

**Addressing the Health
Information Crisis through CALIX
*A Window of Opportunity***



THE CALIX TOOLKIT

This toolkit contains Data Guidelines and Rules of Exchange for data sets traded within the healthcare industry. It is the product of ground-breaking collaboration among multiple stakeholders representing three sectors: Purchasers, Health Plans, and Provider Organizations.

Collaborate on Standards • Cooperate on Implementation • Compete on Quality

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THE CALINX INITIATIVE: AN OVERVIEW

HIPAA (Health Insurance Portability and Accountability Act of 1996)

Administrative Simplification Provisions intend to reduce health care costs and administrative burdens through standardized electronic transmission of administrative and financial health care transactions. Importantly, it requires compliance by 2000 with new data standards for electronic transmission including:

- Transaction Sets:
 - Eligibility - Query & Result (ASC X12N 270/271 v.4010)
 - Enrollment and Disenrollment in a health plan (ASC X12 834 v.4010)
 - Encounter/Claims Professional and Institutional (ASC X12 837 v.4010)
 - Retail Drug Claim (NCPDP 3.2)
 - Referral certification and authorization (ASC X12N 278 v.4010)
 - Health claim status (ASC X12N 276/277 v.4010)
- National identifiers for Individuals, Employers, Health plans, and providers
- Code sets for data elements in the transactions above
- Security and Privacy standards (detailed recommendations to Congress February, 2000)

CALINX (California Information Exchange – Linking Partners for Quality Healthcare) began in late 1996 among California businesses, physicians, health plans, hospitals and health care systems. All stakeholders agreed to collaborate on health care information standards and cooperate on implementation. The Pacific Business Group on Health (PBGH), the National IPA Coalition (NIPAC), and the California Association of Health Plans (CAHP) are managing this effort in collaboration with the American Medical Group Association (AMGA), California Healthcare Association (CHA), and California Medical Association (CMA). Seed money for the project was granted by the California HealthCare Foundation based in Oakland, California. Stakeholders have committed to continued funding as we approach the end of the grant term.

The health care industry lags many other industries in its ability to use information effectively. For example, consumers are sometimes denied care or required to pay out-of-pocket for services to which they are entitled because insurance eligibility cannot be verified. In addition, health plans and providers do not have ready access to the information they need in order to provide optimal service and care. This recognition produced a commitment to change the rules. Competitors agree that they will not compete by manipulating or withholding health care data – instead, they have agreed to work together to develop standards and rules for its electronic exchange. CALINX partner organizations agree that all who engage in health care business in California will implement these standards and rules while assuring that data exchange is secure. All standards are compliant with HIPAA (Health Insurance Portability and Accountability Act) legislation.

CALINX work groups have developed standards and rules for data exchange for the following health care transactions:

- Enrollment
- Eligibility
- Member ID Card
- Encounters and Claims
- Clinical Laboratory Results
- Pharmacy Utilization

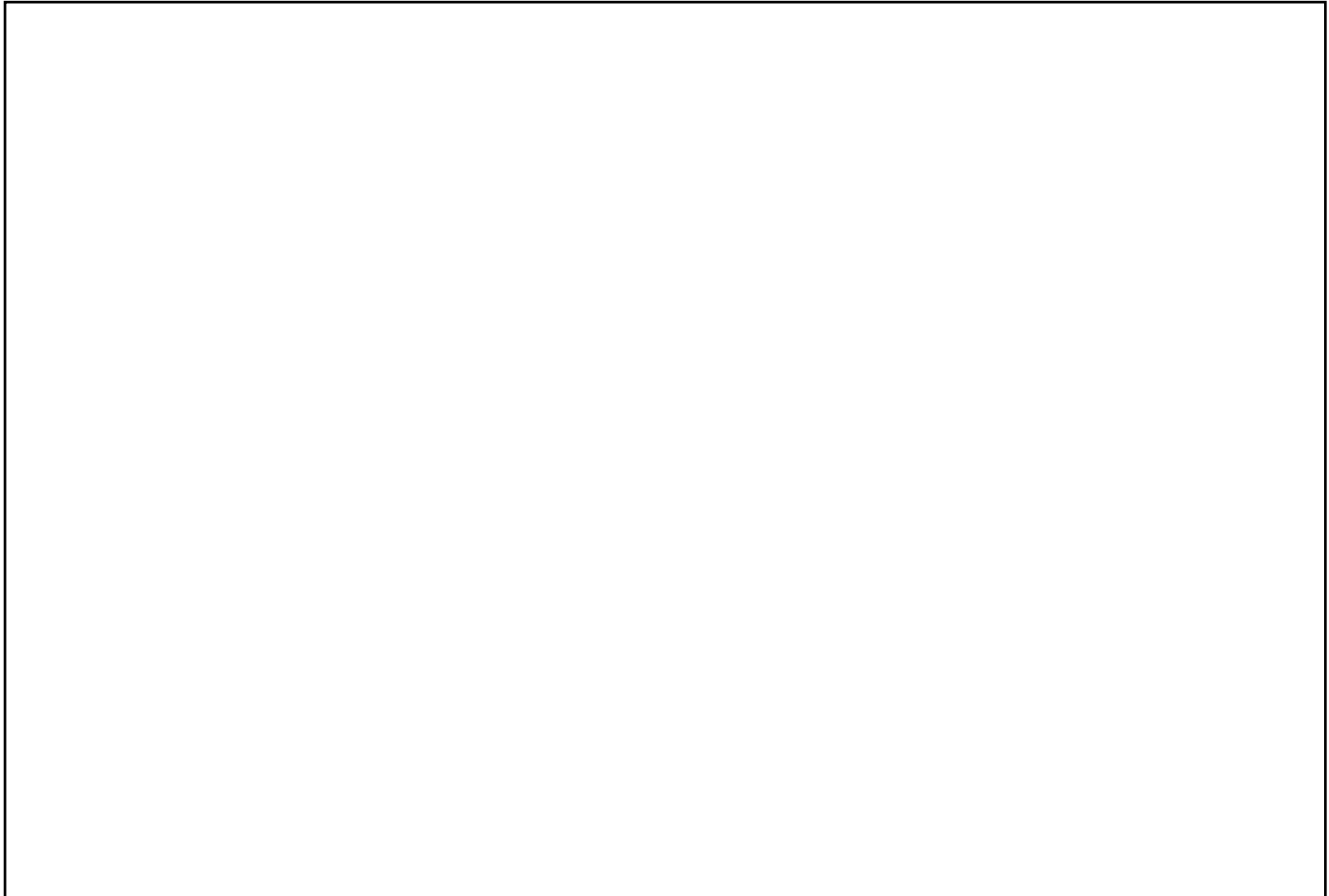
10 STEPS FOR IMPLEMENTATION OF CALINX

These steps are offered to facilitate adoption and implementation of the standards and rules

- 1 Be a strong advocate for the standardized, electronic exchange of health care data and establish the project as a corporate priority.
- 2 Consider the costs of current business practices and assess the benefits of adopting standards and rules for your organization – consider industry and marketplace incentives as well.
- 3 Assign the appropriate resources to the effort, including a project lead and an MIS programmer or analyst.
- 4 Select one or more trading partners who will be willing to work with you to implement the new rules and standardized data sets.
- 5 Evaluate the CALINX Rules of Exchange to determine whether any operational changes should be implemented in order to comply.
- 6 Quantify the benefits – consider conducting a baseline measurement of existing processes to determine your operational costs and the quality and quantity of information currently being exchanged.
- 7 Conduct a gap analysis between CALINX data content standards and your current file layout – consider your current capabilities and develop a matrix of necessary changes.
- 8 Make the necessary system and process changes and submit a test file to your trading partner(s) – when the test files are submitted successfully, move towards routine submission of data files.
- 9 Re-measure the operational benefits after several months of data exchange and determine the savings, improvements and benefits.
- 10 Expand your data exchange to additional trading partners.

HEALTH INFORMATION DATA FLOW

This figure illustrates the flow of data within the California delegated model of care. The numbers on the model correspond to the notes below. The data sets addressed by CALINX are represented in italics. Each CALINX data set has its own table of data elements and Rules of Exchange, most of which can be found in this Toolkit. See the Table of Contents to locate a specific data set.



1. Enrollment data passes from employer to health plan, as notice of coverage. Typically, these data include demographic and benefit coverage information about the enrollees.
2. Eligibility data from health plans inform provider/provider organizations about enrollees. Eligibility data can be a monthly “snapshot” called a roster, or available for inquiry (look-up by provider).
3. Encounter and/or claims data are captured at a doctor’s office and transmitted through provider organizations to health plans. (“Out-of-network” providers may submit claims directly to health plans.) Encounter data records what occurred during a visit, along with all applicable diagnoses.
4. Pharmacy data are managed by health plans that pay for or out-source payment of pharmacy claims. They consist of information about prescriptions filled. Provider organizations can use pharmacy data to manage the clinical care of their enrolled population and to manage costs.
5. Lab tests are ordered by a doctor and the results are transmitted back to the doctor. Aggregated results sent to provider organizations and plans allow both entities to better manage population health.
6. Referral and authorization requests are made by the doctor to provider organizations in the delegated model of care, where provider organizations have ultimate clinical responsibility for a given enrolled population.

INTRODUCTION TO THE TOOL KIT:

Rules of Exchange govern the business processes of trading specific data sets. These Rules address timing, frequency, and accuracy of data sharing. It is recognized that some entities will choose to implement rules prior to undertaking the system conversions necessary to implement data standards. Implementing Rules with existing, proprietary formats is better than no implementation at all. The objective of all organizations however, should be the complete implementation of the agreed upon standard and the accompanying Rules of Exchange.

CALINX data guidelines are lists of data elements developed by work groups and approved by the CALINX Oversight Group for inclusion in standardized formats. Most agreements are based on recognized ANSI or other national standards. These agreements are for use in conjunction with published HIPAA-compliant ANSI Implementation Guides.

It is anticipated that CALINX agreements will evolve through a careful process of comment and feedback. Comments will be considered by CALINX work groups. The agreements printed here are the latest version agreed to by CALINX stakeholders. You will note that many of the agreements are “drafts.” All data guidelines printed here are consistent with standards mandated by the Health Insurance Portability and Accountability Act (HIPAA).

In addition to being used to define content, proper use, and formats for exchange of health information data sets, CALINX agreements provide an important reference for health care and purchaser organizations as they:

- Share data with health care trading partners
- Purchase or update health care software, and
- Select information systems vendors
- Contract with health care partners

RULES AND AGREEMENTS: A SUMMARY

CALINX Rules of Exchange

- Represent unprecedented collaborative effort between CA employer health plans and providers
- Address frequency, timing, and accuracy of data sharing
- Serve as a guide for developing trading partner contracts
- Will be continually monitored and updated to reflect changing market needs

CALINX Data Guidelines

- Represent data guidelines for specific transactions between trading partners
 - Employer to health plan
 - Health plan to provider
 - Provider to health plan
 - Health plan to member
- All agreements are consistent with national electronic transaction standards (HIPAA)

ENROLLMENT RULES OF EXCHANGE (cont.)

than 45 calendar days after a subscriber's or his/her dependent's effective date of coverage. Employers will be responsible for premium payment from the first effective date of coverage except in those cases when both the employer and the health plan have agreed to otherwise.

- Health plans will process data no later than 15 working days of receiving data.

Termination

- Employers will submit disenrollment data to health plans no more than 60 calendar days after the termination date. Employers are encouraged to set a goal of reducing this time to 45 calendar days.

Note: Because disenrollment notification is expected to occur within 60 days of the termination date, health plans will only be expected to credit premiums for up to 60 days. If notification of termination is made more than 60 days after the termination date, then premium paid for terminated coverage over 60 days will be the responsibility of employers.

Other

- Health plans will take responsibility for sending “reminder” letters to subscribers who have just had a baby. The letters will remind parents that the baby only has 30 days of coverage and should be enrolled in a plan within 30 days of birth.
- In coordination with employers, health plans will contact subscribers with children who become “over age” to request the appropriate submission of documentation verifying student status, disability, etc.

ACCURACY AND COMPLETENESS

- Recognizing that the integrity of enrollment data has an effect on all data flows within the healthcare system, employers will strive to supply data that is 95% accurate.
- A health plan will notify an employer within 30 calendar days about a discrepancy between the enrollment record and the premium record.
- The employer will respond to the health plan's notification with an adjustment or explanation within 30 days.

APPROPRIATE USE

Both employers and health plans will employ appropriate and judicious data practices when handling enrollment data. These data may contain sensitive elements, e.g. social security numbers, addresses, and health plan selections. Business processes will be adopted to minimize any occurrence of erroneous enrollment data transmission to incorrect health plans.

Refer to the PBGH Enrollment EDI Users' Guide for more information about the business processes of standardized enrollment transmission.

Enrollment Data Guidelines

Item #	Data Element	Definition	ANSI X12 834 V.4010 Category	CALINX Agreement**	Comments
9	Reason for a Change To Benefits	This element identifies the reason a change occurred to the benefit information for insured persons. Examples are: Divorce, Terminated, Birth. It can also be used to identify the reason for a change in the member's primary care provider.	Required	Essential	
10	Status of the Benefits	The element defines the type of coverage under which benefits are paid.	Required	Essential	
11	Medicare Plan	This element identifies if a member is being enrolled in or is enrolled in a Medicare Program.	Situational	Conditional	
12	Consolidated Omnibus Budget Reconciliation Act (COBRA)	This element identifies if a member is being enrolled in or is enrolled for a benefit covered by COBRA.	Situational	Conditional	
13	Employment Status	This element provides information about the status of the subscriber.	Situational	Conditional	This is required information for the subscriber.
14	Student Status	This element identifies the student status of the patient if the patient is 19 years of age or older, not handicapped, and not the insured.	Situational	Conditional	
15	Insured Individual Death Date		Situational	Conditional	
16	Subscriber Number	This is a unique ID # such as a social security number or other number.	Required	Essential	If the social security number of the subscriber or dependent is known, it should be used.
17	Member Policy Number		Situational	Conditional	
18	Member Identification Number	This is an identification number such as a Health Insurance Claim (HIC) # or prior identifier #, that identifies the member.	Situational	Conditional	

For more information, and code legends, refer to:
ANSI ASC X12 Insurance Subcommittee 834 (004010x095) Benefit Enrollment and Maintenance Implementation Guide

***CALINX – Business Agreement Definitions**

Essential – All data elements must be included.

Conditional – If these data elements are available or applicable to the health plan, required to be included.

Discretionary – These data elements, if available, can be included at the discretion of the health plan.

Enrollment Data Guidelines

Item #	Data Element	Definition	ANSI X12 834 V.4010 Category	CALINX Agreement*	Comments
19	Enrollment/Disenrollment Dates		Situational	Conditional	
20	Member's First, Middle and Last Name		Required	Essential	Middle Name Use is Conditional.
21	Member Communication Numbers	Examples of these numbers are the phone number and email address.	Situational	Conditional	
22	Dependent Mailing Address, City, State and Zip Code, Country	Sent when dependent mailing address is different from subscriber's mail address.	Situational	Conditional	
23	Member Residence Street Address, City, State and Zip Code, Country		Situational	Conditional	
	Member Demographics		Situational	Conditional	
24	Subscriber Birth Date		Required	Essential	
25	Language Used by Member and Description of Language		Situational	Conditional	
26	Race or Ethnicity		Situational	Conditional	
27	Marital Status		Situational	Conditional	
28	Citizenship Status Code		Situational	Conditional	
29	Gender		Required	Essential	
30	Member Mailing Address	This is the postal mailing address used if different from the residence address.	Situational	Conditional	

For more information, and code legends, refer to:
ANSI ASC X12 Insurance Subcommittee 834 (004010x095) Benefit Enrollment and Maintenance Implementation Guide

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Enrollment Data Guidelines

Member Employer Information

Member Employer Name

Employer Communications Numbers

Employer Street Address, City, State and Zip Code, Country

Member School Information

School Name

School Communication Numbers

School Address, City, State and Zip Code, Country

Situational Conditional

This loop information is sent when the member is employed by someone other than the sponsor and the insurance contract requires the payer be notified of this employment.

Situational Conditional

Situational Conditional

Situational Conditional

Situational Conditional

Required Essential

Required Essential

Required Essential

Custodial Parent op2m 91 32.4 283.69 263.904 m f* BT /F9 1 Tf 0 -14 14 0 253.9517 7Xdo69 263.904 m f* BT /F

For more information, and code legends, refer to:
ANSI ASC X12 Insurance Subcommittee 834 (004010x095) Benefit Enrollment and Maintenance Implementation Guide

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Enrollment Data Guidelines

Item #	Data Element	Definition	ANSI X12 834 V.4010 Category	CALINX Agreement*	Comments
41	Custodial Parent or Responsible Party Number		Situational	Conditional	Send if supplied by the subscriber.
42	Communication Numbers		Situational	Conditional	
43	Address, City, State and Zip Code, Country		Situational	Conditional	
	Disability Information	Send this information when enrolling a disabled member or if disability information about an existing member has changed.	Situational	Conditional	
44	Type of Disability		Required	Essential	
45	Medical Code		Situational	Conditional	End Stage Renal Disease is the only medical code information used.
46	Disability Eligibility Dates		Situational	Situational	
	Health Coverage Information		Situational	Situational	
47	Type of Change to Coverage		Required	Essential	
48	Line of Insurance	This element identifies a group of insurance products associated with health coverage.	Required	Essential	
49	Plan Coverage Description		Situational	Conditional	
50	Health Coverage Dates		Required	Essential	
51	Health Coverage Policy Number		Situational	Conditional	
52	Coverage Level	Indicates the level of coverage being provided for the insured.	Situational	Conditional	
53	Insured Group or Policy Number		Required	Required	

For more information, and code legends, refer to:
ANSI ASC X12 Insurance Subcommittee 834 (004010x095) Benefit Enrollment and Maintenance Implementation Guide

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Enrollment Data Guidelines

Item #	Data Element	Definition	ANSI X12 834 V.4010 Category	CALINX Agreement*	Comments
	Identification Card Information		Situational	Conditional	
54	Plan Coverage Description		Required	Essential	
55	Type of Identification Card		Required	Essential	
56	Number of Cards		Situational	Conditional	
57	Reason for Card Request		Situational	Conditional	
	Provider Information		Situational	Conditional	
58	Type of Provider		Required	Essential	
59	Provider Name First, Middle and Last Name		Situational	Conditional	
60	Provider Prefix and Suffix		Situational	Conditional	
61	Type of Provider ID Used		Situational	Conditional	
62	Provider Identifier Number		Situational	Conditional	
63	Patient Relationship to Provider	This information indicates whether or not the member is an existing patient of the provider.	Required	Essential	
64	Reason for PCP Change		Situational	Conditional	
65	Provider Effective Date	This is the effective date of the change of the primary care provider.	Required	Essential	

For more information, and code legends, refer to:
ANSI ASC X12 Insurance Subcommittee 834 (004010x095) Benefit Enrollment and Maintenance Implementation Guide

***CALINX – Business Agreement Definitions**

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Enrollment Data Guidelines

Item #	Data Element	Definition	ANSI X12 834 V.4010 Category	CALINX Agreement*	Comments
	Coordination of Benefits Information		Situational	Conditional	
66	Payer Responsibility Sequence	Identifies the insurance carrier's level of responsibility for payment of a claim.	Required	Essential	
67	Insured Group or Policy Number		Situational	Conditional	Always supply when available.
68	Coordination of Benefits Code	Identifies whether there is a coordination of benefits.	Required	Essential	
69	Additional COB Information Numbers	Example: Member ID Number	Situational	Conditional	
70	COB Eligibility Dates		Situational	Conditional	
71	Other Insurance Company Name		Situational	Conditional	Send when provided to the sponsor.

†1

For more information, and code legends, refer to:
ANSI ASC X12 Insurance Subcommittee 834 (004010x095) Benefit Enrollment and Maintenance Implementation Guide

***CALINX – Business Agreement Definitions**

Essential – All data elements must be included.

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Discretionary – These data elements, if available, can be included at the discretion of the health plan.

Version: January 2000

BACKGROUND

The CALINX goal is trading eligibility data electronically between partners, i.e., health plans to provider organizations and individual providers. Given the current environment of transition from paper or phone verification to electronic information exchange, the realization of the goal will be incremental. There are two levels of eligibility verification, single member verification and roster of members contracted to a provider organization. Implementation is being executed by emphiSOURCE, a non-profit, mutual benefit corporation of California health plans.

CONTENT

Content and format was based on review and agreement by the CALINX Eligibility Workgroup and based on American National Standards Institute (ANSI) definitions in compliance with HIPAA requirements ANSI X12N 270/271 standards for eligibility exchange. Data content includes Subscriber/Member demographic data, carrier, provider and employer information.

- Roster

The roster is a listing of enrollees whose care is covered by a provider organization. The implementation guide for the electronic eligibility transaction set is not finalized by ANSI, however the CALINX agreement was based on the current draft in progress. As an interim solution, CALINX recommends electronic transmission through clearinghouse, healthcare data utility or direct-connect with text file format.

- Inquiry/Response

The individual enrollee information by physician organizations and other health care entities from health plans should be verified for each visit. Transition to ANSI approved Eligibility Transaction set (X12N 270/271) in approximately 2001 (HIPAA requirement). As an interim solution, CALINX recommends electronic transmission through clearinghouse, healthcare data utility, direct-connect with text file format or website.

FREQUENCY

- Roster

Effective 7/1/99 a monthly electronic transmission of full eligibility roster of covered members is expected to be sent to provider organizations from the health plans. A separate “change file” will accompany the roster to track individual changes over the month.

ELIGIBILITY RULES OF EXCHANGE (cont.)

- Inquiry/Response

Verification of individual member eligibility is available from health plan within 24 hours after receipt from employer & verification of accuracy through clearinghouse, healthcare data utility, direct-connect with text file format or website. The verification process for health plans is 7–10 days after receipt of data from the employer

ACCURACY AND COMPLETENESS

- Complete and accurate eligibility data from the health plans will be supplied to providers and physician organizations.
- Health plans will provide the electronic benefit plan conversion tables to the provider organizations in order to assure clarity on the specific benefits available for the subscriber/member.

APPROPRIATE USE

- The intent of these rules is to coordinate the accuracy of communication about enrollees to the appropriate trading partner to ensure coordination of service to enrollees.
- It is expected that all trading partners including employers, health plans and provider organizations will adhere to appropriate privacy protection policies and guidelines.
- The trading partners must be in compliance with HCEFA & HIPAA standards.
- The intent of the eligibility rules is to parallel the enrollment rules with regard to financial accountability for terminations past 60 days. This is contingent on wide adoption of the enrollment rules by employers.

ELIGIBILITY

Single Member Response (ANSI X12 271)

This document represents the inventory of data elements and the format by which health plans will respond to individual or multiple queries from health care providers for eligibility of enrollees. The expectation is that all data elements available to the health plan will be sent in the following format to the provider. The ANSI X12 271 (4010 version) Category represents the electronic transmission requirements for eligibility under the Health Insurance Portability Accountability Act (HIPAA) – 1996. The column for CALINX Agreement is a categorization of the expectations of data sharing based on the CALINX Eligibility Workgroup agreement.

Item #	Data Element	Definition	ANSI X12 271 Category	CALINX Agreement*	Comments
Member Demographics					
1	Last Name (Subscriber/Member)	The surname of the insured individual or subscriber to the coverage.	Situational	Essential	
2	First Name (Subscriber/Member)	The first name of the insured individual or subscriber to the coverage.	Situational	Essential	
3	Middle Name (Subscriber/Member)	The middle name of the subscriber to the indicated coverage or policy.	Situational	Conditional	If none, left blank.
4	Name Suffix (Subscriber/Member)	Suffix of the insured individual or subscriber to the coverage.	Situational	Conditional	
5	Member Identification Number	Insured's or subscriber's unique identification number assigned by a payer.	Situational	Essential	
6	Social Security Number	The unique 9 digit number of the insured individual or subscriber assigned by the Social Security Administration.	Situational	Conditional	
7	Address (Subscriber/Member)	Address line of the current mailing address of the insured individual or subscriber to the coverage	Situational	Essential	

***CALINX – Business Agreement Definitions**

Essential – All data elements must be included.

Conditional – If these data elements are available or applicable to the health plan, required to be included.

Discretionary – These data elements, if available, can be included at the discretion of the health plan.

Eligibility Data Guidelines

8	City	City name of the insured individual or subscriber to the coverage.		
9	State	State postal code of the insured individual or subscriber to the coverage.	Situational	Essential
10	Postal Zone or ZIP Code	The ZIP code of the insured individual or subscriber to the coverage.	Situational	Essential
11	Home Phone			

*CALINX – Business Agreement Definitions

Essential – All data elements must be included.

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Discretionary – These data elements, if available, can be included at the discretion of the health plan.

Eligibility Data Guidelines

Item #	Data Element	Definition	ANSI X12 271 Category	CALINX Agreement*	Comments
CARRIER AND ELIGIBILITY INFORMATION					
19	Health Plan/Payer Name	The organization name who is the source of the eligibility information.	Situational	Essential	Necessary on individual response.
20	Health Plan/Payer Identification Code	Identifies the number by which the information source is know to the receiver.	Required	Essential	
21	Subscriber/Member Effective Date	Date format code conveys the eligibility, service or admission date(s) for the insured individual or subscriber.	Required	Essential	
22	Benefit Code	Information based on Eligibility Benefit Information Code linked to the payer's definitions.	Situational	Conditional	Required for HMO only
23	Benefit Description	Information based on Eligibility Benefit Information Code linked to the payer's definitions.	Situational	Conditional	
24	Co-payment	Amount of co-payment by the subscriber for this particular episode of care.	Situational	Conditional	Message to be provided to distinguish pharmacy, Office visit, ER or other co-payment.
25	Deductible	Amount required to be paid by the subscriber prior to benefit coverage.	Situational	Conditional	
PROVIDER INFORMATION					
26	Medical Group Name	Name of the organization that expects to receive eligibility information.	Situational	Discretionary	Discretionary if ID # is provided.
27	IPA Name	Name of the organization or individual that expects to receive eligibility information.	Situational	Discretionary	Discretionary if ID # is provided.

***CALINX – Business Agreement Definitions**

Essential – All data elements must be included.

Conditional – If these data elements are available or applicable to the health plan, required to be included.

Discretionary – These data elements, if available, can be included at the discretion of the health plan.

Eligibility Data Guidelines

Item #	Data Element	Definition	ANSI X12 271 Category	CALINX Agreement*	Comments
28	Medical Group/IPA Number	The identification number of the individual or organization who expects to receive information.	Situational	Conditional	Required for HMO only
29	Provider Name	Name of the individual that expects to receive eligibility information.	Situational	Conditional	Required for HMO only
30	Provider Code #	Number assigned by the payer, regulatory authority or other authorized body or agency to identify provider.	Situational	Conditional	Encourage use of one number scheme, like state license number, by health plans to coordinate physician identifiers.
31	Subscriber/Member Effective Date	Date format code conveys the eligibility, service or admission date(s) for the insured individual or subscriber.	Required	Essential	
EMPLOYER INFORMATION					
32	Group Number (Employer)	The identification number, control number or code assigned by the carrier or administrator to identify the group under which the individual is covered.	Required	Essential	
33	Employer Name	Name of the insured individual's employer.	Situational	Essential	Links enrollment to benefits.
34	Employer Address/City/State/Zip	Mailing address, city, state code and ZIP code of the insured individual's employer.	Situational	Discretionary	

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***CALINX – Business Agreement Definitions**

Essential – All data elements must be included.

Conditional – If these data elements are available or applicable to the health plan, required to be included.

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ELIGIBILITY

Full Roster

This document represents the inventory of data elements and the format by which health plans will send a full roster of enrollees eligible for health care coverage to health care provider groups. The expectation is that all data elements available to the health plan will be sent in the following format to the provider groups. The ANSI X12 271 (4010 version) Category represents the electronic transmission requirements for eligibility but is not included under the Health Insurance Portability Accountability Act (HIPAA) – 1996. The column for CALINX Agreement is a categorization of the expectations of data sharing based on the CALINX Eligibility Workgroup agreement.

Item #	Data Element	Definition	ANSI X12 271 Category	CALINX Agreement*	Comments
Member Demographics					
1	Last Name (Subscriber/Member)	The surname of the insured individual or subscriber to the coverage.		Essential	
2	First Name (Subscriber/Member)	The first name of the insured individual or subscriber to the coverage.		Essential	
3	Middle Name (Subscriber/Member)	The middle name of the subscriber to the indicated coverage or policy.		Conditional	If none, left blank.
4	Name Suffix (Subscriber/Member)	Suffix of the insured individual or subscriber to the coverage.		Conditional	
5	Member Identification Number	Insured's or subscriber's unique identification number assigned by a payer.		Essential	
6	Social Security Number	The unique 9 digit number of the insured individual or subscriber assigned by the Social Security Administration.		Conditional	The SS# of subscriber needs to be collected as a separate data element regardless of the use. It is used as patient identifier at some health plans.
7	Address (Subscriber/Member)	Address line of the current mailing address of the insured individual or subscriber to the coverage.		Essential	
8	City	City name of the insured individual or subscriber to the coverage.		Essential	

***CALINX – Business Agreement Definitions**

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Eligibility Data Guidelines

Item #	Data Element	Definition	ANSI X12 271 Category	CALINX Agreement*	Comments
9	State	State postal code of the insured individual or subscriber to the coverage.		Essential	
10	Postal Zone or ZIP Code	The ZIP code of the insured individual or subscriber to the coverage.		Essential	
11	Home Phone	Telephone number, including area code, at which the subscriber may be contacted.		Discretionary	
12	Work Phone	Telephone number, including area code, at which the subscriber may be contacted.		Discretionary	
13	Date of Birth	The date of birth of the individual or subscriber to indicated coverage or policy.		Essential	
14	Gender	Code indicating the sex of the insured individual or subscriber to the indicated coverage or policy.		Essential	
SUBSCRIBER RELATIONSHIP TO INSURED					
15	Individual Relationship Code	Code indicating the relationship between two individuals or entities.		Essential	
16	Subscriber Name	The full name of the subscriber to the coverage.		Conditional	Required if the Individual Relationship code used to connect with the subscriber.
17	Subscriber Social Security Number	The unique 9 digit number subscriber assigned by the Social Security Administration.		Conditional	Required if the Individual Relationship code used to connect with the subscriber.
18	Subscriber/Member ID Number	Subscriber's unique identification number assigned by payer.		Essential	
CARRIER AND ELIGIBILITY INFORMATION					
19	Health Plan/Payer Name	The organization name who is the source of the eligibility information.		Discretionary	Anytime electronic information is sent - this information should be in the "header" or envelope to clearly identify the plan.

***CALINX – Business Agreement Definitions**

Essential – All data elements must be included.

Conditional – If these data elements are available or applicable to the health plan, required to be included.

Discretionary – These data elements, if available, can be included at the discretion of the health plan.

Eligibility Data Guidelines

Item #	Data Element	Definition	ANSI X12 271 Category	CALINX Agreement*	Comments
20	Health Plan/Payer Identification Code	Identifies the number by which the information source is know to the receiver.		Essential	
21	Subscriber/Member Effective Date	Date format code conveys the eligibility, service or admission date(s) for the insured individual or subscriber.		Essential	
22	Benefit Code	Information based on Eligibility Benefit Information Code linked to the payer's definitions.		Conditional	Benefit code conversion table to be provided by health plan electronically for HMO only.
PROVIDER INFORMATION					
23	Medical Group Name	Name of the organization that expects to receive eligibility information.		Discretionary	
24	IPA Name	Name of the organization or individual that expects to receive eligibility information.		Discretionary	Confirmatory information
25	Medical Group/IPA Number	The identification number of the individual or organization who expects to receive information.		Conditional	Necessary for HMO members.
26	Subscriber/Member Effective Date (Medical Group/IPA)	Date format code conveys the eligibility, service or admission date(s) for the insured individual or subscriber.		Essential	
27	Provider Name	Name of the individual that expects to receive eligibility information.		Conditional	Discretionary when used with provider code number.
28	Provider Code #	Number assigned by the payer, regulatory authority or other authorized body or agency to identify provider.		Conditional	Encourage use of one number scheme, like state license number, by health plans to coordinate physician identifiers.
29	Subscriber/Member Effective Date (Individual Provider)	Date format code conveys the eligibility, service or admission date(s) for the insured individual or subscriber.		Essential	

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Eligibility Data Guidelines

Item #	Data Element	Definition	ANSI X12 271 Category	CALINX Agreement*	Comments
EMPLOYER INFORMATION					
30	Group Number (Employer)	The identification number, control number or code assigned by the carrier or administrator to identify the group under which the individual is covered.		Essential	
31	Employer Name	Name of the insured individual's employer.		Essential	
32	Employer Address/City/State/Zip	Mailing address, city, state code and ZIP code of the insured individual's employer.		Discretionary	
OTHER					
33	Activity Code	Code indicating type of action.		Essential	Add, delete, change PCP, change address, etc. Clarification of codewill be included in ASI 271 Implementation Guide.

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BACKGROUND

The overall purpose of the CALINX Member ID Card Agreement is to define standards for the member identification card for size and data content to increase consistency of information for providers and health plan members. The long-term goal is adoption of the electronic health care card with an electronic strip to be used as a key to access health plan eligibility databases once a health care infrastructure is available (ANSI NCTIS 284). Current enterprise systems like Kaiser and MediCal operate such systems in California.

CONTENT

The content includes health plan identification, card holder identification, co-pay information and provider identification.

FREQUENCY

- The identification card will be produced and sent to a new subscriber/member no more than 5 working days after the subscriber/member's name is added to the health plan eligibility file and patient benefit choices have been validated, unless effective date is more than 15 days.
- For open enrollment or if a subscriber/member's validation has been completed early, the card should not be sent out sooner than 15 days prior to the effective date of coverage.
 - January effective open enrollment of any year, the card may be sent 20 days prior to effective date of coverage due to holiday schedules and increased changes for large year-end open enrollment period.
- A new card should be generated when there is a change in data elements that affect the delivery of service or validation of member. (e.g., co-pay changes, primary care provider changes, subscriber changes of dependent).

An Implementation Plan for issuing cards under the CALINX agreement for health plans is expected the end of the first quarter of 2000 beginning with new enrollees and renewals.

ACCURACY AND COMPLETENESS

- Currently no central computerized identification infrastructure is available; therefore, network health plans must provide detailed information on the physical card for the health care providers to obtain sufficient data to request verification of eligibility.
- The physical card standard should be a two-sided card the size of a standard credit card that can be oith S4h08eof eligibility.

MEMBER ID CARD RULES OF EXCHANGE (cont.)

- The content of the card is based on the eligibility file and benefit agreement of the health plan and should be 98% accurate.
- No standard format is adopted at this time.

APPROPRIATE USE

The health plan provides the member identification card directly to the subscriber or employer.

MEMBER ID CARD

Health Care Identification Card: A card used to identify the card issuer and the card holder to facilitate health care transactions and to provide data for such transactions. The electronic national standard currently being developed is the ANSI – NITCS 284. The CALINX agreements are based on needs of the provider community to have information about insurance coverage. The goal is to have an electronic method to access health plan eligibility databases and not rely on information printed on cards.

Item #	Data Element	Definition	ANSI NITCS-284 Category	CALINX Agreement*	Comments
1	Health Card Issuer Name and Logo	Name and logo of the health card issuer sponsoring the coverage.(midw)	Mandatory Front Side	Essential	Space must be provided for trademark or tag line. Trademark generally on the front of the card, tag line on the back.
2	Health Card Issuer Identifier	The card issuer identifier shall have zero field length until the card issuer has been assigned an authorized identifier (process pending). The machine-readable form of the identifier shall not contain spaces or special characters. The first five digits, '80840', must be included to indicate the number is a health application in the US. (284)	Mandatory Front Side	Conditional	The card issuer identifier is mandatory for cards issued after one year of the adoption by the USA Registration Committee of a national process for the registration of unique health card issuer identifiers in the US. This information element is not to be used until the issuer of the card has been assigned and authorized identifier.
3	Health Card Issuer Phone #	The primary phone number to access member services. (midw)	Mandatory Back Side	Essential	

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UHC – United HealthCare’s Managed Care Resource Book

Midw – Member Identification Card Workgroup

ANSI 284 – Electronic Health Care Card Standard

X12 - ANSI – Insurance Standard Definition

ANSI NCITS 284 – 1997 – The list of information items are applicable to human-readable information for machine-readable electronic application. *Version: January 2000*

Member ID Card Data Guidelines

Item #	Data Element	Definition	ANSI NITCS-284 Category	CALINX Agreement*	Comments
4	Health Card Holder Name	<p>A specific card is issued for each individual HMO member.</p> <p>The identification name may be a maximum of 27 characters. It must be formatted in sequence of:</p> <p>The identification name may be a maximum of 27 characters. It must be formatted in sequence of:</p> <p style="padding-left: 40px;">Given name and initials Surname Name suffix</p> <p>Punctuation such as period or comma, in general, is not used. (284)</p>	Mandatory Front Side	Essential	<p>The goal is that an individual member name would appear on all product lines requiring Primary Care Provider selection.</p> <p>CALINX Member ID Workgroup recommend 35 characters to accommodate hyphenated and long names.</p>
5	Health Card Holder Identification Number	<p>Subscriber, member or dependent's unique identification number assigned by the payer. (X12)</p> <p>The identification number is defined by the card issuer. It may include alpha characters.</p>	Mandatory Front Side	Essential	
6	Instructions for Hospital Admission	<p>Instructions to members about procedures for admission to hospitals including the phone number to call and time period designated for required notification. (midw)</p>		Essential	
7	Instructions Emergency (Hosp.)	<p>Instructions to members for emergency services including phone number to call and time period designated for required notification. (midw)</p>		Essential	
8	Effective/Issue Date	<p>Defined date a covered person becomes eligible for benefits under an existing contract. (UHC)</p>		Discretionary	

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Member ID Card Data Guidelines

Item #	Data Element	Definition	ANSI NITCS-284 Category	CALINX Agreement*	Comments
9	Employer Group Name	Name of employer group who purchases medical coverage on behalf of its employees. (UHC)		Discretionary	
10	Employer Group Code #	Identification number or code assigned by the carrier to identify the group under which the individual is covered. (X12)	Optional	Conditional	
11	Employer Benefit Plan Code	Code defined by the health plan indicating the type of benefit coverage selected by an employer. (midw)		Conditional	
12	Subscriber/Member Date of Birth	Date of Birth of subscriber, member or dependent. (X2)	Optional	Discretionary	
13	Subscriber/Member Gender	Code indicating gender of subscriber, member or dependent. (X12)		Discretionary	
14	Primary Care Provider Name	The first and last name of the Primary Care Physician assigned to a subscriber, member or dependent. (UHC)		Conditional	
15	Physician ID Number	Number assigned by the payer, regulatory authority or other authorized agency to identify a physician. (X12)		Discretionary	
16	PCP Phone Number	Phone number, including area code, of primary care provider of the enrollee.		Conditional	If the PCP number is available the Provider Organization phone number is not necessary.
17	Provider Organization Name	Name of the physician organization providing care to member, subscriber or dependent. (X12)		Conditional	If provider organization has been delegated the utilization functions this data element is ESSENTIAL .
18	Provider Organization Address	Address of physician organization corresponding to organization name. (midw)		Discretionary	
19	Provider Organization ID #	Unique identification number assigned to medical group or IPA by the payers. (midw)		Discretionary	
20	Provider Organization Phone #	Telephone number, including area code, for the medical group assigned to the subscriber/member.(X12)			

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Member ID Card Data Guidelines

Item #	Data Element	Definition	ANSI NITCS-284 Category	CALINX Agreement*	Comments
21	Co-pay Pharmaceutical	Charge to member for drugs prescribed by a provider. (UCH)		Conditional	Provide coverage indicator, not actual dollar value.
22	Co-pay Office Visit	Charge to member for visit to physician office. (UHC)		Conditional	Provide actual dollar value.
23	Co-pay Emergency	Charge to member for visit to emergency department of hospital (UHC)		Conditional	Provide actual dollar value.
24	Co-pay Hospital	Charge to member for admission to hospital. (UHC)		Discretionary	Provide either coverage indicator, or actual dollar value.
25	Deductible	An indicator for the deductible a covered person must pay each year from his/her own pocket before the plan will make payment for eligible benefits. (UHC)		Conditional	Provide coverage indicator. A health plan may provide dollar value at their discretion.
26	Instructions to Members	General directions to members for use of covered benefits and access to specific resources. (midw)		Conditional	
27	Instructions Out of Geographic Service Area or Network	Instructions for obtaining approval for using services outside the geographic area or network. (midw)		Conditional	
28	Hours	The hours the health plan is accessible by phone for business questions. (midw)		Discretionary	
29	Claims Submission Name, Address, Phone number(s)	Information labeled appropriately for submission of claims, customer service, eligibility, utilization review and/or correspondence. (ANSI 284)	Mandatory Back Side	Essential	
30	Optional/Supplemental Benefits	A code or description of optional services that a health plan may cover or provide in addition to its basic health services. (UHC)		Discretionary	
31	Behavior Health Coverage & Phone #	The mental health and/or chemical dependency disorder benefit is carved-out to a separate entity whose phone number including area code provides access to the carrier. (midw)		Conditional	When carve-out Behavior Health Coverage is a benefit the phone number will be used as the indicator of that coverage and appear on the front of the card.

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Sample Member ID Card

Sample Card-Content Standard Only

Recommendation:

The Member ID Card Workgroup has reviewed the current issues related to identification card development and maintenance. Principles of card acceptance:

1. Primary tool for identification of a health plan to the provider.
2. Provides information on health plan benefit coverage.
3. Provides identification characteristics of the member, although no guarantees.
4. Provides information about financial requirements like co-pays and deductibles.
5. Needs to be cost efficient for health plans to initiate and maintain.

CALINX created categories of agreement for each data element. All cards produced by health plans should include the items in the essential category on the list of recommended elements. The information identified on the conditional category is expected to be included on the card when the information is available in the health plan database. The information identified in the discretionary category can be included on the card at the discretion of the health plan as it relates to their provider networks.

The Sample Card reflects the content expectations of a health care card including the essential and conditional categories but not the format.

CALINX Minimum Standard Card-Network Plans*

Front Side

Essential and Conditional Data Elements

Health Card Holder Name	Health Card Issuer Name
Health Card Holder Identification #	Health Card Issuer Identifier
Employer Group Number	Primary Care Provider Name
Employer Benefit Plan Code	Primary Care Provider Phone Number
	Provider Organization Name

Co-pay RX: Y/N-Office Visit: \$XX-Emergency: \$ XX
 Deductible: Y/N Behavior Health Coverage: XXX-XXX-XXXX
 *Content standard only-format not included



Reverse Side

Essential and Conditional

INSTRUCTIONS FOR HOSPITAL ADMISSION: _____

INSTRUCTIONS FOR EMERGENCY SERVICES: Call 911 _____

INSTRUCTIONS FOR OUT OF AREA SERVICES: _____

GENERAL INSTRUCTIONS TO MEMBERS: _____

Health Card Issuer Phone Number
 Provider Organization Phone Number (When no PCP # available)
 Claims submission Name, Address, Phone Number

BACKGROUND

These rules are intended to be appropriate for all HMO encounter and claims transactions among providers, health plans, and purchasers. Readers should be aware that if there are disagreements between the CALINX Rules of Exchange and the rules and regulations established by the federal government for Medicare and Medicaid transactions, the federal regulations should supercede the CALINX Rules of Exchange. The following rules apply to the HMO line of business only.

CONTENT

- Complete encounter data from the provider will be given to health plans/provider organization
 - ANSI X12N 837 Professional and Institutional
 - HCFA 1500/UB 92 (ANSI 837 standards will supplant HCFA 1500 and UB 92 formats at the point a change-over occurs under HIPAA provisions)
 - HMOIS (ANSI 837 standards will supplant HCFA 1500 and UB 92 formats at the point a change-over occurs under HIPAA provisions)

FREQUENCY

- Provider Organizations will submit encounters to health plans on a 30 day cycle
- Information equivalent to that in HCFA 1500 and UB92 forms, except charge or other financial information that need not be included, will be completely and accurately reported within 60 days from date of service to health plans that prepay for services (i.e., an “encounter” report). This will include data from claims paid to network providers who contract directly with the provider organization.
- Complete HCFA 1500 and UB92 data, including financial charges, will be completely and accurately reported every 30 days to the direct payor of a claim.
- Plans will report complete and accurate encounter data compliance and edit reports to provider organizations within 30 days of receipt of the encounter/claim.

COMPLETENESS

- Provider Organizations are not required to submit cost data when they are reimbursed on a capitated basis.

APPROPRIATE USE

- Only aggregated data that prevent identification of individuals may be provided to employers by either plans or providers with the exception that individually identifiable data may be provided to a third party, as long as they meet confidentiality standards.
- The intent of this rule is to coordinate the accuracy of patient communication, and to ensure a coordinated approach to the care of the patient.
 - Plans directly contacting patients using information obtained from claims or encounter data will give 45-days advanced written notice to the provider organization or individual clinician, as appropriate.¹
 - Every provider organization will designate a recipient for the HMO communication process. This recipient is responsible for 1) verifying communication accuracy, 2) notifying or communicating with all involved individual physicians.
 - Any communication using encounter data must be specific regarding the exact information being sent to an individual member (i.e. suggesting a Pap Smear deficiency must include specific patient identifier).
 - The provider organization may object to the notice within the 45-day timeframe if it finds the specific data on specific patients inaccurate. The provider organization will notify the HMO of its findings and mutually create an accurate notice to specific patients.
 - No written objection by the provider organization within the 45-day timeframe (defined as from date of receipt by designated individual) is evidence of full approval.

¹ Appropriate should be considered as either the contracted entity – i.e., IPA or Medical Group – or the directly contracted clinician.

HCFA 1500	Implementation/Definition – Based on Minnesota HCFA Standards	837 Professional	HMO Information Services Standards (Western Reg.)	CALINX Agreement*	Comments
1a) Insurance Type	1. Medicare 2. Medicaid 4. CHAMPVA 3. CHAMPUS 5. Group Health Plan 6. FECA & Black Lung 7. Other Indicate type by marking box	Required	DAO 6.0	Discretionary	Provider Groups not always able to submit. Health Plans can extract this data from their internal databases if needed.
1b) Insured's ID Number	Refers to item marked in 1a. Enter insured's ID number as shown on insured's ID card (Medicare #, Medicaid #, Sponsor's SSN, VA File #, SSN or ID, SSN, ID)	Required	DAO 18.0	Essential	Reportable to health plan with contractual responsibility for member. Only aggregated data that prevent identification of individuals may be provided to employers by either plans or providers with the exception that individually identifiable data may be provided to a third party as long as they meet confidentiality standards.
2) Patient's Name	Last Name, First Name, Middle Initial	Required	CAO 4.0 CAO 5.0 CAO 6.0	Last Name & First Name Essential M.I. Discretionary	

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Encounter Data Guidelines

HCFA 1500	Implementation/Definition – Based on Minnesota HCFA Standards	837 Professional	HMO Information Services Standards (Western Reg.)	CALINX Agreement*	Comments
3) Patient's Birth Date	Includes Patient's Birth Date and Sex	Situational (Required when self)	CAO 8.0 CAO 9.0	Essential	Reportable to health plan with contractual responsibility for member. Only aggregated data that prevent identification of individuals may be provided to employers by either plans or providers with the exception that individually identifiable data may be provided to a third party as long as they meet confidentiality standards.
4) Insured's Name	Last Name, First Name, Middle Initial Identifies patient's source of insurance. Enter the insured's last name, first name, and middle initial	Required	DAO 19.0 DAO 20.0 DAO 21.0	Essential Discretionary Discretionary	Reportable to health plan with contractual responsibility for member. Insured Last Name required in ANSI 837. Insured First Name and Middle Initial not required. Plans have this information in their system. Only aggregated data that prevent identification of individuals may be provided to employers by either plans or providers with the exception that individually identifiable data may be provided to a third party as long as they meet confidentiality standards.
5) Patient's Address	Multiple Boxes: Enter the patient's house number, street, city, state and zip code.	Required	CAO 11.0 CAO 12.0 CAO 13.0 CAO 14.0 CAO 15.0	Essential Discretionary Essential Essential	Reportable to health plan with contractual responsibility for member. Patient Address 2 is discretionary. Only aggregated data that prevent identification of individuals may be provided to employers by either plans or providers with the exception that individually identifiable data may be provided to a third party as long as they meet confidentiality standards.

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Encounter Data Guidelines

HCFA 1500	Implementation/Definition – Based on Minnesota HCFA Standards	837 Professional	HMO Information Services Standards (Western Reg.)	CALINX Agreement*	Comments
6) Patient's Relationship to Insured	<p>Self means that the insured is the patient. Spouse means that the patient is the spouse of the insured. Other means that the patient is other than the self, spouse of child. Other may include employee, ward, or dependent Identifies patient's source of insurance, and distinguishes patient from insured..</p>	Situational	DAO 17.0	Essential	<p>Reportable to health plan with contractual responsibility for member.</p> <p>Only aggregated data that prevent identification of individuals may be provided to employers by either plans or providers with the exception that individually identifiable data may be provided to a third party as long as they meet confidentiality standards.</p>
7) Insured's Address	Enter the insured's house number, street, city, state and zip code.	Required	N/A	<p>Discretionary (Not Supported by HMOIS)</p> <p>Essential when converting to ANSI 837</p>	<p>Reportable to health plan with contractual responsibility for member.</p> <p>Only aggregated data that prevent identification of individuals may be provided to employers by either plans or providers with the exception that individually identifiable data may be provided to a third party as long as they meet confidentiality standards.</p>
8) Patient Status	<p>Employed means that the patient is employed. Full-time student means that the patient is registered for a full course load at a school or university. Part-time student means the patient is registered at a college or university but not full-time.</p>	Required	CAO 18.0	Discretionary	Information not needed for encounters. Plans can obtain from their systems if desired.

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Encounter Data Guidelines

HCFA 1500	Implementation/Definition – Based on Minnesota HCFA Standards	837 Professional	HMO Information Services Standards (Western Reg.)	CALINX Agreement*	Comments
9) Other Insured's Name	Other Insured means the holder of another policy, which may cover the patient. Identifies additional insurance source. a. Other Insured's Policy or Group Number b. Other Insured's Date of Birth & Sex. c. Employer's Name or School Name d. Insurance Plan Name or Program Name	Situational loop (Required if there is an "other insured")	N/A	Discretionary (Not Supported in HMOIS) Essential when converting to ANSI 837	Reportable to health plan with contractual responsibility for member. Only aggregated data that prevent identification of individuals may be provided to employers by either plans or providers with the exception that individually identifiable data may be provided to a third party as long as they meet confidentiality standards.
10) Is Patient's Condition Related To:	a. Employment? Yes or No b. Auto Accident? Yes or No c. Other Accident? Yes or No – indicates primary liability for condition and may flag claims when sent to inappropriate payer.	Required	EAO 4.0 EAO 5.0	Conditional	Populate when true
10d) Reserved for Local Use	Required and used only by Medicaid or Medicare. Refer to Medicaid or Medicare Manual.				
11) Insured's Policy group or FECA Number	Enter the insured's group number as it appears on the insured's enrollee ID card. For workers' compensation, enter the workers' compensation payer "claim number" if available. a. Insured's Date of Birth & Sex b. Employer's Name or School Name c. Insurance Plan Name or Program Name d. Is There Another health Benefit Plan? Yes or No (if yes then 9 a-d must be completed)	Required	DAO 10.0 DAO 11.0	Discretionary	Provider groups cannot always provide this information. Plans have this information in their system if desired.

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Encounter Data Guidelines

HCFA 1500	Implementation/Definition – Based on Minnesota HCFA Standards	837 Professional	HMO Information Services Standards (Western Reg.)	CALINX Agreement*	Comments
12) Patient's or Authorized Person's Signature	Enter the patient's actual signature, "Signature on File", or "SOF" if release of information exists in the patient's chart. If actual signature, enter date signed. Date needed only if actual signature. Signature may be required by contract. Not required for Medicaid, see Medicaid manual.	Required	DAO 16.0	Discretionary	Patient signature source
13) Insured's or Authorized Person's Signature	Enter the insured's actual signature, "Signature on File" or "SOF" if insured has authorized payment of medical benefits to the provider (assignment of benefits)	Required	N/A (Not supported by HMOIS)	Discretionary	
14) Date of Current Illness, Injury, or Pregnancy	Enter the first date of the present illness, injury or pregnancy. If actual date is unknown, leave blank. Do not enter default date.	Situational	EAO 7.0	Conditional	Populate when true
15) If Patient has had same or Similar Illness – Give first date	Enter the date the patient had the same or a similar illness. Leave blank if no same or similar illness has occurred. Leave blank if unknown.	Situational	EAO 15.0 EAO 16.0	Discretionary	Often not known and of uncertain value
16) Dates Patient Unable to Work in Current Occupation	Enter dates if known. Leave blank if unknown.	Situational	EAO 18.0 EAO 19.0	Discretionary	Purchasers would like this information, but this data is difficult to predict, and release of this information would breach other confidential information. The provider members suggested that the current method of providing this advice to employers, the use of a "note from the doctor" might have to suffice.

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Encounter Data Guidelines

HCFA 1500	Implementation/Definition – Based on Minnesota HCFA Standards	837 Professional	HMO Information Services Standards (Western Reg.)	CALINX Agreement*	Comments
17) Name of Referring Physician or Other Source	Enter the name of the physician or other source who referred the patient to the billing provider or ordered the test or supply, if appropriate.	(Situational - required if claim involved a referral and need to identify primary care provider)	EAO 22.0 EAO 23.0	Conditional	ri9 ew (0 e.ys9HCio 9ppidar0T.n8 .a(csPo9o39e 1n oa(csP
17a) I.D. Number of Referring Physician	Enter the identifier number of the referring or ordering physician or other source.	Loop 2310A - Referring Provider Name (Situational)	EAO 20.0 FAO 24.0		
18) Hospitalization Dates Related to Current Services	Enter the inpatient hospital admission date followed by the discharge date (if discharge has occurred). If not discharged, leave discharge date blank.	(Situational - Loop 2400 overrides it)	EAO 26.0 EAO 27.0		
19) Reserved for Local Use	May be used to list multiple modifiers; see box 24d. May be used to list pickup and delivery addresses for transportation claims. Used for Medicare and Medicaid, refer to Medicare or Medicaid manual.				
20) Outside Lab	For Medicare, enter an X in Yes if the current services are from an outside laboratory. Yes or No Also, include \$ charges				

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Encounter Data Guidelines

HCFA 1500	Implementation/Definition – Based on Minnesota HCFA Standards	837 Professional	HMO Information Services Standards (Western Reg.)	CALINX Agreement	Comments
21) Diagnosis or Nature of Illness or Injury	List up to four ICD9-9-CM diagnosis codes in order of priority. Pointers: Relate lines 1,2,3,4 to lines of service in 24e by line number. Use the highest level of specificity. Used to inform payer of diagnosis. Pointers relate the diagnosis to the service performed for that diagnosis.	Required (except claims for which there are no diagnosis)	EAO 30.0 EAO 31.0 EAO 32.0 EAO 33.0	Essential Conditional Conditional Conditional	HMOIS supports four (4) diagnosis codes. When converting to ANSI 837, allow up to EIGHT ICD-9 diagnosis codes Reportable to health plan with contractual responsibility for member. Only aggregated data that prevent identification of individuals may be provided to employers by either plans or providers with the exception that individually identifiable data may be provided to a third party as long as they meet confidentiality standards.
22) Medicaid Resubmission Code	For Medicaid replacement claims only, refer to code list in Medicaid manual.				
23) Prior Authorization Number	Enter the prior authorization number as required by the payer for the current service. For Medicaid, PA or Home Care Service Agreement or Certification / Second Surgical Opinion, refer to Medicaid manual. Used to determine eligibility of the current service.	Situational – (Required when services on a claim were pre-authorized)	DAO 14.0	Discretionary	Not used by health plans

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Encounter Data Guidelines

24a)

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Encounter Data Guidelines

HCFA 1500	Implementation/Definition – Based on Minnesota HCFA Standards	837 Professional	HMO Information Services Standards (Western Reg.)	CALINX Agreement	Comments
24e) Diagnosis Code Pointers	Used to inform payers which procedure was done for which diagnosis. Enter the pointer number(s) 1, 2, 3, and/or 4 from box 21, which relate the diagnosis to the applicable service. Up to four diagnosis pointer numbers may be used to refer to each line of service. If more than one pointer number applies to a line of service, the first number listed should refer to the primary diagnosis. (Diagnosis codes must be entered in box 21 only. Do not enter them in 24E)	Required	FAO 14.0 FAO 15.0 FAO 16.0 FAO 17.0	Essential Conditional Conditional	HMOIS supports four (4) diagnosis codes. When converting to ANSI 837, allow up to EIGHT ICD-9 diagnosis codes
24f) \$ Charges	Used to inform the payer of the total dollars charged for this line of the current services. Enter the dollar amount listed for each service. If more than one date or unit is shown in 24G, the dollars shown should reflect the TOTAL of the services. If grouping services, the charges for each item within a group must be identical (24F must be evenly divisible by 24G).	(Required)	FAO 13.0	Conditional	Regarding charges: Such charges should only be reported to the entity responsible for direct payment of the fee or, if a capitated service, the organization that is directly responsible for paying the contractor laboratory. Costs or charges should not be reported to upstream organizations, even if those organizations pay capitation to the provider or payor.
24g) Days or Units	Used to inform payer of how many of each service were provided. (Enter the number of days or units being charged on this line of the current services. If only one service was performed, enter a 1. If multiple identical services are provided on consecutive days, enter the actual number, which must correspond with the number of days in box 24a.)	Required	FAO 18.0	Essential	

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Encounter Data Guidelines

HCFA 1500	Implementation/Definition – Based on Minnesota HCFA Standards	837 Professional	HMO Information Services Standards (Western Reg.)	CALINX Agreement*	Comments
24h) EPSDT Family Plan	Used only for Child and Teen checkup (formerly EPSDT) for Medicaid and Medicaid managed care. Otherwise, leave blank.	Required	FBO 22.0	Discretionary	Not used by health plans
24i) EMG	Not required.	Required	FAO 20.0	Discretionary	Not used by health plans
24j) COB	Not required.	Situational	FAO 21.0	Discretionary	Not used by health plans
24k) Reserved for Local Use	Used to inform the payer which provider actually performed this line of service.(Enter the rendering provider's NPI, UPIN, MHCP or other identifier for each line of service 1-6.)	Required (NM108 & NM109 Rendering Provider ID)	TBD		
25) Federal Tax I.D. Number	Used to direct payment to the proper corporate entity, and to issue a 1099 form if tax law requires it. Enter the federal tax identification, social security number or employer identification number of the entity to whom the payment will be made. (Social security numbers of individual providers are to be used ONLY when the provider is an unincorporated business and payment is to be made to the individual provider. Specify type by checking appropriate box.)	Required	BAO 6.0	Essential	Provider ID number
26) Patient's Account Number	Used to post payments to the correct patient account. Enter the patient's account number assigned by the rendering provider's organization.	Required	CAO 3.0	Essential	Are there restrictions

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Version: January 2000

Encounter Data Guidelines

- 27) Accept Assignment Used to indicate that the provider, whether participating or not in Medicare, accepts assignment of benefits for this claim. For Medicare claims, enter an X in the appropriate box to indicate acceptance of assigned benefits for this claim. See Medicare manual.
- 28) Total Charge Used to inform the payer of the total dollars charged for the current PAGE of services. Enter the sum of the charges in column F for ALL lines on the page.

29) Amount Paid

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Encounter Data Guidelines

HCFA 1500	Implementation/Definition – Based on Minnesota HCFA Standards	837 Professional	HMO Information Services Standards (Western Reg.)	CALINX Agreement*	Comments
31) Signature of Physician or Supplier including Degrees or Credentials	Enter the signature of the provider, supplier or representative, and the date signed. Personal signature, computer generated signature, facsimile signature, signature stamp and /or authorized signature is acceptable. This signature certifies statements on the reverse of the HCFA 1500 form.	Required	EAO 35.0 EAO 36.0	Discretionary	Old requirement. Most groups do not collect. Plans do not use.
32) Name and Address of Facility where Services were Rendered	Used to show where services were rendered, especially for purchased services. Enter the name and actual address of the organization or facility. Abbreviate name as needed. For supplies, enter location where supplies were accepted.		EAO 37.0	Discretionary	Restrictions?
33) Physician's Supplier Billing Name, Address, Zip Code & Phone #	Enter the name and address of the provider's organization. Phone number is recommended. For Medicaid, enter the 9-digit PIN only if the payment is being made to an individual provider. Enter group ID number if required by payer contract.	Required	BAO 18.0 FAO 23.0	Essential	Required by 837

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BACKGROUND

These Rules of Exchange are intended to be appropriate for all laboratory results

LABORATORY RULES OF OF EXCHANGE (cont.)

- Plans directly contacting patients using information obtained from laboratory results data will follow an approved policy procedure, which will include advance written notice with applicable information to the provider organization or individual clinician (See Appendix: Laboratory).
 - The purpose is to establish a consistent method of communicating Health Management Programs (HMPs) to PMGs, allowing the PMGs the opportunity to refuse HMPs because of their own existing programs, and documenting that the PMGs HMPs meet or exceed NCQA standards.
- Plans directly contacting patients using information obtained from laboratory results data will give 45-days advanced written notice to the provider organization or individual clinician, as appropriate.¹
 - The intent of this rule is to coordinate the accuracy of patient communication, and to ensure a coordinated approach to the care of the patient.
 - Every provider organization will designate a recipient for the HMO communication process. This recipient is responsible for 1) verifying communication accuracy, 2) notifying or communicating with all involved individual physicians.
 - Any communication using lab result data must be specific regarding the exact information being sent to an individual member (i.e. suggesting a Pap Smear deficiency must include specific patient identifier).
 - The provider organization may object to the notice within the 45-day timeframe if it finds the specific data on specific patients inaccurate. The provider organization will notify the HMO of its findings and mutually create an accurate notice to specific patients.
 - No written objection by the provider organization within the 45-day timeframe (defined as from date of receipt by designated individual) is evidence of full approval.

¹ Appropriate should be considered as either the contracted entity – i.e., IPA or Medical Group – or the directly contracted clinician.

BACKGROUND

The CALINX Pharmacy Workgroup has agreed to share pharmacy data between health plans and provider/physician organizations with the goals defined for all participants as clinical evaluation, disease management and cost management. The agreements are based on NCPDP (National Council for Prescription Drug Programs) definitions when available. NCPDP currently provides electronic standards for communication of prescriptions between physicians and retail pharmacies and communication of claims between retail pharmacies and payers.

CONTENT

The content categories include health plan identification, patient demographic information, prescription description, financial data and prescriber information.

FREQUENCY

Beginning the second quarter of 2000 health plans and/or PBMs will transmit electronic pharmacy data to the provider organizations based on the CALINX agreement and Rules of Exchange.

- Optimally the CALINX electronic pharmacy data will be provided to contracting physician organization at monthly (30 days) intervals from health plans and PBMs with pharmacy carve-out contracts. The reporting interval may be from 30 to 90 days based on the preference of the provider organization.
- The lag time for Pharmacy reporting by the health plans or PBMs to the providers should not be longer than 60 days from the last date of service in the reporting period.

ACCURACY AND COMPLETENESS

- The data forwarded to the physician organization from the health plans are expected to reflect the accurate pharmacy activity for that physician organization's patient and physician populations.

APPROPRIATE USE

- The intent of the use of the data provided by health plans to the physician organizations is for clinical evaluation, disease management and cost management. It was agreed that if there were misuse of the data as evidenced by direct contracting with pharmaceutical manufacturers, the data would be withheld by the health plan. (Sample contract language under development.)
- Physician Organizations may not use individually identifiable reported data in direct contracting with pharmaceutical firms or pharmacy benefit managers.

PHARMACY RULES OF EXCHANGE (cont.)

- Health plan specific pharmacy data including an individually identifiable member will never be provided to a pharmaceutical manufacturer by a physician organization unless approved in advance by the health plan. Upon request, the health plan will provide pharmacy data to a 3rd party data organization contracted with the IPA to merge with other records for aggregate reporting for internal purposes (e.g. individual physician prescribing patterns). The handling of data will adhere to confidentiality standards.
- Employers responsible for pharmacy carve-out benefits are subject to CALINX agreements for electronic data submission using applicable NCPDP fields on all prescriptions filled to contracting physician organization who request the information.

Note:

See the Pharmacy Implementation Guide located in the appendix.

The primary goal of the CALINX Pharmacy Workgroup is to share pharmacy data between health plans and provider organizations for all participants to perform clinical evaluation and disease management functions. The agreements are based on NCPDP definitions although it is recognized that NCPDP is primarily an inbound message between the pharmacy and health plan. Some data elements are beyond NCPDP definitions but are necessary to perform clinical evaluations and disease management. The following list of data elements has been revised during the first half of the demonstration project of data exchange between health plans and provider organizations during the 3rd quarter of 1999.

Health Plan Identification

1	Health Plan ID	Health Plan Identification Code	Required	Essential
2	Batch Number	Assigned by Process/Sender YYDDD (Julian Date)	Optional	Discretionary
3	Run Date	Date on which file/tape/disk was created. (CCYYMMDD)	Optional	Discretionary
4	Version/Release #	CALINX Version and Release Number 10=Ver 1 Rel 0	Required	Essential
5	Submission Number	00=Original Submission 01=First resubmission, etc.		
6	Active Code	8.N [(6)-3545.6eg the 6tch 71 0.6 TD6onal-2.58e2ber		

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NCPDP Compliance Status

Required – Data element must be included in NCPDP format.

Optional – Data element inclusion is dependent on CALINX agreement, but if chosen must be in NCPDP format.

Conditional – Data element is included as an alternative to an expected essential data element and must be in NCPDP format.

Pharmacy Data Guidelines

Item #	Data Element	Definition	NCPDP	CALINX Agreement*	Comments
7	Recipient ID	ID of group to whom data is being sent (assigned by sender)	Optional	Discretionary	
8	Blank	Reserved for CALINX future expansion.			
Patient Demographics					
9	Patient ID	Identification Number assigned to patient by Health Plan	Required	Essential	
10	Patient Last Name	Patient's last name	Required	Essential	
11	Patient First Name	Patient's first name	Required	Essential	
12	Date of Birth	Patient's Date of Birth CCYYMMDD format	Required	Essential	
13	Patient Gender	Patient's Gender 0=Not specified 1=Male 2=Female	Required	Essential	
14	Patient Relation	Patient's relationship to cardholder(insured) 0=Not specified 1=Cardholder 2=Spouse 3=Male child 4=Female child 5=Covered minor dependent of cardholder 7=Previous spouse of cardholder 8=Not used 9=Other (not included above)	Required	Essential	
15	Patient Employer	ID code assigned to cardholder employer group (by Health Plan)	Optional	Discretionary	

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Pharmacy Data Guidelines

Item #	Data Element	Definition	NCPDP	CALINX Agreement*	Comments
25	Quantity Dispensed	Metric Decimal quantity of product dispensed (9999v999S)	Required	Essential	
26	Days Supply	Estimated number of days the prescription will last (999S)	Required	Essential	
27	New/Refill Code	00=New 1-99=Refill number	Required	Essential	
28	Prescription #	Number assigned by pharmacy to transaction provided	Required	Essential	
29	Drug Type	0=Not specified 1=Single source brand 2=Branded generic 3=Generic 4=OTC 5=Multi-source brand	Required	Essential	
30	Formulary status	Y=Yes N=No Z=Unknown	Optional	Discretionary	
31	Pharmacy ID Chain Code	ID assigned by NCPDP to a chain	Optional	Discretionary	
32	Pharmacy ID-NABP Code	ID assigned by NCPDP to a pharmacy	Optional	Discretionary	
33	Place of service	00=Not specified 01=Home 10=Outpatient 99=Other (Consult Implementation Guide for all codes)	Optional	Discretionary	
34	Date Billed		Optional	Discretionary	
35	Co-pay amount	Amount payed by patient \$\$\$\$ccS	Required	Essential	

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Version: January 2000

Pharmacy Data Guidelines

Item #	Data Element	Definition	NCPDP	CALINX Agreement*	Comments
36	Net Amount Due	Amount paid to pharmacy (net cost to plan) \$\$\$\$ccS	Required	Essential	
37	Ingredient Cost	Drug Ingredient Cost included in total amount due \$\$\$\$ccS	Required	Essential	
38	Plan Type	Plan Type as determined by Health Plan (Line of Business Code)	Required	Essential	
39	Claim Number	Unique claim identification number assigned by Health Plan	Required	Essential	
40	Payment Status	0=Paid 1=Reversed	Required	Essential	
Prescriber/Provider Information					
41	Prescriber ID Qualifier	00=Not defined 01=DEA # 02=State License # 03=National Prescriber ID # 04=Tax ID # 05=SS # 06=HIN # 07=Health Plan assigned # 99=Other	Required	Essential	
42	Prescriber ID #	ID assigned to prescriber (in form defined by qualifier)	Required	Essential	
43	Provider Last Name	Last Name of prescribing provider	Required	Essential	
44	Provider First Name	First name of prescribing provider (or initial)	Required	Essential	

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Conditional – Data element is included as an alternative to an expected /F3 1n iNCPDP D0.0277 nt on CALII TD 0 1 Tf-4.36-9 9 .363 -1.16 to tal

Pharmacy Data Guidelines

Item #	Data Element	Definition	NCPDP	CALINX Agreement*	Comments
51	Commercial/Senior Code	0=Unknown 1=Commercial 2=Medicare Risk 3=Senior-Other 4=MediCa 5=Healthy Families 6=Other Government	Optional	Essential	
52	Blank	Reserved for future expansion by CALINX			
53	Filler	Used for additional data specific to trading partners			

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Conditional – Data element is included as an alternative to an expected essential data element and must be in NCPDP format.



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ENCOUNTER HMOIS STANDARD BASED ON CALINX GUIDELINES

RECORD	FIELD NAME	FIELD LENGTH	HMOIS	CALINX AGREEMENT
AA0-File Header Record-Submitter				
1.0	RECORD ID "AA0"	3	R	
2.0	SUB ID	16	R	
3.0	RESERVED (AA0-03.0)	9	N	
4.0	SUBMISSION TYPE	6	R	
5.0	SUBMISSION NO	6	R	
6.0	SUB NAME	33	N	
7.0	SUB ADDRESS-1	30	N	
8.0	SUB ADDRESS-2	30	N	
9.0	SUB CITY	20	N	
10.0	SUB STATE	2	N	
11.0	SUB ZIP	9	N	
12.0	SUB REGION	5	N	
13.0	SUB CONTACT	33	N	
14.0	SUB PHONE	10	N	
15.0	CREATION DATE	8	R	
16.0	SUBMISSION TIME	6	R*	
17.0	RECEIVER ID	16	R	
18.0	RECEIVER TYPE CODE	1	N	
19.0	VERSION CODE-NATIONAL	5	R	
20.0	VERSION CODE-LOCAL	5	C	
21.0	TEST/PROD IND	4	R*	
22.0	PASSWORD	8	N	
23.0	RETRANSMISSION STATUS	1	R*	
24.0	FILLER-NATIONAL	26	N	
25.0	FILLER-LOCAL	28	N	

Encounter HMOIS Standard

RECORD	FIELD NAME	FIELD LENGTH	HMOIS	CALINX AGREEMENT
BA0-Batch Header Record-Provider				
1.0	RECORD ID "BA0"	3	R	
2.0	EMC PROV ID	15	R	
3.0	BATCH TYPE	3	C	
4.0	BATCH NO	4	R	
5.0	BATCH ID	6	O	
6.0	PROV TAX ID	9	R*	E
7.0	RESERVED (BA0-07.0)	6	N	
8.0	PROV TAX ID TYPE	1	R*	
9.0	PROV MEDICARE NO	15	O	
10.0	PROV UPI-USIN ID	6	O	
11.0	RESERVED (BA0-11.0)	6	N	
12.0	PROV MEDICAID NO	15	O	
13.0	PROV CHAMPUS NO	15	O	
14.0	PROV BLUE SHIELD NO	15	O	
15.0	PROV COMMERICAL NO	15	O	
16.0	PROV NO 1	15	N	
17.0	PROV NO 2	15	N	
18.0	PROV ORGANIZATION NAME	33	N	E
19.0	PROV LAST NAME	20	N	
20.0	PROV FIRST NAME	12	N	
21.0	PROV MI	1	N	
22.0	PROV SPECIALTY	3	N	
23.0	SPECIALTY LICENSE NO	15	N	
24.0	STATE LICENSE NO	15	N	
25.0	DENTIST LICENSE NO	15	N	
26.0	ANESTHESIA LICENSE NO	15	N	
27.0	FILLER-NATIONAL	13	N	
28.0	FILLER-LOCAL	14	N	

Encounter HMOIS Standard

RECORD	FIELD NAME	FIELD LENGTH	HMOIS	CALINX AGREEMENT
DA0-Insurance Information Record				
1.0	RECORD ID "DA0"	3	R	
2.0	SEQUENCE NO	2	R	
3.0	PATIENT CONTROL NO	17	R	
4.0	CLAIM FILING IND	1	N	
5.0	SOURCE OF PAY	1	O	
6.0	INSURANCE TYPE CODE	2	O	D
7.0	PAYOR ORGANIZATION ID	5	C	
8.0	PAYOR CLAIM OFFICE NO	4	C	
9.0	PAYOR NAME	33	C	
10.0	GROUP NO	20	C	D
11.0	GROUP NAME	33	C	D
12.0	PPO/HMO IND	1	N	
13.0	PPO ID	15	N	
14.0	PRIOR AUTH NO	15	C	D
15.0	ASSIGN OF BENEFITS IN	1	O	
16.0	PAT SIGNATURE SOURCE	1	N	D
17.0	PAT RELATION TO INSURED	2	R	E
18.0	INSURED ID NO	25	R	E
19.0	INSURED LAST NAME	20	N	E
20.0	INSURED FIRST NAME	12	N	D
21.0	INSURED MI	1	N	D
22.0	INSURED GENERATION	3	N	
23.0	INSURED SEX	1	N	
24.0	INSURED DATE OF BIRTH	8	N	
25.0	INSURED EMPLOYMENT STATUE	1	O	
26.0	SUPPLEMENTAL INSURANCE INDICATOR	1	O	
27.0	TITLE XIX IDENTIFIER	7	O	
28.0	FILLER-NATIONAL	38	N	
29.0	FILLER-LOCAL	47	N	

Encounter HMOIS Standard

RECORD	FIELD NAME	FIELD LENGTH	HMOIS	CALINX AGREEMENT
EA0-Claim Detail Record-Claim Level				
31.0	DIAGNOSIS CODE-2	5	C	C
32.0	DIAGNOSIS CODE-3	5	C	C
33.0	DIAGNOSIS CODE-4	5	C	C
34.0	PROV ASSIGN IND	1	N	D
35.0	PROV SIGNATURE ON FILE	1	N	D
36.0	PROV SIGNATURE DATE	8	N	D
37.0	FACILITY/LAB NAME	33	C	D
38.0	DOCUMENTATION IND	1	N	D
39.0	TYPE OF DOCUMENTATION	1	N	
40.0	FUNCTIONAL STATUS CODE	2	N	
41.0	SPECIAL PROGRAM IND	2	N	
42.0	CHAMPUS NONAVAIL IND	1	N	
43.0	SUPV PROV IND	1	N	
44.0	RESUBMISSION CODE	2	C	
45.0	RESUB REFERENCE NO	15	C	
46.0	DATE LAST SEEN	8	N	
47.0	FILLER-NATIONAL	19	N	
48.0	FILLER-LOCAL	27	N	

**FB0-Service
Line Detail
Record-
Medicaid**

1.0	RECORD ID "FB0"	3	R	
2.0	SEQUENCE NO	2	R	
3.0	PAT CONTROL NO	17	R	
4.0	LINE ITEM CONTROL NO	17	O	
5.0	PUR SVC CHARGE	7	N	
6.0	ALLOWED AMOUNT 7	7	N	
7.0	DEDUCTIBLE AMOUNT	7	N	
8.0	COINSURANCE AMOUNT	7	N	
9.0	ORDERING PROV ID	15	N	
10.0	ORDERING PROV STATE	2	N	
11.0	PUR SVC PROV ID	15	C	
12.0	PUR SVC STATE	2	C	
13.0	PEN GRAMS OF PROTEIN	4	N	
14.0	PEN CALORIES	4	N	
15.0	NATIONAL DRUG CODE	11	O	
16.0	NATIONAL DRUG UNITS	7	O	
17.0	PRESCRIPTION NO	15	O	
18.0	PRESCRIPTION DATE	8	O	
19.0	PRESCRIPTION NO OF MONTHS	2	O	
20.0	SPEC PRICING IND	1	N	
21.0	COPAY STATUS IND	1	N	
22.0	EPSDT IND	1	O	D
23.0	FAMILY PLANNING IND	1	O	
24.0	DME CHARGE IND	1	N	
25.0	HMSA FACILITY ID	15	N	
26.0	HMSA FACILITY ZIP	9	N	
27.0	PUR SVC NAME	33	C	

Encounter HMOIS Standard

RECORD	FIELD NAME	FIELD LENGTH	HMOIS	CALINX AGREEMENT
FB1-Service Line Detail Record-Medicare				
1.0	RECORD ID "FB1"	3	R	
2.0	SEQUENCE NO	2	R	
3.0	PAT CONTROL NO	17	R	
4.0	LINE ITEM CONTROL NO	17	O	
5.0	PLACE OF SVC NAME	33	N	
6.0	ORDERNG PROV LAST	20	N	
7.0	ORDERING PROV FIRST	12	N	
8.0	ORDERING PROV MI	1	N	
9.0	ORDERING PROV UPIN	15	N	
10.0	REFERRING PROV LAST	20	C	
11.0	REFERRING PROV FIRST	12	C	
12.0	REFERRING PROV MI	1	O	
13.0	REFERRING PROV UPIN	15	N	
14.0	RENDERING PROV LAST	20	R*	
15.0	RENDERING PROV FIRST	12	R*	
16.0	RENDERING PROV MI	1	O	
17.0	RENDERING PROV UPIN	15	N	
18.0	SUPERVISING PROV LAST	20	N	
19.0	SUPERVISING PROV FIRST	12	N	
20.0	SUPERVISING PROV MI	1	N	
21.0	SUPERVISING PROV ID	15	N	
22.0	SUPERVISING PROV UPIN	15	N	
23.0	FILLER-NATIONAL	20	N	
24.0	FILLER-LOCAL	21	N	

Encounter HMOIS Standard

RECORD	FIELD NAME	FIELD LENGTH	HMOIS	CALINX AGREEMENT
FD0-Service Line Detail Record-Dental				
1.0	RECORD ID "FD0"	3	R	
2.0	SEQUENCE NO	2	R	
3.0	PAT CONTROL NO	17	R	
4.0	DENTAL FILLER	238	O	
5.0	FILLER-NATIONAL	30	N	
6.0	FILLER-LOCAL	30	N	

Encounter HMOIS Standard

RECORD	FIELD NAME	FIELD LENGTH	HMOIS	CALINX AGREEMENT
XA0-Claim Trailer Record-Totals				
1.0	RECORD ID "XA0"	3	R	
2.0	RESERVED	2	N	
3.0	PAT CONTROL NO	17	R	
4.0	RECORD Cxx COUNT	2	R	
5.0	RECORD Dxx COUNT	2	R	
6.0	RECORD Exx COUNT	2	R	
7.0	RECORD Fxx COUNT	2	R	
8.0	RECORD Gxx COUNT	2	N	
9.0	RECORD Hxx COUNT	2	N	
10.0	CLAIM RECORD COUNT	3	R	
11.0	RESERVED	40	N	
12.0	TOTAL CLAIM CHARGES	7	R	C
13.0	TOTAL DISAL COST CONT CHGS	7	O	
14.0	TOTAL DISAL OTHER CHARGES	7	O	
15.0	TOTAL ALLOWED AMOUNT	7	O	
16.0	TOTAL DEDUCTIBLE AMOUNT	7	O	
17.0	TOTAL COINSURANCE AMOUNT	7	O	
18.0	TOTAL PAYOR AMOUNT PAID	7	O	
19.0	PAT AMOUNT PAID	7	N	
20.0	TOTAL PURCHASE SVC CHARGES	7	N	
21.0	PROV DISCOUNT INFORMATION	16	N	
22.0	REMARKS	103	N	
23.0	FILLER-NATIONAL	31	N	
24.0	FILLER-LOCAL	30	N	

Encounter HMOIS Standard

RECORD	FIELD NAME	FIELD LENGTH	HMOIS	CALINX AGREEMENT
YA0-Batch Trailer Record-Batch Totals				
1.0	RECORD ID "YA0"	3	R	
2.0	EMC PROV ID	15	R	
3.0	BATCH TYPE	3	C	
4.0	BATCH NO	4	R	
5.0	BATCH ID	6	O	
6.0	PROV TAX ID	9	R	
7.0	RESERVED (YA0-07.0)	6	N	
8.0	BATCH SVC LINE COUNT	7	R	
9.0	BATCH RECORD COUNT	7	R	
10.0	BATCH CLAIM COUNT	7	R	
11.0	BATCH TOTAL CHARGES	9	R	
12.0	FILLER-NATIONAL	121	N	
13.0	FILLER-LOCAL	123	N	

RECORD	FIELD NAME	FIELD LENGTH	HMOIS	CALINX AGREEMENT
ZA0-File Trailer Record-File Totals				
1.0	RECORD ID "ZA0"	3	R	
2.0	SUB ID	16	R	
3.0	RESERVED (ZA0-03.0)	9	N	
4.0	RECEIVER ID	16	R	
5.0	FILE SVC LINE COUNT	7	R	
6.0	FILE RECORD COUNT	7	R	
7.0	FILE CLAIM COUNT	7	R	
8.0	BATCH COUNT	4	R	
9.0	FILE TOTAL CHARGES	11	R	
10.0	FILLER-NATIONAL	120	N	
11.0	FILLER-LOCAL	120	N	

PHARMACY STANDARD INFORMATION GUIDE –IMPLEMENTATION

1. PURPOSE OF GUIDE

This CALINX Pharmacy Data Exchange Guide is intended to meet two needs in support of improving patient health care in the State of California.

- To provide a practical guideline for software development as Health Plans and medical partners begin to implement the standard format.
- To ensure a consistent implementation to the standard format throughout the industry.

This guide provides directions and instructions for implementation for the Health Plan and/or PBM agent for the creation of a data set, and for the medical group/provider in its interpretation and use of the data. Please refer to the appropriate sections below for assistance.

2. SCOPE

This document contains a listing of values intended for exchange as defined by the CALINX Rules of Exchange (Pharmacy Data Set) and stipulated by written agreement. In some cases, a value may be essential, conditional or discretionary. Alternate data may be substituted where indicated. Some

PHARMACY IMPLEMENTATION GUIDE (cont.)

Currently, MPOs rely on data supplied in utilization reports and/or from data retrieved from claims processing systems to support their utilization control efforts. This standard is needed to eliminate the creation of unique utilization reports and/or files by MCOs for every MPO.

4. BUSINESS ENVIRONMENT – GENERAL

Since use of this standard will allow for data to be exchanged in a consistent format between the contracting organizations, CALINX recommends the use of this standard format for the exchange of pharmacy data.

In the text that follows, please be sure to carefully read the sections that apply to your business and your trading partners. Each section contains practical information regarding commonly accepted practices in implementing the CALINX standard. Please carefully consider the following when implementing any new electronic data exchange standard.

- Implementation practices, which are generally accepted throughout the industry even if they are not defined in this standard.
- Sample transactions, including field numbers, identities and values.
- Data fields and other areas in the format that are often misused or misunderstood.

5. OBJECTIVES

- The standard is designed to facilitate the flow of information and to improve the integrity of pharmacy data exchanged between MCOs and MPOs.
- The objective of the standard is to establish a data format to handle prescription data for utilization purposes provided to MPOs and MCOs.
- The specific use of the optional data elements, as well as any additional data elements, used to support this format between trading partners, should be defined by contract terms.
- This standard is meant to facilitate the exchange of information without compromising the privacy of the patient.

6. ASSUMPTIONS

- The data format will support exchange of data between widely varying systems.
- The inclusion of optional data elements should not be interpreted as a recommendation for their use.
- The contract terms of the trading partners shall determine the use of optional data elements, and additional data elements will be placed into the filler areas.
- Adjustments to prior data submissions for a reporting period and complete data re-submissions for a specific reporting period shall be accommodated.
- Contract negotiations and maintenance of contract terms will not be addressed in this standard.
- Formats are designed for use on a main frame, mid-range, or a PC/LAN computer system.
- Records will be fixed length.
- Each record within a file will have a header section.
- The Header portion of the record identifies the sender, receiver, and date of the data set.
- All records start with the Health Plan (MCO) ID field.
- All multiple configuration fields have a qualifier.
- All dates are 8 positions CCYYMMDD.
- All currency fields are 8 positions, use implied decimal positioning (e.g.,99999v99) and the right most position contains a sign (blank if positive, “-” if negative).
- Alphanumeric (A/N) fields are left justified and blank filled, and blank if not used.
- Numeric fields are right justified and zero filled. Zero is a valid value and does not mean “not reported.”

PHARMACY IMPLEMENTATION GUIDE (cont.)

7. DISCRETIONARY FIELDS

The standard format includes fields that must be included in the submission before the transaction is valid. Blanks in any essential field will cause the record to be rejected as invalid. Only those fields marked required (E) must be populated with data. Conditional fields must be populated when applicable. Trading partners may determine the extent to which they will include/request data in Discretionary (D) fields. Conditional and Discretionary fields, which do not contain data, should be blank filled. For the purpose of this format, zeros are to be considered valid data.

8. NUMERIC POSITIVE AND NEGATIVE FIELDS

For the purpose of this format, all numeric fields except quantity and currency are considered positive. For quantity or currency fields, positive or negative values are expressed in the right most character of the field. This facilitates the reporting of signed numeric values regardless of the computer system generating or receiving the data. The symbol “b” indicates a “blank” or positive value. The symbol “-” indicates a negative value.

The signed numeric values may be treated as two physical fields depending on the platform and the coding or receiving systems. If the signed numeric values are treated as two physical fields, each value must be interrogated first to determine whether or not it is populated with a numeric or text (spaces) value. If the field contains a numeric value, the program should then interrogate the sign. If the sign contains a space, the value may remain as is. If the sign contains a “-”, the value should be multiplied by negative one.

9. ADDITIONAL DATA FIELDS

Information not contained in the format but required by the trading partners must be negotiated independently utilizing the filler space. It is strongly recommended that defined fields not be used for data other than that included in the description. Any additional data elements should be placed in the filler area at the end of the record. This will allow for subsequent releases to be made to the format without affecting these additional data fields.

10. FREQUENTLY ASKED QUESTIONS

“What is the purpose of using ID Code Qualifiers?”

ID Code Qualifiers (Prescriber ID and Alternate Product ID) are used to eliminate the need for creating individual fields for all possible data types. For example, the prescriber may be

PHARMACY IMPLEMENTATION GUIDE (cont.)

mutually agreed upon between trading partners can be sent by placing that data in the filler area at the end of the record.

11. RECORD FORMAT

A. Component Structure

The Pharmacy Data Record is organized into five (5) segments.

- a. The Header Information Section, which identifies the creator and/or sender of the data, the batch number and creation date, the CALINX version number, the submission and action codes, and the receiver identification.

Each original occurrence of a record must be assigned a unique batch number. This batch number should only be reused to tie a replacement, changed, or deleted record back to the original batch. The submission number counts the number of times a batch has been resent, and the action code is to instruct the receiver as to how the data should be used.

- b. Patient Data Section, identifies the Health Plan Members for whom the prescription was prescribed. This data includes the identification number assigned by the Health Plan. This field does not use a qualifier because there is no industry standard coding for member/patient identification. It also includes the patient's last and first names, the patient's date of birth (used for age calculations, or secondary identification), the patient's gender or sex, and a code indicating the relationship between the person receiving the prescription or service and the person responsible for the health coverage and/or cardholder. Additionally, there is the discretionary ability to include a group or employer identification number, which may be useful for grouping data within a specific group.
- c. Prescription Data Section, which describes the details of the specific product or service actually dispensed and billed to the Health Plan. These fields include the Date Dispensed (or Filled), the National Drug Code (NDC) in eleven digit format (5-manufacturer, 4-product, 2-package size). If the NDC is not used to identify the product, then the alternate product code qualifier and identification **MUST** be used. This area also includes an alpha description of the product or service, and fields to describe the strength, dosage form and route of administration. Numeric fields for the quantity dispensed, days supply, new and refill codes, the prescription number and drug type are also included. Formulary status can be indicated, and the dispensing pharmacy identification is included. The Pharmacy ID is represented in two fields. Field #30 represents the pharmacy's chain affiliation as coded by NCPDP and field #31 represents the individual pharmacy identification (NABP) as coded by NCPDP. Lastly, the place of service can be included if known.
- d. Payment Data Section includes provisions for the date the product or service was billed to the Health Plan. In some instances, this would also represent the date the claim was paid or would correspond to the ending date or financial period that includes the payment or charge for this specific claim. The co-pay amount represents that portion of the total claim amount paid by the member or patient, and net amount due represents the dollar amount paid by the health plan to the pharmacy. The ingredient cost field represents that portion of the total payment, which is assigned specifically to the product or service and is independent of any professional fee or tax. The member plan type as determined by the Health Plan, is included because financial budgets are often based on this value. A specific number assigned to each unique claim can be included and the payment status field indicates whether the claim has been paid, or if it is a reversal of a previously paid claim.

PHARMACY IMPLEMENTATION GUIDE (cont.)

- e. Prescriber Identification Section is included to assist the MPO in determining prescribing patterns for its participating providers. Since there are several coding schemes available, a qualifier code is included to inform the receiver what coding scheme is being used to identify the prescriber. Additionally, the provider's (prescriber's) last and first names are included for reporting purposes. The

PHARMACY IMPLEMENTATION GUIDE (cont.)

- 7 = previous spouse of cardholder
- 8 = not used
- 9 = other (not included above)

Alternate Product Code ID Qualifier:

- 00 = not defined
- 01 = Generic Product Identifier (GPI) (Medi-Span/FDB)
- 02 = American Hospital Formulary Service (AHFS)
- 03 = Generic Code Number (GCN) (First Data Bank)
- 04 = Smart Key (First Data Bank)
- 97 = other - trading partners defined
- 99 = other - not defined

Route of Administration

Use First Data Bank's Route of Administration Codes

Drug Type

- 0 = not specified
- 1 = single source brand
- 2 = branded generic
- 3 = generic
- 4 = OTC (Over-the-Counter)
- 5 = multi-source brand

Formulary Status

- Y = Yes
- N = No
- Z = Unknown or not yet classified

Place of Service:

- 00 = not specified
- 01 = home
- 02 = inter-care
- 03 = nursing care
- 04 = long-term care
- 05 = rest home
- 06 = boarding home
- 07 = skilled care facility
- 08 = sub-acute care facility
- 09 = acute-care facility
- 10 = out-patient/ambulatory
- 11 = hospice
- 99 = other – not included above

PHARMACY IMPLEMENTATION GUIDE (cont.)

Payment Status:

- 0 = paid claim
- 1 = reversal claim

Note: If payment status equals 1, then the quantity field and all currency fields should be negative.

Commercial/Senior/Government Code:

- 0 = Unknown
- 1 = Commercial
- 2 = Medicare Risk
- 3 = Senior - Other
- 4 = MediCal
- 5 = Healthy Families
- 6 = Other Government

C. FIELD USAGE:

Label Name – The brand name should be populated in this field (except for compounded drugs in which case this field will be left blank).

Net Amount Due – The formula for calculating this field is

$$\text{Net Amount Due} = \text{Ingredient Cost} + \text{Dispensing Fee} + \text{Sales Tax} - \text{Co-pay}$$

Generic Drug Name – This field should be populated with the generic equivalent (except for compounded drugs and non-drug items in which case this field will be left blank)

Pharmacy Data Standard Implementation Guide

Field #	Field Name	Field Format	Field Length	Field Location	Definition of Field Value/Comments	Status
1	Health Plan ID	A/N	10	1-10	Health Plan Identification Code	E
2	Batch Number	N	5	11-15	Assigned by Process/Sender YYDDD (Julian Date)	D
3	Run Date	N	8	16-23	Date on which file/tape/disk was created. (CCYYMMDD)	D
4	Version/Release #	N	2	24-25	CALINX Version and Release Number 10=Ver 1 Rel 0	E
5	Submission Number	N	2	26-27	00=Original Submission 01=First resubmission, etc.	D
6	Action Code	N	2	28-29	00=Original Submission (New) 02=Correction/Adjustment to a previous batch 03=Deletion of a previous batch 05=Replacement of a previous batch	E
7	Recipient ID	A/N	10	30-39	ID of group to whom data is being sent (assigned by sender)	D
8	Blank	A/N	6	40-45	Reserved for CALINX future expansion.	
9	Patient ID	A/N	18	46-63	Identification Number assigned to patient by Health Plan	E
10	Patient Last Name	A/N	15	64-78	Patient's last name	E
11	Patient First Name	A/N	12	79-90	Patient's first name	E
12	Date of Birth	N	8	91-98	Patient's Date of Birth CCYYMMDD format	E
13	Patient Gender	N	1	99-99	Patient's Gender 0=Not specified 1=Male 2=Female	E
14	Patient Relation	N	1	100-100	Patient's relationship to cardholder (insured) 0=Not specified 1=Cardholder 2=Spouse 3=Male child 4=Female child 5=Covered minor dependent of cardholder 6=Covered adult dependent (not spouse) 7=Previous spouse of cardholder 8=Not used 9=Other (not included above)	E
15	Patient Employer	A/N	15	101-115	ID code assigned to cardholder employer group (by Health Plan)	D
16	Date Rx Filled	N	8	116-123	Date the prescription was filled for service rendered (CCYYMMDD)	E

Pharmacy Data Standard Format

17	NDC	A/N	11	124-134	National Drug Code 11-digit format 5=Manufacturer 4=Product 2=Package	
18	Label Name	A/N	30	135-164	Product or Service Description - Use brand name (except for compound drugs)	E
19	Alternate Product Code ID Qualifier	N	2	165-166	Alternate Product Code ID Qualifier 00=Not defined 01=GPI 02-AHFS 03=GCN	

Pharmacy Data Standard Implementation Guide

Field #	Field Name	Field Format	Field Length	Field Location	Definition of Field Value/Comments	Status
35	Co-pay amount	D	8	284-291	Amount paid by patient \$\$\$\$ccS	E
36	Net Amount Due	D	8	292-299	Amount paid to pharmacy (net cost to plan) \$\$\$\$ccS	E
37	Ingredient Cost	D	8	300-307	Drug Ingredient Cost included in total amount due \$\$\$\$ccS	E
38	Plan Type	A/N	4	308-311	Plan Type as determined by Health Plan (Line of Business Code)	E
39	Claim Number	N	14	312-325	Unique claim identification number assigned by Health Plan	E
40	Payment Status	N	1	326-326	0=Paid 1=Reversed	E
41	Prescriber ID Qualifier	N	2	327-328	00=Not defined 01=DEA # 02=State License # 03=National Prescriber ID # 04=Tax ID # 05=SS # 06=HIN # 07=Health Plan assigned # 99=Other	E
42	Prescriber ID #	A/N	18	329-346	ID assigned to prescriber (in form defined by qualifier)	E
43	Provider Last Name	A/N	15	347-361	Last Name of prescribing provider	E
44	Provider First Name	A/N	12	362-373	First name of prescribing provider (or initial)	E
45	PCP ID # Qualifier	N	2	374-375	00=Not defined 01=DEA # 02=State License # 03=National Prescriber ID # 04=Tax ID # 05=SS # 06=HIN # 07=Health Plan assigned # 99=Other	D
46	PCP ID code	A/N	18	376-393	ID assigned to the patient's primary care provider (per #44)	D
47	PCP Last Name	A/N	15	394-408	Last Name of Primary Care Provider	D
48	PCP First Name	A/N	15	409-423	First Name of Primary Care Provider	D
49	Provider group	A/N	14	424-437	ID assigned to patient's medical group	D

Pharmacy Data Standard Format

Code	Field Name	Format	Length	Range	Description
50	PSC/DAW	A/N	1	438-438	Product Selection Code/Dispense as Written (0-9) 0=No product selection indicated 1=Substitution not allowed by prescriber 2=Substitution allowed-patient requested product dispensed 3=Substitution allowed-pharmacist selected product dispensed 4=Substitution allowed-generic drug not in stock 5=Substitution allowed-brand drug dispensed as a generic 6=Override 7=Substitution not allowed-brand drug mandated by law 8=Substitution allowed-generic drug not available in market place 9=Payor defined exemption
51	Commercial/Senior Code	A/N	1	439-439	0=Unknown 1- Commercial 2- Medicare Risk 3- Senior - Other 4- MediCal 5- Healthy Families 6- Other Government
52	Blank	A/N	30	440-469	Reserved for future expansion by CALINX
53	Filler	A/N	81	470-550	

FIELD USE	FIELD NAME	SAMPLE DATA VALUE	COMMENTS
E	Health Plan Identification	BSCA	Based on Codes published on CALINX web site (prefer letters)
D	Batch Number	99091	April 1, 1999
D	Run Date	19990401	File was created April 1, 1999
E	Version/Release #	10	CALINX Ver 1 Release 0
D	Submission Number	00	First submission of this batch
E	Action Code	00	Original submission
D	Recipient Identification	B209	XYZ Medical Group
	Blank		
E	Patient Identification	123456789	Number assigned by plan
E	Patient Last Name	JONES	Last name of patient
E	Patient First Name	MICHAEL	First name of patient
E	Date of Birth	19430305	March 5, 1943
E	Patient Gender	1	Male
E	Patient Relation	1	Cardholder
D	Patient Employer	G14217	Any employer
E	Date Prescription Filled	19990329	March 29, 1999
E	NDC	00069422030	Viagra 100 mg.
E	Label Name	VIAGRA TAB	Brand Name of drug
C	Alternate Product Code ID Qualifier	01	GPI
C	Alternate Product ID	40304070100330	Sildenafil Citrate tab 100mg.
C	Product/Service Description		Generic name of drug
C	Strength	100MG.	Strength and units
C	Dosage Form	TABS	Tablet
E	Route of Administration	OR	Oral
E	Quantity Dispensed (Decimal)	0010000b	Ten tablets
E	Days Supply	030b	30 days supply
E	New/Refill Code	00	New (first) prescription
E	Prescription Number	1234567	Prescription number
E	Drug Type	1	Brand name-single source

Pharmacy Data Standard Implementation Guide

Example Information (cont.)

FIELD USE	FIELD NAME	SAMPLE DATA VALUE	COMMENTS
D	Formulary Status	N	Non-formulary
D	Pharmacy Identification-Chain Code	00000	
D	Pharmacy Identification—Pharmacy	0058931	Talbert Cerritos Pharmacy
D	Place of Service	10	Outpatient
D	Date Billed	19990401	April 1, 1999
E	Co-pay amount	0010000b	\$100.00 (positive)
E	Net Amount Due	0000000b	Zero
E	Ingredient Cost	0008750b	\$87.50
E	Plan Type	Comm	Commercial
E	Claim Number	00123456789101	Claim Serial Number
E	Payment Status	0	Paid Claim
E	Prescriber ID Qualifier	01	DEA Number is used
E	Prescriber Identification #	AG1234563	DEA number sequence
E	Provider Last Name	GOODING	Prescriber last name
E	Provider First Name	CHARLES	Prescriber first name
D	PCP ID# Qualifier	07	Health Plan assigned code
D	PCP ID Code	F102327816	Code assigned by plan
D	PCP Last Name	Rice	Last Name of Primary Care Provider (Exclude Degree unless part of last name field)
D	PCP First Name	James	First Name of Primary Care Provider
D	Provider Group ID	B209	XYZ Medical Group
D	PSC/DAW	1	Do not substitute
E	Commercial/Senior Code	2	Medicare Risk/Senior
	Reserved	Blank	Reserved for future CALINX use (not used)
	Filler	Blank	Used for additional data specific to trading partners

FIELD #	FIELD NAME	FORMAT	LENGTH	COBOL PIC
1	Health Plan Identification	A/N	10	X(10)
2	Batch Number	N	5	9(5)
3	Run Date	N	8	9(8)
4	Version/Release #	N	2	9(2)
5	Submission Number	N	2	9(2)
6	Action Code	N	2	9(2)
7	Recipient Identification	A/N	10	X(10)
8	Blank	A/N	6	X(6)
9	Patient Identification	A/N	18	X(18)
10	Patient Last Name	A/N	15	X(15)
11	Patient First Name	A/N	12	X(15)
12	Date of Birth	N	8	9(8)
13	Patient Gender	N	1	9(1)
14	Patient Relation	N	1	9(1)
15	Patient Employer	A/N	15	X(15)
16	Date Prescription Filled	N	8	9(8)
17	NDC	A/N	11	X(11)
18	Label Name	A/N	30	X(30)
19	Alternate Product Code ID Qualifier	N	2	9(2)
20	Alternate Product ID	A/N	18	X(18)
21	Generic Name	A/N	30	X(30)
22	Strength	A/N	8	X(8)
23	Dosage Form	A/N	8	X(8)
24	Route of Administration	A/N	8	X(8)
25	Quantity Dispensed in Metric Decimal	N	7 1	9(4)V9(3) (Sign)x
26	Days Supply	N	3 1	9(3) (Sign)x
27	New/Refill Code	N	2	9(2)
28	Prescription Number	N	7	9(7)
29	Drug Type	N	1	9(1)

Pharmacy Data Standard Format with COBOL Definitions

30	Formulary Status	A/N	1	X(1)
31	Pharmacy Identification—Chain Code	A/N	5	X(5)
32	Pharmacy Identification—NABP Code	A/N	7	X(7)
33	Place of Service	A/N	2	X(2)
34	Date Billed	N	8	9(8)
35	Co-pay amount	D	7 1	
36	Net Amount Due	D	7 1	
37	Ingredient Cost	D	7 1	
38	Plan Type	A/N	4	X(4)

LABORATORY POLICY PROCEDURE FOR PLAN-PATIENT CONTACT

PURPOSE:

To establish a consistent method of communicating Health Management Programs (HMPs) to Medical Groups/IPAs, allowing the Medical Groups/IPAs the opportunity to refuse the HMP because of their own existing programs, and documenting that the Medical Groups/IPAs HMPs meet or exceed NCQA standards.

POLICY:

Health Management Programs will inform the medical directors of all Medical Groups/IPAs when a new HMP will be launched. A mailing that includes an introductory letter and program packet, which generally explains the program, will introduce the program to the medical director. The Medical Director of QI will sign the letter and the Medical Group/IPA medical directors will be referred to the health plan's Medical Director of QI if they have any questions or concerns.

If the medical group does not wish to have their HMO members enrolled in the HMP, Health Management Programs will implement a process to investigate the Medical Group/IPA's programs. The results will be presented by Health Management Program to the health plan's Medical Director of QI. He/she will analyze the results of the investigation and decide on a case-by-case basis if the medical group's patients should be pulled out of the HMP.

PROCEDURE: (see Exhibit A)

An introductory medical director letter will be sent to all Medical Group/IPA medical directors two (2) months prior to enrolling members in the health plan's HMP. The letter will give the medical director the opportunity to refuse the program within one (1) month by submitting NCQA consistent documentation of an existing HMP. Documentation should include the following:

- The process for identifying members for the program.
- The process for educating the physicians about the programs.
- The process for measuring outcomes and any outcomes already achieved.
- Program description including goals, objectives, protocols, and intervention descriptions.
- Program materials (e.g. brochures, newsletters, kits).
- List of HMO members enrolled in the program.

If the Medical Group/IPA medical director does not respond within one month, the members will be enrolled in the health plan's HMP.

If the Medical Group/IPA medical director submits documentation of an existing HMP within one (1) month of the date of the introductory letter, Health Management Programs will investigate the Medical Group/IPA's stage of program development. This will be accomplished by reviewing QMA audit results for disease management, interviewing the QMA assigned to the group, reviewing the DSM survey database, reviewing the ambulatory care special conditions reports, reviewing medical group program documentation, and interviewing a Medical Group/IPA representative. Based on the information obtained through these sources, the Medical Group/IPA's program will be categorized into one of the following stages:

- Stage 1 – Precontemplation: The medical group/IPA has no plan to implement a program in the next 6 months; they have not gathered any baseline data or identified patients.
- Stage 2 – Contemplation: The medical group/IPA is planning to implement a program in six months; they have gathered baseline data; the health plan needs to probe the extent to which the medical group/IPA has allocated resources to the program.
- Stage 3 – Planning: The medical group/IPA has a planned an implementation date within 6 months; they have completed gathering their baseline data, formulated intervention strategies, and allocated resources to the program.

LABORATORY POLICY PROCEDURE FOR PLAN-PATIENT CONTACT (cont.)

- Stage 4 – Operational: The medical group programs are implemented and outcomes are being monitored.
- Stage 5 – Maintenance: The medical group is reporting outcomes for their programs; they are conducting process evaluation and program modification.

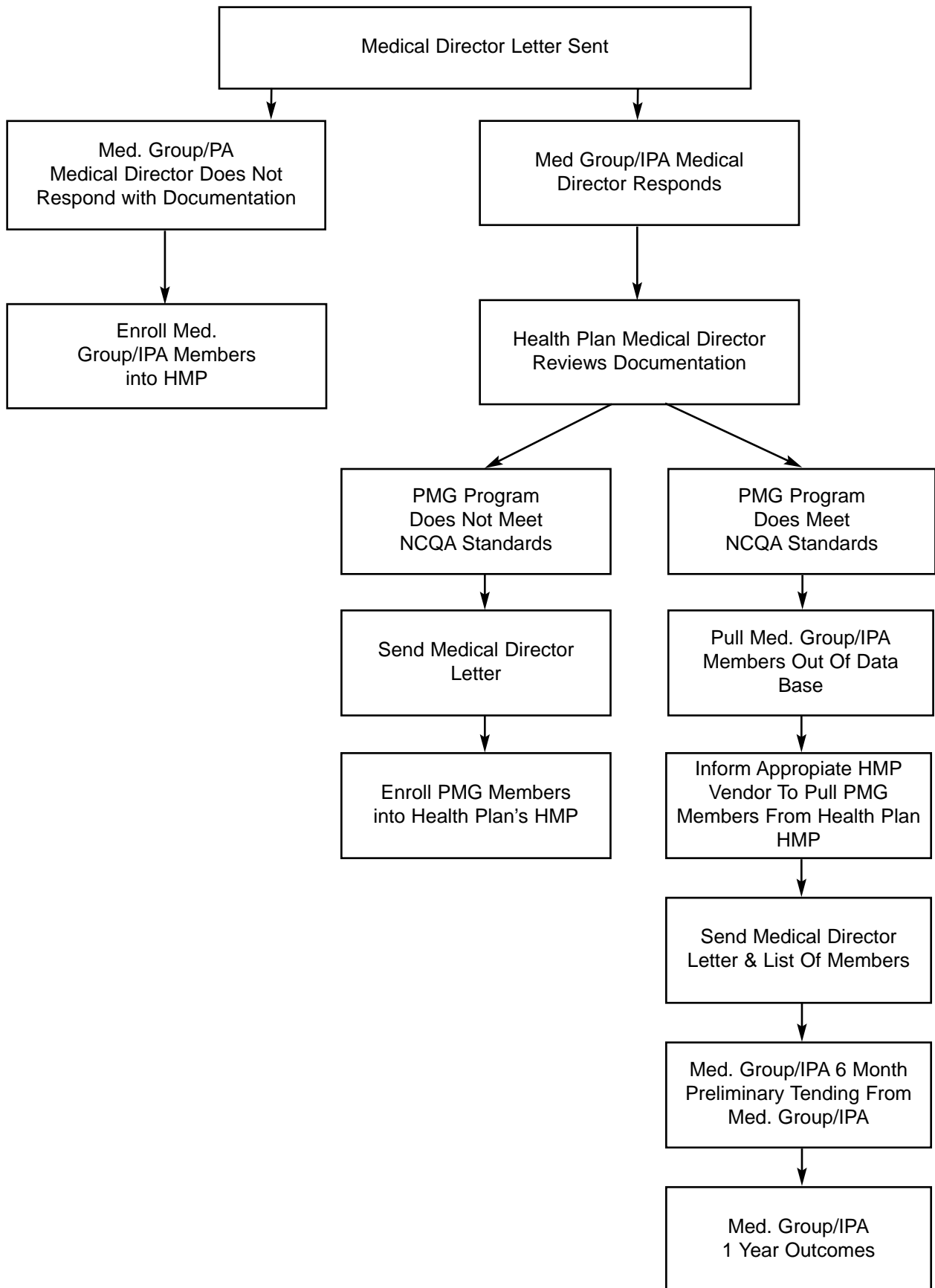
The following general guidelines will assist the Medical Director of QI in determining the best course of action after the Medical Group/IPA's program development stage has been assessed:

- Stages 1 & 2: Indicates members should remain enrolled in the health plan's program
- Stage 3: Indicates members should remain enrolled in the health plan's program and the health plan begins plans to transition members into the Medical Group/IPA's program
- Stages 4 & 5: Indicates members would be disenrolled from the health plan's program

The results of the above mentioned investigation will be presented to the health plan's Medical Director of QI, who will review all documentation and health plan reporting for the Medical Group/IPA.

- If the Medical Director of QI determines the Medical Group/IPA's programs are NCQA consistent, Health Management Programs will disenroll the Medical Group/IPA's HMO members from the health plan's program. A letter with a list of those members will be sent to the Medical Group/IPA medical director. The health plan will require preliminary trending data in 6 months and outcomes data in 1 year, which will be included in the health plan's NCQA reports.
- If the Medical Director of QI determines the Medical Group/IPA's programs are not NCQA consistent, the Medical Group/IPA medical director will receive a letter informing him/her that the Medical Group/IPA's members will be enrolled in the health plan's HMP. The Medical Group/IPA medical director will be invited to call the health plan Medical Director.

EXHIBIT A-PMG DSM REFUSAL ALGORITHM



Resources

CALINX <http://www.calinx.org>

U.S. Government Healthcare Sites

DEPARTMENT/ORGANIZATION	WEBSITE ADDRESS
Department of Health and Human Services	http://www.hhs.gov
Health Care Financing Administration	http://www.hcfa.gov
National Committee on Vital and Health Statistics	http://ncvhs.hhs.gov
National Health Information Center	http://nhic-nt.health.org
Centers for Disease Control	http://www.cdc.gov
National Institutes of Health	http://www.nih.gov
IOM-Institute of Medicine (National Academy of Sciences)	http://www.nas.edu
Agency for Health Care Policy and Research	http://www.ahcpr.gov
Bureau of Primary Healthcare	http://www.bphc.hrsa.dhhs.gov
National Library of Medicine	http://www.nlm.nih.gov
Internet Grateful Medicine	http://igm.nlm.nih.gov
Central Office on ICD-9-CM	http://www.ICD-9-CM.org

Resources For Health News

NEWS ORGANIZATION	WEBSITE ADDRESS
California Healthline (California HealthCare Foundation)(registration required)	http://news.chcf.org/members/
American Healthline	http://www.cloakroom.com
NY Times Your Health	http://www.yourhealthdaily.com
CNN - Health News	http://cnn.com/HEALTH/
Modern Healthcare	http://www.modernhealthcare.com
PR Newswire on Healthcare	http://www.prnewswire.com

Healthcare Standards and HIPAA On-line

DESCRIPTION

WEBSITE ADDRESS

Department of Health and Human Services web site with information dealing with the administrative simplification provisions of HIPAA of 1996. This site contains general information about the administrative simplification portion of HIPAA, an explanation of the Notice of Proposed rulemaking (NPRM) process, updates on when HIPAA standards may be implemented, and presentations made by parties regarding HIPAA.

<http://aspe.os.dhhs.gov/admnsimp>

National Council for Prescription Drug Programs web site. Contains information on how to order the implementation guide and other documentation for the proposed retail drug claim standard: Telecommunications Standard Format Version 3.2 and its batch equivalent. Site contains membership information, meeting minutes, and dates for upcoming conferences.

<http://www.ncpd.org>

Washington Publishing Company web site. Contains all the implementation guides, data conditions, and the data dictionary (except for retail pharmacy) for X12N standards being proposed under HIPAA of 1996.

<http://www.wpc-edi.com>

American National Standards Institute web site that allows one to download ANSI documents. You may download a copy of ANSI Procedures for the Development and Coordination of American National Standards, or a copy of ANSI Appeals Process.

http://www.ansi.org/docs/kiosk_a.htm

Department of Health and Human Services Data Council web site. This site includes information on the purpose of the Data Council, membership information, and meeting minutes.

<http://aspe.os.dhhs.gov/datacncl>

Data Interchange Standards Association web site. This site contains information on ASC X12, information on X12N subcommittees, task groups, and workgroups, including their meeting minutes. This site will contain the test conditions and results of HIPAA.

<http://www.disa.org>

National Uniform Billing Committee web site. This site contains NUBC meeting minutes activities, materials, and deliberations.

<http://www.nubc.org>

National Uniform Claims Committee web

<http://www>

The managed care industry provides health care services to a majority of Californians. Despite tremendous growth and many successes, the industry now faces significant dissatisfaction among all its constituents: consumers, purchasers, health plans, and health care providers. One of the underlying causes of the profound frustration is inaccurate and delayed exchange of health information. CALINX specifically addresses this problem.

“The value of CALINX to Blue Cross of California has been to strengthen the collaborative effort within the health care industry to improve service throughout California. The CALINX agreements to standardize data transmission creates a base line to assure information is exchanged accurately, completely and securely.”

— Ron Williams, President & CEO, Blue Cross of California

CALINX Oversight Group

Bruce Bodaken

President & COO, Blue Shield of California

Peter Lee, JD

Executive Director, Center for Health Care Rights

Jack Lewin, MD

Executive Vice President and CEO,
California Medical Association

Robert Margolis, MD

California Association of Provider Organizations

Nancy Oswald, PhD

President, National IPA Coalition

George Perlstein, MD

American Medical Group Association

Patricia E. Powers

President & CEO, PBGH

Bruce Spurlock, MD

Executive Vice President
California Healthcare Association

Ron Williams

President & CEO, Blue Cross of California

Walter Zelman

President & CEO, California Association of Health Plans

Partner Organizations

Pacific Business Group on Health (PBGH)

221 Main Street, Suite 1500 • San Francisco CA 94105
(415) 281-8660 Tel • (415) 281-0960 Fax

National IPA Coalition (NIPAC)

1999 Harrison Street, Suite 2750 • Oakland, CA 94612
(510) 267-1999 Tel • (510) 267-8988 Fax

California Association of Health Plans (CAHP)

1201 K Street, Suite 750 • Sacramento, CA 95814
(916) 552-2910 Tel • (916) 443-1037 Fax

American Medical Group Association (AMGA)

1422 Duke Street • Alexandria, VA 22314
(703) 838-0033 Tel • (703) 548-1890 Fax

California Medical Association (CMA)

221 Main St., 3rd Floor • PO Box 7690
San Francisco, CA 94105
(415) 541-0900 Tel (415) 882-3349 Fax

California Healthcare Association (CHA)

1215 K Street, Suite 800
Sacramento, CA 95812
(916) 443-7401 Tel (916) 552-7596 Fax