632, 66702, 66712, 66801,
66802, 66811, 66812, 66821, 66822, 66881, 66882, 66891, 66892, 66901, 66902,
66911, 66912, 66921, 66922, 66932, 66941, 66942, 66951, 66961, 6697,  66970,
66971, 66981, 66982, 66991, 66992, 67002, 67012, 67022, 67032, 67082, 67101,
67102, 67111, 67112, 67121, 67122, 67131, 67142, 67151, 67152, 67181, 67182,
67191, 67192, 67202, 67301, 67302, 67311, 67312, 67321, 67322, 67331, 67332,
67381, 67382, 67401, 67402, 67412, 67422, 67432, 67442, 67451, 67452, 67482,
67492, 67501, 67502, 67511, 67512, 67521, 67522, 67581, 67582, 67591, 67592,

67601, 67602, 67611, 67612, 67621, 67622, 67631, 67632, 67641, 67642, 67651,
67652, 67661, 67662, 67681, 67682, 67691, 67692, 67801, 67811, 67901, 67902,
67911, 67912, V270,  V272,  V273,  V275,  V276,  V279
```

   With the exception of V270, V272, V273, V275 and V276, all diagnosis codes will be end dated 9/30/2013. Any DVP request submitted with a date of service after 9/30/2013 with one of the

above diagnosis codes (excluding V270, V272, V273, V275 and V276) will be rejected. However, the request can be resubmitted with one of the "V" diagnosis codes that will be effective (see list below.)

Beginning July 1, 2013, DCH began allowing a DVP for stillborn births. A request for a DVP submitted with a date of service between July 1, 2013 and Sep 30 2013 can have either one of the above diagnosis codes or one of the diagnosis codes listed below that include stillborn births. The list of valid diagnosis codes below will also be stored on a Reference table, which can be updated as needed. However, beginning 10/1/2013 DVP request submitted with dates of service 10/1/2013 and later must include one of the following diagnosis codes or a valid CPT code, and if not it will be rejected. However, the CMO may resubmit with one of the valid diagnosis listed below:

V270, V271, V272, V273, V274, V275, V276, V279

As of July 23, 2014 the list of valid ICD-10 diagnosis codes are:

```
Z370,  Z371,  Z372,  Z373,  Z3750, Z3751, Z3752, Z3753, Z3754, Z3759, Z3760,
Z3761, Z3762, Z3763, Z3764, Z3769,   Z3800, Z3801, Z381,  Z382,  Z383,  Z3830,
Z3831, Z384,    Z386,  Z3861, Z3862, Z3863, Z3864, Z3865, Z3866, Z8368, Z3869,
Z387,  Z388,Z380, Z385
```

However ICD-10 is scheduled to 'go-live' 10/1/2015.

7. **Payment Edit Checks (FFS claims)**
   This edit will check to see if the paid date on the FFS claim paid by the CMO is greater than or equal to the admission date. If the "Capitated or FFS" field contains an "F"; the payment amount must be >$0.00. If the "Capitated or FFS" field contains a "C"; the payment amount must be >= $0.00.

8. **Duplicate Checking**
   Duplicate checking logic will verify that the Member ID on the incoming file is unique on the file. The Member should only be listed once regardless of the number of qualified procedure codes. The CMO cannot submit more than 1 delivery per Member during a cycle. So if a Member delivered on 1/15/2012 and again on 11/30/2012, and the CMO tried to submit both during 1/2013 cycle only one (1) will pay and the other will reject as a duplicate. The CMO must submit one (1) during 1/2013 cycle and the other during 2/2013 or a later cycle.

9. **Gender Check**
   This will check the gender of the Member that delivers. The logic will use the gender of the Member from the MMIS eligibility file. Gender must be female.

10. **MCHB Check**
    This will validate that the member is not enrolled in MCHB with P4HB Aid Category of 180,181, or 183 on the admission date. However, member's that have dual enrollment in Georgia Families' and COE 182 on the date of delivery are eligible for a DVP.

11. **Additional Validations**

In addition, the following two (2) verifications will be done by the DVP process. The CMO may be required to submit proof of service to DCH for any submitted record that would fail the following edits so that failure of those edits can be overridden in the Delivery Kick Payment Detail panel by DCH.

1. Edit 1 – Check mother's age as between 9 and 55 at delivery. If mom's age falls outside of this range, the request will be rejected.

2. Edit 2 – This is the 7th month rule - Any two (2) records for the same member that fall within seven (7) months of each other (i.e. difference between the delivery dates is equal to seven (7) months or less), the request will be rejected. This logic will compare the member ID and delivery date of all incoming request in the current cycle against their history data for the past seven (7) months. If it finds another DVP within seven (7) months the system will reject the current request.

Additional Information:

MMIS RESPONSE CODE

```
SUC             DELIVERY PMT SUCCESSFULLY CREATED
MLN             MEMBER LAST NAME BLANK
MFN             MEMBER FIRST NAME BLANK
MID             INVALID MEMBER MEDICAID ID
AGE             MEMBER AGE INVALID
GND             MEMBER GENDER IS NOT FEMALE
CMO             INVALID CMO ID
TCN             NUM TCN FIELD BLANK
PLN             BILLING PROVIDER LAST NAME BLANK
PFN             BILLING PROVIDER FIRST NAME BLANK
PID             BILLING PROVIDER ID BLANK
IDA             INVALID DATE FORMAT - ADMISSION DATE
IDD             INVALID DATE FORMAT - DELIVERY DATE
IDP             INVALID DATE FORMAT - PAID DATE
DLV             DELIVERY DATE BEFORE IMPLEMENTATION DATE
ADM             ADMISSION DATE AFTER DELIVERY DATE
PDD             PAID DATE BEFORE ADMISSION DATE
PRC             INVALID PROCEDURE CODE
AMT             INVALID PAID AMOUNT
CFI             INVALID CAP/FFS INDICATOR
ASG             MEMBER NOT ASSIGNED TO SUBMITTING CMO ON ADMIT DATE
DUP             DUPLICATE PAYMENT REQUEST ON THIS FILE
SDP             SECOND DVP PAYMENT FOR THIS MEMBER WITHIN 7 MONTHS
HBA             MEMBER HAS HEALTHY BABIES ASSIGNMENT
IDC             INVALID DIAGNOSIS CODES
PDM             PROCEDURE/DIAGNOSIS CODE IS MISSING
PDI             PROCEDURE/DIAGNOSIS CODE IS INVALID
```

ASC x 12N 820 DATA

These records can be identified on the ASC x 12N 820 file as follows:

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The 2000B loop - ENT04 Receiver's Individual Identifier will have a string of contiguous data:

Position 1-4:   Record Type = 2000
Position 5:   Member's Gender = F
Position 6–8:   Capitation Category/Cohort = 618
Position 9-11:   Aid Category = DVP
Position 12-19:   Member's Date of Birth (CCYYMMDD)
Position 20-21:   Member's Service Region (Values 01-06)
Position 22-29:   Payment Issue Date (CCYYMMDD)
Position 30-31:   Capitation Reason Code
Position 32-46:   Regional PMP ID
Position 47-52:   Capitation Month (CCYYMM)
Position 53-67:   Member's Last Name
Position 68-50:   Member's First Name
Position 81:   Member's Middle Initial
Position 82-93:   Member's Medicaid ID