Third Party Administration Project

Contract Medical Database (CMD) Interface

Table of Contents

1 General Information

Title: (40 Character MAX)	Interface #9: TPA-to-CMD
Short description:	Transfer of completed, processed claims from TPA to CCHCS for loading into a reporting database
Process Definition Document (PDD) Legend # / Item #	
BIS Project Phase	☐ Phase 1A ☐ Phase 1B ☒ Phase 1C ☐ Phase 2
Business Team:	
Priority:	☒ High/mandatory ☐ Medium/recommended ☐ Low/optional
Module /Submodule Information	Module: Submodule:
Complexity:	☒ High ☐ Medium ☐ Low
Is there an alternative in the standard system?	☐ Yes ☒ No
Description of alternative:	TPA stores processed claims data until CMD interface is ready.
Reasons why alternative is not acceptable:	☐ Performance problems ☐ Complexity ☐ Other (Specify) :
SAP Transaction code:	
Interface Type	☒ Batch *(one-way transfer of accumulated data)* ☐ Near Real-Time *(one-way message-based transfer of data)* ☐ Real Time *(Immediate transfer of small data set)* ☐ Excel Upload *(manually invoked from SAP session)* ☐ Other (Specify) :
Interface Frequency	☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐ On-demand ☒ Other (Specify) : Mondays and Wednesdays
Type of Records Sent	☐ Full record load *(sends all records every time interface is executed)* ☒ Delta full records *(Only sends records that have changed since previous execution)* ☐ Other (Specify) :
Volume Estimate (per interface frequency)	Average Volume: 8,000 claims/file Peak Volume: 250,000 claims/file
Source System:	TPA
Target System:	CCHCS database tables
Direction	Inbound to SAP: N/A Outbound from SAP: N/A

2 Business Needs & Requirements

CCHCS is contracting with a Third Party Administrator (TPA) to adjudicate specialty medical services claims. TPA will process claims for submission to CDCR's accounting system-of-record, BIS (Interface in the diagram below). BIS will format the claims into claim schedules to be electronically submitted to the State Controller's Office (SCO) for payment to vendors (Interface). Once SCO issues the warrants, information about the payment is transferred to BIS (Interface) and from BIS back to TPA (Interface).

TPA provides a data feed of processed and denied claims. Due to the difficulty of matching the data to CMD requirements, it was decided to download the TPA data into a separate set of tables and allow CCHCS Invoice Processing to query the data using SQL tools. Data will not actually be input into CMD. CCHCS receives the data file and processes the data into these tables.

In February 2010, two additional data sources were added as part of this overall interface:

- BIS Master Vendor data file, and
- TPA Provider data file.

BIS Vendor Master File
CCHCS downloads the same update file sent from BIS to the TPA via Secure FTP using the EIS FTP site. This file is a full update of medical vendors contained in BIS. It includes additions and deletions from the active vendor list (deleted records are marked as inactive rather than actually deleted).

The specifications for this file are defined in Interface, "BIS Vendor Master Records to TPA".

TPA Provider File
The decision was made to not load the data into CMD, it is no longer a requirement to synchronize provider data between CMD and the TPA. Instead, the TPA's Provider data will be downloaded on a regular basis to CCHCS.

A significant update to the interface (referred to as "Phase 2") began in August 2010. Phase 2 addressed requirements discovered since the original interface and maintained a common interface format with the Health Care Provider Network project. The Phase 2 specifications were documented in previous version 10.0 and included addition of new supporting interfaces; Validation Error File and Procedure and Diagnostic Code Descriptions defined below.

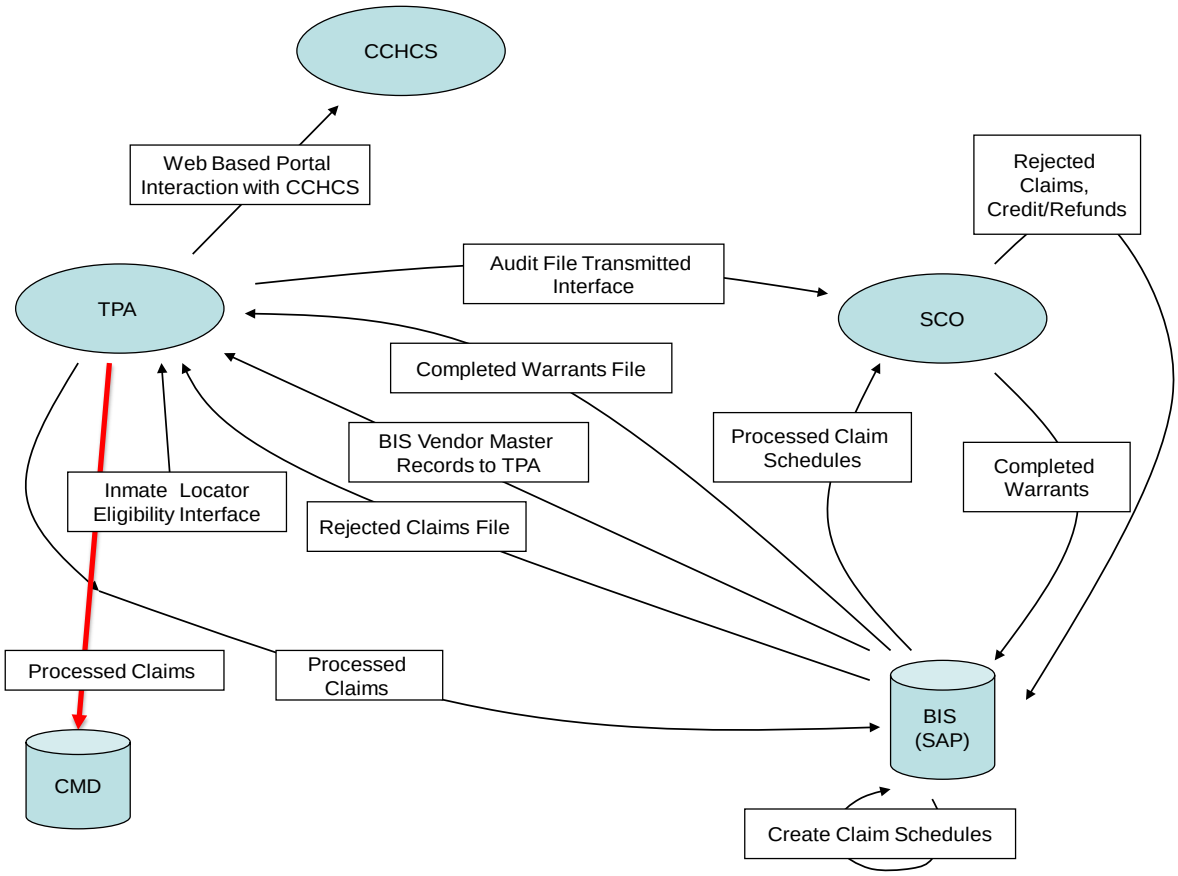
Validation Error File
After CCHCS loads data from the TPA and completes validation, CCHCS sends back to the TPA a listing of claims that failed validation. TPA is expected to address the errors and re-transmit the updated claims.

Procedure and Diagnostic Code Descriptions
CCHCS Healthcare Invoice, Data and Provider Services Branch (HIDPSB) wanted descriptions added to the output file for the procedure and diagnostic codes. The team decided the TPA

would transmit a file of these codes and their descriptions which would be used during the validation process to add the descriptions into the output file.

“Phase 3” was defined in July of 2011 supports additional requirements raised by the Prison Health Care Provider Network (PHCPN). The Phase 3 specifications were documented in version 11.0. All of the changes in Phase 3 were isolated to the TPA Claim Input File and the Process Output Tables.

Phase 4 defined in March of 2013, added additional fields related to conversion from ANSI X-12 4010 to ANSI X-12 5010. These changes were isolated to TPA Claim Input File and the Process Output Tables. These changes are documented in version 12.0 of this document. As of March 2013, CCHCS is using version 11.0.1 (See pages 31-37) of the TPA Input File.



TPA Interface Descriptions:

- Inmate Locator Eligibility Interface
  Interface with CDCR Inmate Locator for automated claim eligibility determinations.
- Processed Claims Interface
  Interface with CDCR Accounting for transmission of adjudicated claims to be processed for payment.
- Audit File Interface
  TPA interfaces with California State Controller's Office (SCO) transmitting specific claim file information for SCO pre-payment auditing purposes.
- BIS Vendor Master Records to TPA
  File transmission of CDCR's medical vendor demographic information from the Accounting office.
- Claim Schedule Creation
  Accounting office generates the electronic claim schedules and paper Std218 for claims received by TPA to be transmitted to SCO for payment.
- Rejected Claims File
  Submitted claims which are rejected by the Accounting office are transmitted to TPA for research, correction and resubmission.
- Processed Claim Schedules
  Processed Claim Schedules transmitted in paper with "wet signatures" to SCO for processing.

- SCO Completed Warrants Transmission
  SCO transmits paid claim information with Warrant/payment information to CDCR Accounting.
- Accounting Completed Warrants Transmission
  Accounting transmits Warrant/payment information to TPA.
- Web Based Portal Interaction with CCHCS
  Web based portals with CDCR for claim reviews, credit/refund requests, and suspended claims.
- Rejected Claims, Credit/Refunds
  SCO communicates to CDCR's Accounting rejected claim batches, questions and/or corrections needed.
- Completed/Processed Claims Data Transfer
  TPA transmits finalized processed claims information to CCHCS.

3 Starting Condition / Dependencies

1. TPA has fully processed claims data to transmit. The data includes warrant ID received from SCO via BIS.
2. TPA may also have denied, duplicate or rejected claims to be transmitted.
3. Provider data will be transmitted on a regular basis from TPA to CCHCS via SFTP. The file will be transmitted twice a week.

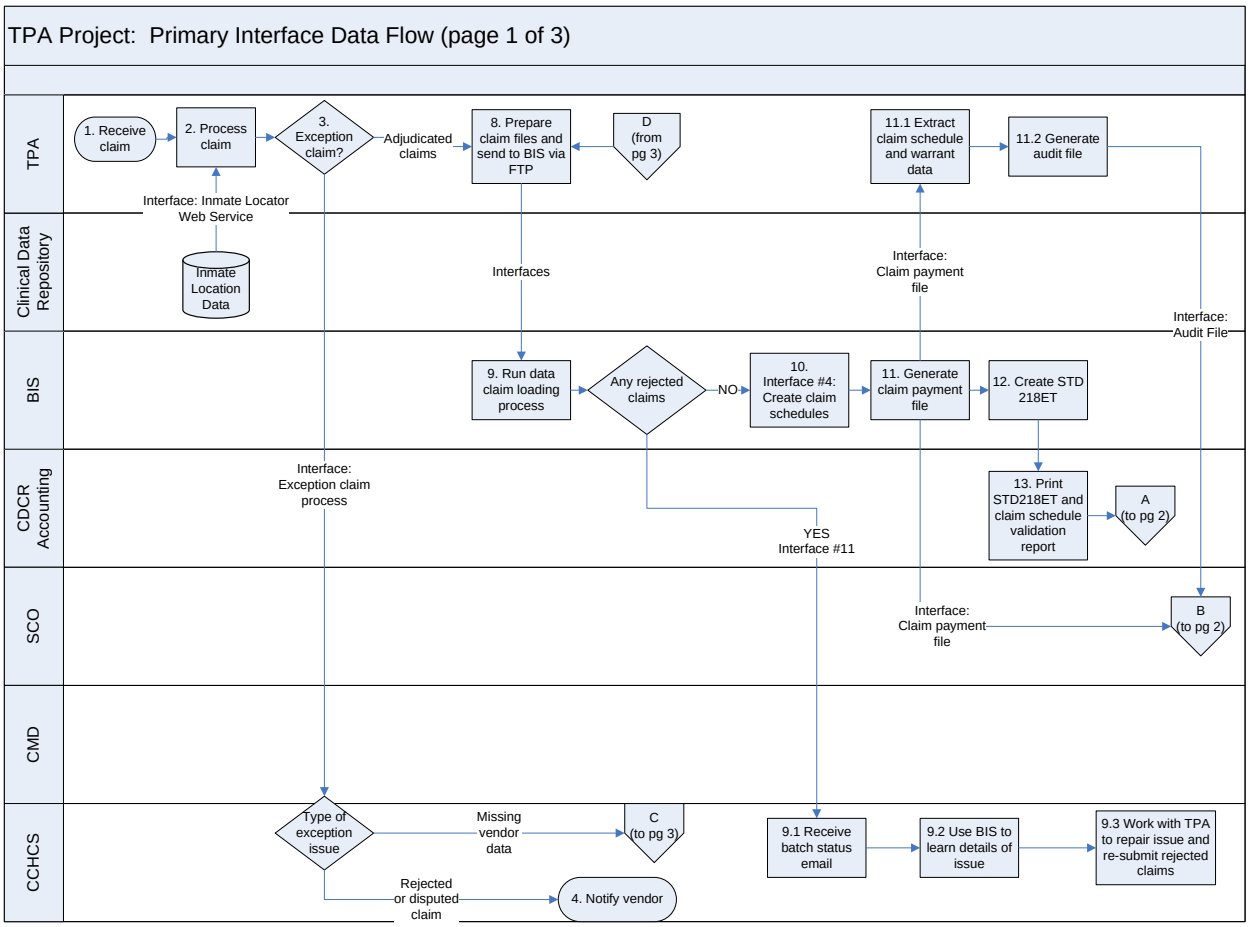
4 Assumptions

1. This interface will not include:
   a. Claims still being processed by the TPA.
   b. Exception claims returned to CCHCS from TPA. Those will be added into this interface once CCHCS resolves the exception and TPA is able to complete processing.
   c. Claims rejected on loading into BIS. When this occurs, TPA will need to resolve the issue so that the claim can be entered into BIS.
2. The file format includes fields to denote records to be entered as credits. As of the writing of these specifications the business process to process credits and refunds has not been determined. These specifications are attempting to provide the capability to process refunds once the business process is defined.
3. This interface data file will be pushed from the TPA to the CCHCS FTP site once per day.
4. This process uses Secure FTP capability provided by CDCR's EIS Branch until the CCHCS Secure FTP capability is ready.
5. CCHCS's installation of Oracle Fusion middleware, located in the Verizon Torrance Data Center, is available to support this process to pick up the daily data file from the FTP site, transform it as required and load it. The extent, to which this middleware is used versus performing the data transformations at the database level, is a design decision. .

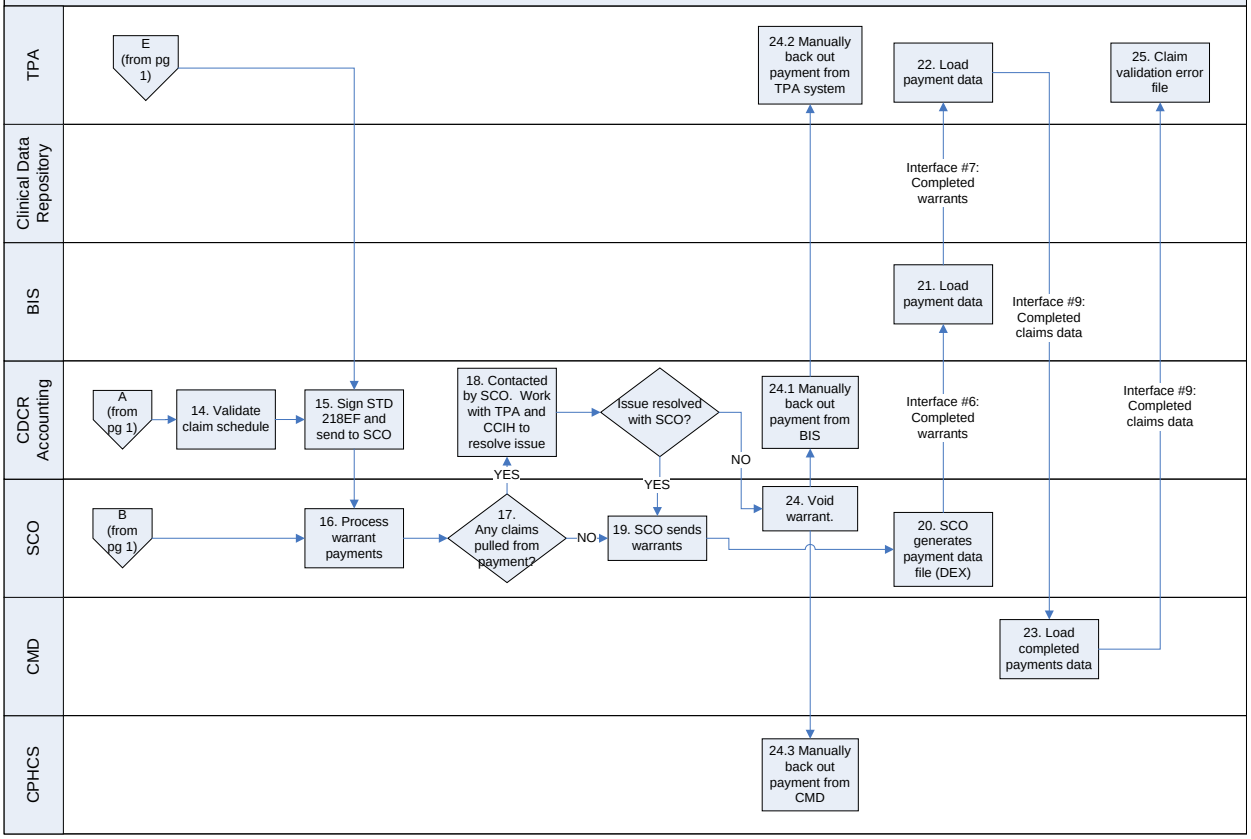
6. CCHCS middleware and CCHCS FTP sites will not be used as long-term storage for the data files. The CCHCS FTP site will retain only the last 30 days of files. Long term storage of processed claims data files by CCHCS is not yet resolved.
7. The Provider data file will be a full listing of all of the Providers.

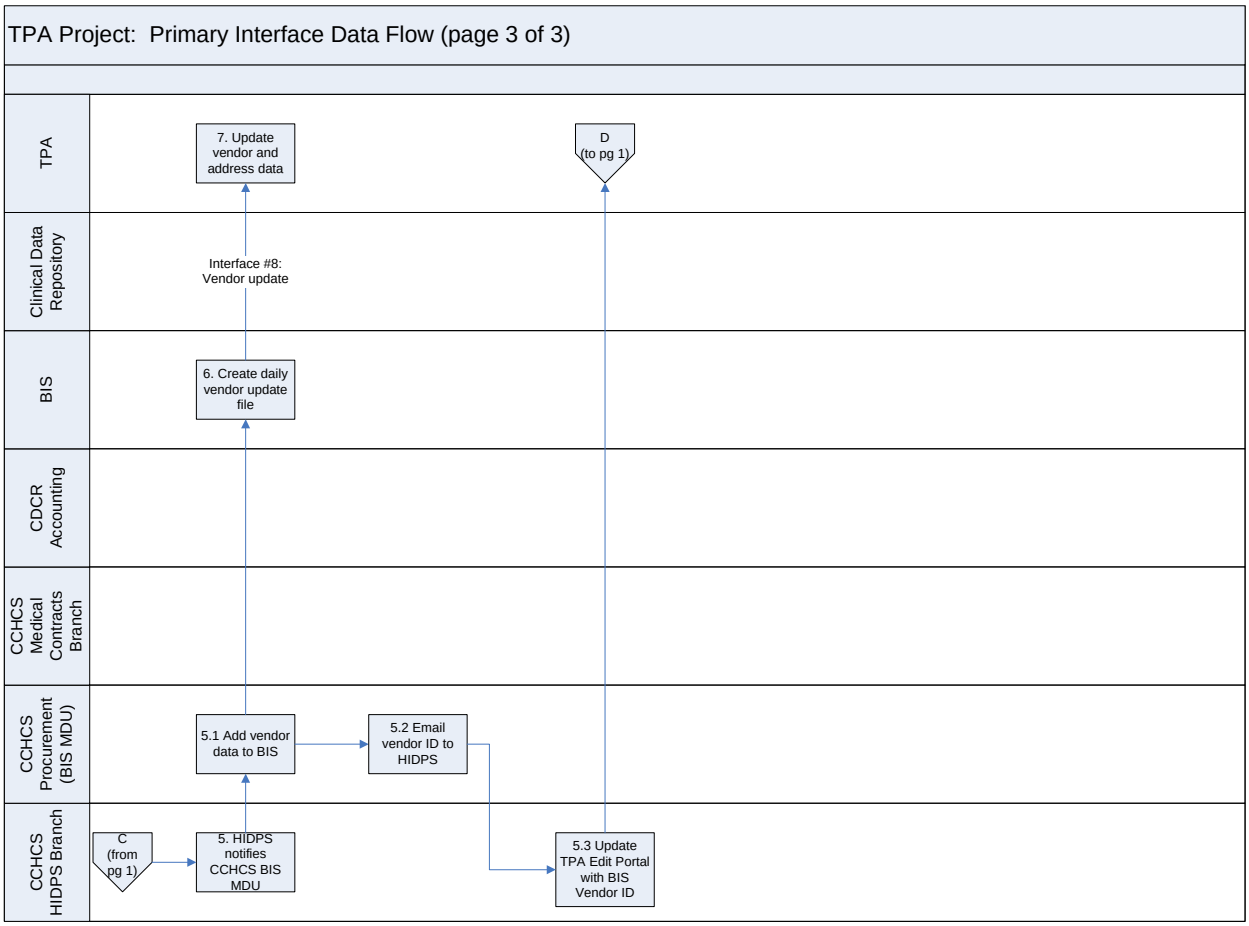
5 Process Flow Diagram

The following diagrams show the overall data flows for claims processed by the TPA. The CMD interface can be found on the second diagram (labelled "page 2 of 3") in steps #22, #23, and #25. Detailed description of the CMD interface business process is described in the next section.



TPA Project: Primary Interface Data Flow (page 2 of 3)



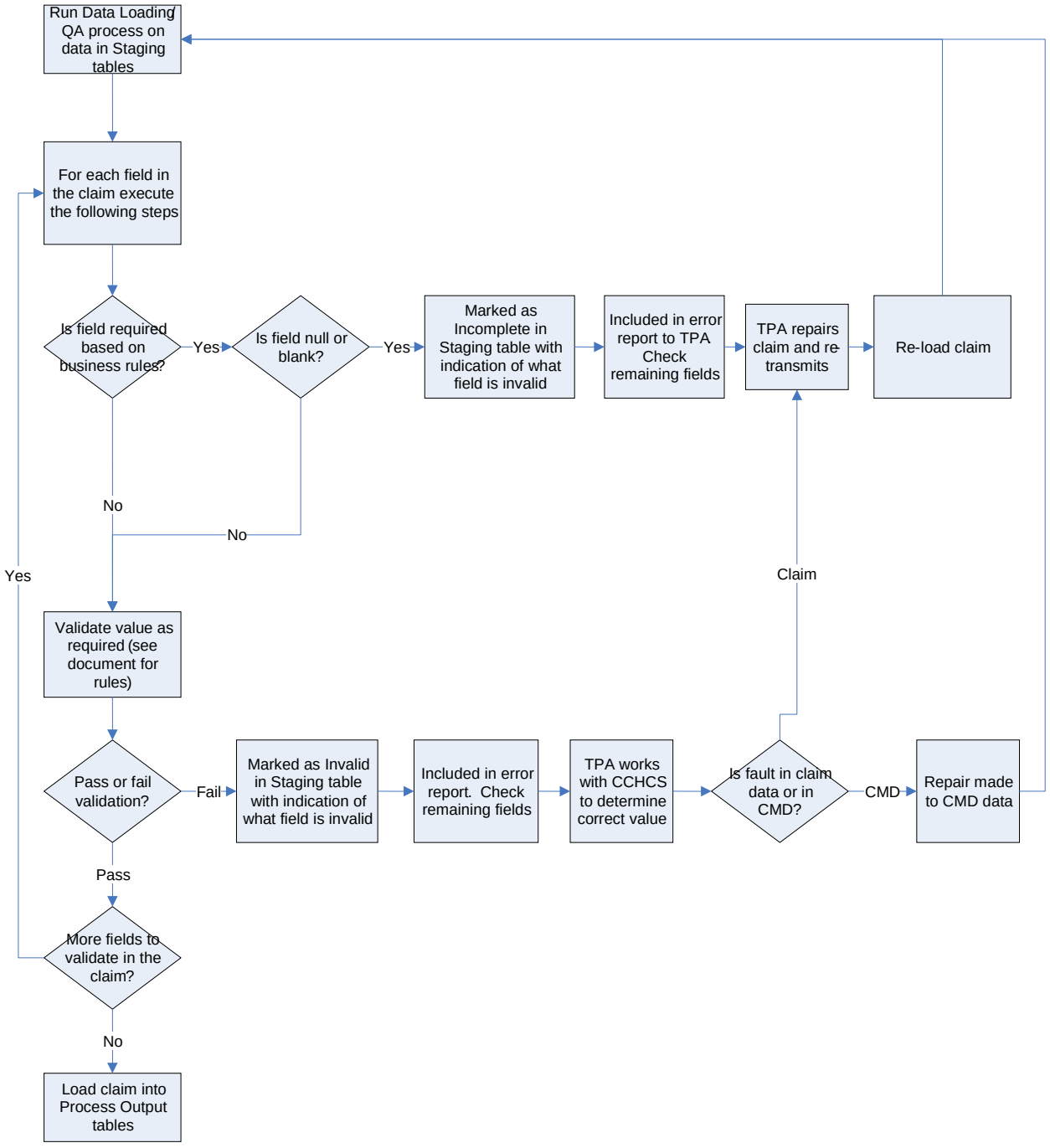

TPA Project: Primary Interface Data Flow (page 3 of 3)
TPA
Clinical Data Repository
BIS
CDCR Accounting
CCHCS Medical Contracts Branch
CCHCS Procurement (BIS MDU)
CCHCS HIDPS Branch
7. Update vendor and address data
D (to pg 1)
Interface #8: Vendor update
6. Create daily vendor update file
5.1 Add vendor data to BIS
5.2 Email vendor ID to HIDPS
C (from pg 1)
5. HIDPS notifies CCHCS BIS MDU
5.3 Update TPA Edit Portal with BIS Vendor ID

6 Detailed Processing Logic & Business Rules

1. TPA generates file of claims to be transmitted to CCHCS.
    a. File contains only those claims processed since the last file was generated.
    b. File may contain the following types of claims:
        i. Completed, processed claims which will include warrant ID and payment date received from SCO via BIS.
        ii. Claims rejected by TPA and not sent to BIS usually because they are duplicates.
        iii. Denied claims determined by TPA to be No Pays
2. Twice per calendar week TPA transmits file to CCHCS FTP site.
    a. CCHCS middleware picks up the daily file and loads it into staging tables. Validation of the data is limited to confirming fields required all the time are populated and data matches format requirements.
    b. See section 7.1 for TPA input file specification.
3. After loading into the staging tables, the following data transformations will be performed:
    a. Derivation of Fiscal Review Code
        i. Check Bill Code to derive Fiscal Review Code. See section 6.1.1.
        ii. If checking Bill Code does not determine Fiscal Review Code, determine Fiscal Review Code based on Place of Service and other data available in the input file. See Section 6.1.2
    b. Extract AOC code from BIS General Ledger code. See Section 6.2
    c. Query for Admit Number from CADDIS and generate default value if query does not return value. See Section 6.3
4. Once the data transformations are completed, detailed field validation can be performed. The data transformations must be done first as some validations are dependent upon the transformations. See Section 6.4.
5. The flow chart in Figure 1 below describes how validation errors will be handled.
6. All data is loaded into the Process Output tables and marked whether it passed validation or not. Process Output tables are defined in Section 7.4.1 and 7.4.2. If a claim fails validation it is still loaded into the Process Output files. If the TPA later updates the data for this or any other claim, the updated data is added to the Process Output tables. The Process Output tables will retain all versions of a claim. Reports that depend on the most recent version of a claim will rely on a database view that filters the list of claims down only the current version.
7. Following completion of the validation and loading into the Process Output tables, an error file listing the header records of claims that failed validation and need data repair by the TPA is transmitted from CCHCS to the TPA. This file is defined in Section 7.4.3

8. The TPA also provides copies of two data sets used by CCHCS to support the validation process and reporting:
    a. The Provider data input file specifications are listed in Section 7.2. This is sent at least weekly by the TPA.
    b. Procedure and Diagnostic Code Description file specifications are listed in Section 7.3. This is an industry standard listing of codes and their descriptions. CCHCS chooses to receive this data from the TPA to avoid discrepancies in the data between TPA and CCHCS. The TPA is expected to provide updated versions of this file when changes occur.

Figure 1 - Data Validation Process Flow Chart



6.1 Deriving Fiscal Review Code (FRC)

Deriving Fiscal Review Code is done in two parts:

1. Check the Bill Code and other parameters on the claim that may determine Fiscal Review Code directly. For example, certain Bill Codes directly map to a Fiscal Review Code. See section 6.1.1
2. If Fiscal Review Code is not determined from logic in Section 6.1.1, then follow the logic in section 6.1.2 to determine Fiscal Review Code based on Place of Service.

The table below lists all possible Fiscal Review Codes (FRC). Not all codes will be used in this interface. The table is provided for informational purposes.

Fiscal Review Code	Fiscal Review Description
1A	Ambulance Inpatient
1H	Community Hospital Inpatient
1P	Physician Inpatient
2A	Ambulance Outpatient
2H	Community Hospital Outpatient
2P	Physician Outpatient
3A	Ambulance (non-hospital)
3MC	Medical Community (non-hosp)
3MI	Medical In-House
3PC	Psych Community (non-hosp)
3PI	Psych In-House
4	Laboratory/Radiology (non-hosp)
6	Misc. Contracts
HCA	High Cost Ambulance
HCH	High Cost Hospital
HCP	High Cost Physician
A	Ambulance Note that this is a general category of Ambulance claim created for this interface because the TPA cannot distinguish Inpatient, Outpatient or Non-Hospital ambulance claims. This is not an official Fiscal Review Code.

6.1.1 Derive Fiscal Review Code Directly from Data

1. If the claim contains any claim lines where CPT_HCPCS Procedure Modifier 1 field = 'GT' then Fiscal Review Code = 3MI.

   If the Fiscal Review Code is determined from this rule, then skip the rest of Section 6.1.1 and skip Section 6.1.2.

2. If the claim header contains one of the following Bill Codes, then read the header-level Fiscal Review Code from the following table.

Bill code	Fiscal Review code
110	1H
111	1H
112	1H
113	1H
114	1H
115	1H
117	1H
118	1H
130	2H
131	2H
132	2H
133	2H
135	2H
137	2H
141	2H
145	2H
147	2H
211	1H
212	1H
213	1H
214	1H
731	3MC

If the Fiscal Review Code is determined from this table, then skip the rest of Section 6.1.1 and skip Section 6.1.2.

3. If the Bill Code and Provider Type meets any of the following conditions then read the header-level Fiscal Review code from the following table:

If Bill Code equals	And Provider Type	Then Fiscal Review Code is
831	= 49000	2H
831	<> 49000	3MC
832	= 49000	2H
832	<> 49000	3MC
837	= 49000	2H
837	<> 49000	3MC
721	<> 49000	4
721	= 49000	2H

If the Fiscal Review Code is determined from this table, then skip the rest of Section 6.1.1 and skip Section 6.1.2.

4. If the Provider Type meets any of the following conditions then read the header-level Fiscal Review Code from the following table:

Provider Type	Fiscal Review code
65000	A
66000	A

If the Fiscal Review Code is determined from this table, then skip the rest of Section 6.1.1 and skip Section 6.1.2.

6.1.2 Determining Fiscal Review Code from Place of Service

The table below shows how to determine the Fiscal Review Code based on input values, primarily Place of Service code. The input file contains Place of Service in the Line Item Detail record. Fiscal Review Code should be evaluated for each Line Item Detail record associated to a claim and where Procedure Paid <> 0 according to the following table:

	Output: Fiscal Review Code								
Input: Place of Service (POS)	**Invalid.**	**A**	**1H**	**1P**	**2H**	**2P**	**3MC**	**3MI**	**4**
01	X								
02	X								
03	X								
04	X								
05	X								
06	X								
07	X								
08	X								
09								X	
10	X								
11							If CPT_HCPCS Procedure Modifier 1 field <> 'GT' or is blank	If CPT_HCPCS Procedure Modifier 1 field = 'GT'	

	Output: Fiscal Review Code								
Input: Place of Service (POS)	**Invalid.**	**A**	**1H**	**1P**	**2H**	**2P**	**3MC**	**3MI**	**4**
12								X	
13	X								
14	X								
15									X
16	X								
17	X								
18	X								
19	X								
20							X		
21			If Bill Code is <> 0	If Bill Code = 0					
22					If Bill Code is <> 0	If Bill Code = 0			
23					If Bill Code is <> 0	If Bill Code = 0			
24							X		
25	X								
26	X								
27	X								
28	X								
29	X								
30	X								
31			If Bill Code is <> 0	If Bill Code = 0					
32			If Bill Code is <> 0	If Bill Code = 0					
33								X	
34	If Institution <> CMF or is blank							If Institution = CMF	
35	X								
36	X								
37	X								
38	X								

	Output: Fiscal Review Code								
Input: Place of Service (POS)	**Invalid.**	**A**	**1H**	**1P**	**2H**	**2P**	**3MC**	**3MI**	**4**
39	X								
40	X								
41		X							
42		X							
43	X								
44	X								
45	X								
46	X								
47	X								
48	X								
49							If CPT_HCPCS Procedure Modifier 1 field <> 'GT' or is blank	If CPT_HCPCS Procedure Modifier 1 field = 'GT'	
50							If CPT_HCPCS Procedure Modifier 1 field <> 'GT' or is blank	If CPT_HCPCS Procedure Modifier 1 field = 'GT'	
51			If Bill Code is <> 0	If Bill Code = 0					
52	x								
53	x								
54			If Bill Code is <> 0	If Bill Code = 0					
55	If Institution is blank or (<> SATF and Institution <> CRC)							If Institution = SATF or CRC	
56	x								
57	x								
58	X								
59	X								
60	X								

	Output: Fiscal Review Code								
Input: Place of Service (POS)	**Invalid.**	**A**	**1H**	**1P**	**2H**	**2P**	**3MC**	**3MI**	**4**
61			If Bill Code is <> 0	If Bill Code = 0					
62							X		
63	X								
64	X								
65									X
66	X								
67	X								
68	X								
69	X								
70	X								
71							If CPT_HCPCS Procedure Modifier 1 field <> 'GT' or is blank	If CPT_HCPCS Procedure Modifier 1 field = 'GT'	
72							If CPT_HCPCS Procedure Modifier 1 field <> 'GT' or is blank	If CPT_HCPCS Procedure Modifier 1 field = 'GT'	
73	X								
74	X								
75	X								
76	X								
77	X								
78	X								
79	X								
80	X								
81									X
82	X								
83	X								
84	X								
85	X								

Input: Place of Service (POS)	Output: Fiscal Review Code								
	Invalid.	A	1H	1P	2H	2P	3MC	3MI	4
86	X								
87	X								
88	X								
89	X								
90	X								
91	X								
92	X								
93	X								
94	X								
95	X								
96	X								
97	X								
98	X								
99	X								

If two different Fiscal Review Codes are derived from a single claim, the single Fiscal Review Code for the overall claim is determined from the following table.

Fiscal Review Description	Fiscal Review Code	Ambulance	Comm Hosp Inpatient	Phys Inpatient	Comm Hosp Outpatient	Phys Outpatient	Med Comm (non-hosp)	Medical In-House	Psych Comm (non-hosp)	Psych (in-house)	Lab/Radiology	Misc Contracts
		A	1H	1P	2H	2P	3MC	3MI	3PC	3PI	4	6
Ambulance	A	A	X	X	X	X	X	X	X	X	X	A
Community Hospital Inpatient	1H		1H	X	1H	X	1H	X	1H	X	1H	1H
Physician Inpatient	1P			1P	X	1P	X	X	X	X	X	1P
Community Hospital Outpatient	2H				2H	X	2H	X	2H	X	X	2H
Physician Outpatient	2P					2P	X	X	X	X	X	2P
Medical Community (non-hosp)	3MC						3MC	X	X	X	X	3MC

Fiscal Review Description	Fiscal Review Code	Ambulance	Comm Hosp Inpatient	Phys Inpatient	Comm Hosp Outpatient	Phys Outpatient	Med Comm (non-hosp)	Medical In-House	Psych Comm (non-hosp)	Psych (in-house)	Lab/Radiology	Misc Contracts
		A	1H	1P	2H	2P	3MC	3MI	3PC	3PI	4	6
Medical In-House	3MI							3MI	X	X	X	3MI
Psych Community (non-hosp)	3PC								3PC	X	X	3PC
Psych In-House	3PI									3PI	X	3PI
Laboratory/Radiology (non-hosp)	4										4	4
Misc. Contracts	6											6

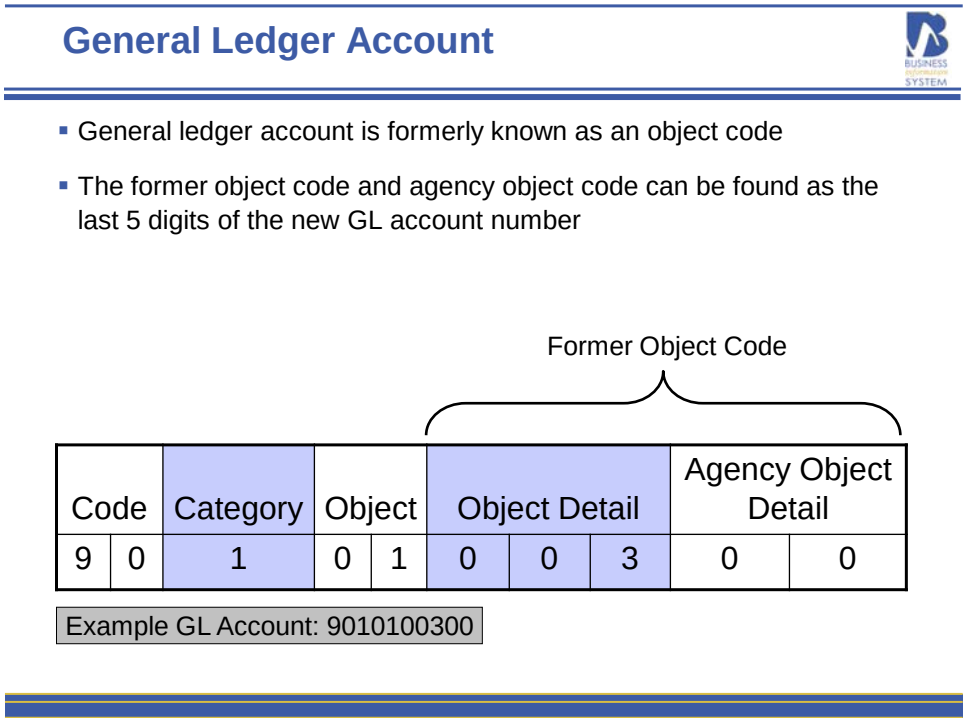
A result of "X" in the table above should not occur. If it does, the claim should be marked as invalid.

It is possible that a claim could result in more than two Fiscal Review Codes being identified. Examination of claim data processed by the TPA shows no occurrence of this situation but it is possible. If a claim contains more than two Fiscal Review Codes then the claim should be marked as invalid.

6.2 Extracting AOC from BIS General Ledger Code

In SAP (BIS), the old AOC codes were replaced with General Ledger (GL) codes. The old AOC code is the last five characters of the GL code. The slide shown in Figure 2 below explains this.

Figure 2 - Derivation of AOC Code



When storing the extracted AOC code in the Process Output tables, put a period between the three digit Object Detail and the two-digit Agency Object Detail. So a GL of 9010141310 would translate into an AOC of 413.10.

6.3 Admit Number

Admit Number actually comes from CCHCS' CADDIS system. It is a unique number assigned to an inmate's episode of care at a hospital. It is used to group together all the separate claims (physician, hospital, ambulance) associated to that episode of care.

Admit Number is included in the incoming file from TPA. At this point we do not expect the field to be populated. It is included for future use if we are able to provide this data to TPA early in their processing of claims. Since we are not expecting TPA to populate it, we will populate it for the output file as follows:

If the claim is for an inpatient service (Fiscal Review Code = 1P or 1H), then:

1. Query Statewide CADDIS database for Admit Number based on CDCR ID and where Begin Service Date is greater than or equal to CADDIS Admit Date (AdmDt) AND less than or equal to CADDIS Discharge Date (DischDt). For this query use the Begin Service Date from the Header record of the input file.

2. If multiple values are returned from CADDIS, then insert the Admit Number with the higher numerical value. Note: to fully account for this situation the rule should also check for match on the this is a compromise business rule until the Hospital Code value
3. If no value returned from CADDIS then insert default value with following format using the Begin Service Date from the Header record of the input file: "X" + CDCR ID + Begin Service Date, where Begin Service Date is in YYYYMMDD format.

If claim is for Outpatient service (2H, 2P, 3MC, 3MI, 3PC, 3PI, 4, or 6), then leave the Admit Number field blank.

6.4 Fiscal Year

CCHCS Invoice Processing Branch has requested addition of the Fiscal Year field into the header record. While fiscal year can be readily derived from the Begin Service Date field during reports, Fiscal Year is a field frequently used to group and filter results. Rather than forcing every report that needs this field to derive it, they have requested it be added to the output table by the data loading/validation process as a convenience to speed report generation.

Business rules for deriving the fiscal year:

1. Fiscal year is always based on where the End Service Date falls relative to the start and end of a fiscal year. It is recognized that claims for prior fiscal years can be received and paid under that prior fiscal year. If that fiscal year is closed, then the claim may be paid under a subsequent year.
2. Change from one fiscal year to the next occurs at midnight on July 1.
3. Fiscal year should be expressed in the format shown in the Description column in the table below:

Begin	End	Description
7/1/04	6/30/05	FY 04/05
7/1/05	6/30/06	FY 05/06
7/1/06	6/30/07	FY 06/07
7/1/07	6/30/08	FY 07/08
7/1/08	6/30/09	FY 08/09
7/1/09	6/30/10	FY 09/10
7/1/10	6/30/11	FY 10/11
7/1/11	6/30/12	FY 11/12
7/1/12	6/30/13	FY 12/13
7/1/13	6/30/14	FY 13/14
7/1/14	6/30/15	FY 14/15
7/1/15	6/30/16	FY 15/16

Begin	End	Description
7/1/16	6/30/17	FY 16/17
7/1/17	6/30/18	FY 17/18
7/1/18	6/30/19	FY 18/19
7/1/19	6/30/20	FY 19/20

6.5 Cross Reference ID

The Cross Reference ID is mandatory for all claims. This ID can be used to tie a sequence of claims together regardless of the claim type. The ID is also independent of the source of the pricing for a claim. Claims that are priced by the PHCPN or the TPA will have a cross reference ID.

The ID is formatted as a 16 character identifier followed by a 2 character sequence number. Related claims can be grouped on the first 16 characters of the ID with the sequence number providing the logical progression of the claim. For example, if a provider submits an interim bill and a subsequent final bill the two claims will share the first 16 characters of their cross reference IDs with the interim bill having a sequence number of 00 and the final bill having a sequence number of 01.

TPA Cross Reference IDs will use the string “TPA” as the first four characters of the ID for identification purposes.

6.6 Data Validation

Data are validated according to the table below. Some validations rely on the CMD database for valid values.

Header Record Validation

Parameter	When Required	Additional Validation Rules
Header/Line	• Always	• None
TPA Claim Prefix	• Always	• None
TPA Claim Number	• Always	• None
TPA Claim Extension	• Always	• None
Paid Claim Flag	• Always	• Valid values are Y or N
CDCR #	• Paid Claim Flag = ‘Y’	• None
CDCR ID to BIS	• Paid Claim Flag = ‘Y’	• None
Inmate Last Name	• Paid Claim Flag = ‘Y’	• None
Inmate First Name	• Paid Claim Flag = ‘Y’	• None
Date of Birth	• Not Required	• None
BIS Vendor ID	• Paid Claim Flag = ‘Y’	• None
Alternate BIS Vendor ID	• Paid Claim Flag = ‘Y’	• None

Parameter	When Required	Additional Validation Rules
Contracted Vendor Name	• Paid Claim Flag = 'Y'	• None
Billing Vendor Name	• Paid Claim Flag = 'Y'	• None
Contract Number	• Paid Claim Flag = 'Y'	• None
TPA Provider Number	• Paid Claim Flag = 'Y' and • FRC = 1P, 2P, 3MC, 3MI, 3PC, or 3PI	• None
TPA Provider ID Suffix	• Paid Claim Flag = 'Y' and • FRC = 1P, 2P, 3MC, 3MI, 3PC, or 3PI	• None
PPO TPA Provider ID	• Not required	• None
Provider NPI	• Not required	• None
Provider Name	• Paid Claim Flag = 'Y' and • FRC = 1P, 2P, 3MC, 3MI, 3PC, or 3PI	• None
Provider First Name	• Not Required	• None
Provider Last Name	• Not Required	• None
Provider Type	• Not Required	• None
Provider Type Description	• Not Required	• None
Admit Number	• Not Required	• See Section 6.3
Admit Date	• Not Required	• Must be a date in the past
Begin Service Date	• Paid Claim Flag = 'Y'	• Must be a date in the past
End Service Date	• Paid Claim Flag = 'Y'	• Must be a date in the past
Bill Code	• Required if Fiscal Review Code = 1H or 2H	• None
Hospital Code	• Required if Fiscal Review Code = 1P, 2P, 1H, 2H or A	• None
Primary Procedure	• Not required	• Must be a valid code from the ICD9Procedure table
Procedure Code 2	• Not required	• Must be a valid code from the ICD9Procedure table
Procedure Code 3	• Not required	• Must be a valid code from the ICD9Procedure table
Procedure Code 4	• Not required	• Must be a valid code from the ICD9Procedure table
Procedure Code 5	• Not required	• Must be a valid code from the ICD9Procedure table
Procedure Code 6	• Not required	• Must be a valid code from the ICD9Procedure table
Primary Diagnosis	• Paid Claim Flag = 'Y'	• Must be a valid code from the ICD9Diagnosis table
Diagnosis Code 2	• Not required	• Must be a valid code from the ICD9Diagnosis table
Diagnosis Code 3	• Not required	• Must be a valid code from the ICD9Diagnosis table
Diagnosis Code 4	• Not required	• Must be a valid code from the ICD9Diagnosis table
Diagnosis Code 5	• Not required	• Must be a valid code from the ICD9Diagnosis table

Parameter	When Required	Additional Validation Rules
Diagnosis Code 6	• Not required	• Must be a valid code from the ICD9Diagnosis table
Diagnosis Code 7	• Not required	• Must be a valid code from the ICD9Diagnosis table
Diagnosis Code 8	• Not required	• Must be a valid code from the ICD9Diagnosis table
Diagnosis Code 9	• Not required	• Must be a valid code from the ICD9Diagnosis table
DRG	• Not required	• None
Patient Discharge Status	• Not required	• None
Discharge Hour	• Not required	• Retain leading zero if included in the data. For example, 9 am should be 0900.
Invoice Amount	• Paid Claim Flag = 'Y'	• None
Record Amount Paid	• Paid Claim Flag = 'Y'	• None
Medicare Allowable Amount	• Not required	• None
Invoice Number	• Paid Claim Flag = 'Y'	• None
Refund Check Number	• Not required	• None
Credit/Debit Flag	• Paid Claim Flag = 'Y'	• Allowed values are "C" or "D"
Date Received	• Paid Claim Flag = 'Y'	• Must be a date in the past
Entry Date	• Paid Claim Flag = 'Y'	• Must be a date in the past
Adjudication Date	• Paid Claim Flag = 'Y'	• Must be a date in the past
Date Sent to PPO TPA	• Not required	• None
Date Recvd by PPO TPA	• Not required	• None
Date Sent by PPO TPA	• Not required	• None
Date Recvd from PPO TPA	• Not required	• None
Date of Invoice	• Paid Claim Flag = 'Y'	• Must be a date in the past
Refund Check Date	• Required if Refund Check Number field is populated	• Must be a date in the past
Date Submitted to BIS	• Paid Claim Flag = 'Y'	• Must be a date in the past
Facility/institution	• Paid Claim Flag = 'Y'	• Must be a valid Institution acronym from CMD Facility table
Claim Schedule	• Paid Claim Flag = 'Y'	• None
SCO Warrant Number	• Paid Claim Flag = 'Y'	• None
SCO Pay Date	• Paid Claim Flag = 'Y'	• Must be a date in the past
Voided Check	• Always	• Allowed values are "Y" and "N"
Refund Reason	• Required if Refund Check Number field is populated	• None
No Pay Reason	• Paid Claim Flag = 'N'	• None
PCA Code	• Paid Claim Flag = 'Y'	• Must be a valid value from the CMD PCA table.
General Ledger Code	• Paid Claim Flag = 'Y'	• Must be a valid BIS code that can be converted to the old AOC code
Cross Reference ID	• Always	• None

Line Item Detail Validation

Parameter	When Required	Additional Validation Rules
Header/Line	• Always	• None
TPA Claim Prefix	• Always	• None
TPA Claim Number	• Always	• None

Parameter	When Required	Additional Validation Rules
TPA Claim Extension	• Always	• None
Claim Line Number	• Always	• None
Begin Service Date	• Paid Claim Flag = 'Y'	• Must be a date in the past
End Service Date	• Paid Claim Flag = 'Y'	• Must be a date in the past
APC Code	• Not required	• None
CPT_HCPCS Code	• Required if Fiscal Review Code = 1P, 2P, 3MC, or 3MI	• None
CPT_HCPCS Procedure Modifier 1	• Not required	• None
CPT_HCPCS Procedure Modifier 2	• Not required	• None
CPT_HCPCS Procedure Modifier 3	• Not required	• None
CPT_HCPCS Procedure Modifier 4	• Not required	• None
Procedure Description	• Not required	• None
Units	• Required if CPT_HCPCS Code field is not blank or not null	• None
Anesthesia Minutes	• Not required	• None
Procedure Paid	• Required if Fiscal Review Code = 1A, 1P, 2A, or 2P	• Sum of Procedure Paid values for the entire claim equals Record Amount Paid value from the header record
Procedure Billed	• Required if Fiscal Review Code = 1A, 1P, 2A, or 2P	• None
Medicare Allowable Amount	• Not required	• None
Credit/Debit Flag	• Paid Claim Flag = 'Y'	• Allowed values are "C" or "D"
UB Revenue Code	• Required if Fiscal Review Code = 1H or 2H	• None
UB Revenue Code Description	• Required if Fiscal Review Code = 1H or 2H	• None
Coverage Code	• Not required	• None
Coverage Description	• Not required	• None
Explanation Message Code 1	• Not required	• None
Explanation Message Description 1	• Not required	• None
Explanation Message Code 2	• Not required	• None
Explanation Message Description 2	• Not required	• None
Explanation Message Code 3	• Not required	• None
Explanation Message Description 3	• Not required	• None
User Explanation Message Code	• Not required	• None
User Explanation Message Description	• Not required	• None
Place Of Service	• Paid Claim Flag = 'Y'	• See process flow diagram within this document

9. If there are any errors encountered in the data loading process:
    a. Records resulting in errors are loaded into Process Output tables but marked as invalid.
    b. An output log is created including the errors.
    c. An automated message is sent to the TPA and CCHCS interface administrators. The message indicates that an error has occurred during data load and where the log file can be located. Ideally, the process will follow the same approach as the BIS system which includes a spreadsheet describing the error records in the notification email. If this is not possible, then the log file must be placed out on the FTP server for TPA retrieval.
    d. TPA and/or CCHCS corrects the errors and the claims are included in a later data file.
10. If there are no errors encountered in the data loading process:
    a. An automated message is sent to the TPA and CCHCS interface administrators. The message indicates successful completion of the process.

Support Processes

Vendors and Contracts

Currently when a new contract is created it is sent to HIDPSB who forwards it to TPA with the BIS vendor ID. To support this interface:

- This interface will use the BIS Vendor ID to identify vendors. The TPA and BIS have already established that BIS is the system-of-record for vendor data.
- Even though we are not loading data into CMD, we still need CMD to be modified to include BIS Vendor ID. This will facilitate reporting and reconciliation against BIS (BIS is CCHCS' true accounting system). For the interface to work correctly, the BIS Vendor ID in each claim must match to one and only one CMD Contractor ID. Examination of the BIS master vendor data shows numerous instances of multiple BIS vendor ID's mapping to a single CMD Contractor ID. To accommodate this it is recommended that the BIS vendor ID be added to CMD in a table allowing multiple BIS vendor ID's to be associated to a single Contractor ID.
- A reconciliation process should be completed prior to implementation of this interface to add the BIS Vendor ID values for Contractors currently in CMD.
- When a new contract is sent to HIDPS Branch, they already load the contract into CMD before sending the contract to TPA. This should include addition of the BIS Vendor ID into CMD. Until a user interface can be built to handle inputs of this data, scripts will be needed to support the administration of this data.

Providers

Providers may be added to contracts throughout the life of the contract. Many of the claims included in the data from TPA require the Provider to be identified. Claims may often contain a Provider previously unknown to CCHCS.

The TPA maintains a separate list of Providers. It was decided that CCHCS will receive the TPA's list of Providers weekly and not attempt synchronization with CMD.

Hospitals

CMD identifies the hospital where services were performed. This list is unique to CCHCS' CMD and CADDIS systems. Currently TPA data is providing the CADDIS/CMD Hospital codes in the Hospital Code field to identify the facility where services were performed.

7 File/Process Specifications

7.1 TPA Claim Input File Specification

Input data provided by TPA will include:

- Completed, processed claims which will include warrant ID and payment date received from SCO via BIS
- Claims rejected by TPA
- Claims determined by TPA as No Pays
- Adjusted claims

Input data file will be fixed field ASCII. File will contain both header and line item detail records.

7.1.1 TPA Claim Input File Version 11.0.1 (Currently used by CCHCS)

Header Record Version 11.0.1

No.	Parameter	Required	Format	Length	Comment
1	Header/Line	Yes	CHAR	1	H = Header
2	TPA Claim Prefix	Yes	NUM	4	4 digit year
3	TPA Claim Number		NUM	9	Claim ID
4	TPA Claim Extension	Yes	NUM	4	0000 – base claim, 0050† - additional payment, 0100† - refund, † - + 1 for additional adjusts
5	Paid Claim Flag	Yes	CHAR	1	Y/N flag 'Y' if this claim was paid and processed 'N' if this claim was not paid (because it was denied or a duplicate)
6	CDCR #		CHAR	6	Inmate ID number. This value may differ from CDCR ID to BIS field if CDCR ID was corrected after claim was submitted to BIS.
7	CDCR ID to BIS		CHAR	6	Inmate ID number included in file to BIS
8	Inmate Last Name		CHAR	40	
9	Inmate First Name		CHAR	40	
10	Date of Birth		DATE	8	YYYYMMDD, Default value = 18000101
11	BIS Vendor ID		NUM	6	BIS Master Vendor ID (not alternate address vendor ID)

No.	Parameter	Required	Format	Length	Comment
					Default value = 000000
12	Alternate BIS Vendor ID		NUM	6	Alternate vendor ID which will indicate if an alternate mailing address was used (other than the mailing address on the master vendor record) If the mailing address from the master vendor record was used, then this will be a repeat of the BIS Master Vendor ID. Default value = 000000
13	Contracted Vendor Name		CHAR	40	Vendor name from BIS master record
14	Billing Vendor Name		CHAR	40	Name from BIS alternate vendor record, if an alternate vendor record was used. If the master vendor record was used, then this will be a repeat of the Contracted Vendor Name.
15	Contract Number		CHAR	20	
16	TPA Provider Number		NUM	9	TPA's Provider Tax ID (without dashes) Default value = 000000000
17	TPA Provider ID Suffix		NUM	4	Sequence number added to TPA Provider Number to distinguish each provider associated to a vendor. Allowing a large number of suffix values to accommodate potential future impact of PPO project. Default value = 0000
18	PPO TPA Provider ID		CHAR	12	Secondary Provider ID value needed for use by the Health Care Provider Network's TPA firm.
19	Provider NPI		CHAR	10	National Provider Identifier value.
20	Provider Name		CHAR	40	Concatenated first and last name, If the Provider only has one name (no first and last name), then that is included here.
21	Provider First Name		CHAR	40	
22	Provider Last Name		CHAR	40	
23	Provider Type		NUM	5	Default value = 00000
24	Provider Type Description		CHAR	16	
25	Admit Number		NUM	5	This field included for future use in case CCHCS can provide Admit Number to TPA via Inmate Locator web service
26	Admit Date		DATE	8	YYYYMMDD. This field has been included to be consistent with interface data provided to TPA under the Health Care Provider Network project.
27	Begin Service Date		DATE	8	YYYYMMDD . This should be the admit date for in-patient claims
28	End Service Date		DATE	8	YYYYMMDD. This should be the discharge date for in-patient claims.

No.	Parameter	Required	Format	Length	Comment
29	Bill Code		NUM	4	Applies to hospital bills only Default value = 0000
30	Hospital Code		CHAR	10	This will be the CADDIS/CMD hospital code.
31	Primary Procedure		CHAR	8	Primary ICD9 Procedure Code
32	Procedure Code 2		CHAR	8	ICD-9 Procedure Code 2
33	Procedure Code 3		CHAR	8	ICD-9 Procedure Code 3
34	Procedure Code 4		CHAR	8	ICD-9 Procedure Code 4
35	Procedure Code 5		CHAR	8	ICD-9 Procedure Code 5
36	Procedure Code 6		CHAR	8	ICD-9 Procedure Code 6
37	Primary Diagnosis		CHAR	8	Primary ICD9 Diagnosis Code
38	Diagnosis Code 2		CHAR	8	ICD-9 Diagnosis Code 2
39	Diagnosis Code 3		CHAR	8	ICD-9 Diagnosis Code 3
40	Diagnosis Code 4		CHAR	8	ICD-9 Diagnosis Code 4
41	Diagnosis Code 5		CHAR	8	ICD-9 Diagnosis Code 5
42	Diagnosis Code 6		CHAR	8	ICD-9 Diagnosis Code 6
43	Diagnosis Code 7		CHAR	8	ICD-9 Diagnosis Code 7
44	Diagnosis Code 8		CHAR	8	ICD-9 Diagnosis Code 8
45	Diagnosis Code 9		CHAR	8	ICD-9 Diagnosis Code 9
46	DRG		CHAR	3	Inpatient only/physicians, hospitals and ambulance This is the value used to price the claim.
47	Patient Discharge Status		CHAR	2	
48	Discharge Hour		NUM	4	Time the patient was discharged, expressed on a 24 hour clock (for example, 3 pm = 1500). Retain leading zeros. For example, 9 am should be 0900.
49	Invoice Amount		CURR	13	xxxxxxxxxx.xx 10 digit + (period)+ 2 digit decimal Total amount on the claim, before adjudication
50	Record Amount Paid		CURR	13	xxxxxxxxxx.xx 10 digit + (period)+ 2 digit decimal Total amount paid on the claim, after adjudication
51	Medicare Allowable Amount		CURR	13	xxxxxxxxxx.xx 10 digit + (period)+ 2 digit decimal Amount allowed by Medicare
52	Invoice Number		CHAR	20	Vendor's invoice number, if provided.
53	Refund Check Number		CHAR	20	Check number if this is a refund
54	Credit/Debit Flag	Yes	CHAR	1	Flag to define whether the transaction is a Credit © or Debit (D)
55	Date Received	Yes	DATE	8	YYYYMMDD Date invoice was first received by TPA.

No.	Parameter	Required	Format	Length	Comment
					NOTE: this will also be the Invoice Received Date in CMD
56	Entry Date	Yes	DATE	8	YYYYMMDD Date claim was entered into CCHCS TPA's system
57	Adjudication Date	Yes	DATE	8	YYYYMMDD Date CCHCS TPA completed adjudication
58	Date Sent to PPO TPA		DATE	8	YYYYMMDD Date CCHCS TPA sent claim to PPO TPA
59	Date Recvd by PPO TPA		DATE	8	YYYYMMDD Date PPO TPA received claim
60	Date Sent by PPO TPA		DATE	8	YYYYMMDD Date PPO TPA sent the claim back to the CCHCS TPA
61	Date Recvd from PPO TPA		DATE	8	YYYYMMDD Date the CCHCS TPA received the claim from PPO TPA
62	Date of Invoice		DATE	8	YYYYMMDD Invoice date
63	Refund Check Date		DATE	8	YYYYMMDD Date on the refund check
64	Date Submitted to BIS		DATE	8	YYYYMMDD Date claim was posted by TPA to BIS
65	Facility/institution	Yes	CHAR	5	Institution acronym. This field may be blank on a denied claim. This is marked as required so that the data loading process knows to check the field as part of the Fiscal Review Code business logic. This is the value that was provided at the time the claim was submitted to BIS.
66	Claim Schedule Number		CHAR	8	Claim schedule number assigned by BIS
67	SCO Warrant Number		CHAR	8	
68	SCO Pay Date		DATE	8	YYYYMMDD
69	Voided Check	Yes	CHAR	1	Y/N flag to designate a returned or voided check
70	Refund Reason		CHAR	50	Reason for the refund
71	No Pay Reason		CHAR	50	Reason the claim was not paid
72	PCA Code		NUM	5	Default value = 00000
73	General Ledger (GL) Code		CHAR	10	BIS GL code (to be converted to AOC code in data transformation). This is the value that was provided at the time the claim was submitted to BIS.
74	Cross Reference ID	Yes	CHAR	18	See section **6.5 Cross Reference ID** for details on this field.
75	Original DRG		CHAR	3	DRG as provided on claim or as calculated by TPA. This value will be the same as field 46 for all claims priced by the TPA, but may be different for PHCPN claims.

No.	Parameter	Required	Format	Length	Comment
76	Admit Diagnosis Code		CHAR	8	ICD-9 Diagnosis Code used to admit the patient on an inpatient claim.
77	Corrected Facility/institution		CHAR	5	See field 65. This field is to be used if the Facility/institution code is corrected to something other than the one provided at the time the claim was submitted for payment.
78	Corrected General Ledger (GL) Code.		CHAR	10	See field 73. This is the GL code as assigned after submission to BIS in the event that the original GL code was assigned incorrectly.
79	Pickup Zip Code		CHAR	10	5 digit + (dash) + 4 digit. Default value is blank. This is the pickup zip code for an ambulance claim

Line Item Detail Record Version 11.0.1
Every claim will have at least one line item detail record.

No..	Parameter	Required	Format	Length	Comment
1	Header/Line	Yes	CHAR	1	L = Line Item Record
2	TPA Claim Prefix	Yes	NUM	4	4 digit year
3	TPA Claim Number		NUM	9	Claim ID
4	TPA Claim Extension	Yes	NUM	4	0000 – base claim, 0050† - additional payment, 0100† - refund, † - + 1 for additional adjusts
5	Claim Line Number	Yes	NUM	3	TPA assigned claim line number
6	Begin Service Date		DATE	8	YYYYMMDD
7	End Service Date		DATE	8	YYYYMMDD
8	APC Code		CHAR	4	
9	CPT_HCPCS Code		CHAR	5	HCPCS/CPT Code
10	CPT_HCPCS Procedure Modifier 1		CHAR	3	
11	CPT_HCPCS Procedure Modifier 2		CHAR	3	
12	CPT_HCPCS Procedure Modifier 3		CHAR	3	
13	CPT_HCPCS Procedure Modifier 4		CHAR	3	
14	Procedure Description		CHAR	50	

No..	Parameter	Required	Format	Length	Comment
15	Units		NUM	5	Default value = 0. Maintained for compatibility with earlier specifications.
16	Anesthesia Minutes		NUM	4	Default value = 0
17	Procedure Paid		CURR	13	xxxxxxxxxx.xx 10 digit + (period)+ 2 digit decimal
18	Procedure Billed		CURR	13	xxxxxxxxxx.xx 10 digit + (period)+ 2 digit decimal
19	Medicare Allowable Amount		CURR	13	xxxxxxxxxx.xx 10 digit + (period)+ 2 digit decimal Amount allowed by Medicare for this procedure
20	Credit/Debit Flag	Yes	CHAR	1	Flag to define whether the line item is a Credit (C) or Debit (D)
21	UB Revenue Code		NUM	5	For example, this will be revenue code 169 on a Hospital claim Default value = 0
22	UB Revenue Code Description		CHAR	50	
23	Coverage Code		CHAR	4	
24	Coverage Description		CHAR	24	
25	Explanation Message Code 1		CHAR	5	
26	Explanation Message Description 1		CHAR	32	
27	Explanation Message Code 2		CHAR	5	
28	Explanation Message Description 2		CHAR	32	
29	Explanation Message Code 3		CHAR	5	
30	Explanation Message Description 3		CHAR	32	
31	User Explanation Message Code		CHAR	5	
32	User Explanation Message Description		CHAR	32	
33	Place Of Service		CHAR	5	
34	Units: Extended precision		NUM	7	5 digit + (period) + 1 digit decimal. Default = 0.0. This field supersedes field 15. For ambulance claims the decimal will only be non-zero when the mileage is less than 100 miles.

End of File Record

Every data file will have a line at the end of file that records the number of records contained in the file.

No.	Parameter	Required	Format	Length	Comment

No.	Parameter	Required	Format	Length	Comment
1	End of Record marker	Yes	CHAR	1	E = End of File record
2	Number of claims	Yes	NUM	10	Leading zero padded count of claim headers in the data file.
3	Number of lines	Yes	NUM	10	Leading zero padded count of claim lines in the data file.

7.1.2 TPA Claim Input File Version 12.0.3 (Additional field specifications adopted for CCHCS, planned implementation in July 2013).)

Header Record

No.	Parameter	Required	Format	Length	Comment
1	Header/Line	Yes	CHAR	1	H = Header
2	TPA Claim Prefix	Yes	NUM	4	4 digit year
3	TPA Claim Number		NUM	9	Claim ID
4	TPA Claim Extension	Yes	NUM	4	0000 – base claim, 0050† - additional payment, 0100† - refund, † - + 1 for additional adjusts
5	Paid Claim Flag	Yes	CHAR	1	Y/N flag 'Y' if this claim was paid and processed 'N' if this claim was not paid (because it was denied or a duplicate)
6	CDCR #		CHAR	6	Inmate ID number. This value may differ from CDCR ID to BIS field if CDCR ID was corrected after claim was submitted to BIS.
7	CDCR ID to BIS		CHAR	6	Inmate ID number included in file to BIS
8	Inmate Last Name		CHAR	40	
9	Inmate First Name		CHAR	40	
10	Date of Birth		DATE	8	YYYYMMDD, Default value = 18000101
11	BIS Vendor ID		NUM	6	BIS Master Vendor ID (not alternate address vendor ID) Default value = 000000
12	Alternate BIS Vendor ID		NUM	6	Alternate vendor ID which will indicate if an alternate mailing address was used (other than the mailing address on the master vendor record) If the mailing address from the master vendor record was used, then this will be a repeat of the BIS Master Vendor ID. Default value = 000000

No.	Parameter	Required	Format	Length	Comment
13	Contracted Vendor Name		CHAR	40	Vendor name from BIS master record
14	Billing Vendor Name		CHAR	40	Name from BIS alternate vendor record, if an alternate vendor record was used. If the master vendor record was used, then this will be a repeat of the Contracted Vendor Name.
15	Contract Number		CHAR	20	
16	TPA Provider Number		NUM	9	TPA's Provider Tax ID (without dashes) Default value = 000000000
17	TPA Provider ID Suffix		NUM	4	Sequence number added to TPA Provider Number to distinguish each provider associated to a vendor. Allowing a large number of suffix values to accommodate potential future impact of PPO project. Default value = 0000
18	PPO TPA Provider ID		CHAR	16	Secondary Provider ID value needed for use by the Health Care Provider Network's TPA firm.
19	Provider NPI		CHAR	10	National Provider Identifier value.
20	Provider Name		CHAR	40	Concatenated first and last name, If the Provider only has one name (no first and last name), then that is included here.
21	Provider First Name		CHAR	40	
22	Provider Last Name		CHAR	40	
23	Provider Type		NUM	5	Default value = 00000
24	Provider Type Description		CHAR	16	
25	Admit Number		NUM	5	This field included for future use in case CCHCS can provide Admit Number to TPA via Inmate Locator web service
26	Admit Date		DATE	8	YYYYMMDD. This field has been included to be consistent with interface data provided to TPA under the Health Care Provider Network project.
27	Begin Service Date		DATE	8	YYYYMMDD . This should be the admit date for in-patient claims
28	End Service Date		DATE	8	YYYYMMDD. This should be the discharge date for in-patient claims.
29	Bill Code		NUM	4	Applies to hospital bills only Default value = 0000
30	Hospital Code		CHAR	10	This will be the CADDIS/CMD hospital code.
31	Primary Procedure		CHAR	8	Primary ICD9 Procedure Code
32	Procedure Code 2		CHAR	8	ICD-9 Procedure Code 2

No.	Parameter	Required	Format	Length	Comment
33	Procedure Code 3		CHAR	8	ICD-9 Procedure Code 3
34	Procedure Code 4		CHAR	8	ICD-9 Procedure Code 4
35	Procedure Code 5		CHAR	8	ICD-9 Procedure Code 5
36	Procedure Code 6		CHAR	8	ICD-9 Procedure Code 6
37	Primary Diagnosis		CHAR	8	Primary ICD9 Diagnosis Code
38	Diagnosis Code 2		CHAR	8	ICD-9 Diagnosis Code 2
39	Diagnosis Code 3		CHAR	8	ICD-9 Diagnosis Code 3
40	Diagnosis Code 4		CHAR	8	ICD-9 Diagnosis Code 4
41	Diagnosis Code 5		CHAR	8	ICD-9 Diagnosis Code 5
42	Diagnosis Code 6		CHAR	8	ICD-9 Diagnosis Code 6
43	Diagnosis Code 7		CHAR	8	ICD-9 Diagnosis Code 7
44	Diagnosis Code 8		CHAR	8	ICD-9 Diagnosis Code 8
45	Diagnosis Code 9		CHAR	8	ICD-9 Diagnosis Code 9
46	DRG		CHAR	3	Inpatient only/physicians, hospitals and ambulance This is the value used to price the claim.
47	Patient Discharge Status		CHAR	2	
48	Discharge Hour		NUM	4	Time the patient was discharged, expressed on a 24 hour clock (for example, 3 pm = 1500). Retain leading zeros. For example, 9 am should be 0900.
49	Invoice Amount		CURR	13	xxxxxxxxxx.xx 10 digit + (period)+ 2 digit decimal Total amount on the claim, before adjudication
50	Record Amount Paid		CURR	13	xxxxxxxxxx.xx 10 digit + (period)+ 2 digit decimal Total amount paid on the claim, after adjudication
51	Medicare Allowable Amount		CURR	13	xxxxxxxxxx.xx 10 digit + (period)+ 2 digit decimal Amount allowed by Medicare
52	Invoice Number		CHAR	20	Vendor's invoice number, if provided.
53	Refund Check Number		CHAR	20	Check number if this is a refund
54	Credit/Debit Flag	Yes	CHAR	1	Flag to define whether the transaction is a Credit © or Debit (D)
55	Date Received	Yes	DATE	8	YYYYMMDD Date invoice was first received by TPA.

No.	Parameter	Required	Format	Length	Comment
					NOTE: this will also be the Invoice Received Date in CMD
56	Entry Date	Yes	DATE	8	YYYYMMDD Date claim was entered into CCHCS TPA's system
57	Adjudication Date	Yes	DATE	8	YYYYMMDD Date CCHCS TPA completed adjudication
58	Date Sent to PPO TPA		DATE	8	YYYYMMDD Date CCHCS TPA sent claim to PPO TPA
59	Date Recvd by PPO TPA		DATE	8	YYYYMMDD Date PPO TPA received claim
60	Date Sent by PPO TPA		DATE	8	YYYYMMDD Date PPO TPA sent the claim back to the CCHCS TPA
61	Date Recvd from PPO TPA		DATE	8	YYYYMMDD Date the CCHCS TPA received the claim from PPO TPA
62	Date of Invoice		DATE	8	YYYYMMDD Invoice date
63	Refund Check Date		DATE	8	YYYYMMDD Date on the refund check
64	Date Submitted to BIS		DATE	8	YYYYMMDD Date claim was posted by TPA to BIS
65	Facility/institution	Yes	CHAR	5	Institution acronym. This field may be blank on a denied claim. This is marked as required so that the data loading process knows to check the field as part of the Fiscal Review Code business logic. This is the value that was provided at the time the claim was submitted to BIS.
66	Claim Schedule Number		CHAR	8	Claim schedule number assigned by BIS
67	SCO Warrant Number		CHAR	8	
68	SCO Pay Date		DATE	8	YYYYMMDD
69	Voided Check	Yes	CHAR	1	Y/N flag to designate a returned or voided check
70	Refund Reason		CHAR	50	Reason for the refund
71	No Pay Reason		CHAR	50	Reason the claim was not paid
72	PCA Code		NUM	5	Default value = 00000
73	General Ledger (GL) Code		CHAR	10	BIS GL code (to be converted to AOC code in data transformation). This is the value that was provided at the time the claim was

No.	Parameter	Required	Format	Length	Comment
					submitted to BIS.
74	Cross Reference ID	Yes	CHAR	18	See section **6.5 Cross Reference ID** for details on this field.
75	Original DRG		CHAR	3	DRG as provided on claim or as calculated by TPA. This value will be the same as field 46 for all claims priced by the TPA, but may be different for PHCPN claims.
76	Admit Diagnosis Code		CHAR	8	ICD-9 Diagnosis Code used to admit the patient on an inpatient claim.
77	Corrected Facility/institution		CHAR	5	See field 65. This field is to be used if the Facility/institution code is corrected to something other than the one provided at the time the claim was submitted for payment.
78	Corrected General Ledger (GL) Code.		CHAR	10	See field 73. This is the GL code as assigned after submission to BIS in the event that the original GL code was assigned incorrectly.
79	Pickup Zip Code		CHAR	10	5 digit + (dash) + 4 digit. Default value is blank. This is the pickup zip code for an ambulance claim.
80	PID		CHAR	8	This is the new Prisoner ID field. The value will be a character encoded number. The value will be in the form of 99999999 and will be transmitted as 8 spaces if it does not exist for a record.
81	EDI Filename		CHAR	50	This is the name of the file in which the claim was originally received by TPA.
82	POA 01		CHAR	1	Present on Admission identifier for the 1st Diagnosis Code.
83	POA 02		CHAR	1	Present on Admission identifier for the 2st Diagnosis Code.
84	Admit Time		CHAR	4	HHMM; For claims that do not have the minutes available they will be sent as 00. If there is no admit time associated with the claim, all 4 characters will be spaces.
85	Service Facility Name		CHAR	60	From the CMS/HFCA 1500 form box 32
86	Service Facility Address Line 1		CHAR	55	From the CMS/HFCA 1500 form box 32
87	Service Facility Address Line 2		CHAR	55	From the CMS/HFCA 1500 form box 32
88	Service Facility City		CHAR	30	From the CMS/HFCA 1500 form box 32
89	Service Facility State		CHAR	2	From the CMS/HFCA 1500 form box 32
90	Service Facility Postal Code		CHAR	15	From the CMS/HFCA 1500 form box 32 ANSI-X12 indicates 15 characters. All records are currently holding 9

No.	Parameter	Required	Format	Length	Comment
					digits.
91	Service Facility NPI		CHAR	10	CMS/HCFA 1500 box 32A
92	Referring Physician Last Name or Organization		CHAR	60	Last name of referring physician/provider or Organization name from CMS/HCFA 1500 form box 17.
93	Referring Physician First Name		CHAR	35	First name of referring physician from CMS/HCFA 1500 form box 17. This field will be blank if the referring physician is an organization
94	Referring Physician NPI		CHAR	10	NPI number for referring physician from CMS/HCFA 1500 form box 17.
95	Condition Code		CHAR	2	
96	Occurrence Code 01		CHAR	2	
97	Occurrence Date 01		DATE	8	YYYYMMDD
98	Occurrence Code 02		CHAR	2	
99	Occurrence Date 02		DATE	8	YYYYMMDD
100	Value Code 01		CHAR	2	
101	Value Amount 01		CURR	13	xxxxxxxxxx.xx 10 digit + (period)+ 2 digit decimal Value amounts can take on different meanings based on the associated Value Code.
102	Value Code 02		CHAR	2	
103	Value Amount 02		CURR	13	xxxxxxxxxx.xx 10 digit + (period)+ 2 digit decimal Value amounts can take on different meanings based on the associated Value Code.
104	ICD Version		NUM	2	Identifies the ICD version for the ICD diagnosis codes and ICD procedure codes. If this field is empty, ICD-09 values were used. ICD-09 can also be identified as 09. ICD-10 will be identified as 10.

Line Item Detail Record
Every claim will have at least one line item detail record.

No..	Parameter	Required	Format	Length	Comment
1	Header/Line	Yes	CHAR	1	L = Line Item Record

No..	Parameter	Required	Format	Length	Comment
2	TPA Claim Prefix	Yes	NUM	4	4 digit year
3	TPA Claim Number		NUM	9	Claim ID
4	TPA Claim Extension	Yes	NUM	4	0000 – base claim, 0050† - additional payment, 0100† - refund, † - + 1 for additional adjusts
5	Claim Line Number	Yes	NUM	3	TPA assigned claim line number
6	Begin Service Date		DATE	8	YYYYMMDD
7	End Service Date		DATE	8	YYYYMMDD
8	APC Code		CHAR	4	
9	CPT_HCPCS Code		CHAR	5	HCPCS/CPT Code
10	CPT_HCPCS Procedure Modifier 1		CHAR	3	
11	CPT_HCPCS Procedure Modifier 2		CHAR	3	
12	CPT_HCPCS Procedure Modifier 3		CHAR	3	
13	CPT_HCPCS Procedure Modifier 4		CHAR	3	
14	Procedure Description		CHAR	50	
15	Units		NUM	5	Default value = 0. Maintained for compatibility with earlier specifications.
16	Anesthesia Minutes		NUM	4	Default value = 0
17	Procedure Paid		CURR	13	xxxxxxxxxx.xx 10 digit + (period)+ 2 digit decimal
18	Procedure Billed		CURR	13	xxxxxxxxxx.xx 10 digit + (period)+ 2 digit decimal
19	Medicare Allowable Amount		CURR	13	xxxxxxxxxx.xx 10 digit + (period)+ 2 digit decimal Amount allowed by Medicare for this procedure
20	Credit/Debit Flag	Yes	CHAR	1	Flag to define whether the line item is a Credit (C) or Debit (D)
21	UB Revenue Code		NUM	5	For example, this will be revenue code 169 on a Hospital claim

No..	Parameter	Required	Format	Length	Comment
					Default value = 0
22	UB Revenue Code Description		CHAR	50	
23	Coverage Code		CHAR	4	
24	Coverage Description		CHAR	24	
25	Explanation Message Code 1		CHAR	5	
26	Explanation Message Description 1		CHAR	32	
27	Explanation Message Code 2		CHAR	5	
28	Explanation Message Description 2		CHAR	32	
29	Explanation Message Code 3		CHAR	5	
30	Explanation Message Description 3		CHAR	32	
31	User Explanation Message Code		CHAR	5	
32	User Explanation Message Description		CHAR	32	
33	Place Of Service		CHAR	5	
34	Units: Extended precision		NUM	7	5 digit + (period) + 1 digit decimal. Default = 0.0. This field supersedes field 15. For ambulance claims the decimal will only be non-zero when the mileage is less than 100 miles.
35	NDC Code		CHAR	15	National Drug Code
36	NDC Unit		CHAR	2	Drug Units
37	NDC Quantity		CHAR	15	
38	Tooth		CHAR	2	Tooth Number; Will be blank on non-dental claim lines
39	Rendering Provider NPI		CHAR	10	Box 24J on CMS/HCFA 1500

End of File Record
Every data file will have a line at the end of file that records the number of records contained in the file.

No.	Parameter	Required	Format	Length	Comment
1	End of Record marker	Yes	CHAR	1	E = End of File record
2	Number of claims	Yes	NUM	10	Leading zero padded count of claim headers in the data file.
3	Number of lines	Yes	NUM	10	Leading zero padded count of claim lines in the data file.

7.2 TPA Provider Data File

No.	Parameter	Required	Format	Length	Comment
1	Provider Number	Yes	NUMERIC	10	Unique ID for the Provider/vendor.
2	Provider ID Suffix	Yes	NUMERIC	4	Incremental value appended to Provider Number to uniquely identify a single Physician.
3	Inactive Flag	Yes	NUMERIC	1	0 = Active; 1 = Inactive
4	Alpha Key	Yes	CHAR	10	Alpha key used by TPA for sorting purposes
5	Provider Tax ID	No	NUMERIC	10	Provider's Federal Tax ID
6	Provider SSN	No	NUMERIC	10	Provider's SSN
7	PPO TPA Provider ID	No	CHAR	12	Optional secondary ID value used by Health Care Provider Network TPA firm
8	Name	Yes	CHAR	40	Provider's name
9	Address Line 1	No	CHAR	40	Provider address line 1
10	Address Line 2	No	CHAR	40	Provider address line 2
11	City	No	CHAR	34	Provider city
12	State	No	CHAR	2	Provider state code
13	Zip Code	No	CHAR	10	Provider zip code (with no dashes)
14	Physician Last Name	No	CHAR	20	Physician's last name
15	Physician First Name	No	CHAR	20	Physician's first name
16	NPI Number	No	NUMERIC	10	National Provider Identifier number
17	Specialty Code 1	No	NUMERIC	5	
18	Specialty Code 2	No	NUMERIC	5	
19	Specialty Code 3	No	NUMERIC	5	
20	Specialty Code 4	No	NUMERIC	5	
21	Specialty Code 5	No	NUMERIC	5	

No.	Parameter	Required	Format	Length	Comment
22	Specialty Code 6	No	NUMERIC	5	
23	Specialty Code 7	No	NUMERIC	5	
24	Specialty Code 8	No	NUMERIC	5	
25	Specialty Code 9	No	NUMERIC	5	
26	Specialty Code 10	No	NUMERIC	5	
27	Specialty Code 11	No	NUMERIC	5	
28	Specialty Code 12	No	NUMERIC	5	
29	Specialty Code 13	No	NUMERIC	5	
30	Specialty Code 14	No	NUMERIC	5	
31	Specialty Code 15	No	NUMERIC	5	
32	Specialty Code 16	No	NUMERIC	5	
33	Specialty Code 17	No	NUMERIC	5	
34	Specialty Code 18	No	NUMERIC	5	
35	Specialty Code 19	No	NUMERIC	5	
36	Specialty Code 20	No	NUMERIC	5	
37	Last Change Date	Yes	DATE	8	YYYYMMDD. Date the last time the record was created or updated.

7.3 Procedure or Diagnosis Description Table

In Phase 2 it was decided the TPA will provide a separate table of Procedure and Diagnosis Codes and CCHCS will lookup the description values as needed. This mapping table will be provided by the TPA once and updated by the TPA when the mapping values change. CCHCS will store this mapping table and use it as part of the data upload/validation process.

No.	Parameter	Required	Format	Length	Comment
1	Diagnosis or Procedure Code	Yes	CHAR	8	ICD-9 Diagnosis or ICD-9 Procedure Code Field length extended to 8 characters to accommodate future use of ICD-10 codes
2	Description	Yes	CHAR	100	Diagnosis or Procedure Description
3	Code Type Flag	Yes	CHAR	1	Flag to determine if the code is a Diagnosis Code (D) or Procedure Code (P)

7.4 Process Output Tables

The output tables should contain the following fields:

7.4.1 Claim Header table

No.	Parameter	Format	Length
1	TPA Claim Prefix	NUM	4
2	TPA Claim Number	NUM	9
3	TPA Claim Extension	NUM	4
4	Paid Claim Flag	CHAR	1
5	CDCR #	CHAR	6
6	CDCR ID to BIS	CHAR	6
7	Inmate Last Name	CHAR	40
8	Inmate First Name	CHAR	40
9	Date of Birth	DATE	8
10	BIS Vendor ID	NUM	6
11	Alternate BIS Vendor ID	NUM	6
12	Contracted Vendor Name	CHAR	40
13	Billing Vendor Name	CHAR	40
14	Contract Number	CHAR	20
15	TPA Provider Number	NUM	9
16	TPA Provider ID Suffix	NUM	4
17	PPO TPA Provider ID	CHAR	12
18	Provider NPI	CHAR	10
19	Provider Name	CHAR	40
20	Provider First Name	CHAR	40
21	Provider Last Name	CHAR	40
22	Provider Type	NUM	5
23	Provider Type Description	CHAR	16
24	Admit Number	NUM	5
25	Admit Date	DATE	8

No.	Parameter	Format	Length
26	Begin Service Date	DATE	8
27	End Service Date	DATE	8
28	Fiscal Year	CHAR	8
29	Bill Code	NUM	4
30	Hospital Code	CHAR	10
31	Primary Procedure	CHAR	8
32	Procedure Code 2	CHAR	8
33	Procedure Code 3	CHAR	8
34	Procedure Code 4	CHAR	8
35	Procedure Code 5	CHAR	8
36	Procedure Code 6	CHAR	8
37	Primary Diagnosis	CHAR	8
38	Diagnosis Code 2	CHAR	8
39	Diagnosis Code 3	CHAR	8
40	Diagnosis Code 4	CHAR	8
41	Diagnosis Code 5	CHAR	8
42	Diagnosis Code 6	CHAR	8
43	Diagnosis Code 7	CHAR	8
44	Diagnosis Code 8	CHAR	8
45	Diagnosis Code 9	CHAR	8
46	DRG	CHAR	3
47	Patient Discharge Status	CHAR	2
48	Discharge Hour	NUM	4
49	Invoice Amount	CURR	13
50	Record Amount Paid	CURR	13
51	Medicare Allowable Amount	CURR	13
52	Invoice Number	CHAR	20
53	Refund Check Number	CHAR	20
54	Credit/Debit Flag	CHAR	1
55	Date Received	DATE	8
56	Entry Date	DATE	8
57	Adjudication Date	DATE	8
58	Date Sent to PPO TPA	DATE	8
59	Date Recvd by PPO TPA	DATE	8
60	Date Sent by PPO TPA	DATE	8
61	Date Recvd from PPO TPA	DATE	8
62	Date of Invoice	DATE	8
63	Refund Check Date	DATE	8
64	Date Submitted to BIS	DATE	8
65	Facility/Institution	CHAR	5
66	Claim Schedule	CHAR	8
67	SCO Warrant Number	CHAR	8
68	SCO Pay Date	DATE	8
69	Voided Check	CHAR	1
70	Refund Reason	CHAR	50
71	No Pay Reason	CHAR	50
72	PCA Code	NUM	5
73	Fiscal Review Code (per business rules defined in Section 6)	CHAR	3
74	AOC Code	CHAR	6
75	Cross Reference ID	CHAR	18

7.4.2 Claim Line Item table

No.	Parameter	Format	Length
1	TPA Claim Prefix (foreign key to Claim Header table)	NUM	4
2	TPA Claim Number (foreign key to Claim Header table)	NUM	9
3	TPA Claim Extension (foreign key to Claim Header table)	NUM	4
4	Claim Line Number	NUM	3
6	Begin Service Date	DATE	8
7	End Service Date	DATE	8
8	APC Code	CHAR	4
9	CPT_HCPCS Code	CHAR	5
10	CPT_HCPCS Procedure Modifier 1	CHAR	3
11	CPT_HCPCS Procedure Modifier 2	CHAR	3
12	CPT_HCPCS Procedure Modifier 3	CHAR	3
13	CPT_HCPCS Procedure Modifier 4	CHAR	3
14	Procedure Description	CHAR	50
15	Units	NUM	5
16	Anesthesia Minutes	NUM	4
17	Procedure Paid	CURR	13
18	Procedure Billed	CURR	13
19	Medicare Allowable Amount	CURR	13
20	Credit/Debit Flag	CHAR	1
21	UB Revenue Code	NUM	5
22	UB Revenue Code Description	CHAR	50
23	Coverage Code	CHAR	4
24	Coverage Description	CHAR	24
25	Explanation Message Code 1	CHAR	5
26	Explanation Message Description 1	CHAR	32
27	Explanation Message Code 2	CHAR	5
28	Explanation Message Description 2	CHAR	32
29	Explanation Message Code 3	CHAR	5
30	Explanation Message Description 3	CHAR	32
31	User Explanation Message Code	CHAR	5
32	User Explanation Message Description	CHAR	32
33	Place Of Service	CHAR	5

7.4.3 Error File

This is a listing of claim header records requiring attention by the TPA. This file is communicated from CCHCS to the TPA.

When either the header or any associated line item records fails the validation process, a copy of the header record will be included in this file. Additional fields are added to the end of the record to include the error message and the file where the claim was sent from the CCHCS TPA to CCHCS.

Note the current version of the error file will need to be updated to incorporate the Phase 2 field changes.

This file is delimited. The delimiting character is ASCII CHR(222).

No.	Parameter	Format
1	TPA Claim Prefix	NUM
2	TPA Claim Number	NUM
3	TPA Claim Extension	NUM
4	Paid Claim Flag	CHAR
5	CDCR #	CHAR
6	CDCR ID to BIS	CHAR
7	Inmate Last Name	CHAR
8	Inmate First Name	CHAR
9	Date of Birth	DATETIME
10	BIS Vendor ID	NUM
11	Alternate BIS Vendor ID	NUM
12	Contracted Vendor Name	CHAR
13	Billing Vendor Name	CHAR
14	Contract Number	CHAR
15	TPA Provider Number	NUM
16	TPA Provider ID Suffix	NUM
17	PPO TPA Provider ID	CHAR
18	Provider NPI	CHAR
19	Provider Name	CHAR
20	Provider First Name	CHAR
21	Provider Last Name	CHAR
22	Provider Type	NUM
23	Provider Type Description	CHAR
24	Admit Number	NUM
25	Admit Date	DATETIME
26	Begin Service Date	DATETIME
27	End Service Date	DATETIME
28	Bill Code	NUM
29	Hospital Code	CHAR
30	Primary Procedure	CHAR
31	Procedure Code 2	CHAR
32	Procedure Code 3	CHAR
33	Procedure Code 4	CHAR
34	Procedure Code 5	CHAR
35	Procedure Code 6	CHAR
36	Primary Diagnosis	CHAR
37	Diagnosis Code 2	CHAR
38	Diagnosis Code 3	CHAR
39	Diagnosis Code 4	CHAR
40	Diagnosis Code 5	CHAR
41	Diagnosis Code 6	CHAR
42	Diagnosis Code 7	CHAR
43	Diagnosis Code 8	CHAR
44	Diagnosis Code 9	CHAR
45	DRG	CHAR
46	Patient Discharge Status	CHAR
47	Discharge Hour	NUM
48	Invoice Amount	CURR
49	Record Amount Paid	CURR
50	Medicare Allowable Amount	CURR
51	Invoice Number	CHAR
52	Refund Check Number	CHAR

No.	Parameter	Format
53	Credit/Debit Flag	CHAR
54	Date Received	DATETIME
55	Entry Date	DATETIME
56	Adjudication Date	DATETIME
57	Date Sent to PPO TPA	DATETIME
58	Date Recvd by PPO TPA	DATETIME
59	Date Sent by PPO TPA	DATETIME
60	Date Recvd from PPO TPA	DATETIME
61	Date of Invoice	DATETIME
62	Refund Check Date	DATETIME
63	Date Submitted to BIS	DATETIME
64	Facility/Institution	CHAR
65	Claim Schedule	CHAR
66	SCO Warrant Number	CHAR
67	SCO Pay Date	DATETIME
68	Voided Check	CHAR
69	Refund Reason	CHAR
70	No Pay Reason	CHAR
71	PCA Code	NUM
72	Fiscal Review Code	CHAR
73	AOC Code	CHAR
74	Cross Reference ID	CHAR
75	Invalid Record Flag (failed validation = True)	CHAR
76	Error Message	CHAR
77	Source File (filename where claim was submitted to CCHCS)	CHAR

8 Security / Authorization Requirements

All data in this interface will be encrypted while in transit.

Access to the data received from the TPA via this interface must be limited to users authorized under CCHCS' Clinical Data Access procedure.

The following requirements need to be met to allow TPA access to the Secure FTP server designated to receive TPA-to-CMD payment files:

1. Login (user id & password) for server.
2. Navigation rights to the repository directory if not the login node.
3. Minimal write access to the repository
    a. Directory read access would be helpful to allow TPA to validate the transfer.
4. Appropriate HIPAA transmission protocol (assumed to be SFTP – version to be determined))

9 Testing Scenarios

Normal Functionality - test cases that ensure the conversion requirement, as it should.	
ID	**Description**
1	Create a payment file and run an editing program to test that each data element in the payment file is an exact match for the corresponding entries in the TPA claims database.
2	Complete transfer to CCHCS middleware and execute data load into Process Output tables.
3	Remove detail line and test that the omission is detected by the recipient is extracted.
4	Remove a header line and test that the omission is detected by the recipient is extracted.
5	Add an item where the sum of the details does not equal the header and test that the omission is detected by the recipient is extracted.
Exception - special logic or exceptions	
	Are the following error conditions captured? Is the error logged and the record not loaded into Process Output tables?
1	Invalid ICD-9 code.
2	Invalid DRG code
3	Invalid CPT code
4	Invalid or unknown Hospital Code

10 Error Handling, Monitoring, Reconciliation

The error handling, monitoring, reconciliation section identifies a step by step list of instructions to mitigate errors encountered during processing.

Errors

- FTP will handle errors at the transmission layer.

- Data load process will validate individual claim details. Process will generate log file that identifies the erroneous records and the reasons for the errors. This will be communicated to the TPA who will fix the erroneous records and include them in a subsequent file. Records containing errors will not be loaded into Process Output tables. Specific error conditions the process should check for are defined in the Testing Scenarios section:

Monitoring:
- TPA will log all data transmissions (time sent, file name, length, etc.)
- Data load process will log all executions of the process storing overall success or failure, and number of errors and identification of file containing details of erroneous records

Reconciliation
- TPA is to receive confirmation email regarding success or failure of each execution of the process. Erroneous records are not loaded into Process Output tables. Error conditions must be repaired by TPA and the repaired records included in later files.

11 External System Considerations

- Process is dependent upon FTP site, CCHCS middleware and staging database availability.
- Transmission will use the Internet.
- Transmission will require the origin FTP client to be in operation.
- Receipt will require the destination FTP server to be in operation.
- Receipt will require sufficient space on the server to accept the transmission

12 Data Retention Requirements

TPA will retain data used in the payment files in perpetuity and is able to recreate source data as needed. Individual TPA Claims Input files will be stored for 30 days in case a file is not loaded into the receiving system.

13 Interface Trigger / Scheduling Requirements

Extraction and transmission process will typically be triggered automatically once a day at a time to be determined. If necessary it can be initiated manually.

14 Expected Performance and Service Level Agreement Requirements

Daily transmission within 30 minutes of the scheduled time is to be the expectation.