

**Request for Proposals: Actuarial and Related Services for Health
Benefits Programs
RFP # OHB03-1
Issued: February 14, 2003**

**ADDENDUM 1
February 28, 2003**

This Addendum incorporates certain general comments and answers to questions posed during the optional pre-proposal conference held on February 24, 2003

GENERAL

Verbal responses to questions at the pre-proposal conference are unofficial and are not binding. Only these written responses may be relied upon by offerors.

Participants at the pre-proposal conference were required to register their attendance and to provide their fax numbers. A list of all attendees at the conference is enclosed for informational purposes.

Questions and Answers:

1. Please provide a copy of the data record lay out for the claim data provided by Magellan and Anthem/Trigon as well as the Benefits Eligibility Systems (BES) eligibility.
 - A. **Claims layout** is provided on Attachments I and II located after the questions.

BES layout will comply with HIPAA requirements by July 1, 2003 (currently being tested with carriers and current contractor) using ASC X12N 834. Additional information may be found at the following web site:
http://hipaa.wpc-edi.com/HIPAA_40.asp
Note: The Department will use version 004010X095A1, which incorporates the addendum published Oct 2002
2. On a yearly basis what is the approximate number of claims that must be investigated and resolved?
 - A. Over 60,000 payment records fail edits. Most are resolved, through investigation, as non-errors. A payment record is not necessarily equal to one "claim."
3. Are the rates currently adjusted by sex, risk or other demographic factors? If they are, what type of adjustment is currently done?
 - A. Yes. The Department self bills all fully insured carriers monthly and the premiums paid are adjusted to reflect each carrier's enrollee's demographics.

4. Please describe some of the standards, tasks or deliverables that the on-site performance review would encompass that would not be part of the claims audit?
 - A. The performance review is synonymous with the term “procedural audit.” Its’ purpose is to determine whether the operational procedures utilized by the vendors to administer the plan effectively support achievement of the contractual claim processing accuracy, quality, and service standards.
5. Do the Commonwealth's current Business Associate HIPAA agreements permit audits of the Business Associate?
 - A. The Department is currently finalizing Business Associate HIPAA agreements and they will contain a provision to permit audits as defined in each contract.
6. Please describe the extent of choice between cash and non-cash benefit options for employees anticipated under task 3.10.
 - A. Currently under the 125 plan the Commonwealth offers a choice between cash (taxable benefit) and the health benefits plan, medical reimbursement account and a dependent day care assistance account (non-taxable benefit). It is the Department’s desire to offer the Commonwealth’s employees a full cafeteria plan at some time in the future. At that time, the Contractor would be involved in the design and provide technical advice. However, due to the current fiscal situation, this will not take place in the foreseeable future.
- 7.a. The RFP refers to two systems that are currently in place, the BES and a claims data base (see task 3.4). Are these systems owned by the Commonwealth that the contractor will manage?
 - A. The Commonwealth owns and operates the BES system. The Commonwealth owns the claim data history.
- 7.b. Will these systems have to be newly developed by the Contractor? Is it anticipated that the contractor will use an existing system that they already have in place?
 - A. It is contemplated that a new contractor, if applicable, would utilize its’ own claims analysis and modeling systems. The carriers and BES would transmit the data utilizing the same or similar layout. Claims history would be transmitted to the new contractor by the current contractor.
- 7.c. How many years of historical data will be transferred from the current contractor to the new contractor?
 - A. Three Years.

8. How were these systems originally developed and by what organization?
- A. The contractor developed these systems.
- 8.b. Are any of the data or systems documentation proprietary to an organization other than the Commonwealth?
- A. Claims Data Base (Task 3.4): The current vendor will provide non-proprietary DDL scripts, and ASCII delimited files. It will not provide the source code, nor the stored procedures it developed for the loading and access of participant eligibility and claims.
- Forecasting Model (Task 3.5): The current vendor's Benefits Modeling System, which is used to model plan design changes and develop alternative rate and contribution scenarios, is proprietary and will not be provided.
9. In task 3.4 it refers to the contractor making enhancements to a claims database. What types of enhancements are already on the drawing board and anticipated for 2003?
- A. No enhancements are on the drawing board and none are anticipated for 2003.
10. Please explain what is expected of the contractor as described in Appendix 1 where it requires the contractor to "validate that Carrier claims are paid to eligible individuals under the correct program of benefits." Will this require the contractor to review actual claims detail? Or will the individual be enrolled and eligible to receive benefit payments according to the BES?
- A. All membership eligibility for the Commonwealth's enrollees is contained on BES. Regular feeds containing any change transactions are transmitted electronically to all carriers. Claims should only be paid for enrollees that are incurred while coverage is in effect. The contractor's responsibility is to validate that all claims payments are made for individuals that were eligible for the coverage at the time the claim was incurred and if not, identify those claims and send them back to the carrier and the Department for corrective action.
11. The Appendix also "requires that the consultant eligibility data mirror BES..." Does this mean that the consultant will maintain a separate database from the carriers and the Commonwealth?
- A. A separate system to mirror BES is required, since direct access to BES is not available.

12. How does the current contractor track eligibility to mirror BES?
 - A. The Commonwealth provides to all vendors and the current contractor daily transaction feeds reflecting all eligibility changes made to BES.

Attachment I

Commonwealth of Virginia
Claims Database
Data Definitions
April 2, 1999

Facility Provider Type

- 01: Hospital
- 02: Skilled Nursing Facility
- 03: Home Health Agency
- 04: Physical Therapy Clinic
- 05: Outpatient Clinic
- 06: Health Maintenance Organization
- 07: Visiting Nurses Association
- 08: Private Laboratory
- 09: Alcohol Rehabilitation Facility
- 10: Ambulatory Surgical Facility Level I
- 11: Ambulatory Surgical Facility Level II
- 12: Ambulatory Surgical Facility Level III
- 13: Ambulatory Surgical Facility Level IV
- 14: Partial Day Psychiatric Facility
- 15: Other Facility

Professional Provider Type

- 31: Medical Doctor (MD)
- 32: Ambulatory Surgery Physician: High Level
- 33: Ambulatory Surgery Physician: Low Level
- 34: Ambulatory Surgery Provider
- 35: Clinical Nurse Specialist (CNS)
- 36: Doctor of Osteopath (DO)
- 37: Dentist (DDS/DMD)
- 38: Doctor of Podiatry (DPM)
- 39: Licensed Psychologist (LP)
- 40: Certified Registered Nurse Anesthetist (CRNA)
- 41: Consultant
- 42: Medical Laboratory
- 43: Christian Science Nurse
- 44: Hospital Outpatient Endorsement
- 45: Physical Therapist
- 46: Occupational Therapist
- 47: Speech Therapist
- 48: Optician
- 49: Nurse Midwife
- 50: Hospital Emergency Room Physician
- 51: Licensed Professional Counselor (LPC)
- 52: Durable Medical Equipment Supplier (DME)
- 53: Chiropractor (DC)

- 54: Optometrist
- 55: Licensed Clinical Psychologist (LCP)
- 56: Licensed Clinical Social Worker (LCSW)
- 57: Audiologist
- 58: School Psychologist
- 59: Home Health Agency
- 60: I.V. Therapy
- 61: Other Professional Provider

Pharmacy Provider Type

- 91: Retail Only
- 92: Retail & Maintenance
- 93: Mail Order Only

Provider Specialty (Professional Only)

- 01: Addictionology
- 02: Administration/Preventive Medicine
- 03: Adolescent Medicine
- 04: Allergy
- 05: Ambulance Services
- 06: Anesthesiology (Osteopath)
- 07: Anesthesiology
- 08: Audiology
- 09: Cardiac Surgery
- 10: Cardiology
- 11: Cardiovascular Disease
- 12: Child Psychiatry
- 13: Chiropractor
- 14: Christian Science Nurse
- 15: Clinical Nurse Specialist
- 16: Clinical Psychology
- 17: Colon/Rectal Surgery
- 18: Critical Care
- 19: CRNA
- 20: Dermatology (Osteopath)
- 21: Dermatology
- 22: Dermatopathology
- 23: Diagnostic Radiology
- 24: Diagnostic Roentgenology
- 25: Durable Medical Equipment
- 26: Ear Nose & Throat
- 27: Emergency Medicine
- 28: Endocrinology
- 29: Endodontist (Dentist)
- 30: Eye, Ear, Nose & Throat (Osteopath)
- 31: Family Practice (Osteopath)
- 32: Family Practice
- 33: Forensic Pathology
- 34: Gastroenterology

- 35: General Anesthesia (Dentist)
- 36: General Practice (Dentist)
- 37: General Practice (M.D.)
- 38: General Practice (Osteopath)
- 39: General Surgery
- 40: General Surgery (Osteopath)
- 41: Genetics Metabolism
- 42: Geriatrics Medicine
- 43: Gynecological Oncology
- 44: Gynecology (Osteopath)
- 45: Gynecology
- 46: Hand Surgery
- 47: Head & Neck Surgery
- 48: Hematology/Oncology
- 49: Hepatology
- 50: Home Health Agency (Professional Only)
- 51: Hospital
- 52: Hospital Outpatient Endorsement
- 53: Hospital Psychiatric Care
- 54: Hospital Reference Lab
- 55: Immunology
- 56: Independent Laboratory
- 57: Infectious Disease
- 58: Internal Medicine (Osteopath)
- 59: Internal Medicine
- 60: IV Therapy
- 61: Licensed Professional Counselor
- 62: Licensed Psychologist
- 63: Manipulative Therapy
- 64: Maternal/Fetal Medicine
- 65: Maxillo-Facial Surgery (Dentist)
- 66: Medical Genetics
- 67: Multi Specialty Clinic
- 68: Neonatal/Perinatal Medicine
- 69: Nephrology
- 70: Neurological Surgery
- 71: Neurology
- 72: Neurotology
- 73: Nuclear Medicine
- 74: Nurse Midwife
- 75: Nurse Practitioner
- 76: Obstetrics (Osteopath)
- 77: Obstetrics
- 78: Obstetrics/Gynecology
- 79: Occupational Therapy
- 80: Ophthalmology
- 81: Optician
- 82: Optometrist
- 83: Oral Pathologist
- 84: Oral Surgery (Dentist)
- 85: Orthodontist (Dentist)
- 86: Orthopedics

87: Orthopedic Surgery
88: Orthopedic Surgery (Osteopath)
89: Other (Dentist)
90: Otology
91: Pain management
92: Pathology (Osteopath)
93: Pathology
94: Pediatric Allergy
95: Pediatric Anesthesiology
96: Pediatric Cardiac Surgery
97: Pediatric Cardiology
98: Pediatric Cardiovascular Disease
99: Pediatric Critical Care
A0: Pediatric Dentistry
A1: Pediatric Dermatology
A2: Pediatric Ear Nose & Throat
A3: Pediatric Emergency Medicine
A4: Pediatric Endocrinology
A5: Pediatric Gastroenterology
A6: Pediatric Hematology/Oncology
A7: Pediatric Hepatology
A8: Pediatric Immunology
A9: Pediatric Infectious Disease
B0: Pediatric Internal Medicine
B1: Pediatric Nephrology
B2: Pediatric Neurological Surgery
B3: Pediatric Neurology
B4: Pediatric Ophthalmology
B5: Pediatric Orthopedic Surgery
B6: Pediatric Orthopedics
B7: Pediatric Pathology
B8: Pediatric Physical Medicine & Rehabilitation
B9: Pediatric Plastic Surgery
C0: Pediatric Pulmonary Medicine
C1: Pediatric Radiology
C2: Pediatric Rheumatology
C3: Pediatric Surgery
C4: Pediatric Surgical Oncology
C5: Pediatric Trauma
C6: Pediatric Urology
C7: Pediatrics (Osteopath)
C8: Pediatrics
C9: Periodontist (Dentist)
D0: Peripheral Vascular
D4: Physical Medicine & Rehabilitation
D5: Physical Therapy
D6: Plastic Surgery
D7: Podiatry
D8: Proctology
D9: Prosthodontist (Dentist)
E0: Psychiatry
E1: Psychiatry/Neurology

E2: Public Health
 E3: Pulmonary Diseases
 E4: Radiation Oncology
 E5: Radiation Therapy
 E6: Radiology
 E7: Reproductive Endocrinology
 E8: Rheumatology
 E9: Roentgenology/Radiology
 F0: School Psychologist
 F1: Skilled Nursing Facilities
 F2: Social Worker
 F3: Speech Pathology
 F4: Sports Medicine
 F5: Surgical Oncology
 F6: Surgical Pathology
 F7: Therapeutic Radiology
 F8: Thoracic Surgery
 F9: Transplant Surgery
 G0: Trauma Surgery
 G1: Urgent Care Provider
 G2: Urology
 G3: Vascular Surgery
 XX: Specialty Unknown

Place of Treatment Codes

00: Other Unlisted Licensed Facility
 0G: Hemophilia Treatment Center
 10: Inpatient Hospital
 1S: Hospital Affiliated Hospice
 1Z: Inpatient Rehabilitation Hospital
 20: Outpatient Hospital
 2E: Hospital Emergency Room
 2F: Hospital Based Ambulatory Surgery Facility
 2S: Outpatient Hospital Bases Hospice
 2Z: Outpatient Rehabilitation Hospital
 30: Providers Office
 3S: Hospice Service Rendered in Providers Office
 40: Patient's Home
 4S: Hospice Service Rendered in Patient's Home
 51: Inpatient Psychiatric Facility
 52: Outpatient Psychiatric Facility
 53: Day/Night Partial Day Psychiatric Facility
 54: Psychiatric or Substance Abuse Night Facility
 55: Residential Substance Abuse Treatment Facility
 56: Outpatient Substance Abuse Treatment Facility
 57: Psychiatric Halfway House
 58: Hospital, Partial Hospitalization
 60: Independent Clinical Lab
 70: Nursing Home
 80: Skilled Nursing Facility/Extended Care Facility

90: Ground Ambulance
 9A: Air Ambulance
 9C: Sea Ambulance
 B0: Free standing Ambulatory Medical Facility
 BD: Free-standing dialysis facility
 BF: Free standing Ambulatory Surgery Facility
 BM: Free standing Alternate Birth Center
 BR: Free standing Cardiac Rehabilitation Facility
 BS: Free standing Hospice Facility
 BT: Free standing Substance Abuse Facility - Inpatient
 BU: Free standing Substance Abuse Facility – Outpatient
 BV: Free standing Substance Abuse Facility – Partial Hospitalization
 C0: Pharmacy

Type of Service Codes

000: Unknown Type of Service
 200: Surgery
 2M0: Oral Surgery
 2P0: Surgery/Professional Component
 2R0: Donor Surgery
 2R1: Surgery/Transplant Recipient
 2T0: Assistant at Surgery
 2U0: Surgery/Supplemental Accident
 2V0: Surgery/Technical Component
 300: Maternity
 3Q0: Elective Abortion
 400: Anesthesia
 4R0: Anesthesia/Donor Surgery
 4R1: Anesthesia/Transplant Surgery
 4U0: Anesthesia/Supplemental Accident
 500: Diagnostic Radiology/Nuclear Medicine & Ultrasound
 530: Diagnostic Radiology/Maternity Care
 5A0: Diagnostic Radiology/Emergency Medical Care
 5I0: Diagnostic Radiology/Digital Subtraction Angiography
 5K0: Diagnostic Radiology/Pre-Admission Testing
 5N0: Diagnostic Radiology/Emergency Medical Care
 5P0: Diagnostic Radiology/Professional Component
 5R0: Diagnostic Radiology/Donor Surgery
 5R1: Diagnostic Radiology/Transplant Surgery
 5U0: Diagnostic Radiology/Supplemental Accident
 5V0: Diagnostic Radiology/Technical Component
 600: Medical Care
 6A0: Emergency Medical Care
 6B0: Concurrent Care
 6J0: Medical Care/Home Health Care Program
 6K0: Medical Care/Pre-Admission Testing
 6L0: Medical Care/EKG, EEG & Other Electronic Diagnostic Procedures
 6N0: Medical Care/Emergency Accident Care
 6P0: Medical Care/Professional Component
 6R0: Medical Care/Donor Surgery

6R1: Medical Care/Transplant Recipient
 6S0: Medical Care/Psychiatric Care
 6U0: Medical Care/Supplemental Accident
 6V0: Medical Care/Technical Component
 6W0: Medical Care/Second Surgical Opinion
 600: Medical Care
 6X0: Alcohol Rehabilitation
 6X1: Alcohol And/Or Drug Detoxification
 6Y0: Medical Care/Consultation
 6Z0: Drug Rehabilitation
 740: Hemodialysis
 750: Hyperthermia Therapy
 7C0: Chemotherapy
 7D0: Physical Medicine (Therapy)
 7E0: Therapeutic Radiology
 7F0: Occupational Therapy
 7G0: Speech Therapy
 7H0: Respiratory Therapy
 7P0: Therapeutic Radiology/Professional Component
 7V0: Therapeutic Radiology/Technical Component
 800: Diagnostic Pathology (Laboratory)
 830: Diagnostic Pathology/Maternity Care
 8A0: Diagnostic Pathology/Emergency Medical Care
 8K0: Diagnostic Pathology/Pre-Admission Testing
 8N0: Diagnostic Pathology/Emergency Accident Care
 8P0: Diagnostic Pathology/Professional Component
 8R0: Diagnostic Pathology/Donor Surgery
 8R1: Diagnostic Pathology/Transplant Recipient
 8U0: Diagnostic Pathology/Supplemental Accident
 8V0: Diagnostic Pathology/Technical Component
 9A0: Well Baby/Well Child Care
 9B0: Whole Blood, Blood Derivatives, Administration & Processing
 9C0: Hospice Care Program
 9D0: Dental Care
 9F0: Ambulance
 9G0: Physical Accessories, Purchase
 9H0: Physical Accessories, Rental
 9J0: Home Health Care Program
 9K0: Prescription Drug Program
 9L0: Prescription Drugs and Medicine
 9M0: Vision Care Program
 9N0: Visiting Nurse Services
 9P0: Private Duty Nursing
 9R0: Transportation of Surgical/Harvesting Team & Donor Organ
 9R1: Recipient Transportation & Lodging
 9T0: Individual Benefits Management
 9V0: Hearing Care Program
 L00: Not Medically Necessary Admission
 L10: Admission Primarily Diagnostic Studies (Diagnostic Admission)
 L20: Admission Primarily for Custodial/Domiciliary Care
 L30: Admission Primarily for Physical Therapy

Commonwealth of Virginia
Claims Database
Claims File
Data Specifications
May 20, 2002

- Transmittal Frequency:** Same frequency as billing to Commonwealth. For example, a Carrier providing both ASO and Insured plans, might provide the ASO claims weekly and the Insured claims monthly.
- Medium:** (1) 1600/6250 bpi magnetic tape (no cartridge). EBCDIC labeled or ASCII unlabeled. No packed or binary data. No variable length records. Block size <= 32767.
- or-
- (2) 3.5" 1.44mb diskette. ASCII data. PC formatted records, i.e. CR, LF at end of each record. Data compressed with PKZIP.
- or-
- (3) Same as (2) except transmitted electronically (assuming compatible hardware and software).
- Data Requirements:** All dollar amounts should have leading sign, 2 decimal places and implied decimal point. Field can be zero or blank filled. E.g. a 9 byte field containing the value (\$100.00) could be coded either 'bbb-10000' or '-00010000'. Positive amounts can either have '+' sign or be unsigned. \$100.00 can be represented as '+00010000', '000010000', 'bbb+10000', or 'bbbb10000'.
- All dates should be provided CCYYMMDD where CC denotes Century, YY denotes year, MM denotes Month, and DD denotes Day. E.g. July 11, 1946 is '19460711'. If date is Not Applicable, field should be coded '00000000'.
- File will consist of 5 type records: Header, Facility, Professional (including Dental), Pharmacy, and Trailer. There will be 1 Header record as the first record on the file, 1 Trailer record at the end of the file, and the remaining records between the Header and Trailer records. Each of the Professional and Pharmacy records should correspond to an item (line) of a bill, where a bill can be represented as multiple records with the same claim number, the same provider, and the same processing date. For Facility claims, each record should correspond to the aggregate claim for the Facility; any breakdown will be provided within the aggregate record.
- The file should contain all claims processed on behalf of the Commonwealth during the transmittal period, regardless of the funding type or billing arrangement. Denied claims and adjustments to denied claims should be included on the file. Where capitated arrangements are

in place, the claims file should still contain the underlying claims. Dollar amounts for capitated claims should be completed to the level of detail for which data is available.

Record type	Field Name	Size	Data type	Comments
Header	Record Type	1	Char	Value = 'A'
Header	Carrier Code	3	Char	To be assigned by the Commonwealth of Virginia (COV)
Header	File type	10	Char	Value = "CLAIM"
Header	Earliest processing date	8	Date	Claim Processed Date
Header	Latest processing date	8	Date	Claim Processed Date
Header	Filler	670	Char	Value = Spaces
	Record Length	700		
Prof	Record Type	1	Char	Value = 'P'
Prof	Carrier Code	3	Char	To be defined by COV
Prof	Covered Group	1	Char	"C" – Commonwealth of Virginia "S" – TLC School Group "G" – TLC Governmental Group
Prof	Plan Code	4	Char	To be defined by COV
Prof	Contract Number (Subscriber SSN)	9	Char	No '-'.
Prof	Subscriber Birth Date	8	Date	
Prof	Subscriber Sex	1	Char	"M" : Male "F" : Female
Prof	Subscriber Zip Code	10	Char	
Prof	Subscriber Agency/ TLC Group	3	Char	For State, Agency Code from BES feed. If not active, COV may provide desired code(s) to denote COBRA, early Retiree, Medicare Retiree. For TLC, School or Government Group Identifier.
Prof	Patient SSN	9	Char	Optional. No '-'.
Prof	Patient Last Name	20	Char	
Prof	Patient First Name	15	Char	
Prof	Patient Birth Date	8	Date	
Prof	Patient Relationship to Subscriber	1	Char	"E" : Self "S" : Spouse "C" : Child "O" : Other
Prof	Patient Sex	1	Char	"M" : Male "F" : Female
Prof	Patient Zip Code	10	Char	
Prof	Claim Number	20	Char	
Prof	Claim Number Suffix	2	Char	Optional. Can be used to differentiate multiple items (lines) on claim.
Prof	Claim Incurred Date	8	Date	
Prof	Claim Received Date	8	Date	
Prof	Claim Adjudicated Date	8	Date	

Prof	Claim Processed Date	8	Date	
Prof	Claim Check Date	8	Date	Date on the check when issued.
Prof	Claim Paid Date	8	Date	This date should be the date upon which claims are booked to your financial and accounting systems.
Prof	Claim Disposition	1	Char	“O” : Original Claim “P” : Positive Adjustment “N” : Negative Adjustment
Prof	Optional Benefit Utilization (Expanded Benefit)	1	Char	“Y” : Used expanded benefit “N” : Did not use expanded benefit or expanded benefit option not part of this plan design
Prof	Optional Benefit Utilization (Buy-up Utilization)	1	Char	For claims prior to 7/1/1998 only. N or space: Buyup non applicable A : 80% Buy-up Utilized B : 85% Buy-up Utilized C : 90% Buy-up Utilized D : 95% Buy-up Utilized
Prof	Optional Benefit Utilization	1	Char	Reserved for future use
<i>Prof</i>	Claim Approved/Denied	1	Char	Space or “A” – Approved “D” – Denied (Total Charges = Not Covered Charges)
Prof	Capitated/Non-Capitated	1	Char	Space or “N” – Non-capitated “C” - Capitated
Prof	Inpatient/Outpatient	1	Char	“I” : Inpatient “O” : Outpatient
Prof	Place of Treatment	5	Char	See attached list of valid codes.
Prof	Type of Service	5	Char	See attached list of valid codes.
Prof	Claim Primary Payer	1	Char	“T” : This carrier is primary “M” : Medicare is primary “O” : Other carrier is primary
Prof	Claim Secondary Payer	1	Char	“T” : This carrier is secondary “M” : Medicare is secondary “O” : Other carrier is secondary “N” : No secondary payer “U” : Secondary payer not verified
Prof	Claim Tertiary Payer	1	Char	“T” : This carrier is tertiary “O” : Other carrier is tertiary “N” : No tertiary payer “U” : Tertiary payer not verified
Prof	Principal HCPCS Code	5	Char	Actual Code or “N/A”. HCPCS includes Level 1 (CPT), Level 2
Prof	HCPCS Code Modifier	5	Char	Modifier or blank
Prof	Additional HCPCS Code	5	Char	Actual Code or “N/A”
Prof	HCPCS Code Modifier	5	Char	Modifier or blank
Prof	CDT-2 Code	5	Char	American Dental Association code. Actual Code or “N/A”.
Prof	CDT-2 Level	1	Char	N – Not applicable, no CDT-2 code 1 – Dental Claim processed as Block 1

				(Diagnostic and Preventive) 2 – Dental Claim processed as Block 2 (Primary) 3 – Dental Claim processed as Block 3 (Major) 4 – Dental Claim processed as Block 4 (Orthodontic) M – Dental Claim paid under medical plan.
Prof	ICD-9 Principal Diagnosis Code	6	Char	Actual Code with “.” or “N/A”. Required.
Prof	ICD-9 Secondary Diagnosis Code	6	Char	Actual Code with “.” or “N/A”
Prof	Provider ID type	2	Char	FI – Federal Taxpayer’s ID Number PC – Provider Commercial Number UP – Unique Physician ID Number HI – HCFA National Provider ID OT – Other ID (subject to COV approval) COV plans to require HCFA ID if the National Provider ID is mandated for use.
Prof	Provider ID	15	Char	
Prof	Provider Name	50	Char	
Prof	Provider Type	2	Char	See attached list of valid codes.
Prof	Provider Specialty	2	Char	See attached list of valid codes.
Prof	Provider Location – City	20	Char	
Prof	Provider Location – State	2	Char	
Prof	Provider Location – Zip Code	10	Char	
Prof	Provider Referral	1	Char	“P” : Provider is PCP “R” : PCP referral “S” : Self referral “T” <i>Specialist referral</i>
Prof	Provider In/Out Network	1	Char	“I” : Provider in Network “P” : Participating Provider not in Network “N” : Non-participating Provider
Prof	Provider Contract Level	10	Char	“HMO” “HMO POS” “EPO” “POS PPO” “PPO” “PHO” “INDEMNITY”
Prof	Total Charges	10	Amount	
Prof	Non-benefit Charges not covered	10	Amount	e.g. convenience items
Prof	Benefit Charges not covered	10	Amount	e.g. a benefit not covered by COV’s plan.
Prof	Discount	10	Amount	If Schedule of Allowance is less than Total Charges – Non-benefit Charges Not

				Covered – Benefit Charges Not covered, Discount = Total Charges – Non-benefit Charges Not Covered – Benefit Charges Not Covered – Schedule of Allowance. Otherwise, Discount is zero.
Prof	Schedule of Allowance	10	Amount	Applicable to this procedure, provider, and to the COV.
Prof	Eligible Charges	10	Amount	Should be lesser of Schedule of Allowance and Total Charges – Non-benefit Charges Not Covered – Benefit Charges Not Covered.
Prof	Deductible	10	Amount	
Prof	Coinsurance	10	Amount	<i>Copayment is stored in separate field</i>
Prof	COB	10	Amount	
Prof	Net Payment After Application of Reimbursement Method	10	Amount	Expected relationship of amounts is Net Payment After Application of Reimbursement Method + COB + Copayment + Coinsurance + Deductible = Eligible Charge.
Prof	Internal Claim ID	20	Char	Claims may be edited for having been paid on covered individuals under the correct plan of benefits. To facilitate problem resolution, you may include an internal claim ID that will be included on the edit report.
Prof	Copayment	10	Amount	<i>Copayment separate from Coinsurance</i>
Prof	<i>Contract Type</i>	1	Char	<i>Blank or 'A' – Active 'C' – Cobra 'R' - Retiree</i>
Prof	Filler	222	Char	Spaces
	Record length	700		
Fac	Record Type	1	Char	Value = 'F'
Fac	Carrier Code	3	Char	To be defined by COV
Fac	Covered Group	1	Char	"C" – Commonwealth of Virginia "S" – TLC School Group "G" – TLC Governmental Group
Fac	Plan Code	4	Char	To be defined by COV
Fac	Contract Number (Subscriber SSN)	9	Char	No '–'
Fac	Subscriber Birth Date	8	Date	
Fac	Subscriber Sex	1	Char	"M" : Male "F" : Female
Fac	Subscriber Zip Code	10	Char	
Fac	Subscriber Agency/ TLC Group	3	Char	For State, Agency Code from BES feed. If not active, COV may provide desired code(s) to denote COBRA, early Retiree, Medicare Retiree. For TLC, School or Government Group Identifier.
Fac	Patient SSN	9	Char	Optional. No '–'.

Fac	Patient Last Name	20	Char	
Fac	Patient First Name	15	Char	
Fac	Patient Birth Date	8	Date	
Fac	Patient Relationship to Subscriber	1	Char	“E” : Self “S” : Spouse “C” : Child “O” : Other
Fac	Patient Sex	1	Char	“M” : Male “F” : Female
Fac	Patient Zip Code	10	Char	
Fac	Claim Number	20	Char	
Fac	Claim Number Suffix	2	Char	Optional. Can be used to differentiate multiple items (lines) on claim.
Fac	Claim Incurred Date - Begin	8	Date	
Fac	Claim Incurred Date – End	8	Date	
Fac	Number of Days Covered	5	Num	Signed. Right Justified. 0 Decimal places. Should be negative for negative adjustment.
Fac	Claim Received Date	8	Date	
Fac	Claim Adjudicated Date	8	Date	
Fac	Claim Processed Date	8	Date	
Fac	Claim Check Date	8	Date	Date on the check when issued.
Fac	Claim Paid Date	8	Date	This date should be the date upon which claims are booked to your financial and accounting systems.
Fac	Claim Disposition	1	Char	“O” : Original Claim “P” : Positive Adjustment “N” : Negative Adjustment
Fac	Optional Benefit Utilization (Expanded Benefit)	1	Char	“Y” : Used expanded benefit “N” : Did not use expanded benefit or expanded benefit option not part of this plan design
Fac	Optional Benefit Utilization (Buy-up Utilization)	1	Char	For claims prior to 7/1/1998 only. N or space: Buyup non applicable A : 80% Buy-up Utilized B : 85% Buy-up Utilized C : 90% Buy-up Utilized D : 95% Buy-up Utilized
Fac	Optional Benefit Utilization	1	Char	Reserved for future use
Fac	Claim Approved/Denied	1	Char	Space or “A” – Approved “D” – Denied (Total Charges = Not Covered Charges)
Fac	Capitated/Non-Capitated	1	Char	Space or “N” – Non-capitated “C” - Capitated
Fac	Inpatient/Outpatient	1	Char	“I” : Inpatient “O” : Outpatient
Fac	Place of Treatment	5	Char	See attached list of valid codes.
Fac	Type of Service	5	Char	See attached list of valid codes.

Fac	Claim Primary Payer	1	Char	“T” : This carrier is primary “M” : Medicare is primary “O” : Other carrier is primary
Fac	Claim Secondary Payer	1	Char	“T” : This carrier is secondary “M” : Medicare is secondary “O” : Other carrier is secondary “N” : No secondary payer “U” : Secondary payer not verified
Fac	Claim Tertiary Payer	1	Char	“T” : This carrier is tertiary “O” : Other carrier is tertiary “N” : No tertiary payer “U” : Tertiary payer not verified
Fac	DRG Code	3	Char	For inpatient facility claims, carrier should provide DRG Code, ICD-9 Principal Diagnosis Code, and ICD-9 Principal Procedure Code. If carrier cannot provide DRG Code, then carrier must provide all ICD-9 diagnosis and procedure codes.
Fac	ICD-9 Principal Diagnosis Code	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Principal Procedure Code	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Additional Procedure Code	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Additional Procedure Code	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Additional Procedure Code	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Additional Procedure Code	6	Char	Actual Code with “.” or “N/A”
Fac	ICD-9 Additional Procedure Code	6	Char	Actual Code with “.” or “N/A”
Fac	Ambulatory Patient Group (APG)	10	Char	For outpatient facility claims, carrier should provide APG Code. If carrier cannot provide APG Code, then carrier must

	Revenue Code			
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Provider ID type	2	Char	<p>FI – Federal Taxpayer’s ID Number PC – Provider Commercial Number UP – Unique Physician ID Number HI – HCFA National Provider ID OT – Other ID (subject to COV approval)</p> <p>COV plans to require HCFA ID if the National Provider ID is mandated for use.</p>
Fac	Provider ID	15	Char	
Fac	Provider Name	50	Char	
Fac	Provider Type	2	Char	See attached list of valid codes.
Fac	Provider Location – City	20	Char	
Fac	Provider Location – State	2	Char	
Fac	Provider Location – Zip Code	10	Char	
Fac	Pre-Certified Admission	1	Char	<p>“Y” : Yes “N” : No or Not Applicable</p>
Fac	Provider In/Out Network	1	Char	<p>“T” : Provider in Network “P” : Participating Provider not in Network “N” : Non-participating Provider</p>
Fac	Provider Contract Level	10	Char	<p>“HMO” “HMO POS” “EPO” “POS PPO” “PPO” “PHO” “INDEMNITY”</p>
Fac	Total Charges	10	Amount	
Fac	Non-benefit Charges not covered	10	Amount	e.g. convenience items
Fac	Benefit Charges not covered	10	Amount	
Fac	Eligible Charge	10	Amount	Should be equal to Total Charges – Non-benefit Charges not covered – Benefit Charges not covered
Fac	Deductible	10	Amount	
Fac	Coinsurance	10	Amount	<i>Copayment is stored in separate field</i>
Fac	COB	10	Amount	
Fac	Facility Liability	10	Amount	Amount owed facility if no discount

	(pre-discount)			relationship in place. Expected relationship of amounts is: Facility liability (pre-discount) + COB + Copayment + Deductible = Eligible Charge.
Fac	Facility Liability (post-discount)	10	Amount	Amount contracted with Facility.
Fac	Discount retained by carrier	10	Amount	Portion of total discount retained by carrier for ASO. Remainder of discount is assumed to be Commonwealth's, which may consist of 2 portions: a guaranteed portion which is credited immediately and a settlement amount which is credited later, usually after the close of the fiscal year.
Fac	Discount guaranteed to Commonwealth	10	Amount	Amount of discount credited to Commonwealth on initial bill
Fac	Commonwealth's settlement discount	10	Amount	Amount of discount credited (or due to be credited, if known in advance) to Commonwealth after close of fiscal year.
Fac	Net Payment After Application of Reimbursement Method	10	Amount	The expected relationship is that Net Payment After Application of Reimbursement Method = Facility Liability (pre-discount) – Discount guaranteed to Commonwealth – Commonwealth's Settlement Discount
Fac	Internal Claim ID	20	Char	Claims may be edited for having been paid on covered individuals under the correct plan of benefits. To facilitate problem resolution, you may include an internal claim ID that will be included on the edit report.
Fac	Copayment	10	Amount	<i>Copayment separate from Coinsurance</i>
Fac	<i>Contract Type</i>	1	Char	<i>Blank or 'A' – Active 'C' – Cobra 'R' – Retiree</i>
Fac	Filler	32	Char	Spaces
	Record length	700		
Pharm	Record Type	1	Char	Value = 'D'
Pharm	Carrier Code	3	Char	To be defined by COV
Pharm	Covered Group	1	Char	"C" – Commonwealth of Virginia "S" – TLC School Group "G" – TLC Governmental Group
Pharm	Plan Code	4	Char	To be defined by COV
Pharm	Contract Number (Subscriber SSN)	9	Char	No '-'
Pharm	Subscriber Birth Date	8	Date	
Pharm	Subscriber Sex	1	Char	"M" : Male "F" : Female
Pharm	Subscriber Zip Code	10	Char	

Pharm	Subscriber Agency/ TLC Group	3	Char	For State, Agency Code from BES feed. If not active, COV may provide desired code(s) to denote COBRA, early Retiree, Medicare Retiree. For TLC, School or Government Group Identifier.
Pharm	Patient SSN	9	Char	Optional. No ‘-‘.
Pharm	Patient Last Name	20	Char	
Pharm	Patient First Name	15	Char	
Pharm	Patient Birth Date	8	Date	
Pharm	Patient Relationship to Subscriber	1	Char	“E” : Self “S” : Spouse “C” : Child “O” : Other
Pharm	Patient Sex	1	Char	“M” : Male “F” : Female
Pharm	Patient Zip Code	10	Char	
Pharm	Claim Number	20	Char	
Pharm	Claim Number Suffix	2	Char	Optional. Can be used to differentiate multiple items (lines) on claim.
Pharm	Claim Incurred Date	8	Date	
Pharm	Claim Received Date	8	Date	
Pharm	Claim Adjudicated Date	8	Date	
Pharm	Claim Processed Date	8	Date	
Pharm	Claim Check Date	8	Date	Date on the check when issued.
Pharm	Claim Paid Date	8	Date	This date should be the date upon which claims are booked to your financial and accounting systems.
Pharm	Claim Disposition	1	Char	“O” : Original Claim “P” : Positive Adjustment “N” : Negative Adjustment
Pharm	Optional Benefit Utilization (Expanded Benefit)	1	Char	“Y” : Used expanded benefit “N” : Did not use expanded benefit or expanded benefit option not part of this plan design
Pharm	Optional Benefit Utilization	1	Char	Reserved for future use
Pharm	Optional Benefit Utilization	1	Char	Reserved for future use
Pharm	Claim Approved/Denied	1	Char	Space or “A” – Approved “D” – Denied (Total Charges = Not Covered Charges)
Pharm	Capitated/Non- Capitated	1	Char	Space or “N” – Non-capitated “C” - Capitated
Pharm	Claim Primary Payer	1	Char	“T” : This carrier is primary “M” : Medicare is primary “O” : Other carrier is primary
Pharm	Claim Secondary Payer	1	Char	“T” : This carrier is secondary “M” : Medicare is secondary “O” : Other carrier is secondary “N” : No secondary payer

				“U” : Secondary payer not verified
Pharm	Claim Tertiary Payer	1	Char	“T” : This carrier is tertiary “O” : Other carrier is tertiary “N” : No tertiary payer “U” : Tertiary payer not verified
Pharm	NDC Drug Code	11	Char	In 5-4-2 format.
Pharm	Therapeutic Class Code	2	Char	00-99 from NDDF User Manual
Pharm	Generic Drug Category	1	Char	“B” : Brand Drug with NO generic equivalent “E” : Brand Drug with generic equivalent “G” : Generic Drug
Pharm	Number Days Drug Supplied	5	Num	Signed. 0 assumed decimal places. If negative adjustment, signed negative.
Pharm	Provider ID type	2	Char	FI – Federal Taxpayer’s ID Number PC – Provider Commercial Number NA – National Association of Boards of Pharmacy Number HI – HCFA National Provider ID OT – Other ID (subject to COV approval) COV plans to require HCFA ID if the National Provider ID is mandated for use.
Pharm	Provider ID	15	Char	
Pharm	Provider Name	50	Char	
Pharm	Provider Type	2	Char	See attached list of valid codes.
Pharm	Provider Location – City	20	Char	
Pharm	Provider Location – State	2	Char	
Pharm	Provider Location – Zip Code	10	Char	
Pharm	Provider In/Out Network	1	Char	“I” : Provider in Network “P” : Participating Provider not in Network “N” : Non-participating Provider
Pharm	Provider Contract Level	10	Char	“HMO” “HMO POS” “EPO” “POS PPO” “PPO” “PHO” “INDEMNITY”
Pharm	Total Charges	10	Amount	
Pharm	Non-benefit Charges not covered	10	Amount	e.g. convenience items
Pharm	Benefit Charges not covered	10	Amount	e.g. a benefit not covered by COV’s plan.
Pharm	Discount	10	Amount	If Schedule of Allowance is less than Total Charges – Non-benefit Charges Not Covered – Benefit Charges Not covered, Discount = Total Charges – Non-benefit Charges Not Covered – Benefit Charges

				Not Covered – Schedule of Allowance. Otherwise, discount is zero.
Pharm	Schedule of Allowance	10	Amount	Applicable to this procedure, provider, and to the COV.
Pharm	Eligible Charges	10	Amount	Should be lesser of Schedule of Allowance and Total Charges – Non-benefit Charges Not Covered – Benefit Charges Not Covered.
Pharm	Deductible	10	Amount	
Pharm	Coinsurance	10	Amount	<i>Copayment is stored in separate field</i>
Pharm	COB	10	Amount	
Pharm	Net Payment After Application of Reimbursement Method	10	Amount	Expected relationship of amounts is Net Payment After Application of Reimbursement Method + COB + Copayment + Deductible = Eligible Charge.
Pharm	Drug Acquisition Cost	10	Amount	
Pharm	Drug Dispense Fee	10	Amount	Expected relationship is Drug Acquisition Cost + Drug Dispense Fee = Eligible Charge.
Pharm	Drug Process Fee	10	Amount	
Pharm	Internal Claim ID	20	Char	Claims may be edited for having been paid on covered individuals under the correct plan of benefits. To facilitate problem resolution, you may include an internal claim ID that will be included on the edit report.
Pharm	Copayment	10	Amount	<i>Copayment separate from Coinsurance</i>
Pharm	<i>Payment Tier</i>	1	Char	<i>Blank or 'N' – Payment Tier Not Applicable '1' – Tier 1 '2' – Tier 2 '3' – Tier 3</i>
Pharm	<i>Contract Type</i>	1	Char	<i>Blank or 'A' – Active 'C' – Cobra 'R' – Retiree</i>
Pharm	Filler	224	Char	Spaces
	Record length	700		
Trailer	Record Type	1	Char	Value = 'Z'
Trailer	Carrier Code	3	Char	To be assigned by COV
Trailer	File type	10	Char	Value = "CLAIM"
Trailer	Lowest processing date on file	8	Date	Claim Processed Date
Trailer	Highest processing date on file	8	Date	Claim Processed Date
Trailer	Number of Professional records on file	6	Numeric	Unsigned. Right Justify. 0 decimals.
Trailer	Amount of Professional Total Charges on file	12	Amount	
Trailer	Number of Facility	6	Numeric	Unsigned. Right Justify. 0 decimals.

	records on file			
Trailer	Amount of Facility Total Charges on file	12	Amount	
Trailer	Number of Pharmacy records on file	6	Numeric	Unsigned. Right Justify. 0 decimals.
Trailer	Amount of Pharmacy Total Charges on file	12	Amount	
Trailer	Filler	616	Char	Spaces
	Record length	700		

**Companies Represented at
Optional Pre-proposal Conference
For the RFP# OHB03-1
Actuarial and Related Services for Health Benefits Programs
Held 2/24/2003 @ 10:00 a.m.**

AON Consulting, Inc.
The Segal Company
Watson Wyatt & Company