DHS Office of HIPAA Compliance

820 Transaction Project

Payroll Deducted and Other Group Premium Payment for Insurance Products

HIPAA Integrated Gap Analysis & Requirements

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Version 2.1

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1 Introduction

1.1 *Background & Purpose of Document*

The Department of Health Services' (DHS) compliance efforts for the Health Insurance Portability and Accountability Act of 1996 (HIPAA) have been progressing since May 2000. The DHS-Office of HIPAA Compliance (OHC) is pleased to present this document, which contains the findings of the 820 Transaction Project, HIPAA Gap Analysis & Requirements. This document marks a major milestone and completion of a significant work effort for DHS in its HIPAA compliance efforts.

The Integrated Gap Analysis & Requirements document is intended to elaborate on the specific business, legal, and technical gap analysis findings and link the findings together into one cohesive document. *Phase 3 - Gap Analysis and Requirements* of the Transactions and Code Sets HIPAA Compliance Life Cycle originally called for three (3) separate Gap Analysis & Requirements deliverables to document the business, legal, and technical findings. However, the 820 Transaction Team concluded that the business and technical gap analysis and requirements findings could be presented in a more unified manner as one document; allowing the reader a more comprehensive understanding of the global HIPAA impacts to DHS. Furthermore, the legal assessment conducted in the previous phase of the project did not identify any significant precedents established in case law, or common law, pertinent to the ASC X12N 820 Transaction. As the compliance date for the Transactions Rule passes, and the true extent of the health care industry's compliance deficiencies becomes evident, we may expect to see an environment ripe for new legal interpretations in this area.[1] HIPAA related judicial precedents will establish a national standard of accepted practice that may encourage individual actions under state law.

The purpose of this document is to:

- Provide decision makers with a high-level understanding of the gaps that exist between the current operational environment and the requirements of a HIPAA compliant environment
- Provide supervisors, senior analysts, and information systems technical staff with:
    1. Enough information to understand in detail the components of the gaps, and
    2. Information regarding the characteristics of the gaps that will need to be modified in order to achieve HIPAA compliance.

[1] (2003) U.S Supreme Court opinion 02-215, *Pacificare Health Systems, Inc., et al. v. Book et al*, compelled arbitration of claims for treble damages under the RICO statute, ERISA, and federal and state prompt-pay statutes, for a group of physicians who alleged that Pacificare and United Healthcare unlawfully failed to reimburse them for covered health care services they provided to patients.

Following this document, there will be a Solution Alternatives document that outlines all possible solutions for compliance with the ASC X12N 820 Transaction. Once a solution alternative and remediation strategy are selected, an implementation plan will be prepared as the final document in this analytical series of *Phase 3 - Gap Analysis and Requirements*.

1.2 *The Gap Analysis Process*

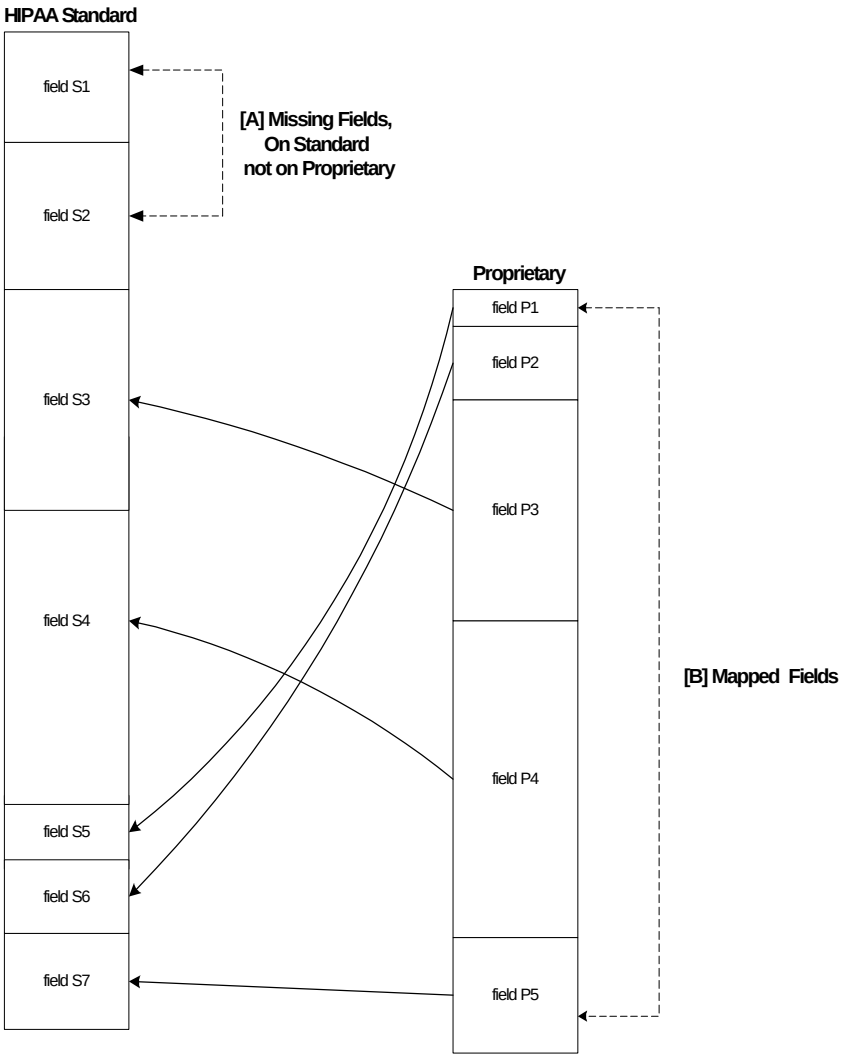
The 820 Transaction Project, HIPAA Business, Legal, and Technical Assessment findings conveyed that the DHS-FMB Accounting Section, Medi-Cal Local Assistance Payment Unit supports the Medi-Cal program by performing a HIPAA covered financial transaction. The premium and capitation payments made to MCOs and health plans qualify as covered HIPAA premium payment transactions.

Using this core finding as a foundation upon which to continue HIPAA remediation activities, OHC launched the HIPAA Gap Analysis & Requirements phase in October 2003, and completed the analysis in November 2003.

The analysis efforts concentrated on the Department of Health Services Accounting Section Payments Database System (CMS64) and the California State Accounting and Reporting System (CALSTARS). Information pertaining to CMS64 and CALSTARS capabilities and functionality was collected during the Technical Assessment. This information has been organized, reviewed, and analyzed in light of the requirements of the HIPAA regulations. An Electronic Data Interchange (EDI) Mapping tool was used to crosswalk data requirements specified in the implementation guides to data that is currently captured in both proprietary systems. This EDI mapping exercise serves to highlight the many business decisions and issues that must be resolved before implementing a standard transaction.

Figure 1 - Transaction Mapping Example shows how the EDI mapping exercise was accomplished.

Figure 1 - Transaction Mapping Example



1.3 *Next Steps*

The findings of the HIPAA Gap Analysis provide a detailed understanding of the gaps that exist in comparing both CMS64 and CALSTARS current operating environments to the requirements of the HIPAA regulations. The subsequent activity of the Gap Analysis & Requirements phase, known as Solution Alternatives, will identify and analyze the alternative solutions available to remediate the gaps, and will result in the selection of the appropriate solutions that will most efficiently and effectively remediate the identified HIPAA gaps to compliance.

2 Payroll Deducted and Other Group Premium Payment for Insurance Products Transaction (820)[2]

2.1 *Business Usage*

The Payroll Deducted and Other Group Premium Payment for Insurance Products Transaction, and subsequently known in this document as the 820 Transaction, is the transmission of any of the following from the entity that is arranging for the provision of health care or is providing health care coverage payments for an individual to a health plan:

(a) Payment.

(b) Information about the transfer of funds.

(c) Detailed remittance information about individuals for whom premiums are being paid.

(d) Payment processing information to transmit health care premium payments including any of the following:

(1) Payroll deductions.

(2) Other group premium payments.

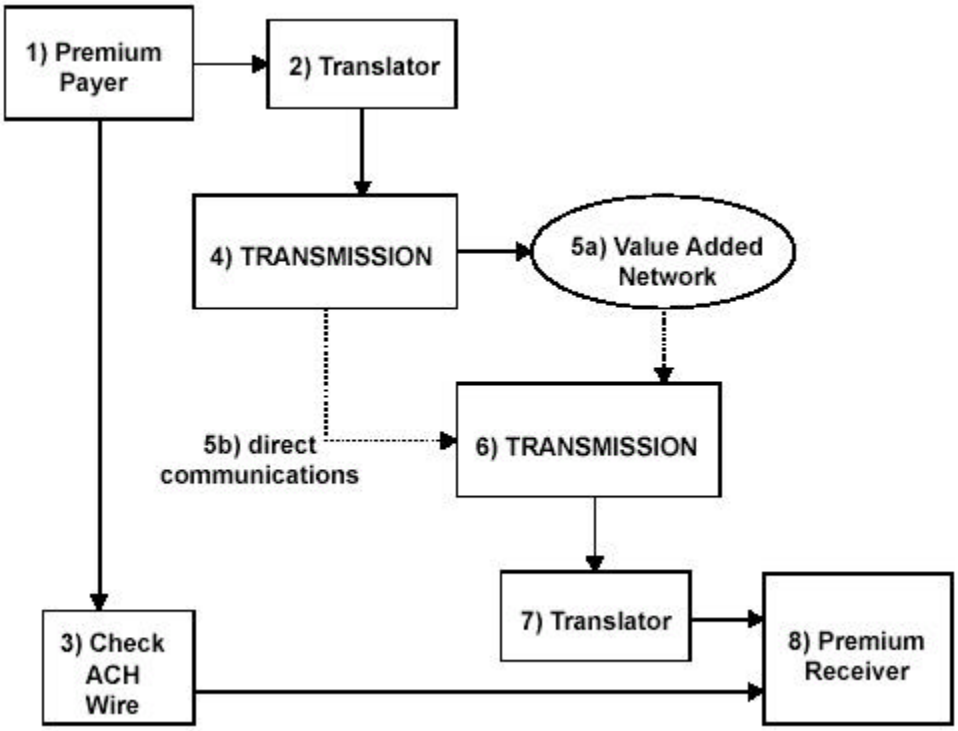
(3) Associated group premium payment information

The 820 Transaction can be sent to a bank to move money only; to a bank to move money as well as detailed or summary remittance information; or to a payee directly to move detailed or summary remittance information. The 820 Transaction is mandated under HIPAA to be utilized by the Accounting Section to move only detailed or summary remittance information. The State Controller's Office (SCO) will continue to issue paper warrants to the MCOs and health plans.

[2] Section 2 contains excerpts from National Electronic Data Interchange Transaction Set Implementation Guide for the ASC X12N 820 – Payroll Deducted and Other Group Premium Payment For Insurance Products.

Figure 2 – Data Flow Example of Separate Dollars and Remittance shows how an 820 Transaction payment can separate both remittance and dollars into different data flow processes using either a Value Added Network (VAN) or direct communications to deliver the data. The payment may be sent as a paper warrant, separate ACH[3] transaction, or wire transmission. The example provided shows how premium dollars and remittance data can flow separately. DHS usage will be documented in the Solution Alternatives document.

Figure 2 – Data Flow Example of Separate Dollars and Remittance



Each of the steps in **Figure 2** is described below:

1) A premium/capitation payer creates a Premium/Capitation Remittance Extract file. The extract file is processed through EDI translation software.
2) The EDI translation software creates an 820 Transaction.

[3] ACH – Automated Clearing House is a payment mechanism that replaces paper checks (warrants) with electronic transactions. ACH transactions are processed through the ACH Network, a reliable and efficient nationwide batch-oriented electronic funds transfer (EFT) system managed by the Federal Reserve Bank (FRB). The FRB acts as an operator that receives, distributes, and performs settlement of funds associated with an ACH.

3) The premium/capitation payer creates a paper warrant, separate ACH transaction, or wire payment for the total premium/capitation paid and sends it to the premium/capitation receiver.

4) If a direct communication method is used, the premium/capitation payer transmits the 820 Transaction directly to the receiver and Step 5 does not apply. If a VAN is used, the 820 Transaction is transmitted to the VAN for delivery.

5) The VAN delivers the 820 Transaction to premium/capitation receiver's mailbox.

6) If a VAN is used, the premium/capitation receiver pulls the 820 Transaction from the VAN mailbox. If a direct communication method is used, the premium/capitation receiver receives the 820 Transaction directly from the premium/capitation payer.

7) The premium/capitation receiver processes the 820 Transaction using EDI translation software. The software creates a remittance file that can be processed by the premium/capitation receiver.

8) The premium/capitation receiver processes the remittance file and the payment, and performs the re-association. After re-association the premium/capitation receiver credits the premium/capitation payer's account.

2.2 *ASC X12N Data Architecture and Nomenclature*

The 820 Transaction is divided into three (3) tables:

- Table 1, the Header, contains information related to the total premium payment, the sender, and the receiver of the payment.
- Table 2, the Detail, provides remittance information. The remittance information can be sent as a summary bill payment, or an individual or list bill payment.
- Table 3, the Trailer, provides a control number and total count of segments represented in an 820 Transaction.

Figure 3 - 820 Transaction Set is a representative sample of the 820 Transaction Set looping structures.

Figure 3 - 820 Transaction Set

Table 1 - Header

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
010	ST	Transaction Set Header	R	1	
020	BPR	Financial Information	R	1	
	. . .				

Table 2 - Detail, Organization Summary Remittance

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
		LOOP ID - 2000A ORGANIZATION SUMMARY REMITTANCE			>1
010	ENT	Organization Summary Remittance	S	1	
		LOOP ID - 2300A ORGANIZATION SUMMARY REMITTANCE DETAIL			>1
150	RMR	Organization Summary Remittance Detail	S	1	
	. . .				
		LOOP ID - 2320A ORGANIZATION SUMMARY REMITTANCE LEVEL ADJUSTMENT			>1
210	ADX	Organization Summary Remittance Level Adjustment	S	1	

Table 3 - Summary

POS. #	SEG. ID	NAME	USAGE	REPEAT	LOOP REPEAT
010	SE	Transaction Set Trailer	R	1	

Table 2 – Detail, Organization Summary Remittance can be structured in two ways. The first structure provides remittance information associated with a summary bill payment. The second structure provides remittance information associated with an individual or list bill payment. The structure used is dependent on business needs.

A summary bill is submitted to a premium payer with one or more amounts representing a summary of the premiums due. An individual / list bill is submitted to a premium payer with one or more amounts representing detail premiums due for each individual of an organization.

There are two possible uses for the detailed remittance information. In the first use, the premium payment is specific to the employee / subscriber. Dependent payments are made as part of the employee payment and the dependents are not included in the detailed remittance information. In the second usage, every individual has an associated specific premium payment. In this case, each employee and dependent must be separately included in the remittance information.

Whatever the case may be, the remittance information is not intended to act as an enrollment or disenrollment mechanism. The ASC X12N 834 Benefit Enrollment and Maintenance Transaction should be used for those functions.

As previously stated in Section 2.1, the 820 Transaction is capable of sending premium payment remittance data with or without the dollars represented by the data. When the remittance data is sent separately from the monetary amounts, reassociation requires

that both remittance and monetary data contain information that allows a system to match the items received. The premium receiver should have a method to ensure that payment and remittance advice are reconciled in their accounts receivable system.

Two key pieces of information contained within the 820 Transaction facilitate reassociation – (1) the trace number in the Reassociation Key, and (2) the Originating Company Identifier. The trace number in conjunction with the company ID provides a unique number that identifies the transaction. When the payment is received by check, the check number is contained in the trace number, and the company ID is in the Originating Company Identifier.

The ASC X12 standards define commonly used business transactions (such as a health care claim) in a formal structure called "transaction sets." A transaction set is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment.

The data element is the smallest named unit of information in the ASC X12 standard. Data elements are identified as either simple or component. Each data element is assigned an industry usage status. Industry usages include:

- **Required** – This item must be used to be compliant with this implementation guide.
- **Not Used** – This item must not be used when complying with this implementation guide.
- **Situational** – The use of this item varies, depending on data content and business context. The defining rule is generally documented in a syntax or usage note attached to the item and is found in the implementation guide. The item should be used whenever the situation defined in the note is true; otherwise, the item should not be used.

The data segment is an intermediate unit of information in a transaction set. In the data stream, a data segment consists of a segment identifier, one or more composite data structures or simple data elements each preceded by a data element separator and succeeded by a segment terminator.

Each data segment has a unique two- or three-character identifier, a name, and a purpose. The identifier serves as a label for the data segment. A segment can be further defined using syntax notes, semantic notes, and comments.

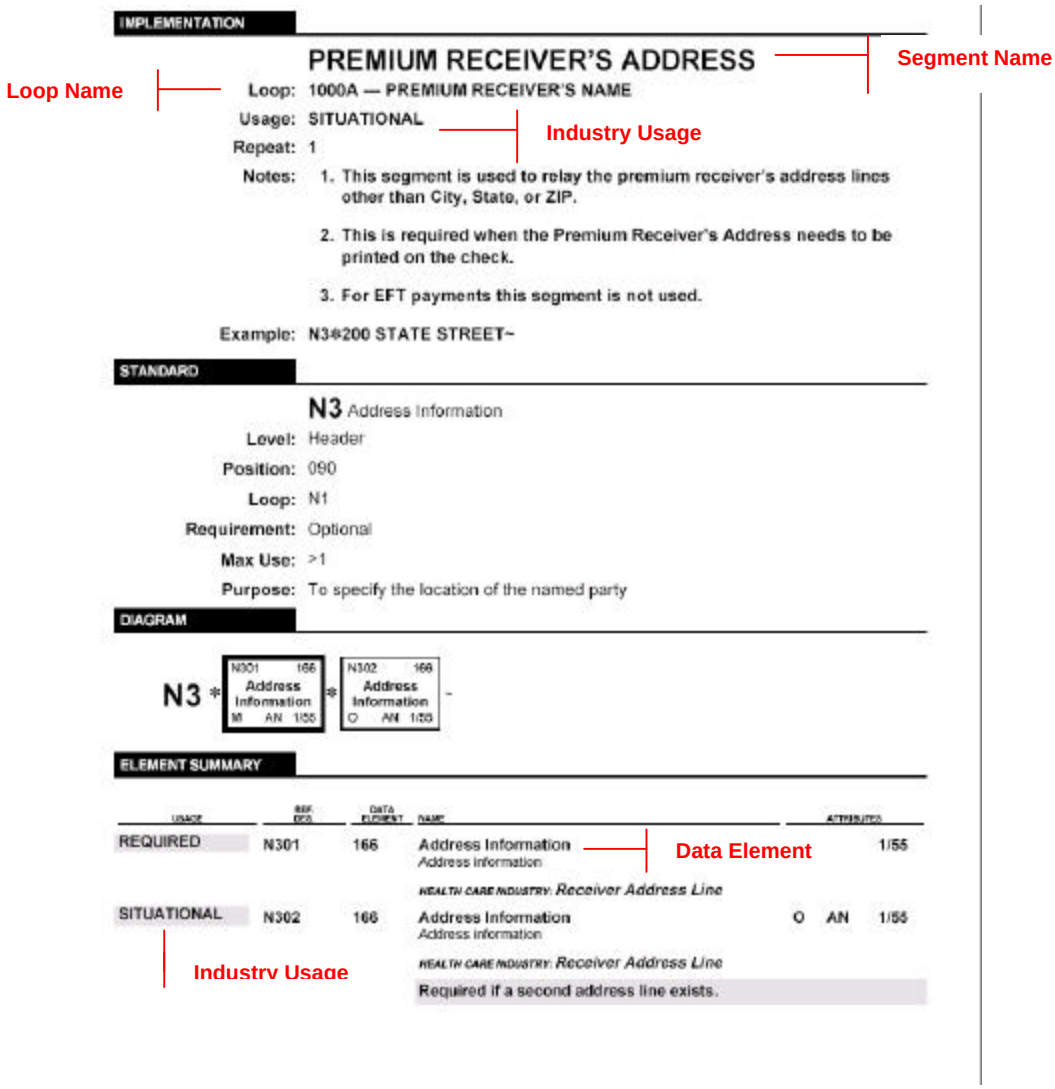
Loops are groups of semantically related segments. Loop usage within ASC X12 transactions and their implementation guides can be confusing. Care must be used to read the loop requirements in terms of the context or location within the transaction. The usage designator of a loop's beginning segment indicates the usage of the loop. Segments within a loop cannot be sent without the beginning segment of that loop.

If the first segment is *Required*, the loop must occur at least once unless it is nested in a loop that is not being used. A note on the *Required* first segment of a nested loop will indicate dependency on the higher level loop.

If the first segment is *Situational*, there will be a Segment Note addressing use of the loop. Any required segments in loops beginning with a Situational segment only occur when the loop is used. Similarly, nested loops only occur when the next higher level loop is used.

Figure 4 - Loop and Segment Data Structure, shows an example of a data segment within a loop and the supporting data elements for that segment.

Figure 4 - Loop and Segment Data Structure



3 Summary of Findings

This section summarizes the findings of the gap analysis from two perspectives: (1) business and operational requirements and (2) system requirements. The detailed findings are presented in subsequent Sections of this document.

3.1 *Business and Operational Requirements*

The outcome from the detailed analysis shows that there will be no significant impediments to the business or operational environments to the Medi-Cal Managed Care Division (MMCD), the Medi-Cal Dental Services Branch (MDSB), or the Third Party Liability Branch (TPLB). As an example, the original assessment indicated the need to remediate the MMCD business process of using the Master File spreadsheet to report detailed eligible counts to the MCOs. The existing Master File spreadsheet contains detailed eligible counts (add/change/delete) by aid code and aid code grouping for the current month and the previous thirteen (13) to fifteen (15) months. During the current assessment and detailed analysis activities, the Master File spreadsheet was determined to be out of the scope of the 820 Transaction. Therefore, the issuance of the Master File by MMCD should not be impeded by the implementation of the 820 Transaction.

The Medi-Cal Local Assistance Payment Unit of DHS Financial Management Branch (FMB) may feel the effects of minimal business process modifications concerning the data that is entered into CMS64. The Unit's requirement to use the uniform coding system should not be impeded by the implementation of the 820 Transaction, as the coding requirements for reporting to the SCO are not within the data requirements of the 820 Transaction set.

3.2 *System Requirements*

There is no clear-cut data source that contains all data fields necessary for the generation of an 820 Transaction.

CALSTARS and CMS64 were the two system sources identified that had potential influence on the creation of an 820 Transaction. While each system has its own data repository and is able to provide significant degrees of detailed information required for the 820 Transaction, neither system was able to provide the warrant number, which is a critical piece of data. However, the warrant number is available from other sources. The Solutions Alternative document will pursue the melding of warrant number source with the other data sources available.

4 Business & Operational Requirements

This section of the document details the impacts that HIPAA remediation may have on the current business and technical environments. These requirements center on the business and operational requirements of the DHS-Financial Management Branch (FMB)-Accounting Section, Medi-Cal Local Assistance Payment Unit. Additionally, the business and operational requirements currently established by MMCD and MDSB relative to capitation payments, and by TPLB for premium payments under the Health Insurance Premium Payment (HIPP) program, Breast and Cervical Cancer Treatment Program (BCCTP), and the Medicare Plus Choice (M+C) Premium Payment program, are analyzed and documented for potential related impacts that may occur due to implementing the ASC X12N 820 Transaction.

4.1 *DHS-Financial Management Branch (FMB)*

4.1.1 Business Overview

The Medi-Cal Local Assistance Payment Unit of the Accounting Section [herein referred to as the Unit] is responsible for assisting MMCD and TPLB [herein referred to as Program Business Areas] with their capitation and premium payments processes. Capitation payments to the MCOs must be processed by the 21st of each month in order for the payment to be received by the MCOs on or before the 25th of each month.

Upon receipt of invoices and any supporting documentation sent by the Program Business Areas, the Unit enters claim schedules based on the Program Business Area's invoice in CMS64.

CMS64 provides a daily upload file to CALSTARS of all the claim schedules enter for that day. The upload file contains the necessary data for CALSTARS to create the Remittance Advice and Warrant Write File so that the State Controller can issue a warrant for payment.

Additionally, the Unit prepares numerous State and federally mandated financial statements and reports, various fiscal reports and analysis for department managers, and maintains cash management records for state and federal accounting purposes.

The Unit annually accounts for $25 billion in local assistance and $746 million in state operations expenditures which are made from 1,109 separate expenditure accounts linked to 135 appropriations, 56 federal grants, 180 reimbursement contracts and 57 different funds.

4.1.2 Business Requirements

Section 13300 of the Government Code has mandated the development, installation, and supervision of a modern and complete accounting system for each agency of the State that is permitted or charged by law with the handling of public money. This mandate was modified and reaffirmed by AB 3322[4] that required, among other things, that a coding system be developed in order to obtain accurate and comparable records, reports, and statements of all the financial affairs of the State. Further, it was necessary that the coding system provide the State Controller with all information necessary for the maintenance of a comprehensive system of central accounts for the entire State. In addition to using a uniform coding system for reporting to the State Controller, the Unit is required to use this coding system, or chart of accounts, for budgetary purposes.

The Unit's requirement to use the uniform coding system described above should not be impeded by the implementation of the 820 Transaction, as the coding requirements for reporting to the SCO are not within the data requirements of the 820 Transaction set.

4.2 *DHS-Medi-Cal Managed Care Division (MMCD)*

4.2.1 Business Overview

The Claims Payment Unit, which is housed within the Fiscal Analysis Section of MMCD, is responsible for initiating capitation payments to the MCOs. Included with the medical MCOs is the initiation of capitation payments for the dental MCOs on behalf of MDSB. In addition to the MCOs, the Claims Payment Unit, on the behalf of the OLTC, initiates payments to PACE and S/HMO (SCAN) programs.

The Claims Payment Unit receives the current month's Fiscal Intermediary Access to Medi-Cal Eligibility (FAME) Health Care Plan (HCP) Extract from DHS–Information Technology Systems Division (ITSD). The FAME HCP Extract is a subset of the Medi-Cal Eligibility Data System (MEDS) and is recreated by ITSD when MEDS is updated via the nightly and month-end MEDS update processes. The Claims Payment Unit reconciles the capitation payments made to the MCOs and manually inputs the results into the Master File, which is a Microsoft Excel spreadsheet. The Claims Payment Unit also calculates the CMS 64.9 Waiver Data on all invoices. The Master File is updated for all applicable changes (e.g. aid code, rates, contract term) within the MCO contracts. As needed during the month, retroactive and adjusting invoices are produced and submitted to the Accounting Section within DHS Administration for payment. The Master File is the source for the Capitation Payment Invoices (Capitation Worksheets) that are forwarded to the Accounting Section.

[4] Chapter 1284, Statutes of 1978

4.2.2 Business Requirements

The current method of informing the health plans of the breakdown of the monthly capitation payments is via an Excel spreadsheet, known as the Master File. A hardcopy of the spreadsheet is mailed directly to the health plans separate from the Remittance Advice and Warrant issued by the SCO.

The business processes of the health plans and MMCD require the level of detail supplied by the Master File. The existing spreadsheet contains detailed eligible counts (add/change/delete) by aid code and aid code grouping for the current month and the previous thirteen (13) to fifteen (15) months. This eligibility information has been determined to be out of the scope of the 820 Transaction. Therefore, the issuance of the Master File by MMCD should not be impeded by the implementation of the 820 Transaction.

4.3 *Medi-Cal Dental Services Branch (MDSB)*

4.3.1 Business Overview

In order to determine Delta Dental's monthly Pure Premium Fund (PPF) payment amounts, the DHS-Information Technology Systems Division (ITSD) sends the FAM110 file to MDSB and Delta Dental. The FAM110 file lists the number of eligible beneficiaries by Aid Code. Delta Dental prepares two (2) invoices each month, one for the "All Others" eligible category and one for the "Refugees" eligible category, based on appropriated contracted aid codes and the number of associated beneficiaries and submits the invoice to MDSB. MDSB validates the invoiced amount and submits the PPF payment invoice to the FMB Accounting Section to initiate the actual PPF payment process.

4.3.2 Business Requirements

Implementation of the 820 Transaction will have no bearing on the internal business requirements and business processes of MDSB.

4.4 *Third Party Liability Branch (TPLB)*

4.4.1 Business Overview

The premium payment process for the Health Insurance Premium Payment (HIPP) program for eligible beneficiaries starts with an invoice, which is generated from the HIPP/BCCTP Database. This invoice is attached to a copy of the insurance carrier's premium notice or documentation of payment provided by the beneficiary and sent to the DHS-FMB-Accounting Section as a request for payment.

The HIPP staff also handles the premium payment process for eligible State-only Breast and Cervical Cancer Treatment Program (BCCTP) beneficiaries. This process is similar to the process for making premium payments under HIPP. The HIPP/BCCTP Database generates an invoice that is attached to a copy of the insurance carrier's premium notice and is then sent to the DHS-FMB-Accounting Section.

The Medicare Operations Unit (MOU) generates an invoice from the Medicare+Choice (M+C) Extract and sends the payment request to the DHS-FMB-Accounting Section. The M+C Extract is created from a process that starts with The Center for Medicare and Medicaid Services (CMS) sending a Finders File that contains individuals with Medicare HMO plans, to DHS-ITSD. ITSD runs the Finders File against the Medi-Cal Eligibility Data System (MEDS) in order to identify dual eligible members. ITSD extracts matches into the BYN350 system. MOU retrieves the file from ITSD in order to initiate enrollment into the M+C Premium Payment program.

4.4.2 Business Requirements

Implementation of the 820 Transaction will have no bearing on the internal business requirements and business processes of the HIPP, BCCTP and M+C Premium Payment programs.

5 Detailed Analysis of CMS64

The analysis and findings presented in this section are at a summary level. Additional documentation is provided in ***Attachment A – CMS64 Mapping to ASC X12N 820*** at a detailed level, and at a minimum, should be reviewed by designated information technology stakeholders.

The subsequent activity of the Gap Analysis & Requirements phase, known as Solution Alternatives, will identify and analyze the alternative solutions available to remediate the identified gaps.

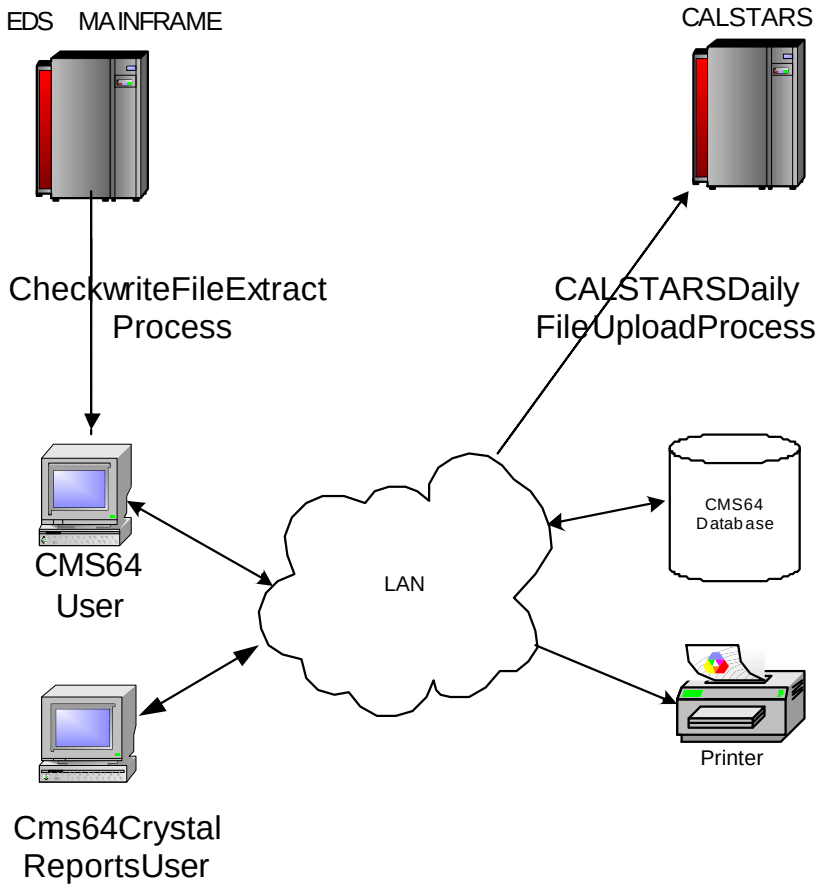
5.1 *System Overview*

The CMS64 Accounting Subsystem was developed to automate many of the accounting and reporting requirements of the DHS Accounting Medical Care Services Section. It was designed to provide for a single point of entry for all Checkwrite and Handfiled Claim Schedules, including HCFA and Non-HCFA Adjustments. Files and documents are created to interface with the State Controller's Office, CALSTARS, and the State Treasurer. It was designed, developed, implemented and supported by Electronic Data Systems (EDS). The main components of the CMS64 are:

- **CMS64 weekly check write file extract process** – This process combines check write data for Medi-Cal, Abortion and CHDP for current year, prior year and prior to that year to create a weekly check write file. The Contractor used a set of COBOL programs to implement the solution.
- **CMS64 system user interface and reports** – This contains screens for data entry, data maintenance and user maintenance. Various reports such as Plan of Financial Adjustment (PFA), Remittance Advice (RA), Transfer Letter, CALSTARS posting tags and worksheets for various funds are generated. Visual Basic forms, Visual Basic modules and SQL server database were used to implement this functionality.
- **CMS64 Crystal Reports** – This contains screens to view, print and export various crystal reports. Visual Basic forms, Visual Basic modules, Crystal Reports programs and SQL server database were used to implement this functionality.
- **CMS64 Database** – This is a relational database. The Contractor developed the database using Microsoft's SQL Server 2000 Relational Database Management System (RDBMS). The HCFA64 is the primary database.

Figure 5 - CMS64 System Architecture presents an overview of CMS64 Subsystem architecture.

Figure 5 - CMS64 System Architecture



A transaction mapping exercise was performed on CMS64 to determine the amount of effort that is needed to obtain compliance with the ASC X12N 820 Transaction if remediation to CMS64 is chosen as the solution alternative. This mapping exercise pinpointed the relevant data inputs on the CMS64 side to the equivalent data outputs on the 820 Transaction. Section ***CMS64 Mapping Exercise Results*** discusses the results of this mapping exercise in further detail.

5.2 *CMS64 Mapping Exercise Results*

The 820 Transaction Project Analyst mapped CMS64 data fields to the ASC X12N 820 Transaction standard data elements. The Analyst used an EDI Transaction Mapping tool to crosswalk data requirements specified in the implementation guide to data that is currently captured in CMS64 and used to build the proprietary Remittance Advice. Each standard transaction contains a maximum defined data set that is based on the implementation guides. A *maximum defined data set* contains all of the HIPAA *required* and *situational* data elements named with a standard transaction.

Situational data elements are those data elements that are both relevant to the particular transaction and necessary to process it. Situational data elements are defined by conditions documented within the HIPAA implementation guides. ***Required*** data elements are those data elements that must always be present in the transaction.

The Analyst mapped CMS64 data fields used to build the proprietary Remittance Advice file to the data elements in the required loops and subsequent segments, if the segment was applicable to the premium and capitation payments process. For example, in the Header there is the Non-U.S. Currency Segment that is "Situational" within the Loop. The Analyst classified this segment as "Not Applicable Segment (NAS)" because its use did not apply to the premium or capitation business operations. Additionally, there are 26 data elements classified as "Not Applicable Element (NAE)" because the data elements are located in a "Not Applicable Loop (NAL)" or "Not Applicable Segment (NAS)", or located in a usable Segment, but that data element is not applicable to the business operations. Lastly, Identifiers (I) were not addressed when mapping because these data elements identify a specific industry code list, format or entity and are part of the X12N format. There are 37 Identifiers in the 820 Transaction.

Table 1- CMS64 to 820 Transaction Mapping Exercise Findings outlines how the data available in CMS64 compares to the required data in the ASC X12N 820 Transaction. The detailed mapping is presented in ***Attachment A – CMS64 Mapping to ASC X12N 820*** Standard at the end of this document.

To complete the documentation of the mapping process described above, it was necessary to assign each data element a status. **Table 1** represents the status each data element was assigned. The "Status Code" used in **Table 1** corresponds to the "Status" column in the detailed Mapping Tool found in Attachment A. Each of the "Status Code" acronyms is defined in the "Status" column in the Mapping Tool. The "Status Code Definition" briefly describes the status usage.

Table 1- CMS64 to 820 Transaction Mapping Exercise Findings

106 Required or Situational Data Elements on ASC X12N 820		
Number of Data Elements	**Status Code[5]**	**Mapping Definition**
37	I	An **Identifier [I]** data element contains a value from a predefined list of codes that is maintained by the ASC X12 Committee or some other body recognized by the Committee. The applicable value is generally hard coded and defined in the companion guide.
14	M	The standard data element was **Matched [M]** to the proprietary data element. All attributes are consistent.
19	MP	The proprietary system does not support the data element. Therefore, it is labeled **Missing on Proprietary [MP]**.
26	NAE	Indicates that the item is NOT supported or necessary to fulfill the business operations/functions. Therefore, it is labeled as **Not an Applicable Data Element [NAE]**.
9	SYS	This identifies an item that is **System Generated [SYS]** during the creation of the transaction.
2	TSH	The **Transaction Set Header [TSH]** identifies the start and identifier of the transaction set.
2	TST	The **Transaction Set Trailer [TST]** identifies the end of the transaction set and provides a count of the data segments, which include the header and trailer segments.
0	NAL	Indicates the business operations/functions do not support the information reported in this Loop. Therefore, the Loop is labeled as **Not an Applicable Loop [NAL].**

[5] Data elements assigned NAL, NAL/S or NAS status are not supported or required by a Business Need.

106 Required or Situational Data Elements on ASC X12N 820		
Number of Data Elements	**Status Code[5]**	**Mapping Definition**
0	NAL/S	This Segment resides within a Loop that is situational and is not supported by business needs. Therefore, the information reported in this Segment is labeled as **Not an Applicable Loop/Segment [NAL/S].**
0	NAS	This Segment resides within a required Loop. The information reported in this Segment is not supported by business operations or need. Therefore, the Segment is labeled as **Not an Applicable Segment [NAS].**

The CMS64 to 820 Transaction mapping exercise finds that 14 out of the 33 (42%) required/situational 820 Transaction data elements are present on CMS64. Missing are 19 (58%) of the required/situational 820 Transaction data elements on CMS64. These missing data elements, whether 'required' or 'situational', represent data that is not currently captured in CMS64.

The missing data elements are discussed in ***Table 2 – CMS64 Missing Data Elements.***

Table 2 – CMS64 Missing Data Elements

Loop ID	Reference Descriptor	Segment Name	Data Element Name	Usage Description
Header	BPR16	Financial Information	Check Issue or EFT Effective Date	For check payment, this date element specifies the check issuance date.
Header	TRN02	Re-association Key	Check or EFT Trace Number	This field is used to re-associate the payment with the remittance information.
Header	DTM06	Coverage Period	Coverage Period	This is required when the premium payer is paying on an account for a coverage period.
1000A	N104	Premium Receiver's Name	Receiver Identifier	For HIPAA Health Premium Payments this element is required
1000B	N104	Premium Payer's Name	Premium Payer Identifier	For HIPAA Health Premium Payments this element is required
1000B	N301	Premium Payer's Address	Premium Payer Address Line	
1000B	N302	Premium Payer Address	Premium Payer Address	
1000B	N401	Premium Payer City ST ZIP	Premium Payer City	
1000B	N402	Premium Payer City State ZIP	Premium Payer State	
1000B	N403	Premium Payer City State ZIP	Premium Payer Postal Zone or ZIP Code	

Loop ID	Reference Descriptor	Segment Name	Data Element Name	Usage Description
1000B	N404	Premium Payer City State ZIP	Country Code	This is required when the address is outside the U.S.
1000B	N403	Premium Payer Administrative Contact	Premium Payer Contact Name	
1000B	PER04	Premium Payer Administrative Contact	Communication Number	
2000A	ENT04	Organization Summary Remittance	Organization Identification Code	
2000B	ENT04	Individual Remittance	Receiver's Individual Identifier	
2300A	RMR05	Organization Summary Remittance Detail	Billed Premium Amount	This is required when the paid amount is different from the amount billed.
2320A	ADX01	Organization Summary Remittance Level Adjustment	Adjustment Amount	This is the dollar difference between the billed amount and the paid amount.
2300B	RMR05	Individual Premium Remittance Detail	Billed Premium Amount	This is required when the paid amount is different from the amount billed.
2320B	ADX01	Individual Premium Adjustment	Adjustment Amount	This is the dollar difference between the billed amount and the paid amount.

6 Detailed Analysis of CALSTARS

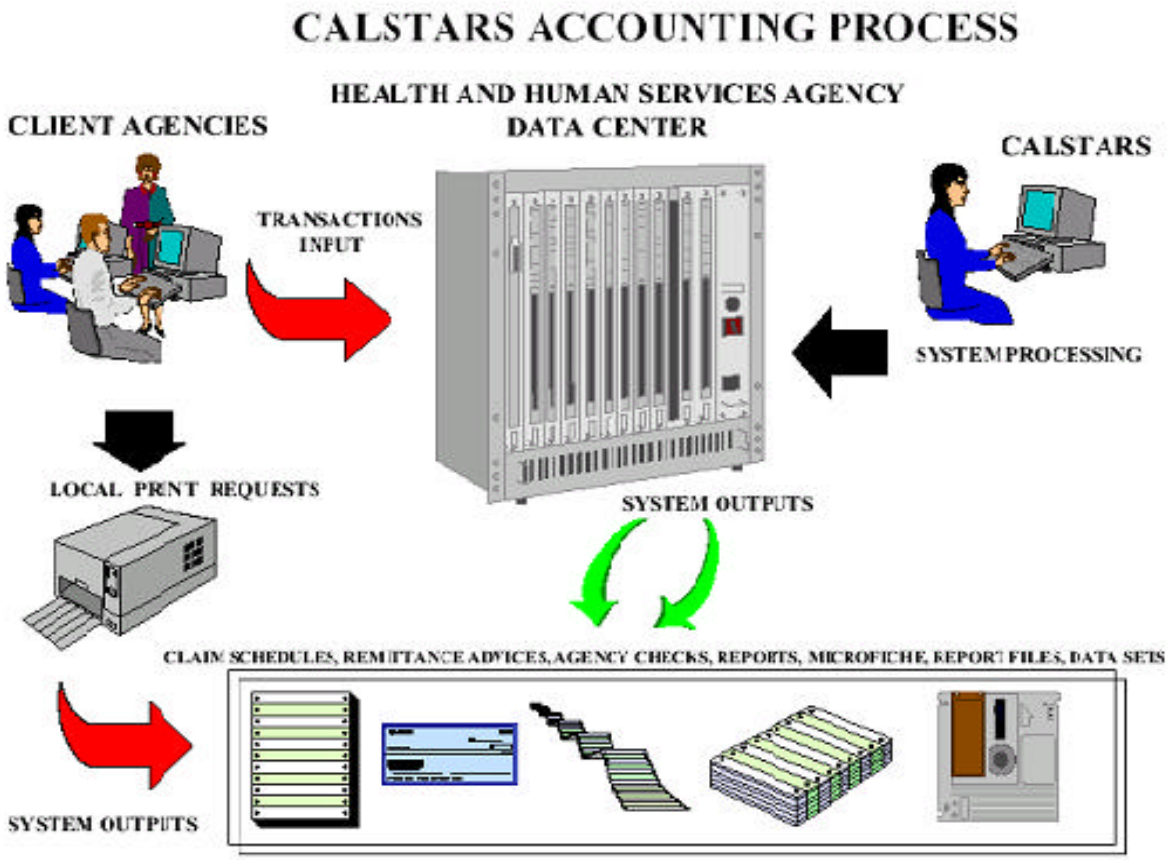
The analysis and findings presented in this section are at a summary level. Additional documentation is provided in ***Attachment B - CALSTARS Mapping to ASC X12N 820*** at a detailed level, and at a minimum, should be reviewed by designated information technology stakeholders.

The subsequent activity of the Gap Analysis & Requirements phase, known as Solution Alternatives, will identify and analyze the alternative solutions available to remediate the identified gaps.

Under the provisions of Government Code Section 13300, the California State Accounting and Reporting System (CALSTARS) was developed to provide all agencies of the state with an automated organization and program cost accounting system to accurately and systematically account for all revenue, expenditures, receipts, disbursements, and property of the state. CALSTARS was specifically designed to improve the timeliness and accuracy of financial information, standardize the accounting and reporting functions within and across the state agencies, and expand each agency's accounting and reporting capabilities.

Figure 6 - CALSTARS Accounting Process is an overview of the CALSTARS accounting process.

Figure 6 - CALSTARS Accounting Process



6.1 *System Overview*

CALSTARS was designed to conform to Generally Accepted Accounting Principles (GAAP) and to satisfy Government Code, State Administrative Manual (SAM), and other State accounting requirements.

The system design also incorporated the State's Uniform Codes Manual (UCM) to provide for consistency and uniformity between the budgeting and accounting processes of the State and between the State agencies.

6.1.1 Operating Environment

CALSTARS production operation and system development work is performed by Department of Finance (DOF) CALSTARS staff and processed at the State of California, Health and Human Services Data Center (HHSDC) on the 'Shared System' which has the following characteristics:

- Two CPUs have the appearance of one system or CPU to its customers. Specific hardware models are:
  - IBM 9672 Model R96
  - IBM 9672 Model R86
- Operating System:
  - OS/390
  - ESP (Execution Scheduling Process) Job Scheduler
- Access to System:
  - JES2 (Job Entry Subsystem)
  - VTAM (Virtual Telecommunications Access Method)
  - TSO/SPF (Time Sharing Option/System Productivity Facility) CICS

6.1.2 Files and File Structures

CALSTARS currently uses 17 financial master files and 25 table files. Each of these files has auxiliary files, such as transaction or posting files, shadow files for on-line data entry and inquiry, and special copies for producing reports.

The system financial audit trail is maintained through a History file, which is retained for seven (7) years. In addition, there are other files and tables used to support system processes.

The various versions of these files and tables are stored and accessed using one of three methods:

- ADABAS (Adaptable Data Base) is used for all files of the on-line system and the primary files of the batch system.
- VSAM (Virtual Storage Access Method) is used for standard reporting and some tables processing.
- QSAM (Queued Sequential Access Method) is used for the Transaction History file, backup copies of files and for other purposes not requiring the random or direct access ability provided by VSAM.

6.1.3 Programming Languages

The programming languages used in the current system are:

- Natural and COBOL, which are the primary programming languages used in the CALSTARS system. Natural is used for the online system and some batch processing. COBOL is used in the reporting system and some batch processing. In all, there are approximately 950 COBOL or Natural programs in the CALSTARS application system.
- DYL 280, which is used for production processing and for special reporting and processing by CALSTARS staff.

6.1.4 Support Software

The following software is used to support the CALSTARS application system:

- ROPES (Remote On-line Print Executive System) is a software package used to distribute CALSTARS reports to agency local printers for viewing and printing. The use of ROPES is controlled by COBOL application programs that issue ROPES commands (on-line and batch).
- IAM (Innovation Access Method) was installed in May 1992. This product significantly reduces run times and costs for production jobs using VSAM files.
- PREDICT is an ADABAS Data Dictionary.

6.2 *CALSTARS Mapping Exercise Results*

The 820 Transaction Project Analyst mapped CALSTARS data fields to the ASC X12N 820 Transaction standard data elements. The Analyst used an EDI Transaction Mapping tool to crosswalk data requirements specified in the implementation guide to data that is currently captured in CALSTARS and used to build the proprietary Remittance Advice. Each standard transaction contains a maximum defined data set that is based on the implementation guides. A *maximum defined data set* contains all of the HIPAA *required* and *situational* data elements named with a standard transaction.

Situational data elements are those data elements that are both relevant to the particular transaction and necessary to process it. Situational data elements are defined by conditions documented within the HIPAA implementation guides. ***Required*** data elements are those data elements that must always be present in the transaction.

The Analyst mapped CALSTARS data fields used to build the proprietary Remittance Advice to the data elements in the required loops and subsequent segments, if the segment was applicable to the premium and capitation payments process. For example, in the Header there is the Non-U.S. Currency Segment that is “Situational” within the Loop. The Analyst classified this segment as “Not Applicable Segment (NAS)” because its use did not apply to the premium or capitation business operations. Additionally, there are 26 data elements classified as “Not Applicable Element (NAE)” because the data elements are located in a “Not Applicable Loop (NAL)” or “Not Applicable Segment (NAS)”, or located in a usable Segment, but that data element is not applicable to the business operations. Lastly, Identifiers (I) were not addressed when mapping because these data elements identify a specific industry code list, format or entity and are part of the X12N format. There are 37 Identifiers in the 820 Transaction.

Table 3 - CALSTARS to 820 Transaction Mapping Exercise Findings outlines how the data available in CALSTARS (Proprietary) compares to the required data in the ASC X12N 820 Transaction (Standard). The detailed mapping is presented in ***Attachment B - CALSTARS Mapping to ASC X12N 820***.

To complete the documentation of the mapping process described above, it was necessary to assign each data element a status. **Table 3** represents the status each data element was assigned. The "Status Code" used in **Table 3** corresponds to the "Status" column in the detailed Mapping Tool found in Attachment B. Each of the "Status Code" acronyms is defined in the "Status" column in the Mapping Tool. The "Status Code Definition" briefly describes the status usage.

Table 3 - CALSTARS to 820 Transaction Mapping Exercise Findings

106 Required or Situational Data Elements on ASC X12N 820		
Number of Data Elements	**Status Code[6]**	**Status Code Definition**
37	I	An **Identifier [I]** data element contains a value from a predefined list of codes that is maintained by the ASC X12 Committee or some other body recognized by the Committee. The applicable value is generally hard coded and defined in the companion guide.
26	M	The standard data element was **Matched [M]** to the proprietary data element. All attributes are consistent.
7	MP	The proprietary system does not support the data element. Therefore, it is labeled **Missing on Proprietary [MP]**.
26	NAE	Indicates that the item is NOT supported or necessary to fulfill the business operations/functions. Therefore, it is labeled as **Not an Applicable Data Element [NAE]**.
6	SYS	This identifies an item that is **System Generated [SYS]** during the creation of the transaction.
2	TSH	The **Transaction Set Header [TSH]** identifies the start and identifier of the transaction set.
2	TST	The **Transaction Set Trailer [TST]** identifies the end of the transaction set and provides a count of the data segments, which include the header and trailer segments.
0	NAL	Indicates the business operations/functions do not support the information reported in this Loop. Therefore, the Loop is labeled as **Not an Applicable Loop [NAL].**
0	NAL/S	This Segment resides within a Loop that is situational and is not supported by business needs. Therefore, the information reported in this Segment is labeled as **Not an Applicable Loop/Segment [NAL/S].**

[6] Data elements assigned to **NAL, NAL/S or NAS** status are not supported or required by a Business Need.

106 Required or Situational Data Elements on ASC X12N 820		
Number of Data Elements	**Status Code[6]**	**Status Code Definition**
0	NAS	This Segment resides within a required Loop. The information reported in this Segment is not supported by business operations or need. Therefore, the Segment is labeled as **Not an Applicable Segment [NAS].**

The CALSTARS to 820 Transaction mapping exercise revealed that 79% of the data needed to generate a compliant ASC X12N 820 Transaction resides within CALSTARS. There are seven data elements (21%) on the 820 Transaction missing in CALSTARS. These missing data elements, whether 'required' or 'situational', represent data that is not currently captured in CALSTARS.

The missing data elements are discussed in ***Table 4 - CALSTARS Missing Data Elements***.

Table 4 - CALSTARS Missing Data Elements

Loop ID	Segment Name	Data Element Name	Usage Description
Header	Financial Information	Check Issue or EFT Effective Date	For check payment, this date element specifies the check issuance date.
Header	Reassociation Key	Check or EFT Trace Number	This field is used to reassociate the payment with the remittance information.
Header	Coverage Period	Coverage Period	This is required when the premium payer is paying on an account for a coverage period.
2300A	Organization Summary Remittance Detail	Billed Premium Amount	This is required when the paid amount is different from the amount billed.
2320A	Organization Summary Remittance Level Adjustment	Adjustment Amount	This is the dollar difference between the billed amount and the paid amount.
2300B	Individual Premium Remittance Detail	Billed Premium Amount	This is required when the paid amount is different from the amount billed.
2320B	Individual Premium Adjustment	Adjustment Amount	This is the dollar difference between the billed amount and the paid amount.

7 Integrated Gap Analysis & Requirements Approval

We have reviewed the document "*820 Transaction Project, Payroll Deducted and Other Group Premium Payment for Insurance Products, HIPAA Integrated Gap Analysis & Requirements*" and hereby approve it as the official DHS position.

_____ Date_____

Steve Soto; Chief, DHS-MMCD-Plan Monitoring and Member Rights Branch

_____ Date_____

Victor Bianchini; Chief, DHS-Financial Management Branch, Accounting Section

_____ Date_____

Allan Schaden; Chief, DHS-Third Party Liability Branch

_____ Date_____

Jeff Kemp; Chief, DHS-TPLB-Health Insurance Section

_____ Date_____

Alan Muck; Chief, DHS-TPLB-Other Coverage Unit

_____ Date_____

Vivian Auble; Chief, DHS-TPLB-Recovery Section

_____ Date_____

Eric Morikawa; Chief, DHS-TPLB-Analysis and Implementation

_____ Date_____

Leanna Pierson, Chief, DHS-TPLB-Medicare Operations Unit

_____ Date_____

Jerry Walters, Chief, DHS-TPLB-Cost Avoidance Unit

_____ Date_____

Shelley Thomas; Chief, DHS-PSD-Medi-Cal Dental Services Branch

_____ Date_____

Ken Lane; Chief, Department of Finance, CALSTARS

_____ Date_____

Russ Hart; IT Section Chief, DHS-PSD-Office of HIPAA Compliance

8 Attachments

8.1 *Attachment A – CMS64 Mapping to ASC X12N 820*

Attachment A – CMS64 Mapping to ASC X12N 820

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
								TABLE 1, HEADER									FUNCTIONAL GROUP ID: RA			
								HEADER		ST								R	1	
									TRANSACTION SET IDENTIFIER CODE	ST01	143			M	ID	3/3	820	R		SYS
									TRANSACTION SET CONTROL NUMBER	ST02	329			M	AN	4/9		R		SYS
								FINANCIAL INFORMATION		BPR								R	1	
									TRANSACTION HANDLING CODE	BPR01	305			M	ID	1/2	"I" Remittance Information Only	R		I
									TOTAL PREMIUM PAYMENT AMOUNT	BPR02	782			M	R	1/18		R		M
									CREDIT/DEBIT FLAG CODE	BPR03	478			M	ID	1/1	C'	R		I
									PAYMENT METHOD CODE	BPR04	591			M	ID	3/3	"CHK"	R		I
									PAYMENT FORMAT CODE	BPR05	812			O	ID	1/10		S		I
									(DFI) ID NUMBER QUALIFIER	BPR06	506			X	ID	2/2		S		I
									(DFI) IDENTIFICATION NUMBER	BPR07	507			X	AN	3/12		S		NAE
									ACCOUNT NUMBER QUALIFIER	BPR08	569			O	ID	1/3		S		I
									SENDER BANK ACCOUNT NUMBER	BPR09	508			X	AN	1/35		S		NAE
									ORIGINATING COMPANY IDENTIFIER	BPR10	509			O	AN	10/10		S		NAE

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
									ORIGINATING COMPANY SUPPLEMENTAL CODE	BPR11	510			O	AN	9/9		S		NAE
									(DFI) ID NUMBER QUALIFIER	BPR12	506			X	ID	2/2		S		I
									(DFI) IDENTIFICATION NUMBER	BPR13	507			X	AN	3/12		S		NAE
									ACCOUNT NUMBER QUALIFIER	BPR14	569			O	ID	1/3		S		I
									RECEIVER BANK ACCOUNT NUMBER	BPR15	508			X	AN	1/35		S		NAE
									CHECK ISSUE OR EFT EFFFECTIVE DATE	BPR16	373			O	DT	8/8	For check payment, this data element specifies the check issuance date. This information is not supplied in CMS64.	R		MP
								REASSOCIATION KEY		TRN								R	1	
									TRACE TYPE CODE	TRN01	481			M	ID	1/2	"3"	R		I
									CHECK OR EFT TRACE NUMBER	TRN02	127			M	AN	1/30	This field is used to re-associate the payment with the remittance information. This information is no supplied in CMS64.	R		MP
									ORIGINATING COMPANY IDENTIFIER	TRN03	509			O	AN	10/10	This is required when the receiver needs an originating company ID to reassociate a payment to a remittance	S		NAE

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
									ORIGINATING COMPANY SUPPLEMENTAL CODE	TRN04	127			O	AN	1/30	This is required when the Payer is sending multiple premium payments for multiple group plans and the receiver needs an additional identifier for re-association	S		NAE
								NON-US DOLLARS CURRENCY		CUR								S	1	NAS
									ENTITY IDENTIFIER CODE	CUR01	98			M	ID	2/3		R		I
									CURRENCY CODE	CUR02	100			M	ID	3/3		R		I
									EXCHANGE RATE	CUR03	280			O	R	4/10	This is required when the currency for payment is not the same currency specified on the bill/invoice	S		NAE
								PREMIUM RECEIVERS IDENTIFICATION KEY		REF							For HIPAA Health Premium Payments one occurrence of this segment is REQUIRED	S	>1	
									REFERENCE IDENTIFICATION QUALIFIER	REF01	128			M	ID	2/3	14' Master Account Number	R		I
	VENDORS	10	A/N	vendor_no					PREMIUM RECEIVER REFERNCE IDENTIFIER	REF02	127			X	AN	1/30		R		M
								PROCESS DATE		DTM							For HIPAA Premium Payments this segment is NOT	Not Used	1	NAS

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
																	USED.			
									DATE/TIME QUALIFIER	DTM01	374			M	ID	3/3		Not Used		NAE
									DATE	DTM02	373			X	DT	8/8		Not Used		NAE
								DELIVERY DATE		DTM							For HIPAA Premium Payments this segment is NOT USED.	Not Used	1	NAS
									DATE/TIME QUALIFIER	DTM01	374			M	ID	3/3		Not Used		NAE
									DATE	DTM02	373			X	DT	8/8		Not Used		NAE
								COVERAGE PERIOD		DTM							This segment is required when the premium payer is not paying from an invoice but paying on account for a coverage period	S	1	
									DATE/TIME QUALIFIER	DTM01	374			M	ID	3/3	582	R		I
									DATE TIME PERIOD FORMAT QUALIFIER	DTM05	1250			X	ID	2/3	RD8 CCYYMMDD-CCYYMMDD	R		I
									COVERAGE PERIOD	DTM06	1251			X	AN	1/35	For MMCD, this segment may be used for the capitation payment coverage month.	R		MP
								LOOP ID - 1000A PREMIUM RECEIVER'S NAME										R	1	

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
								NAME												
								PREMIUM RECEIVER'S NAME		N1								R	1	
									ENTITY IDENTIFIER CODE	N101	98			M	ID	2/3	PE	R		I
	VENDORS	40	A/N	vendor_name					INFORMATION RECEIVER LAST OR ORGANIZATION NAME	N102	93			X	AN	1/60		R		M
									IDENTIFICATION CODE QUALIFIER	N103	66			X	ID	1/2	"FI" Federal Taxpayer's ID Number	R		I
									RECEIVER IDENTIFIER	N104	67			X	AN	2/80		R		MP
								PREMIUM RECEIVER'S ADDITIONAL NAME		N2							This is required when the sender needs more characters than available in the N102	S	1	NAS
									RECEIVER ADDITIONAL NAME	N201	93			M	AN	1/60	Free-form name	S		NAE
								PREMIUM RECEIVER'S ADDRESS		N3								S	1	
	VENDORS	39	A/N	vendor_add1					RECEIVER ADDRESS LINE	N301	166			M	AN	1/55		R		M
	VENDORS	30	A/N	vendor_add2					RECEIVER ADDRESS LINE	N302	166			O	AN	1/55		S		M
								PREMIUM RECEIVER'S CITY, STATE, ZIP		N4							This segment is used to relay the premium receiver's city, state and zip	S	1	
	VENDORS	15	A/N	vendor_city					CITY NAME	N401	19			O	AN	2/30		R		M

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
	VENDORS	2	A/N	vendor_state					STATE OR PROVINCE CODE	N402	156			O	ID	2/2		R		M
	VENDORS	9	A/N	vendor_zip					POSTAL CODE	N403	116			O	ID	3/15		R		M
	VENDORS	12	A/N	Foreign_cntry					COUNTRY CODE	N404	26			O	ID	2/3		S		M
								LOOP ID - 1000B PREMIUM PAYER'S NAME										R	1	
								PREMIUM PAYER'S NAME		N1								R	1	
									ENTITY IDENTIFIER CODE	N101	98			M	ID	2/3	PR	R		I
									PREMIUM PAYER NAME	N102	93			X	AN	1/60		R		M
									IDENTIFICATION CODE QUALIFIER	N103	66			X	ID	1/2	"FI" Federal Taxpayer's ID Number	R		I
									PREMIUM PAYER INDENTIFIER	N104	67			X	AN	2/80		R		MP
								PREMIUM PAYER ADDITIONAL NAME		N2							This is required when the sender needs more characters than available in the N102	S	1	NAS
									PREMIUM PAYER ADDITIONAL NAME	N201	93			M	AN	1/60	Free-form name	S		NAE
								PREMIUM PAYER ADDRESS		N3							This segment is used to relay the premium payer's city, state and zip	S	1	
									PREMIUM PAYER ADDRESS LINE	N301	166			M	AN	1/55		R		MP
									PREMIUM PAYER ADDRESS LINE	N302	166			O	AN	1/55		S		MP
								PREMIUM PAYER'S CITY, STATE, ZIP		N4								S	1	

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
									PREMIUM PAYER CITY NAME	N401	19			O	AN	2/30		R		MP
									PREMIUM PAYER STAE CODE	N402	156			O	ID	2/2		R		MP
									PREIUM PAYER POSTAL ZONE OR ZIP CODE	N403	116			O	ID	3/15		R		MP
									COUNTRY CODE	N404	26			O	ID	2/3		S		MP
								PREMIUM PAYER'S ADMINISTRATIVE CONTACT		PER								S	>1	
									CONTACT FUNCTION CODE	PER01	366			M	ID	2/2	IC Information Contact	S		I
									PREMIUM PAYER CONTACT NAME	PER02	93			O	AN	1/60		R		MP
									COMMUNICATION NUMBER QUALIFIER	PER03	365			X	ID	2/2		S		I
									COMMUNICATION NUMBER	PER04	364			X	AN	1/80		S		MP
									COMMUNICATION NUMBER QUALIFIER	PER05	365			X	ID	2/2		S		I
									COMMUNICATION NUMBER	PER06	364			X	AN	1/80		S		NAE
									COMMUNICATION NUMBER QUALIFIER	PER07	365			X	ID	2/2		S		I
									COMMUNICATION NUMBER	PER08	364			X	AN	1/80		S		NAE
								TABLE 2: DETAIL, ORGANIZATION SUMMARY REMITTANCE									Propose to use Organization Summary for MCO capitation payments and dental FI Pure Premium payments.			

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
								LOOP ID - 2000A ORGANIZATION SUMMARY REMITTANCE										S	1	
								ORGANIZATION SUMMARY REMITTANCE		ENT								S	1	
									ASSIGNED NUMBER	ENT01	554			O	N0	1/6		R		SYS
									ENTITY IDENTIFIER CODE	ENT02	98			X	ID	2/3	"2L" Corporation	R		I
									IDENTIFICATION CODE QUALIFIER	ENT03	66			X	ID	2/3	"FI" Federal Taxpayer's ID Number	S		I
									ORGANIZATION IDENTIFICATION CODE	ENT04	67			X	AN	2/80		R		MP
								LOOP ID - 2300A ORGANIZATION SUMMARY REMITTANCE DETAIL										R	>1	
								ORGANIZATION SUMMARY REMITTANCE DETAIL		RMR							Used to provide detailed remittance detail	R	1	
									REFERENCE IDENTIFICATION QUALIFIER	RMR01	128			X	ID	2/3	"IK" Invoice Number For HIPAA Health Premium Payments this code is REQUIRED when an invoice has not been received from the health plan	R		I
	CS_Invoice_Detail	19	A/N	CS_Invoice_Detail					CONTRACT, INVOICE, ACCOUNT, GROUP, OR POLICY	RMR02	127			X	AN	1/30		R		M

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
									NUMBER											
									PAYMENT ACTION CODE	RMR03	482			O	ID	2/2	For HIPAA Health Premium Payments this element is NOT USED	Not Used		NAE
	CS_Batch_Header	8	N	BatchAmount					DETAIL PREMIUM PAYMENT AMOUNT	RMR04	782			O	R	1/18		R		M
									BILLED PREMIUM AMOUNT	RMR05	782			O	R	1/18	This is required when the Insurer sent an invoice and the paid amount is different that the amount invoiced	S		MP
								LOOP ID - 2310A SUMMARY LINE ITEM										R	1	
								SUMMARY LINE ITEM		IT1							For HIPAA Health Premium Payments this segment is REQUIRED	R	1	
									LINE ITEM CONTROL NUMBER	IT101	350			O	AN	1/20	Assigned for uniqueness, suggest "1" be used.	R		SYS
								LOOP ID - 2315A MEMBER COUNT										R	>1	
								MEMBER COUNT		SLN							For HIPAA Health Premium Payments one occurrence of this segment is REQUIRED	R	1	
									LINE ITEM CONTROL NUMBER	SLN01	350			O	AN	1/20	Assigned for uniqueness, suggest "1" be	R		SYS

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
																	used.			
									INFORMATION ONLY INDICATOR	SLN03	662			M	ID	1/1	"O" Information Only	R		I
									HEAD COUNT	SLN04	380			X	R	1/15		R		MP
									COMPOSITE UNIT OF MEASURE	SLN05	C001			X			Not data	R		Null
									UNIT OR BASIS FOR MEASUREMENT CODE	SLN05-1	355			M	ID	2/2	"IE" Person	R		I
								LOOP ID - 2320A ORGANIZATION SUMMARY REMITTANCE LEVEL ADJUSTMENT										S	>1	
								ORGANIZATION SUMMARY REMITTANCE LEVEL ADJUSTMENT		ADX							This segment is REQUIRED when the paid amount is different from any invoiced amount. The ADX segment must be used as necessary to fulfill the balancing requirements	S	1	
									ADJUSTMENT AMOUNT	ADX01	782			M	R	1/18		R		MP
									ADJUSTMENT REASON CODE	ADX02	426			M	ID	2/2		R		I
								TABLE 2: DETAIL, INDIVIDUAL REMITTANCE									Propose to use Organization Summary for HIPP, BCCTP, and M+C premium payments.			

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
								LOOP ID - 2000B INDIVIDUAL REMITTANCE										S	>1	
								INDIVIDUAL REMITTANCE		ENT								S	1	NAS
									ASSIGNED NUMBER	ENT01	554			O	NO	1/6		R		SYS
									ENTITY IDENTIFIER CODE	ENT02	98			X	ID	2/3	"J2" Individual	R		I
									IDENTIFICATION CODE QUALIFIER	ENT03	66			X	ID	2/3	"34" SSN	R		I
									RECEIVER'S INDIVIDUAL IDENTIFIER	ENT04	67			X	AN	2/80		R		MP
								LOOP ID - 2200B INDIVIDUAL NAME										S		NAL
								INDIVIDUAL NAME		NM1								S	>1	NAS/S
									ENTITY IDENTIFIER CODE	NM101	98			X	ID	2/3	"QE" Policy Holder	R		I
									ENTITY TYPE QUALIFIER	NM102	1065			M	ID	2/3	1 Person	S		I
									INDIVIDUAL LAST NAME	NM103	1035			O	AN	1/35		S		NAE
									INDIVIDUAL FIRST NAME	NM104	1036			O	AN	1/25		S		NAE
									INDIVIDUAL MIDDLE NAME	NM105	1037			O	AN	1/25		S		NAE
									INDIVIDUAL NAME PREFIX	NM106	1038			O	AN	1/10		S		NAE
									INDIVIDUAL NAME SUFFIX	NM107	1039			O	AN	1/10		S		NAE
									IDENTIFICATION CODE QUALIFER	NM108	66			X	ID	1/2	"N" Insured's Unique ID Number	S		I
									INDIVIDUAL IDENTIFIER	NM109	67			X	AN	2/80		S		NAE
								LOOP ID - 2300B INDIVIDUAL PREMIUM REMITTANCE										R	>1	

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
								REMITTANCE DETAIL												
								INDIVIDUAL PREMIUM REMITTANCE DETAIL		RMR							For HIPAA Health Premium Payments this segment is REQUIRED	R	1	
									REFERENCE IDENTIFICATION QUALIFIER	RMR01	128			X	ID	2/3	"CT" Contract Number Will be the MCO contract number provided by MMCD "IK" Invoice Number Will be the Health Plan premium invoice number	R		I
									INSURANCE REMITTANCE REFERENCE NUMBER	RMR02	127			X	AN	1/30		R		M
									PAYMENT ACTION CODE	RMR03	482			O	ID	2/2	For HIPAA Health Premium Payment this element is NOT USED	Not Used		NAE
									DETAIL PREMIUM PAYMENT AMOUNT	RMR04	782			O	R	1/18		R		M
									BILLED PREMIUM AMOUNT	RMR05	782			O	R	1/18	This is required when the paid amount is different than the amount billed	S		MP

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
								INDIVIDUAL COVERAGE PERIOD		DTM							This segment is required whet the premium payer is not paying from an invoice but paying on account for a coverage period	S	1	
									DATE/TIME QUALIFIER	DTM01	374			M	ID	3/3	"582" Report Period	R		I
									DATE TIME PERIOD FORMAT QUALIFIER	DTM05	1250			X	ID	2/3	"RD8" CCYYMMDD-CCYYMMDD	R		I
									COVERAGE PERIOD	DTM06	1251			X	AN	1/35		R		NAE
								LOOP ID - INDIVIDUAL PREMIUM ADJUSTMENT										S	>1	
								INDIVIDUAL PREMIUM ADJUSTMENT		ADX							This segment is REQUIRED when the paid amount is different from any invoiced amount	S	1	
									ADJUSTMENT AMOUNT	ADX01	782			M	R	1/18		R		MP
									ADJUSTMENT REASON CODE	ADX02	426			M	ID	2/2		R		I
								TABLE 3: SUMMARY												
								820 TRAILER		SE								R	1	
									TRANSACTION SEGMENT COUNT	SE01	96			M	NO	1/10		R		SYS
									TRANSACTION SET CONTROL NUMBER	SE02	329			M	AN	4/9	MUST MATCH ST02	R		SYS

8.2 *Attachment B – CALSTARS Mapping to ASC X12N 820*

Attachment B - CALSTARS Mapping to ASC X12N 820

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
								TABLE 1, HEADER									FUNCTIONAL GROUP ID: RA			
								HEADER		ST								R	1	
									TRANSACTION SET IDENTIFIER CODE	ST01	143			M	ID	3/3	820	R		TSH
									TRANSACTION SET CONTROL NUMBER	ST02	329			M	AN	4/9		R		TSH
								FINANCIAL INFORMATION		BPR								R	1	
									TRANSACTION HANDLING CODE	BPR01	305			M	ID	1/2	"I" Remittance Infromtion Only	R		I
	WARRANT WRITE PROCESS						Calculated during Warrant Write process. Amount reported on RA in Total Payment field.		TOTAL PREMIUM PAYMENT AMOUNT	BPR02	782			M	R	1/18		R		M
									CREDIT/DEBIT FLAG CODE	BPR03	478			M	ID	1/1	C'	R		I
									PAYMENT METHOD CODE	BPR04	591			M	ID	3/3	"CHK"	R		I
									PAYMENT FORMAT CODE	BPR05	812			O	ID	1/10		S		I
									(DFI) ID NUMBER QUALIFIER	BPR06	506			X	ID	2/2		S		I
									(DFI) IDENTIFICATION NUMBER	BPR07	507			X	AN	3/12		S		NAE

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
								ACCOUNT NUMBER QUALIFIER	BPR08	569			O	ID	1/3		S		I
								SENDER BANK ACCOUNT NUMBER	BPR09	508			X	AN	1/35		S		NAE
								ORIGINATING COMPANY IDENTIFIER	BPR10	509			O	AN	10/10		S		NAE
								ORIGINATING COMPANY SUPPLEMENTAL CODE	BPR11	510			O	AN	9/9		S		NAE
								(DFI) ID NUMBER QUALIFIER	BPR12	506			X	ID	2/2		S		I
								(DFI) IDENTIFICATION NUMBER	BPR13	507			X	AN	3/12		S		NAE
								ACCOUNT NUMBER QUALIFIER	BPR14	569			O	ID	1/3		S		I
								RECEIVER BANK ACCOUNT NUMBER	BPR15	508			X	AN	1/35		S		NAE
								CHECK ISSUE OR EFT EFFFECTIVE DATE	BPR16	373			O	DT	8/8	For check payment, this data element specifies the check issuance date. This information is not supplied in CALSTARS.	R		MP
							REASSOCIATION KEY		TRN								R	1	
								TRACE TYPE CODE	TRN01	481			M	ID	1/2	"3"	R		I
								CHECK OR EFT TRACE NUMBER	TRN02	127			M	AN	1/30	This field is used to re-associate the payment with the remittance information. This information is no supllied in	R		MP

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
																CALSTARS.			
								ORIGINATING COMPANY IDENTIFIER	TRN03	509			O	AN	10/10	This is required when the receiver needs an originating company ID to reassociate a payment to a remittance	S		NAE
								ORIGINATING COMPANY SUPPLEMENTAL CODE	TRN04	127			O	AN	1/30	This is required when the Payer is sending multiple premium payments for multiple group plans and the receiver needs an additional identifier for re-association	S		NAE
							NON-US DOLLARS CURRENCY		CUR								S	1	NAS
								ENTITY IDENTIFIER CODE	CUR01	98			M	ID	2/3		R		I
								CURRENCY CODE	CUR02	100			M	ID	3/3		R		I
								EXCHANGE RATE	CUR03	280			O	R	4/10	This is required when the currency for payment is not the same currency specified on the bill/invoice	S		NAE
							PREMIUM RECEIVERS IDENTIFICATION KEY		REF							For HIPAA Health Premium Payments one occurrence of this segment is	S	>1	

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
																REQUIRED			
								REFERENCE IDENTIFICATION QUALIFIER	REF01	128			M	ID	2/3	14' Master Account Number	R		I
	VENDOR EDIT	12	AN	VENDOR NO		Free-format ID, designated by Accounting		PREMIUM RECEIVER REFERNCE IDENTIFIER	REF02	127			X	AN	1/30		R		M
							PROCESS DATE		DTM							For HIPAA Premium Payments this segment is NOT USED.	Not Used	1	NAS
								DATE/TIME QUALIFIER	DTM01	374			M	ID	3/3		Not Used		NAE
								DATE	DTM02	373			X	DT	8/8		Not Used		NAE
							DELIVERY DATE		DTM							For HIPAA Premium Payments this segment is NOT USED.	Not Used	1	NAS
								DATE/TIME QUALIFIER	DTM01	374			M	ID	3/3		Not Used		NAE
								DATE	DTM02	373			X	DT	8/8		Not Used		NAE
							COVERAGE PERIOD		DTM							This segment is required when the premium payer is not paying from an invoice but paying on account for a coverage period	S	1	
								DATE/TIME QUALIFIER	DTM01	374			M	ID	3/3	582	R		I

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
								DATE TIME PERIOD FORMAT QUALIFIER	DTM05	1250			X	ID	2/3	RD8 CCYYMMDD-CCYYMMDD	R		I
								COVERAGE PERIOD	DTM06	1251			X	AN	1/35	For MMCD, this segment may be used for the capitation payment coverage month.	R		MP
							LOOP ID - 1000A PREMIUM RECEIVER'S NAME										R	1	
							PREMIUM RECEIVER'S NAME		N1								R	1	
								ENTITY IDENTIFIER CODE	N101	98			M	ID	2/3	PE	R		I
	VENDOR EDIT	30	AN	NAME				INFORMATION RECEIVER LAST OR ORGANIZATION NAME	N102	93			X	AN	1/60		R		M
						"XV" National Plan ID will be required when mandated for use.		IDENTIFICATION CODE QUALIFIER	N103	66			X	ID	1/2	"FI" Federal Taxpayer's ID Number	R		I
	VENDOR EDIT	9	AN	FEIN		Not a current business requirement. If FTIN is not available, default to all nines (9).		RECEIVER IDENTIFIER	N104	67			X	AN	2/80		R		M

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
							PREMIUM RECEIVER'S ADDITIONAL NAME		N2							This is required when the sender needs more characters than available in the N102	S	1	NAS
								RECEIVER ADDITIONAL NAME	N201	93			M	AN	1/60	Free-form name	S		NAE
							PREMIUM RECEIVER'S ADDRESS		N3								S	1	
	VENDOR EDIT	30	AN	ADDRESS 1				RECEIVER ADDRESS LINE	N301	166			M	AN	1/55		R		M
	VENDOR EDIT	30	AN	ADDRESS 2				RECEIVER ADDRESS LINE	N302	166			O	AN	1/55		S		M
							PREMIUM RECEIVER'S CITY, STATE, ZIP		N4							This segment is used to relay the premium receiver's city, state and zip	S	1	
	VENDOR EDIT	15	AN	CITY				CITY NAME	N401	19			O	AN	2/30		R		M
	VENDOR EDIT	2	AN	STATE				STATE OR PROVINCE CODE	N402	156			O	ID	2/2		R		M
	VENDOR EDIT	5/9	Nm	ZIP				POSTAL CODE	N403	116			O	ID	3/15		R		M
	VENDOR EDIT	12	AN	FOREIGN COUNTRY				COUNTRY CODE	N404	26			O	ID	2/3		S		M
							LOOP ID - 1000B PREMIUM PAYER'S NAME										R	1	
							PREMIUM PAYER'S NAME		N1								R	1	
								ENTITY IDENTIFIER CODE	N101	98			M	ID	2/3	PR	R		I

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
	VENDOR EDIT	12	AN	VENDOR NO	AAAAAAAAAA-00		Prints the agency's Name, Address, City, State, Zip Code, and Phone Number on Remittance Advice		PREMIUM PAYER NAME	N102	93			X	AN	1/60		R		M
									IDENTIFICATION CODE QUALIFIER	N103	66			X	ID	1/2	"FI" Federal Taxpayer's ID Number	R		I
	VENDOR EDIT	9	AN	FEIN	680317191				PREMIUM PAYER INDENTIFIER	N104	67			X	AN	2/80		R		M
								PREMIUM PAYER ADDITIONAL NAME		N2							This is required when the sender needs more characters than available in the N102	S	1	NAS
									PREMIUM PAYER ADDITIONAL NAME	N201	93			M	AN	1/60	Free-form name	S		NAE
								PREMIUM PAYER ADDRESS		N3							This segment is used to relay the premium payer's city, state and zip	S	1	
	VENDOR EDIT	30	AN	ADDRESS 1	AAAAAAAAAA-00		Prints the agency's Name, Address, City, State, Zip Code, and Phone Number on Remittance Advice		PREMIUM PAYER ADDRESS LINE	N301	166			M	AN	1/55		R		M

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
	VENDOR EDIT	30	AN	ADDRESS 2	AAAAAAAAAA-00		Prints the agency's Name, Address, City, State, Zip Code, and Phone Number on Remittance Advice		PREMIUM PAYER ADDRESS LINE	N302	166			O	AN	1/55		S		M
								PREMIUM PAYER'S CITY, STATE, ZIP		N4								S	1	
	VENDOR EDIT	15	AN	CITY	AAAAAAAAAA-00		Prints the agency's Name, Address, City, State, Zip Code, and Phone Number on Remittance Advice		PREMIUM PAYER CITY NAME	N401	19			O	AN	2/30		R		M
	VENDOR EDIT	2	AN	STATE	AAAAAAAAAA-00		Prints the agency's Name, Address, City, State, Zip Code, and Phone Number on Remittance Advice		PREMIUM PAYER STAE CODE	N402	156			O	ID	2/2		R		M

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
	VENDOR EDIT	5/9	Nm	ZIP	AAAAAAAAAA-00		Prints the agency's Name, Address, City, State, Zip Code, and Phone Number on Remittance Advice		PREIUM PAYER POSTAL ZONE OR ZIP CODE	N403	116			O	ID	3/15		R		M
	VENDOR EDIT	12	AN	FOREIGN COUNTRY					COUNTRY CODE	N404	26			O	ID	2/3		S		M
								PREMIUM PAYER'S ADMINISTRATIVE CONTACT		PER								S	>1	
									CONTACT FUNCTION CODE	PER01	366			M	ID	2/2	IC Information Contact	S		I
	VENDOR EDIT	40	AN	CONTACT NAME					PREMIUM PAYER CONTACT NAME	PER02	93			O	AN	1/60		R		M
									COMMUNICATION NUMBER QUALIFIER	PER03	365			X	ID	2/2		S		I
	VENDOR EDIT	10	Nm	PHONE			REQUIRED for vendor number AAAAAAAAAA-00.		COMMUNICATION NUMBER	PER04	364			X	AN	1/80		S		M
									COMMUNICATION NUMBER QUALIFIER	PER05	365			X	ID	2/2		S		I
									COMMUNICATION NUMBER	PER06	364			X	AN	1/80		S		NAE
									COMMUNICATION NUMBER QUALIFIER	PER07	365			X	ID	2/2		S		I

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
								COMMUNICATION NUMBER	PER08	364			X	AN	1/80		S		NAE
							TABLE 2: DETAIL, ORGANIZATION SUMMARY REMITTANCE												
							LOOP ID - 2000A ORGANIZATION SUMMARY REMITTANCE										S	1	
							ORGANIZATION SUMMARY REMITTANCE		ENT								S	1	
								ASSIGNED NUMBER	ENT01	554			O	N0	1/6		R		SYS
								ENTITY IDENTIFIER CODE	ENT02	98			X	ID	2/3	"2L" Corporation	R		I
								IDENTIFICATION CODE QUALIFIER	ENT03	66			X	ID	2/3	"FI" Federal Taxpayer's ID Number	S		I
	VENDOR EDIT	9	AN	FEIN				ORGANIZATION IDENTIFICATION CODE	ENT04	67			X	AN	2/80		R		M
							LOOP ID - 2300A ORGANIZATION SUMMARY REMITTANCE DETAIL										R	>1	
							ORGANIZATION SUMMARY REMITTANCE DETAIL		RMR							Used to provide detailed remittance detail	R	1	
								REFERENCE IDENTIFICATION QUALIFIER	RMR01	128			X	ID	2/3	"CT" Contract Number "IK" Invoice Number Will be the Health Plan premium invoice number	R		I

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
	WARRANT WRITE PROCESS			REF/SUFFIX (REF DOC)			For capitation payments this will be the MCO contract number. For HIPP, BCCTP, and M+C premium payments this will be the original invoice number submitted by the health plan.		CONTRACT, INVOICE, ACCOUNT, GROUP, OR POLICY NUMBER	RMR02	127			X	AN	1/30		R		M
									PAYMENT ACTION CODE	RMR03	482			O	ID	2/2	For HIPAA Health Premium Payments this element is NOT USED	Not Used		NAE
	WARRANT WRITE PROCESS			AMOUNT			Amount by invoice on RA		DETAIL PREMIUM PAYMENT AMOUNT	RMR04	782			O	R	1/18		R		M
									BILLED PREMIUM AMOUNT	RMR05	782			O	R	1/18	This is required when the Insurer sent an invoice and the paid amount is different than the amount invoiced	S		MP
								LOOP ID - 2310A SUMMARY LINE ITEM										R	1	
								SUMMARY LINE ITEM		IT1							For HIPAA Health Premium Payments this segment is REQUIRED	R	1	

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
								LINE ITEM CONTROL NUMBER	IT101	350			O	AN	1/20	Used to provide optional member counts under a summary RMR item. The member count will be transmitted in the SLN segment to follow.	R		SYS
							LOOP ID - 2315A MEMBER COUNT										R	>1	
							MEMBER COUNT		SLN							For HIPAA Health Premium Payments one occurrence of this segment is REQUIRED	R	1	
								LINE ITEM CONTROL NUMBER	SLN01	350			O	AN	1/20	Use to provide optional member counts under a summary RMR/IT1 item. The member count is the total number of members/insured reprsented in the summary line item payment (RMR).	R		SYS
								INFORMATION ONLY INDICATOR	SLN03	662			M	ID	1/1	"O" Information Only	R		I
								HEAD COUNT	SLN04	380			X	R	1/15		R		SYS
								COMPOSITE UNIT OF MEASURE	SLN05	C001			X			Not Data	R		SYS
								UNIT OR BASIS FOR MEASUREMENT CODE	SLN05-1	355			M	ID	2/2	"IE" Person	R		I

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
							LOOP ID - 2320A ORGANIZATION SUMMARY REMITTANCE LEVEL ADJUSTMENT										S	>1	
							ORGANIZATION SUMMARY REMITTANCE LEVEL ADJUSTMENT		ADX							This segment is REQUIRED when the paid amount is different from any invoiced amount. The ADX segment must be used as necessary to fulfill the balancing requirements	S	1	
								ADJUSTMENT AMOUNT	ADX01	782			M	R	1/18		R		MP
								ADJUSTMENT REASON CODE	ADX02	426			M	ID	2/2		R		I
							TABLE 2: DETAIL, INDIVIDUAL REMITTANCE												
							LOOP ID - 2000B INDIVIDUAL REMITTANCE										S	>1	
							INDIVIDUAL REMITTANCE		ENT								S	1	
								ASSIGNED NUMBER	ENT01	554			O	NO	1/6		R		SYS
								ENTITY IDENTIFIER CODE	ENT02	98			X	ID	2/3	"J2" Individual	R		I
								IDENTIFICATION CODE QUALIFIER	ENT03	66			X	ID	2/3	"34" SSN	R		I

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
	WARRANT WRITE PROCESS			INVOICE NUMBER			This will be the SSN or Member ID of the individual for which the payment is being made.		RECEIVER'S INDIVIDUAL IDENTIFIER	ENT04	67			X	AN	2/80	This is the identification number of the individual used by the receiver.	R		M
								LOOP ID - 2100B INDIVIDUAL NAME										S		NAL
								INDIVIDUAL NAME		NM1								S	>1	NAL/S
									ENTITY IDENTIFIER CODE	NM101	98			X	ID	2/3	"QE" Policy Holder	R		I
									ENTITY TYPE QUALIFIER	NM102	1065			M	ID	2/3	1 Person	S		I
									INDIVIDUAL LAST NAME	NM103	1035			O	AN	1/35		S		NAE
									INDIVIDUAL FIRST NAME	NM104	1036			O	AN	1/25		S		NAE
									INDIVIDUAL MIDDLE NAME	NM105	1037			O	AN	1/25		S		NAE
									INDIVIDUAL NAME PREFIX	NM106	1038			O	AN	1/10		S		NAE
									INDIVIDUAL NAME SUFFIX	NM107	1039			O	AN	1/10		S		NAE
									IDENTIFICATION CODE QUALIFER	NM108	66			X	ID	1/2	"N" Insured's Unique ID Number	S		I
									INDIVIDUAL IDENTIFIER	NM109	67			X	AN	2/80	this field is to be used if the value in ENTT04 is not reported.	S		NAE
								LOOP ID - 2300B INDIVIDUAL PREMIUM REMITTANCE DETAIL										R	>1	

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc	Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
								INDIVIDUAL PREMIUM REMITTANCE DETAIL		RMR							For HIPAA Health Premium Payments this segment is REQUIRED	R	1	
									REFERENCE IDENTIFICATION QUALIFIER	RMR01	128			X	ID	2/3	"CT" Contract Number	R		I
	WARRANT WRITE PROCESS			INVOICE NUMBER			This will be the SSN or Member ID of the individual for which the payment is being made.		INSURANCE REMITTANCE REFERENCE NUMBER	RMR02	127			X	AN	1/30		R		M
									PAYMENT ACTION CODE	RMR03	482			O	ID	2/2	For HIPAA Health Premium Payment this element is NOT USED	Not Used		NAE
	WARRANT WRITE PROCESS			AMOUNT			Amount by invoice on RA		DETAIL PREMIUM PAYMENT AMOUNT	RMR04	782			O	R	1/18		R		M
									BILLED PREMIUM AMOUNT	RMR05	782			O	R	1/18	This is required when the paid amount is different than the amount billed	S		MP
								INDIVIDUAL COVERAGE PERIOD		DTM							This segment is required when the premium payer is not paying from an invoice but paying on account for a coverage period	S	1	
									DATE/TIME QUALIFIER	DTM01	374			M	ID	3/3	"582" Report Period	R		I
									DATE TIME PERIOD FORMAT QUALIFIER	DTM05	1250			X	ID	2/3	"RD8" CCYYMMDD-CCYYMMDD	R		I

Internal Record ID	Table/ Database	Fld Len	Fld Type	Field Name	Code Value	Code Desc Comment	Segment Name	Industry/Element Name	Ref Des.	Element Number	Code Value	Code Desc	Attributes			Notes	Use	Re-peat	Status
								QUALIFIER								CCYYMMDD			
								COVERAGE PERIOD	DTM06	1251			X	AN	1/35		R		NAE
							LOOP ID - 2320B INDIVIDUAL PREMIUM ADJUSTMENT										S	>1	
							INDIVIDUAL PREMIUM ADJUSTMENT		ADX							This segment is REQUIRED when the paid amount is different from any invoiced amount	S	1	
								ADJUSTMENT AMOUNT	ADX01	782			M	R	1/18		R		MP
								ADJUSTMENT REASON CODE	ADX02	426			M	ID	2/2		R		I
							TABLE 3: SUMMARY												
							820 TRAILER		SE								R	1	
								TRANSACTION SEGMENT COUNT	SE01	96			M	NO	1/10		R		TST
								TRANSACTION SET CONTROL NUMBER	SE02	329			M	AN	4/9	MUST MATCH ST02	R		TST