

Idaho Medicaid Pay for Performance (P4P) Data Submission Requirements

Column Heading	Description	Required	Field length
Provider ID Number	Clinic Medicaid provider ID number. This number will be used to issue the P4P payment and identify the participant as being seen by the provider.	Yes	9-digit numeric value stored as text
Submit Date	Ending period date for submission. This should always be 6/30 and the current year.	Yes	MM/DD/YYYY
Participant Medicaid ID Number	Medicaid participant ID number.	Yes	7-digit numeric value stored as text
Patient Name	Name of patient. This is used to verify the ID number submitted for payment.	Yes	no limit
New Patient	This Yes/No value indicates if this individual is a new participant in the P4P program.	No (information will be validated based on previous submissions)	Yes or No
Diabetes Diagnosis Code	Indicates the type of diabetes.	Yes	3-5 digit numeric value with no decimals
MH Diagnosis Code	Indicates the type of mental health diagnosis the participant may have in conjunction with diabetes.	No	3-5 digit numeric value with no decimals
DD Diagnosis Code	Indicates the type of developmental disability diagnosis the participant may have in conjunction with diabetes.	No	3-5 digit numeric value with no decimals
DM Plan	This date indicates the last time a participant's diabetes management plan was created or updated.	No- Provide the information if available	MM/DD/YYYY
A ₁ C 1st QTR	If an HbA _{1c} test was done between July of the previous year and September of the previous year, indicate date of the test.	No- Provide the information if available	MM/DD/YYYY

Column Heading	Description	Required	Field length
A ₁ C Results 1st QTR	If an HbA ₁ c test was done between July of the previous year and September of the previous year, indicate the result.	No- Provide the information if available	1-2 digit numeric value
A ₁ C 2nd QTR	If an HbA ₁ c test was done between October of the previous year and December of the previous year, indicate the date of test.	No- Provide the information if available	MM/DD/YYYY
A ₁ C Results 2nd QTR	If an HbA ₁ c test was done between October of the previous year and December of the previous year, indicate the result.	No- Provide the information if available	1-2 digit numeric value
A ₁ C 3rd QRT	If an HbA ₁ c test was done between January of the current year and March of the current year, indicate the date of test.	No- Provide the information if available	MM/DD/YYYY
A ₁ C Results 3rd QTR	If an HbA ₁ c test was done between January of current year and March of current year indicate result.	No- Provide the information if available	1-2 digit numeric value
A ₁ C 4th QTR	If an HbA ₁ c test was done between April of the current year and June of the current year, indicate the date of test.	No- Provide the information if available	MM/DD/YYYY
A ₁ C Results 4th QTR	If an HbA ₁ c test was done between April of the current year and June of the current year, indicate the result.	No- Provide the information if available	1-2 digit numeric value
Influenza Vaccine	Date of influenza vaccine given between July of the previous year and June of the current year.	No- Provide the information if available	MM/DD/YYYY
Blood Pressure Evaluation	Date of blood pressure taken between July of the previous year and June of the current year.	No- Provide the information if available	MM/DD/YYYY
Blood Pressure Elevation Results	Result of blood pressure taken between July of the previous year and June of the current year.	No- Provide the information if available	2-3numeric systolic rate / 2-3 numeric diastolic rate

Column Heading	Description	Required	Field length
Lipid Studies	Date of lipid test completed between July of the previous year and June of the current year.	No- Provide the information if available	MM/DD/YYYY
Triglycerides	Total triglyceride result of test completed between July of the previous year and June of the current year.	No- Provide the information if available	1-4 digit numeric
Total Cholesterol	Total cholesterol result of test completed between July of the previous year and June of the current year.	No- Provide the information if available	1-4 digit numeric
HDL	HDL result of test completed between July of the previous year and June of the current year.	No- Provide the information if available	1-4 digit numeric
LDL	LDL result of test completed between July of the previous year and June of the current year.	No- Provide the information if available	1-4 digit numeric
Urine Microalbumin	Date of urine microalbumin test completed between July of the previous year and June of the current year.	No- Provide the information if available	MM/DD/YYYY
Urine Microalbumin Result	Result of urine microalbumin test completed between July of the previous year and June of the current year.	No- Provide the information if available	1-4 digit numeric
Foot exam Inspection	Date of foot exam completed between July of the previous year and June of the current year.	No- Provide the information if available	MM/DD/YYYY
Foot exam Monofilament	Date of foot exam monofilament completed between July of previous year and June of current year.	No- Provide the information if available	MM/DD/YYYY
Funduscopy Exam	Date of funduscopy exam appointment made or completed between July of the previous year and June of the current year.	No- Provide the information if available	MM/DD/YYYY
Depression Screening	Date of depression screening completed between July of the previous year and June of the current year.	No- Provide the information if available	MM/DD/YYYY

Column Heading	Description	Required	Field length
Behavioral Monitoring Smoking	Date of behavioral monitoring for smoking completed between July of the previous year and June of the current year.	No- Provide the information if available	MM/DD/YYYY
Behavioral Monitoring Weight Control	Date of behavioral monitoring weight control completed between July of the previous year and June of the current year.	No- Provide the information if available	MM/DD/YYYY