ValueOptions

January 23, 2004

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Procurement Administrator
Office of Procurement
1740 W. Adams Street, Room 303
Phoenix, Arizona 85007

We are pleased to submit our Best and Final Offer to provide Behavioral Health Administration services for Maricopa County, pursuant to ADHS/DBHS RFP No.HP432188. We have carefully considered the issues raised by the ADHS/DBHS Proposal Review Team on January 7th and the questions included in the subsequent Best and Final solicitation. We have modified our initial proposal to address these issues and to clarify our responses to some of the initial RFP questions.

In this response we:

- modified the administrative expense allocation from the parent company to the local ValueOptions Maricopa County RBHA;
- clarified the portion of net earnings that we will commit to community reinvestment initiatives;
- increased the resources devoted to training and provided additional detail regarding our planned training and practice development initiatives;
- restructured the current Network Management and Program Development Department to better align its clinical and non-clinical functions with other departments within our organization;
- strengthened our Provider Relations function by creating new Provider Liaison positions to serve as a single, primary point of contact for each contracted provider;
- described the ways in which we will solicit and utilize consumer and family input in our quality management program;
- provided additional detail regarding development of the children's system, the coordination of provider monitoring across ValueOptions departments, and the implementation of cultural competence initiatives with non-Latino ethnic and cultural minorities; and
- presented additional information about a variety of issues related to our IT and finance functions.

We believe that our Best and Final Offer significantly clarifies and enhances our initial proposal and addresses the issues raised in our meeting with Review Team members on January 7th. We look forward to the opportunity to continue to work with ADHS/DBHS and other stakeholders to build an exemplary system of behavioral health services for the residents of Maricopa County.

Sincerely,

Michael R. Zent

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Chief Executive Officer

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1. As discussed during the site visit/oral presentation, the Offeror indicated it would reduce the amount of administrative cost allocated to the parent company. Describe the new proposal detailing the amount allocated to the parent company and specify the administrative services to be provided by the parent company under the new proposal. Also, describe how the Offeror will use the balance of the administrative funding including practice development initiatives discussed during the site visit. Maximum 2 pages (Volume 1 d)

Past Allocation of Administrative Costs

ValueOptions has always managed the administrative dollars (combined local and corporate) within the 7.5% allowed under the ADHS/DBHS contract. Historically, we have allocated the costs generated from our contract up to the contractually-established administrative percentage. The corporate allocation model through FY04 has not delineated between direct versus indirect expenses.

The corporate allocation represents the allocation of salaries of Corporate staff who provide support to the Maricopa County RBHA as well as the direct allocation of expenses for services that can best be procured from a centralized contract. The latter, for example, includes IT maintenance contracts and insurance premiums. Maricopa County RBHA administrative costs would be significantly higher if these services were not procured as part of a larger package through ValueOptions, Inc. purchasing arrangements.

Expenses are allocated from the ValueOptions' parent company depending on function by one of four primary allocation methods:

- Percent of revenue
- Number of providers
- Number of claims
- Cost of capital of restricted cash deposits

Proposal for the Future Allocation of Administrative Costs from the Parent Company

For the contract effective July 1, 2004, the ValueOptions, Inc. parent company will reduce the corporate overhead allocation to no more than 35% of the total 7.5% allowed administrative cost. Over the life of the contract, ValueOptions will make every effort to move more administrative services to Arizona. Additionally, the ValueOptions Arizona Service Center will purchase directly insurance premiums, outside legal services, IT maintenance contracts, and all other services that are needed to operate the service center. Historically, these costs have been included in the corporate allocation.

The following administrative services will continue to be provided by the parent company and allocated to the Maricopa County RBHA:

- Treasury management
- Tax services
  - Federal
  - Arizona/State
  - Sales/Use tax
  - Vendor 1099's
- Claims check production
- Fixed asset management
- Internal audit
- Employee benefits management
- Payroll
- Salary market surveys
- Security
- WAN support services
- Membership services
- National research and outcomes
- National recovery experts
- Corporate purchasing programs
  - IT Equipment
  - Supplies
  - Facilities Management
- Underwriting/actuarial support
- Compliance:
  - Sarbanes Oxley
  - HIPAA
- Access to new products, pricing, and delivery systems
- Cost of capital
- National data
  - Utilization data from other markets
  - FTE/staffing ratios from other markets
  - Provider/rate comparisons facility
  - Program specifications from other markets
- MHS licensure/system maintenance

- Hosting services
  - 24/7 Systems Availability (web portals, MHS, etc.)
  - Hardware Upgrades
  - OS Upgrades and PTS Releases
  - Daily, weekly, monthly backups
  - File Reorganizations/Optimizations
  - Disk Capacity Planning
  - National Systems Infrastructure Disaster Recovery
  - Telecommunications Support Services
  - Recovery Services (3 hot sites)
  - National Call Center/Clinical Line Disaster Recovery Services (Business Recovery Services)
- Access to Alternative Behavioral System clinical expertise
- Establishment of national quality protocols
- Establishment of national provider relations protocols
- Software development and technical support Services
  - MHS
  - Data Warehousing
  - Electronic Claims Software
  - e-Member and e-Provider Web Portals, electronic authorization/claims technical support line/services
  - Quality Assurance Testing, Training, and Technical Documentation Services for All Software
- Executive leadership
- Establishment of national clinical protocols
- Development/maintenance of utilization management "Best Practices"

A portion of the reduced corporate allocation amount will be used by the ValueOptions Maricopa County RBHA to support practice development and other initiatives discussed during the site visit, including the following:

1. Training and Expanded Clinical Practice Development Initiatives

   These additional monies will be used to support the expanded practice development initiatives and core training curriculum of the Training Department (please refer to BAFO Question 11 for detailed explanation), including the training of ValueOptions staff, provider staff, and state agency staff.

2. Administrative Reorganization

   These additional monies will be used in conjunction with the current funding to hire the new positions identified in the reorganization plan outlined in the RFP response.

3. Automated Clinical Information Sharing System

   These monies will be used to support and enhance the development of a web-based clinical information-sharing system that will enable the real-time sharing of information between ValueOptions and primary care providers, as well as the eventual sharing of information with selected state agency staff (in conformance with HIPAA and state confidentiality regulations).

2. Describe who within the Offeror's organization is responsible for communications between the Offeror and providers. Describe the concept of a single point of contact as discussed during the site visit/oral presentation. Maximum 2 pages (Volume 1 k)

Our initial proposal described the role of the Network Management Department in ensuring the prompt distribution of policy/procedure and other information via Provider Notices. The Director of Network Systems and Operations is responsible for overseeing the provider communication process. In addition to the communication processes described in the proposal, we will assign each provider to a designated ValueOptions Network Management Department staff person who will be responsible for serving as a primary contact and point of communication and problem/issue resolution for the provider.

We adopted the concept of a single point of contact, as discussed during the site visit, and created Provider Liaison positions to support Maricopa County's network providers. Four Provider Liaison positions have been created to serve the more than 80 subcontracted providers and additional agencies and individuals providing services under Single Case Agreements. Each Provider Liaison will be responsible for a provider caseload of 20 – 25 providers at any given time. In response to feedback from providers, we propose to convert and upgrade existing Network Development Coordinator positions within the Network Management Department to Provider Liaisons. As described below, we will restructure the role and functions of these positions to enhance their ability to provide excellent customer service to their assigned providers.

In the past, some providers have felt that their assigned Network Development Coordinators lacked the experience or knowledge to competently respond to the wide range of providers' issues. As a result, providers often made direct contact with multiple ValueOptions administrative staff. These multiple communication channels made it difficult for ValueOptions to communicate effectively with providers and increased the likelihood that providers would receive different responses from multiple staff. We propose to upgrade the minimum job qualifications and to clarify, through job descriptions and internal protocols, the expectations and roles of our new Provider Liaisons.

Enhanced Job Qualifications
Provider Liaisons will be expected to have significant clinical/programmatic experience and knowledge in at least one of our three programmatic areas – Serious Mental Illness, Children's Behavioral Health, or Adult General Mental Health/Substance Abuse. Ideally, Provider Liaisons will have had work experience in a provider agency setting in order to enhance their understanding of administrative and clinical/program issues at the provider level. Our primary goal will be to hire individuals who (1) have credibility with all levels of provider agency staff and (2) have a good understanding of RBHA department operations and who can therefore effectively facilitate the resolution of provider issues and problems within and across departments.

Expanded Provider Liaison Role
The role of Provider Liaison staff will be to:

- Maintain direct and frequent communication with provider management staff regarding contract discussions, problem solving, provider performance, and other technical assistance and training needs;
- Assume daily operational responsibility for facilitating prompt communication of all relevant operational and policy/procedure information to the provider;
- Facilitate interdepartmental communication and problem-resolution regarding issues affecting the provider;
- Assist in the logistical aspects of the contracting process, including the coordination of contract negotiations; and
- Become knowledgeable and informed regarding the provider's performance in the following areas: quality management, data validation, contract performance, grievance and appeals, and the implementation of corrective actions.

It will not be the job of Provider Liaisons to directly solve all provider problems, but instead to provide an single, direct, and easily-accessible point of contact for the provider and to facilitate and ensure the timely completion of cross-departmental problem-solving on the provider's behalf.

Specific Provider Liaison Responsibilities
Specific responsibilities of Provider Liaison staff will include the following:

- Triage calls from assigned provider agency staff and facilitate a timely, accurate, customer friendly response. Types of calls include:
  - Questions regarding provider contract
  - Credentialing
  - Policy and procedures
  - System requirements
  - Single case agreements
  - Requests for training and/or technical assistance
  - Complaints about ValueOptions staff/clinics
- Collaborates with all RBHA Departments related to provider/network issues. Types of calls include:
  - Provider contract compliance
  - Program development and implementation
  - Provider performance issues and/or needs for training or technical assistance
  - Identification of new providers/programs
  - Single case agreements
  - Policy and procedures
  - System requirements
  - Client specific issues
  - Complaints about providers
- Coordinate with population-specific Program Managers in the Clinical Department regarding provider issues/concerns.
- Arrange and facilitate meetings with providers and internal staff regarding issues/concerns.
- Provide technical assistance to providers to familiarize them with ValueOptions policies and procedures and ValueOptions-ADHS/DBHS contract requirements.
- Maintain telephonic contact twice a month (at a minimum) with each assigned provider CEO to offer assistance, communicate system changes/initiatives, and develop positive relationships.
- Participate in quarterly onsite meetings at the provider agency to learn about provider programs, offer assistance and discuss system requirements/changes.

In addition, for new providers entering the system, Provider Liaison staff will participate in the Initial Credentialing Site Visit with ValueOptions credentialing staff and organize and facilitate New Provider Orientation sessions in accordance with established protocols.

Assignment of Provider Liaison Caseloads
The methodology for assigning Provider Liaisons to providers will involve the matching of provider services and programs to the area of programmatic expertise of each Liaison. The primary consumer population served by the provider will guide the assignment process. One Provider Liaison will be assigned to residential providers who do not deliver outpatient services. We believe that the restructuring and upgrading of Provider Liaison positions will greatly enhance our ability to provide timely, responsive customer service to our providers and will provide a single point of contact that reduces redundancy and confusion in our interface with provider staff.

Tracking and Trending of Provider Issue Resolution; Provider Satisfaction Surveys
To improve internal oversight of our provider relations function, we will implement systems to track the issue resolution process that will be managed by Provider Liaisons. Similar to the tracking of problem resolutions in the Customer Service Department, the Network Management tracking system will allow us to monitor the timeliness with which provider problems or issues are resolved and to track and trend the number and types of issues that are presented by specific providers or provider types. In addition, the Network Management Department will participate in the design and administration of an annual Provider Satisfaction Survey to help identify opportunities for improvement in the new Provider Liaison function.

3. As discussed during the site visit/oral presentation, describe the management services the Offeror will subcontract including any administrative services provided by any affiliated organizations. Maximum 2 pages (Volume 1 i)

In the next contract period, the ValueOptions Maricopa County RBHA will hold one management services subcontract with a non-affiliated organization and three contracts with ValueOptions-affiliated organizations. In addition, as described in our response to Question 1, the ValueOptions parent company will provide specified administrative services and support for the Maricopa County RBHA. The details of these subcontracts and relationships are as follows:

Non-Affiliated Organizations

Management Services Subcontract
ValueOptions holds a subcontract for management services with:

Systems Xcellence USA, Inc.
2505 S. Finley Rd., Suite 110
Lombard, IL 86048-4867
(630) 268 - 3600

At the direction of ValueOptions, Systems Xcellence USA, Inc. supplies online transaction processing of prescription drug claims for programs and benefit plans relating to prescription drug services provided by participating pharmacies to consumers enrolled in ValueOptions programs. Compensation is transaction-based, utilizing a sliding fee schedule.

Affiliated Organizations

Administrative Services
The ValueOptions Arizona Service Center receives administrative services from ValueOptions, Inc., the parent company. Administrative services received from the parent company are reimbursed as an overhead allocation on a monthly basis. The major categories of administrative services received from the Parent Company are:

- Treasury management
- Tax services
- Claims check production
- Fixed asset management
- Internal audit
- Employee benefits management
- Corporate purchasing programs
- Underwriting/actuarial support
- Compliance
- Payroll
- Salary market surveys
- National data
- Hosting services
- MHS licensure/system maintenance
- Software development and technical support services
- Security
- WAN support services
- Membership services
- Establishment of national clinical protocols
- Development and maintenance of utilization management “Best Practices”
- Access to Alternative Behavioral System (ABS) clinical expertise
- Establishment of national quality protocols
- Establishment of national provider relations protocols
- Executive leadership
- Cost of capital
- National research and outcomes
- National recovery experts
- Access to new products, pricing, and delivery systems

Other Related Party Transactions

First Hospital Laboratories, Inc. (dba FirstLab, a sister corporation of ValueOptions, Inc.) provides specific laboratory services to the Maricopa County Regional Behavioral Health Authority.

Rx Innovaton, LLC (a subsidiary of Worldside, Inc., which is a subsidiary of FirstLab, a sister corporation of ValueOptions, Inc.) provides pharmaceuticals and specialty pharmacy services to the Maricopa County Regional Behavioral Health Authority.

ABSolute Integrated Solutions, Inc. (a subsidiary of ValueOptions, Inc.) provides licensing of software and support services to the Maricopa County Regional Behavioral Health Authority. The ABSolute system is the SMI consumer tracking and management information system.

4. Describe the amount of profits that will be used to fund the Community Reinvestment. Maximum 1 page (Volume 1 o)

ValueOptions will commit 5% of its net earnings to the Community Reinvestment initiative described in our initial proposal.

We will fully implement the community input process as described in the proposal to guide us in identifying and selecting appropriate reinvestment opportunities. We will target reinvestment funds to a variety of possible provider and community development initiatives, including but not limited to those described in the proposal. We will also use reinvestment funds to assist providers with special management and financial needs to strengthen their financial viability and their ability to provide critical services within the ValueOptions network.

5. As described in the proposal and discussed in the site visit/oral presentation, the way the network function is organized is unacceptable. Consider having the clinical aspects of the Network and Program Development section report to the Chief Clinical Officer or its Deputy, leaving the Network Systems operations and other network functions with Network Management. Maximum 1 page (Volume 2 a)

As suggested above, we will reorganize the reporting relationships of the current Network Management and Program Development Department to better support the clinical and administrative functions within the department. We will reorganize the existing department into two separate and distinct units. We propose the following reconfiguration of staff:

Clinical/Program Development Staff
The clinical/program development aspects of the current Network Department will be combined into a single unit that will report directly to the Chief Clinical Officer. Clinical/program development areas include:

- General Mental Health and Substance Abuse Adult Services (12 FTEs),
- Seriously Mentally Ill Adult Services (1 FTE),
- Children and Adolescence Services (23 FTEs),
- Consumer Affairs staff (2 FTEs), and
- Prevention Education and Outreach Services staff (4 FTEs).

Program development staff are responsible for designing, implementing, and monitoring provider programs and services, including new system initiatives. These staff also provide training and technical assistance to providers and facilitate the resolution of problems that involve clinical or programmatic issues.

We believe that this organizational structure will enhance the coordination of program initiatives and the implementation of consistent clinical principles and practices within and across ValueOptions and its contracted providers. While this is especially important in the area of SMI services due to the provision of clinical services by ValueOptions' Direct Service sites, it is also critical to maintain close coordination between provider services and other ValueOptions direct services, including crisis telephone, evaluation, access line, and rapid response team services. Placing the oversight for all of these services under the new Chief Clinical Officer position will achieve this coordination.

Network Operations and Provider Liaison Staff
The Network Systems and Operations unit will become the Network Management Department and will consist of the following staff: Vice President of Network Management, Administrative Assistant, Director of Network System and Operations, Network System and Operation staff (12 FTEs), and Provider Liaison staff (4 FTEs).

Network Management staff are responsible for the day-to-day operational tasks of network management, including network sufficiency analysis, provider credentialing and privileging, provider liaison and provider communications, and contracting functions, including the production and maintenance of provider contracts and amendments.

Consistent with our initial proposal, the Network Systems and Operations functions will report directly to the Chief Clinical Officer. This would enhance coordination between the clinical/program and network operations functions. We have also considered, as an alternative, having the Network Systems and Operations function report to the Chief Administrative Officer. This would enhance the coordination of these functions with other administrative and financial functions within the organization. We will continue to evaluate the effectiveness of our revised organizational structure and will propose changes in the future if we believe they are warranted.

6. Describe how the Offeror will address cultural and linguistic needs of non-Latinos and other cultures (e.g., Native American, Asian, gender, and sexual preference). Maximum 2 pages (Volume 2 h)

ValueOptions is committed to meeting the cultural and linguistic needs of all of our consumers and their families. During the current contract period we focused primarily on the needs of the Latino population, a rapidly growing and significantly underserved population in Maricopa County. We developed and began to implement a Cultural Competence Plan based on nationally recognized standards. Using the plan as a strategic template for achieving cultural competency, we initiated a comprehensive assessment of our service delivery system, including an in-depth assessment of population trends, enrollment and service delivery patterns, and access to care issues impacting the Latino community. We established contractual goals for children's providers and made a concerted effort to recruit and retain bilingual staff throughout the system. As a result of these activities we were able to increase the enrollment of Title XIX Latino children and the number of Spanish-speaking staff in the system. We also conducted a geo-access analysis to identify high-priority ZIP codes for service delivery expansion to Title XIX Latino adults and children. Our commitment to our minority community is also evident in a number of other initiatives, most notably the establishment of our People of Color Network. With ValueOptions encouragement and financial support, a group of minority providers recognized in this community for their ability to serve minorities was organized into a single network. These providers include Ebony House, Native American Connections, Centro de Amistad, Chicanos Por La Causa and Friendly House – providers who serve not only Latino but also Native American and African American consumers and who have additionally developed gender-based programming for minority women. Finally, ValueOptions has consistently addressed diversity issues in our housing programs. Minority providers have been included in the development and acquisition of permanent housing stock. Much care and attention is paid to community placement of our consumers, with cultural and linguistic needs incorporated into service contracts. Preference for lifestyle choice and gender compatibility has and will continue to be recognized and honored in housing placement.

We are now ready to apply what we have learned in this initial phase of implementation of our Cultural Competence Plan to other racial/ethnic groups and special populations, including special populations defined by gender and sexual orientation. Just as with the Latino population, we will assess the adequacy of our current cultural competency structures and processes, collect and analyze data, develop targeted implementation plans for each cultural group, and then implement a two-pronged effort to train staff and providers and to initiate targeted outreach and engagement activities to achieve our goals.

Finally, we will integrate our expanded cultural competence initiatives into the ongoing activities of all departments, including the network sufficiency analysis functions of the Network Management Department and the monitoring and performance improvement activities within the Quality Management Department.

Assessment of ValueOptions Cultural Competency Structures and Processes

Prior to July, 2004, we will review our Cultural Competency Plan and the composition of our Cultural Competency Committee and will make modifications, if needed, to ensure that issues affecting the multiple racial/ethnic and cultural groups in Maricopa County are fully represented. We will actively seek strong advocates for other cultural groups to complement the Latino advocates who have helped us to identify and address Latino cultural issues in the past five years.

Needs Assessment: Data Collection and Analysis

We will initiate a needs assessment process for all targeted ethnic/cultural groups that encompasses the same core data collection and analysis that we have completed for the Latino population. This includes an analysis of census data, enrollment and service data, provider location and specialized program data, and data on the preferred language of consumers and bilingual capabilities of ValueOptions and provider staff. The data-gathering processes and programming logic for data analysis and reporting that were developed to support our Latino initiatives can now be easily applied to other racial/ethnic groups that are identified in ADHS/DBHS enrollment data sets. As with previous initiatives, we will implement additional surveys to obtain data regarding consumers' preferred languages, and we will continually update our data regarding ValueOptions and provider staff language competencies.

The assessment of special needs defined by gender and sexual orientation is somewhat more complex. Although gender can be readily identified via enrollment data, sexual orientation information must be obtained via key informant surveys and interviews, including enrollment estimates and other service-planning information that specialty providers may be able to contribute. In this area, the inclusion of gay, lesbian, bisexual, and transgender individuals in our planning processes will be very important.

We will conduct a comprehensive needs assessment as described above during the first six months of the new contract cycle. The results of the needs assessment will allow us to identify targeted interventions to increase the linguistic and cultural competency of our system with regards to non-Latino minorities and other special cultures. We anticipate that the needs assessment will identify cultural communities that have special needs for outreach and service-planning, including Asian, Native American, African American, Russian/Eastern European, and Middle Eastern residents of Maricopa County.

Training of ValueOptions and Provider Staff

Diversity and cultural competency will be a major focus of the expanded ValueOptions training program. Training will incorporate the findings from our needs assessment process, as well as an exploration of both general and specific cultural identity issues. We recognize that major ethnic groups are themselves heterogeneous and are comprised of multiple sub-groups. "Asians", for example, are comprised of many nationalities and sub-cultures within each nationality, each sub-group having unique needs and characteristics that must be addressed in outreach, engagement, and service provision. Training will address diversity and cultural competency as complex issues which cannot be addressed through simplistic solutions based on stereotypes.

ValueOptions will also offer training that focuses on gender and sexual preference issues. This training will be designed to provide staff, clinicians, and practitioners a theoretical and practical foundation from which to enhance and increase their effectiveness in treating behavioral health disorders in a manner sensitive to gender and sexual orientation or preference. ValueOptions will also offer staff and provider training to develop awareness and understanding of traditional healing, spirituality and change, and deafness and hearing impairments.

Outreach and Engagement

In addition to those methods noted in our original proposal, our new Community Relations Department will actively solicit input from community members by hosting community meetings and by participating in local agency and neighborhood forums. Through this process, gaps in culturally relevant services within the African American, Native American, Asian and other minority groups will be identified, and we will seek to bridge those gaps by developing collaborative partnerships with minority community providers and by helping providers to develop culturally-sensitive outreach and engagement strategies and clinical interventions. Our efforts are designed to promote awareness of mental health and behavioral health services within minority communities, and to increase penetration by developing culturally competent services for all consumers. In addition to our planned outreach initiatives to the above-mentioned groups, we will:

- Provide outreach and behavioral health education to the Lesbian, Gay and Transgender community through local advocacy organizations, churches, and through targeted media outlets. We will continue our support of Phoenix Shanti and other agencies targeting HIV prevention.
- Complete a survey of our contracted providers to determine the availability and prevalence of gender-based services offered within the network, and will work with providers to develop and integrate such services into their programs.
- Outreach and support Arab-American and Middle-Eastern groups and consumers as they cope with behavioral health issues related to the current world political situation, and work to ensure behavioral health staff remain culturally sensitive to the impact of political events on all our consumers.

Linguistic Needs

As described in our proposal, we actively ensure that services are available in the consumer's preferred language. In addition to English and Spanish, more than 30 different languages are spoken within our provider network, including Arabic, Farsi, Navajo, Vietnamese, and Filipino. We will regularly assess providers' linguistic capabilities to assist us in making appropriate consumer referrals and in developing targeted staff recruitment strategies to better meet the needs of our non-English speaking consumers. As described in our proposal, we will also implement protocols to facilitate the collection of consumer language preferences at intake so that these data can guide our initiatives to recruit and retain multilingual staff.

We fully embrace the cultural competency initiatives described above as well as the additional initiatives described in our initial proposal and look forward to moving into the next phase of implementing these initiatives with non-Latino ethnic/cultural groups.

7. Re-address Volume 2 question j and focus on the issue of "rapidly" adjusting contracts. The methods proposed do not adequately address how Offeror will respond to service needs in a timely manner. Maximum 3 pages (Volume 2 j)

The goal of the ValueOptions contracting function is to ensure that contracts and payment mechanisms are continually in place to support the behavioral health service needs of eligible Maricopa County residents. This involves two contracting processes:

1. The prospective planning of provider contracts based on an evaluation of current/needed capacity and a prediction of consumer service demand; and
2. The rapid production and modification of provider contracts during the year as unanticipated service demands become apparent.

This response will describe our basic contract modification process, including our new initiatives to make contracting processes more efficient and timely. We will also describe the ongoing cross-departmental contract planning process that helps us to match provider capacity to consumer service demand.

Contract Production and Execution

Overview of Basic Contract Modification Process

For contract amendment requests that involve technical changes or that require only limited internal staff review, the contract modification process may be completed very rapidly – often in less than two weeks. For requests that require more complex analysis and internal review (e.g., requests for additional funds, rate increases, or expansion of contracted services), the review and modification process will be completed in not more than 30 days. The following steps will be monitored by Network Systems and Operation staff, and aggregate data from this process will be summarized by the QM/UM Department for review by the QM/UM Committee:

1. Contract request is received; provider is notified immediately of receipt.
2. Contract request is categorized and assigned to a Provider Liaison to implement the most appropriate expedited review process for each request type.
3. Internal review process is completed and recommendations are submitted to Vice President of Network Management and to ValueOptions Chief Executive Officer for approval or denial.
4. If request is approved, appropriate documentation is sent to Contracts Unit for processing of amendment.
5. Provider is notified in writing of the decision to approve or deny the contract modification request.

Current and Planned Enhancements to Expedite Contract Amendments

In prior years the efficiency of the contract amendment process has been negatively impacted by the lack of readily available data upon which to assess provider requests for additional funding. Internal ValueOptions protocols for reviewing available data and making contract recommendations have also been somewhat cumbersome. In order to improve our performance related to the contract modification process, we have instituted the following changes in protocol:

1. During FY04 we implemented protocols to ensure that contract modification requests were accompanied by sufficient provider financial data to allow us to review the request without multiple subsequent requests for provider information.
2. We implemented a cross-departmental review process to ensure the necessary coordination between Finance, Clinical, and Network Management Departments and to ensure an adequate "due diligence" process in the expenditure of ADHS/DBHS contract funds.
3. We developed an automated contract production and tracking process to improve our monitoring of the timeliness of the contracting process.

We are currently implementing additional protocols to eliminate unnecessary delays in the mid-year contract modification process:

1. We will identify a Provider Liaison to be the single point of initial contact for each contracted provider. Contract amendment requests will be submitted to the Provider Liaison, who will be responsible for immediately initiating and expediting the internal review process.

2. We will categorize each contract amendment request and implement internal review processes which are appropriate for that type of request. For instance, requests for technical changes (e.g., provider address/site changes, changes in ADHS/DBHS provider type or OBHL licensure type) will initiate a very limited and rapid review process; changes in work statements will initiate a limited review by Network and Clinical staff; and changes affecting rates or contract dollars will initiate a review that includes the Finance Department. This will expedite many requests with minimal staff involvement, so that staff time can be more productively used to carefully review the more complex contract amendment requests.
3. For requests involving program or funding changes, the Program Design and Development (PDD) Committee will continue to be used to achieve cross-departmental input and recommendations. The frequency of PDD meetings will be increased to weekly, in order to ensure that we meet our performance standard of 30 days processing time for contract amendments.
4. We are implementing closer monitoring of our contracting performance by assigning this function to our Quality Management Department, which will trend and analyze data from the Network Management Department and will report our performance directly to the Quality Management/Utilization Management Committee.
5. We are implementing a "tickler" or "red flag" system to immediately identify and elevate to a higher administrative level any contract amendment request which has not been finalized within 25 days, thus enhancing the probability of our actually completing the process within 30 days.
6. We are implementing a standard form letter that will allow us to communicate to providers the actual outcome of each contract amendment request, including decisions not to amend a contract as well as those to offer contract modifications. This will reduce ambiguity and ensure that providers receive clear and timely information about the outcome of their requests.

Implementation of a Proactive Contract Amendment Process

In our analysis of current contract amendment processes, we have identified several opportunities for improvement in the efficiency of our internal protocols, as described above. In addition, we have also identified changes in protocol that we believe will reduce the *need* for providers to seek mid-year contract amendments. Our long-range goal is to make the contracting process more responsive to changing service demands by proactively anticipating needed changes and implementing them on an ongoing basis throughout each fiscal year. We believe that this will achieve the following desired outcomes:

1. Providers will be reassured that changes in service demand will be reviewed and responded to by ValueOptions before the provider reaches a critical point in attempting to manage its capacity.
2. Confidence in the new process will reduce the frequency and urgency with which providers now request contract modifications.
3. The implementation of a planned, proactive contract modification process will minimize the need for repeated "reactive" processes involving the review and analysis of complex data by multiple ValueOptions departments;
4. The processing of contract amendments will be able to be managed within departmental workloads in a more planful and less disruptive manner.

Therefore, we are implementing the following process to continuously assess and adjust contract capacity to meet service demand by instituting a proactive contract review and modification process.

Quarterly, ValueOptions will complete a thorough review of the demand for services by analyzing the number of intakes, enrollees, encounters, and expenses, by provider and system wide. Based on the increased or decreased demand, contracts may be modified within and/or across providers and fund sources. For instance, if the increase in demand is specific to one provider, ValueOptions Inc. will consider the following:

1. Shifting Access Line referrals to another comparable provider who is has excess capacity, in order to relieve pressure on the provider experiencing unexpected demand;
2. Shifting contract funds and service capacity from providers with excess funding/capacity to those with the ability to provide services beyond those anticipated in the initial annual contract; and/or
3. Adjusting capacity within or across providers by adjusting contract rates to more equitably correlate with provider costs.

The above process is proactive, planned, and orderly. Providers know at the beginning of each year that their needs will be reviewed and that contracts will be adjusted on a regular schedule throughout the contract year.

Implementation of New Contracting Processes

In February 2004 the review process for annual FY2005 contracts will begin. This process will analyze projected demand and service costs by reviewing current trend lines for intakes, enrollments, encounters and expenses by program and provider. Contracts will be based on anticipated demand, and fair and equitable rates will be established at the beginning of the contract year. Anticipating the demand for services and contracting to that demand when the contract is first executed is crucial; if accomplished successfully, it will minimize the subsequent changes that need to be made through either the quarterly contract adjustment process or through individual provider amendment requests. Quarterly contract reviews will be initiated in the first half of FY2005.

Cross-departmental Contract Planning

Mid-year contract amendments are necessitated by the unexpected/unplanned demand for services at specific providers when those providers' contracts were established based on a lesser expected demand or by a different consumer eligibility mix than is reflected in mid-year encounter data. The development of new programs and/or new service locations, in particular, can change provider service demand during the course of a contract cycle.

The need for mid-year contract amendments is greatly reduced to the extent that July 1 annual provider contracts accurately anticipate the nature and quantity of services that consumers will seek from each provider. In order to design sound annual contracts, it is important to involve key staff in a cross-departmental contract planning process. This ensures that relevant data and information from multiple sources guides the development of provider contracts.

The first step in the annual contract-planning process is the assessment of service capacity and the prediction of service demand. We rely on historical utilization trends, as well as planned changes in specific programs, to estimate existing capacity and to anticipate service demand by provider.

The second critical element in the annual contracting process is the establishment of provider service rates that are correlated with the provider's true costs of delivering each service. Rates that greatly exceed provider costs result in the provider's overproduction of contract value and require that we assess whether we should adjust total contract dollars or contract rates in order to maintain equity in the provider system. Rates that are lower than provider costs result in the appearance of underproduction when in fact the provider may need higher rates and/or more contract dollars to meet the demand for services.

In order to create sound annual contracts in a timely manner, we initiate the contract development process in the third quarter of each fiscal year. We review utilization data, provider financial data, and internal program development initiatives to identify the optimal service and funding mix for each provider. During FY04 we began to more closely scrutinize provider financial data, so that in future contracts we could establish differential rates by provider reflecting differences in provider costs. This is a critical component of the capacity-management process that is implemented through the contracting function. Our goal is to deliver all providers with an annual contract during June of each year, so that contracts can be signed and returned to ValueOptions prior to the July 1 start of the fiscal year.

8. Consider using the term "Prior Authorization Criteria" rather than "Clinical Care Criteria" within the Provider Manual Section 3.14. Maximum 1 page (Volume 3 p)

On page 55 of Volume 3 of the ValueOptions response we agree to change "clinical care criteria" to "prior authorization criteria". We also agree to make this change in any other part of the proposal in which the term "prior authorization criteria" would be the more correct term to use.

9. Provide additional information regarding the expansion of Title XIX services including the type of service and timeframes. Maximum 2 pages (Volume 3 u)

ValueOptions will target Title XIX services for expansion in Fiscal Years 2005 and 2006 that will specifically support operating the system consistent with the 12 Principles, full implementation of Child and Family Teams, and the obligations of the JK Settlement. In the following tables, ValueOptions identifies the specific services targeted for expansion, as well as an action plan that outlines the strategies for achieving the expansion.

Expansion of Title XIX Services for FY2005 and FY2006			
TXIX Services	**FY2005 Expansion**	**FY2006 Expansion**	**Total Expansion**
Therapeutic Foster Care	Homes for 55 children	Homes for 55 children	Homes for 110 children
Respite - Non-Facility Based	156,930 units	156,930 units	315,860 units
Respite - Non-Facility Based Extended	446 days	446 days	892 days
Home Care Training (Family Support)	18,237 units	18,237 units	36,474 units
Personal Care	7,650 units	7,650 units	15,300 units
Personal Care Extended	1645 Days	1645 Days	3,290 Days
Living Skills	99,630 units	99,630 units	199,260 units
Peer Support	20 children as peer support 18 Family Support Partners	20 children as peer support	40 children as peer support 18 Family Support Partners

Action Plan for Expansion of Title XIX Services for FY2005 and FY2006

Task	Target Date	Assigned Staff
Increase Therapeutic Foster Care (TFC) Capacity 1. Monitor the progress of recruitment, training and licensing of the existing TFC subcontracted providers 2. Identify barriers to expansion and involve outside parties to facilitate resolution 3. Assess capacity of existing TFC contractors to see if additional contractors are needed 4. Recruit additional TFC providers as needed to achieve expansion goals	1. Ongoing 2. Ongoing 3. September 2004 and every 6 months thereafter 4. October 2004 and as needed thereafter	Program Development Staff, Clinical Staff
Increase Non-Facility Based Respite Capacity 1. Assess capacity of existing respite providers 2. Provide consultation and technical assistance for providers to support their efforts and strengthen individual provider plans for development of respite services 3. Modify contract requirements as necessary with Comprehensive Service Providers to redirect resources and set goals for new capacity 4. Utilize currently contracted specialty providers to expand respite capacity if necessary 5. Recruit additional specialty providers as needed to achieve expansion goals	1. Ongoing 2. Ongoing 3. June 2004, 2005, 2006 4. September 2004 5. October 2004 and as needed thereafter	Program Development Staff, Clinical Staff
Increase Support Services Capacity (i.e. home care training, personal care, living skills) 1. Assess capacity of existing providers 2. Modify contract requirements as necessary with Comprehensive Service Providers to redirect resources and set goals for new support services capacity 3. Utilize currently contracted specialty providers to expand capacity, if	1. Ongoing 2. June 2004, 2005, 2006 3. September 2004	Program Development Staff, Clinical Staff

Task	Target Date	Assigned Staff
necessary 4. Recruit additional specialty providers as needed to achieve expansion goals	4. October 2004 and as needed thereafter	
Develop Peer Support 1. Meet with prevention providers to identify strategies for recruitment of youth as potential peer support providers 2. Identify training needs and develop curriculum 3. Recruit youth and parents for peer support	1. March 2004 2. April 2004 3. Begin April 2004 and ongoing thereafter	Program Development Staff Prevention staff and Providers Training Dept

Rationale and Assumptions Underlying the Expansion of Targeted Services

Therapeutic Foster Care (TFC)
Rationale: TFC is a critical component to providing alternatives to institutional care. ValueOptions understands that there will always be families that are unable, for shorter or longer periods of time, to provide full-time care for their children. TFC provides a non-institutional environment that can lead to better outcomes as children become adults and that can improve the potential for eventual family reunification with natural supports.
Assumptions: Estimates for expansion of TFC account for serving children from DES receiving professional foster care and reaching our overall goal of reducing children in Level I and II placements from an average of over 250 per day to an average of 126 children.

Respite
Rationale: ValueOptions has received feedback from family members, Child/Family Team (CFT) Facilitators, Family Support Partners, Coaches and others that it is difficult to access respite when families are in need. Insufficient respite contributes to requests for out of home care and reduces the effectiveness of Child and Family Teams. ValueOptions recognizes that families need time to rest and gather strength so they can meet the daily challenge of taking care of their children who have significant behavioral health needs.
Assumptions: Respite is expanded by approximately 40 percent over current utilization. ValueOptions believes that significant expansion is necessary to prevent unnecessary out-of-home placements, improve outcomes for children remaining in the home, and respond to implementation of Child and Family Teams for all children in the system.

Home Care Training, Personal Care, Living Skills
Rationale: Home Care Training, Personal Care, and Living Skills are closely-related support services that directly support children and that assist families (including foster families) in developing the necessary skills to effectively care for their children. In addition, these services provide essential support when needed to supplement the care and supervision of the primary caretakers. Similar feedback, as on respite, has been received for support services.
Assumptions: The combination of Home Care Training, Personal Care, and Living Skills is expanded by approximately 40 percent over current utilization. Significant expansion is needed to meet the needs of families.

Peer Support
Rationale: Peer support provided by youth in the system will be a new initiative for ValueOptions. Based on the success of peer mentoring programs in the prevention area, peer support has the potential to be an important resource in helping children and families. Peer support for parents is already established through the use of Family Support Partners. Our goal is to meet the needs of families with complex needs who have fully facilitated Child and Family Teams and study how we can use this resource to assist all families.
Assumptions: We estimated the needed expansion of peer support provided by youth based on reasonable development of a new component to the system. Family Support Partners are based on caseload size of 12 to 15 for intensive need families.

ValueOptions will continually review progress toward expansion in the targeted areas and will modify existing approaches and/or develop new action plans as necessary. Specific services targeted for expansion will be adjusted based on ongoing assessment of need. In addition, as we continue to review and learn about what is most helpful to families, new services will be added for targeted expansion.

10. As discussed during the site visit/oral presentation, provide additional information regarding the use of national experts/coaches for the system for the two year training plan stated on page 73 of Volume 3 response. Maximum 1 page (Volume 3 u.)

ValueOptions will utilize national coaches/experts to assist in implementation of the two year training plan and overall system development. ValueOptions proposes the following plan for Fiscal Years 2005 and 2006. Beginning in April of 2004 and continuing through Fiscal Year 2005 (15 months), ValueOptions will utilize national experts for a total of 465 days. In addition, we propose to use local Child and Family Team (CFT) experts for a total of 152 days to assist primarily in the area of facilitation skill development and development of direct support services. The use of local expertise will provide more responsive assistance for Child and Family Teams and will provide greater flexibility of scheduling than that provided by national experts' on-site schedules. The use of local experts will also assist us in strengthening our long-range capability to provide prompt assistance to providers in developing and maintaining a strong CFT system. ValueOptions proposes to utilize national experts for 186 days in Fiscal Year 2006 and local expertise for 122 days. We believe the areas that national experts will focus on will be developed sufficiently to reduce the days for Fiscal Year 2006. Availability of local expertise will remain at a constant annualized level through Fiscal Year 2006.

Following is a breakdown of proposed areas of need and allocation of days for national and local experts:

Goal	Target Audience	April 2004-June 2005 (15 mo.)	FY2006 (12 mo.)
Increase quality of facilitation; Support clinicians assuming facilitation responsibilities; Provide rapid response support to ValueOptions' Program Development Staff;	Comprehensive Service Provider and Family Involvement Center coaches, Case managers on complex cases, Clinicians, ValueOptions Program Development staff	130 days local experts; 5 days national experts	104 days local experts
Enable coordination between major system partners (includes strategic planning, barriers resolution, development of operating guidelines, and cross training);	ValueOptions Program Development staff	25 days national experts	12 days national experts
Ensure effective clinical participation on CFTs; Develop Clinical strategies that support the CFT process and result in effective change for families; Ensure effective supervision of CFT facilitation;	Clinicians and supervisors on collaborative clinical practice within the model	155 days national experts	62 days national experts
Focus on short-term treatment and return to home and community; Deliver education that introduces new treatment concepts and orientation of management;	Residential Providers	215 days national experts	86 days national experts
Create community and home alternatives to prevent out of home placements; Ensure effective support for children returning from residential treatment and inpatient settings;	ValueOptions Program Development and Implementation Staff	22 days local experts; 12 days national experts	18 days local experts; 5 days national experts
Develop CSP leadership; Identify strategies and techniques for full implementation of CFT model; Ensure effective approaches for family involvement at all level;	Comprehensive Service Providers (CSP)	53 days national experts	21days national experts

ValueOptions is committed to the use of national experts for Fiscal Years 2005 and 2006. We will modify the proposed plan, if necessary, based on discussions with ADHS/DBHS and our stakeholders.

11. As discussed at the site visit/oral presentation, discuss the financial resources that will be devoted to training and how these resources will be used. Specially discuss how these resources will be used to provide clinical training. Maximum 2 pages (Volume 3 w)

Training Resources

ValueOptions currently devotes extensive resources to the training and education of personnel, providers, consumers, families and other stakeholders. A description of all the resources needed to fully implement the training outlined in the ADHS/ValueOptions Contract, Office of Behavioral Health Licensure requirements, Quality Management/Utilization Management (QM/UM) plans and four strategic plans for Adults with Serious Mental Illness (ADHS/DBHS Strategic Plans for Dual Diagnosis, Housing, Employment and Rehabilitation, and Clinical Team Services) follows. This description includes the resources in the Training Department as well as all other RBHA Departments and contracted training resources needed to fully implement the Arizona Vision and ADHS/ValueOptions Contract. The total resources dedicated to the ValueOptions training function will be $4,072,882, excluding the IT staff training resources identified in Question 19.

Components of Proposed Training Program

Part I - Information Dissemination and System Orientation

Some training focuses primarily on dissemination of factual information. ValueOptions will provide this training through the development and dissemination of training modules that will be available initially as in-person training and eventually as self-directed training through an on-line library of training.

ValueOptions estimates that a comprehensive orientation for ValueOptions providers, ValueOptions Direct Service Staff, ValueOptions Community Service Agencies, ValueOptions Therapeutic Foster Care Homes for Children, and ValueOptions Therapeutic Foster Care Homes for Adults that complies with the ADHS/ValueOptions contract will require a total of approximately 230 hours of training.

Creation, maintenance and conversion of these modules to an on-line, self-directed format with pre- and post-testing of competency will require four FTEs for a total cost of $217,800.

Part II - Clinical skills training

ValueOptions recognizes that certain training topics require more than just information dissemination. Therefore a system of training will be implemented to ensure that clinical skills are taught and that clinical competency is tested. ValueOptions will create a system of in-depth training, coaching, mentoring, and competency determination for the following topics:

- Motivational Enhancement Therapy - 1 FTE ($54,450)
- Strength-based Assessment and Treatment Planning - 2 FTE ($108,900)
- Co-occurring Substance Use Disorders - 1 FTE ($54,450)
- Tuition reimbursement - $1,000,000 for outside professional development for employees
- Crisis Intervention Training (CIT) for first responders – 1 FTE ($54,450)
- Child Family Team Process - 2 FTE ($108,900)
- Clinical Supervision and Leadership - 1 FTE ($54,450)
- Housing First - 1 FTE ($54,450)
- Recovery and Rehabilitation - 1 FTE ($54,450)
- Information and Technology training for clinical staff - 4 FTE ($217,800)

The model that will be used for most clinical skills training has already been implemented for Motivational Enhancement Therapy and includes the following:

- In-person or on-line dissemination of clinical information
- Demonstration of clinical skills through multi-media format (e.g., live and video-taped demonstrations)
- Testing of clinical skills through an in-person or audio-tape review
- Follow-up in-person coaching of skills as needed

In addition to developing internal expertise in the above area, ValueOptions recognizes the need to use external experts and coaches to further enhance the ValueOptions System of Care. The following training initiatives will require $1,452,000 in external contracted resources:

- DBT - contract with DBT experts
- Child Family Team Implementation - Coaches
- Child and Family Team Orientation
- Family Involvement

The total cost to implement this intensive system of clinical training, coaching, mentoring, and competency determination is $3,214,300.

Part III – Quality/Performance Improvement Skills Training
ValueOptions will build a system to follow-up on findings based on ongoing review of all ValueOptions performance-monitoring initiatives. The ValueOptions Training Department will work closely with Quality Management and the population-specific advisory committees to respond to specific training needs.

In the past we have focused on training providers and employees in specific clinical topic areas to address performance deficiencies. Our new focus will also include training in how to use performance improvement technologies to identify the reasons for unacceptable results, plan effective actions, and achieve positive change and improved consumer outcomes. ValueOptions will require two FTEs at a cost of $108,900 to create this system of targeted training in quality/performance improvement skills.

Part IV - Administrative Training Functions
The ValueOptions Training Department will fulfill the role of a centralized department responsible for the collection, tracking, trending, and analysis of all training delivered by ValueOptions. To effectively track and monitor all training activities, develop strategic training plans and strategic outcomes, identify gaps in training or training resources and receive and synthesize information from QM/UM and external stakeholders, ValueOptions will require 1 Training Director, 2 Training Managers, and 4 support staff. The total cost of the administrative structure to support the training function is $321,860.

Part V – Non-Employee Costs
ValueOptions will require infrastructure resources to support the overall mission of the ValueOptions Training Plan. A summary of costs associated with the development of a fully functioning training department include the lease of a dedicated training center, new equipment costs, training supplies and copying, utilities and phones, learning management systems and space rental. The total cost of these expenses is estimated at $210,022.

Part VI – Computer Based Training and Information Technology Department Coordination
The ValueOptions Training Department will work in collaboration with the ValueOptions Information Technology Department in the creation of an on-line learning library (Computer Based Training). The on-line learning library will be comprehensive in providing knowledge to ensure a consistent orientation and training to ValueOptions Network Providers, ValueOptions Stakeholders, and ValueOptions employees. The on-line learning library will include clinical as well as other topics. The resources dedicated to training IT employees are outlined in question 19 and are not included in this training budget.

12. Describe how the Offeror will integrate feedback from consumers and family members (families for both adult and children consumers), in the overall Quality Management process. Include how the Maricopa County Steering Committee will inform your quality management structure. Maximum 2 pages (Volume 4 a.3)

One of ValueOptions' highest priorities is to involve consumers and family members in the ongoing development and operations of our Quality Management Program. Consumers and their families are the reason for our existence, and we solicit their input and guidance regarding all aspects of our operations. The stakeholders who serve and advocate for consumers and families offer alternative perspectives and valuable insights into system operations. We plan to continue our partnerships with consumers, families, and their advocates as an ongoing part of our Quality Management program through the activities described below.

Committees

In order to involve consumers, families and their advocates, ValueOptions will continue the three Population-Specific Advisory Committees dedicated to Serious Mental Illness, Children and Adolescents, and General Mental Health/Substance Abuse services. The Advisory Committees will advise the ValueOptions Population-Specific Management Teams about policy, needed actions, and unintended consequences of actions under consideration, and will represent ValueOptions actions and policies accurately to the community. The Advisory Committees will meet monthly and otherwise as needed, and will be composed of consumers, family members, advocates, providers, and external experts. The Advisory Committees will have as a standing agenda item the identification and discussion of quality and utilization management issues and opportunities. In addition, ValueOptions will continue to involve consumers, family members and consumer advocates through their participation in the Community Advisory Board, the Maricopa Consumer Advisory Council, and the Tenant Advisory Committee. The minutes of all of these Committees will be provided to the ValueOptions Quality Management staff who will synthesize issues with input from other sources and trend the data. Quality Management Department staff will present trended results to the Quality Management and Utilization Management Committee (QM/UM Committee), which will review and discuss the concerns and issues identified. The QM/UM Committee will prioritize the issues and will direct that appropriate actions be taken by the ValueOptions Population-Specific Management Teams to improve system performance. In addition, we will utilize these advisory committees as sources of key informant data whenever we implement stakeholder surveys to solicit input on particular quality of care issues.

Forums and Focus Groups

The continuing guidance provided by consumers, families and consumer advocates through community forums and focus groups has proven to be invaluable. During 2003, more than thirty (30) focus groups were conducted in order to obtain input on behavioral health system performance, including service needs and priorities, ValueOptions and provider performance, and recommendations for system improvement. ValueOptions will continue these forums, which will include consumers, families and consumer advocates, throughout the contract period. The forums and focus groups will be conducted on a quarterly basis at a minimum, and will include representatives from all consumer populations (i.e., Serious Mental Illness, Children and Adolescents, and General Mental Health/Substance Abuse). The ValueOptions Quality Management Department will assist in the development of agendas and topics for these meetings, will synthesize the resulting recommendations, and will present them to the QM/UM Committee for further prioritization and action.

Consumer and Family Satisfaction Surveys

ValueOptions uses the Arizona Department of Health Services, Division of Behavioral Health Services Biennial Behavioral Health Recipient Satisfaction Survey as a source of information about consumer and family member perceptions of the strengths of the service delivery system, as well as a source for identifying opportunities for improvement within the system. The ValueOptions Quality Management Department will analyze the results of the surveys in order to identify consumer and family concerns and opportunities for improvement, and will present them to the QM/UM Committee for further prioritization and action.

Analysis of Problem Resolutions, Complaints, Grievances and Appeals

The ValueOptions Quality Management Department will produce quarterly trending analyses of consumer and family Problem Resolutions, Complaints, Grievances and Appeals. These reports will be analyzed by the Quality Management Department for patterns, trends and outliers, and will be submitted to the QM/UM Committee for further prioritization and action.

Consumer Report Card

The ValueOptions Quality Management Department will continue to use the Consumer Report Card, a survey that is conducted by and for consumers with serious mental illness that captures their evaluation of their own recovery efforts as well as the helpfulness of ValueOptions staff in a variety of areas. The information currently obtained is specific to each ValueOptions Direct Service Clinic, but will be expanded in 2004 to also apply to the services offered by contracted providers in the community. The results of these surveys will be analyzed by the Quality Management Department for patterns, trends and outliers, and will be submitted to the QM/UM Committee for further prioritization and action.

Maricopa County Steering Committee

The Maricopa County Steering Committee (now called the "Children's Collaborative") is dedicated to the full implementation of the Twelve Principles contained in the J.K. Settlement Agreement for services to children, adolescents and their families. The Children's Collaborative meets monthly, is currently chaired by the Chief Executive Officer of the Family Involvement Center, and includes the continuing participation of family members, child and family advocates, and providers.

ValueOptions Program Development staff actively participate in the meetings of the Children's Collaborative and will recommend that the Children's Collaborative include as a standing agenda item the identification and discussion of quality management and utilization management concerns and issues to be communicated to ValueOptions through the minutes of the Collaborative. The ValueOptions Quality Management and Utilization Management staff will regularly review the minutes of the Children's Collaborative, synthesize and trend issues, and forward summaries to the QM/UM Committee which will review and discuss the concerns and issues identified. The QM/UM Committee will prioritize the issues identified and will direct that appropriate actions be taken by the ValueOptions Population-Specific Management Teams to improve system performance.

The Children's Collaborative Assessment and Outcomes Subcommittee includes ValueOptions Program Development and Quality Management staff. The Subcommittee provides direction and oversight of all monitoring activities conducted by the Children's Collaborative and the Family Involvement Center. Through the Subcommittee, the Children's Collaborative conducts ongoing reviews of the performance of all Comprehensive Service Providers using the Family Interview Form and the Facilitator Interview Form to identify opportunities for improvement in the following areas: adequacy of the child and family team; cultural competence; services and natural supports; family voice and choice; collaboration; availability of resources and funding; and meeting family goals. The results and recommendations of these reviews are given to the Children's Collaborative and to the Child and Family Teams, and will be given to the Quality Management Department for further analysis of patterns and trends in system performance. The Quality Management Department will provide quarterly analyses of the results and recommendations to the QM/UM Committee for further prioritization and action.

Summary

Specific information from the sources described above will be regularly reviewed, synthesized with information from all other sources and trended by the Quality Management Department. Synthesized, trended information will be presented quarterly to the QM/UM Committee for prioritization and action, which will be taken through the Population-Specific Management Teams. Trended information and results of actions taken will be reported regularly to the Executive Management Team, Advisory Committees, Children's Collaborative and ValueOptions staff. As the above initiatives are implemented, ValueOptions will continue to look for additional opportunities to enhance consumer and family input into our quality management and utilization management processes. The information obtained from the multiple sources described above will provide invaluable guidance as we implement our quality management program and performance improvement initiatives.

13. As discussed during the site visit, describe the Offeror's plan to unite and strengthen provider monitoring (both direct and subcontracted) and site visits conducted by the quality management and utilization management functions. Maximum 2 pages (Volume 4 a.8)

The best practices of both quality management and utilization management in behavioral health care require the retrospective and concurrent review of clinical records, interviews of provider staff, and interviews of consumers. Although necessary to ensure the quality and appropriateness of care, these activities are time-consuming for both the reviewers and for the provider staff and consumers involved. In addition, the reviews require considerable clinical experience and specialized skills to yield meaningful results, identify critical opportunities for improvement, and develop courses of action that result in the most effective service outcomes for consumers. In order to maximize the efficiency of these reviews, minimize any potential disruption to the service delivery system, and provide the most comprehensive and knowledgeable clinical perspective to these reviews, ValueOptions will establish Review Teams that include experienced staff from both the Quality Management and Clinical Operations Departments.

Beginning in 2004, the Quality Management and Clinical Operations Departments will collaboratively conduct Scheduled On-Site Reviews and Ad Hoc Focused Reviews for both contracted and directly operated service providers. In accordance with ADHS/DBHS requirements, ValueOptions will monitor designated services (i.e., Treatment Services, Rehabilitation Services, Medical Services, Family Support, Support Services Including Case Management, Crisis Intervention Services, Inpatient Services, Residential Services, and Behavioral Health Day Programs) and service sites (i.e., Outpatient Clinic, Level I Hospital, Level I Psychiatric Hospital, Level I Subacute Facility, Level I RTC, Level II Behavioral Health Residential, Level III Behavioral Health Residential, Therapeutic Foster Care Home, and Community Service Agency) for both directly operated and contracted providers.

In selecting the cases for joint review by the Quality Management and Clinical Operations Departments, priority will be given to selection of cases based on the following criteria:

- High risk, high volume, or problem prone services or service sites;
- High strategic importance for implementing the Arizona System Principles, Arizona Children's Vision and Principles, or Principles for Persons with a Serious Mental Illness;
- Services or service sites having outstanding corrective actions from 2003; and
- Services or service sites manifesting potential under-utilization or potential over-utilization, as identified by ValueOptions utilization monitors.

All reviews conducted by the Quality Management Department and Clinical Operations Department will use the 2004 ValueOptions Clinical Record Review Tool, which has been developed based on the domains and standards included in the 2003 ADHS/DBHS Independent Case Review, anticipated changes for the 2004 ADHS/DBHS Independent Case Review, the Arizona System Principles; the Arizona Children's Vision and Principles as described in the J.K. Settlement Agreement, the Principles for Persons with a Serious Mental Illness as described in the Arnold v. ADHS Exit Stipulation, the ADHS/DBHS Key Performance Indicators, and the ADHS/DBHS 2003 Administrative Review. The domains in the 2004 ValueOptions Clinical Record Review Tool include:

- Assessment and Treatment Planning
- Consumer and Family Involvement
- Case Management Services
- Outreach and Follow up
- Clinical Liaison
- Cultural Competency
- Medications and Consent
- Coordination with PCP
- Clinical Outcomes
- Service Plans and Service Delivery

The ValueOptions Clinical Record Reviews will be “consumer-based” rather than “provider-based”, so that the cases selected for review will include the clinical records from all directly operated and all contracted service providers for review at the same time using the same tool and standards. The sample of records for review will be randomly selected from consumers who received services within the prior twelve months. Interviews with provider staff and consumers will be conducted as necessary to determine levels of compliance with required standards, and to identify and clarify opportunities for improvement.

The reviewers in the Quality Management and Clinical Operations Departments will complete an extensive education program that includes didactic training on the standards and scoring of the tool, interactive discussion of specific cases with peers and a clinical supervisor, and the attainment of a minimum of 90% adherence to established scores derived from reviews of each of three clinical records (one from each consumer population: serious mental illness, child/adolescent, and general mental health/substance abuse). A sample of all cases reviewed during the year will undergo a second-level review by a clinical supervisor, and periodic studies of inter-rater reliability will be conducted throughout the year.

The goal of these reviews is to assure positive system change through performance improvement. The Quality Management Department will prepare summary reports of its findings and recommendations based on the Annual Site Visits and Ad Hoc Focused Reviews of directly operated and contracted service providers. These reports will be submitted to the Quality Management and Utilization Management Committee, which will identify specific areas for performance improvement actions across the service delivery system or with specific populations, and which will establish the priorities for systemic performance improvement. The reports will also be submitted to providers having identified opportunities for improvement, and summary data from the conjoint Clinical Record Reviews will be included in Provider Report Cards. When performance improvement opportunities are identified, providers must submit a Performance Improvement Plan to the Quality Management Department. The Quality Management Department will review the Performance Improvement Plan, and will either approve the Plan as adequate, or will require additional actions to be developed as a part of the Performance Improvement Plan. The Quality Management Department will provide technical assistance, support and coordination of RBHA performance improvement activities, and will serve as a resource center for expertise in quality improvement technologies and implementation of performance improvement activities to ensure attainment of desired outcomes across the service delivery system. In collaboration with the Training Department, the Quality Management Department will help to develop and will subsequently utilize training modules on using performance improvement technologies to achieve results. Follow-up reviews of providers who have outstanding corrective actions will be strengths-based and will focus on identifying the positive results that have been achieved.

14. During the site visit/oral presentation, the Offeror indicated there was an error in the proposal regarding reviewing 10% of the cases when consumers do not show for follow-up services and reviewing "all" cases in care over 120 days. The Offeror indicated there would be a 10% sample for all. Correct this language. Maximum 1 page (Volume 4 a.10)

ValueOptions will monitor under utilization for outpatient by reviewing a 10 percent random sample of cases closed within 30 days of admission.

ValueOptions will monitor over utilization of outpatient services by reviewing a 10 percent random sample of cases in care over 120 days.

15. During the site visit/oral presentation, the Offeror presented a plan and diagram outlining the Offeror's intention to have a fully redundant system at a local level. Describe the Offeror's plan for implementing this fully redundant system including a diagram of the system. Maximum 5 pages (Volume 5 d)

In December 2003, ValueOptions' Arizona Service Center received an IBM iSeries 810 to serve as a redundant backup to our primary systems in Virginia. We have begun system configuration and testing and will continue these processes until the end of April 2004, with the system planned to come online in May 2004.

The server will be utilized as a "hot" backup server in the event that the corporate iSeries 840 in Virginia goes offline, with the switchover process from the 840 to the 810 resulting in minimal service downtime. The following sections summarize the national and local disaster recovery and business continuity plans, updated to include the Arizona Service Center's new iSeries 810-midrange server.

High-level implementation plan for fully redundant Arizona IBM iSeries 810

Task	Start Date	End Date	Status
Order IBM iSeries 810 Midrange Server	12/01/2003	12/02/2003	Completed
Negotiate transfer of IBM 510	12/01/2003	12/02/2003	Completed
Prepare Arizona Data Center for installation	12/05/2003	12/29/2003	Completed
IBM iSeries 810 Midrange Server received	12/26/2003	12/26/2003	Completed
Order additional server components	01/04/2004	01/30/2004	In Progress
IBM iSeries 810 Midrange Server Installed and configured	01/12/2004	01/15/2004	Completed
System operations testing	01/16/2004	03/15/2004	In Progress
Installation of additional hardware and software	02/02/2004	02/27/2004	Pending
Testing of newly installed hardware and software	03/01/2004	03/19/2004	Pending
"Hot" site redundancy test	03/22/2004	04/23/2004	Pending
Go live with full implementation	04/26/2004	04/30/2004	Pending

The following sections detail how the new midrange server will integrate into the multi-tiered, national and local disaster recovery and business continuity plan. Refer to figure 15.1, note section, for a visual of the multi-tiered plan.

Disaster Recovery and Information Systems (IS) Business Continuity

ValueOptions' IS Department, both at the local and corporate levels, is responsible for maintaining and executing the Disaster Recovery/IS Business Continuity Plan. This plan is regarded as one of the best IS Business Continuity plans in the mental health care industry. It reflects ValueOptions' commitment to ensuring compliance with IS and business requirements in the event of a disaster that might otherwise interrupt normal business operations.

ValueOptions performs standard daily, weekly, monthly, and annual system backups of all servers to ensure that the content of all ValueOptions' production systems can be recovered in the event of a disaster. These backups are performed on both host and Local Area Network (LAN) systems. Applications and production data files are copied to tape. A verification and audit program is then used to confirm that the system backup tapes are complete and accurate. The backup tapes are then stored off-site at a secure storage facility. In the event of a physical disaster, the backup tapes can be used to recover and reload the ValueOptions' production systems, replacement systems or backup systems at a designated disaster recovery site. System backup tapes are rotated regularly to ensure the physical integrity of the tapes, and to minimize tape parity error problems. This industry standardized backup approach provides a fail-safe for all ValueOptions' data and programs to ensure business continuity. Annual backup tapes are retained in a secure, offsite storage facility for a minimum of seven years, or longer if specified by contract.

Local Disaster Recovery/Business Continuity

Our local Data Center, located in the ValueOptions Arizona Service Center Administration Building, houses all local file, email and Data Warehouse business servers, as well as the previously mentioned IBM iSeries 810 "Hot Spare". During the course of the first two quarters of 2004, the Arizona IS Department will implement a new Disaster Recovery/Business Continuity Plan, offering even greater security and redundancy for continued operations than the current plan. This new

approach will eliminate any single point of failure within the data systems and will offer almost seamless transition of services and connectivity should disaster strike at any point within our systems.

Under the proposed plan, an alternate data center will be implemented at an existing Direct Care facility—our Arcadia site. This facility will be equipped with power backup, alarm, and security and fire suppression systems similar to our Administrative Data Center, with the exception that no midrange server will be housed here. In addition, this site will also have direct connectivity to Corporate Headquarters in Reston, Virginia, via the Sprint Frame Relay, as well as a VPN fail-over connection through a one-megabyte circuit to Cox Internet services. This site will also house its own termination of the 45 megabyte Qwest ATM circuit for connectivity to all local sites. (See Figure 15.2)

With the Arcadia Data Center in place, all connectivity paths, both primary and fail-over, from ValueOptions' Direct Care sites to Corporate Headquarters will have been duplicated, offering complete redundancy in the event of a complete loss of connectivity in either location. In addition, each direct care site will have its own broadband Internet connection with secure VPN capabilities for an additional fail-over option should both data centers go offline or should a loss of the local Qwest ATM circuit occur. This VPN fail-over option would allow backup connectivity from the Direct Care sites to either of the two local Data Centers, or Corporate Headquarters in Reston, Virginia in the case of a widespread occurrence. During normal operations, the Direct Care facilities will be divided into two groups, each group pointing to a different Data Center for load balancing.

The Arcadia Data Center will also house backup server equipment for the recovery of email and file server operations in the event of a complete loss of the Primary facility, though these units would require recovery from tape backup. This plan also allows for the upgrade of our HP Net Server 6000 (VO-PHX-DWH1) and its relocation to the Arcadia Data Center, where it will take on the roll of a "live" duplicate of our existing local Data Warehouse (VO-PHX-SQL01). This would allow for almost transparent fail-over should the primary Data Warehouse fail.

This combined effort on the part of the ValueOptions' Corporate and local IS teams will create a total IS Disaster Recovery/Business Continuity Plan that will offer comprehensive defense of systems, data, and processes from a multitude of failures and a variety of points, both on a local and corporate level. We believe that, once fully operational, this plan will be unmatched in the mental health care industry, further showing ValueOptions' continuing commitment to providing the best care possible to the people of the State of Arizona, the Arizona Department of Health Services and all of its local and national providers.

National Disaster Recovery/Business Continuity

Our National Data Center located in Reston, Virginia, houses the IBM iSeries 840 production server and supporting hardware. The iSeries 840 is the production platform for the primary Arizona applications: ABSolute-IS and MHS. A three-day, refillable, 1,000 KVA diesel generator provides continuous backup power to the data center in the event of a power outage. If the power generator detects a power outage, the entire building will be back up within minutes. ValueOptions' computer rooms are also supported with multiple uninterruptible power supplies to provide continuous operations while the building backup power generator is activated. This procedure ensures continuity of processing during a local power failure.

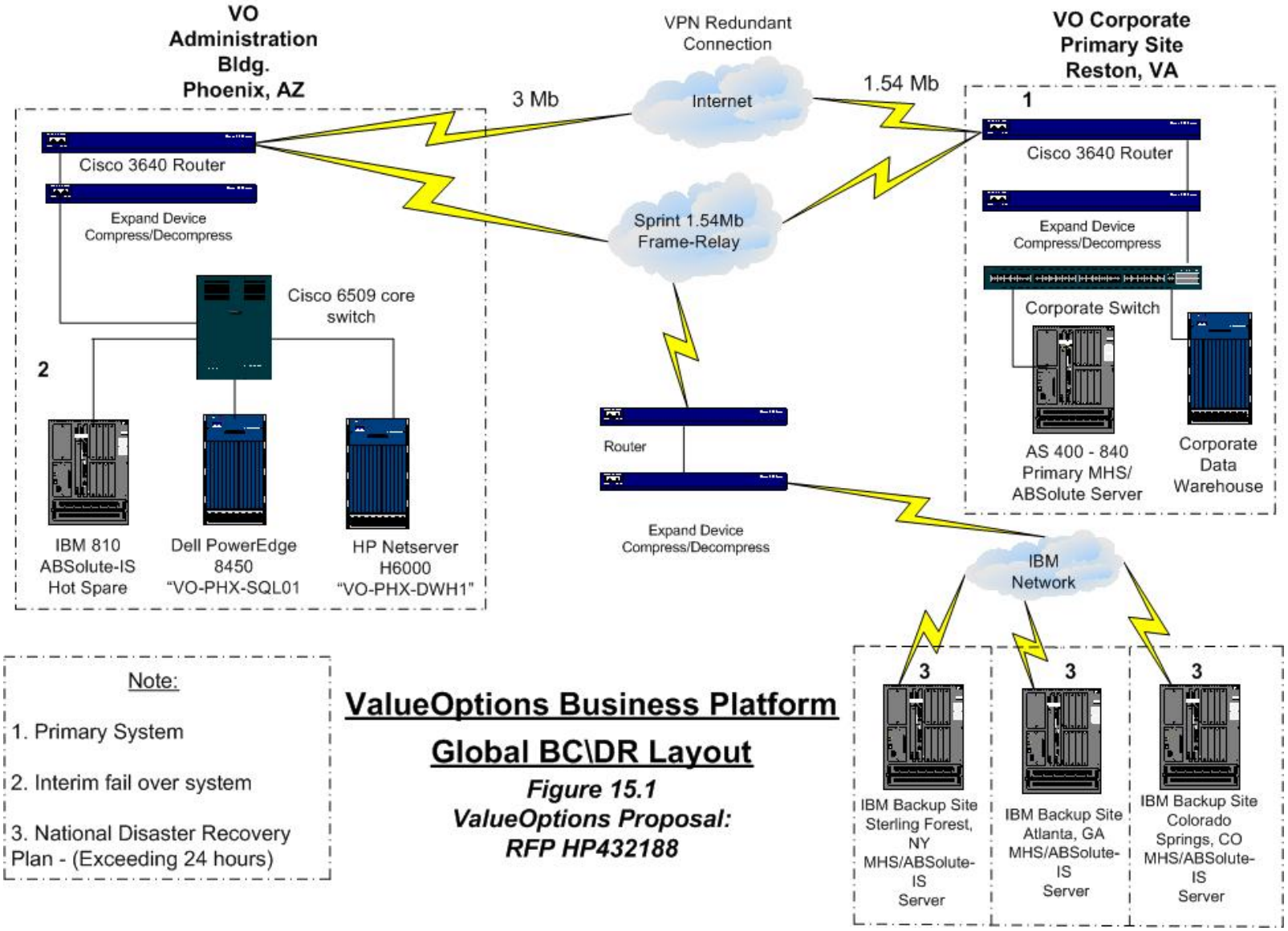
In the event our primary data lines go down, a "Site-to-Site" Virtual Private Network (VPN) provides the redundancy necessary to connect to the corporate offices in Virginia, with connectivity achieved through a three-megabyte connection provided by Cox Communications. ValueOptions is also implementing a "fail-over" system that is currently being configured to provide full redundancy in Arizona. The Arizona client data residing in the ABSolute-IS application will be replicated, real time, from the Reston, Virginia, iSeries 840 to the iSeries 810 residing in the Arizona Data Center. In the event of server outage in Reston, the Arizona iSeries 810 serves as a "fail-over" server for the Arizona client database and ABSolute application. The iSeries 810 will serve as an interim "fail-over" server until the primary IBM site is re-activated, if required. (See Figure 15.1)

In addition, ValueOptions has upgraded its National Disaster Recovery Plan by engaging IBM's Business Continuity and Recovery Services (BCRS). Over the past six years, IBM BCRS has supported over 400 worldwide customers during many types of regional disasters. IBM's BCRS has the authority to assemble all necessary human and technology resources available from the IBM Corporation to ensure a successful recovery from beginning to end. This includes 24 x 7 access to over 500 dedicated recovery specialists, ready-equipped and hardened recovery suite(s), telephone services, office space and

systems reference manuals available for use at the IBM recovery site. IBM BCRS provides exclusive, dedicated recovery suites. When utilizing IBM BCBS resources, ValueOptions will not physically share any equipment or space with another customer, nor will we compromise the exclusivity of our IS environment.

The plan gives ValueOptions access to any one of three geographically distributed IBM recovery sites located in Sterling Forest, New York; Atlanta, Georgia; and Boulder, Colorado. During a recovery event, IBM support personnel are available on-site or on-call to assist ValueOptions in obtaining optimum efficiency in its operation of the hardware and software provided by IBM. Testing of the recovery exercise methodology that IBM BCRS provides is a thorough process, with the primary objective being to conduct a successful recovery exercise. ValueOptions performs, at a minimum, an annual test of the IBM recovery methodology. Our most recent recovery exercise (or test) was conducted during the fourth quarter of 2003. The test consisted of a full successful system restore at the IBM hot sites.

To mitigate the unlikely event of a disaster in Reston, ValueOptions would send the latest tapes to the selected IBM site, where IBM will restore the ABSolute-IS and MHS application software and data to an iSeries 840 backup server. All service center data network traffic would be automatically rerouted to the backup site. In the case of a disruption in the Reston Service Center, the primary and secondary automatic telephone backup centers would provide support, with all calls seamlessly and automatically rerouted to the appropriate backup service center. Personnel in the backup service center are trained to service consumers and also have secure, controlled access to the Arizona applications and data.



Note:

1. Primary System
2. Interim fail over system
3. National Disaster Recovery Plan - (Exceeding 24 hours)

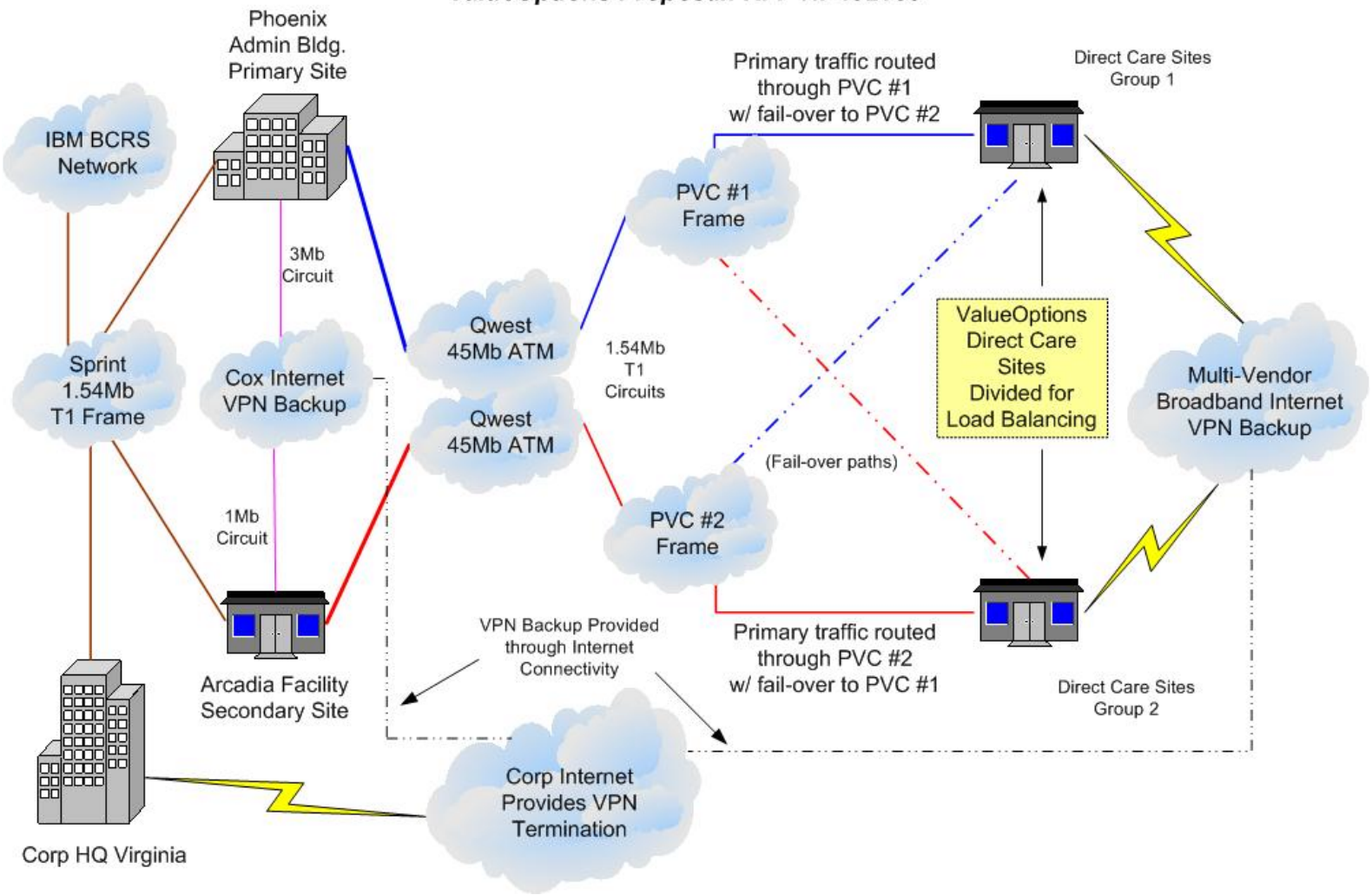
ValueOptions Business Platform

Global BC\DR Layout

Figure 15.1
ValueOptions Proposal:
RFP HP432188

ValueOptions Arizona Service Center
Local BC\DR Project 2004

Figure 15.2
ValueOptions Proposal: RFP HP432188



16. DHS requires all data to be submitted electronically. Describe how paper submissions that are processed through Offeror will be submitted electronically to DHS. Maximum 2 pages (Volume 5 d)

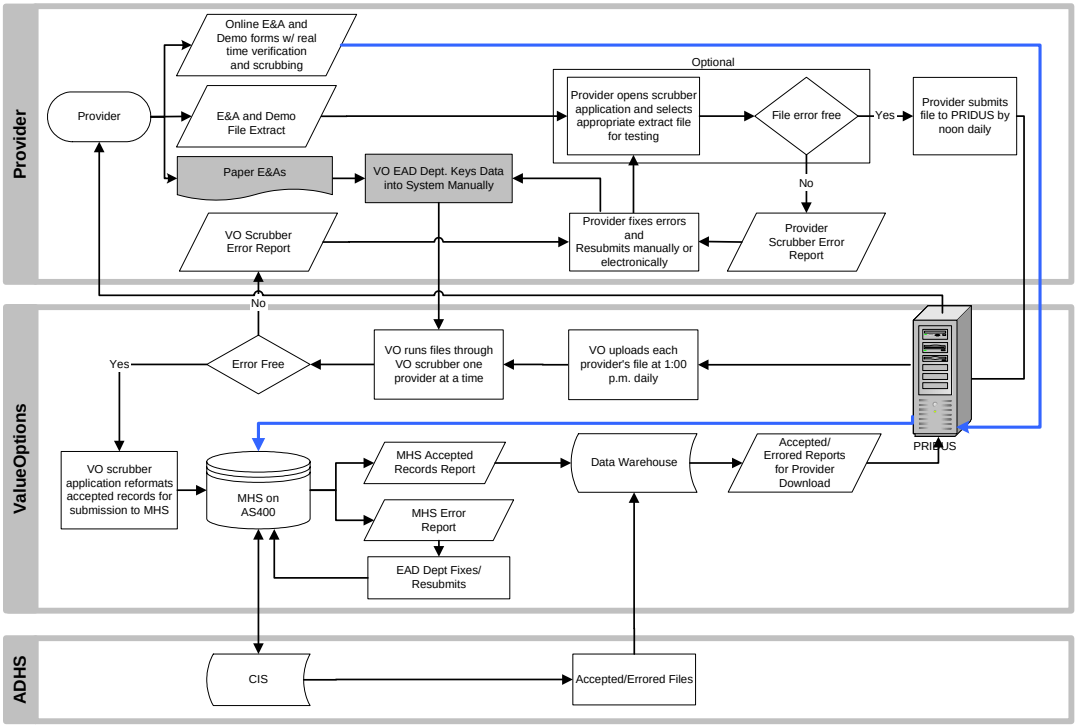
ValueOptions currently accepts paper claims, enrollment, disenrollment, and demographic information from some of our providers. Utilizing ValueOptions Standardized data collection forms and appropriate claim forms, paper submissions via private or public mail courier, hand delivered by agency staff or faxed (except claims). They are then reviewed for completeness, processed and maintained in electronic format, as illustrated in figures 5k.1 and 5k.4 below.

Enrollments/Disenrollment/Demographics

ValueOptions' Enrollment, Assessment and Disenrollment (EAD) Unit receives enrollment and demographic paper submissions daily from our providers. These standardized forms are reviewed for completeness, returned to the provider if incomplete, and then entered into our web-based enrollment system by EAD staff. The data is then subjected to the same data edits and scrubbers as data submitted electronically through PRIDUS, our web based electronic submission server. At this point all paper submissions have been keyed into our system, converted to an electronic record, and maintained in the same way data received electronically is stored. After processing through our systems, records exhibiting errors are returned to their respective providers for correction, while those passing all edits are forwarded to MHS for processing. When all processing is complete they are then transferred to the state in the HIPAA defined format. Once processed at ADHS/DBHS CIS system, error and accepted records reports are produced. Providers are then contacted to provide corrections. After corrections are made to the data it's automatically flagged to be reprocessed at CIS. Figure 5k.1, below, illustrates the process.

Figure 5k.1 (revised 1/20/04)

Electronic Enrollment and Demographic File Submission Process



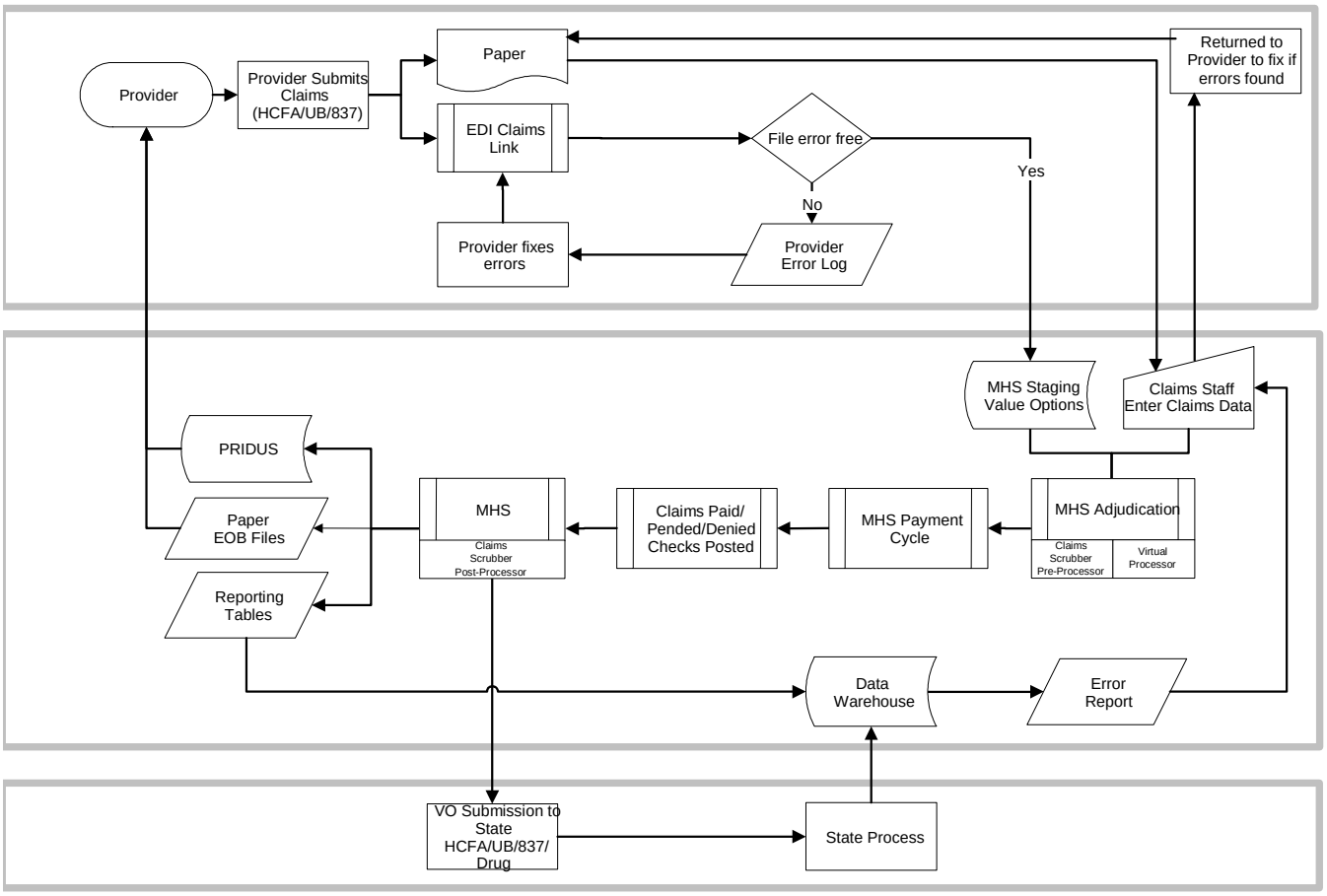
CIS-Client Informatin System
PRIDUS - Provider Reporting Information Download/Upload Server
MHS - Managed Healthcare System

Claims

ValueOptions' Claims Department receives paper claims from our providers on a daily basis. All are reviewed for completeness, returned to the submitting provider if incomplete or in error, date stamped, and imaged according to ValueOptions' Claim Policies. Once imaged, claims personnel key them into our MHS system, where they are subjected to the hard and soft claim edits identified in Volume 5, Section k, are then transferred to the state in the HIPAA defined format. Errors identified after initial submission and processing in MHS, are returned to the submitting provider through paper EOB files, 835 HIPAA Formats, and through summary reporting.

Figure 5k.4 (Revised 01/14/04)

ValueOptions Arizona Claims Submission and Processing



CIS-Client Informatin System
PRIDUS - Provider Reporting Information Download/Upload Server
MHS - Managed Healthcare System
EDI - Electronic Data Interchange

17. Identify the software used for the electronic data interface to transfer information from and to DHS. Maximum 1 page (Volume 5 e)

Software Used for Electronic Data Transfers

ValueOptions utilizes two different software applications—one for uploading, and the other for downloading—to facilitate the transfer of data between ValueOptions and ADHS/DBHS.

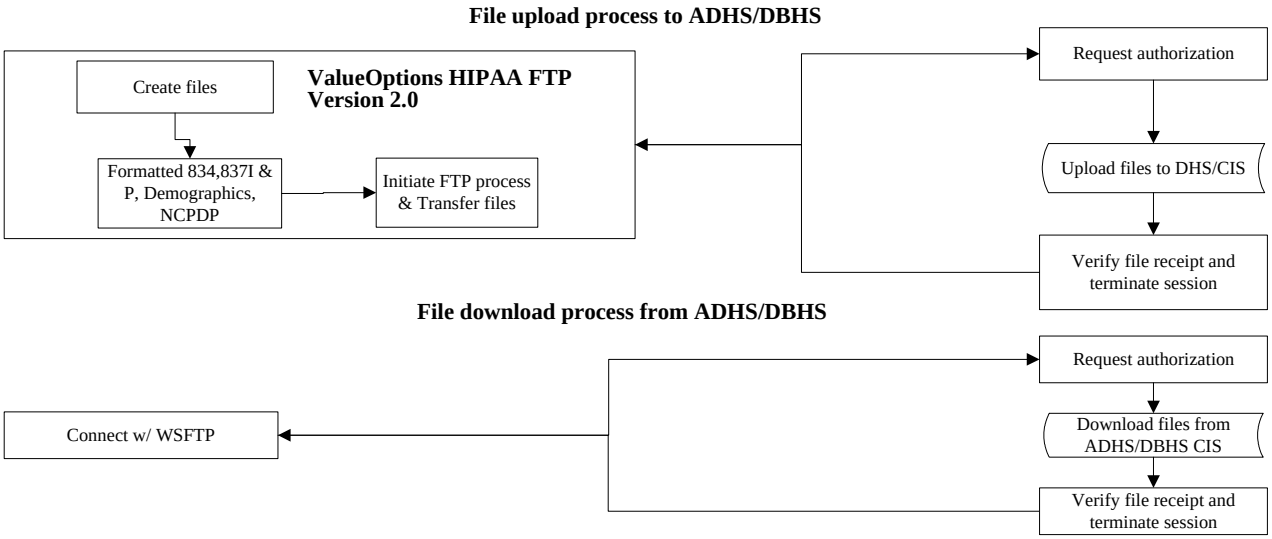
Uploading

ValueOptions' HIPAA FTP Version 2.0 software application is used to facilitate the creation and transfer of data for the following file formats: 834, 837 (Institutional and Professional), Demographic, and NCPDP. ValueOptions developed the application for the sole purpose of transferring files in the HIPAA required formats to ADHS/DBHS. The program initially requests authorization from the destination system to upload data. At that time the user must manually authenticate to the system by providing a required login and password. The application was developed with no embedded passwords to alleviate potential security problems associated with automated systems. After authorization has been granted, the application starts the upload process. When the upload is complete, the session is terminated. This software can be utilized to both upload and download data files. However, we currently utilize it primarily for uploading purposes. (See Figure 17.1 for a visual representation of the process)

Downloading

ValueOptions' Arizona IS Department uses WSFTP Version 5.08, from IPSwitch, for the purpose of downloading our Regional Behavioral Health Authority data files from ADHS/DBHS information systems. The application allows for a standard FTP connection with authorization requirements and access controls, via login security, to download files. Upon successful login authentication, the user downloads the necessary files and the session is terminated upon completion. (See Figure 17.1 for a visual representation of the process)

Electronic File Transfer Process
Fig. 17.1



18. Provide the last six months history of scheduled system downtimes. Provide the last six months history of unscheduled system downtimes. Maximum 5 pages (Volume 5 f)

History of Scheduled and Unscheduled Downtimes
Original Proposal Time Period: 04/03-09/03

In this response, we used the same six-month time period for which summary data was provided in our initial proposal (April, 2003 – September, 2003). Included below are the supplemental tables detailing the history of scheduled and unscheduled downtimes for all core business systems that were identified in Volume 5, section F, of ValueOptions original proposal:

ABSolute Scheduled Downtimes			
Time Offline	**Time Online**	**Description**	**Total Downtime (hh:mm)**
3/5/03 9:00 PM	3/6/03 5:00 AM	HMS Day end – 530	8:00
3/16/03 7:00 PM	3/17/03 4:00 AM	Full backup - Migration Prep	9:00
4/5/03 5:00 AM	4/5/03 10:22 PM	Migration to IBM 400 in VA	18:22
4/13/03 5:00 AM	4/13/03 12:00 PM	Software Upgrade	7:00
4/27/03 3:00 AM	4/27/03 5:00 AM	Software Upgrade	2:00
5/11/03 12:00 AM	5/11/03 3:00 AM	Backup	3:00
5/18/03 2:00 AM	5/18/03 6:00 AM	MHS Migration	4:00
6/1/03 5:00 AM	6/1/03 11:00 AM	Software Upgrade	6:00
6/6/03 8:00 AM	6/6/03 5:00 PM	Router/Switch Install	9:00
6/20/03 6:00 PM	6/20/03 9:00 PM	Network Maintenance	3:00
6/22/03 5:00 AM	6/22/03 11:00 AM	Software Upgrade	6:00
7/3/03 6:00 PM	7/3/03 9:00 PM	Network Maintenance	3:00
7/7/03 12:00 AM	7/7/03 6:00 AM	Backup – Data	6:00
7/29/03 6:00 PM	7/29/03 7:00 PM	Router Maintenance	1:00
8/1/03 8:00 PM	8/1/03 9:00 PM	Network Software Upgrade	1:00
8/9/03 3:00 AM	8/9/03 10:00 AM	Software Upgrade	7:00
8/10/03 1:00 AM	8/10/03 8:00 AM	Backup	7:00
8/13/03 7:00 PM	8/13/03 10:00 PM	WAN Switch Upgrade	3:00
8/22/03 6:30 PM	8/22/03 6:45 PM	Emergency Network Upgrade	0:15
9/5/03 6:00 PM	9/5/03 10:00 PM	Corporate Testing	4:00
9/7/03 5:00 AM	9/7/03 10:00 AM	Software Upgrade	5:00
9/14/03 5:00 AM	9/14/03 10:00 AM	Backup – Data	5:00
9/16/03 5:00 PM	9/16/03 6:00 PM	ISP Migration	1:00
9/23/03 10:00 PM	9/23/03 11:45 PM	ISP Conversion	1:45
		Total Scheduled Downtime	**120:22**

ABSolute Unscheduled Downtimes			
Time Offline	**Time Online**	**Description**	**Total Downtime (hh:mm)**
None			00:00
		Total Unscheduled Downtime	**00:00**

ABSolute Total Downtimes		
	Total Downtime (hh:mm)	**120:22**
	Total Uptime (hh:mm)	**4199:38**
	Percent Downtime	**2.727%**
	Percent Uptime	**97.273%**

MHS Scheduled Downtimes			
Time Offline	**Time Online**	**Description**	**Total Downtime (hh:mm)**
4/6/03 6:00 AM	4/6/03 8:15 AM	Backup	2:15
4/13/03 1:00 AM	4/13/03 7:00 AM	Backup	6:00
4/20/03 11:00 AM	4/20/03 5:10 PM	Maintenance - MHS Migration	6:10
5/3/03 10:50 PM	5/4/2003 6:10 PM	Full backup of AS400 730 in prep to load new MHS Prod A in Reston (moved to Reston)	19:20
5/18/03 10:00 AM	5/18/03 2:27 PM	New 840 Equipment install - New Configuration	4:27
6/1/03 6:00 AM	6/1/03 12:35 PM	Backup	6:35
6/8/03 1:00 AM	6/8/03 6:50 AM	Backup	5:50
6/15/03 6:00 AM	6/15/03 6:37 AM	Backup	0:37
6/20/03 7:00 PM	6/21/03 2:00 AM	MHS Implementation	9:00
6/22/03 6:00 AM	6/22/03 6:23 AM	Backup	0:23
6/29/03 1:00 AM	6/29/03 6:35 AM	Backup	5:35
7/4/03 9:00 PM	7/4/03 9:30 PM	Backup - Data	0:30
7/6/03 6:00 AM	7/6/03 12:35 PM	Backup	6:35
7/11/03 9:00 PM	7/11/03 9:30 PM	Backup - Data	0:30
7/13/03 6:00 AM	7/13/03 6:40 AM	Backup	0:40
7/18/03 9:00 PM	7/18/03 9:30 PM	Backup	0:30
7/20/03 1:00 AM	7/20/03 6:22 AM	Backup	5:22
7/25/03 9:00 PM	7/25/03 9:30 PM	Backup - Data	0:30
7/27/03 6:00 AM	7/27/03 11:26 AM	Backup	5:26
8/1/03 9:00 PM	8/1/03 9:30 PM	Backup	0:30
8/2/03 1:00 AM	8/2/03 3:28 AM	Backup	2:28
8/8/03 9:00 PM	8/8/03 9:30 PM	Backup - Data	0:30
8/15/03 9:00 PM	8/15/03 9:30 PM	Backup - Data	0:30
8/17/03 6:00 AM	8/17/03 11:35 AM	Backup	5:35
8/22/03 9:00 PM	8/22/03 9:30 PM	Backup	0:30
8/24/03 1:00 AM	8/24/03 6:20 AM	Backup	5:20
8/29/03 9:00 PM	8/29/03 9:30 PM	Backup	0:30
8/31/03 1:00 AM	8/31/03 6:50 AM	Backup	5:50
9/5/03 9:00 PM	9/5/03 9:30 PM	Backup - Data	0:30
9/7/03 6:00 AM	9/7/03 9:47 AM	Backup	3:47
9/12/03 9:00 PM	9/12/03 9:30 PM	Backup	0:30
9/14/03 1:00 AM	9/14/03 7:00 AM	Backup	6:00
9/19/03 9:00 PM	9/19/03 9:30 PM	Backup	0:30
9/21/03 1:00 AM	9/21/03 6:41 AM	Backup	5:41
9/26/03 9:00 PM	9/26/03 9:30 PM	Backup - Data	0:30
9/28/03 1:00 AM	9/28/03 6:47 AM	Backup	5:47
		Total Scheduled Downtime	**131:13**

MHS Unscheduled Downtimes			
Time Offline	**Time Online**	**Description**	**Total Downtime (hh:mm)**
5/14/03 1:40 PM	5/14/03 2:30 PM	Emergency software maintenance on MHS Libraries	0:50
9/12/03 9:30 PM	9/13/03 4:07 AM	System problems, IBM called	6:37
		Total Unscheduled Downtime	**07:27**

MHS Total Downtimes		
	Total Downtime (hh:mm)	**138:40**
	Total Uptime (hh:mm)	**4181:20**
	Percent Downtime	**3.210%**
	Percent Uptime	**96.790%**

VO-PHX-SQL01 Scheduled Downtimes			
Time Offline	**Time Online**	**Description**	**Total Downtime (hh:mm)**
4/25/03 4:27 PM	4/25/03 4:31 PM	Critical Update	0:04
5/21/03 10:00 AM	5/21/03 10:16 AM	Critical Update	0:16
6/26/03 6:09 PM	6/26/03 6:13 PM	Critical Update	0:04
8/8/03 5:11 PM	8/8/03 5:44 PM	Break Fix Backing up NOS	0:34
8/8/03 6:09 PM	8/8/03 6:22 PM	Backing up NOS and Critical update	0:14
8/12/03 7:17 AM	8/12/03 7:21 AM	Critical Update	0:05
8/20/03 5:29 PM	8/20/03 5:52 PM	Backing up NOS and Critical update	0:24
8/20/03 6:05 PM	8/20/03 6:09 PM	Critical Update	0:04
8/20/03 6:18 PM	8/20/03 6:22 PM	Critical Update	0:04
8/20/03 6:32 PM	8/20/03 6:36 PM	Critical Update	0:04
8/20/03 6:49 PM	8/20/03 6:53 PM	Critical Update	0:04
8/22/03 8:13 AM	8/22/03 8:40 AM	Critical Update	0:28
8/28/03 6:17 PM	8/28/03 6:35 PM	Critical Update	0:18
8/28/03 7:09 PM	8/28/03 7:13 PM	Critical Update	0:04
8/28/03 7:32 PM	8/28/03 7:36 PM	Critical Update	0:04
8/28/03 7:40 PM	8/28/03 7:44 PM	Critical Update	0:04
9/11/03 6:06 PM	9/11/03 6:19 PM	Critical Update	0:13
9/11/03 6:27 PM	9/11/03 6:31 PM	Critical Update	0:04
9/15/03 6:47 PM	9/15/03 6:51 PM	Critical Update	0:05
		Total Scheduled Downtime	**3:17**

VO-PHX-SQL01 Unscheduled Downtimes			
Time Offline	**Time Online**	**Description**	**Total Downtime (hh:mm)**
8/5/03 7:16 AM	8/5/03 7:27 AM	Drive Failure	0:11
8/5/03 8:09 AM	8/5/03 8:21 AM	Drive Failure	0:12
8/5/03 8:58 PM	8/6/03 6:58 AM	Processor Failure	10:00
		Total Unscheduled Downtime	**10:23**

VO-PHX-SQL01 Total Downtime		
	Total Downtime (hh:mm)	**13:40**
	Total Uptime (hh:mm)	**4306:20**
	Percent Downtime	**0.316%**
	Percent Uptime	**99.684%**

VO-PHX-DWH1 Scheduled Downtimes			
Time Offline	**Time Online**	**Description**	**Total Downtime (hh:mm)**
3/25/03 3:12 PM	3/25/03 3:15 PM	Critical Update	0:03
4/26/03 1:03 PM	4/26/03 1:06 PM	Critical Update	0:03
6/16/03 1:42 PM	6/16/03 1:45 PM	Critical Update	0:03
6/18/03 8:39 AM	6/18/03 8:42 AM	Critical Update	0:03
8/12/03 7:36 AM	8/12/03 7:38 AM	Critical Update	0:03
8/12/03 7:46 AM	8/12/03 7:49 AM	Critical Update	0:03

VO-PHX-DWH1 Scheduled Downtimes Continued			
8/12/03 8:13 AM	8/12/03 8:16 AM	Critical Update	0:03
9/11/03 6:03 PM	9/11/03 6:44 PM	Backing up NOS and Critical update	0:42
9/11/03 6:50 PM	9/11/03 7:10 PM	Critical Update	0:20
9/11/03 8:28 PM	9/11/03 8:31 PM	Critical Update	0:03
9/11/03 8:45 PM	9/11/03 8:48 PM	Critical Update	0:03
		Total Scheduled Downtime	**1:29**

VO-PHX-DWH1 Unscheduled Downtimes			
Time Offline	**Time Online**	**Description**	**Total Downtime (hh:mm)**
NONE			0:00
		Total Unscheduled Downtime	**0:00**

VO-PHX-DWH1 Total Downtime		
	Total Downtime (hh:mm)	**1:29**
	Total Uptime (hh:mm)	**4318:31**
	Percent Downtime	**0.035%**
	Percent Uptime	**99.965%**

CorpDWH Scheduled Downtimes			
Time Offline	**Time Online**	**Description**	**Total Downtime (hh:mm)**
3/20/03 9:00 PM	3/21/03 12:27 AM	System Upgrade	3:27
4/1/03 9:00 PM	4/1/03 11:20 PM	System Upgrade	2:20
4/10/03 9:00 PM	4/10/03 10:37 PM	System Upgrade	1:37
5/8/03 9:30 AM	5/9/03 5:48 AM	Server moved to Reston	20:18
6/12/03 9:00 PM	6/13/03 12:26 AM	System Upgrade	3:26
6/19/03 9:00 PM	6/19/03 11:10 PM	System Upgrade	2:10
6/26/03 9:02 PM	6/26/03 10:54 PM	System Upgrade	1:52
9/4/03 9:00 PM	9/4/03 9:55 PM	Application update	0:55
		Total Scheduled Downtime	**36:05**

CorpDWH Unscheduled Downtimes			
Time Offline	**Time Online**	**Description**	**Total Downtime (hh:mm)**
3/5/03 11:31 AM	3/5/03 12:24 PM	Software issue – OS	0:53
4/5/03 7:30 AM	4/5/03 1:10 PM	Software issue - Application	5:40
4/26/03 1:15 PM	4/26/03 1:51 PM	Software issue – OS	0:36
5/28/03 2:21 PM	5/28/03 2:59 PM	Software issue – OS	0:38
6/3/03 8:11 AM	6/3/03 9:12 AM	Software issue - Application	1:01
6/5/03 2:12 PM	6/5/03 2:44 PM	Software issue - Application	0:32
6/10/03 12:07 PM	6/10/03 12:33 PM	Software issue - Application	0:26
6/22/03 00:54 AM	6/22/03 5:12 PM	Software issue - Application	16:18
7/3/03 8:26 AM	7/3/03 2:16 PM	Software issue - Application	5:50
7/7/03 5:07 PM	7/7/03 6:06 PM	Software issue - Application	0:59
7/15/03 9:07 AM	7/15/03 10:18 AM	Software issue – OS	1:11
7/25/03 3:10 PM	7/25/03 5:45 PM	Software issue – OS	2:35
7/26/03 1:05 PM	7/26/03 3:01 PM	Software issue - Application	1:56
8/5/03 11:05 AM	8/5/03 12:00 PM	Software issue - Application	0:55
8/8/03 2:50 PM	8/8/03 3:55 PM	Software issue - Application	1:05
8/9/03 4:31 PM	8/9/03 5:41 PM	Software issue - Application	1:10
		Total Unscheduled Downtime	**41:45**

CorpDWH Total Downtimes		
	Total Downtime (hh:mm)	**77:50**
	Total Uptime (hh:mm)	**4242:10**
	Percent Downtime	**1.802%**
	Percent Uptime	**98.198%**

WAN Scheduled Downtimes			
Time Offline	**Time Online**	**Description**	**Total Downtime (hh:mm)**
6/6/03 6:00 PM	6/6/03 9:00 PM	Router/Switch (6509) Install	3:00
6/6/03 8:00 AM	6/6/03 6:00 PM	Router/Switch (6509) Install	10:00
6/20/03 6:00 PM	6/20/03 9:00 PM	Network Maintenance	3:00
7/3/03 6:00 PM	7/3/03 9:00 PM	Network Maintenance	3:00
7/29/03 6:00 PM	7/29/03 7:00 PM	Router (3640) Maintenance	1:00
8/1/03 8:00 PM	8/1/03 9:00 PM	Software Upgrades	1:00
8/22/03 6:30 PM	8/22/03 6:45 PM	Emergency Software Upgrade	0:15
9/5/03 6:00 PM	9/5/03 10:00 PM	Corporate testing	4:00
9/16/03 8:00 PM	9/16/03 9:00 PM	ISP Conversion	1:00
9/23/03 10:00 PM	9/23/03 11:45 PM	ISP Conversion	1:45
		Total Scheduled Downtime	**28:00**

WAN Unscheduled Downtimes			
Time Offline	**Time Online**	**Description**	**Total Downtime (hh:mm)**
NONE			0:00
		Total Unscheduled Downtime	**0:00**

WAN Total Downtimes		
	Total Downtime (hh:mm)	**28:00**
	Total Uptime (hh:mm)	**4292:00**
	Percent Downtime	**0.652%**
	Percent Uptime	**99.348%**

PBX Scheduled Downtimes			
Time Offline	**Time Online**	**Description**	**Total Downtime (hh:mm)**
9/19/04 5:30 AM	9/19/04 5:40 AM	Maintenance/System Updating	0:10
		Total Scheduled Downtime	**0:10**

PBX Unscheduled Downtimes			
Time Offline	**Time Online**	**Description**	**Total Downtime (hh:mm)**
NONE			0:00
		Total Unscheduled Downtime	**0:00**

PBX Total Downtimes		
	Total Downtime (hh:mm)	**0:10**
	Total Uptime (hh:mm)	**4319:50**
	Percent Downtime	**0.004%**
	Percent Uptime	**99.996%**

19. Describe the training that is provided on Computer Based Training (CBT). Describe the type of training regularly provided to employees to update skills and knowledge. Discuss the budget for each employee. Describe the training that is provided for COGNOS products. Maximum 5 pages (Volume 5 g)

Computer Based Training (CBT)

ValueOptions utilizes CBT for system-wide, interactive training of employees. This training is designed to train many of the core business systems and on HIPAA Privacy requirements. Utilizing CBT has been highly successful within our organization. In one example, ValueOptions trained all employees through an interactive CBT on HIPAA Privacy. ValueOptions also provides 75% of its core MHS system training, via CBT, to all users. All CBT courses are available to employees based on their job function as noted below.

Listed below are some of the core items trained through the use of CBTs:

System	Module	Target Audience
MHS	Case Management	Clinical Staff
MHS	Claims Processing	Claims Staff
MHS	Claims Research	Claims Staff
MHS	Client Specific Detail	Eligibility and Enrollment Staff
MHS	Eligibility	Eligibility and Enrollment Staff
MHS	Inquiry Tracking	Customer Service Staff
MHS	Provider Referral	Contract and Network Staff
MHS	Workplace Services	Clinical and Network Staff
MHS	Testing	All Staff
MHS Data Warehousing	Training on Data Tables	Reporting Staff
Data Warehouse (Sybase11.9/SQL 2000)	Training on Data Warehouse Reporting Tables	Reporting Staff
HIPAA	Privacy	All Staff
COGNOS	COGNOS Powerplay 6.6 Web Tool for Data Exploration	Department Management Staff
Crystal Reports	Report Development Version 8	Reporting Staff
Microsoft Office	Word (97/2000)	All Staff
Microsoft Office	Excel (97/2000)	All Staff
Microsoft Office	PowerPoint (97/2000)	All Staff
Microsoft 2000 Operating System & Core Modules	Workstation Server SQL 2000 NT Enterprise Network Infrastructure Active Directory XP	IS Staff

Regular Training Provided to IS Staff

Regular training stems from a change in a work process, core business system change, or when employee performance enhancements are required. Each IS employee is allocated 16 hours of training time per month. Four hours a month are dedicated to core business system training for each employee. Eight hours a month is allocated towards cross training IS employees, for instance, training programmers to be the backup Database Administrator (DBA) in the event the DBA is unavailable. This training varies from employee to employee and is assigned by their respective supervisor. The training is reviewed for goal accomplishment and skill development during our annual evaluation processes. Following is a table with some of the regular courses the IS team is trained on.

Training Topic	Description
Premise wiring	The operations team is trained in the fundamentals and application of Premise wiring for Cat3 and Cat5 cabling.
PBX system maintenance	The operations team is trained in the fundamentals and application of adds, changes and deletions of user accounts on all 22 PBX systems.
Specialized Telecommunications Equipment	The operations team is trained in the fundamentals and application of specialized testing and monitoring telecommunications equipment. (Fluke and Fluke Runner, STM8, etc,)
PBX and voice recorder reporting	The operations team is trained in the fundamentals and application of report creation, management and analysis on all 22 PBX and voice recording systems.
PC hardware and software troubleshooting	The operations team is trained in basic troubleshooting techniques for diagnosing hardware and software issues.
Helpdesk operations	The operations team is trained in the basic support functions of the helpdesk.
LAN and WAN security	The operations team is trained in the fundamentals and application of LAN and WAN security as it relates to our local operation and corporate policies.
Clinical system training	Our development and analyst staff is trained on the core functions of the clinical system from the users perspective to better enhance development.
Project Management	The business and system analysts are trained on the principals of project management and the tools used in that endeavor.
Leadership Training	Any IS employee in a lead or management role has the opportunity to take monthly leadership/supervisory training courses.
COGNOS	Management staff has the opportunity to train in the analytical use of COGNOS.

The remaining four hours of dedicated monthly training time is allotted to each IS employee's work-related special training needs. This not only enhances performance within their current job functions, but ensures their continued growth and development in the IS industry. This training typically includes items such as telecommunications wiring or database security management for Local Area Network (LAN) support staff. Deeper knowledge in such areas not only enhances employees' knowledge, but provides additional resources for the cross-training of others. This training time can also be allocated to professional certification courses, such as Cisco, or to college-level courses taken in pursuit of Associate, Bachelor, Master or Doctorate degrees.

IS Training Budget

The Arizona service center's annual IS department training budget for fiscal year 2003 was $46,000. This is roughly $1,200 per staff member. However, it has always been our goal to maximize training resources by bringing in specialized instructors to train large numbers of staff whenever possible. Examples this year included training in SQL 2000 and Microsoft Exchange 2000 training, in which we were able to provide eight employees with 40 hours of specialized training for $7,000. This budget did not include the 16 hours per month of core business system training, cross training, or specialized training. Department-wide training varies from year to year; however, based on average employee expenditures, it accounts for approximately $7,400 of additional training per IS employee.

This gives each IS employee the opportunity to receive approximately $8,500 per year in training. Our commitment to training has been one of the main reasons that we have been able to maintain a departmental turnover rate of less than four percent since 1999. In addition, each employee's benefit plan includes the availability of tuition reimbursement. This is discussed in the response to Question 11 in this document.

COGNOS Training

Since 2001, COGNOS has been a standard reporting tool at ValueOptions' corporate office. In early 2003, the Arizona Service Center began to develop data cubes for analytical use throughout many of the core service center departments (including Claims, Contracts, Networks, and Corporate Compliance departments). To date, IS has worked together with other internal departments to develop multiple data cubes to enhance reporting capabilities.

This tool is being used to monitor key performance data, among them provider encounter production rates. Training capabilities include both CBT and direct classroom and one-on-one training. This allows the user to become fully interactive with the PowerPlay web tool for analytical reporting on their desktop. We also have direct classroom/one-on-one training in COGNOS Cube Development and Programming. This training is limited to IS staff only, as it requires programming and report creation experience.

Users are currently being trained on Data Exploration of the Web utilizing the COGNOS PowerPlay 6.6. This training shows users how to manipulate data stored in multidimensional COGNOS cubes in order to obtain new perspectives and gain a better insight into business performance. Training not only emphasizes best practices, customized solutions and standardization, but also technical/business-oriented presentations and hands-on labs. Users deepen skills that can increase the value of planning, budgeting, and business intelligence, thereby enhancing the return on investment.

20. Discuss if the recovery plan has ever been tested. If so, describe when and what were the results. Discuss if the Business Continuity plan has ever been tested or implemented. If so, describe when and what were the results. Maximum 2 pages (Volume 5 h)

ValueOptions has undertaken the following initiative/exercises towards validation of its Disaster Recovery/Business Continuity plans at the corporate and local levels.

Corporate Disaster Recovery/Business Continuity Testing
ValueOptions' Corporate IS Disaster Recovery Plan is built on a business continuity partnership with IBM. In September 2003 ValueOptions entered into an expanded relationship with IBM by engaging their Business Continuity Services division for improved IS Disaster Recovery planning and readiness for its core business systems: MHS, ABSolute, and its Wide Area Network services. **With this expanded service offering ValueOptions plans to execute its first annual recovery exercise with IBM in the summer of 2004.**

ValueOptions and IBM were successful at fully restoring the MHS and ABSolute applications and associated data to an IBM "hot site" iSeries during Hurricane Isabel (September 2003). Ultimately, the outcome of Hurricane Isabel did not necessitate a disaster declaration and ValueOptions services continued to be delivered from the Reston National Data Center while the restoration of data was occurring at the IBM hot site.

ValueOptions' current local IS Disaster Recovery Plan incorporates recovery of systems in two main areas, data recovery and continuity, and Call Center operations. Both of these systems are necessary for the continued operation of the Arizona Service Center and each is addressed below.

Local Data Recovery Systems Testing
Two methods are currently employed for data recovery on our local systems; disk imaging and tape backup. For operating system restoration, both backup methods are utilized allowing for a rapid recovery of operating systems should a problem arise. Complete operating system restoration from disk image takes 45 minutes or less depending upon the specific hardware the recovery is being performed on. Tape restores are used for selective file recovery from within the operating systems but can be utilized for full data restoration if necessary. For data-only recovery, tape backup is the primary method employed.

The primary core business system maintained by the local ValueOptions IS Team is the local Data Warehouse. We have two local, independent Data Warehouse servers, each of which holds copies of the data dumps from our Corporate Data Center. These two servers, combined, offer three additional levels of security to the data than that offered by backup alone. Each server runs on a different hardware platform, utilizes a different operating system and employs different database applications. This gives us protection from failures based on hardware, viruses that are specific to operating systems, and viruses specific to the application like 'SQL Slammer'.

Listed below is a table outlining the most recent recovery operations utilizing the above methods for the two primary Data Warehouse servers. In addition to these servers, our local email and file servers follow the same methodology for backup and recovery and undergo restoration validity testing on a monthly basis in conjunction with scheduled server maintenance procedures outlined in response to question 21 of this offering.

Systems	Date	Random Data Recovery Tests	Results
VO-PHX-SQL01	Apr-03	Restored Finance	Successful
VO-PHX-EX01	May-03	Restored information stores	Successful
VO-PHX-FS03	Jun-03	Restored users share	Successful
VO-PHX-EX02	Jul-03	Restored information stores	Successful
VO-PHX-DWH1	Aug-03	Restored corporate download files	Successful
VO-PHX-WEB	Sep-03	Restored helpdesk applications	Successful

System	Date	Real World Data Recovery	Results
VO-PHX-SQL01	Dec-03	Rebuilt disk array	Successful
	Nov-03	Restored entire data volume from tape	Successful
	Nov-03	Restored NOS from image	Successful
	Aug-03	Restored entire data volume from RAID	Successful
	Apr-03	Restored entire data volume from tape	Successful
	Feb-03	Restored entire data volume from tape	Successful
VO-PHX-DWH01	Nov-03	Restored single data volume from tape	Successful

Local Telecommunication Disaster Recovery/Business Continuity

In addition to ValueOptions' Data Services, the local IS team is responsible for the local telecommunications services. These services include our Crisis Hotline, Access Line, and Customer Service line. Each is separated into different functions and is handled differently than their data counterparts. In the event of an emergency evacuation of the Administrative Office, the Crisis line automatically forwards to mobile cell phones. If an extended evacuation is necessary (more than 30 minutes) the calls are then forwarded to a designated local "hot site" via our local Business Continuity Plan. Access Line and Customer Service calls are automatically rerouted to an alternate service center. In the event of an extended evacuation (more than 1 hour) the calls are forwarded to a designated local "hot site" per the Business Continuity Plan.

In the event of a complete power or system failure, our phone service provider (Qwest Communications) is notified and all inbound lines are manually rerouted to designated call centers based on our National Disaster Telephonic Recovery Plan. We are currently working with Qwest to implement a new automated Call Routing Plan, which will provide for the automatic redirection of designated numbers to primary and secondary locations in the event of a major telecommunications outage.

Listed below is a table showing the most recent voice system tests performed at the Arizona Service Center.

System	Date	Tests	Results
Phx Admin PBX	Aug-03	Calls were rerouted per recovery plan	Successful
	Oct-03	Calls were rerouted per recovery plan	Successful

21. Describe the frequency of review for security audit reports. State the schedule for applying operating system updates and service packs. Maximum 2 pages (Volume 5 i)

Reviews of security audit logs are done on a regular basis, based on the vulnerability or potential exposure we are trying to mitigate through the auditing. Audits are conducted on the following core business systems at the frequencies indicated.

Wide Area Network (WAN)

Type	Method	Frequency
Internet	IDS software	Hourly automated reports
DMZ	IDS software	Hourly automated reports
Intranet	IDS software	Hourly automated reports

Local Data Warehouse (DWH)

Type	Method	Frequency
User NT Logins	Manual	Monthly and Random
NT Security Logs on Local Servers	Manual	Monthly and Random

ABSolute

Type	Method	Frequency
Password Violations	Security Audit Software	Daily automated reports
ODBC and FTP transactions	Security Audit Software	Daily automated reports
System Values	Security Audit Software	Daily automated reports
List of a rejected transactions	Security Audit Software	Daily automated reports
Profiles reports of SYSAdmins and "all rights" authority holders	Security Audit Software	Daily automated reports

MHS and Corporate DWH

Type	Method	Frequency
Audit logs	Security Audit Software	Daily automated reports
Anomalous events	Security Audit Software	Trigger immediate notification.

Local and Corporate LAN/WAN and Data Warehouse Update Procedures

The Microsoft website is reviewed weekly for new security and software updates. Additionally, the LAN and WAN teams receive email notification, from Microsoft and third party sources, upon release of any emergency update. Core systems are covered under maintenance contracts that require notification of critical updates and patches. Upon receipt of any notification, the LAN/WAN staff conducts a review to determine if the update is necessary.

If the review of information indicates that the updates and/or service packs are needed immediately, management approval is requested for scheduled emergency downtime. Upon approval, the emergency downtime is scheduled for the first available low usage time, usually within 48 hours, and the updates are applied. The servers are backed up through drive imaging, and the use of daily tape backups before the updates are applied so that an update that fails, or creates problems, can be rolled back safely.

Periodic updates that are not considered to be critical in nature or an emergency are scheduled and applied during normal server maintenance, which is conducted monthly.

ABSolute and MHS Update Procedures

As our main systems are AS400 based, general application updates are applied quarterly; however, operations staff review vendors' websites for updates. Core systems are covered under maintenance contracts that require notification of critical updates and patches. Once updates have passed testing on development hardware and/or passed vendor testing, application updates can occur as needed based on business needs.

Our current schedule provides for quarterly updates on MHS and monthly updates on ABSolute.

22. Resubmit the mapping of NCPDP, 8371 (Institutional Claim), 837P (Professional Claim), Demographic Data File, and 834 Intake and Closure transactions. The original response had old values mapped and the records were incomplete. Maximum 75 pages (Volume 5 j)

The following data elements are submitted to ADHS/DBHS and represent the minimum data necessary for ADHS/DBHS and ValueOptions to conduct their oversight and regulatory functions covered under HIPAA. As you will see from the tables and data mapping that follow, all required HIPAA and CIS file layout requirements are currently in-place and are being exchanged as specified in the contract and the RFP. This information was verified against the Demographic file layout in the CIS manual version 1.4, updated at 1:47PM, January 8, 2004. The other file transfers were verified against the file formats downloaded from the State FTP server:

File Name and Version	File Date & Time from State FTP Server	
834_RBHA.Ver1.7.xls	September 9	07:38
837I_RBHA.Ver1.6.xls	January 15	09:24
837P_RBHA.Ver1.9.xls	January 15	09:15
NCPDP_RBHA_to_BHS.XLS	September 19	12:36

NCPDP Files:
Table/Extract: Encounter NCPDP Data

Description:
All consumers who receive service through the RBHA system must have current identifying data in the ADHS/DBHS CIS. NCPDP Universal Pharmacy Claims/Encounters billing data are potentially time-sensitive and should reflect current identifying data and other consumer status items.

Purpose/Uses:
This file is used to send the form C (Pharmacy) Claims to CIS for approval. These claims are approved at CIS on a monthly basis and are subsequently transmitted to AHCCCS for approval.

NCPDP Mapping (Envelope)
Values in < > represent the hex ASCII value for a single character – for example <1C> would be a single character with the ASCII value of hex 1C. These are literal values hard-Coded directly into the program that generates this file, and is not retrieved from any data store.
Values in quotes represent literal strings that are hard-Coded directly into the program.
When the Table Name.Field Name contains a "N/A" it indicates that no value is retrieved from a data store for that field.
A logic entry of "System Generated" indicates a value that is generated or calculated at file creation time by the program.
A logic entry of "Spaces" indicates a field that is filled entirely with spaces.
Overpunch formatted numbers have the last digit of the number replaced by the following table to indicate the sign of the number:

	Pos	Neg
0	{	}
1	A	J
2	B	K
3	C	L
4	D	M
5	E	N
6	F	O
7	G	P
8	H	Q
9	I	R

CIS MANUAL NCPDP DATA MAPPING (ENVELOPE)											VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	HIPAA USAGE	SEGMENT REPEAT	ELEMENT NAME	FIELD	BHS USAGE	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
N-1	Batch Header	Mandatory	1	Text Indicator	880-K4	Req	AN	1	1	<02>	N/A	<02>
N-2				Segment Identifier	701	Req	AN	2	2	Always "00" = File Control Header	N/A	"00"
N-3				Transmission Type	880-K6	Req	AN	1	1	"T" (Transaction)	N/A	"T"
N-4				Sender ID	880-K1	Req	AN	24	24	Defined by the processor/switch	N/A	"08"
N-5				Batch Number	880-5C	Req	AN	7	7	Assigned by Sender / matches trailer	N/A	System Generated
N-6				Creation Date	880-K2	Req	N	8	8	ccyymmdd	N/A	System Generated
N-7				Creation Time	880-K3	Req	N	4	4	hhmm	N/A	System Generated
N-8				File Type	702	Req	AN	1	1	Test = "T" Production = "P"	N/A	"P"
N-9				Version/Release Number	101-A2	Req	AN	2	2	Always "11" =Ver 1 Rel 1	N/A	"11"
N-10				Receiver ID	880-K7	Req	AN	24	24	Defined by the processor/switch	N/A	"ADHS/BHS"
N-11				Text Indicator	880-K4	Req	AN	1	1	<03>	N/A	<03>
N-12	Detail Record (up to 9,999,999,997 per batch)	Mandatory	> 1	Text Indicator	880-K4	Req	AN	1	1	<02>	N/A	<02>
N-13				Segment Identifier	701	Req	AN	2	2	Always "G1" = Detail Data Record	N/A	"G1"
N-14				Transaction Reference Number	880-K5	Req	AN	10	10	TBD by Provider	EncounterDrugFile.ICN_NBR	Internal and state require ICN Number to be 11 digits long, with the first digit always being a 2. The NCPDP format only allows for 10 digits, the constant 2 is stripped off before inserting into the file, and replaced when BHS converts the data from NCPDP to their old proprietary format
N-15				NCPDP Data Record		Req	AN			See below	N/A	Detail record from subsequent maps
N-16				Text Indicator	880-K4	Req	AN	1	1	<03>	N/A	<03>
N-17	Batch Trailer Record	Mandatory	1	Text Indicator	880-K4	Req	AN	1	1	<02>	N/A	<02>
N-18				Segment Identifier	701	Req	AN	2	2	Always "99" = File Trailer	N/A	"99"
N-19				Batch Number	806-5C	Req	AN	7	7	Same as in header record above	N/A	System Generated
N-20				Record Count	751	Req	AN	10	10	Including header & trailer	N/A	System Generated
N-21				Message	504-F4	Req	AN	35	35		N/A	Spaces
N-22				Text Indicator	880-K4	Req	AN	1	1	<02>	N/A	<02>

NCPDP B1 Mapping (Billing)

Values in < > represent the hex ASCII value for a single character – for example <1C> would be a single character with the ASCII value of hex 1C. These are literal values hard-Coded directly into the program that generates this file, and is not retrieved from any data store.
Values in quotes represent literal strings that are hard-Coded directly into the program.
When the Table Name.Field Name contains a "N/A" it indicates that no value is retrieved from a data store for that field.
A logic entry of "System Generated" indicates a value that is generated or calculated at file creation time by the program.
A logic entry of "Spaces" indicates a field that is filled entirely with spaces.
Overpunch formatted numbers have the last digit of the number replaced by the following table to indicate the sign of the number:

	Pos	Neg
0	{	}
1	A	J
2	B	K
3	C	L
4	D	M
5	E	N
6	F	O
7	G	P
8	H	Q
9	I	R

CIS MANUAL NCPDP DATA MAPPING (BILLING)											VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	HIPAA USAGE	SEGMENT REPEAT	ELEMENT NAME	FIELD	BHS USAGE	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
B1-14-1	Transaction Header	Mandatory	1	Bin Number	101-A1	Req	N	6	6	0	N/A	"0"
B1-14-2				Version/Release Number	102-A2	Req	AN	2	2	51	N/A	"51"
B1-14-3				Transaction Code	103-A3	Req	AN	2	2	"B1"	N/A	"B1"
B1-14-4				Processor Control Number	104-A4	Req	AN	10	10	ICN-Number (last 10 digits)	EncounterDrugFile.ICN_NBR	Internal and state require ICN Number to be 11 digits long, with the first digit always being a 2. The NCPDP format only allows for 10 digits, the constant 2 is stripped off before inserting into the file, and replaced when BHS converts the data from NCPDP to their old proprietary format
B1-14-5				Transaction Count	109-A9	Req	AN	1	1	LINE-NUMBER "Always 1"	N/A	"1"
B1-14-6				Service Provider ID Qualifier	202-B2	Req	AN	2	2	"5" - Medicaid	N/A	"5"
B1-14-7				Service Provider ID	201-B1	Req	AN	15	15	AHCCCS Provider ID & Loc for Pharmacy	EncounterDrugFile.NABP-ID	Field Value

CIS MANUAL NCPDP DATA MAPPING (BILLING)											VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	HIPAA USAGE	SEGMENT REPEAT	ELEMENT NAME	FIELD	BHS USAGE	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
B1-14-8				Date Of Service	401-D1	Req	AN	8	8	Service start date	EncounterDrugFile.Service_Start_Date	Field Value
B1-14-9				Software Vendor/Certification ID	110-AK	Req	AN	10	10	Spaces	N/A	Spaces
B1-14-10	**Segment Separator**			Field Separator			AN	3	3	<1E>AM	N/A	<1E>"AM"
B1-14-11	Insurance Segment	Optional		Segment Identifier	111-AM	Req	AN	2	2	04	N/A	"04"
B1-14-12				Field Separator			AN	3	3	<1C>C2	N/A	<1C>"C2"
B1-14-13				Cardholder ID	302-C2	Req	AN	20	20	CIS Client ID	EncounterDrugFile.Client_ID	Field Values
B1-14-14				Field Separator			AN	3	3	<1C>C1	N/A	<1C>"C1"
B1-14-15				Group ID	301-C1	Req	AN	15	15	RHBA ID	EncounterDrugFile.RBHA_ID	Field Values
B1-14-16	Group Separator						AN	1	1	<1D>	N/A	<1D>
B1-14-17	Segment Separator						AN	3	3	<1E>AM	N/A	<1E>"AM"
B1-14-18	Claim Segment	Optional		Segment Identifier	111-AM	Req	AN	2	2	07	N/A	"07"
B1-14-19				Field Separator			AN	3	3	<1C>EM	N/A	<1C>"EM"
B1-14-20				Prescription/Service Ref. Num. Qualifier	455-EM	Req	AN	1	1	1	N/A	"1"
B1-14-21				Field Separator			AN	3	3	<1C>D2	N/A	<1C>"D2"
B1-14-22				Prescription/Service Ref. Num.	402-D2	Req	N	7	7	9(7)	N/A	"9999999"
B1-14-23				Field Separator			AN	3	3	<1C>E1	N/A	<1C>"E1"
B1-14-24				Product/Service ID Qualifier	436-E1	Req	AN	2	2	03	N/A	"03"
B1-14-25				Field Separator			AN	3	3	<1C>D7	N/A	<1C>"D7"
B1-14-26				Product/Service ID	407-D7	Req	AN	19	19	NDC Code	EncounterDrugFile.NDC_Code1, EncounterDrugFile.NDC_Code2, EncounterDrugFile.NDC_Code3,	NDC_Code1 + NDC_Code2 + NDC_Code3
B1-14-27				Field Separator			AN	3	3	<1C>SE	N/A	<1C>"SE"
B1-14-28				Procedure Modifier Code Count	442-SE	Sit	N	1	1	1	N/A	"1"
B1-14-29				Field Separator			AN	3	3	<1C>ER	N/A	<1C>"ER"
B1-14-30				Procedure Modifier Code	442-ER	Sit	N	2	2	Modifier	EncounterDrugFile.Modifier	Field Value
B1-14-31				Field Separator			AN	3	3	<1C>E7	N/A	<1C>"E7"
B1-14-32				Quantity Dispensed	442-E7	Req	N	10	10	9(7)v999	EncounterDrugFile.Dispense_Quantity	Field Value
B1-14-33				Field Separator			AN	3	3	<1C>D3	N/A	<1C>"D3"
B1-14-34				Fill Number	403-D3	Req	N	2	2		EncounterDrugFile.Number_This_Refill	Field Value
B1-14-35				Field Separator			AN	3	3	<1C>DE	N/A	<1C>"DE"

CIS MANUAL NCPDP DATA MAPPING (BILLING)											VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	HIPAA USAGE	SEGMENT REPEAT	ELEMENT NAME	FIELD	BHS USAGE	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
B1-14-36				Date Prescription Written	414-DE	Req	N	8	8	ccyymmdd	EncounterDrugFile.Rx_Order_Date	Field Value
B1-14-37				Field Separator			AN	3	3	<1C>DF	N/A	<1C>"DF"
B1-14-38				Number Of Refills Authorized	415-DF	Req	N	2	2		EncounterDrugFile.Authorized_Refill	Field Value
CIS MANUAL NCPDP DATA MAPPING (BILLING)											VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	HIPAA USAGE	SEGMENT REPEAT	ELEMENT NAME	FIELD	BHS USAGE	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
B1-14-39	Segment Separator						AN	3	3	<1E>AM	N/A	<1E>"AM"
B1-14-40	Pricing Segment	Optional		Segment Identifier	111-AM	Req	AN	2	2	11	N/A	"11"
B1-14-41				Field Separator			AN	3	3	<1C>DU	N/A	<1C>"DU"
B1-14-42				Gross Amount Due	430-DU	Sit	N	8	8	s9(6)v99 (see overpunch information)	EncounterDrugFile.Prescription_Cost	Overpunch formatted

NCPDP B2 Mapping (Reversal)

Values in < > represent the hex ASCII value for a single character – for example <1C> would be a single character with the ASCII value of hex 1C. These are literal values hard-Coded directly into the program that generates this file, and is not retrieved from any data store.
Values in quotes represent literal strings that are hard-Coded directly into the program.
When the Table Name.Field Name contains a "N/A" it indicates that no value is retrieved from a data store for that field.
A logic entry of "System Generated" indicates a value that is generated or calculated at file creation time by the program.
A logic entry of "Spaces" indicates a field that is filled entirely with spaces.
Overpunch formatted numbers have the last digit of the number replaced by the following table to indicate the sign of the number:

	Pos	Neg
0	{	}
1	A	J
2	B	K
3	C	L
4	D	M
5	E	N
6	F	O
7	G	P
8	H	Q
9	I	R

CIS MANUAL NCPDP DATA MAPPING (REVERSAL)											VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	HIPAA USAGE	SEGMENT REPEAT	ELEMENT NAME	FIELD	BHS USAGE	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
B2-14-1	Transaction Header	Mandatory	1	Bin Number	101-A1	Req	N	6	6	0	N/A	"0"
B2-14-2				Version/Release Number	102-A2	Req	AN	2	2	51	N/A	"51"
B2-14-3				Transaction Code	103-A3	Req	AN	2	2	"B2"	N/A	"B2"

CIS MANUAL NCPDP DATA MAPPING (REVERSAL)											VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	HIPAA USAGE	SEGMENT REPEAT	ELEMENT NAME	FIELD	BHS USAGE	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
B2-14-4				Processor Control Number	104-A4	Req	AN	10	10	ICN-Number (length issue)	EncounterDrugFile.ICN_NBR	Internal and state require ICN Number to be 11 digits long, with the first digit always being a 2. The NCPDP format only allows for 10 digits, the constant 2 is stripped off before inserting into the file, and replaced when BHS converts the data from NCPDP to their old proprietary format
B2-14-5				Transaction Count	109-A9	Req	AN	1	1	1	N/A	"1"
B2-14-6				Service Provider Id Qualifier	202-B2	Req	AN	2	2	"5" - Medicaid	N/A	"5"
B2-14-7				Service Provider Id	201-B1	Req	AN	15	15	AHCCCS Provider ID & Loc for Pharmacy	EncounterDrugFile.NABP-ID	Field Value
B2-14-8				Date Of Service	401-D1	Req	AN	8	8	Service start date	EncounterDrugFile.Service_Start_Date	Field Value
B2-14-9				Software Vendor/Certification ID	110-AK	Req	AN	10	10	Spaces	N/A	Spaces
B2-14-10	Segment Separator			Segment Seperator			AN	3	3	<1E>AM	N/A	<1E>"AM"
B2-14-11	Insurance Segment	Optional		Segment Identifier	111-AM	Req	AN	2	2	04	N/A	"04"
B2-14-12				Field Separator			AN	3	3	<1C>C2	N/A	<1C>"C2"
B2-14-13				Cardholder ID	302-C2	Req	AN	20	20	CIS Client ID	EncounterDrugFile.Client_ID	Field Value
B2-14-14				Field Separator			AN	3	3	<1C>C1	N/A	<1C>"C1"
B2-14-15				Group ID	301-C1	Req	AN	15	15	RHBA ID	EncounterDrugFile.RBHA_ID	Field Value
B2-14-16	Group Separator			Group Seperator			AN	1	1	<1D>	N/A	<1D>
B2-14-17	Segment Separator			Segment Seperator			AN	3	3	<1E>AM	N/A	<1E>"AM"
B2-14-18	Claim Segment	Optional		Segment Identifier	111-AM	Req	AN	2	2	07	N/A	"07"
B2-14-19				Field Separator			AN	3	3	<1C>EM	N/A	<1C>"EM"
B2-14-20				Prescription/Service Ref. Num. Qualifier	455-EM	Req	AN	1	1	1	N/A	"1"
B2-14-21				Field Separator			AN	3	3	<1C>D2	N/A	<1C>"D2"
B2-14-22				Prescription/Service Ref. Num.	402-D2	Req	N	7	7	9(7)	N/A	"9999999"
B2-14-23				Field Separator			AN	3	3	<1C>E1	N/A	<1C>"E1"
B2-14-24				Product/Service ID Qualifier	436-E1	Req	AN	2	2	03	N/A	"03"
B2-14-25				Field Separator			AN	3	3	<1C>D7	N/A	<1C>"D7"

CIS MANUAL NCPDP DATA MAPPING (REVERSAL)											VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	HIPAA USAGE	SEGMENT REPEAT	ELEMENT NAME	FIELD	BHS USAGE	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
B2-14-26				Product/Service ID	407-D7	Req	AN	19	19	NDC Code	EncounterDrugFile.NDC_Code 1, EncounterDrugFile.NDC_Code 2, EncounterDrugFile.NDC_Code 3,	NDC_Code1 + NDC_Code2 + NDC_Code3
B2-14-27				Field Separator			AN	3	3	<1C>SE	N/A	<1C>"SE"
B2-14-28				Procedure Modifier Code Count	442-SE	Req	N	10	10	1	N/A	"1"
B2-14-29				Field Separator			AN	3	3	<1C>ER	N/A	<1C>"ER"
B2-14-30				Procedure Modifier Code	442-ER	Req	N	10	10	Modifier	EncounterDrugFile.Modifier	Field Value
B2-14-31				Field Separator			AN	3	3	<1C>E7	N/A	<1C>"E7"
B2-14-32				Quantity Dispensed	442-E7	Req	N	10	10		EncounterDrugFile.Dispense_ Quantity	Field Value
B2-14-33				Field Separator			AN	3	3	<1C>D3	N/A	<1C>"D3"
B2-14-34				Fill Number	403-D3	Req	N	2	2		EncounterDrugFile.Number_Th is_Refill	Field Value
B2-14-35				Field Separator			AN	3	3	<1C>DE	N/A	<1C>"DE"
B2-14-36				Date Prescription Written	414-DE	Req	N	8	8	ccyymmdd	EncounterDrugFile.Rx_Order_ Date	Field Value
B2-14-37				Field Separator			AN	3	3	<1C>DF	N/A	<1C>"DF"
B2-14-38				Number Of Refills Authorized	415-DF	Req	N	2	2		EncounterDrugFile.Authorized_ Refill	Field Value
B2-14-39	Segment Separator			Segment Seperator			AN	3	3	<1E>AM	N/A	<1E>"AM"
B2-14-40	Pricing Segment	Optional		Segment Identifier	111-AM	Req	AN	2	2	11	N/A	"11"
B2-14-41				Field Separator			AN	3	3	<1C>DU	N/A	<1C>"DU"
B2-14-42				Gross Amount Due	430-DU	Sit	N	8	8	s9(6)v99 (see overpunch information)	EncounterDrugFile.Prescription _Cost	Overpunch formatted

NCPDP B3 Mapping (Rebill)

Values in < > represent the hex ASCII value for a single character – for example <1C> would be a single character with the ASCII value of hex 1C. These are literal values hard-Coded directly into the program that generates this file, and is not retrieved from any data store.
Values in quotes represent literal strings that are hard-Coded directly into the program.
When the Table Name.Field Name contains a "N/A" it indicates that no value is retrieved from a data store for that field.
A logic entry of "System Generated" indicates a value that is generated or calculated at file creation time by the program.
A logic entry of "Spaces" indicates a field that is filled entirely with spaces.
Overpunch formatted numbers have the last digit of the number replaced by the following table to indicate the sign of the number:

	Pos	Neg
0	{	}
1	A	J
2	B	K
3	C	L
4	D	M
5	E	N
6	F	O
7	G	P
8	H	Q
9	I	R

CIS MANUAL NCPDP DATA MAPPING (REBILL)											VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	HIPAA USAGE	SEGMENT REPEAT	ELEMENT NAME	FIELD	BHS USAGE	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
B3-14-1	Transaction Header	Mandatory	1	Bin Number	101-A1	Req	N	6	6	0	N/A	"0"
B3-14-2				Version/Release Number	102-A2	Req	AN	2	2	51	N/A	"51"
B3-14-3				Transaction Code	103-A3	Req	AN	2	2	"B3"	N/A	"B3"
B3-14-4				Processor Control Number	104-A4	Req	AN	10	10	ICN-Number (length issue)	EncounterDrugFile.ICN_NBR	The internal and state required ICN Number is 11 digits long, with the first digit always being a 2. Since the NCPDP format only allows for 10 digits, the constant 2 is stripped off before inserting into the file, and replaced when BHS converts the data from NCPDP to their old proprietary format
B3-14-5				Transaction Count	109-A9	Req	AN	1	1	"1" only 1 transaction	N/A	"1"
B3-14-6				Service Provider ID Qualifier	202-B2	Req	AN	2	2	"5" - Medicaid	N/A	"5"
B3-14-7				Service Provider ID	201-B1	Req	AN	15	15	AHCCCS Provider ID & Loc for Pharmacy	EncounterDrugFile.NABP-ID	Field Value

CIS MANUAL NCPDP DATA MAPPING (REBILL)											VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	HIPAA USAGE	SEGMENT REPEAT	ELEMENT NAME	FIELD	BHS USAGE	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
B3-14-8				Date Of Service	401-D1	Req	AN	8	8	Service start date	EncounterDrugFile.Service_Start_Date	Field Value
B3-14-9				Software Vendor/Certification ID	110-AK	Req	AN	10	10	Spaces	N/A	Spaces
B3-14-10	Segment Separator			Field Separator			AN	3	3	<1E>AM	N/A	<1E>"AM"
B3-14-11	Insurance Segment	Optional		Segment Identifier	111-AM	Req	AN	2	2	04	N/A	"04"
B3-14-12				Field Separator			AN	3	3	<1C>C2	N/A	<1C>"C2"
B3-14-13				Cardholder ID	302-C2	Req	AN	20	20	CIS Client ID	EncounterDrugFile.Client_ID	Field Value
B3-14-14				Field Separator			AN	3	3	<1C>C1	N/A	<1C>"C1"
B3-14-15				Group ID	301-C1	Req	AN	15	15	RHBA ID	EncounterDrugFile.RBHA_ID	Field Value
B3-14-16	Group Separator						AN	1	1	<1D>	N/A	<1D>
B3-14-17	Segment Separator						AN	3	3	<1E>AM	N/A	<1E>"AM"
B3-14-18	Claim Segment	Optional		Segment Identifier	111-AM	Req	AN	2	2	07	N/A	"07"
B3-14-19				Field Separator			AN	3	3	<1C>EM	N/A	<1C>"EM"
B3-14-20				Prescription/Service Ref. Num. Qualifier	455-EM	Req	AN	1	1	1	N/A	"1"
B3-14-21				Field Separator			AN	3	3	<1C>D2	N/A	<1C>"D2"
B3-14-22				Prescription/Service Ref. Num.	402-D2	Req	N	7	7	9(7)	N/A	"9999999"
B3-14-23				Field Separator			AN	3	3	<1C>E1	N/A	<1C>"E1"
B3-14-24				Product/Service ID Qualifier	436-E1	Req	AN	2	2	03	N/A	"03"
B3-14-25				Field Separator			AN	3	3	<1C>D7	N/A	<1C>"D7"
B3-14-26				Product/Service ID	407-D7	Req	AN	19	19	NDC Code	EncounterDrugFile.NDC_Code1, EncounterDrugFile.NDC_Code2, EncounterDrugFile.NDC_Code3,	NDC_Code1 + NDC_Code2 + NDC_Code3
B3-14-27				Field Separator			AN	3	3	<1C>SE	N/A	<1C>"SE"
B3-14-28				Procedure Modifier Code Count	442-SE	Req	N	10	10	1	N/A	"1"
B3-14-29				Field Separator			AN	3	3	<1C>ER	N/A	<1C>"ER"
B3-14-30				Procedure Modifier Code	442-ER	Req	N	10	10	Modifier	EncounterDrugFile.Modifier	Field Value
B3-14-31				Field Separator			AN	3	3	<1C>E7	N/A	<1C>"E7"
B3-14-32				Quantity Dispensed	442-E7	Req	N	10	10		EncounterDrugFile.Dispense_Quantity	Field Value
B3-14-33				Field Separator			AN	3	3	<1C>D3	N/A	<1C>"D3"
B3-14-34				Fill Number	403-D3	Req	N	2	2		EncounterDrugFile.Number_This_Refill	Field Value
B3-14-35				Field Separator			AN	3	3	<1C>DE	N/A	<1C>"DE"
B3-14-36				Date Prescription Written	414-DE	Req	N	8	8	ccyymmdd	EncounterDrugFile.Rx_Order_Date	Field Value
B3-14-37				Field Separator			AN	3	3	<1C>DF	N/A	<1C>"DF"
B3-14-38				Number Of Refills Authorized	415-DF	Req	N	2	2		EncounterDrugFile.Authorized_Refill	Field Value
B3-14-39	Segment Separator						AN	3	3	<1E>AM	N/A	<1E>"AM"
B3-14-40	Pricing Segment	Optional		Segment Identifier	111-AM	Req	AN	2	2	11	N/A	"11"
B3-14-41				Field Separator			AN	3	3	<1C>DU	N/A	<1C>"DU"
B3-14-42				Gross Amount Due	430-DU	Sit	N	8	8	s9(6)v99 (see overpunch information)	EncounterDrugFile.Prescription_Cost	Overpunch formatted

837 I File:

Table/Extract: 837I – Institutional Claims

Description

This file contains all the hospital claims that have been paid during the prior week. The file is sent to CIS weekly.

Purpose/Uses

This is a HIPAA compliant file that is used to send the UB92 (Inpatient hospital) claims to CIS for approval. After these claims are approved at BHS they are transmitted to AHCCCS for approval.

837 I Mapping (Used)

Values in quotes represent literal strings that are hard-Coded directly into the program.
When the Table Name.Field Name contains a "N/A" it indicates that no value is retrieved from a data store for that field.
A logic entry of "System Generated" indicates a value that is generated or calculated at file creation time by the program.
A logic entry of "Spaces" indicates a field that is filled entirely with spaces.

CIS MANUAL 837 I DATA MAPPING (USED)																VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837i-001	Transaction Set Header	R	1			Transaction Set Identifier Code	R	ST01	143	M	ID	3	3	"837"	N/A	"837"
837i-002						Transaction Set Control Number	R	ST02	329	M	ID	4	9	Incremented Number	N/A	System Generated
837i-003	Beginning of Hierarchical Transaction	R	1			Hierarchical Structure Code	R	BHT01	1005	M	ID	4	4	"0019"	N/A	"0019"
837i-004						Transaction Set purpose Code	R	BHT02	353	M	ID	2	2	"00"	N/A	"00"
837i-005						Reference Identification	R	BHT03	127	O	AN	1	30	Originator Application Transaction Identifier	N/A	System Generated
837i-006						Date	R	BHT04	373	O	DT	8	8	Transaction Set Creation Date	N/A	System Generated
837i-007						Time	R	BHT05	337	O	TM	4	8	Transaction Set Creation Time	N/A	System Generated
837i-008						Transaction Type Code	R	BHT06	640	O	ID	2	2	"RP"	N/A	"RP"
837i-009	Transmission Type Identification	R	1			Reference Identification Qualifier	R	REF01	128	M	ID	2	3	"87"	N/A	"87"
837i-010						Reference Identification	R	REF02	127	X	AN	1	30	"004010X096A1" or "004010X096DA1" for test	N/A	"004010X096A1"
837i-011	Submitter Name	R	1	1000A	1	Entity Identifier Code	R	NM101	98	M	ID	2	3	"41"	N/A	"41"
837i-012						Entity Type Qualifier	R	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837i-013						Name Last / Organization Name	R	NM103	1035	O	AN	1	35	RBHA Name	N/A	"ValueOptions"
837i-014						Name First	S	NM104	1036	O	AN	1	25		N/A	Not Used
837i-015						Name Middle	S	NM105	1037	O	AN	1	25		N/A	Not Used
837i-016						Identification Code Qualifier	R	NM108	66	X	ID	1	2	"46"	N/A	"46"
837i-017						Identification Code	R	NM109	67	X	AN	2	80	RBHA Contractor Id	N/A	"54-1414194"
837i-018	Submitter EDI Contact Information	R	2	1000A	1	Contact Function Code	R	PER01	366	M	ID	2	2	"IC"	N/A	"IC"

CIS MANUAL 837 I DATA MAPPING (USED)																VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837i-019						Name	R	PER02	93	O	AN	1	60	Contact Person	N/A	"Steve Myers"
837i-020						Communication Number Qualifier	R	PER03	365	X	ID	2	2	Codes ED, EM, FX, TE	N/A	"EM"
837i-021						Communication Number	R	PER04	364	X	AN	1	80	Communication number	N/A	"steve.myers@valueoptions.com"
837i-022						Communication Number Qualifier	S	PER05	365	X	ID	2	2		N/A	"TE"
837i-023						Communication Number	S	PER06	364	X	AN	1	80		N/A	"6029145926"
837i-024						Communication Number Qualifier	S	PER07	365	X	ID	2	2		N/A	Not Used
837i-025						Communication Number	S	PER08	364	X	AN	1	80		N/A	Not Used
837i-026	Receiver Name	R	1	1000B	1	Entity Identifier Code	R	NM101	98	M	ID	2	3	"40"	N/A	"40"
837i-027						Entity Type Qualifier	R	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837i-028						Name Last / Organization Name	R	NM103	1035	O	AN	1	35	"ADHS/BHS"	N/A	"ADHS/BHS"
837i-029						Identification Code Qualifier	R	NM108	66	X	ID	1	2	"46"	N/A	"46"
837i-030						Identification Code	R	NM109	67	X	AN	2	80	"86-6004791"	N/A	"86-6004791"
837i-031	Billing/Pay-to provider hierarchical level	R	1	2000A	>1	Hierarchical ID Number	R	HL01	628	M	AN	1	12	Starts with 1 and is incremented by 1 for each HL	N/A	System Generated
837i-032						Hierarchical Level Code	R	HL03	735	M	ID	1	2	"20"	N/A	"20"
837i-033						Hierarchical Child Code	R	HL04	736	O	ID	1	1	"1"	N/A	"1"
837i-039	Billing Provider Name	R	1	2010AA	1	Entity Identifier Code	R	NM101	98	M	ID	2	3	"85"	N/A	"85"
837i-040						Entity Type Qualifier	R	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837i-041						Name Last / Organization Name	R	NM103	1035	O	AN	1	35	Group Biller / Provider Name	UB92_Header.Provider_Name	Field Value
837i-042						Identification Code Qualifier	R	NM108	66	X	ID	1	2	"24" until Nat Provider ID issued; then "XX"	N/A	"24"
837i-043						Identification Code	R	NM109	67	X	AN	2	80	Grp Biller's EIN until Nat Provider ID issued	UB92_Header.Provider_ID	Field Value
837i-044	Billing Provider Address	R	1	2010AA	1	Address Information	R	N301	166	M	AN	1	55	Group Biller / Provider Address	UB92_Header.Provider_Address	Field Value
837i-045						Address Information	S	N302	166	O	AN	1	55		N/A	Not Used
837i-046	Billing Provider City/State/Zip Code	R	1	2010AA	1	City Name	R	N401	19	O	AN	2	30	Group Biller / Provider City	UB92_Header.Provider_City	Field Value
837i-047						State or Providence Code	R	N402	156	O	ID	2	2	Group Biller / Provider State	UB92_Header.Provider_State	Field Value
837i-048						Postal Code	R	N403	116	O	ID	3	15	Group Biller / Provider Zip Code	UB92_Header.Provider_Zip	Field Value
837i-049						Country Code	S	N404	26	O	ID	2	3		N/A	Not Used
837i-050	Billing Provider Secondary Identification	S	8	2010AA	1	Reference Identification Qualifier	R	REF01	128	M	ID	2	3	"1D"	N/A	"1D"
837i-051						Reference Identification	R	REF02	127	X	AN	1	30	Group Biller / Provider ID and Location	N/A	Not Used
837i-062	Pay-to Provider Name	S	1	2010AB	1	Entity Identifier Code	R	NM101	98	M	ID	2	3	"87"	N/A	"87"
837i-063						Entity Type Qualifier	R	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837i-064						Name Last / Organization Name	R	NM103	1035	O	AN	1	35	Provider Name	N/A	Not Used
837i-065						Identification Code Qualifier	R	NM108	66	X	ID	1	2	"24" until Nat Provider ID issued; then "XX"	N/A	"24"
837i-066						Identification Code	R	NM109	67	X	AN	2	80	Provider's EIN until Nat Provider ID issued	N/A	Not Used
837i-067	Pay-to Provider Address	R	1	2010AB	1	Address Information	R	N301	166	M	AN	1	55	Provider Address Line	N/A	Not Used

CIS MANUAL 837 I DATA MAPPING (USED)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837i-068						Address Information	S	N302	166	O	AN	1	55		N/A	Not Used
837i-069	Pay-to Provider City/State/Zip Code	R	1	2010AB	1	City Name	R	N401	19	O	AN	2	30	Provider City Name	N/A	Not Used
837i-070						State or Province Code	R	N402	156	O	ID	2	2	Provider State Code	N/A	Not Used
837i-071						Postal Code	R	N403	116	O	ID	3	15	Provider Zip Code	N/A	Not Used
837i-072						Country Code	S	N404	26	O	ID	2	3		N/A	Not Used
837i-073	Pay-to Provider Secondary Identification	S	5	2010AB	1	Reference Identification Qualifier	R	REF01	128	M	ID	2	3	"G2"	N/A	"G2"
837i-074						Reference Identification	R	REF02	127	X	AN	1	30	Provider ID	N/A	Not Used
837i-075	Subscriber Hierarchical Level	R	1	2000B	>1	Hierarchical Id Number	R	HL01	628	M	AN	1	12	Next HL# (incremented by 1 for each HL)	N/A	System Generated
837i-076						Hierarchical Parent ID Number	R	HL02	734	O	AN	1	12	HL01 from provider HL level	N/A	System Generated
837i-077						Hierarchical Level Code	R	HL03	735	M	ID	1	2	"22"	N/A	"22"
837i-078						Hierarchical Child Code	R	HL04	736	O	ID	1	1	"0"	N/A	"0"
837i-079	Subscriber Information	R	1	2000B	>1	Payer Responsibility Sequence Number Code	R	SBR01	1138	M	ID	1	1	"P"	N/A	"P"
837i-080						Individual Relationship Code	S	SBR02	1069	O	ID	2	2	"18"	N/A	"18"
837i-081						Reference Identification	S	SBR03	127	O	AN	1	30		N/A	Not Used
837i-082						Name	S	SBR04	93	O	AN	1	60	"AHCCCS"	N/A	"AHCCCS"
837i-083						Claim Filling Indicator Code	S	SBR09	1032	O	ID	1	2	"MC"	N/A	"MC"
837i-084	Subscriber Name	R	1	2010BA	1	Entity Identifier Code	R	NM101	98	M	ID	2	3	"IL"	N/A	"IL"
837i-085						Entity Type Qualifier	R	NM102	1065	M	ID	1	1	"1"	N/A	"1"
837i-086						Name Last / Organization Name	R	NM103	1035	O	AN	1	35	Client's Last Name	Dw_curmem.Lstnam	Field Value
837i-087						Name First	S	NM104	1036	O	AN	1	25		Dw_curmem.Fstnam	Field Value
837i-088						Name Middle	S	NM105	1037	O	AN	1	25		Dw_curmem.Midnam	Field Value
837i-089						Name suffix	S	NM107	1039	O	AN	1	10		N/A	Not Used
837i-090						Identification Code Qualifier	S	NM108	66	X	ID	1	2	"MI"	N/A	"MI"
837i-091						Identification Code	S	NM109	67	X	AN	2	80	Client ID	UB92_Header.Client_id	Field Value
837i-092	Subscriber Address	S	1	2010BA	1	Address Information	R	N301	166	M	AN	1	55		Dw_curmem.Adrln1	Field Value
837i-093						Address Information	S	N302	166	O	AN	1	55		N/A	Not Used
837i-094	Subscriber City/State/Zip Code	S	1	2010BA	1	City Name	R	N401	19	O	AN	2	30		Dw_curmem.citycd	Field Value
837i-095						State or Province Code	R	N402	156	O	ID	2	2		Dw_curmem.stacd	Field Value
837i-096						Postal Code	R	N403	116	O	ID	3	15		Dw_curmem.Zipcod	Field Value
837i-097						Country Code	S	N404	26	O	ID	2	3		N/A	Not Used
837i-098	Subscriber Demographic Information	S	1	2010BA	1	Date Time Period format Qualifier	R	DMG01	1250	X	ID	2	3	"D8"	N/A	"D8"
837i-099						Date Time Period	R	DMG02	1251	X	AN	1	35	Subscriber Date of Birth	Dw_curmem.bthdat	Field Value
837i-100						Gender Code	R	DMG03	1068	O	ID	1	1	Subscriber Gender	Dw_curmem.sexcod	Field Value
837i-115	Payer Name	R	1	2010BC	1	Entity Identifier Code	R	NM101	98	M	ID	2	3	"PR"	N/A	"PR"

CIS MANUAL 837 I DATA MAPPING (USED)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837i-116						Entity Type Qualifier	R	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837i-117						Name Last / Organization Name	R	NM103	1035	O	AN	1	35	"ADHS/BHS"	N/A	"ADHS/BHS"
837i-118						Identification Code Qualifier	R	NM108	66	X	ID	1	2	"PI"	N/A	"PI"
837i-119						Identification Code	R	NM109	67	X	AN	2	80	"86-6004791"	N/A	"86-6004791"
837i-165	Claim Information	R	1	2300	100	Claim submitter's Identifier	R	CLM01	1028	M	AN	1	38	ICN Number	UB92_Header.ICN-Nbr	Field Value
837i-166						Monetary Amount	R	CLM02	782	O	R	1	18	Sum of 2400 loop Billed amounts	N/A	System Generated
837i-167						Health Care Service Location Information	R	CLM05	C023	O					Composite Element	Composite Element
837i-168						Facility Code Value	R	CLM05-1	1331	M	AN	1	2	Bill Type Position 1 and 2	UB92_Header.Bill_Type	Bill Type Position 1 and 2
837i-169						Facility Code Qualifier	R	CLM05-2	1325	O	ID	1	1	Code A - UB Claim Form Type	N/A	Not Used
837i-170						Claim Frequency Type Code	R	CLM05-3	1325	O	ID	1	1	Bill Type Position 3	UB92_Header.Bill_Type	Bill Type Position 3
837i-171						Yes/No Condition or Response Code	R	CLM06	1073	O	ID	1	1	Provider Signature on File (Y/N)	N/A	"Y"
837i-172						Provider Accept Assigment Code	S	CLM07	1359	O	ID	1	1		N/A	Not Used
837i-173						Yes/No Condition or Response Code	R	CLM08	1073	O	ID	1	1	Assignment of Benefits Indicator. (Y/N)	N/A	"Y"
837i-174						Release of Information Code	R	CLM09	1363	O	ID	1	1	A, I, M, N, O, or Y	N/A	Not Used
837i-175						Yes/No Condition or Response Code	R	CLM18	1073	O	ID	1	1	"N"	N/A	"N"
837i-176						Delay Reason Code	S	CLM20	1514	O	ID	1	2		N/A	Not Used
837i-177	Discharge Hour	S	1	2300	100	Date/Time Qualifier	R	DTP01	374	M	ID	3	3	"096"	N/A	"096"
837i-178						Date Time Period Format Qualifier	R	DTP02	1250	M	ID	2	3	"TM"	N/A	"TM"
837i-179						Date Time Period	R	DTP03	1251	M	AN	1	35	HHMM	UB92_Header.Discharg_Hour	Field Value
837i-180	Statement Dates	S	1	2300	100	Date/Time Qualifier	R	DTP01	374	M	ID	3	3	"434"	N/A	"434"
837i-181						Date Time Period Format Qualifier	R	DTP02	1250	M	ID	2	3	"RD8" (CCYYMMDD-CCYYMMDD)	N/A	"RD6"
837i-182						Date Time Period	R	DTP03	1251	M	AN	1	35	Statement Covers Period	UB92_Header.Service_Start_dt, UB92_Header.Service_End_dt	Field Value
837i-183	Admission Date/Hour	S	1	2300	100	Date/Time Qualifier	R	DTP01	374	M	ID	3	3	"435"	N/A	"435"
837i-184						Date Time Period Format Qualifier	R	DTP02	1250	M	ID	2	3	"DT" (CCYYMMDDHHMM)	UB92_Header.Admission_Dt, UB92_Header.Admit_Hour	Field Value
837i-185						Date Time Period	R	DTP03	1251	M	AN	1	35		N/A	Not Used
837i-186	Institutional Claim Code	S	1	2300	100	Admission Type Code	S	CL101	1315	O	ID	1	1		UB92_Header.Admission_Type	Field Value
837i-187						Admission Source Code	S	CL102	1314	O	ID	1	1		UB92_Header.Admission_Source	Field Value
837i-188						Patient Status Code	S	CL103	1352	O	ID	1	2		UB92_Header.Patient_Status	Field Value

CIS MANUAL 837 I DATA MAPPING (USED)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837i-193	Contract Information	S	1	2300	100	Contract Type Code	R	CN101	1166	M	ID	2	2	"05" or "02"	UB92_Header.Svc_Type	Data Warehouse "02" = HIPAA "05, all other values = HIPAA "02"
837i-194						Monetary Amount	S	CN102	782	O	R	1	18	Special Net Value or Net-Paid	UB92_Line_InpAncillary.Net_Paid	Field Value
837i-195						Percent	S	CN103	332	O	R	1	6		N/A	Not Used
837i-196						Reference Identification	S	CN104	127	O	AN	1	30		N/A	Not Used
837i-197						Terms Discount Percent	S	CN105	338	O	R	1	6		N/A	Not Used
837i-198						Version Identifier	S	CN106	799	O	AN	1	30		N/A	Not Used
837i-215	Original Reference Number (ICN/DCN)	S	1	2300	100	Reference Identification Qualifier	R	REF01	128	M	ID	2	3	"F8"	N/A	"F8"
837i-216						Reference Identification	R	REF02	127	X	AN	1	30	Claim Original Reference Number	UB92_Header.Adjustment_icn	Field Value
837i-223	Prior Authorization or Referral Number	S	2	2300	100	Reference Identification Qualifier	R	REF01	128	M	ID	2	3	"G1"	N/A	"G1"
837i-224						Reference Identification	R	REF02	127	X	AN	1	30	Prior Authorization Number	UB92_Header.Prior_Auth_Nbr	Field Value
837i-232	Billing Note	S	1	2300	100	Note Reference Code	R	NTE01	363	O	ID	3	3	"ADD"	N/A	"ADD"
837i-233						Description	R	NTE02	352	M	AN	1	80	String the three fields into a single 10 char entry	UB92_Line_InpAncillary.Dup_Override_Ind, UB92_Header.Oth_Ins_Cov_Flag, UB92_Header.Encounter_Process_Dt	String the three fields into a single 10 char entry
837i-276	Principal, Admitting, e-Code and Patient reason for visit diagnosis information	S	1	2300	100	Health Care Code Information	R	HI01	C022	M					Composite Element	Composite Element
837i-277						Code List Qualifier Code	R	HI01-1	1270	M	ID	1	3	"BK"	N/A	"BK"
837i-278						Industry Code	R	HI01-2	1271	M	AN	1	30		UB92_Header.Diagnosis_Code	Field Value
837i-279						Health Care Code Information	S	HI02	C022	O					Composite Element	Composite Element
837i-280						Code List Qualifier Code	R	HI02-1	1270	M	ID	1	3	"BJ"	N/A	"BJ"
837i-281						Industry Code	R	HI02-2	1271	M	AN	1	30		UB92_Header.Admit_Diag_cd	Field Value
837i-282						Health Care Code Information	S	HI03	C022	O					Composite Element	Composite Element
837i-283						Code List Qualifier Code	R	HI03-1	1270	M	ID	1	3	"BN"	N/A	"BN"
837i-284						Industry Code	R	HI03-2	1271	M	AN	1	30		UB92_Header.Trauma_Diag_cd	Field Value
837i-288	Other Diagnosis Information	S	2	2300	100	Health Care Code Information	R	HI01	C022	M					Composite Element	Composite Element
837i-289						Code List Qualifier Code	R	HI01-1	1270	M	ID	1	3	"BF"	N/A	"BF"
837i-290						Industry Code	R	HI01-2	1271	M	AN	1	30		UB92_Header.Diagnosis_cd_1	Field Value
837i-291						Health Care Code Information	S	HI02	C022	O					Composite Element	Composite Element
837i-292						Code List Qualifier Code	R	HI02-1	1270	M	ID	1	3	"BF"	N/A	"BF"
837i-293						Industry Code	R	HI02-2	1271	M	AN	1	30		UB92_Header.Diagnosis_cd_2	Field Value
837i-294						Health Care Code Information	S	HI03	C022	O					Composite Element	Composite Element
837i-295						Code List Qualifier Code	R	HI03-1	1270	M	ID	1	3	"BF"	N/A	"BF"

CIS MANUAL 837 I DATA MAPPING (USED)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837i-296						Industry Code	R	HI03-2	1271	M	AN	1	30		UB92_Header.Diagnosis_cd_3	Field Value
837i-297						Health Care Code Information	S	HI04	C022	O					Composite Element	Composite Element
837i-298						Code List Qualifier Code	R	HI04-1	1270	M	ID	1	3	"BF"	N/A	"BF"
837i-299						Industry Code	R	HI04-2	1271	M	AN	1	30		UB92_Header.Diagnosis_cd_4	Field Value
837i-300						Health Care Code Information	S	HI05	C022	O					Composite Element	Composite Element
837i-301						Code List Qualifier Code	R	HI05-1	1270	M	ID	1	3	"BF"	N/A	"BF"
837i-302						Industry Code	R	HI05-2	1271	M	AN	1	30		UB92_Header.Diagnosis_cd_5	Field Value
837i-303						Health Care Code Information	S	HI06	C022	O					Composite Element	Composite Element
837i-304						Code List Qualifier Code	R	HI06-1	1270	M	ID	1	3	"BF"	N/A	"BF"
837i-305						Industry Code	R	HI06-2	1271	M	AN	1	30		UB92_Header.Diagnosis_cd_6	Field Value
837i-306						Health Care Code Information	S	HI07	C022	O					Composite Element	Composite Element
837i-307						Code List Qualifier Code	R	HI07-1	1270	M	ID	1	3	"BF"	N/A	"BF"
837i-308						Industry Code	R	HI07-2	1271	M	AN	1	30		UB92_Header.Diagnosis_cd_7	Field Value
837i-309						Health Care Code Information	S	HI08	C022	O					Composite Element	Composite Element
837i-310						Code List Qualifier Code	R	HI08-1	1270	M	ID	1	3	"BF"	N/A	"BF"
837i-311						Industry Code	R	HI08-2	1271	M	AN	1	30		UB92_Header.Diagnosis_cd_8	Field Value
837i-312						Health Care Code Information	S	HI09	C022	O					N/A	Not Used
837i-313						Code List Qualifier Code	R	HI09-1	1270	M	ID	1	3		N/A	Not Used
837i-314						Industry Code	R	HI09-2	1271	M	AN	1	30		N/A	Not Used
837i-315						Health Care Code Information	S	HI10	C022	O					N/A	Not Used
837i-316						Code List Qualifier Code	R	HI10-1	1270	M	ID	1	3		N/A	Not Used
837i-317						Industry Code	R	HI10-2	1271	M	AN	1	30		N/A	Not Used
837i-318						Health Care Code Information	S	HI11	C022	O					N/A	Not Used
837i-319						Code List Qualifier Code	R	HI11-1	1270	M	ID	1	3		N/A	Not Used
837i-320						Industry Code	R	HI11-2	1271	M	AN	1	30		N/A	Not Used
837i-321						Health Care Code Information	S	HI12	C022	O					N/A	Not Used
837i-322						Code List Qualifier Code	R	HI12-1	1270	M	ID	1	3		N/A	Not Used
837i-323						Industry Code	R	HI12-2	1271	M	AN	1	30		N/A	Not Used
837i-329	Principal Procedure Information	S	2	2300	100	Health Care Code Information	R	HI01	C022	M					Composite Element	Composite Element
837i-330						Code List Qualifier Code	R	HI01-1	1270	M	ID	1	3	"BR"	N/A	"BR"
837i-331						Industry Code	R	HI01-2	1271	M	AN	1	30		UB92_Header.ICD9_Proc_Code_1	Field Value
837i-332						Date Time Period format Qualifier	S	HI01-3	1250	X	ID	2	3	"D8" (currently only using MMDD)	N/A	"D8"
837i-333						Date time Period	S	HI01-4	1251	X	AN	1	35		UB92_Header.ICD9_Proc_Date_1	Field Value
837i-329	Other Procedure Information	S	2	2300	100	Health Care Code Information	R	HI01	C022	M					Composite Element	Composite Element
837i-330						Code List Qualifier Code	R	HI01-1	1270	M	ID	1	3	"BQ"	N/A	"BQ"
837i-331						Industry Code	R	HI01-2	1271	M	AN	1	30		UB92_Header.ICD	Field Value

CIS MANUAL 837 I DATA MAPPING (USED)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
															9_Proc_Code_2	
837i-332						Date Time Period format Qualifier	S	HI01-3	1250	X	ID	2	3	"D8" (currently only using MMDD)	N/A	"D8"
837i-333						Date time Period	S	HI01-4	1251	X	AN	1	35		UB92_Header.ICD 9_Proc_Date_2	Field Value
837i-334						Health Care Code Information	S	HI02	C022	O					Composite Element	Composite Element
837i-335						Code List Qualifier Code	R	HI02-1	1270	M	ID	1	3	"BQ"	N/A	"BQ"
837i-336						Industry Code	R	HI02-2	1271	M	AN	1	30		UB92_Header.ICD 9_Proc_Code_3	Field Value
837i-337						Date Time Period format Qualifier	S	HI02-3	1250	X	ID	2	3	"D8" (currently only using MMDD)	N/A	"D8"
837i-338						Date time Period	S	HI02-4	1251	X	AN	1	35		UB92_Header.ICD 9_Proc_Date_3	Field Value
837i-339						Health Care Code Information	S	HI03	C022	O					Composite Element	Composite Element
837i-340						Code List Qualifier Code	R	HI03-1	1270	M	ID	1	3	"BQ"	N/A	"BQ"
837i-341						Industry Code	R	HI03-2	1271	M	AN	1	30		UB92_Header.ICD 9_Proc_Code_4	Field Value
837i-342						Date Time Period format Qualifier	S	HI03-3	1250	X	ID	2	3	"D8" (currently only using MMDD)	N/A	"D8"
837i-343						Date time Period	S	HI03-4	1251	X	AN	1	35		UB92_Header.ICD 9_Proc_Date_4	Field Value
837i-344						Health Care Code Information	S	HI04	C022	O					Composite Element	Composite Element
837i-345						Code List Qualifier Code	R	HI04-1	1270	M	ID	1	3	"BQ"	N/A	"BQ"
837i-346						Industry Code	R	HI04-2	1271	M	AN	1	30		UB92_Header.ICD 9_Proc_Code_5	Field Value
837i-347						Date Time Period format Qualifier	S	HI04-3	1250	X	ID	2	3	"D8" (currently only using MMDD)	N/A	"D8"
837i-348						Date time Period	S	HI04-4	1251	X	AN	1	35		UB92_Header.ICD 9_Proc_Date_5	Field Value
837i-349						Health Care Code Information	S	HI05	C022	O					N/A	Not Used
837i-350						Code List Qualifier Code	R	HI05-1	1270	M	ID	1	3		N/A	Not Used
837i-351						Industry Code	R	HI05-2	1271	M	AN	1	30		N/A	Not Used
837i-352						Date Time Period format Qualifier	S	HI05-3	1250	X	ID	2	3		N/A	Not Used
837i-353						Date time Period	S	HI05-4	1251	X	AN	1	35		N/A	Not Used
837i-354						Health Care Code Information	S	HI06	C022	O					N/A	Not Used
837i-355						Code List Qualifier Code	R	HI06-1	1270	M	ID	1	3		N/A	Not Used
837i-356						Industry Code	R	HI06-2	1271	M	AN	1	30		N/A	Not Used
837i-357						Date Time Period format Qualifier	S	HI06-3	1250	X	ID	2	3		N/A	Not Used
837i-358						Date time Period	S	HI06-4	1251	X	AN	1	35		N/A	Not Used
837i-359						Health Care Code Information	S	HI07	C022	O					N/A	Not Used
837i-360						Code List Qualifier Code	R	HI07-1	1270	M	ID	1	3		N/A	Not Used
837i-361						Industry Code	R	HI07-2	1271	M	AN	1	30		N/A	Not Used
837i-362						Date Time Period format Qualifier	S	HI07-3	1250	X	ID	2	3		N/A	Not Used
837i-363						Date time Period	S	HI07-4	1251	X	AN	1	35		N/A	Not Used
837i-364						Health Care Code Information	S	HI08	C022	O					N/A	Not Used
837i-365						Code List Qualifier Code	R	HI08-1	1270	M	ID	1	3		N/A	Not Used
837i-366						Industry Code	R	HI08-2	1271	M	AN	1	30		N/A	Not Used

CIS MANUAL 837 I DATA MAPPING (USED)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837i-367						Date Time Period format Qualifier	S	HI08-3	1250	X	ID	2	3		N/A	Not Used
837i-368						Date time Period	S	HI08-4	1251	X	AN	1	35		N/A	Not Used
837i-369						Health Care Code Information	S	HI09	C022	O					N/A	Not Used
837i-370						Code List Qualifier Code	R	HI09-1	1270	M	ID	1	3		N/A	Not Used
837i-371						Industry Code	R	HI09-2	1271	M	AN	1	30		N/A	Not Used
837i-372						Date Time Period format Qualifier	S	HI09-3	1250	X	ID	2	3		N/A	Not Used
837i-373						Date time Period	S	HI09-4	1251	X	AN	1	35		N/A	Not Used
837i-374						Health Care Code Information	S	HI10	C022	O					N/A	Not Used
837i-375						Code List Qualifier Code	R	HI10-1	1270	M	ID	1	3		N/A	Not Used
837i-376						Industry Code	R	HI10-2	1271	M	AN	1	30		N/A	Not Used
837i-377						Date Time Period format Qualifier	S	HI10-3	1250	X	ID	2	3		N/A	Not Used
837i-378						Date time Period	S	HI10-4	1251	X	AN	1	35		N/A	Not Used
837i-379						Health Care Code Information	S	HI11	C022	O					N/A	Not Used
837i-380						Code List Qualifier Code	R	HI11-1	1270	M	ID	1	3		N/A	Not Used
837i-381						Industry Code	R	HI11-2	1271	M	AN	1	30		N/A	Not Used
837i-382						Date Time Period format Qualifier	S	HI11-3	1250	X	ID	2	3		N/A	Not Used
837i-383						Date time Period	S	HI11-4	1251	X	AN	1	35		N/A	Not Used
837i-384						Health Care Code Information	S	HI12	C022	O					N/A	Not Used
837i-385						Code List Qualifier Code	R	HI12-1	1270	M	ID	1	3		N/A	Not Used
837i-386						Industry Code	R	HI12-2	1271	M	AN	1	30		N/A	Not Used
837i-387						Date Time Period format Qualifier	S	HI12-3	1250	X	ID	2	3		N/A	Not Used
837i-388						Date time Period	S	HI12-4	1251	X	AN	1	35		N/A	Not Used
837i-449	Occurrence Information	S	2	2300	100	Health Care Code Information	R	HI01	C022	M					Composite Element	Composite Element
837i-450						Code List Qualifier Code	R	HI01-1	1270	M	ID	1	3	"BH"	N/A	"BH"
837i-451						Industry Code	R	HI01-2	1271	M	AN	1	30		UB92_Header.Occurrence_Code1	Field Value
837i-452						Date Time Period format Qualifier	R	HI01-3	1250	X	ID	2	3	"D8"	N/A	"D8"
837i-453						Date time Period	R	HI01-4	1251	X	AN	1	35		UB92_Header.Occurrence_Date1	Field Value
837i-454						Health Care Code Information	S	HI02	C022	O					Composite Element	Composite Element
837i-455						Code List Qualifier Code	R	HI02-1	1270	M	ID	1	3	"BH"	N/A	"BH"
837i-456						Industry Code	R	HI02-2	1271	M	AN	1	30		UB92_Header.Occurrence_Code2	Field Value
837i-457						Date Time Period format Qualifier	R	HI02-3	1250	X	ID	2	3	"D8"	N/A	"D8"
837i-458						Date time Period	R	HI02-4	1251	X	AN	1	35		UB92_Header.Occurrence_Date2	Field Value
837i-459						Health Care Code Information	S	HI03	C022	O					Composite Element	Composite Element
837i-460						Code List Qualifier Code	R	HI03-1	1270	M	ID	1	3	"BH"	N/A	"BH"
837i-461						Industry Code	R	HI03-2	1271	M	AN	1	30		UB92_Header.Occurrence_Code3	Field Value
837i-462						Date Time Period format Qualifier	R	HI03-3	1250	X	ID	2	3	"D8"	N/A	"D8"
837i-463						Date time Period	R	HI03-4	1251	X	AN	1	35		UB92_Header.Occurrence_Date3	Field Value
837i-464						Health Care Code Information	S	HI04	C022	O					Composite Element	Composite Element
837i-465						Code List Qualifier Code	R	HI04-1	1270	M	ID	1	3	"BH"	N/A	"BH"

CIS MANUAL 837 I DATA MAPPING (USED)																VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837i-466						Industry Code	R	HI04-2	1271	M	AN	1	30		UB92_Header.Occurrence_Code4	Field Value
837i-467						Date Time Period format Qualifier	R	HI04-3	1250	X	ID	2	3	"D8"	N/A	"D8"
837i-468						Date time Period	R	HI04-4	1251	X	AN	1	35		UB92_Header.Occurrence_Date4	Field Value
837i-469						Health Care Code Information	S	HI05	C022	O					Composite Element	Composite Element
837i-470						Code List Qualifier Code	R	HI05-1	1270	M	ID	1	3	"BH"	N/A	"BH"
837i-471						Industry Code	R	HI05-2	1271	M	AN	1	30		UB92_Header.Occurrence_Code5	Field Value
837i-472						Date Time Period format Qualifier	R	HI05-3	1250	X	ID	2	3	"D8"	N/A	"D8"
837i-473						Date time Period	R	HI05-4	1251	X	AN	1	35		UB92_Header.Occurrence_Date5	Field Value
837i-474						Health Care Code Information	S	HI06	C022	O					Composite Element	Composite Element
837i-475						Code List Qualifier Code	R	HI06-1	1270	M	ID	1	3	"BH"	N/A	"BH"
837i-476						Industry Code	R	HI06-2	1271	M	AN	1	30		UB92_Header.Occurrence_Code6	Field Value
837i-477						Date Time Period format Qualifier	R	HI06-3	1250	X	ID	2	3	"D8"	N/A	"D8"
837i-478						Date time Period	R	HI06-4	1251	X	AN	1	35		UB92_Header.Occurrence_Date6	Field Value
837i-479						Health Care Code Information	S	HI07	C022	O					Composite Element	Composite Element
837i-480						Code List Qualifier Code	R	HI07-1	1270	M	ID	1	3	"BH"	N/A	"BH"
837i-481						Industry Code	R	HI07-2	1271	M	AN	1	30		UB92_Header.Occurrence_Code7	Field Value
837i-482						Date Time Period format Qualifier	R	HI07-3	1250	X	ID	2	3	"D8"	N/A	"D8"
837i-483						Date time Period	R	HI07-4	1251	X	AN	1	35		UB92_Header.Occurrence_Date7	Field Value
837i-484						Health Care Code Information	S	HI08	C022	O					Composite Element	Composite Element
837i-485						Code List Qualifier Code	R	HI08-1	1270	M	ID	1	3	"BH"	N/A	"BH"
837i-486						Industry Code	R	HI08-2	1271	M	AN	1	30		UB92_Header.Occurrence_Code8	Field Value
837i-487						Date Time Period format Qualifier	R	HI08-3	1250	X	ID	2	3	"D8"	N/A	"D8"
837i-488						Date time Period	R	HI08-4	1251	X	AN	1	35		UB92_Header.Occurrence_Date8	Field Value
837i-489						Health Care Code Information	S	HI09	C022	O					N/A	Not Used
837i-490						Code List Qualifier Code	R	HI09-1	1270	M	ID	1	3		N/A	Not Used
837i-491						Industry Code	R	HI09-2	1271	M	AN	1	30		N/A	Not Used
837i-492						Date Time Period format Qualifier	R	HI09-3	1250	X	ID	2	3		N/A	Not Used
837i-493						Date time Period	R	HI09-4	1251	X	AN	1	35		N/A	Not Used
837i-494						Health Care Code Information	S	HI10	C022	O					N/A	Not Used
837i-495						Code List Qualifier Code	R	HI10-1	1270	M	ID	1	3		N/A	Not Used
837i-496						Industry Code	R	HI10-2	1271	M	AN	1	30		N/A	Not Used
837i-497						Date Time Period format Qualifier	R	HI10-3	1250	X	ID	2	3		N/A	Not Used
837i-498						Date time Period	R	HI10-4	1251	X	AN	1	35		N/A	Not Used
837i-499						Health Care Code Information	S	HI11	C022	O					N/A	Not Used
837i-500						Code List Qualifier Code	R	HI11-1	1270	M	ID	1	3		N/A	Not Used
837i-501						Industry Code	R	HI11-2	1271	M	AN	1	30		N/A	Not Used
837i-502						Date Time Period format Qualifier	R	HI11-3	1250	X	ID	2	3		N/A	Not Used

CIS MANUAL 837 I DATA MAPPING (USED)																VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837i-503						Date time Period	R	HI11-4	1251	X	AN	1	35		N/A	Not Used
837i-504						Health Care Code Information	S	HI12	C022	O					N/A	Not Used
837i-505						Code List Qualifier Code	R	HI12-1	1270	M	ID	1	3		N/A	Not Used
837i-506						Industry Code	R	HI12-2	1271	M	AN	1	30		N/A	Not Used
837i-507						Date Time Period format Qualifier	R	HI12-3	1250	X	ID	2	3		N/A	Not Used
837i-508						Date time Period	R	HI12-4	1251	X	AN	1	35		N/A	Not Used
837i-509	Value Information	S	2	2300	100	Health Care Code Information	R	HI01	C022	M					Composite Element	Composite Element
837i-510						Code List Qualifier Code	R	HI01-1	1270	M	ID	1	3	"BE"	N/A	"BE"
837i-511						Industry Code	R	HI01-2	1271	M	AN	1	30	"M09" for MedA; "A2" for others	N/A	"M09" for MedA, "A2" for others
837i-512						Monetary Amount	R	HI01-5	782	O	R	1	18		UB92_Header.Co_insurance	Field Value
837i-513						Health Care Code Information	S	HI02	C022	O					N/A	Not Used
837i-514						Code List Qualifier Code	R	HI02-1	1270	M	ID	1	3		N/A	Not Used
837i-515						Industry Code	R	HI02-2	1271	M	AN	1	30		N/A	Not Used
837i-516						Monetary Amount	R	HI02-5	782	O	R	1	18		N/A	Not Used
837i-517						Health Care Code Information	S	HI03	C022	O					N/A	Not Used
837i-518						Code List Qualifier Code	R	HI03-1	1270	M	ID	1	3		N/A	Not Used
837i-519						Industry Code	R	HI03-2	1271	M	AN	1	30		N/A	Not Used
837i-520						Monetary Amount	R	HI03-5	782	O	R	1	18		N/A	Not Used
837i-521						Health Care Code Information	S	HI04	C022	O					N/A	Not Used
837i-522						Code List Qualifier Code	R	HI04-1	1270	M	ID	1	3		N/A	Not Used
837i-523						Industry Code	R	HI04-2	1271	M	AN	1	30		N/A	Not Used
837i-524						Monetary Amount	R	HI04-5	782	O	R	1	18		N/A	Not Used
837i-525						Health Care Code Information	S	HI05	C022	O					N/A	Not Used
837i-526						Code List Qualifier Code	R	HI05-1	1270	M	ID	1	3		N/A	Not Used
837i-527						Industry Code	R	HI05-2	1271	M	AN	1	30		N/A	Not Used
837i-528						Monetary Amount	R	HI05-5	782	O	R	1	18		N/A	Not Used
837i-529						Health Care Code Information	S	HI06	C022	O					N/A	Not Used
837i-530						Code List Qualifier Code	R	HI06-1	1270	M	ID	1	3		N/A	Not Used
837i-531						Industry Code	R	HI06-2	1271	M	AN	1	30		N/A	Not Used
837i-532						Monetary Amount	R	HI06-5	782	O	R	1	18		N/A	Not Used
837i-533						Health Care Code Information	S	HI07	C022	O					N/A	Not Used
837i-534						Code List Qualifier Code	R	HI07-1	1270	M	ID	1	3		N/A	Not Used
837i-535						Industry Code	R	HI07-2	1271	M	AN	1	30		N/A	Not Used
837i-536						Monetary Amount	R	HI07-5	782	O	R	1	18		N/A	Not Used
837i-537						Health Care Code Information	S	HI08	C022	O					N/A	Not Used
837i-538						Code List Qualifier Code	R	HI08-1	1270	M	ID	1	3		N/A	Not Used
837i-539						Industry Code	R	HI08-2	1271	M	AN	1	30		N/A	Not Used
837i-540						Monetary Amount	R	HI08-5	782	O	R	1	18		N/A	Not Used
837i-541						Health Care Code Information	S	HI09	C022	O					N/A	Not Used
837i-542						Code List Qualifier Code	R	HI09-1	1270	M	ID	1	3		N/A	Not Used
837i-543						Industry Code	R	HI09-2	1271	M	AN	1	30		N/A	Not Used

CIS MANUAL 837 I DATA MAPPING (USED)																VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837i-544						Monetary Amount	R	HI09-5	782	O	R	1	18		N/A	Not Used
837i-545						Health Care Code Information	S	HI10	C022	O					N/A	Not Used
837i-546						Code List Qualifier Code	R	HI10-1	1270	M	ID	1	3		N/A	Not Used
837i-547						Industry Code	R	HI10-2	1271	M	AN	1	30		N/A	Not Used
837i-548						Monetary Amount	R	HI10-5	782	O	R	1	18		N/A	Not Used
837i-549						Health Care Code Information	S	HI11	C022	O					N/A	Not Used
837i-550						Code List Qualifier Code	R	HI11-1	1270	M	ID	1	3		N/A	Not Used
837i-551						Industry Code	R	HI11-2	1271	M	AN	1	30		N/A	Not Used
837i-552						Monetary Amount	R	HI11-5	782	O	R	1	18		N/A	Not Used
837i-553						Health Care Code Information	S	HI12	C022	O					N/A	Not Used
837i-554						Code List Qualifier Code	R	HI12-1	1270	M	ID	1	3		N/A	Not Used
837i-555						Industry Code	R	HI12-2	1271	M	AN	1	30		N/A	Not Used
837i-556						Monetary Amount	R	HI12-5	782	O	R	1	18		N/A	Not Used
837i-659	Attending Physician Name	S	1	2310A	1	Entity Identifier Code	R	NM101	98	M	ID	2	3	Use "71" for Attending Physician	N/A	"71"
837i-660						Entity Type Qualifier	R	NM102	1065	M	ID	1	1	"1"	N/A	"1"
837i-661						Name Last / Organization Name	R	NM103	1035	O	AN	1	35	Attending Physician's Last Name	UB92_Line_InpAncillary.Attending_Physician_Name	Field Value
837i-662						Name First	S	NM104	1036	O	AN	1	25		N/A	Not Used
837i-663						Name Middle	S	NM105	1037	O	AN	1	25		N/A	Not Used
837i-664						Name suffix	S	NM107	1039	O	AN	1	10		N/A	Not Used
837i-665						Identification Code Qualifier	R	NM108	66	X	ID	1	2	"24" until Nat Provider ID issued; then "XX"	N/A	"24"
837i-666						Identification Code	R	NM109	67	X	AN	2	80	Attending Physician's EIN until Nat Prov ID	UB92_Line_InpAncillary.Attending_Physician_ID	Field Value
837i-670	Attending Physician Secondary Identification	S	5	2310A	1	Reference Identification Qualifier	R	REF01	128	M	ID	2	3	"N5"	N/A	"N5"
837i-671						Reference Identification	R	REF02	127	M	AN	1	30	Attending Physician	UB92_Header.Attending_ Physician	Field Value
837i-819	Other Subscriber Information (Oth Ins Loop)	S	1	2320	10	Payer Responsibility Sequence Number Code	R	SBR01	1138	M	ID	1	1	"P", "S" or "T"	N/A	"P"
837i-820						Individual Relationship Code	R	SBR02	1069	O	ID	2	2	"18"	N/A	"18"
837i-821						Reference Identification	S	SBR03	127	O	AN	1	30		N/A	Not Used
837i-822						Name	S	SBR04	93	O	AN	1	60		N/A	Not Used
837i-823						Claim Filling Indicator Code	S	SBR09	1032	O	ID	1	2	"C1"	N/A	"C1"
837i-824	Payer Prior Payment	S	1	2320	10	Amount Qualifier Code	R	AMT01	522	M	ID	1	3	"C4"	N/A	"C4"
837i-825						Monetary Amount	R	AMT02	782	M	R	1	3	Other Insurance Payment	UB92_Header.Oth_InsPymt	Field Value
837i-826	Other Subscriber Demographic Information	S	1	2320	1	Date Time Period format Qualifier	R	DMG01	1250	X	ID	2	3	"D8"	N/A	"D8"
837i-827						Date Time Period	R	DMG02	1251	X	AN	1	35	Subscriber Date of Birth	Dw_curmem.bthdat	Field Value
837i-828						Gender Code	R	DMG03	1068	O	ID	1	1	Subscriber Gender	Dw_curmem.sexcod	Field Value
837i-829	Other Subscriber Name	R	1	2330A	1	Entity Identifier Code	R	NM101	98	M	ID	2	3	"IL"	N/A	"IL"

CIS MANUAL 837 I DATA MAPPING (USED)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837i-830						Entity Type Qualifier	R	NM102	1065	M	ID	1	1	"1"	N/A	"1"
837i-831						Name Last / Organization Name	R	NM103	1035	O	AN	1	35	Client's Last Name	Dw_curmem.Lstnam	Field Value
837i-832						Name First	S	NM104	1036	O	AN	1	25		N/A	Not Used
837i-833						Name Middle	S	NM105	1037	O	AN	1	25		N/A	Not Used
837i-834						Name suffix	S	NM107	1039	O	AN	1	10		N/A	Not Used
837i-835						Identification Code Qualifier	R	NM108	66	X	ID	1	2	"MI"	N/A	"MI"
837i-836						Identification Code	R	NM109	67	X	AN	2	80	Client's Other Insurance ID	N/A	"1000"
837i-837	Other Payer Name	R	1	2330B	1	Entity Identifier Code	R	NM101	98	M	ID	2	3	"PR"	N/A	"PR"
837i-838						Entity Type Qualifier	R	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837i-839						Name Last / Organization Name	R	NM103	1035	O	AN	1	35	Other Ins Company Name	N/A	"Other"
837i-840						Identification Code Qualifier	R	NM108	66	X	ID	1	2	"PI" until Nat Prov ID issued; then "XV"	N/A	"PI"
837i-841	(End of Oth Ins Loop)					Identification Code	R	NM109	67	X	AN	2	80	"003" until Nat Prov ID issued	N/A	"003"
837i-842	Other Subscriber Information (Medicare Loop)	S	1	2320	10	Payer Responsibility Sequence Number Code	R	SBR01	1138	M	ID	1	1	"P", "S" or "T"	N/A	"P" if no other insurance, "S" if other insurance
837i-843						Individual Relationship Code	R	SBR02	1069	O	ID	2	2	"18"	N/A	"18"
837i-844						Reference Identification	S	SBR03	127	O	AN	1	30		N/A	Not Used
837i-845						Name	S	SBR04	93	O	AN	1	60		N/A	Not Used
837i-846						Claim Filling Indicator Code	S	SBR09	1032	O	ID	1	2	"MA" or "MB"	N/A	"MA"
837i-847	Claim Level Adjustments	S	5	2320	10	Claim Adjustment Group Code	R	CAS01	1033	M	ID	1	2	"PR"	N/A	"PR"
837i-848						Claim Adjustment Reason Code	R	CAS02	1034	M	ID	1	5	"1" - Deductible Amt	N/A	"1"
837i-849						Monetary Amount	R	CAS03	782	M	R	1	18	Medicare Deductible	UB92_Header.Medicare_Deductible	Field Value
837i-850						Quantity	S	CAS04	380	O	R	1	15		N/A	Not Used
837i-851						Claim Adjustment Reason Code	S	CAS05	1034	X	ID	1	5		N/A	Not Used
837i-852						Monetary Amount	S	CAS06	782	X	R	1	18		N/A	Not Used
837i-853						Quantity	S	CAS07	380	X	R	1	15		N/A	Not Used
837i-854						Claim Adjustment Reason Code	S	CAS08	1034	X	ID	1	5		N/A	Not Used
837i-855						Monetary Amount	S	CAS09	782	X	R	1	18		N/A	Not Used
837i-856						Quantity	S	CAS10	380	X	R	1	15		N/A	Not Used
837i-857						Claim Adjustment Reason Code	S	CAS11	1034	X	ID	1	5		N/A	Not Used
837i-858						Monetary Amount	S	CAS12	782	X	R	1	18		N/A	Not Used
837i-859						Quantity	S	CAS13	380	X	R	1	15		N/A	Not Used
837i-860						Claim Adjustment Reason Code	S	CAS14	1034	X	ID	1	5		N/A	Not Used
837i-861						Monetary Amount	S	CAS15	782	X	R	1	18		N/A	Not Used
837i-862						Quantity	S	CAS16	380	X	R	1	15		N/A	Not Used
837i-863						Claim Adjustment Reason Code	S	CAS17	1034	X	ID	1	5		N/A	Not Used
837i-864						Monetary Amount	S	CAS18	782	X	R	1	18		N/A	Not Used
837i-865						Quantity	S	CAS19	380	X	R	1	15		N/A	Not Used
837i-866	COB Total Allowed Amount	S	1	2320	10	Amount Qualifier Code	R	AMT01	522	M	ID	1	3	"B6"	N/A	"B6"

CIS MANUAL 837 I DATA MAPPING (USED)																VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837i-867						Monetary Amount	R	AMT02	782	M	R	1	18	Medicare Allow Amount	UB92_Header.Medicare_Allow_Amount	Field Value
837i-868	COB Total Medicare Paid Amount	S	1	2320	10	Amount Qualifier Code	R	AMT01	522	M	ID	1	3	Code 'N1'	N/A	"N1"
837i-869						Monetary Amount	R	AMT02	782	M	R	1	18	Medicare Payment	UB92_Header.Medicare_Payment	Field Value
837i-870	Other Insurance Coverage Information	R	1	2320	10	Yes/No Condition or Response Code	R	OI03	1073	O	ID	1	1	Assignment of Benefits Indicator. (Y/N)	N/A	"Y"
837i-871						Release of Information Code	R	OI06	1363	O	ID	1	1	A, I, M, N, O, or Y	N/A	"Y"
837i-872	Other Subscriber Name	R	1	2330A	1	Entity Identifier Code	R	NM101	98	M	ID	2	3	"IL"	N/A	"IL"
837i-873						Entity Type Qualifier	R	NM102	1065	M	ID	1	1	"1"	N/A	"1"
837i-874						Name Last / Organization Name	R	NM103	1035	O	AN	1	35	Client's Last Name	Dw_curmem.Lstnam	Field Value
837i-875						Name First	S	NM104	1036	O	AN	1	25		N/A	Not Used
837i-876						Name Middle	S	NM105	1037	O	AN	1	25		N/A	Not Used
837i-877						Name Suffix	S	NM107	1039	O	AN	1	10		N/A	Not Used
837i-878						Identification Code Qualifier	R	NM108	66	X	ID	1	2	"MI"	N/A	"MI"
837i-879						Identification Code	R	NM109	67	X	AN	2	80	Client's medicare ID	UB92_Header.Consumer_Medicare_ID	Field Value
837i-880	Other Payer Name	R	1	2330B	1	Entity Identifier Code	R	NM101	98	M	ID	2	3	"PR"	N/A	"PR"
837i-881						Entity Type Qualifier	R	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837i-882						Name Last / Organization Name	R	NM103	1035	O	AN	1	35	"Medicare"	N/A	"Medicare"
837i-883						Identification Code Qualifier	R	NM108	66	X	ID	1	2	"PI" until Nat Prov ID issued; then "XV"	N/A	"PI"
837i-884	(End of Medicare Loop)					Identification Code	R	NM109	67	X	AN	2	80	"002"	N/A	"002"
837i-885	Service Line Number	R	1	2400	999	Assigned Number	R	LX01	554	M	N0	1	6	Line Number	UB92_Line_InpAncillary.Line_nbr	Field Value
837i-886	Institutional Service Line	R	1	2400	999	Product/Service ID	R	SV201	234	M	AN	1	48	Service Line Revenue Code	UB92_Header.Revenue_Cd	Field Value
837i-887						Composite Medical Procedure Identifier	S	SV202	C003	X					Composite Element	Composite Element
837i-888						Product/Service ID Qualifier	R	SV202-1	235	M	ID	2	2	"HC", or "N4"	N/A	"HC"
837i-889						Product/Service ID	R	SV202-2	234	M	AN	1	48	Procedure Code	UB92_Line_InpAncillary.Procedure_Code	Field Value
837i-890						Procedure Modifier	S	SV202-3	1339	O	AN	2	2		N/A	Not Used
837i-891						Procedure Modifier	S	SV202-4	1339	O	AN	2	2		N/A	Not Used
837i-892						Procedure Modifier	S	SV202-5	1339	O	AN	2	2		N/A	Not Used
837i-893						Procedure Modifier	S	SV202-6	1339	O	AN	2	2		N/A	Not Used
837i-894						Monetary Amount	R	SV203	782	O	R	1	18	Line Item Charge Amount	UB92_Line_InpAncillary.Billed_Amount	Field Value
837i-895						Unit or Basis for Measurement Code	R	SV204	355	X	ID	2	2	Codes : DA, F2, UN ??	N/A	"UN"
837i-896						Quantity	R	SV205	380	X	R	1	15		UB92_Line_InpAncillary.Unit_of_Service	Field Value
837i-897						Unit Rate	S	SV206	1371	O	R	1	10		N/A	Not Used

CIS MANUAL 837 I DATA MAPPING (USED)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837i-898						Monetary Amount	S	SV207	782	O	R	1	18	Line Item Non-Covered Charge Amt	UB92_Line_InpAncillary.Non_covered_chg	Field Value
837i-899	Transaction Set Trailer	R	1			Number of Included Segments	R	SE01	96	M	N0	1	10		N/A	Not Used
837i-900						Transaction Set Control Number	R	SE02	329	M	AN	4	9		N/A	Not Used
*Items in grey not used in CIS																

837 P Files:

Table/Extract: 837P Professional Claims

Description:
This file contains all the HCFA-1500 claims that have been paid in MHS. The file is sent to CIS daily.

Purpose/Uses:
This file is used to send the HCFA-1500 Claims to CIS for approval. These claims are approved at CIS monthly and are subsequently transmitted to AHCCCS for approval.

837 P (Original)

Values in quotes represent literal strings that are hard-Coded directly into the program.
When the Table Name.Field Name contains a "N/A" it indicates that no value is retrieved from a data store for that field.
A logic entry of "System Generated" indicates a value that is generated or calculated at file creation time by the program.
A logic entry of "Spaces" indicates a field that is filled entirely with spaces.

CIS MANUAL 837 P (ORIGINAL)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837p-001	Transaction Set Header	Required	1			Transaction Set Identifier Code	Req	ST01	143	M	ID	3	3	"837"	N/A	"837"
837p-002						Transaction Set Control Number	Req	ST02	329	M	ID	4	9	Incremented Number	N/A	System Generated
837p-003	Beginning of Hierarchical Transaction	Required	1			Hierarchical Structure Code	Req	BHT01	1005	M	ID	4	4	"0019"	N/A	"0019"
837p-004						Transaction Set purpose Code	Req	BHT02	353	M	ID	2	2	"00"	N/A	"00"
837p-005						Reference Identification	Req	BHT03	127	O	AN	1	30	Originator Application Transaction Identifier	N/A	System Generated

CIS MANUAL 837 P (ORIGINAL)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837p-006						Date	Req	BHT04	373	O	DT	8	8	Transaction Set Creation Date	N/A	System Generated
837p-007						Time	Req	BHT05	337	O	TM	4	8	Transaction Set Creation Time	N/A	System Generated
837p-008						Transaction Type Code	Req	BHT06	640	O	ID	2	2	"RP"	N/A	"RP"
837p-009	Transmission Type Identification	Required	1			Reference Identification Qualifier	Req	REF01	128	M	ID	2	3	"87"	N/A	"87"
837p-010						Reference Identification	Req	REF02	127	X	AN	1	30	"004010X098A1" (004010X098DA1 for test file)	N/A	"004010X098A1"
837p-011	Submitter Name	Required	1	1000A	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"41"	N/A	"41"
837p-012						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837p-013						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	RBHA Name	N/A	"ValueOptions"
837p-014						Name First	Sit	NM104	1036	O	AN	1	25		N/A	Not Used
837p-015						Name Middle	Sit	NM105	1037	O	AN	1	25		N/A	Not Used
837p-016						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"46"	N/A	"46"
837p-017						Identification Code	Req	NM109	67	X	AN	2	80	RBHA Contractor ID	N/A	"54-1414194"
837p-018	Submitter EDI Contact Information	Required	2	1000A	1	Contact Function Code	Req	PER01	366	M	ID	2	2	"IC"	N/A	"IC"
837p-019						Name	Req	PER02	93	O	AN	1	60	Contact Person	N/A	"Steve Myers"
837p-020						Communication Number Qualifier	Req	PER03	365	X	ID	2	2	Codes ED, EM, FX, TE	N/A	"EM"
837p-021						Communication Number	Req	PER04	364	X	AN	1	80	Communication number	N/A	"steve.myers@valueoptions.com"
837p-022						Communication Number Qualifier	Sit	PER05	365	X	ID	2	2		N/A	"TE"
837p-023						Communication Number	Sit	PER06	364	X	AN	1	80		N/A	"6029145926"
837p-024						Communication Number Qualifier	Sit	PER07	365	X	ID	2	2		N/A	Not Used
837p-025						Communication Number	Sit	PER08	364	X	AN	1	80		N/A	Not Used
837p-026	Receiver Name	Required	1	1000B	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"40"	N/A	"40"
837p-027						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837p-028						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	"ADHS/BHS"	N/A	"ADHS/BHS"
837p-029						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"46"	N/A	"46"
837p-030						Identification Code	Req	NM109	67	X	AN	2	80	"86-6004791"	N/A	"86-6004791"
837p-031	Billing/Pay-to provider hierarchical level	Required	1	2000A	>1	Hierarchical Id Number	Req	HL01	628	M	AN	1	12	Starts with 1 and is incremented for each HL	N/A	System Generated
837p-032						Hierarchical Level Code	Req	HL03	735	M	ID	1	2	"20"	N/A	"20"
837p-033						Hierarchical Child Code	Req	HL04	736	O	ID	1	1	"1"	N/A	"1"
837p-039	Billing Provider Name	Required	1	2010AA	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"85"	N/A	"85"
837p-040						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837p-041						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	Group Biller Name / Provider Name	N/A	Not Used
837p-045						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"24" until Nat Prov Id issued, then "XX"	N/A	"24"
837p-046						Identification Code	Req	NM109	67	X	AN	2	80	EIN until Nat Prov ID issued	N/A	Not Used
837p-047	Billing Provider Address	Required	1	2010AA	1	Address Information	Req	N301	166	M	AN	1	55	Group Biller / Provider Address	N/A	Not Used
837p-048						Address Information	Sit	N302	166	O	AN	1	55		N/A	Not Used

CIS MANUAL 837 P (ORIGINAL)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837p-049	Billing Provider City/State/Zip Code	Required	1	2010AA	1	City Name	Req	N401	19	O	AN	2	30	Group Biller / Provider City	N/A	Not Used
837p-050						State or Providence Code	Req	N402	156	O	ID	2	2	Group Biller / Provider State	N/A	Not Used
837p-051						Postal Code	Req	N403	116	O	ID	3	15	Group Biller / Provider Zip Code	N/A	Not Used
837p-052						Country Code	Sit	N404	26	O	ID	2	3		N/A	Not Used
837p-053	Billing Provider Secondary Identification	Situational	8	2010AA	1	Reference Identification Qualifier	Req	REF01	128	M	ID	2	3	"1D"	N/A	"ID"
837p-054						Reference Identification	Req	REF02	127	X	AN	1	30	Group Biller ID / Provider Id	Dw_claim.Provider_ID	Field Value
837p-065	Pay-to Provider Name	Situational	1	2010AB	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"87"	N/A	"87"
837p-066						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837p-067						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	Provider Name	Dw_claim.Provider_Name	Field Value
837p-071						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"24" until Nat Prov ID issued, then "XX"	N/A	"24"
837p-072						Identification Code	Req	NM109	67	X	AN	2	80	EIN until Nat Prov ID issued	Dw_claim.Provider_TaxID	Field Value
837p-073	Pay-to Provider Address	Required	1	2010AB	1	Address Information	Req	N301	166	M	AN	1	55	Provider Address	Dw_claim.Provider_Adrln1	Field Value
837p-074						Address Information	Sit	N302	166	O	AN	1	55		N/A	Not Used
837p-075	Pay-to Provider City/State/Zip Code	Required	1	2010AB	1	City Name	Req	N401	19	O	AN	2	30	Provider City	Dw_claim.Provider_City	Field Value
837p-076						State or Province Code	Req	N402	156	O	ID	2	2	Provider State	Dw_claim.Provider_State	Field Value
837p-077						Postal Code	Req	N403	116	O	ID	3	15	Provider Zip Code	Dw_claim.Provider_Zip	Field Value
837p-078						Country Code	Sit	N404	26	O	ID	2	3		N/A	Not Used
837p-079	Pay-to Provider Secondary Identification	Situational	5	2010AB	1	Reference Identification Qualifier	Req	REF01	128	M	ID	2	3	"G2"	N/A	"G2"
837p-080						Reference Identification	Req	REF02	127	X	AN	1	30	Provider ID	N/A	Not Used
837p-081	Subscriber Hierarchical Level	Required	1	2000B	>1	Hierarchical Id Number	Req	HL01	628	M	AN	1	12	Next HL# (incremented by 1 for each HL)	N/A	System Generated
837p-082						Hierarchical Parent ID Number	Req	HL02	734	O	AN	1	12	HL01 from provider HL level	N/A	System Generated
837p-083						Hierarchical Level Code	Req	HL03	735	M	ID	1	2	"22"	N/A	"22"
837p-084						Hierarchical Child Code	Req	HL04	736	O	ID	1	1	"0"	N/A	"0"
837p-085	Subscriber Information	Required	1	2000B	1	Payer Responsibility Sequence Number Code	Req	SBR01	1138	M	ID	1	1	"T"	N/A	"T"
837p-086						Individual Relationship Code	Sit	SBR02	1069	O	ID	2	2	"18"	N/A	"18"
837p-087						Reference Identification	Sit	SBR03	127	O	AN	1	30		N/A	Not Used
837p-088						Name	Sit	SBR04	93	O	AN	1	60		N/A	Not Used
837p-089						Insurance Type Code	Sit	SBR05	1336	O	ID	1	3		N/A	Not Used
837p-090						Claim Filling Indicator Code	Sit	SBR09	1032	O	ID	1	2	"MC"	N/A	"MC"
837p-096	Subscriber Name	Required	1	2010BA	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"IL"	N/A	"IL"
837p-097						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"1"	N/A	"1"
837p-098						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	Client's Last Name	Dw_claim.Lstnam	Field Value
837p-099						Name First	Sit	NM104	1036	O	AN	1	25	Client's First Name	Dw_claim.Fstnam	Field Value

CIS MANUAL 837 P (ORIGINAL)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837p-100						Name Middle	Sit	NM105	1037	O	AN	1	25		Dw_claim.Midnam	Field Value
837p-101						Name Suffix	Sit	NM107	1039	O	AN	1	10		N/A	Not Used
837p-102						Identification Code Qualifier	Sit	NM108	66	X	ID	1	2	"MI"	N/A	"MI"
837p-103						Identification Code	Sit	NM109	67	X	AN	2	80	Client ID	Dw_claim.Client_id	Field Value
837p-104	Subscriber Address	Situational	1	2010BA	1	Address Information	Req	N301	166	M	AN	1	55		Dw_claim.Adrln1	Field Value
837p-105						Address Information	Sit	N302	166	O	AN	1	55		N/A	Not Used
837p-106	Subscriber City/State/Zip Code	Situational	1	2010BA	1	City Name	Req	N401	19	O	AN	2	30		Dw_claim.CityCd	Field Value
837p-107						State or Province Code	Req	N402	156	O	ID	2	2		Dw_claim.Stacd	Field Value
837p-108						Postal Code	Req	N403	116	O	ID	3	15		Dw_claim.Zipcod	Field Value
837p-109						Country Code	Sit	N404	26	O	ID	2	3		N/A	Not Used
837p-110	Subscriber Demographic Information	Situational	1	2010BA	1	Date Time Period format Qualifier	Req	DMG01	1250	X	ID	2	3	"D8"	N/A	"D8"
837p-111						Date Time Period	Req	DMG02	1251	X	AN	1	35		Dw_claim.Bthdat	Field Value
837p-112						Gender Code	Req	DMG03	1068	O	ID	1	1		Dw_claim.Sexcod	Field Value
837p-117	Payer Name	Required	1	2010BB	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"PR"	N/A	"PR"
837p-118						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837p-119						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	"ADHS/BHS"	N/A	"ADHS/BHS"
837p-120						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"PI"	N/A	"PI"
837p-121						Identification Code	Req	NM109	67	X	AN	2	80	"86-6004791"	N/A	"86-6004791"
837p-183	Claim Information	Required	1	2300	100	Claim submitter's Identifier	Req	CLM01	1028	M	AN	1	38	ICN Number	Dw_claim.ICN_Nbr	Field Value
837p-184						Monetary Amount	Req	CLM02	782	O	R	1	18	Line Item Charge Amount	Dw_claim.Billed_Amount	Field Value
837p-185	**NOTE** The 2300 through 2330B info					Health Care Service Location Information	Req	CLM05	C023	O					Composite Segment	Composite Segment
837p-186	Must be repeated for each line of a multi					Facility Code Value	Req	CLM05-1	1331	M	AN	1	2	Place of Service	Dw_claim.Place_of_Svc	Field Value
837p-187	Line HCFA when Medicare or Other Ins					Claim Frequency Type Code	Req	CLM05-3	1325	O	ID	1	1	"1"	N/A	"1"
837p-188	Information is present					Yes/No Condition or Response Code	Req	CLM06	1073	O	ID	1	1	"Y"	N/A	"Y"
837p-189						Provider Accept Assignment Code	Req	CLM07	1359	O	ID	1	1	"A"	N/A	"A"
837p-190						Yes/No Condition or Response Code	Req	CLM08	1073	O	ID	1	1	"Y"	N/A	"Y"
837p-191						Release of Information Code	Req	CLM09	1363	O	ID	1	1	"A", "I", "M", "O", "Y"	N/A	"Y"
837p-192						Patient Signature Source Code	Sit	CLM10	1351	O	ID	1	1	"C"	N/A	"C"
837p-193						Related Causes Information	Sit	CLM11	C024	O					N/A	Not Used
837p-194						Related-Causes Code	Req	CLM11-1	1362	M	ID	2	3		N/A	Not Used
837p-195						Related-Causes Code	Sit	CLM11-2	1362	O	ID	2	3		N/A	Not Used
837p-196						Related-Causes Code	Sit	CLM11-3	1362	O	ID	2	3		N/A	Not Used
837p-197						State or Province Code	Sit	CLM11-4	156	O	ID	2	2		N/A	Not Used
837p-198						Country Code	Sit	CLM11-5	26	O	ID	2	3		N/A	Not Used
837p-199						Special Program Code	Sit	CLM12	1366	O	ID	2	3		N/A	Not Used
837p-200						Provider Agreement Code	Sit	CLM16	1360	O	ID	1	1		N/A	Not Used
837p-201						Delay Reason Code	Sit	CLM20	1514	O	ID	1	2		N/A	Not Used

CIS MANUAL 837 P (ORIGINAL)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837p-272	Prior Authorization or Referral Number	Situational	2	2300	100	Reference Identification Qualifier	Req	REF01	128	M	ID	2	3	"G1"	N/A	"G1"
837p-273						Reference Identification	Req	REF02	127	X	AN	1	30	Prior Authorization Number	Dw_claim.Prior_Auth_nbr	Field Value
837p-274	Original Reference Number (ICN/DCN)	Situational	1	2300	100	Reference Identification Qualifier	Req	REF01	128	M	ID	2	3	"F8"	N/A	Not Used
837p-275						Reference Identification	Req	REF02	127	X	AN	1	30	Claim Original Reference Number	N/A	Not Used
837p-293	Claim Note	Situational	1	2300	100	Note Reference Code	Req	NTE01	363	O	ID	3	3	"ADD"	N/A	"ADD"
837p-294						Description	Req	NTE02	352	M	AN	1	80	String the three fields into a single 10 char entry	Dw_claim.Dup_Override_Ind, Dw_claim.Oth_Ins_Cov_Flag, Dw_claim.Encounter_Process_Dt	Field Value-String the three fields into a single 10 char entry
837p-295	Ambulance Transport information	Situational	1	2300	100	Unit or Basis for Measurement Code	Sit	CR101	355	X	ID	2	2		N/A	Not Used
837p-296	Required For Transportation Encounters					Weight	Sit	CR102	81	X	R	1	10		N/A	Not Used
837p-297	ONLY!!!					Ambulance Transport Code	Req	CR103	1316	O	ID	1	1	"X" Replaces "2X" modifier	N/A	"X"
837p-298						Ambulance Transport Reason Code	Req	CR104	1317	O	ID	1	1	"A", "B", "C", "D", or "E"	N/A	"A"
837p-299						Unit or Basis for Measurement Code	Req	CR105	355	X	ID	2	2	"DH"	N/A	"DH"
837p-300						Quantity	Req	CR106	380	X	R	1	15	Miles (should be same as SV104)	N/A	System Generated
837p-301						Description	Sit	CR109	352	O	AN	1	80	Required when CR103 = "X"	N/A	Not Used
837p-302						Description	Sit	CR110	352	O	AN	1	80		N/A	Not Used
837p-329	Health Care Diagnosis Code	Situational	1	2300	100	Health Care Code Information	Req	HI01	C022	M					Composite Segment	Composite Segment
837p-330						Code List Qualifier Code	Req	HI01-1	1270	M	ID	1	3	"BK"	N/A	"BK"
837p-331						Industry Code	Req	HI01-2	1271	M	AN	1	30	Diagnosis Code	Dw_claim.Diagnosis_Code	Field Value
837p-332						Health Care Code Information	Sit	HI02	C022	O					Composite Segment	Composite Segment
837p-333						Code List Qualifier Code	Req	HI02-1	1270	M	ID	1	3	"BF"	N/A	"BF"
837p-334						Industry Code	Req	HI02-2	1271	M	AN	1	30	ICD9 Code 2	Dw_claim.icd9_Code_2	Field Value
837p-335						Health Care Code Information	Sit	HI03	C022	O					Composite Segment	Composite Segment
837p-336						Code List Qualifier Code	Req	HI03-1	1270	M	ID	1	3	"BF"	N/A	"BF"
837p-337						Industry Code	Req	HI03-2	1271	M	AN	1	30	ICD9 Code 3	Dw_claim.icd9_Code_3	Field Value
837p-338						Health Care Code Information	Sit	HI04	C022	O					Composite Segment	Composite Segment
837p-339						Code List Qualifier Code	Req	HI04-1	1270	M	ID	1	3	"BF"	N/A	"BF"
837p-340						Industry Code	Req	HI04-2	1271	M	AN	1	30	ICD9 Code 4	Dw_claim.icd9_Code_4	Field Value
837p-387	Rendering Provider Name	Situational	1	2310B	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"82"	N/A	"82"

CIS MANUAL 837 P (ORIGINAL)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837p-388						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837p-389						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	Rendering provider Name	Dw_claim.Provider_Name	Field Value
837p-393						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"24"	N/A	"24"
837p-394						Identification Code	Req	NM109	67	X	AN	2	80	Identification Code	Dw_claim.Provider_taxid	Field Value
837p-432	Other Subscriber Information (Medicare Loop)	Situational	1	2320	10	Payer Responsibility Sequence Number Code	Req	SBR01	1138	M	ID	1	1	"P" or "S"	N/A	"P"
837p-433						Individual Relationship Code	Req	SBR02	1069	O	ID	2	2	18	N/A	"18"
837p-434						Reference Identification	Sit	SBR03	127	O	AN	1	30		N/A	Not Used
837p-435						Name	Sit	SBR04	93	O	AN	1	60		N/A	Not Used
837p-436						Insurance Type Code	Req	SBR05	1336	O	ID	1	3	"MB" or "MP"	N/A	"MB"
837p-437						Claim Filling Indicator Code	Sit	SBR09	1032	O	ID	1	2	"MB"	N/A	"MB"
837p-457	COB Payer Paid Amount	Situational	1	2320	10	Amount Qualifier Code	Req	AMT01	522	M	ID	1	3	"D"	N/A	"D"
837p-458						Monetary Amount	Req	AMT02	782	M	R	1	18	Medicare Payment	Dw_claim.Medicare_Payment	Field Value
837p-461	COB Allowed Amount	Situational	1	2320	10	Amount Qualifier Code	Req	AMT01	522	M	ID	1	3	"B6"	N/A	"B6"
837p-462						Monetary Amount	Req	AMT02	782	M	R	1	18	Medicare Allowed Amount	Dw_claim.Medicare_Allow_Amount	Field Value
837p-463	COB Patient Responsibility Amount	Situational	1	2320	10	Amount Qualifier Code	Req	AMT01	522	M	ID	1	3	"F2"	N/A	"F2"
837p-464						Monetary Amount	Req	AMT02	782	M	R	1	18	Medicare Deductible Amount	Dw_claim.Medicare_Deductible	Field Value
837p-477	Subscriber Demographic Information	Situational	1	2320	10	Date Time Period format Qualifier	Req	DMG01	1250	X	ID	2	3	"D8"	N/A	"D8"
837p-478						Date Time Period	Req	DMG02	1251	X	AN	1	35	Date of Birth	Dw_claim.Bthdat	Field Value
837p-479						Gender Code	Req	DMG03	1068	O	ID	1	1	Gender	Dw_claim.Sexcod	Field Value
837p-480	Other Insurance Coverage Information	Required	1	2320	10	Yes/No Condition or Response Code	Req	OI03	1073	O	ID	1	1	"Y"	N/A	"Y"
837p-481						Patient Signature Source Code	Sit	OI04	1351	O	ID	1	1	"C"	N/A	"C"
837p-482						Release of Information Code	Req	OI06	1363	O	ID	1	1	"A"	N/A	"A"
837p-492	Other Subscriber Name	Required	1	2330A	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"IL"	N/A	"IL"
837p-493						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"1"	N/A	"1"
837p-494						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	Client's Last Name	Dw_claim.Lstnam	Field Value
837p-495						Name First	Sit	NM104	1036	O	AN	1	25	Client's First Name	Dw_claim.Fstnam	Field Value
837p-496						Name Middle	Sit	NM105	1037	O	AN	1	25		N/A	Not Used
837p-497						Name Suffix	Sit	NM107	1039	O	AN	1	10		N/A	Not Used
837p-498						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"MI"	N/A	"MI"
837p-499						Identification Code	Req	NM109	67	X	AN	2	80	Client's medicare ID	Dw_claim.Medicare_ID	Field Value
837p-508	Other Payer Name	Required	1	2330B	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"PR"	N/A	"PR"
837p-509						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837p-510						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	"Medicare"	N/A	"Medicare"
837p-511						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"PI" until Nat Plan ID issued; then "XV"	N/A	"PI"

CIS MANUAL 837 P (ORIGINAL)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837p-512	(End of Medicare Loop)					Identification Code	Req	NM109	67	X	AN	2	80	Payer's Plan ID until Nat Plan ID issued	N/A	"002"
837p-432	Other Subscriber Information (Oth Ins Loop)	Situational	1	2320	10	Payer Responsibility Sequence Number Code	Req	SBR01	1138	M	ID	1	1	"P" or "S"	N/A	"S"
837p-433						Individual Relationship Code	Req	SBR02	1069	O	ID	2	2	18	N/A	"18"
837p-434						Reference Identification	Sit	SBR03	127	O	AN	1	30		N/A	Not Used
837p-435						Name	Sit	SBR04	93	O	AN	1	60		N/A	Not Used
837p-436						Insurance Type Code	Req	SBR05	1336	O	ID	1	3	"C1"	N/A	"C1"
837p-437						Claim Filling Indicator Code	Sit	SBR09	1032	O	ID	1	2	any valid Code except "MB" or "MC"	N/A	Not Used
837p-457	COB Payer Paid Amount	Situational	1	2320	10	Amount Qualifier Code	Req	AMT01	522	M	ID	1	3	"D"	N/A	"D"
837p-458						Monetary Amount	Req	AMT02	782	M	R	1	18	Other Insurance Payment	N/A	Not Used
837p-477	Subscriber Demographic Information	Situational	1	2320	10	Date Time Period format Qualifier	Req	DMG01	1250	X	ID	2	3	"D8"	N/A	"D8"
837p-478						Date Time Period	Req	DMG02	1251	X	AN	1	35		N/A	Not Used
837p-479						Gender Code	Req	DMG03	1068	O	ID	1	1		N/A	Not Used
837p-480	Other Insurance Coverage Information	Required	1	2320	10	Yes/No Condition or Response Code	Req	OI03	1073	O	ID	1	1	"Y"	N/A	"Y"
837p-481						Patient Signature Source Code	Sit	OI04	1351	O	ID	1	1	"C"	N/A	"C"
837p-482						Release of Information Code	Req	OI06	1363	O	ID	1	1	"A"	N/A	"A"
837p-492	Other Subscriber Name	Required	1	2330A	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"IL"	N/A	"IL"
837p-493						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"1"	N/A	"1"
837p-494						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	Client's Last Name	N/A	Not Used
837p-495						Name First	Sit	NM104	1036	O	AN	1	25	Client's First Name	N/A	Not Used
837p-496						Name Middle	Sit	NM105	1037	O	AN	1	25		N/A	Not Used
837p-497						Name Suffix	Sit	NM107	1039	O	AN	1	10		N/A	Not Used
837p-498						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"MI"	N/A	"MI"
837p-499						Identification Code	Req	NM109	67	X	AN	2	80	Client's Other Insurance ID	N/A	Not Used
837p-508	Other Payer Name	Required	1	2330B	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"PR"	N/A	"PR"
837p-509						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837p-510						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	Insurance Company Name	N/A	Not Used
837p-511						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"PI" until Nat Plan ID issued; then "XV"	N/A	"PI"
837p-512	(End of Oth Ins Loop)					Identification Code	Req	NM109	67	X	AN	2	80	Payer's Plan ID until Nat Plan ID issued	N/A	Not Used
837p-556	Service Line	Required	1	2400	50	Assigned Number	Req	LX01	554	M	N0	1	6	Line Number for single line HCFAs	Dw_claim.Line_nbr	Field Value
837p-557	Professional Service	Required	1	2400	50	Composite Medical Procedure Identifier	Req	SV101	C003	M					Composite Segment	Composite Segment
837p-558						Product/Service ID Qualifier	Req	SV101-1	235	M	ID	2	2	"HC"	N/A	"HC"
837p-559						Product/Service ID	Req	SV101-2	234	M	AN	1	48	Procedure Code	Dw_claim.Procedure_Code	Field Value
837p-560						Procedure Modifier	Sit	SV101-3	1339	O	AN	2	2	Procedure Code Modifier	Dw_claim.Proc_Code_modifier	Field Value

CIS MANUAL 837 P (ORIGINAL)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837p-561						Procedure Modifier	Sit	SV101-4	1339	O	AN	2	2	Procedure Code Modifier	N/A	Not Used
837p-562						Procedure Modifier	Sit	SV101-5	1339	O	AN	2	2		N/A	Not Used
837p-563						Procedure Modifier	Sit	SV101-6	1339	O	AN	2	2		N/A	Not Used
837p-564						Monetary Amount	Req	SV102	782	O	R	1	18	Line Item Charge Amount	Dw_claim.Billed_Amount	Field Value
837p-565						Unit or Basis for Measurement Code	Req	SV103	355	X	ID	2	2	"UN"	N/A	"UN"
837p-566						Quantity	Req	SV104	380	X	R	1	15	Unit of Service	Dw_claim.Unit_Of_Service	Field Value
837p-567						Facility Code Value	Sit	SV105	1331	O	AN	1	2	Place of Service	Dw_claim.Place_of_svc	Field Value
837p-568						Composite Diagnosis Code Pointer	Sit	SV107	C004	O					Composite Segment	Composite Segment
837p-569						Diagnosis Code Pointer	Req	SV107-1	1328	M	N0	1	2	"1"	N/A	"1"
837p-570						Diagnosis Code Pointer	Sit	SV107-2	1328	O	N0	1	2	"2"	N/A	"2"
837p-571						Diagnosis Code Pointer	Sit	SV107-3	1328	O	N0	1	2	"3"	N/A	"3"
837p-572						Diagnosis Code Pointer	Sit	SV107-4	1328	O	N0	1	2	"4"	N/A	"4"
837p-573						Yes/No Condition or Response Code	Req	SV109	1073	O	ID	1	1	"Y" if Emergency, no value of not emergency	N/A	"Y" if Emergency, no value if not emergency
837p-574						Yes/No Condition or Response Code	Sit	SV110	1073	O	ID	1	1		N/A	Not Used
837p-575						Yes/No Condition or Response Code	Sit	SV111	1073	O	ID	1	1		N/A	Not Used
837p-576						Co-pay Status Code	Sit	SV115	1327	O	ID	1	1		N/A	Not Used
837p-587	Ambulance Transport Information	Situational	1	2400	50	Unit or Basis for Measurement Code	Sit	CR101	355	X	ID	2	2	Not expected / not stored	N/A	Not Used
837p-588	**USED FOR MULTI-LINE HCFAs ONLY					Weight	Sit	CR102	81	X	R	1	10	Not expected / not stored	N/A	Not Used
837p-589	To over-ride CR1 segment in 2300 loop					Ambulance Transport Code	Req	CR103	1316	O	ID	1	1	"X" Replaces "2X" modifier	N/A	"X"
837p-590						Ambulance Transport Reason Code	Req	CR104	1317	O	ID	1	1	"A", "B", "C", "D", or "E"	N/A	"A"
837p-591						Unit or Basis for Measurement Code	Req	CR105	355	X	ID	2	2	"DH"	N/A	"DH"
837p-592						Quantity	Req	CR106	380	X	R	1	15	Miles (should be same as SV104)	N/A	Not Used
837p-593						Description	Sit	CR109	352	O	AN	1	80	Required when CR103 = "X"	N/A	Not Used
837p-594						Description	Sit	CR110	352	O	AN	1	80	Not expected / not stored	N/A	Not Used
837p-627	Date - Service Date	Required	1	2400	50	Date/Time Qualifier	Req	DTP01	374	M	ID	3	3	Code 472 - Service	N/A	"472"
837p-628						Date/Time Period Format Qualifier	Req	DTP02	1250	M	ID	2	3	"RD8" CCYYMMDD-CCYYMMDD	N/A	"RD8"
837p-629						Date/Time Period	Req	DTP03	1251	M	AN	1	35	Service Date - End Date	Dw_claim.Start-Dt, Dw_claim.End_dt	Field Value
837p-669	Contract Information	Situational	1	2400	50	Contract Type Code	Req	CN101	1166	M	ID	2	2	"05" or "02"	Dw_claim.Svc_Type	Data Warehouse “02” = HIPAA “05, all other values = HIPAA “02”

CIS MANUAL 837 P (ORIGINAL)															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837p-670						Monetary Amount	Sit	CN102	782	O	R	1	18	Special Net Value or Net-Paid	Dw_claim.Special_Net_Value, Dw_claim.Net_Paid	If HIPAA Svc_Type="05" use Special_Net_Value, if HIPAA_Svc_Type = "02" use Net_Paid
837p-681	Line Item Control Number	Situational	1	2400	50	Reference Identification Qualifier	Req	REF01	128	M	ID	2	3	"6R"	N/A	"6R"
837p-682	**USED FOR MULTI-LINE HCFAs ONLY					Reference Identification	Req	REF02	127	M	AN	1	30	Line Number for multi-line HCFAs	N/A	System Generated
837p-865	Transaction Set Trailer	Required	1			Number of Included Segments	Req	SE01	96	M	N0	1	10	Total # of segments (including ST and SE)	N/A	System Generated
837p-866						Transaction Set Control Number	Req	SE02	329	M	AN	4	9		N/A	Not Used

837 P Mapping (Void/Replace)

Values in quotes represent literal strings that are hard-Coded directly into the program.
When the Table Name.Field Name contains a “N/A” it indicates that no value is retrieved from a data store for that field.
A logic entry of “System Generated” indicates a value that is generated or calculated at file creation time by the program.
A logic entry of “Spaces” indicates a field that is filled entirely with spaces.

CIS MANUAL 837 P (VOID/REPLACE) DATA MAPPING																VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837p-001	Transaction Set Header	Required	1			Transaction Set Identifier Code	Req	ST01	143	M	ID	3	3	"837"	N/A	"837"
837p-002						Transaction Set Control Number	Req	ST02	329	M	ID	4	9	Incremented Number	N/A	System Generated
837p-003	Beginning of Hierarchical Transaction	Required	1			Hierarchical Structure Code	Req	BHT01	1005	M	ID	4	4	"0019"	N/A	"0019"
837p-004						Transaction Set purpose Code	Req	BHT02	353	M	ID	2	2	"00"	N/A	"00"
837p-005						Reference Identification	Req	BHT03	127	O	AN	1	30	Originator Application Transaction Identifier	N/A	System Generated
837p-006						Date	Req	BHT04	373	O	DT	8	8	Transaction Set Creation Date	N/A	System Generated
837p-007						Time	Req	BHT05	337	O	TM	4	8	Transaction Set Creation Time	N/A	System Generated
837p-008						Transaction Type Code	Req	BHT06	640	O	ID	2	2	"RP"	N/A	"RP"
837p-009	Transmission Type Identification	Required	1			Reference Identification Qualifier	Req	REF01	128	M	ID	2	3	"87"	N/A	"87"
837p-010						Reference Identification	Req	REF02	127	X	AN	1	30	"004010X098A1" (004010X098DA1 for test file)	N/A	"004010X098A1"
837p-011	Submitter Name	Required	1	1000A	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"41"	N/A	"41"
837p-012						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837p-013						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	RBHA Name	N/A	"ValueOptions"
837p-014						Name First	Sit	NM104	1036	O	AN	1	25		N/A	Not Used
837p-015						Name Middle	Sit	NM105	1037	O	AN	1	25		N/A	Not Used
837p-016						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"46"	N/A	"46"
837p-017						Identification Code	Req	NM109	67	X	AN	2	80	Contractor ID	N/A	"54-1414194"
837p-018	Submitter EDI Contact Information	Required	2	1000A	1	Contact Function Code	Req	PER01	366	M	ID	2	2	"IC"	N/A	"IC"
837p-019						Name	Req	PER02	93	O	AN	1	60	Contact Person	N/A	"Steve Myers"
837p-020						Communication Number Qualifier	Req	PER03	365	X	ID	2	2	Codes ED, EM, FX, TE	N/A	"EM"
837p-021						Communication Number	Req	PER04	364	X	AN	1	80	Communication number	N/A	"steve.myers@valueoptions.com"
837p-022						Communication Number Qualifier	Sit	PER05	365	X	ID	2	2		N/A	"TE"
837p-023						Communication Number	Sit	PER06	364	X	AN	1	80		N/A	"6029145926"
837p-024						Communication Number Qualifier	Sit	PER07	365	X	ID	2	2		N/A	Not Used
837p-025						Communication Number	Sit	PER08	364	X	AN	1	80		N/A	Not Used
837p-026	Receiver Name	Required	1	1000B	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"40"	N/A	"40"
837p-027						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837p-028						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	"ADHS/BHS"	N/A	"ADHS/BHS"

CIS MANUAL 837 P (VOID/REPLACE) DATA MAPPING																VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837p-029						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"46"	N/A	"46"
837p-030						Identification Code	Req	NM109	67	X	AN	2	80	"86-6004791"	N/A	"86-6004791"
837p-031	Billing/Pay-to provider hierarchical level	Required	1	2000A	>1	Hierarchical ID Number	Req	HL01	628	M	AN	1	12	Starts with 1 and is incremented for each HL	N/A	System Generated
837p-032						Hierarchical Level Code	Req	HL03	735	M	ID	1	2	"20"	N/A	"20"
837p-033						Hierarchical Child Code	Req	HL04	736	O	ID	1	1	"1"	N/A	"1"
837p-039	Billing Provider Name	Required	1	2010AA	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"85"	N/A	"85"
837p-040						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837p-041						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	Group Biller Name	N/A	Not Used
837p-045						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"24" until Nat Prov Id issued, then "XX"	N/A	"24"
837p-046						Identification Code	Req	NM109	67	X	AN	2	80	EIN until Nat Prov ID issued	N/A	Not Used
837p-047	Billing Provider Address	Required	1	2010AA	1	Address Information	Req	N301	166	M	AN	1	55	Group Biller Address	N/A	Not Used
837p-048						Address Information	Sit	N302	166	O	AN	1	55		N/A	Not Used
837p-049	Billing Provider City/State/Zip Code	Required	1	2010AA	1	City Name	Req	N401	19	O	AN	2	30	Group Biller City	N/A	Not Used
837p-050						State or Providence Code	Req	N402	156	O	ID	2	2	Group Biller State	N/A	Not Used
837p-051						Postal Code	Req	N403	116	O	ID	3	15	Group Biller Zip Code	N/A	Not Used
837p-052						Country Code	Sit	N404	26	O	ID	2	3		N/A	Not Used
837p-053	Billing Provider Secondary Identification	Situational	8	2010AA	1	Reference Identification Qualifier	Req	REF01	128	M	ID	2	3	"1D"	N/A	"ID"
837p-054						Reference Identification	Req	REF02	127	X	AN	1	30	Group Biller ID / Provider Id	Dw_claim.Provider_ID	Field Value
837p-065	Pay-to Provider Name	Situational	1	2010AB	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"87"	N/A	"87"
837p-066						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837p-067						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	Provider Name	Dw_claim.Provider_Name	Field Value
837p-071						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"24" until Nat Prov ID issued, then "XX"	N/A	"24"
837p-072						Identification Code	Req	NM109	67	X	AN	2	80	EIN until Nat Prov ID issued	Dw_claim.Provider_TaxID	Field Value
837p-073	Pay-to Provider Address	Required	1	2010AB	1	Address Information	Req	N301	166	M	AN	1	55	Provider Address	Dw_claim.Provider_Adrln1	Field Value
837p-074						Address Information	Sit	N302	166	O	AN	1	55		N/A	Not Used
837p-075	Pay-to Provider City/State/Zip Code	Required	1	2010AB	1	City Name	Req	N401	19	O	AN	2	30	Provider City	Dw_claim.Provider_City	Field Value
837p-076						State or Province Code	Req	N402	156	O	ID	2	2	Provider State	Dw_claim.Provider_State	Field Value
837p-077						Postal Code	Req	N403	116	O	ID	3	15	Provider Zip Code	Dw_claim.Provider_Zip	Field Value
837p-078						Country Code	Sit	N404	26	O	ID	2	3		N/A	Not Used
837p-079	Pay-to Provider Secondary Identification	Situational	5	2010AB	1	Reference Identification Qualifier	Req	REF01	128	M	ID	2	3	"G2"	N/A	"G2"
837p-080						Reference Identification	Req	REF02	127	X	AN	1	30	Provider ID	N/A	Not Used
837p-081	Subscriber Hierarchical Level	Required	1	2000B	>1	Hierarchical ID Number	Req	HL01	628	M	AN	1	12	Next HL# (incremented by 1 for each HL)	N/A	System Generated
837p-082						Hierarchical Parent ID Number	Req	HL02	734	O	AN	1	12	HL01 from provider HL	N/A	System Generated

CIS MANUAL 837 P (VOID/REPLACE) DATA MAPPING															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
														level		
837p-083						Hierarchical Level Code	Req	HL03	735	M	ID	1	2	"22"	N/A	"22"
837p-084						Hierarchical Child Code	Req	HL04	736	O	ID	1	1	"0"	N/A	"0"
837p-085	Subscriber Information	Required	1	2000B	1	Payer Responsibility Sequence Number Code	Req	SBR01	1138	M	ID	1	1	"T"	N/A	"T"
837p-086						Individual Relationship Code	Sit	SBR02	1069	O	ID	2	2	"18"	N/A	"18"
837p-087						Reference Identification	Sit	SBR03	127	O	AN	1	30		N/A	Not Used
837p-088						Name	Sit	SBR04	93	O	AN	1	60		N/A	Not Used
837p-089						Insurance Type Code	Sit	SBR05	1336	O	ID	1	3		N/A	Not Used
837p-090						Claim Filling Indicator Code	Sit	SBR09	1032	O	ID	1	2	"MC"	N/A	"MC"
837p-096	Subscriber Name	Required	1	2010BA	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"IL"	N/A	"IL"
837p-097						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"1"	N/A	"1"
837p-098						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	Client's Last Name	Dw_claim.Lstnam	Field Value
837p-099						Name First	Sit	NM104	1036	O	AN	1	25	Client's First Name	Dw_claim.Fstnam	Field Value
837p-100						Name Middle	Sit	NM105	1037	O	AN	1	25		Dw_claim.Midnam	Field Value
837p-101						Name Suffix	Sit	NM107	1039	O	AN	1	10		N/A	Not Used
837p-102						Identification Code Qualifier	Sit	NM108	66	X	ID	1	2	"MI"	N/A	"MI"
837p-103						Identification Code	Sit	NM109	67	X	AN	2	80	Client ID	Dw_claim.Client_id	Field Value
837p-104	Subscriber Address	Situational	1	2010BA	1	Address Information	Req	N301	166	M	AN	1	55		Dw_claim.Adrln1	Field Value
837p-105						Address Information	Sit	N302	166	O	AN	1	55		N/A	Not Used
837p-106	Subscriber City/State/Zip Code	Situational	1	2010BA	1	City Name	Req	N401	19	O	AN	2	30		Dw_claim.CityCd	Field Value
837p-107						State or Province Code	Req	N402	156	O	ID	2	2		Dw_claim.Stacd	Field Value
837p-108						Postal Code	Req	N403	116	O	ID	3	15		Dw_claim.Zipcod	Field Value
837p-109						Country Code	Sit	N404	26	O	ID	2	3		N/A	Not Used
837p-110	Subscriber Demographic Information	Situational	1	2010BA	1	Date Time Period format Qualifier	Req	DMG01	1250	X	ID	2	3	"D8"	N/A	"D8"
837p-111						Date Time Period	Req	DMG02	1251	X	AN	1	35		Dw_claim.Bthdat	Field Value
837p-112						Gender Code	Req	DMG03	1068	O	ID	1	1		Dw_claim.Sexcod	Field Value
837p-117	Payer Name	Required	1	2010BB	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"PR"	N/A	"PR"
837p-118						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837p-119						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	"ADHS/BHS"	N/A	"ADHS/BHS"
837p-120						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"PI"	N/A	"PI"
837p-121						Identification Code	Req	NM109	67	X	AN	2	80	"86-6004791"	N/A	"86-6004791"
837p-183	Claim Information	Required	1	2300	100	Claim submitter's Identifier	Req	CLM01	1028	M	AN	1	38	ICN Number	Dw_claim.ICN_Nbr	Field Value
837p-184	**NOTE** The 2300 through 2330B info					Monetary Amount	Req	CLM02	782	O	R	1	18	Sum of 2400 Billed-amounts	Dw_claim.Billed_Amount	Field Value
837p-185	Must be repeated for each line of a multi					Health Care Service Location Information	Req	CLM05	C023	O					Composite Element	Composite Element
837p-186	Line HCFA when Medicare or Other Ins					Facility Code Value	Req	CLM05-1	1331	M	AN	1	2	Place of Service	Dw_claim.Place_of_Svc	Field Value
837p-187	Information is present					Claim Frequency Type Code	Req	CLM05-3	1325	O	ID	1	1	"7"=Replace or "8"=Void	N/A	"8"
837p-188						Yes/No Condition or Response Code	Req	CLM06	1073	O	ID	1	1	"Y"	N/A	"Y"

CIS MANUAL 837 P (VOID/REPLACE) DATA MAPPING															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837p-189						Provider Accept Assigment Code	Req	CLM07	1359	O	ID	1	1	"A"	N/A	"A"
837p-190						Yes/No Condition or Response Code	Req	CLM08	1073	O	ID	1	1	"Y"	N/A	"Y"
837p-191						Release of Information Code	Req	CLM09	1363	O	ID	1	1	"A", "I", "M", "O", "Y"	N/A	"Y"
837p-192						Patient Signature Source Code	Sit	CLM10	1351	O	ID	1	1	"C"	N/A	"C"
837p-193						Related Causes Information	Sit	CLM11	C024	O					N/A	Not Used
837p-194						Related-Causes Code	Req	CLM11-1	1362	M	ID	2	3		N/A	Not Used
837p-195						Related-Causes Code	Sit	CLM11-2	1362	O	ID	2	3		N/A	Not Used
837p-196						Related-Causes Code	Sit	CLM11-3	1362	O	ID	2	3		N/A	Not Used
837p-197						State or Province Code	Sit	CLM11-4	156	O	ID	2	2		N/A	Not Used
837p-198						Country Code	Sit	CLM11-5	26	O	ID	2	3		N/A	Not Used
837p-199						Special Program Code	Sit	CLM12	1366	O	ID	2	3		N/A	Not Used
837p-200						Provider Agreement Code	Sit	CLM16	1360	O	ID	1	1		N/A	Not Used
837p-201						Delay Reason Code	Sit	CLM20	1514	O	ID	1	2		N/A	Not Used
837p-272	Prior Authorization or Referral Number	Situational	2	2300	100	Reference Identification Qualifier	Req	REF01	128	M	ID	2	3	"G1"	N/A	"G1"
837p-273						Reference Identification	Req	REF02	127	X	AN	1	30	Prior Authorization Number	Dw_claim.Prior_Auth_nbr	Field Value
837p-274	Original Reference Number (ICN/DCN)	Situational	1	2300	100	Reference Identification Qualifier	Req	REF01	128	M	ID	2	3	"F8"	N/A	"F8"
837p-275						Reference Identification	Req	REF02	127	X	AN	1	30	Claim Original Reference Number	Dw_claim.Adjustment_icn	Field Value
837p-293	Claim Note	Situational	1	2300	100	Note Reference Code	Req	NTE01	363	O	ID	3	3	"ADD"	N/A	"ADD"
837p-294						Description	Req	NTE02	352	M	AN	1	80	String the three fields into a single 10 char entry	Dw_claim.Dup_Override_Ind, Dw_claim.Oth_Ins_Cov_Flag, Dw_claim.Encounter_Process_Dt	Field Value-String the three fields into a single 10 char entry
837p-295	Ambulance Transport information	Situational	1	2300	100	Unit or Basis for Measurement Code	Sit	CR101	355	X	ID	2	2		N/A	Not Used
837p-296	Required For Transportation Encounters					Weight	Sit	CR102	81	X	R	1	10		N/A	Not Used
837p-297	ONLY!!!					Ambulance Transport Code	Req	CR103	1316	O	ID	1	1	"X" Replaces "2X" modifier	N/A	"X"
837p-298						Ambulance Transport Reason Code	Req	CR104	1317	O	ID	1	1	"A", "B", "C", "D", or "E"	N/A	"A"
837p-299						Unit or Basis for Measurement Code	Req	CR105	355	X	ID	2	2	"DH"	N/A	"DH"
837p-300						Quantity	Req	CR106	380	X	R	1	15	Miles (should be same as SV104)	N/A	Not Used
837p-301						Description	Sit	CR109	352	O	AN	1	80	Required when CR103 = "X"	N/A	Not Used
837p-302						Description	Sit	CR110	352	O	AN	1	80		N/A	Not Used
837p-329	Health Care Diagnosis Code	Situational	1	2300	100	Health Care Code Information	Req	HI01	C022	M					Composite Element	Composite Element
837p-330						Code List Qualifier Code	Req	HI01-1	1270	M	ID	1	3	"BK"	N/A	"BK"
837p-331						Industry Code	Req	HI01-2	1271	M	AN	1	30	Diagnosis Code	Dw_claim.Diagnosis_Code	Field Value

CIS MANUAL 837 P (VOID/REPLACE) DATA MAPPING																VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837p-332						Health Care Code Information	Sit	HI02	C022	O					Composite Element	Composite Element
837p-333						Code List Qualifier Code	Req	HI02-1	1270	M	ID	1	3	"BF"	N/A	"BF"
837p-334						Industry Code	Req	HI02-2	1271	M	AN	1	30	ICD9 Code 2	Dw_claim.icd9_Code_2	Field Value
837p-335						Health Care Code Information	Sit	HI03	C022	O					Composite Element	Composite Element
837p-336						Code List Qualifier Code	Req	HI03-1	1270	M	ID	1	3	"BF"	N/A	"BF"
837p-337						Industry Code	Req	HI03-2	1271	M	AN	1	30	ICD9 Code 3	Dw_claim.icd9_Code_3	Field Value
837p-338						Health Care Code Information	Sit	HI04	C022	O					Composite Element	Composite Element
837p-339						Code List Qualifier Code	Req	HI04-1	1270	M	ID	1	3	"BF"	N/A	"BF"
837p-340						Industry Code	Req	HI04-2	1271	M	AN	1	30	ICD9 Code 4	Dw_claim.icd9_Code_4	Field Value
837p-387	Rendering Provider Name	Situational	1	2310B	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"82"	N/A	"82"
837p-388						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837p-389						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	Rendering provider Name	Dw_claim.Provider_Name	Field Value
837p-393						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"24"	N/A	"24"
837p-394						Identification Code	Req	NM109	67	X	AN	2	80	Identification Code	Dw_claim.Provider_taxid	Field Value
837p-432	Other Subscriber Information (Medicare Loop)	Situational	1	2320	10	Payer Responsibility Sequence Number Code	Req	SBR01	1138	M	ID	1	1	"P" or "S"	N/A	"P"
837p-433						Individual Relationship Code	Req	SBR02	1069	O	ID	2	2	18	N/A	"18"
837p-434						Reference Identification	Sit	SBR03	127	O	AN	1	30		N/A	Not Used
837p-435						Name	Sit	SBR04	93	O	AN	1	60		N/A	Not Used
837p-436						Insurance Type Code	Req	SBR05	1336	O	ID	1	3	"MB" or "MP"	N/A	"MB"
837p-437						Claim Filling Indicator Code	Sit	SBR09	1032	O	ID	1	2	"MB"	N/A	"MB"
837p-457	COB Payer Paid Amount	Situational	1	2320	10	Amount Qualifier Code	Req	AMT01	522	M	ID	1	3	"D"	N/A	"D"
837p-458						Monetary Amount	Req	AMT02	782	M	R	1	18	Medicare Payment	Dw_claim.Medicare_Payment	Field Value
837p-461	COB Allowed Amount	Situational	1	2320	10	Amount Qualifier Code	Req	AMT01	522	M	ID	1	3	"B6"	N/A	"B6"
837p-462						Monetary Amount	Req	AMT02	782	M	R	1	18	Medicare Allowed Amount	Dw_claim.Medicare_Allow_Amount	Field Value
837p-463	COB Patient Responsibility Amount	Situational	1	2320	10	Amount Qualifier Code	Req	AMT01	522	M	ID	1	3	"F2"	N/A	"F2"
837p-464						Monetary Amount	Req	AMT02	782	M	R	1	18	Medicare Deductible Amount	Dw_claim.Medicare_Deductible	Field Value
837p-477	Subscriber Demographic Information	Situational	1	2320	10	Date Time Period format Qualifier	Req	DMG01	1250	X	ID	2	3	"D8"	N/A	"D8"
837p-478						Date Time Period	Req	DMG02	1251	X	AN	1	35	Date of Birth	Dw_claim.Bthdat	Field Value
837p-479						Gender Code	Req	DMG03	1068	O	ID	1	1	Gender	Dw_claim.Sexcod	Field Value
837p-480	Other Insurance Coverage Information	Required	1	2320	10	Yes/No Condition or Response Code	Req	OI03	1073	O	ID	1	1	"Y"	N/A	"Y"
837p-481						Patient Signature Source Code	Sit	OI04	1351	O	ID	1	1	"C"	N/A	"C"
837p-482						Release of Information Code	Req	OI06	1363	O	ID	1	1	"A"	N/A	"A"
837p-492	Other Subscriber Name	Required	1	2330A	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"IL"	N/A	"IL"

CIS MANUAL 837 P (VOID/REPLACE) DATA MAPPING																VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
837p-493						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"1"	N/A	"1"
837p-494						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	Client's Last Name	Dw_claim.Lstnam	Field Value
837p-495						Name First	Sit	NM104	1036	O	AN	1	25	Client's First Name	Dw_claim.Fstnam	Field Value
837p-496						Name Middle	Sit	NM105	1037	O	AN	1	25		N/A	Not Used
837p-497						Name Suffix	Sit	NM107	1039	O	AN	1	10		N/A	Not Used
837p-498						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"MI"	N/A	"MI"
837p-499						Identification Code	Req	NM109	67	X	AN	2	80	Client's Medicare ID	Dw_claim.Medicare_ID	Field Value
837p-508	Other Payer Name	Required	1	2330B	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"PR"	N/A	"PR"
837p-509						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837p-510						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	"Medicare"	N/A	"Medicare"
837p-511						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"PI" until Nat Plan ID issued; then "XV"	N/A	"PI"
837p-512	(End of Medicare Loop)					Identification Code	Req	NM109	67	X	AN	2	80	Payer's Plan ID until Nat Plan ID issued	N/A	"002"
837p-432	Other Subscriber Information (Oth Ins Loop)	Situational	1	2320	10	Payer Responsibility Sequence Number Code	Req	SBR01	1138	M	ID	1	1	"P" or "S"	N/A	"S"
837p-433						Individual Relationship Code	Req	SBR02	1069	O	ID	2	2	18	N/A	"18"
837p-434						Reference Identification	Sit	SBR03	127	O	AN	1	30		N/A	Not Used
837p-435						Name	Sit	SBR04	93	O	AN	1	60		N/A	Not Used
837p-436						Insurance Type Code	Req	SBR05	1336	O	ID	1	3	"C1"	N/A	"C1"
837p-437						Claim Filling Indicator Code	Sit	SBR09	1032	O	ID	1	2	any valid Code except "MB" or "MC"	N/A	Not Used
837p-457	COB Payer Paid Amount	Situational	1	2320	10	Amount Qualifier Code	Req	AMT01	522	M	ID	1	3	"D"	N/A	"D"
837p-458						Monetary Amount	Req	AMT02	782	M	R	1	18	Other Insurance Payment	N/A	Not Used
837p-477	Subscriber Demographic Information	Situational	1	2320	10	Date Time Period format Qualifier	Req	DMG01	1250	X	ID	2	3	"D8"	N/A	"D8"
837p-478						Date Time Period	Req	DMG02	1251	X	AN	1	35		N/A	Not Used
837p-479						Gender Code	Req	DMG03	1068	O	ID	1	1		N/A	Not Used
837p-480	Other Insurance Coverage Information	Required	1	2320	10	Yes/No Condition or Response Code	Req	OI03	1073	O	ID	1	1	"Y"	N/A	"Y"
837p-481						Patient Signature Source Code	Sit	OI04	1351	O	ID	1	1	"C"	N/A	"C"
837p-482						Release of Information Code	Req	OI06	1363	O	ID	1	1	"A"	N/A	"A"
837p-492	Other Subscriber Name	Required	1	2330A	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"IL"	N/A	"IL"
837p-493						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"1"	N/A	"1"
837p-494						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	Client's Last Name	N/A	Not Used
837p-495						Name First	Sit	NM104	1036	O	AN	1	25	Client's First Name	N/A	Not Used
837p-496						Name Middle	Sit	NM105	1037	O	AN	1	25		N/A	Not Used
837p-497						Name Suffix	Sit	NM107	1039	O	AN	1	10		N/A	Not Used
837p-498						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"MI"	N/A	"MI"
837p-499						Identification Code	Req	NM109	67	X	AN	2	80	Client's Other Insurance ID	N/A	Not Used
837p-508	Other Payer Name	Required	1	2330B	1	Entity Identifier Code	Req	NM101	98	M	ID	2	3	"PR"	N/A	"PR"
837p-509						Entity Type Qualifier	Req	NM102	1065	M	ID	1	1	"2"	N/A	"2"
837p-510						Name Last / Organization Name	Req	NM103	1035	O	AN	1	35	Insurance Company	N/A	Not Used

CIS MANUAL 837 P (VOID/REPLACE) DATA MAPPING															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
														Name		
837p-511						Identification Code Qualifier	Req	NM108	66	X	ID	1	2	"PI" until Nat Plan ID issued; then "XV"	N/A	"PI"
837p-512	(End of Oth Ins Loop)					Identification Code	Req	NM109	67	X	AN	2	80	Payer's Plan ID until Nat Plan ID issued	N/A	Not Used
837p-556	Service Line	Required	1	2400	50	Assigned Number	Req	LX01	554	M	N0	1	6	Line Number	Dw_claim.Line_nbr	Field Value
837p-557	Professional Service	Required	1	2400	50	Composite Medical Procedure Identifier	Req	SV101	C003	M					Composite Element	Composite Element
837p-558						Product/Service ID Qualifier	Req	SV101-1	235	M	ID	2	2	"HC"	N/A	"HC"
837p-559						Product/Service ID	Req	SV101-2	234	M	AN	1	48	Procedure Code	Dw_claim.Procedure_Code	Field Value
837p-560						Procedure Modifier	Sit	SV101-3	1339	O	AN	2	2	Procedure Code Modifier	Dw_claim.Proc_Code_modifier	Field Value
837p-561						Procedure Modifier	Sit	SV101-4	1339	O	AN	2	2	Procedure Code Modifier	N/A	Not Used
837p-562						Procedure Modifier	Sit	SV101-5	1339	O	AN	2	2		N/A	Not Used
837p-563						Procedure Modifier	Sit	SV101-6	1339	O	AN	2	2		N/A	Not Used
837p-564						Monetary Amount	Req	SV102	782	O	R	1	18	Line Item Charge Amount	Dw_claim.Billed_Amount	Field Value
837p-565						Unit or Basis for Measurement Code	Req	SV103	355	X	ID	2	2	"UN"	N/A	"UN"
837p-566						Quantity	Req	SV104	380	X	R	1	15	Unit of Service	Dw_claim.Unit_Of_Service	Field Value
837p-567						Facility Code Value	Sit	SV105	1331	O	AN	1	2	Place of Service	Dw_claim.Place_of_svc	Field Value
837p-568						Composite Diagnosis Code Pointer	Sit	SV107	C004	O					Composite Element	Composite Element
837p-569						Diagnosis Code Pointer	Req	SV107-1	1328	M	N0	1	2	"1"	N/A	"1"
837p-570						Diagnosis Code Pointer	Sit	SV107-2	1328	O	N0	1	2	"2"	N/A	"2"
837p-571						Diagnosis Code Pointer	Sit	SV107-3	1328	O	N0	1	2	"3"	N/A	"3"
837p-572						Diagnosis Code Pointer	Sit	SV107-4	1328	O	N0	1	2	"4"	N/A	"4"
837p-573						Yes/No Condition or Response Code	Req	SV109	1073	O	ID	1	1	"Y" if Emergency, no value of not emergency	N/A	"Y" if Emergency, no value if not emergency
837p-574						Yes/No Condition or Response Code	Sit	SV110	1073	O	ID	1	1		N/A	Not Used
837p-575						Yes/No Condition or Response Code	Sit	SV111	1073	O	ID	1	1		N/A	Not Used
837p-576						Co-pay Status Code	Sit	SV115	1327	O	ID	1	1		N/A	Not Used
837p-587	Ambulance Transport Information	Situational	1	2400	50	Unit or Basis for Measurement Code	Sit	CR101	355	X	ID	2	2	Not expected / not stored	N/A	Not Used
837p-588	**USED FOR MULTI-LINE HCFAs ONLY					Weight	Sit	CR102	81	X	R	1	10	Not expected / not stored	N/A	Not Used
837p-589	To over-ride CR1 segment in 2300 loop					Ambulance Transport Code	Req	CR103	1316	O	ID	1	1	"X" Replaces "2X" modifier	N/A	"X"
837p-590						Ambulance Transport Reason Code	Req	CR104	1317	O	ID	1	1	"A", "B", "C", "D", or "E"	N/A	"A"
837p-591						Unit or Basis for Measurement Code	Req	CR105	355	X	ID	2	2	"DH"	N/A	"DH"
837p-592						Quantity	Req	CR106	380	X	R	1	15	Miles (should be same as SV104)	N/A	System Generated
837p-593						Description	Sit	CR109	352	O	AN	1	80	Required when CR103 =	N/A	System Generated

CIS MANUAL 837 P (VOID/REPLACE) DATA MAPPING															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	USAGE	SEGMENT REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	USAGE	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	VALUEOPTIONS TABLE.FIELD	MAPPING LOGIC
														"X"		
837p-594						Description	Sit	CR110	352	O	AN	1	80	Not expected / not stored	N/A	Not Used
837p-627	Date - Service Date	Required	1	2400	50	Date/Time Qualifier	Req	DTP01	374	M	ID	3	3	Code 472 - Service	N/A	"472"
837p-628						Date Time Period Format Qualifier	Req	DTP02	1250	M	ID	2	3	"RD8" CCYYMMDD-CCYYMMDD	N/A	"RD8"
837p-629						Date Time Period	Req	DTP03	1251	M	AN	1	35	Service Date - End Date	Dw_claim.Start-Dt, Dw_claim.End_dt	Field Value
837p-669	Contract Information	Situational	1	2400	50	Contract Type Code	Req	CN101	1166	M	ID	2	2	"05" or "02"	Dw_claim.Svc_Type	Data Warehouse “02” = HIPAA “05, all other values = HIPAA “02”
837p-670						Monetary Amount	Sit	CN102	782	O	R	1	18	Special Net Value or Net-Paid	Dw_claim.Special_Net_Value, Dw_claim.Net_Paid	If HIPAA Svc_Type=”05” use Special_Net_Value, if HIPAA_Svc_Type = “02” use Net_Paid
837p-681	Line Item Control Number	Situational	1	2400	50	Reference Identification Qualifier	Req	REF01	128	M	ID	2	3	"6R"	N/A	"6R"
837p-682	**USED FOR MULTI-LINE HCFAs ONLY					Reference Identification	Req	REF02	127	M	AN	1	30	Line Number	N/A	System Generated
837p-865	Transaction Set Trailer	Required	1			Number of Included Segments	Req	SE01	96	M	N0	1	10	Total # of segments (including ST and SE)	N/A	System Generated
837p-866						Transaction Set Control Number	Req	SE02	329	M	AN	4	9		N/A	Not Used

* Items in Grey are not used by CIS

Demographic Files:

Table/Extract: Demographic

Description:
All consumers who receive service through the RBHA system must have current demographic data in CIS. Demographic information is time-sensitive and intended to reflect changes in consumers' demographic, financial, clinical, and categorical eligibility status. All consumers who remain enrolled for more than 30 days must have demographic data submitted within 45 days of enrollment. Unless otherwise noted, all items must be completed for demographic data submissions. Demographic data are submitted at enrollment, when data information changes and annually thereafter; identified elements are submitted at disenrollment.

Purpose/Uses
The Demographics file is a required file by the Department of Behavioral Health Services. This file is submitted to DBHS when new consumers are enrolled into CIS. This file is a collection of required demographics and clinical information.

Column Definitions

CIS	Client Information System field
MHS	Mental Health System field
Data Type	Type of data stored in field
Length	Length of field
Description/Exclusions	Description of data stored in field
Logic	Supporting logic

Demographics File (File Header)
Values in quotes represent literal strings that are hard-Coded directly into the program.
When the Table Name.Field Name contains a "N/A" it indicates that no value is retrieved from a data store for that field.
A logic entry of "System Generated" indicates a value that is generated or calculated at file creation time by the program.
A logic entry of "Spaces" indicates a field that is filled entirely with spaces.

CIS Demographic Data File Layout – CIS Last Update 1:47 PM, 1/8/04									ValueOptions Corresponding Mapping	
FIELD NO.	RECORD LOCATION FROM	TO	COLUMN NAME	TYPE	SIZE	JUSTIFY	DEFAULT	DESCRIPTIONS/COMMENTS	MHS TABLE/FIELD NAME	LOGIC/COMMENT
1	1	1	Record-Type	Char	1	None	Space	Distinguishes Header from Data Record. Valid value for Header Record is an "H".	N/A	"H"
2	2	3	RBHA-ID	Char	2	Left	Zeros	Identifies RBHA submitting the file.	N/A	"08"
3	4	8	File-Name	Char	5	Left	Spaces	Indicates the name of the file. Valid Value: DEMOG = Demographic File.	N/A	"DEMOG"
4	9	16	Submittal-Record-Count	Char	8	Right	Zeros	Indicates the total record count for the file. This does not include Header Record.	N/A	System Generated
5	17	24	Submittal-Date	Date	8	None	Zeros	This is the date the file was produced for submission.	N/A	System Generated
6	25	30	Submittal-Time	Char	6	Right	Zeros	Indicates the time the file was produced for submission. Format is HHMMSS using 24 hour clock.	N/A	System Generated
7	31	330	Record-Filler	Char	300	Left	Spaces	This is the filler for the remainder of the fixed length record.	N/A	Spaces

Demographics File (Detail Record)

Values in quotes represent literal strings that are hard-Coded directly into the program.
When the Table Name.Field Name contains a "N/A" it indicates that no value is retrieved from a data store for that field.
A logic entry of "System Generated" indicates a value that is generated or calculated at file creation time by the program.
A logic entry of "Spaces" indicates a field that is filled entirely with spaces.

CIS Demographic Data File Layout – CIS Last Update 1:47 PM, 1/8/04									ValueOptions Corresponding Mapping	
FIELD NO.	RECORD LOCATION FROM	TO	COLUMN NAME	TYPE	SIZE	JUSTIFY	DEFAULT	DESCRIPTIONS/COMMENTS	MHS TABLE/FIELD NAME	Logic/Comment
1	1	1	Record-Type	Char	1	None	Space	Distinguishes Header from Data Records. Valid value for Data Record is a space.	N/A	Spaces
2	2	3	RBHA-ID	Char	2	Right	Zeros	RBHA Identification Number. Valid values: 03=Excel Group 08=ValueOptions 11=Gila River Indian Tribe 14=Navajo Nation 15=NARBHA 23=PGBHA 25=Pascua Yaqui 26=CPSA 5 27=CPSA 5	N/A	"08"
3	4	4	Reason–for-Submission	Char	1	None	Spaces	Indicates Transaction Type: 1=Intake 2=Annual Update 3=Significant Change 4=Disenrollment	TblDemographic File.reason-four-submission	Type "3" is never used because always send complete updates
4	5	14	Client-ID	Char	8	Right	Zeros	The unique CIS identifier for the client..	Enrmas.membno	Field Value
5	15	22	Intake-Date	Date	8	None	Zeros	Initial intake date	Enrmas.enrdat	Field Value
6	23	47	Client-First-Name	Char	25	Left	Spaces	Client's first name. (For validation only).	Enrmas.fstnam	Field Value
7	48	72	Client-Middle-Name	Char	25	Left	Spaces	Client's middle name. (For validation only).	Enrmas.Midnam	Field Value
8	73	107	Client-Last-Name	Char	35	Left	Spaces	Client's last name. (For validation only).	Enrmas.Lstnam	Field Value
9	108	115	Date-of-Birth	Date	8	None	Zeros	Client's date of birth.. (For validation only).	Enrmas.bthdat	Field Value
10	116	123	Referral-Date	Char	8	None	Zeros	This is the date that the client first requested an appointment	Enrmas.refdat	Field Value
11	124	125	Referral-Source	Char	2	None	Space	The Source of the client referral Valid Values: 01 – Self/family/friend 03 – Other behaviora; health provider 19 – Federal Agencies 35 – AHCCCS health plan 36 – CPS 24-Hour Urgent Response (child) 37 – Community agency other than Behavioral Health Provider (homeless shelter, church, employer) 38 – ADES (Other CPS, DDD< RSA) 39 – ADE – Department of Education 40 – Criminal justice/correctional (includes AOC-Probation, ADOC, ADJC) 41 – Other (anything not captured above)	Enrmas.rersrc	Field Value
12	126	126	OMB – American Indian	Char	1	Left	Space	OMB Race Category – Is client American Indian or Alaska Native? Valid Values: Y for Yes, N for No (Default).	Enrmas.racecd	Field Value
13	127	127	OMB – Asian	Char	1	Left	Space	OMB Race Category – Is client Asian? Valid Values: Y for Yes, N for No (Default).	Enrmas.Racecd	Field Value
14	128	128	OMB – Black	Char	1	Left	Space	OMB Race Category – Is client Black or African American? Valid Values: Y for Yes, N for No (Default).	Enrmas.Racecd	Field Value

CIS Demographic Data File Layout – CIS Last Update 1:47 PM, 1/8/04									ValueOptions Corresponding Mapping	
FIELD NO.	RECORD LOCATION FROM	TO	COLUMN NAME	TYPE	SIZE	JUSTIFY	DEFAULT	DESCRIPTIONS/COMMENTS	MHS TABLE/FIELD NAME	Logic/Comment
15	129	129	OMB – Native Hawaiian	Char	1	Left	Space	OMB Race Category – Is client Native Hawaiian or Pacific Islander? Valid Values: Y for Yes, N for No (Default).	Enrmas.Racecd	Field Value
16	130	130	OMB – White	Char	1	Left	Space	OMB Race Category – Is client White? Valid Values: Y for Yes, N for No (Default).	Enrmas.Racecd	Field Value
17	131	131	OMB – Hispanic-Latino	Char	1	Left	Space	OMB Race Category – Is client Hispanic-Latino? Valid Values: Y for Yes, N for No (Default).	Enrmas.Racecd	Field Value
18	132	132	PC-Suicidal	Char	1	None	Space	Presenting Concern – Suicidal/DTS Valid Values: Y for Yes, N for No (Default).	Enrmas.Priprb	If = '01' then 'Y' else default to 'N'
19	133	133	PC-Assaultive	Char	1	None	Space	Presenting Concern – Assaultive I/DTO Valid Values: Y for Yes, N for No (Default).	Enrmas.Priprb	If = '18' then 'Y' Else Default to 'N'
20	134	134	PC-Victim-ANV	Char	1	None	Space	Presenting Concern – Victim of Abuse/Neglect/Violence Valid Values: Y for Yes, N for No (Default).	Enrmas.Priprb	If = '02' then 'Y' Else Default to 'N'
21	135	135	PC-Anxiety-Stress	Char	1	None	Space	Presenting Concern – Anxiety-Stress Valid Values: Y for Yes, N for No(Default).	Enrmas.Priprb	If = '03' then 'Y' Else Default to 'N'
22	136	136	PC-Depressed	Char	1	None	Space	Presenting Concern – Depressed Mood. Valid Values: Y for Yes, N for No (Default).	Enrmas.Priprb	If = '04' then 'Y' Else Default to 'N'
23	137	137	PC-Psychotic	Char	1	None	Space	Presenting Concern – Psychotic (impaired reality, thought disorganization). Valid Values: Y for Yes, N for No (Default).	Enrmas.Priprb	If = '05' then 'Y' Else Default to 'N'
24	138	138	PC-Substance-Abuse	Char	1	None	Space	Presenting Concern – Substance-Abuse Valid Values: Y for Yes, N for No (Default).	Enrmas.Priprb	If = '05' then 'Y' Else Default to 'N'
25	139	139	PC-Unable-to-care	Char	1	None	Space	Presenting Concern – unable to care for self (dehydrated, malnourished, malodorous). Valid Values: Y for Yes, N for No (Default).	Enrmas.Priprb	If = '13' then 'Y' Else Default to 'N'
26	140	140	PC-Relational	Char	1	None	Space	Presenting Concern – Family relational problem Valid Values: Y for Yes, N for No (Default).	Enrmas.Priprb	If = '10' then 'Y' Else Default to 'N'
27	141	141	PC-Child-Behavior	Char	1	None	Space	Presenting Concern – Child-behavior problem Valid Values: Y for Yes, N for No (Default).	Enrmas.Priprb	If = '16' then 'Y' Else Default to 'N'
28	142	142	PC-Other	Char	1	None	Space	Presenting Concern – Other Valid Values: Y for Yes, N for No (Default).	Enrmas.Priprb	If = '14' then 'Y' Else Default to 'N'
29	143	150	PC-Descr-Char-Eff-Date	Date	8	None	Zeros	Effective date of descriptive characteristics addition or change.	TblDemographicFile.desc-char-effdate	Field Value
30	151	152	Household-Size	Char	2	Right	Zeros	Number in household including client. Valid numbers 01 – 99.	Cmpmas.hsize	Field Value
31	153	158	Household-Income	Char	6	Right	Zeros	Cross Annual Income of household of client	Cmpmas.hincom	Field Value
32	159	159	Treatment-Participation	Char	1	None	Space	Treatment participation reason under which a client enters the facility or service. Valid Values: 1 = Voluntary 6 = Civil or MH Court Order 7 = DUI Court Order 8 = Criminal Court Order	Enrmas.nattrt	Field Value
33	160	160	OA-ADC-Parole	Char	1	None	Space	Other Agency – ADC-Parole Valid Values: Y for Yes, N for No (Default).	Cmpmas.agdc	Field Value
34	161	161	OA-ADJC-Parole	Char	1	None	Space	Other Agency – ADJC-Parole Valid Values: Y for Yes, N for No (Default).	Cmpmas.agadjc	Field Value
35	162	162	OA-ADHS-CRS	Char	1	None	Space	Other Agency – ADHS-CRS Valid Values: Y for Yes, N for No (Default).	TblDemographicFile.oa-adhs-crs	Field Value
36	163	163	OA-AOC-Adult-Probation	Char	1	None	Space	Other Agency – AOC-Adult-Probation Valid Values: Y for Yes, N for No (Default).	Cmpmas.agcap	Field Value

CIS Demographic Data File Layout – CIS Last Update 1:47 PM, 1/8/04									ValueOptions Corresponding Mapping	
FIELD NO.	RECORD LOCATION FROM	TO	COLUMN NAME	TYPE	SIZE	JUSTIFY	DEFAULT	DESCRIPTIONS/COMMENTS	MHS TABLE/FIELD NAME	Logic/Comment
37	164	164	OA-AOC-Juvenile-Probation	Char	1	None	Space	Other Agency – DES-CPS Valid Values: Y for Yes, N for No (Default).	Cmpmas.agcjp	Field Value
38	165	165	OA-DES-CPS	Char	1	None	Space	Other Agency – DES-CPS Valid Values: Y for Yes, N for No (Default).	TblDemographicFile.oa-des-cps	Field Value
39	166	166	OA-DES-DDD	Char	1	None	Space	Other Agency – DES-DDD Valid Values: Y for Yes, N for No (Default).	Cmpmas.agddd	Field Value
40	167	167	OA-DES-RSA	Char	1	None	Space	Other Agency – DES-RSA Valid Values: Y for Yes, N for No (Default).	TblDemographicFile.oa-des-rsa	Field Value
41	168	168	Filler	Char	1	None	Space	Filler Reserved for Future use	N/A	Spaces
42	169	169	OA-School-Special-Ed	Char	1	None	Space	Other Agency – School-Special-Ed Valid Values: Y for Yes, N for No (Default).	TblDemographicFile.oa-school	Field Value
43	170	170	OA-Other	Char	1	None	Space	Other Agency – Other Valid Values: Y for Yes, N for No (Default).	TblDemographicFile.oa-other	Field Value
44	171	175	Filler	Char	5	None	None	Filler – reserved for future use.	N/A	Spaces
45	176	176	Formal-Schooling-Level	Char	1	None	Space	Highest Formal School Level Completed Valid Values: 1 = Less than 1 year. 2 = Grades K to 11 3 = High School Graduate or GED 4 = Vocational/technical school 5 = Some college, no degree 6 = AA / BA degree 7 = Graduate or Post-graduate 8 = Unknown	Cmpmas.schyrs	Field Value
46	177	177	SF-COOL	Char	1	None	Space	Indicates source of special funding from COOL. Valid Values: Y for Yes, N for No (Default)	Sppmas.spopcd	If Field Value = “05” then “Y” else default to “N”
47	178	178	SF-HB2003	Char	1	None	Space	Indicates source of special funding from HB2003. Valid Values: Y for Yes, N for No (Default)	Sppmas.spopcd	If Field Value = “07” or ’08’ then “Y” else default to “N”
48	179	183	Filler	Char	5	None	None	Filler – reserved for future use.	Filler	
49	184	184	SF-Pregnancy	Char	1	None	Space	Indicates the client is pregnant or post-partum woman. Valid Values: Y for Yes, N for No (Default)	Enrmas.sppreg	Field Value
50	185	185	SF-Woman-DC	Char	1	None	Space	Indicates the client a woman with dependent child(ren). Valid Values: Y for Yes, N for No (Default)	Enrmas.spwdch	Field Value
51	186	190	Filler	Char	5	None	None	Filler – reserved for future use.	N/A	Spaces
52	191	192	AXIS-III-1	Char	2	Left	Spaces	AXIS-III Medical Condition. Valid Values: 00 = N/A 01 = Infectious and parasitic diseases. 02 = Neoplasms 03 = Endocrine, nutritional, metabolic diseases, and immunity disorders. 04 = Diseases of the blood and blood-forming organs 05 = Diseases of the nervous system and sensory organs. 06 = Diseases of the circulatory system. 07 = Diseases of the respiratory system. 08 = Diseases of the digestive system. 09 = Diseases of the genitourinary system. 10 = Complications of pregnancy, childbirth, puerperium. 11 = Diseases of the skin and subcutaneous tissues. 12 = Diseases of the musculoskeletal system and connective tissue. 13 = Congenital anomalies. 04 = Diseases of the blood and blood-forming organs. 14 = Conditions originating in the prenatal period.. 15 = Symptoms, signs, and ill-defined conditions.. 16 = Injury or poisoning.	TblDemographicFile.axis-iii-1	Field Value

CIS Demographic Data File Layout – CIS Last Update 1:47 PM, 1/8/04									ValueOptions Corresponding Mapping	
FIELD NO.	RECORD LOCATION FROM	TO	COLUMN NAME	TYPE	SIZE	JUSTIFY	DEFAULT	DESCRIPTIONS/COMMENTS	MHS TABLE/FIELD NAME	Logic/Comment
53	193	194	AXIS-III-2	Char	2	Left	Spaces	AXIS-III Medical Condition. Valid Values: Same as with AXIS-III-1.	TblDemographicFile.axis-iii-2	Field Value
54	195	196	AXIS-III-3	Char	2	Left	Spaces	AXIS-III Medical Condition. Valid Values: Same as with AXIS-III-1.	TblDemographicFile.axis-iii-3	Field Value
55	197	198	AXIS-III-4	Char	2	Left	Spaces	AXIS-III Medical Condition. Valid Values: Same as with AXIS-III-1.	TblDemographicFile.axis-iii-4	Field Value
56	199	200	AXIS-III-5	Char	2	Left	Spaces	AXIS-III Medical Condition. Valid Values: Same as with AXIS-III-1.	TblDemographicFile.axis-iii-5	Field Value
57	201	208	Outcome-Measures-Eff-Date	Date	8	None	Zeros	Effective date of outcome measures addition or change.	TblDemographicFile.outcome-effdate	Field Value
58	209	214	AXIS-I-1	Char	6	Right	Spaces	ICD-9 Axis-I Medical Condition. Denotes clinical syndromes. Valid ICD-9 Code – 6 byte format is XXX.XX.	Cmpmas.dsma1p	Field Value
59	215	220	AXIS-I-2	Char	6	Right	Spaces	ICD-9 Axis-I Medical Condition. Denotes clinical syndromes. Valid ICD-9 Code – 6 byte format is XXX.XX.	Cmpmas.dsma1a	Field Value
60	221	226	AXIS-I-3	Char	6	Right	Spaces	ICD-9 Axis-I Medical Condition. Denotes clinical syndromes. Valid ICD-9 Code – 6 byte format is XXX.XX.	TblDemographicFile.axis-i-3	Field Value
61	227	232	AXIS-I-4	Char	6	Right	Spaces	ICD-9 Axis-I Medical Condition. Denotes clinical syndromes. Valid ICD-9 Code – 6 byte format is XXX.XX.	TblDemographicFile.axis-i-4	Field Value
62	233	238	AXIS-I-5	Char	6	Right	Spaces	ICD-9 Axis-I Medical Condition. Denotes clinical syndromes. Valid ICD-9 Code – 6 byte format is XXX.XX.	TblDemographicFile.axis-i-5	Field Value
63	239	244	AXIS-II-1	Char	6	Right	Spaces	ICD-9 Axis-II Medical Condition. Denotes Developmental and personality disorders. Valid ICD-9 Code – 6 byte format is XXX.XX.	Cmpmas.dsma2p	Field Value
64	245	250	AXIS-II-2	Char	6	Right	Spaces	ICD-9 Axis-II Medical Condition. Denotes Developmental and personality disorders. Valid ICD-9 Code – 6 byte format is XXX.XX.	Cmpmas.dsma2a	Field Value
65	251	251	Behavioral-Health-Category	Char	1	None	Spaces	Behavioral health category. Valid Values: C = Child S = Adult, with SMI M = Adult, non SMI, with general mental health need G = Adult, non-SMI, Substance abuse, either alcohol or drug	Enrmas.rbhafs	If Field Value = “c” then “c”, else if field = “c” and SMI/SED field = “y” then = “z”, else if field = “s” then “s”, else if field = “m” then “m”, else if field = “d” or “a” then “g”
66	252	253	Employment-Status	Char	2	None	Spaces	Employment Status. Valid Values: 03 =Employed full-time with support 01 =Employed full-time without support 04 =Employed part-time with support 02 =Employed part-time without support 17 =Unpaid rehabilitation activities 14 =Volunteer 18 =Retired, homemaker, or student 08 =Unemployed 99 =Unknown	Cmpmas.empsta	Field Value
67	254	254	Educational-Status	Char	1	None	Space	Educational status. The client is in a school or vocational program. Valid Values: Y for Yes, N for No (Default).	Cmpmas.Edstat	if “01” or “02” then = “Y” else “N”
68	255	259	Filler	Char	5	None	None	Filler – reserved for future use.	N/A	Spaces

CIS Demographic Data File Layout – CIS Last Update 1:47 PM, 1/8/04									ValueOptions Corresponding Mapping	
FIELD NO.	RECORD LOCATION FROM	TO	COLUMN NAME	TYPE	SIZE	JUSTIFY	DEFAULT	DESCRIPTIONS/COMMENTS	MHS TABLE/FIELD NAME	Logic/Comment
69	260	261	Primary-Residence	Char	2	Left	Space	Primary place of residence. Valid Values: 07 = Homeless/homeless shelter 09 = Foster home 16 = Home with family 01 = Independent (roommate, by self, no support) 03 = Boarding home 04 = Supervisory care/assisted living 23 = Transitional housing (level 4) 02 = Hotel 19 = Crisis shelter 05 = Arizona State Hospital 06 = Jail/prison/Hospital 22 = OBHL Level 1,2, or 3 treatment setting 12 = Nursing home 08 = Other	Enrmas.prires	Field Value
70	262	264	AXIS-V	Char	3	Right	Zeros	Axis-V Global Assessment Functioning. Two-digit CGAS/GAF score. Valid Values: 01-100. See Demographic Definitions for detail.	TblDemographicFile.axis-v	Field Value
71	265	266	Number-of-Arrests	Char	2	Right	Zeros	For initial intake, number in 6 months prior to intake and for updates/disenrollment, the number since last update. Valid Values: 01-99.	Cmpmas.arrest	Field Value
72	267	270	SA-Type-1	Char	4	Left	Spaces	Current Substance Abuse Primary type. Valid Values: 0001 - None (No substance abuse in past 30 days) 0201 - Alcohol (Beverage Alcohol) 0302 - Cocaine / Crack (CNS Stimulants) 0401 - Marijuana/Hashish (Marijuana) 0501 – Heroin/Morphine (Opiates/Narcotics) 0706 – Other Opiates/ Synthetics 0902 – Hallucinogens 1001 – Methamphetamine/Speed (CNS Stimulants) 1201 – Other Stimulants 1308 – Benzodiazepines (CNS Depressants) 1605 – Other Sedatives/Tranquilizers (CNS Depressants) 1703 - Inhalants 2002 – Other Drugs	Cmpmas.sbtyp1	Field Value
73	271	271	SA-Freq-1	Char	1	None	Spaces	Freq-sub-use, Type: Primary Valid Frequency Values : 1 = No use past month 2 = 1-3 Times in past month 3 = 1-2 time per week 4 = 3-6 times per week 5 = One or more times per day	Cmpmas.sbfrq1	Field Value
74	272	272	SA-Route-1	Char	1	None	Spaces	Route of administration Primary Valid Route Values: 1 = Oral 2 = Smoking 3 = Inhalation 4 = Injection	Cmpmas.sbrte1	Field Value
75	273	274	SA-Age-First-Use-1	Char	2	Right	Zeros	Age of first use of SA-Type-1	Cmpmas.sbage1	Field Value
76	275	278	SA-Type-2	Char	4	Left	Spaces	Current Substance Abuse Secondary type Select a valid Code from above list, but must not be the same as the one used for SA-Type-1.	Cmpmas.sbtype2	Field Value
77	279	279	SA-Freq-2	Char	1	None	Spaces	Freq-sub-use, Type: Secondary. Use same values as in SA-Freq-1.	Cmpmas.sbfrq2	Field Value

CIS Demographic Data File Layout – CIS Last Update 1:47 PM, 1/8/04									ValueOptions Corresponding Mapping	
FIELD NO.	RECORD LOCATION FROM	TO	COLUMN NAME	TYPE	SIZE	JUSTIFY	DEFAULT	DESCRIPTIONS/COMMENTS	MHS TABLE/FIELD NAME	Logic/Comment
78	280	280	SA-Route-2	Char	1	None	Spaces	Route of administration Secondary. Use same values as in SA-Route-1.	Cmpmas.sbrte2	Field Value
79	281	282	SA-Age-First-Use-2	Char	2	Right	Zeros	Age of first use of SA-Type-2	Cmpmas.sbage2	Field Value
80	283	286	Past-Sa-Type	Char	4	Left	Spaces	Past Substance Abuse. Select a valid Code from list as SA-TYPE-1.	Cmpmas.sbtyp3	Field Value
81	287	288	Reason-for-Disenrollment	Char	2	Left	Spaces	Indicates the reason for the disenrollment. Valid Values: 01 = Treatment complete 02 = Change in Eligibility/Entitlement Information. 03 = Client Declined Further Service 04 = Lack of contact 06 = Incarceration 07 = Death 08 = Moved out of area 09 = Inter RHBA Transfer (If not being disenrolled, use default of spaces.).	Dismas.Disrsn	Field Value
82	287	288	Filler	Char	42	Left	Spaces	Filler – reserved for future use.	N/A	Spaces

834 Files:
Table/Extract: 834 Intake – Add and Changes

Description
This is a HIPAA compliant file that is sent to CIS on a daily basis. The file contains current data for identifying consumers receiving services through ValueOptions. The data also contains closure and some demographic information that is collected in MHS from ValueOptions providers and Direct Service Sites.

Purpose/Uses
All consumers who receive service through the RBHA system must have current identifying data in the ADHS/DBHS CIS system. Intake information is time-sensitive and is intended to reflect current data for consumer identification and other consumer status items. All consumers who remain enrolled for more than 30 days must have demographic data submitted within 45 days of the initial enrollment.

Table/Extract: 834 Closure– Add and Changes

Description
All consumers who receive service through the RBHA system must have current identifying data in the ADHS/DBHS Client Information System. Closure information is time-sensitive and is intended to reflect current identifying data and other consumer status items.

Purpose/Uses
The file is a HIPAA compliant file extract that is sent to Client Information System on a daily basis. This file is used to terminate consumers in MHS and CIS.

834 Intake (Add)

Values in quotes represent literal strings that are hard-Coded directly into the program.
When the Table Name.Field Name contains a "N/A" it indicates that no value is retrieved from a data store for that field.
A logic entry of "System Generated" indicates a value that is generated or calculated at file creation time by the program.
A logic entry of "Spaces" indicates a field that is filled entirely with spaces.

CIS MANUAL 834 Intake (Add) Data Mapping															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	R/S	SEG. REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	R/S	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
834-001	Transaction set Header	R	1			Transaction Set Identifier Code	R	ST01	143	M	ID	3	3	"834"	N/A	"834"
834-002						Transaction Set Control Number	R	ST02	329	M	ID	4	9	Incremental Number	N/A	System Generated
834-003	Beginning Segment	R	1			Transaction Set Purpose Code	R	BGN01	353	M	ID	2	2	"00"	N/A	"00"
834-004						Reference Identification	R	BGN02	127	M	AN	1	30	Originator Application Transaction Number	N/A	System Generated
834-005						Date	R	BGN03	373	M	DT	8	8	Transaction Set Create Date	N/A	System Generated
834-006						Time	R	BGN04	337	X	TM	4	8	Transaction Set Create Time	N/A	System Generated

CIS MANUAL 834 Intake (Add) Data Mapping															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	R/S	SEG. REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	R/S	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
834-007						Time Code	S	BGN05	623	O	ID	2	2		N/A	Not Used
834-008						Reference Identification	S	BGN06	127	O	AN	1	30		N/A	Not Used
834-009						Action Code	R	BGN08	306	O	ID	1	2	"2"	N/A	"2"
834-012	File effective Date	S	>1			Date/Time Qualifier	R	DTP01	374	M	ID	3	3	"007"	N/A	"007"
834-013						Date Time Period Format Qualifier	R	DTP02	1250	M	ID	2	3	"D8"	N/A	"D8"
834-014						Date Time Period	R	DTP03	1251	M	AN	1	35	CCYYMMDD (Process Date)	N/A	System Generated
834-015	Sponsor Name	R	1	1000A	1	Entity Identifier Code	R	N101	98	M	ID	2	3	"P5"	N/A	"P5"
834-016						Name	S	N102	93	X	AN	1	60	'Behavioral Health Services'	N/A	"Behavioral Health Services"
834-017						Identification Code Qualifier	R	N103	66	X	ID	1	2	"FI"	N/A	"FI'
834-018						Identification Code	R	N104	67	X	AN	2	80	"86-6004791"	N/A	"86-6004791"
834-019	Payer	R	1	1000B	1	Entity Identifier Code	R	N101	98	M	ID	2	3	"IN"	N/A	"IN"
834-020						Name	S	N102	93	X	AN	1	60	RBHA Name (Used to look up RBHA Number)	N/A	"ValueOptions"
834-021						Identification Code Qualifier	R	N103	66	X	ID	1	2	"FI"	N/A	"FI"
834-022						Identification Code	R	N104	67	X	AN	2	80	RBHA's Federal Taxpayer's ID	N/A	"54-1414194"
834-029	Member Level Detail	R	1	2000	>1	Response Code	R	INS01	1073	M	ID	1	1	"Y" = Subscriber	N/A	"Y"
834-030						Individual Relationship Code	R	INS02	1069	M	ID	2	2	"18" = Self	N/A	"18"
834-031						Maintenance Type Code	R	INS03	875	O	ID	3	3	021=add(A)	N/A	"021"
834-032						Maintenance Reason Code	S	INS04	1203	O	ID	2	3	20=active	N/A	"20"
834-033						Benefit Status Code	R	INS05	1216	O	ID	1	1	"A" = active	N/A	"A"
834-034						Medicare Plan Code	S	INS06	1218	O	ID	1	1		N/A	Not Used
834-035						CORBA Qualifying	S	INS07	1219	O	ID	1	2		N/A	Not Used
834-036						Employment Status Code	S	INS08	584	O	ID	2	2	"FT" = Eligible for Benefits	N/A	"FT"
834-037						Student Status Code	S	INS09	1220	O	ID	2	2		N/A	Not Used
834-038						Handicap Indicator	S	INS10	1073	O	ID	2	2		N/A	Not Used
834-039						Date Time Period Format Qualifier	S	INS11	1250	X	ID	2	3		N/A	Not Used
834-040						Date Time Period	S	INS12	1251	X	AN	1	35		N/A	Not Used
834-041						Number	S	INS17	1470	O	N0	1	9		N/A	Not Used
834-042	Subscriber Number	R	1	2000	>1	Reference Identification Qualifier	R	REF01	128	M	ID	2	3	"0F" (Numeric zero)	N/A	"0F"
834-043						Reference Identification	R	REF02	127	X	AN	1	30	RBHA Client_id	ENRMAS.tempno, ENRMAS.membno	Tempno sent if membno does not exist
834-046	Member Identitification Number	S	5	2000	>1	Reference Identification Qualifier	R	REF01	128	M	ID	2	3	"6O" = Cross Reference Number (alpha O)	N/A	"6O"

CIS MANUAL 834 Intake (Add) Data Mapping																VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	R/S	SEG. REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	R/S	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
834-047						Reference Identification	R	REF02	127	X	AN	1	30	AHCCCS ID	ENRMAS.accsid	Field Value
834-048	Member Identitification Number	S	5	2000	>1	Reference Identification Qualifier	R	REF01	128	M	ID	2	3	"23" = Client Number	N/A	"23"
834-049						Reference Identification	R	REF02	127	X	AN	1	30	CIS Client ID	ENRMAS.membno	Field Value
834-052	Member Level Dates	S	20	2000	>1	Date/Time Qualifier	R	DTP01	374	M	ID	3	3	"356" = Intake Date	N/A	"356"
834-053						Date Time Period Format Qualifier	R	DTP02	1250	M	ID	2	3	"D8"	N/A	"D8"
834-054						Date Time Period	R	DTP03	1251	M	AN	1	35	Intake Date (CCYYMMDD)	ENRMAS.enrdat	Field Value
834-055	Member Name	R	1	2100A	1	Entity Identifier Code	R	NM101	98	M	ID	2	3	"74"=Corrected Insured "IL"=Insured or Subscriber	N/A	"74"
834-056						Entity Type Qualifier	R	NM102	1065	M	ID	1	1	"1"	N/A	"1"
834-057						Name Last	R	NM103	1035	O	AN	1	35	Subscriber Last Name	ENRMAS.lstnam	Field Value
834-058						Name First	R	NM104	1036	O	AN	1	25	Subscriber First Name	ENRMAS.fstnam	Field Value
834-059						Name Middle	S	NM105	1037	O	AN	1	25	Subscriber Middle Name	ENRMAS.midnam	Field Value
834-060						Name Prefix	S	NM106	1038	O	AN	1	10		N/A	Not Used
834-061						Name Suffix	S	NM107	1039	O	AN	1	10		N/A	Not Used
834-062						Identification Code Qualifier	S	NM108	66	X	ID	1	2	"34" = Social Security Number	N/A	"34"
834-063						Identification Code	S	NM109	67	X	AN	2	80	SSN	ENRMAS.socsec	Field Value
834-071	Member Residence Street Address	S	1	2100A	1	Address Information	R	N301	166	M	AN	1	55	Address Line 1	ENRMAS.adrln1	Field Value
834-072						Address Information	S	N302	166	O	AN	1	55	Address Line 2	ENRMAS.adrln2	Field Value
834-073	Member Residence City, State, ZIP Code	S	1	2100A	1	City Name	R	N401	19	O	AN	2	30	City	ENRMAS.citycd	Field Value
834-074						State or Province Code	R	N402	156	O	ID	2	2	State	ENRMAS.stacod	Field Value
834-075						Postal Code	R	N403	116	O	ID	3	15	Zip	ENRMAS.zipcod	Field Value
834-076						Country Code	S	N404	26	O	ID	2	3		N/A	Not Used
834-077						Location Qualifier	S	N405	309	X	ID	1	2	"CY" = County	N/A	"CY"
834-078						Location Identifier	S	N406	310	O	AN	1	30	County (Location Identification Code)	ENRMAS.county	Field Value
834-079	Member demographics	S	1	2100A	1	Date Time Period format Qualifier	R	DMG01	1250	X	ID	2	3	"D8"	N/A	"D8"
834-080						Date Time Period	R	DMG02	1251	X	AN	1	35	Date of Birth (CCYYMMDD)	ENRMAS.bthdat	Field Value
834-081						Gender Code	R	DMG03	1068	O	ID	1	1	Sex	ENRMAS.sexcod	Field Value
834-082						Marital Status Code	S	DMG04	1067	O	ID	1	1	Marital Status	ENRMAS.marsta	MHS “1” = HIPAA “I”, MHS “2” = HIPAA “M” , MHS “3” = HIPAA “D”, MHS “4” = HIPAA “W”, MHS “5” = HIPAA “S”

CIS MANUAL 834 Intake (Add) Data Mapping															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	R/S	SEG. REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	R/S	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
834-083						Race or Ethnicity Code	S	DMG05	1109	O	ID	1	1	Race / Ethnicity Code	ENRMAS.ethcod, ENRMAS.racecd	racecd “1” = HIPAA “C” racecd “2” = HIPAA “B” racecd “3” = HIPAA “H” racecd “4” = HIPAA “A” racecd “5” = HIPAA “I”
834-084						Citizenship Status Code	S	DMG06	1066	O	ID	1	2		N/A	Not Used
834-095	Member Language	S	5	2100A	1	Identifier Code Qualifier	S	LUI01	66	X	ID	1	2	"LE" - ISO639 Language Codes Used	N/A	"LE"
834-096						Identification Code	S	LUI02	67	X	AN	2	80	Language Code from ISO639 list	N/A	Not Used
834-097						Description	S	LUI03	352	X	AN	1	80		N/A	Not Used
834-098						Use of Language Indicator	S	LUI04	1303	O	ID	1	2		N/A	Not Used
834-208	Health Coverage	S	1	2300	99	Maintenance Type Code	R	HD01	875	M	ID	3	3	021=add(A) 030=override (O)	ENRMAS.cissta	"021"
834-209						Insurance Line Code	R	HD03	1205	O	ID	2	3	"AK" = Mental Health	N/A	"AK"
834-210						Plan Coverage Description	S	HD04	1204	O	AN	1	50		N/A	Not Used
834-211						Coverage Level Code	S	HD05	1207	O	ID	3	3		N/A	Not Used
834-212	Health Coverage Dates	R	4	2300	99	Date/Time Qualifier	R	DTP01	374	M	ID	3	3	"348" - benefit begin	N/A	"348"
834-213						Date Time Period Format Qualifier	R	DTP02	1250	M	ID	2	3	"D8"	N/A	"D8"
834-214						Date Time Period	R	DTP03	1251	M	AN	1	35	Intake Date	ENRMAS.enrdat	Field Value
834-251	Coordination of Benefits	S	1	2320	5	Payer Responsibility Sequence Code	R	COB01	1138	O	ID	1	1	"P"	N/A	"P"
834-252						Reference Identification	S	COB02	127	O	AN	1	30		N/A	Not Used
834-253						Coordination of Benefits Code	R	COB03	1143	O	ID	1	1	5	N/A	Not Used
834-256	Other Insurance Company Name	S	1	2320	5	Entity Identifier Code	R	N101	98	M	ID	2	3	"IN"	N/A	"IN"
834-257						Name	S	N102	93	X	AN	1	60	Use names from table	ENRMAS.medin1	MHS "1"=HIPAA "Medicare" MHS "2"=HIPAA "AHCCCS" MHS "3"=HIPAA "Private" MHS "4"=HIPAA "CHAMPUS/VA" MHS "5"=HIPAA "Other" MHS "6"=HIPAA "Blue Cross" MHS "7"=HIPAA "HMO"
834-258						Identification Code Qualifier	S	N103	66	X	ID	1	2		N/A	Not Used
834-259						Identification Code	S	N104	67	X	AN	2	80		N/A	Not Used
834-263	Coordination of Benefits	S	1	2320	5	Payer Responsibility Sequence Code	R	COB01	1138	O	ID	1	1	"S"	N/A	"S"

CIS MANUAL 834 Intake (Add) Data Mapping															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	R/S	SEG. REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	R/S	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
834-264						Reference Identification	S	COB02	127	O	AN	1	30		N/A	Not Used
834-265						Coordination of Benefits Code	R	COB03	1143	O	ID	1	1	5	N/A	Not Used
834-268	Other Insurance Company Name	S	1	2320	5	Entity Identifier Code	R	N101	98	M	ID	2	3	"IN"	N/A	"IN"
834-269						Name	S	N102	93	X	AN	1	60	Use names from table	ENRMAS.medin2	MHS "1"=HIPAA "Medicare" MHS "2"=HIPAA "AHCCCS" MHS "3"=HIPAA "Private" MHS "4"=HIPAA "CHAMPUS/VA" MHS "5"=HIPAA "Other" MHS "6"=HIPAA "Blue Cross" MHS "7"=HIPAA "HMO"
834-270						Identification Code Qualifier	S	N103	66	X	ID	1	2		N/A	Not Used
834-271						Identification Code	S	N104	67	X	AN	2	80		N/A	Not Used
834-275	Coordination of Benefits	S	1	2320	5	Payer Responsibility Sequence Code	R	COB01	1138	O	ID	1	1	"T"	N/A	"T"
834-276						Reference Identification	S	COB02	127	O	AN	1	30		N/A	Not Used
834-277						Coordination of Benefits Code	R	COB03	1143	O	ID	1	1	5	N/A	Not Used
834-280	Other Insurance Company Name	S	1	2320	5	Entity Identifier Code	R	N101	98	M	ID	2	3	"IN"	N/A	"IN"
834-281						Name	S	N102	93	X	AN	1	60	Use names from table	ENRMAS.medin3	MHS "1"=HIPAA "Medicare" MHS "2"=HIPAA "AHCCCS" MHS "3"=HIPAA "Private" MHS "4"=HIPAA "CHAMPUS/VA" MHS "5"=HIPAA "Other" MHS "6"=HIPAA "Blue Cross" MHS "7"=HIPAA "HMO"
834-282						Identification Code Qualifier	S	N103	66	X	ID	1	2		N/A	Not Used
834-283						Identification Code	S	N104	67	X	AN	2	80		N/A	Not Used

CIS MANUAL 834 Intake (Add) Data Mapping															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	R/S	SEG. REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	R/S	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
834-287	Transaction Set Trailer	R	1			Number of Included Segments	R	SE01	96	M	N0	1	10	Transaction segment Count	N/A	System Generated
834-288						Transaction Set Control Number	R	SE02	329	M	AN	4	9	Identical to ST02	N/A	System Generated

* Items in Grey are not used by CIS

834 (Change)

Values in quotes represent literal strings that are hard-Coded directly into the program.
When the Table Name.Field Name contains a “N/A” it indicates that no value is retrieved from a data store for that field.
A logic entry of “System Generated” indicates a value that is generated or calculated at file creation time by the program.
A logic entry of “Spaces” indicates a field that is filled entirely with spaces.

CIS MANUAL 834 (CHANGE) DATA MAPPING															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	R/S	SEG. REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	R/S	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
834-001	Transaction set Header	R	1			Transaction Set Identifier Code	R	ST01	143	M	ID	3	3	"834"	N/A	"834"
834-002						Transaction Set Control Number	R	ST02	329	M	ID	4	9	Incremental Number	N/A	System Generated
834-003	Beginning Segment	R	1			Transaction Set Purpose Code	R	BGN01	353	M	ID	2	2	"00"	N/A	"00"
834-004						Reference Identification	R	BGN02	127	M	AN	1	30	Originator Application Transaction Number	N/A	System Generated
834-005						Date	R	BGN03	373	M	DT	8	8	Transaction Set Create Date	N/A	System Generated
834-006						Time	R	BGN04	337	X	TM	4	8	Transaction Set Create Time	N/A	System Generated
834-007						Time Code	S	BGN05	623	O	ID	2	2		N/A	Not Used
834-008						Reference Identification	S	BGN06	127	O	AN	1	30		N/A	Not Used
834-009						Action Code	R	BGN08	306	O	ID	1	2	"2"	N/A	"2"
834-012	File effective Date	S	>1			Date/Time Qualifier	R	DTP01	374	M	ID	3	3	"007"	N/A	"007"
834-013						Date Time Period Format Qualifier	R	DTP02	1250	M	ID	2	3	"D8"	N/A	"D8"
834-014						Date Time Period	R	DTP03	1251	M	AN	1	35	CCYYMMDD (Process Date)	N/A	System Generated
834-015	Sponsor Name	R	1	1000A	1	Entity Identifier Code	R	N101	98	M	ID	2	3	"P5"	N/A	"P5"
834-016						Name	S	N102	93	X	AN	1	60	'Behavioral Health Services'	N/A	"Behavioral Health Services"
834-017						Identification Code Qualifier	R	N103	66	X	ID	1	2	"FI"	N/A	"FI"
834-018						Identification Code	R	N104	67	X	AN	2	80	"86-6004791"	N/A	"86-6004791"
834-019	Payer	R	1	1000B	1	Entity Identifier Code	R	N101	98	M	ID	2	3	"IN"	N/A	"IN"
834-020						Name	S	N102	93	X	AN	1	60	RBHA Name (Used to look up RBHA Number)	N/A	"ValueOptions"
834-021						Identification Code Qualifier	R	N103	66	X	ID	1	2	"FI"	N/A	"FI"
834-022						Identification Code	R	N104	67	X	AN	2	80	RBHA's Federal Taxpayer's ID	N/A	"54-1414194"
834-029	Member Level Detail	R	1	2000	>1	Response Code	R	INS01	1073	M	ID	1	1	"Y" = Subscriber	N/A	"Y"
834-030						Individual Relationship Code	R	INS02	1069	M	ID	2	2	"18" = Self	N/A	"18"
834-031						Maintenance Type Code	R	INS03	875	O	ID	3	3	021=add(A)	N/A	"021"
834-032						Maintenance Reason Code	S	INS04	1203	O	ID	2	3	20=active	N/A	"20"
834-033						Benefit Status Code	R	INS05	1216	O	ID	1	1	"A" = active	N/A	"A"
834-034						Medicare Plan Code	S	INS06	1218	O	ID	1	1		N/A	Not Used
834-035						CORBA Qualifying	S	INS07	1219	O	ID	1	2		N/A	Not Used
834-036						Employment Status Code	S	INS08	584	O	ID	2	2	"FT" = Eligible for Benefits	N/A	"FT"

CIS MANUAL 834 (CHANGE) DATA MAPPING															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	R/S	SEG. REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	R/S	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
834-037						Student Status Code	S	INS09	1220	O	ID	2	2		N/A	Not Used
834-038						Handicap Indicator	S	INS10	1073	O	ID	2	2		N/A	Not Used
834-039						Date Time Period Format Qualifier	S	INS11	1250	X	ID	2	3		N/A	Not Used
834-040						Date Time Period	S	INS12	1251	X	AN	1	35		N/A	Not Used
834-041						Number	S	INS17	1470	O	N0	1	9		N/A	Not Used
834-042	Subscriber Number	R	1	2000	>1	Reference Identification Qualifier	R	REF01	128	M	ID	2	3	"0F" (Numeric zero)	N/A	"0F"
834-043						Reference Identification	R	REF02	127	X	AN	1	30	RBHA Client_id	ENRMAS.tempno, ENRMAS.membno	Tempno sent if membno does not exist
834-046	Member Identification Number	S	5	2000	>1	Reference Identification Qualifier	R	REF01	128	M	ID	2	3	"6O" = Cross Reference Number (alpha O)	N/A	"6O"
834-047						Reference Identification	R	REF02	127	X	AN	1	30	AHCCCS ID	ENRMAS.accsid	Field Value
834-048	Member Identification Number	S	5	2000	>1	Reference Identification Qualifier	R	REF01	128	M	ID	2	3	"23" = Client Number	N/A	"23"
834-049						Reference Identification	R	REF02	127	X	AN	1	30	CIS Client ID	ENRMAS.membno	Field Value
834-052	Member Level Dates	S	20	2000	>1	Date/Time Qualifier	R	DTP01	374	M	ID	3	3	"356" = Intake Date	N/A	"356"
834-053						Date Time Period Format Qualifier	R	DTP02	1250	M	ID	2	3	"D8"	N/A	"D8"
834-054						Date Time Period	R	DTP03	1251	M	AN	1	35	Intake Date (CCYYMMDD)	ENRMAS.enrdat	Field Value
834-055	Member Name	R	1	2100A	1	Entity Identifier Code	R	NM101	98	M	ID	2	3	"74"=Corrected Insured "IL"=Insured or Subscriber	N/A	"74"
834-056						Entity Type Qualifier	R	NM102	1065	M	ID	1	1	"1"	N/A	"1"
834-057						Name Last	R	NM103	1035	O	AN	1	35	Subscriber Last Name	ENRMAS.lstnam	Field Value
834-058						Name First	R	NM104	1036	O	AN	1	25	Subscriber First Name	ENRMAS.fstnam	Field Value
834-059						Name Middle	S	NM105	1037	O	AN	1	25	Subscriber Middle Name	ENRMAS.midnam	Field Value
834-060						Name Prefix	S	NM106	1038	O	AN	1	10		N/A	Not Used
834-061						Name Suffix	S	NM107	1039	O	AN	1	10		N/A	Not Used
834-062						Identification Code Qualifier	S	NM108	66	X	ID	1	2	"34" = Social Security Number	N/A	"34"
834-063						Identification Code	S	NM109	67	X	AN	2	80	SSN	ENRMAS.socsec	Field Value
834-071	Member Residence Street Address	S	1	2100A	1	Address Information	R	N301	166	M	AN	1	55	Address Line 1	ENRMAS.adrln1	Field Value
834-072						Address Information	S	N302	166	O	AN	1	55	Address Line 2	ENRMAS.adrln2	Field Value
834-073	Member Residence City, State, ZIP Code	S	1	2100A	1	City Name	R	N401	19	O	AN	2	30	City	ENRMAS.citycd	Field Value
834-074						State or Province Code	R	N402	156	O	ID	2	2	State	ENRMAS.stacod	Field Value
834-075						Postal Code	R	N403	116	O	ID	3	15	Zip	ENRMAS.zipcod	Field Value
834-076						Country Code	S	N404	26	O	ID	2	3		N/A	Not Used
834-077						Location Qualifier	S	N405	309	X	ID	1	2	"CY" = County	N/A	"CY"
834-078						Location Identifier	S	N406	310	O	AN	1	30	County (Location Identification Code)	ENRMAS.county	Field Value
834-079	Member demographics	S	1	2100A	1	Date Time Period format Qualifier	R	DMG01	1250	X	ID	2	3	"D8"	N/A	"D8"
834-080						Date Time Period	R	DMG02	1251	X	AN	1	35	Date of Birth (CCYYMMDD)	ENRMAS.bthdat	Field Value

CIS MANUAL 834 (CHANGE) DATA MAPPING															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	R/S	SEG. REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	R/S	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
834-081						Gender Code	R	DMG03	1068	O	ID	1	1	Sex	ENRMAS.sexcod	Field Value
834-082						Marital Status Code	S	DMG04	1067	O	ID	1	1	Marital Status	ENRMAS.marsta	MHS “1” = HIPAA “I”, MHS “2” = HIPAA “M” , MHS “3” = HIPAA “D”, MHS “4” = HIPAA “W”, MHS “5” = HIPAA “S”
834-083						Race or Ethnicity Code	S	DMG05	1109	O	ID	1	1	Race / Ethnicity Code	ENRMAS.ethcod, ENRMAS.racecd	racecd “1” = HIPAA “C” racecd “2” = HIPAA “B” racecd “3” = HIPAA “H” racecd “4” = HIPAA “A” racecd “5” = HIPAA “I”
834-084						Citizenship Status Code	S	DMG06	1066	O	ID	1	2		N/A	Not Used
834-095	Member Language	S	5	2100A	1	Identifier Code Qualifier	S	LUI01	66	X	ID	1	2	"LE" - ISO639 Language Codes Used	N/A	"LE"
834-096						Identification Code	S	LUI02	67	X	AN	2	80	Language Code from ISO639 list	N/A	Not Used
834-097						Description	S	LUI03	352	X	AN	1	80		N/A	Not Used
834-098						Use of Language Indicator	S	LUI04	1303	O	ID	1	2		N/A	Not Used
834-208	Health Coverage	S	1	2300	99	Maintenance Type Code	R	HD01	875	M	ID	3	3	021=add(A) 030=override (O)	ENRMAS.cissta	"001"
834-209						Insurance Line Code	R	HD03	1205	O	ID	2	3	"AK" = Mental Health	N/A	"AK"
834-210						Plan Coverage Description	S	HD04	1204	O	AN	1	50		N/A	Not Used
834-211						Coverage Level Code	S	HD05	1207	O	ID	3	3		N/A	Not Used
834-212	Health Coverage Dates	R	4	2300	99	Date/Time Qualifier	R	DTP01	374	M	ID	3	3	"303" - Maint effective	N/A	"303"
834-213						Date/Time Period Format Qualifier	R	DTP02	1250	M	ID	2	3	"D8"	N/A	"D8"
834-214						Date/Time Period	R	DTP03	1251	M	AN	1	35	Intake Date	ENRMAS.enrdat	Field Value
834-251	Coordination of Benefits	S	1	2320	5	Payer Responsibility Sequence Code	R	COB01	1138	O	ID	1	1	"P"	N/A	"P"
834-252						Reference Identification	S	COB02	127	O	AN	1	30		N/A	Not Used
834-253						Coordination of Benefits Code	R	COB03	1143	O	ID	1	1	5	N/A	Not Used
834-256	Other Insurance Company Name	S	1	2320	5	Entity Identifier Code	R	N101	98	M	ID	2	3	"IN"	N/A	"IN"
834-257						Name	S	N102	93	X	AN	1	60	Use names from table	ENRMAS.medin1	MHS "1"=HIPAA "Medicare" MHS "2"=HIPAA "AHCCCS" MHS "3"=HIPAA "Private" MHS "4"=HIPAA "CHAMPUS/VA" MHS "5"=HIPAA "Other" MHS "6"=HIPAA "Blue Cross" MHS "7"=HIPAA "HMO"
834-258						Identification Code Qualifier	S	N103	66	X	ID	1	2		N/A	Not Used
834-259						Identification Code	S	N104	67	X	AN	2	80		N/A	Not Used
834-263	Coordination of Benefits	S	1	2320	5	Payer Responsibility Sequence Code	R	COB01	1138	O	ID	1	1	"S"	N/A	"S"

CIS MANUAL 834 (CHANGE) DATA MAPPING															VALUEOPTIONS CORRESPONDING DATA MAPPING	
ELEMENT ID	SEGMENT NAME	R/S	SEG. REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	R/S	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
834-264						Reference Identification	S	COB02	127	O	AN	1	30		N/A	Not Used
834-265						Coordination of Benefits Code	R	COB03	1143	O	ID	1	1	5	N/A	Not Used
834-268	Other Insurance Company Name	S	1	2320	5	Entity Identifier Code	R	N101	98	M	ID	2	3	"IN"	N/A	"IN"
834-269						Name	S	N102	93	X	AN	1	60	Use names from table	ENRMAS.medin2	MHS "1"=HIPAA "Medicare" MHS "2"=HIPAA "AHCCCS" MHS "3"=HIPAA "Private" MHS "4"=HIPAA "CHAMPUS/VA" MHS "5"=HIPAA "Other" MHS "6"=HIPAA "Blue Cross" MHS "7"=HIPAA "HMO"
834-270						Identification Code Qualifier	S	N103	66	X	ID	1	2		N/A	Not Used
834-271						Identification Code	S	N104	67	X	AN	2	80		N/A	Not Used
834-275	Coordination of Benefits	S	1	2320	5	Payer Responsibility Sequence Code	R	COB01	1138	O	ID	1	1	"T"	N/A	"T"
834-276						Reference Identification	S	COB02	127	O	AN	1	30		N/A	Not Used
834-277						Coordination of Benefits Code	R	COB03	1143	O	ID	1	1	5	N/A	Not Used
834-280	Other Insurance Company Name	S	1	2320	5	Entity Identifier Code	R	N101	98	M	ID	2	3	"IN"	N/A	"IN"
834-281						Name	S	N102	93	X	AN	1	60	Use names from table	ENRMAS.medin3	MHS "1"=HIPAA "Medicare" MHS "2"=HIPAA "AHCCCS" MHS "3"=HIPAA "Private" MHS "4"=HIPAA "CHAMPUS/VA" MHS "5"=HIPAA "Other" MHS "6"=HIPAA "Blue Cross" MHS "7"=HIPAA "HMO"
834-282						Identification Code Qualifier	S	N103	66	X	ID	1	2		N/A	Not Used
834-283						Identification Code	S	N104	67	X	AN	2	80		N/A	Not Used
834-287	Transaction Set Trailer	R	1			Number of Included Segments	R	SE01	96	M	N0	1	10	Transaction segment Count	N/A	System Generated
834-288						Transaction Set Control Number	R	SE02	329	M	AN	4	9	Identical to ST02	N/A	System Generated

* Items in Grey are not used by CIS

834 (Closure)

Values in quotes represent literal strings that are hard-Coded directly into the program.
When the Table Name.Field Name contains a “N/A” it indicates that no value is retrieved from a data store for that field.
A logic entry of “System Generated” indicates a value that is generated or calculated at file creation time by the program.
A logic entry of “Spaces” indicates a field that is filled entirely with spaces.

CIS MANUAL 834 (CLOSURE) DATA MAPPING																VALUEOPTIONS DATA MAPPING	
ELEMENT ID	SEGMENT NAME	R/S	SEG. REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	R/S	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
834-001	Transaction set Header	R	1			Transaction Set Identifier Code	R	ST01	143	M	ID	3	3	"834"	N/A	"834"
834-002						Transaction Set Control Number	R	ST02	329	M	ID	4	9	Incremental Number	N/A	System Generated
834-003	Beginning Segment	R	1			Transaction Set Purpose Code	R	BGN01	353	M	ID	2	2	"00"	N/A	"00"
834-004						Reference Identification	R	BGN02	127	M	AN	1	30	Originator Application Transaction Number	N/A	System Generated
834-005						Date	R	BGN03	373	M	DT	8	8	Transaction Set Create Date	N/A	System Generated
834-006						Time	R	BGN04	337	X	TM	4	8	Transaction Set Create Time	N/A	System Generated
834-007						Time Code	S	BGN05	623	O	ID	2	2		N/A	Not Used
834-008						Reference Identification	S	BGN06	127	O	AN	1	30		N/A	Not Used
834-009						Action Code	R	BGN08	306	O	ID	1	2	"2"	N/A	"2"
834-012	File effective Date	S	>1			Date/Time Qualifier	R	DTP01	374	M	ID	3	3	"007"	N/A	"007"
834-013						Date/Time Period Format Qualifier	R	DTP02	1250	M	ID	2	3	"D8"	N/A	"D8"
834-014						Date/Time Period	R	DTP03	1251	M	AN	1	35	CCYYMMDD (Process Date)	N/A	System Generated
834-015	Sponsor Name	R	1	1000A	1	Entity Identifier Code	R	N101	98	M	ID	2	3	"P5"	N/A	"P5"
834-016						Name	S	N102	93	X	AN	1	60	'Behavioral Health Services'	N/A	"Behavioral Health Services"
834-017						Identification Code Qualifier	R	N103	66	X	ID	1	2	"FI"	N/A	"FI"
834-018						Identification Code	R	N104	67	X	AN	2	80	"86-6004791"	N/A	"86-6004791"
834-019	Payer	R	1	1000B	1	Entity Identifier Code	R	N101	98	M	ID	2	3	"IN"	N/A	"IN"
834-020						Name	S	N102	93	X	AN	1	60	RBHA Name (Used to look up RBHA Number)	N/A	"ValueOptions"
834-021						Identification Code Qualifier	R	N103	66	X	ID	1	2	"FI"	N/A	"FI"
834-022						Identification Code	R	N104	67	X	AN	2	80	RBHA's Federal Taxpayer's ID	N/A	"54-1414194"
834-029	Member Level Detail	R	1	2000	>1	Response Code	R	INS01	1073	M	ID	1	1	"Y" = Subscriber	N/A	"Y"
834-030						Individual Relationship Code	R	INS02	1069	M	ID	2	2	"18" = Self	N/A	"18"
834-031						Maintenance Type Code	R	INS03	875	O	ID	3	3	001=change 024=termination	DISMAS.cissta	M = Change, blank = termination
834-032						Maintenance Reason Code	S	INS04	1203	O	ID	2	3	07=termination	N/A	"07"
834-033						Benefit Status Code	R	INS05	1216	O	ID	1	1	"A" = active	N/A	"A"
834-034						Medicare Plan Code	S	INS06	1218	O	ID	1	1		N/A	Not Used
834-035						CORBA Qualifying	S	INS07	1219	O	ID	1	2		N/A	Not Used
834-036						Employment Status Code	S	INS08	584	O	ID	2	2	"TE"	N/A	"TE"

CIS MANUAL 834 (CLOSURE) DATA MAPPING															VALUEOPTIONS DATA MAPPING	
ELEMENT ID	SEGMENT NAME	R/S	SEG. REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	R/S	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
834-037						Student Status Code	S	INS09	1220	O	ID	2	2		N/A	Not Used
834-038						Handicap Indicator	S	INS10	1073	O	ID	2	2		N/A	Not Used
834-039						Date Time Period Format Qualifier	S	INS11	1250	X	ID	2	3		N/A	Not Used
834-040						Date Time Period	S	INS12	1251	X	AN	1	35		N/A	Not Used
834-041						Number	S	INS17	1470	O	N0	1	9		N/A	Not Used
834-042	Subscriber Number	R	1	2000	>1	Reference Identification Qualifier	R	REF01	128	M	ID	2	3	"0F" (Numeric zero)	N/A	"0F"
834-043						Reference Identification	R	REF02	127	X	AN	1	30	RBHA Client_id	DISMAS.membno	Field Value
834-048	Member Identitification Number	S	5	2000	>1	Reference Identification Qualifier	R	REF01	128	M	ID	2	3	"23" = Client Number	N/A	"23"
834-049						Reference Identification	R	REF02	127	X	AN	1	30	CIS Client ID	DISMAS.Membno	Field Value
834-052	Member Level Dates	S	20	2000	>1	Date/Time Qualifier	R	DTP01	374	M	ID	3	3	"356" = Intake Date	N/A	"356"
834-053						Date Time Period Format Qualifier	R	DTP02	1250	M	ID	2	3	"D8"	N/A	"D8"
834-054						Date Time Period	R	DTP03	1251	M	AN	1	35	Intake Date (CCYYMMDD)	DISMAS.enrdat	Field Value
834-052	Member Level Dates	S	20	2000	>1	Date/Time Qualifier	R	DTP01	374	M	ID	3	3	"357" = Closure Date	N/A	"357"
834-053						Date Time Period Format Qualifier	R	DTP02	1250	M	ID	2	3	"D8"	N/A	"D8"
834-054						Date Time Period	R	DTP03	1251	M	AN	1	35	Closure Date (CCYYMMDD)	DISMAS.disdat	Field Value
834-055	Member Name	R	1	2100A	1	Entity Identifier Code	R	NM101	98	M	ID	2	3	"74"=Corrected Insured "IL"=Insured or Subscriber	N/A	"74"
834-056						Entity Type Qualifier	R	NM102	1065	M	ID	1	1	"1"	N/A	"1"
834-057						Name Last	R	NM103	1035	O	AN	1	35	Subscriber Last Name	DISMAS.Lstnam	Field Value
834-058						Name First	R	NM104	1036	O	AN	1	25	Subscriber First Name	DISMAS.fstnam	Field Value
834-059						Name Middle	S	NM105	1037	O	AN	1	25	Subscriber Middle Name	DISMAS.midnam	Field Value
834-060						Name Prefix	S	NM106	1038	O	AN	1	10		N/A	Not Used
834-061						Name suffix	S	NM107	1039	O	AN	1	10		N/A	Not Used
834-062						Identification Code Qualifier	S	NM108	66	X	ID	1	2	"34" = Social Security Number	N/A	"34"
834-063						Identification Code	S	NM109	67	X	AN	2	80	SSN	DISMAS.socsec	Field Value
834-071	Member Residence Street Address	S	1	2100A	1	Address Information	R	N301	166	M	AN	1	55	Address Line 1	N/A	Not Used
834-072						Address Information	S	N302	166	O	AN	1	55	Address Line 2	N/A	Not Used
834-073	Member Residence City, State, ZIP Code	S	1	2100A	1	City Name	R	N401	19	O	AN	2	30	City	N/A	Not Used
834-074						State or Province Code	R	N402	156	O	ID	2	2	State	N/A	Not Used
834-075						Postal Code	R	N403	116	O	ID	3	15	Zip	N/A	Not Used
834-076						Country Code	S	N404	26	O	ID	2	3		N/A	Not Used
834-077						Location Qualifier	S	N405	309	X	ID	1	2	"CY" = County	N/A	"CY"
834-078						Location Identifier	S	N406	310	O	AN	1	30	County (Location Identification Code)	N/A	Not Used
834-079	Member demographics	S	1	2100A	1	Date Time Period format Qualifier	R	DMG01	1250	X	ID	2	3	"D8"	N/A	"D8"
834-080						Date Time Period	R	DMG02	1251	X	AN	1	35	Date of Birth (CCYYMMDD)	DISMAS.bthdat	Field Value
834-081						Gender Code	R	DMG03	1068	O	ID	1	1	Sex	N/A	Not Used
834-082						Marital Status Code	S	DMG04	1067	O	ID	1	1	Gap in Codes available	N/A	Not Used

CIS MANUAL 834 (CLOSURE) DATA MAPPING																VALUEOPTIONS DATA MAPPING	
ELEMENT ID	SEGMENT NAME	R/S	SEG. REPEAT	LOOP	LOOP REPEAT	ELEMENT NAME	R/S	ABBREV. NAME	DATA ELEMENT	REQ. DES.	DATA TYPE	MIN LEN	MAX LEN	SHORT DESCRIPTION	TABLE NAME.FIELD NAME	MAPPING LOGIC
834-083						Race or Ethnicity Code	S	DMG05	1109	O	ID	1	1	Gap in Codes available	N/A	Not Used
834-084						Citizenship Status Code	S	DMG06	1066	O	ID	1	2		N/A	Not Used
834-287	Transaction Set Trailer	R	1			Number of Included Segments	R	SE01	96	M	N0	1	10	Transaction segment Count	N/A	System Generated
834-288						Transaction Set Control Number	R	SE02	329	M	AN	4	9	Identical to ST02	N/A	System Generated

* Items in grey not used by CIS

23. Chart 5k.1 indicates MHS errors are fixed and submitted directly to DHS/CIS. Discuss how these errors are corrected in the MHS system. The proposal reflects there is no scrubbing for PRIDUS on-line transactions. Discuss if this is correct. Maximum 1 page (Volume 5 k)

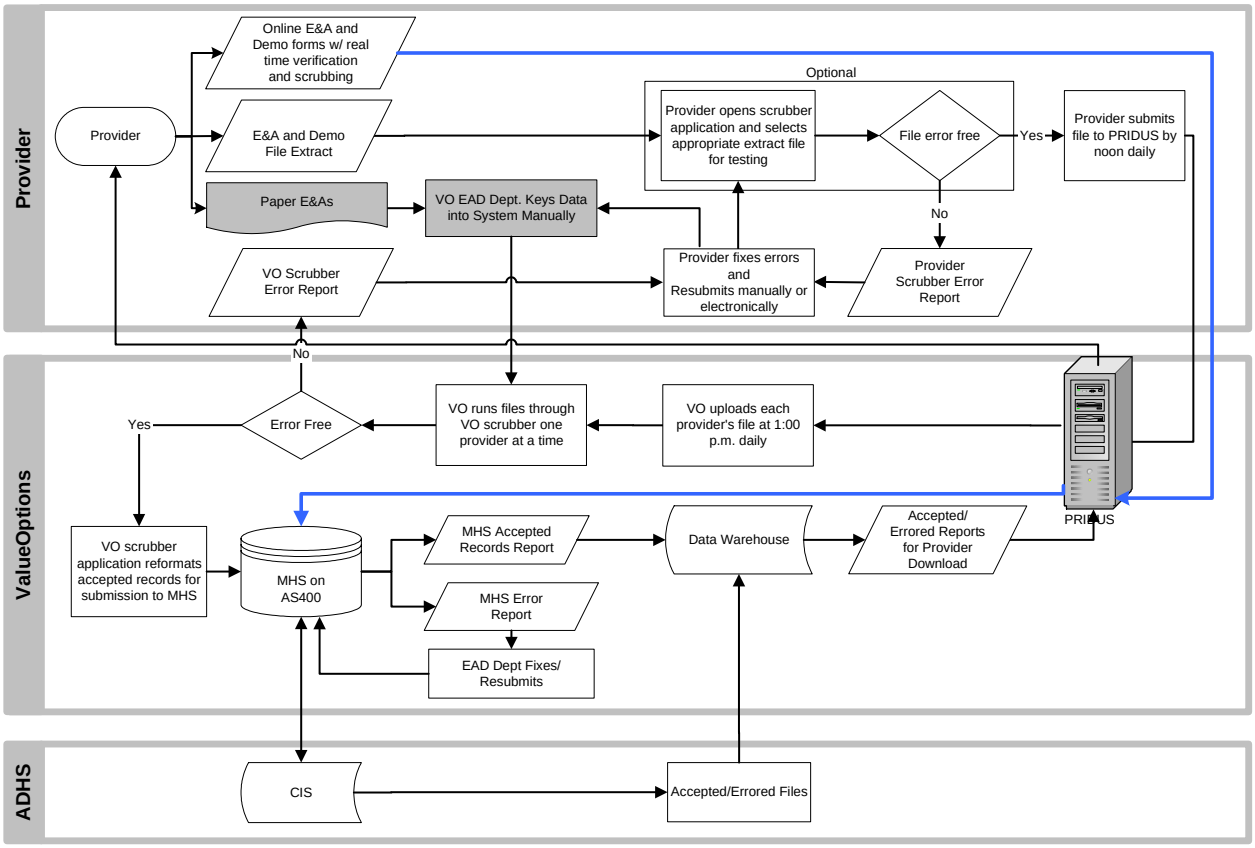
ValueOptions' staff work independently—and in concert with providers—to fix errors identified through ValueOptions' pre-submission scrubbing process, MHS, and/or ADHS/DBHS error reports. Those errors identified via the "pre-scrubber" are corrected and forwarded to MHS, while those identified by ADHS/DBHS, and other internal reports, are researched and fixed by the appropriate department within MHS. Specific details on fixing MHS errors have been addressed in Question 16, under both the Enrollment/Disenrollment/Demographic and Claims Sections. For a visual presentation of the process refer to Figure 5k.1 below.

PRIDUS Data Scrubbing

ValueOptions' PRIDUS system does provide data scrubbing. The same application that provides editing on-line, via the web, for our EAD Department applies the same process to providers' submissions to PRIDUS. PRIDUS then provides submission reporting to the provider each day. Subsequent to the submission of our proposal in November 2003, PRIDUS has become fully operational as designed.

Figure 5k.1 (revised 1/20/04)

Electronic Enrollment and Demographic File Submission Process



CIS-Client Informatin System
PRIDUS - Provider Reporting Information Download/Upload Server
MHS - Managed Healthcare System

24. As discussed during the site visit/oral presentation, describe methods for controlling costs for the Title XIX/XXI populations. Maximum 1 page (Volume 6 e)

ValueOptions has developed strong financial and administrative procedures that are designed to provide internal controls and warning systems to alert staff and management when expenditures exceed pre-established thresholds. These procedures ensure consistency and provide important checks and balances in our administrative operations including information processing, claims adjudication, contracting, and budgeting for all funding populations. Our key financial and administrative protocols that ValueOptions uses to control costs for *all* funding populations are outlined in the paragraphs that follow.

Establishing Budgets for Service Expenditures
Finance staff work closely with clinical and network staff to establish an annual budget with financial targets by fund type and level of care. This cross-departmental process results in a budget that both supports the clinical goals of the behavioral health system and ensures that projected service expenditures are in line with projected revenue. A key part of budget establishment is the identification of priorities for the consumers we serve, both non-Title XIX/XXI and Title XIX/XXI. In collaboration with consumers, stakeholders, and providers we establish priorities for the use of these funds. Each funding source presents its own set of challenges. Non-Title XIX funding is fixed and does not increase proportionately to increased population growth, whereas Title XIX funding budget is a prediction based upon eligibility trends. Once established, we use the budget process - for both non-Title XIX/XXI and Title XIX/XXI funding - to monitor projected expenditures and revenues against actual performance.

Contract Development
ValueOptions Finance staff takes the lead in analyzing anticipated program costs and predicting revenue. Then Finance, Program Development, and Network Management staff work together to ensure that an adequate network is in place and that variances in service expenditures compared to estimated revenues are reviewed both internally and with providers to determine the source of the variances and any needed adjustments.

Monitoring Financial Performance
ValueOptions financial performance is monitored through the analysis of monthly financial statements. Immediate action is taken if expenditures are not in line with revenues, enabling both administrative expenses and service utilization to be proactively managed.

We manage provider financial performance through encounter validation where claims and encounters are tested for timeliness, completeness, and accuracy. We also monitor encounter under-production by fund type where we validate provider payments and alert providers when they are not meeting contract thresholds. At the same time, we alert clinical and network staff to potential provider performance issues. We monitor provider financial performance through a review of their production of encounter value compared to contract payments and the number and type of services provided. We also review individual provider operational efficiency by monitoring implementation of financial management procedures and measuring staffing levels and productivity by evaluating provider caseloads.

ValueOptions has expanded our current use of a multi-disciplinary team review process for providers that are identified as needing special assistance to a more integrated cross-departmental monitoring of financial performance, productivity and capacity. ValueOptions finance and administrative staff, working with Network Management and Program Development staff and with Clinical and Quality Management departments, will develop and implement a multi-disciplinary team that will systematically review outlier performers.

Additional cost containment strategies
Additional cost containment strategies include our implementation of efficient contracting systems and cost-efficient utilization management systems to minimize expense for our providers and ValueOptions. Our innovative use of technology also contains cost through more efficient use of resources and the use of electronic forms to reduce paper usage.

25. Describe how the Offeror will allocate expenses incurred for block purchases (services) to the different rate cells / programs and the reason this methodology would be used. Maximum 1 page (Volume 6 e)

ValueOptions assumes that the definition of a rate cell / program intersection is the combination of the service provided and the program that pays for that service. The service would be defined as the procedure code, modifier, and place of service combination that a provider would bill in a claim. The program would be defined as the ultimate fund source responsible for service payment, based on a particular consumer's eligibility. The ADHS/DBHS Office of Financial Review produces the Crosswalk to Covered Services Guide that associates claim level billing codes to the Quarterly Statement of Activities' expense line items. This document forms the basis of the allocation methodology used by ValueOptions to allocate the block purchased service expenditures to the mandated ADHS/DBHS reporting protocols.

ValueOptions will capture the actual utilization by billable service and aggregate it using the crosswalk. The member's eligibility will determine the fund source associated with the claim, unless the service does not qualify for reimbursement under that eligibility assignment or another payer trumps the assigned eligibility assignment for that claim. The actual utilization will be summarized according to ADHS-identified funding sources and the service categories delineated in the Quarterly Statement of Activities. The resulting grid of utilization values will be converted to percentages by dividing each value by the total value of services provided by fund source. The total block purchase expenditures by fund sources will be allocated to each service category by multiplying the total amount expended by fund source and the utilization percentage profile value as found in the grid described above.

Block purchases allow ValueOptions to contract for services from providers in the least restrictive way while maintaining reasonable fiscal controls. Providers will receive payments for broad categories of service such as residential or outpatient, allowing them to tailor the provision of services to meet changing service demands, consumer needs, and special contract requirements related to planned changes in service delivery philosophy and service mix. In addition, block purchases will provide a mechanism to fund providers in a prospective way, improving providers' cash flow and financial health. Providers will be required to submit encounters for all block purchase arrangements in amounts equal to or greater than cash payments.

ValueOptions will employ this allocation methodology to provide the ADHS/DBHS with the information required in the RBHA Financial Reporting Guide - most specifically the Quarterly Statement of Activities. In order to report the results of operating activities in the required categories listed in the Quarterly Statement of Activities, an allocation methodology will be necessary because the ValueOptions does not employ a strict fee-for-service purchase paradigm. This allocation methodology will provide ValueOptions with a mechanism of associating expenditures under a block purchase paradigm using broad categories of service with the specific utilization driven detail usually achieved in a fee-for-service environment.

26. As discussed at the site visit/oral presentation, explain the methodology used to allocate expenses in Attachment H – Estimated Expenditures. Provide a revised attachment H – Estimated Expenditures. Break out profit and administrative expenses on separate lines. Maximum 3 pages for the narrative (Volume 6 c)

Methodology

1. The utilization data contained in the RFP data book were reviewed, analyzed, and compared to internal data sources for consistency.
2. The RFP Scope of Work, paragraphs C (services), G (service delivery system requirements), and Q (financial management) were reviewed to ensure that the utilization data reflected the services that are to be provided, the service delivery requirements for the programs contained in Attachment H, and that expenses reflect the costs associated with financial management.
3. The ADHS/DBHS Reporting Guides crosswalks were reviewed to ascertain the grouping of the detail of the data. Those groupings were also compared to the groupings contained in the Leff Report (Principles for Persons with Serious Mental Illness) and the Arizona Children's Principles to ensure accurate comparisons of trended data to the applicable treatment principles.
4. The percentage of each service category [(individual category expense) / (total expenses)] were calculated for the programs included on Attachment H, for each fiscal year presented in the RFP data book. Incremental changes in percentages between each fiscal year were calculated and reviewed. Using the trends reflected in those changes, service mix percentages (without administrative expenses or profit margins) were then projected for FY'04, FY'05, FY'06, and FY'07 (adjustments were made for rounding errors). The resultant service mixes were provided to ValueOptions clinical, network, and direct service representatives to evaluate against treatment principles, clinical trends, program development plans, and field observations. Their feedback was incorporated into revised trends.
5. The trended data for the SMI programs were evaluated against the Leff Report to ensure that projections reflect ValueOptions' commitment to service delivery and program requirements for persons determined to have a serious mental illness. Trended data for the Title XIX Children programs were evaluated for compliance to Arizona Children's Principles.
6. Volume 6, item c requires the Offeror to provide, in percent format, "estimated expenditures for all services and other expenses." As administrative expenses allowed by ADHS cannot exceed 7.5% of revenue and ValueOptions' historical financial statements show an average of 7.5% in administrative expenses, this percentage was used for the projections.
7. A profit corridor has been established by ADHS for all programs at 4% of service revenue (92.5%); loss corridors have been established at 4% of service revenue for Title XIX and Title XXI programs [RFP, Special Terms and Conditions, paragraph F.3]. The projections were built assuming that service expenses would not be less than 89% of the total [(92.5%) x (1 - .04), rounded up].

General Assumptions

1. The total of service expenses, administrative expenses, and profit margins will equal 100% of total revenues for each fiscal year. Profit margins are controlled as set forth in the RFP.
2. The growth rates experienced in Title XIX eligibility counts will continue, but at a slower rate than reported in the data book for FY'03 (based on review of eligibility and other data for September and October 2003).
3. Tax expense is allocated and reported within the various service categories.
4. No provision for the 1% incentive payments referenced in the RFP has been made; however, it is ValueOptions' intention to continuously strive to meet the criteria established to earn the incentive.
5. New enrollees to the system in Maricopa County will exhibit similar needs as current consumers.
6. Based on the trends observed at the time, we assumed that revenue for the Title XIX and Title XXI programs would continue to grow, allowing expansion of those programs, and that Non-Title XIX funding would remain at the FY'04 level.

Population-Specific Assumptions

Children (Title XIX CMDP and Title XIX Non-CMDP)

ValueOptions has been working with its comprehensive service providers to fully achieve the Arizona Children's Vision and practice model. Although the influx of children from DES to the behavioral health system has impacted our ability to move children from higher levels of care, progress has been made and we believe that the trend of increasing support services, continued implementation of the Child and Family Teams, with corresponding decreases in inpatient and residential services will be achieved. The service mix for Non-CMDP children is different than the mix for CMDP children, as CMDP children have, historically, much greater utilization of inpatient and residential services than the Non-CMDP children. The actual service mixes for FY'02 and FY'03, with projections for FY'04 through FY'07, without any profit or administrative expenses, are presented below.

TXIX CMDP CHILDREN						
Category of Service	**ACTUAL FY'02**	**ACTUAL FY'03**	**PROJECTED FY'04**	**PROJECTED FY'05**	**PROJECTED FY'06**	**PROJECTED FY'07**
Treatment Services	23.00%	14.00%	14.00%	14.00%	13.00%	11.00%
Rehabilitation Services	2.00%	1.00%	2.00%	2.00%	2.00%	2.00%
Medical Services	4.00%	2.00%	2.00%	2.00%	2.00%	2.00%
Support Services	16.00%	18.00%	19.00%	23.00%	30.00%	37.00%
Crisis Intervention Services	1.00%	0.00%	1.00%	1.00%	1.00%	1.00%
Inpatient Services	34.00%	43.00%	38.00%	37.00%	32.00%	28.00%
Residential Services	6.00%	14.00%	10.00%	7.00%	6.00%	5.00%
Behavioral Health Day Programs	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
Medications	13.00%	7.00%	13.00%	13.00%	13.00%	13.00%
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

TXIX NON-CMDP CHILDREN						
Category of Service	**ACTUAL FY'02**	**ACTUAL FY'03**	**PROJECTED FY'04**	**PROJECTED FY'05**	**PROJECTED FY'06**	**PROJECTED FY'07**
Treatment Services	36.00%	32.00%	26.00%	26.00%	25.00%	25.00%
Rehabilitation Services	1.00%	1.00%	3.00%	3.00%	3.00%	3.00%
Medical Services	8.00%	6.00%	7.00%	6.00%	5.00%	4.00%
Support Services	18.00%	29.00%	30.00%	33.00%	37.00%	39.00%
Crisis Intervention Services	2.00%	1.00%	1.00%	1.00%	1.00%	1.00%
Inpatient Services	13.00%	11.00%	9.00%	8.00%	7.00%	6.00%
Residential Services	3.00%	3.00%	3.00%	2.00%	1.00%	1.00%
Behavioral Health Day Programs	1.00%	2.00%	1.00%	1.00%	1.00%	1.00%
Medications	18.00%	15.00%	20.00%	20.00%	20.00%	20.00%
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

ValueOptions is currently experiencing a deficit in the Title XIX Children's programs for FY'04. Our review of encounter data supports a higher capitation rate for the Title XIX Children's programs; therefore, ValueOptions has chosen to accept the rates that ADHS will develop in its customary rate development process. We are anticipating a capitation rate increase sufficient to fully support the Arizona Children's practice model. Additionally, we will continue to reduce residential expenses by transitioning children to community-based alternatives, when appropriate. Therefore, Attachment H has been revised to reflect profits for the applicable fiscal years.

Persons With Serious Mental Illness (Title XIX and Non-Title XIX)

ValueOptions has developed SMI programs, internally and with its providers, utilizing the Principles for Persons With Serious Mental Illness. We assume that the trends established under the implementation of these principles will continue and that we will see increases in rehabilitation, and support services, decreases in treatment services, and stable expenses in crisis/inpatient services. The actual service mixes for FY'02 and FY'03, with projections for FY'04 through FY'07, without any profit or administrative expenses, are presented below.

TXIX SMI						
Category of Service	**ACTUAL FY'02**	**ACTUAL FY'03**	**PROJECTED FY'04**	**PROJECTED FY'05**	**PROJECTED FY'06**	**PROJECTED FY'07**
Treatment Services	10.00%	8.00%	8.00%	7.00%	6.00%	5.00%
Rehabilitation Services	8.00%	6.00%	7.00%	8.00%	9.00%	10.00%
Medical Services	8.00%	5.00%	7.00%	6.00%	5.00%	5.00%

TXIX SMI						
Category of Service	**ACTUAL FY'02**	**ACTUAL FY'03**	**PROJECTED FY'04**	**PROJECTED FY'05**	**PROJECTED FY'06**	**PROJECTED FY'07**
Support Services	39.00%	52.00%	53.00%	54.00%	55.00%	55.00%
Crisis Intervention Services	2.00%	1.00%	2.00%	2.00%	2.00%	2.00%
Inpatient Services	5.00%	2.00%	2.00%	2.00%	2.00%	2.00%
Residential Services	9.00%	8.00%	3.00%	3.00%	3.00%	3.00%
Behavioral Health Day Programs	1.00%	2.00%	1.00%	1.00%	1.00%	1.00%
Medications	18.00%	16.00%	17.00%	17.00%	17.00%	17.00%
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

NTXIX SMI						
Category of Service	**ACTUAL FY'02**	**ACTUAL FY'03**	**PROJECTED FY'04**	**PROJECTED FY'05**	**PROJECTED FY'06**	**PROJECTED FY'07**
Treatment Services	12.00%	9.00%	8.00%	7.00%	7.00%	5.00%
Rehabilitation Services	6.00%	5.00%	5.00%	5.00%	6.00%	5.00%
Medical Services	9.00%	5.00%	5.00%	5.00%	5.00%	5.00%
Support Services	33.00%	51.00%	48.00%	49.00%	49.00%	52.00%
Crisis Intervention Services	3.00%	1.00%	2.00%	2.00%	2.00%	2.00%
Inpatient Services	6.00%	2.00%	2.00%	2.00%	2.00%	2.00%
Residential Services	7.00%	5.00%	3.00%	3.00%	2.00%	2.00%
Behavioral Health Day Programs	1.00%	2.00%	1.00%	1.00%	1.00%	1.00%
Medications	23.00%	20.00%	26.00%	26.00%	26.00%	26.00%
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

General Mental Health/Substance Abuse (Title XIX and Non-Title XIX)

ValueOptions Network Management Department has been working closely with general mental health and substance abuse providers in developing programs that shift the service mix to more rehabilitative/recovery and support services and provides for lower expenses in treatment, inpatient, and crisis services. The actual service mixes for FY'02 and FY'03, with projections for FY'04 through FY'07, without any profit or administrative expenses, are presented below.

TXIX GMH/SA						
Category of Service	**ACTUAL FY'02**	**ACTUAL FY'03**	**PROJECTED FY'04**	**PROJECTED FY'05**	**PROJECTED FY'06**	**PROJECTED FY'07**
Treatment Services	27.00%	28.00%	26.00%	26.00%	24.00%	24.00%
Rehabilitation Services	1.00%	1.00%	1.00%	1.00%	2.00%	2.00%
Medical Services	11.00%	11.00%	12.00%	11.00%	11.00%	11.00%
Support Services	21.00%	22.00%	24.00%	25.00%	26.00%	26.00%
Crisis Intervention Services	7.00%	4.00%	3.00%	3.00%	2.00%	2.00%
Inpatient Services	5.00%	5.00%	3.00%	3.00%	2.00%	2.00%
Residential Services	11.00%	10.00%	9.00%	9.00%	10.00%	10.00%
Behavioral Health Day Programs	2.00%	4.00%	2.00%	2.00%	3.00%	3.00%
Medications	15.00%	15.00%	20.00%	20.00%	20.00%	20.00%
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

NTXIX GMH/SA						
Category of Service	**ACTUAL FY'02**	**ACTUAL FY'03**	**PROJECTED FY'04**	**PROJECTED FY'05**	**PROJECTED FY'06**	**PROJECTED FY'07**
Treatment Services	32.00%	35.00%	32.00%	30.00%	29.00%	27.00%
Rehabilitation Services	1.00%	0.00%	1.00%	1.00%	1.00%	2.00%
Medical Services	10.00%	9.00%	10.00%	10.00%	10.00%	10.00%
Support Services	23.00%	22.00%	23.00%	26.00%	27.00%	29.00%
Crisis Intervention Services	12.00%	10.00%	12.00%	11.00%	12.00%	12.00%
Inpatient Services	8.00%	8.00%	8.00%	7.00%	6.00%	5.00%
Residential Services	4.00%	4.00%	4.00%	5.00%	5.00%	5.00%
Behavioral Health Day Programs	4.00%	6.00%	4.00%	4.00%	4.00%	4.00%
Medications	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%
Total	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

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REVISED Attachment H: Estimated Expenditures

Offeror Name:
ValueOptions, Inc.

Contract Year 2005

Category of Service		Title XIX				Non-Title XIX	Non-Title XIX SA
		Child*	Child CMDP	SMI	GMH/SA	SMI	
501	Treatment Services	23.00%	13.00%	6.00%	23.00%	6.00%	27.00%
502	Rehabilitation Services	2.75%	1.50%	7.00%	1.00%	4.50%	1.00%
503	Medical Services	5.50%	1.75%	5.00%	10.00%	4.50%	9.00%
504	Support Services	29.50%	20.25%	48.00%	22.25%	44.00%	22.25%
505	Crisis Intervention Services	1.00%	1.00%	1.75%	2.50%	1.75%	10.00%
506	Inpatient Services	7.00%	33.00%	1.75%	2.50%	1.75%	6.25%
507	Residential Services	1.75%	6.00%	2.50%	8.00%	2.50%	4.50%
508	Behavioral Health Day Programs	1.00%	1.00%	1.00%	1.75%	1.00%	3.50%
510	Medications	17.50%	11.50%	16.00%	18.00%	23.00%	5.50%
513	Subtotal	89.00%	89.00%	89.00%	89.00%	89.00%	89.00%
	Administration	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%
	Profit/Contingencies	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%
	Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Contract Year 2006

Category of Service		Title XIX				Non-Title XIX	Non-Title XIX SA
		Child*	Child CMDP	SMI	GMH/SA	SMI	
501	Treatment Services	23.00%	11.50%	5.00%	22.00%	5.50%	25.75%
502	Rehabilitation Services	2.50%	1.50%	8.00%	1.50%	5.00%	1.00%
503	Medical Services	4.00%	1.50%	5.00%	10.00%	4.50%	9.00%
504	Support Services	32.50%	27.00%	48.00%	23.00%	44.50%	24.25%
505	Crisis Intervention Services	1.00%	1.00%	1.75%	1.50%	1.75%	10.50%
506	Inpatient Services	6.00%	29.00%	1.75%	1.50%	1.75%	5.50%
507	Residential Services	1.50%	5.00%	2.50%	9.00%	2.00%	4.50%
508	Behavioral Health Day Programs	1.00%	1.00%	1.00%	2.50%	1.00%	3.50%
510	Medications	17.50%	11.50%	16.00%	18.00%	23.00%	5.00%
513	Subtotal	89.00%	89.00%	89.00%	89.00%	89.00%	89.00%
	Administration	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%
	Profit/Contingencies	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%
	Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Contract Year 2007 Offeror Name: ValueOptions, Inc.

Category of Service		Title XIX				Non-Title XIX	Non-Title XIX
		Child*	Child CMDP	SMI	GMH/SA	SMI	SA
501	Treatment Services	22.00%	10.00%	4.50%	21.00%	4.50%	24.00%
502	Rehabilitation Services	2.50%	1.50%	8.50%	1.75%	4.50%	1.75%
503	Medical Services	4.00%	1.50%	4.50%	10.00%	4.50%	9.00%
504	Support Services	35.00%	33.00%	49.00%	23.50%	46.00%	26.00%
505	Crisis Intervention Services	1.00%	1.00%	1.50%	1.25%	1.75%	10.75%
506	Inpatient Services	5.00%	25.00%	1.50%	1.25%	1.75%	4.50%
507	Residential Services	1.00%	4.50%	2.50%	9.75%	2.00%	4.50%
508	Behavioral Health Day Programs	1.00%	1.00%	1.00%	2.50%	1.00%	3.50%
510	Medications	17.50%	11.50%	16.00%	18.00%	23.00%	5.00%
513	Subtotal	89.00%	89.00%	89.00%	89.00%	89.00%	89.00%
	Administration	7.50%	7.50%	7.50%	7.50%	7.50%	7.50%
	Profit/Contingencies	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%
	Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Note: Total should equal 100%

* Does not include children that are enrolled in CMDP.

ValueOptions

27. Submit a signed attestation that the Offeror will have sufficient assets at the beginning of the contract. The attestation shall state, "Although the financial statements submitted with the offer do not show sufficient capitalization, the Offeror (or its affiliate) has the resources available and intends to transfer these resources (assets) to ValueOptions – Maricopa County RBHA in order to fully comply with the minimum capitalization requirements." Disclose any encumbrances that are associated with the investment (Volume 6 b)

CERTIFIED ATTESTATION

The undersigned, Thomas E. Oram, hereby certifies that he is the duly elected Executive Vice President and Chief Financial Officer of ValueOptions, Inc., a Virginia Corporation, (the "Corporation") and that as such he is authorized to execute this attestation on behalf of the Corporation.

Although the financial statements of ValueOptions, Inc. submitted with the offer do not show sufficient capitalization, ValueOptions, Inc. (or its affiliates), has the resources available and intends to transfer these resources (assets) to ValueOptions – Maricopa County RBHA in order to fully comply with the minimum capitalization requirements. There are no encumbrances associated with the investment.

Witness the signature of the undersigned this 20th day of January 2004

VALUEOPTIONS, INC.

TEO

Thomas E. Oram
Executive Vice President and Chief Financial Officer