ATTACHMENT # 9

Administración de Seguros de Salud

ATTACHMENT 9

Information Systems Processes
& Data Exchange Layouts

1. Enrollment Manual

1 Enrollment Manual
2 ASES 820 Mapping
3 ASES Query Process
4 Current Layout for Claims & Encounters
5. Carrier to ASES Data Submissions – Version 1.7B

Enrollment Manual

August 2010

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I. Introduction This document is the reference manual to guide Insurance Companies and Medicare Advantage Organizations contracted by ASES in enrolling their contracted beneficiaries.

a. Background

Previous to January 2006 Mi Salud beneficiaries were assigned to MCO's or TPA's by region. (MCO's, TPA's and MAO's will be referred to as "carriers" in this document). Enrollment, which is the process by which the carrier sends an electronic record to ASES notifying of the subscription of a member, was done at the family level. With one record the carrier would enroll all the members of a family. At the most there could be two carriers in a region, one MCO and one TPA so conflicts were minimal. The establishment of the Medicare Platino Plans by ASES starting on January 2006 increased the complexity of identifying in the ASES database which member is covered by which organization. Once Medicare Platino was implemented the enrollment had to be done at the member level since a family could have members subscribed by different carriers. The complexity was also affected by having MAO's providing services to all the ASES regions. Therefore Medicare Platino beneficiaries had a wide choice of options which included the capacity to change carriers on a monthly basis.

b. Basic Eligibility Concepts

i. Eligibility for Mi Salud beneficiaries is determined by Medicaid Offices. Typically the beneficiaries are given eligibility for a year after which they must recertify.

ii. Those beneficiaries which do not recertify are cancelled at the eligibility expiration date. This occurs at the end of each month.

iii. Data for eligible beneficiaries is sent by Medicaid Offices to ASES and updated in the ASES database on a daily basis.

iv. ASES sends any updates, cancellations or additions to the carriers on a daily basis.

a) Mi Salud carriers receive data for all the members in their contracted regions.

b) Medicare Platino carriers receive data for all their members enrolled in each contracted region.

v. Mi Salud eligible members are those which appear as eligible in the ASES database.

vi. Medicare Platino eligible members are those Mi Salud eligible members which also have Medicare A&B coverage.

a) Medicare A&B coverage is determined by the Medicare Platino carriers by querying CMS.

b) Medicare Platino carriers also have to query ASES to determine Mi Salud eligibility.

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c. General Enrollment Concepts

The enrollment record (see attached) used by the carriers to notify ASES of the subscription of a member contains a series of data elements for verification of correctness and to inform ASES the particulars of the enrollment. A member can be enrolled in one of three different **Plan Types**:

01 = Mi Salud 02 = Medicare Platino MA-SNP (Special Needs Plan) 03 = Medicare Platino MA-PD (Medicare Advantage Prescription Drugs)

A particular carrier can offer different products under a Plan Type. These products are identified by their **Plan Version** number. ASES assigns a **Plan Version** number for each Medicare Platino product contracted. For Mi Salud enrollments the Plan Version field must equal the **coverage code** assigned to the particular beneficiaries. Some of the Plans contracted with ASES may require the assignment of **Primary Centers** (IPAs) and /or **PCPs** to the beneficiaries. The enrollment record includes those fields as well as the Plan Type and Version. The record also informs of the date the member was processed by the carrier and the effective date of the enrollment. (For more detail se section II.b below.)

II. Enrollment Process

a. Data Flow

The data flow for Mi Salud and Medicare Platino enrollments is similar with the principal exception of the queries that are needed in the Medicare Platino process. (see flow diagram attached)

i. **Mi Salud** – The process starts with the receipt of the eligibility data by the carriers. The carriers update their database and communicate with the beneficiaries. The beneficiaries visit the carriers' premises and sign up in the Mi Salud Plan. The carrier then produces the electronic enrollment record and sends it to ASES. These transmissions occur on a daily basis. In ASES the records are passed through an edit program. The records that pass the edits are updated to the ASES database and the beneficiaries are deemed enrolled. Those record found with error are returned to the carriers for correction. Until the records are submitted correctly the member is not enrolled in ASES.

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ii. **Medicare Platino** – Before a Medicare Platino Plan can enroll a member it must verify Medicare coverage by querying CMS. They must also query ASES to verify if the member is eligible for Mi Salud. Once those requirements are met then the enrollment is submitted to ASES. In ASES the record follows the same process as described above for Mi Salud.

b. Enrollment Record

i. **Data Definition** – The enrollment record contains the following data elements to be complimented by the carrier:

a) RECORD_TYPE – This is always an "E" it identifies the record as an enrollment file record.

b) TRAN_ID – This is the field which identifies to the ASES system which action to take based on the data contained in the record. It can have one of several values:

1) **E** = means that the record is a new enrollment for a member which has not been previously enrolled.

2) **C** = Change Carrier. Used when the member has selected a different carrier than the one in which he/she is presently enrolled. It is also used for initial enrollment in Medicare Platino Plans.

3) **P** = Changes the Plan Type. It is used when a member enrolled under a particular carrier chooses to change the product the carrier offers to one which is identified under a different Plan Type under the same carrier. Example: changing from an MA-PD Plan (Type 03) to a SNP Plan (Type 02) under the same carrier.

4) **V** = Type Version change. It is used when a member enrolled under a particular carrier and Plan Type chooses to change the product the carrier offers to one which is identified under the same Plan Type but with a different version number under the same carrier. Example: changing from a SNP Plan (Type 02 Version 001) to a SNP Plan (Type 02 Version 002) under the same carrier. The version change value in the Tran_id is also used when a Mi Salud member changes coverage code. In this case the carrier must reissue an ID Card with the new benefits and submit a version change enrollment record to ASES where the Version number is equal to the coverage code.

5) **I** = IPA (Primary Center) Change. Used to record in ASES a change in the beneficiaries' selected IPA under the same carrier, Plan Type and Version.

6) **1** = PCP1 change. Used to record in ASES a change in the beneficiaries' selected PCP1 under the same carrier, Plan Type, Version and IPA.

7) **2** = PCP2 change. Used to record in ASES a change in the beneficiaries' selected PCP2 under the same carrier, Plan Type, Version and IPA.

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8) **3** = PCP1 and PCP2 change. Used to record in ASES a change in the beneficiaries' selected PCP1 and PCP2 under the same carrier, Plan Type, Version and IPA.
9) **X** = delete incorrect enrollment 10)
O = Contract number change only 11)
D = Disenroll. For future use.

c) PROCESS_DATE – Sign up date. Date the member contracted with the carrier. Relationship with effective date:

1) Medicare Platino – Process date must be less than effective date.
2) Mi Salud – process date must be equal or less than effective date.

d) REGION – Contains ASES region code. Must be the region in which the member is located in the ASES database. Medicare Platino carriers obtain this code from the ASES query response.

e) CARRIER - Two digit carrier code assigned by ASES.

f) MEMBER_PRIMARY_CENTER – Up to four digits assigned by carrier to identify their Primary centers (IPAs). Not required for some Plan Types/Versions.

g) ODSI_FAMILY_ID – Eleven digit family ID assigned by MEDICAID OFFICES (ODSI). This is the first part of the key for the beneficiaries in the ASES database. Medicare Platino carriers obtain this code from the ASES query response.

h) MEMBER_SSN – Social Security number of the member. It is required that this number matches with the one for the member in the ASES database.

i) MEMBER_SUFFIX – Two digit number which identifies a member within a family. Second part of the key in the ASES database.

j) EFFECTIVE_DATE – Date in which the carriers starts coverage for the member under the enrolled Plan or effective date of the change for which the

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k) PLAN_TYPE – Plan Type code under which the member is enrolled.

l) PLAN_VERSION – Plan version under which the member is enrolled. m) MPI – Master Patient Index. Unique number which identifies a Member in ASES and MEDICAID OFFICESs databases.

n) PCP1 – Fifteen digit number assigned by carriers. Use to identify the PCP1 selected by the beneficiaries.

o) PCP1_EFFECTIVE_DATE – Date in which the PCP1 assignment was effective.

p) PCP2 – Fifteen digit number assigned by carriers. Use to identify the PCP2 selected by the beneficiaries.

q) PCP2_EFFECTIVE_DATE – Date in which the PCP2 assignment was effective.

r) FAMILY_PRIMARY_CENTER – IPA assigned to all Mi Salud family members.

s) FAM_PRIMARY_CENTER_EFF_DATE – Date in which the assignment of the family IPA was effective.

t) IPA_PCP_CHANGE_REASON – Not in use.

u) MEDICARE INDICATOR – Required for Medicare Platino enrollments. (1=A&B, 3=A, 9=B)

v) HIC NUMBER – Medicare Health Insurance Claim Number. Required for Medicare Platino enrollment.

w) IPA_ESPECIAL – A "1" indicates that the member is assigned to a special IPA which is not the family IPA. Used for Mi Salud.

x) Contract Number – Contract number assigned by the carrier. It should be the number by which the member is identified in the carriers ID card and internally in their database.

y) Special Enroll – Used to identify that the enrollment is for a newborn (N) or an emergency (E) case submitted by MEDICAID OFFICES or ASES. When this field is used then if the values is:

1) N – The system allows enrollment as of the date of birth.
2) E – The system allows enrollment as of the certification date.
3) This mechanism can be utilized in cases where the **date of birth** or **certification** is on or after January 1, 2006.

z) Other data elements complimented by ASES – When the record is edited the ASES system enters the following data in the enrollment record:

1) Reject Identifier - As a result of the edits the record could be accepted or rejected. This field contains the codes that specify that result. ("A" = Accepted; "M" = Accepted Retroactive; "R" = Rejected; "X" = Deleted)

2) Record Key – Internal number assigned by the ASES system.
3) Error Codes one to ten – record up to ten possible error codes.
4) Update Date – Date to which the edit run belongs. Correspond to the date of the daily cycle the edit run was a part of.
5) Update User – ASES internal user code.

ii. **Uses**

a) The enrollment record can be used to trigger several actions in the ASES database. The content of the TRAN_ID field determines which action. An "E" for a Mi Salud carrier will perform the original enrollment of a member. A "C" will transfer a member from one carrier to the one submitting the enrollment or perform the original enrollment for a Medicare Platino carrier. Codes P, V, I, 1, 2, and 3 will inform the ASES system that the carrier has changed a beneficiaries Plan, Version, IPA or PCP. An "X" will delete a previously submitted record and an "O" will change a beneficiaries Contract number. In the future a "D" will produce the disenrollment of a member from its existing carrier.

iii. **Edit and update process** – Carriers can transmit enrollment files to ASES on a daily basis. They must follow the naming convention for those files which is as follows:

CCYYMMDD.SUS
CC = Carrier Code YY =
Year MM = Month

DD = Day
.SUS = File extension identifies enrollment file.

The enrollment file can contain records pertaining to any of the regions contracted by the carrier. The files received by 9:00am are entered in the ASES daily cycle. If a file is received after 9:00am it will be entered in the following day's cycle. In the cycle there are several steps which handle the enrollment records:

a) Enrollment Merge – joins the enrollment files from all carriers into a single file.

b) Enrollment Region Split – Separates the merged file into different files (one per region) based on the region code in the enrollment records. If the record sent does not have a valid region code it will go into a special error file and will not continue processing.

c) Edits - ASES run a separate edit and update cycle for each region. The enrollments are passed though the edit programs and are identified as valid or rejected.

d) Update - Valid enrollments will be used to update the beneficiaries' record in the ASES database. In this process the data in the enrollment record is entered into the beneficiaries' record. There are to types of Valid enrollments:

1) Reject identifier = A – Identifies an accepted enrollment which is to be applied at a future effective date. The update process moves the enrollment fields (carrier, Plan, Version, Ipa and PCP) to the fields destined for new enrollments in the member's record. Until the new effective date is reached the member stays under the present enrollment condition (same carrier, Plan, Version, Ipa and PCP). At the month end cycle previous to the effective date the new field are moved to the actual fields and the enrollment becomes effective.

2) Reject identifier = M – Indicates a retroactive enrollment. In these cases the enrollment data (carrier, Plan, Version, Ipa and PCP) is updated directly to the actual enrollment field in the member's record.

e) Carrier eligibility file extract – When the member's information is updated because of an enrollment being processed, a record is sent to the carrier affected in the

Carrier eligibility file which is produced in every daily cycle.

c. Carrier Responsibilities

In order to process enrollment transactions correctly the carriers need to maintain in their particular systems the updated member eligibility data received from ASES. Such data is sent by ASES in the following files:

i. **Carrier Eligibility File (Daily & Month End)** – Produced by the ASES daily cycle. Contains all the data pertaining to the beneficiaries that have been added, updated or cancelled in the daily cycle. This includes updates caused by enrollment records being processed in that cycle. The carrier's system must identify the following situations based on the data received in these files:

a) When a member is added. 1) Mi Salud carriers must start the enrollment process with the member.

b) When a member changes carrier:

1) The carrier which lost the member must identify the loss of business.

c) When any of the enrollment data changes. This includes Plan Type, Version, IPA, PCPs.

1) The carrier system must be updated accordingly, If not this could cause the rejection of future enrollment record submissions.

d) When a Member's demographics Changes: 1) The carrier needs to update the new data in their database.

e) When a member is cancelled:

1) All carriers must cancel effective at the end of the month

2) Carriers should follow up with member in case the cancellation is caused by expiration of certification.

f) When a member has a change in **coverage code**:

1) Carriers must evaluate if the new coverage code requires that the member be enrolled in a different Plan_Version and send a Version change enrollment record to ASES before the end of the month.

2) Members where the Plan_Version does not agree with the coverage code will be disenrolled by ASES during the month end cycle. (For valid members,

the carrier must then re-enroll the member under a new Plan_Version that agrees with the new coverage code.)

ii. **Enrollment Reject File** – Produced by the ASES daily cycle. It contains the enrollment records rejected by the validation program. The carrier must examine the rejected records and take action to correct the cause based on the error codes included. See details below about the specific error codes. The carriers system must have the capability of identifying the errors and provide the mechanisms for correction and submittal to ASES for reprocessing.

d. Enrollment Record Rejections

i. **Reject Process** - Rejected enrollments are sent daily on a file which includes the error codes for the edit that failed the validation process. The carriers must correct the errors found and submit the corrected records to ASES in the next enrollment file. The file name for the reject file is:

CCYYMMDD.rjc

CC = Carrier Code YY = Year MM = Month DD = Day .rjc = File extension identifies reject file.

ii. **Error Codes** – The attached table contains the error codes produced by the Validation Program. Additional descriptions and possible corrective actions have been included to assist in the correction process.

III. Premium Payment

a. Concepts

The new Premium Payment System works under the concept that premiums are calculated and paid for only those beneficiaries that are enrolled by the first day of the payment month. The carriers do not need to submit billing documents or files. There is one payment run per month per ASES region in which the payment for all carriers in the region is calculated.

b. Relation to Enrollment

Enrolled beneficiaries are those which are eligible and assigned to a particular carrier as the result of an enrollment transaction. For a particular month's run the system will consider enrolled beneficiaries in the ASES database with an enrollment date (update date in ASES) previous to the 1st day of that month. Beneficiaries enrolled after that date will be considered for payment in the next payment run after the enrollment date.

c. Types of payment calculations

The payment system computes several categories of payments:

i. **Monthly payments** – For all beneficiaries enrolled at the beginning of the month for which the system is run (**Payment Month**).

ii. **Prorate Payments** – Prorate payments are calculated for Mi Salud beneficiaries that were enrolled during the previous month to the payment month. A prorated daily premium is calculated based on effective date of the enrollment.

iii. **Retroactive Payments** – Is calculated when the effective date of the enrollment is previous to the payment month. In Medicare Platino this calculation may include the previous month since no prorate is paid and because the enrollment always starts at the beginning of a month. In Mi Salud retroactive payments are always for periods two month or more before the payment month.

Retroactive prorate payments - Retroactive prorate payments are calculated when the effective date of the enrollment falls within the first month considered for a retroactive payment

Adjustments – Adjustments are calculated when a member changes Carrier retroactively after ASES had paid the first carrier in a previous payment run. The adjustment takes away the premium amount paid the first carrier.

IV. SYSPREM – Enrollment in History

a. Enrollment concepts

i. Enrollments are applied to the current eligibility data.

ii. Enrollments are allowed only in a member's current eligibility period. The **current eligibility period** is the:

a) eligibility period after a cancellation period (for a member that has been cancelled and then re-certified)

b) the current period since the initial update in ASES (as eligible) and the present time when the member has not been cancelled and remains eligible

iii. When an enrollment is not sent in time by the carrier (or a rejected record is not corrected) the eligibility data for the member will remain un-enrolled.

Premiums will not be paid for un-enrolled beneficiaries when the premium payment system is run.

If the member is then cancelled or enrolled in a second carrier the first carrier is prevented (by the system edits) to enroll the member in a period previous to the cancellation or the enrollment.

b. **SYSPREM Functionality**

i. The SYSPREM sub-system will permit the enrollment of beneficiaries to be recorded in historic data. The main functions are:

ii. Identification of enrollment records that are candidates for processing against the history database. Rejected with error codes:

a) **107**- Effective date before current eligibility period for family

b) **108**- Effective date before current eligibility period for member

c) **280**- Family must be eligible in current eligibility period

d) **281**- Member must be eligible in current eligibility period

e) **177**- Enrolled in another carrier at or after effective date

iii. Limitations:

a) Member must be active on effective date

b) Member must not have family members with errors not acceptable by SYSPREM in the same Mi Salud enrollment batch

c) Enroll record must not have Effective Date before 01/01/2006***

iv. New Error Codes (Reject File) for **accepted** history enrollments:

a) **996** – SYSPREM record inserted in history. No action by the carrier is required.

v. New Error Codes (Reject File) for **rejected** history enrollments:

a) **980** - Process date in enroll record must be greater than process date of the previously enrolled Member record

b) **981** – Member must not have family members with errors not acceptable by SYSPREM in the same enrollment batch (for Mi Salud).

c) **982** – Enroll record must not have Effective Date before 01/01/2006***

d) **983** – Enrollment record was processed by SYSPREM but the member was already enrolled in the same carrier in history at the effective date in the enrollment record.

e) **984** - Enrollment record was processed by SYSPREM but the member was already enrolled in a different carrier in history at the effective date in the enrollment record. If the Tran_Id = 'E', and the effective date is not 1st of the month the enrollment will be rejected. The Carrier should re submit this transaction as a Carrier Change (Tran_id = C) with an effective date of the 1st of the following month.

f) **985** - If special_enroll = 'E', effective date should be at least as recent as member certification date at the specified Effective Date.

g) **986** - For SYSPREM processing, the Effective Date should be before the Effective Date of the current record at Member Eligibility.

h) **995** - Had 22F but was re-evaluated because the records with errors in its family were processed by SYSPREM.

vi. Carrier Eligibility File – The daily carrier eligibility file will include the data for the members updated in history by the SYSPREM sub-system. The TRAN_ID field will contain an "H" to identify history data. The carriers must modify their systems so that the SYSPREM data is not included as actual data when processing the eligibility file.

c. Premium Payment for SYSPREM enrollments

i. Monthly Premium Payment run will include all SYSPREM records processed during the previous month.

ii. Payment will be calculated for months from the effective date of the SYSPREM enrollment up to:

a) The month in which the member is enrolled in a different carrier

b) The month in which the Member is cancelled

iii. Actual Billing date

d. SYSPREM in summary

i. SYSPREM will enroll beneficiaries in history for cases where the enrollment cannot be applied to actual data.

ii. Some members will not be enrolled in history because they are:

a) Not eligible at the effective date b) Enrolled in a different carrier

iii. Carriers need to evaluate cases rejected by SYSPREM in order to determine:

a) Errors in the effective date assigned

b) Correctness of the beneficiaries' data included in the enrollment record

V. Addendums

Enrollment Record Layout
Enroll Relationship Requirements
Error Code Table
Carrier Eligibility File Layout
Flow Diagram

Addendum – b

Enroll Relationship Requirements

Enrollment Record Layout

ENROLLMENT FILE

This file is received by ASES from carriers on a daily basis. It contains data pertinent to **new enrollment** and members which have selected to **change their enrollment** to the organization sending the file. Also used to record changes in Plan Type, Plan Version, IPAs/HCOs and PCPs

Member Record			
Record Fields	**Position**	**Size**	**Notes**
RECORD_TYPE	1	1	**"E" for Enrollment Record (Constant)**
TRAN_ID	2	1	E=new enrollment, P=Plan Type change, C=Carrier change, V= Version change, I=IPA change, 1=PCP1 change, 2=PCP2 change, 3=PCP1 and PCP2 change, X= Delete incorrect enrollment, O=Contract Number Change only
PROCESS_DATE	3	8	MMDDYYYY - Date Enrolled by Carrier
REGION	11	1	Region code
CARRIER	12	2	Carrier code
MEMBER_PRIMARY_CENTER	14	4	IPA or PHO code
ODSI_FAMILY_ID	18	11	
MEMBER_SSN	29	9	
MEMBER_SUFFIX	38	2	
EFFECTIVE_DATE	40	8	MMDDYYYY- Card issue date for new Reforma enrollment (Trans_ID= E) or Effective date (1st day of month) for other Trans_ID's
PLAN_TYPE	48	2	See Plan Type Table
PLAN_VERSION	50	3	Used to identify version of Plan within PLAN_TYPE (if needed)
MPI	53	13	Alpha-numeric ej.-"0080012345678"
PCP1	66	15	Text
PCP1_EFFECTIVE_DATE	81	8	MMDDYYYY
PCP2	89	15	Text
PCP2_EFFECTIVE_DATE	104	8	MMDDYYYY
FAMILY_PRIMARY_CENTER	112	4	IPA or PHO code
FAM_PRIMARY_CENTER_EFF_DATE	116	8	MMDDYYYY
IPA_PCP_CHANGE_REASON	124	2	Code Table to be supplied
MEDICARE INDICATOR	126	1	1=A&B, 3=A, 9=B
HIC NUMBER	127	12	
Reject Identifier	139	1	"A" = Accepted; "M" = MA Retroactive; "R" = Rejected; "X" = Deleted
Record Key	140	14	YYYYMMDD999999
Error Code 1	154	3	Indicates error (see error code table)
Error Code 2	157	3	Indicates error (see error code table)
Error Code 3	160	3	Indicates error (see error code table)
Error Code 4	163	3	Indicates error (see error code table)
Error Code 5	166	3	Indicates error (see error code table)
Error Code 6	169	3	Indicates error (see error code table)

Enrollment Record Layout

ENROLLMENT FILE

This file is received by ASES from carriers on a daily basis. It contains data pertinent to **new enrollment** and members which have selected to **change their enrollment** to the organization sending the file. Also used to record changes in Plan Type, Plan Version, IPAs/HCOs and PCPs

Member Record			
Error Code 7	172	3	Indicates error (see error code table)
Error Code 8	175	3	Indicates error (see error code table)
Error Code 9	178	3	Indicates error (see error code table)
Error Code 10	181	3	Indicates error (see error code table)
Update Date	184	8	YYYYMMDD
Update User	192	8	"SYSTUPD "
IPA_ESPECIAL	200	1	1 = IPA Especial
Contract Number	201	13	Character left justified
Special Enroll	214	1	E = Emergency N = New Born
Filler	215	15	
	230		

Addendum – c

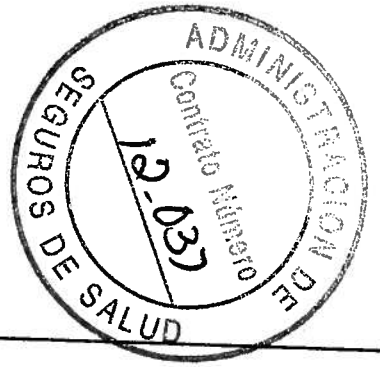
Error Code Table

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

Error Code	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
011	Invalid Record Type		Must be "E"
021	Spaces in Trans ID.		
022	Invalid Trans ID.		
031	Spaces in Process Date.		
032	Invalid Process Date.		
033	Except for newborns enrollments, Process Date should be less or equal than Effective Date and greater or equal than three months before Effective Date (Reforma)	For **Reforma** (Plan Type = 01) the Process Date must be **equal or less** that the Effective Date. Effective Date has to be within 2 months of the Process Date.	Verify process date versus effective date.
034	If Tran_Id = "E" and Reform and Process_Date >= 11/16/2006, then Effective_Date cannot be 11/01/2006	Special edit for coverage conversion of Nov.2006.	
035	Process Date should be less than Effective Date and greater or equal than three months before Effective Date (Platino)	For **Platino** (Plan Type = 02 or 03) the Process Date must be **less** that the Effective Date. Effective Date has to be within 2 months of the Process Date.	Verify process date versus effective date.
036	Process Date should be greater or equal than three months before PCP1_EFFECTIVE_DATE	PCP1_EFFECTIVE_DATE can not be more than 3 month greater that the process date.	
037	Process Date should be greater or equal than three months before PCP2_EFFECTIVE_DATE	PCP2_EFFECTIVE_DATE can not be more than 3 month greater that the process date.	
038	Process Date should be greater or equal than three months before FAM_PRIMARY_CENTER_EFF_DATE	FAM_PRIMARY_CENTER_EFF_DATE can not be more than 3 month greater that the process date.	
041	Spaces in Region		
042	Invalid Region		

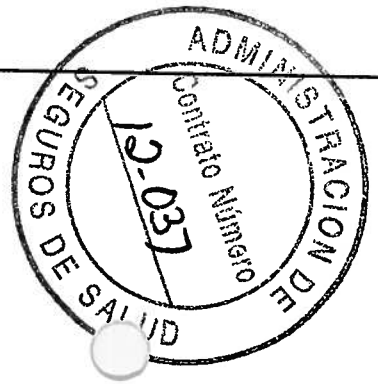
PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

Error Code	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
051	Spaces in Carrier		
052	Invalid Carrier		
053	Carrier equal to actual Carrier and is requesting a change.	**The enrollment has a C (carrier change) in the Tran_ID and the carrier is the same as the carrier in the member record in ASES.**	Verify if the record should have been send with another Tran_ID (like V or I). If not the member is already enrolled and no further action should be required.
054	If plan type=01 and effective_date is future should be 1st of the month	**Enrollments for future dates must have effective dates for the 1st of the month.**	
055	Carrier not contracted in the municipality or region at the enrollment effective date.	**Match Carriers_contracted table by Carrier and region. The effective date of the enrollment has to be within the effective and expiration dates of the selected carriers_contracted table record for that carrier and Region. Carrier must be contracted at the effective date of the enrollment. The enrollment record plan_type has to be 01 if the Reforma column is "Y". Else the plan in the enrollment has to be "02" or "03". The Plan_Type must match the carriers_contracted table record for the effective date of the enrollment. If the "Todos_Municipios" column is "N" then the municipality code in the member_eligibility record for the member in the enrollment record has to match one of the municipality codes in the selected table record. If some municipalities are contracted in a region then the municipality code must match.**	Carrier should review member's address an insure that the municipality in included in the ASES contract.



PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

Error Code	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
056	Plan type = 01 and effective date is 20101001 at enrollment, and new_plan_type = 02 and new_carrier_eff_date is 20101001 at member_eligibility	**This is a temporary error code to be operating during the month of September 2010 related to the October 1, 2010 conversion.**	
057	Plan type = 01 and effective date is 20101001 at enrollment, and plan_type = 02 at member_eligibility	**This is a temporary error code to be operating during the month of September 2010 related to the October 1, 2010 conversion.**	
061	Trans ID in ("E","C","P","V","I") and is required then Member Primary Center had spaces	Member Primary center is required when the enrollment has a Tran_ID of "E","C","P","V","I" in Reforma or if the Platino Plan is identified as requiring Primary Center.	
062	Trans ID in ("1","2","3") and Member Primary Center is different from actual subscribed Primary Center.	The enrollment is for a PCP change but has a Primary Center different from the one in the member record in ASES.	PCP changes are accepted if the record has the same carrier, Plan Type, Version and IPA as the ASES database for the member. Check if the intention is to change both the IPA and the PCP and submit a IPA change (Tran_ID = I) with the new IPA and PCPs.
063	Primary Center equal to actual Primary Center	IPA change when the IPA in the ASES database for the member is the same.	Verify if the record should have been send with another Tran_ID. If not the member is already enrolled in the IPA and no further action should be required.
064	if Tran_ID="D" should be space		
065	For the Special region. Invalid Member Primary Center for Direct Contract Carrier. A record in our tables was not found for the given region, carrier, member_primary_center and effective_date.	Incorrect IPA in the enrollment record.	Verify and correct.



PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

Error Code	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
066	For any region other than Special. Invalid Member Primary Center for Direct Contract Carrier. A record in our tables was not found for the given region, carrier, member_primary_center and effective_date.	Incorrect IPA in the enrollment record.	Verify and correct.
071	Spaces in Family ID		
072	Length of Family ID not equal 11		
073	Family ID Not Found	Family_Id not found in the region indicated in the enrollment record.	Verify if the family ID used is correct. Verify if the region code is the correct one for the member.
081	Spaces Member SSN		
082	Length of Member SSN not equal 9		
083	Member SSN Not Found		Verify if the Member SSN used is correct. Verify if the region code is the correct one for the member.
091	Spaces in Member Suffix		
092	Length of Member Suffix not equal 2		
093	Member Suffix Not Found in ASES Eligibility	No record for the member found in the ASES database.	Verify that the assignment of the Suffix in the carrier database coincides with ASES. If the family_id or the Member SSN is also in error this code will appear.
101	Spaces in Effective Date		
102	Invalid Effective Date		
103	In Enroll and Reform, effective date should be less than run process date	**For Reforma (Plan Type = 01) original enrollment (Tran_ID = E) the Effective Date has to be less than the run date. It is assumed that the member was enrolled before the enrollment record was sent to ASES. Original enrollments are not for future periods.**	Verify dates and correct.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

Error Code	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
104	Other than Enroll and Reform, effective date should be greater than daily process date and 1st of the month.	**For Reforma (Plan Type = 01) where the Tran_ID is not E the effective date must be greater than the run date and 1st of the month.**	Verify dates and correct.
105	Other than Reform, effective date should be 1st of the month.		
106	if TRAN_ID IN ("D") then effective date should be 1st of the month		
107	EFFECTIVE DATE SHOULD BE DURING THE LAST ACTIVE PERIOD FOR THE FAMILY	**The family to which the member belongs was cancelled after the effective date in the enrollment record.**	This cases will be submitted to be enrolled in history under the new version of the enrollment system (SYSPREM).
108	EFFECTIVE DATE SHOULD BE DURING THE LAST ACTIVE PERIOD FOR THE MEMBER	**The the member was cancelled after the effective vdate in the enrollment record.**	This cases will be submitted to be enrolled in history under the new version of the enrollment system (SYSPREM).
109	There should be records for family at family_eligibility_history at or before effective_date except for special_enroll in ('E','N')	**The family was not eligible at the effective date in the enrollment record.**	Verify the Effective Date submitted and correct. Verify if the enrollment should be identified as new born or emergency and correct accordingly.
10A	If special_enroll = 'E', effective date should be at least as recent as the family eligibility effective date.	**For emergencies the effective date can not be less that the family eligibility effective date.**	Verify and correct.
10B	If special_enroll = 'N', effective date should be at least as recent as member birth date and effective date should not be more than a year forward from the birth date	**For new borns the effective date can not be less than the birth date or a year after the birth date.**	Verify and correct.
111	Spaces in Plan Type		
112	Length of Plan Type not equal 2		
113	Invalid Plan Type,Carrier and Plan Version	Enrollment records have to match the Plan Type and Plan Version contracted by the carrier with ASES.	Verify and correct.
114	if Trans_ID="D" should be "01"		

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

Error Code	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
121	Spaces in Plan Version		
122	Length of Plan Version not equal 3		
123	Invalid Plan Version		Verify that the Plan, Version in the enrollment is the Plan Version contracted with ASES.
124	if Trans_ID="D" should be "001"		
131	Length of MPI Number not equal 13		
132	MPI Number Not Found in ASES Eligibility		Verify that the correct MPI was used. Verify if the region code is the correct one for the member.
141	Spaces in PCP1 when Tran ID <> "2" <>"D" is required.	For enrollments where the PCP1 is required the PCP1 Field must not be in spaces.	
142	PCP1 should be spaces when Tran ID = "2" ="D"	For changes in PCP2 the PCP1 field must be spaces.	
151	Spaces in PCP1 Effective Date when Tran ID <> "2" <>"D" is required.	**Spaces or invalid date was entered in PCP1 Effective Date in enrollments where PCP1 is required.**	Verify and correct.
152	Invalid PCP1 Effective Date when Tran ID <> "2" <> "D" is required.		
153	PCP1 Effective Date whitout spaces when Tran ID <> "2" <> "D" is not required.	**PCP1 effective date must be in spaces when the enrollment is not for a PCP2 change and PCP1 is not required.**	Verify and correct.
154	PCP1 Effective Date should be spaces when Tran ID = "2"	**PCP1 effective date must be in spaces when the enrollment is for a PCP2 change.**	Verify and correct.
155	In Enroll, PCP1 effective date should be less than run process date	**For Reforma (Plan Type = 01) original enrollment (Tran_ID = E) the PCP1 Effective Date has to be less than the run date. It is assumed that the member was enrolled before the enrollment record was sent to ASES. Original enrollments are not for future periods.**	Verify and correct.

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

Error Code	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
156	Other than Enroll, PCP1 effective date should be 1st of the month.		
157	if PCP1 not null PCP1_effective_Date should be not null and viceversa	**When there is data in the PCP1 field there should be a valid date in the PCP1 Effective Date field and vice versa.**	Verify and correct.
158	if new enroll, carrier change or ipa change, and PCP1 not null, PCP1_effective_Date should be same as Effective_Date. if plan type change, plan version change, pcp1 change or pcp1 and pcp2 change, and PCP1 not null, PCP1_effective_Date should be greater or equal than Effective_Date in member_eligibility.		Verify and correct.
161	Spaces in PCP2 when If Trans_ID in ("2", "3")	Tran_ID 2 and 3 require data in PCP2 field.	Verify and correct.
162	PCP2 should be spaces when If Trans_ID not in ("2", "3")		
171	Spaces in PCP2 Effective Date when If Trans_ID in ("2", "3")	**Tran_ID 2 and 3 require date in PCP2 effective Date field field.**	Verify and correct.
172	Invalid PCP2 Effective Date when Tran ID <> "2"	**Invalid data in PCP2 Effective Data**	
173	In Enroll, PCP2 effective date should be less than run process date	**For Reforma (Plan Type = 01) original enrollment (Tran_ID = E) the PCP2 Effective Date has to be less than the run date. It is assumed that the member was enrolled before the enrollment record was sent to ASES. Original enrollments are not for future periods.**	Verify and correct.
174	Other than Enroll, PCP2 effective date should be 1st of the month.		

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

Error Code	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
175	if PCP2 not null PCP2_effective_Date should be not null and viceversa	**When there is data in the PCP2 field there should be a valid date in the PCP2 Effective Date field an dvice versa.**	
176	if Tran_ID="D" should be null		
177	Enrolled in other carrier at or after enrollment Effective Date	**The member was enrolled in another carrier after the effective date in the enrollment record**	
178	if new enroll, carrier change or ipa change, and PCP2 not null, PCP2_effective_Date should be same as Effective_Date. if plan type change, plan version change, pcp2 change or pcp1 and pcp2 change, and PCP2 not null, PCP2_effective_Date should be greater or equal than Effective_Date in member_eligibility.		Verify and correct.
179	Future subscription already set for another carrier at enrollment future Effective Date		
181	Is required then Family Primary Center had spaces	**family Primary Center required for Reforma**	
182	Is not required and Family Primary Center didn't had spaces.		
183	if Tran_ID = "D" should be space		
191	Is required and Family Primary Center Effective Date have spaces		
192	Incorrect Family Primary Center Effective Date		
193	Is not required and Family Primary Center Effective Date did not have spaces		
194	if Tran_ID="D" should be null		
200	if Tran_ID = "D" should be space		

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

Error Code	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
211	Incorrect Plan and Version: Members is not Federal Medicaid	The Plan Type and Version contracted by the carrier require that the member be Federal Medicare and the ASES database indicates the member is not Federal Medicare.	
221	Duplicate Enrollment	Two enrollment records entered in the same daily run for the same member as defined by Family_ID and Suffix.	
222	Already Enroll in the Same Carrier	When the Tran_ID is E and the ASES database has the member as enrolled in the same carrier	Verify if the record should have been send with another Tran_ID (like V or I). If not the member is already enrolled and no further action should be required.
223	Already Enroll in Other Carrier	When the Tran_ID is E and the ASES database has the member as enrolled in another carrier.	Verify if the record should have been send with a carrier change Tran_ID (E).
224	Member Not Eligible At Carrier Effective Date		
225	Incorrect SSN		
226	Incorrect MPI		
227	Trans ID = "P" and Carrier is different from actual subscribed Carrier.	**Only the current carrier in the ASES database can submit a Plan Change enrollment record. The Member is enrolled under a different carrier in the ASES database.**	Verify if the record should have been send with another Tran_ID.
228	Trans ID = "V" and Carrier or Plan Type are different as the actual data.	**Version changes are allowed under the same carrier and Plan Type. Only the current carrier in the ASES database can submit a Version Change enrollment record. The Member is enrolled under a different carrier or Plan Type in the ASES database.**	Verify if the record should have been send with another Tran_ID

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

Error Code	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
229	Trans ID = "I" and Carrier or Plan Type or Version are different as the actual data.	**Ipa changes are allowed under the same carrier, Plan Type and Version. Only the current carrier in the ASES database can submit a IPA Change enrollment record. The Member is enrolled under a different carrier or Plan Type or Version in the ASES database.**	Verify if the record should have been send with another Tran_ID
22A	Trans ID in ("1", "2", "3") and Carrier orPlan Type or Version or Primary Center are different as the actual data.	**PCP changes are allowed under the same carrier, Plan Type, Version and IPA. Only the current carrier in the ASES database can submit a PCP Change enrollment record. The Member is enrolled under a different carrier or Plan Type or version or IPA in the ASES database.**	Verify if the record should have been send with another Tran_ID
22B	if TransID=3 , PCP1 and PCP2 both effective dates must be future or retroactive dates		
22C	Member in the same family should be in the same carrier,plan_type,version,primary center, PCP1, PCP2	**For Reforma members in a family.**	
22D	Invalid new field date values	**Effective date can not be greater than run date by more than 4 months**	
22E	if PLAN_TYPE="01" then PLAN_VERSION should be the same as the COVERAGE_CODE	**In Enrollment record for Reform (Plan Type 01) beneficiaries the Version field must match the coverage code field in the ASES database for the member being enrolled.**	Verify and correct.

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

Error Code	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
22F	if PLAN_TYPE="01" and exists an Error_code in one family_id all member are rejected	**When and enrollment record for one family member has errors, all the family members are given the 22F error code. This Keeps all the enrollment record for a family together and avoids partial processing of the family members in the same run.**	Correct the errors other than 22F in all family Members.
22G	if PLAN_TYPE="02" or "03" (Platino) then PLAN_VERSION in the Enrollment record should match the PLAN_VERSION with the same COVERAGE_CODE assigned in the Plan Detail table.	**For Platino enrollments: The member Coverage Code is assigned a specific Version in the Plan Detail Table. If a different Version is used this error will be produced. For members with Coverage Code 012 or 013 the Version for Coverage Code 011 must be used.**	Correct Version and submitt Enrollment again.
241	When Plan Type =1 and new enrollment		
242	carrier change to plan type =1 and already exist in Member eligibility table		
250	if Tran_ID = "D" should be space		
260	if Tran_ID = "D" should be space		
270	if Tran_ID="D" should be null		
280	Family should be elegible		
281	Member should be eligible		
980	Record already enrolled in history has higher or equal process date.		
981	Rejected family member has errors not accepted by SYSPREM.		

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION
SUBSCRIPTION FILE ERROR DESCRIPTION

Error Code	Mensaje de Error	Additional Description (where needed)	Possible Corrective Actions
982	Effective Date before '01/01/2006'		
983	Already subscribed in the same Carrier at the specified Effective Date.		
984	Tran_Id = 'E', Effective Date is not 1st of the month and member is already subscribed in another Carrier.		Must be resubmitted as a carrier change (tran_id = "C". Effective date must be 1st of the following month.
985	If special_enroll = 'E', effective date should be at least as recent as member certification date at the specified Effective Date.		
986	For SYSPREM processing, the Effective Date should be before the Effective Date of the current record at Member Eligibility.		Verify Effective Date.
995	Had 22F but was re-evaluated because the records with errors in its family were processed by SYSPREM.		
996	Processed by SYSPREM	Not an Error	No Action Should be taken.
998	Spaces in Record Key.	Not an Error	No Action Should be taken.
999	New Case with a Record Key.	Not an Error	No Action Should be taken.

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Addendum – d

Carrier Eligibility File Layout

CARRIER ELIGIBILITY FILE
FAMILY RECORD

CARRIER ELIGIBLITY OUTPUT FILE

This file is created by the DAILY export program and contains the demographic and eligibility information sent to ASES from the Department of Health and verified by ASES as eligible for Health Reform. (Modified on May 2003 for the direct contracting pilot project. See entries in bold. Modified on March 2004 for Smartcard project. See entries in bold and highlighted. Modified on July 2005 for Medicare Project. Modified on January 2008 to add tran_id = H for sysprem records.)

# Field	Record Fields	Position	Size	Notes
1	RECORD-TYPE	1	1	"F" for family
2	TRAN-ID	2	1	E=eligible, I=ineligible, R=reject, **H= SYSPREM (history)**
3	PROCESS-DATE	3	8	MMDDYYYY
4	FAMILY-SSN	11	9	SSN of Head-of-Household(HOH)
5	FAMILY-SUFFIX	20	2	"00"
6	FILLER	22	14	
7	ODSI-FAMILY-ID	36	11	"Gx"+HOH SSN for ELA (x=0,1,2 ... by subscription period)
8	HOH-1ST-LAST-NAME	47	15	
9	HOH-2ND-LAST-NAME	62	15	
10	HOH-FIRST-NAME	77	20	
11	REGION	97	1	
12	MUNICIPALITY	98	4	Zero fill, right justify.
13	FACILITY	102	4	
14	INVESTIGATION-IND	106	1	
15	TRANSACTION-TYPE	107	1	
16	EFFECTIVE-DATE	108	8	Start date of eligibility MMDDYYYY
17	FINANCIAL-RESP-PCT	116	1	
18	CERTIFIER-NUMBER	117	2	
19	EXPIRATION-DATE	119	8	End date of eligibility MMDDYYYY
20	COND-ELIG-IND	127	1	
21	MAILING-ADDRESS1	128	25	
22	MAILING-ADDRESS2	153	25	
23	MAILING-CITY	178	16	
24	MAILING-ZIP	194	5	
25	MAILING-ZIP4	199	4	
26	RESIDENCE-ADDRESS1	203	25	
27	RESIDENCE-ADDRESS2	228	25	
28	RESIDENCE-CITY	253	16	
29	RESIDENCE-ZIP	269	5	
30	RESIDENCE-ZIP4	274	4	
31	PHONE	278	7	
32	OTHER-INSURER1	285	2	Insurance co. code
33	OTH-POLICY1	287	20	Policy number
34	OTHER-INSURER2	307	2	Insurance co. code
35	OTH-POLICY2	309	20	Policy number
36	OTHER-INSURER3	329	2	Insurance co. code
37	OTH-POLICY3	331	20	Policy number
38	MEMBERS	351	2	# members in family
39	ODSI-MEMBERS-ELIGIBLE	353	2	# members eligible ODSI / optionals ELA-SB-Vet
40	USER-CODE	355	6	
41	ENTRY-DATE	361	8	MMDDYYYY
42	PCT-OF-POVERTY-LEVEL	369	3	
43	DEDUCTIBLE-LEVEL-CODE	372	1	
44	HCRE-MEMBERS-ELIGIBLE	373	2	# members eligible by ASES. Zero fill, right justify.
45	HCRE-DENIAL-CODE	375	2	Zero fill, right justify.
46	CARRIER-CODE	377	2	
47	EFFECTIVE-CARRIER-DATE	379	8	For Family Carrier . MMDDYYYY
48	ELA-ERRORS	387	10	5 2-digit error codes for ELA-SB-Vet
49	MANCOMUNADO	397	1	Y / N (ELA Only)
50	FILLER	398	3	
51	**Family-PRIMARY-CENTER**	401	4	**IPA or PHO**
52	**NEW-CARRIER**	405	2	**New carrier code**
53	**NEW-Family-PRIMARY-CENTER**	407	4	**new IPA or PHO for families changing carrier**
54	**NEW-Family-PRIMARY CENTER EFFECTIVE DATE**	411	8	**MMDDYYYY - effective date of IPA/PHO change**
55	***CONTRACT NUMBER***	419	13	***Parte común del contrato***
56	***REGION ASES***	432	1	
58	***NEW CARRIER EFFECTIVE DATE***	433	8	***New Carrier MMDDYYYY***
59	***FAMILY PRIMARY CENTER EFFECTIVE DATE***	441	8	***MMDDYYYY***

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CARRIER ELIGIBILITY FILE
FAMILY RECORD

CARRIER ELIGIBLITY OUTPUT FILE

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# Field	Record Fields	Position	Size	Notes
60	*CERTIFICATION DATE*	449	8	*MMDDYYYY*
61	*PRIMARY CENTER PCP CHANGE REASON*	457	2	*Basado en tabla de Código de Razón.*
63	AUTO_ENROLL_INDICATOR	459	1	*0 = Not Auto; >0 = Auto Enroll*
64	AUTO_ENROLL_DATE	460	8	*MMDDYYYY*
62	*FILLER*	468	72	
		540		

*** All are Text Fields

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CARRIER ELIGIBILITY FILE
MEMBERS RECORD

CARRIER ELIGIBLITY OUTPUT FILE

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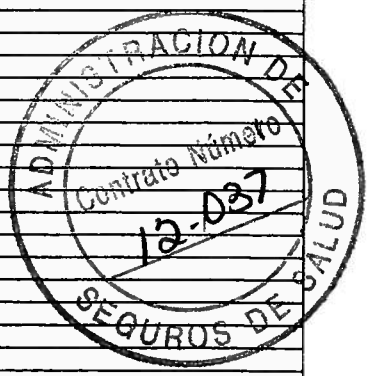
# Field	Record Fields	Position	Size	Notes
1	RECORD-TYPE	1	1	"M" for member
2	TRAN-ID	2	1	E=eligible, I=ineligible, R=reject, **H= SYSPREM (history)**
3	PROCESS-DATE	3	8	MMDDYYYY
4	FAMILY-SSN	11	9	SSN of Head-of-Household
5	FAMILY-SUFFIX	20	2	Zero fill, right justify.
6	FILLER	22	1	
7	MEMBER-SSN	23	9	
8	MEMBER-SUFFIX	32	2	
9	FILLER	34	14	
10	1ST-LAST-NAME	48	15	
11	2ND-LAST-NAME	63	15	
12	FIRST-NAME	78	20	
13	MIDDLE-INITIAL	98	1	
14	RELATIONSHIP	99	1	
15	DATE-OF-BIRTH	100	8	MMDDYYYY
16	PLACE-OF-BIRTH	108	1	
17	SEX	109	1	
18	CATEGORY	110	1	
19	CATEGORY-2	111	1	
20	CONDITION	112	1	
21	SOURCE-CODE	113	1	
22	RECEIVE-SS	114	1	
23	MED-INS-CODE	115	1	Zero fill, right justify.
24	POLICY	116	2	
25	CLASS	118	1	
26	CLASS-2	119	1	
27	DENIAL-CAT	120	1	
28	DENIAL-CAT-2	121	1	
29	MARITAL-STATUS	122	1	
30	SSN	123	9	
31	PREG-IND	132	1	
32	ABSENT-PARENT	133	1	
33	HICN	134	11	
34	PILOT-CAT	145	1	
35	PILOT-CLASS	146	1	
36	PILOT-DENIAL	147	1	
37	HCRE-ELIGIBILITY-IND	148	1	
38	HCRE-DENIAL-CODE	149	2	Zero fill, right justify.
39	OTHER-INSURER1	151	2	Insurance co. code
40	OTH_POLICY1	153	20	Policy number
41	OTHER-INSURER2	173	2	Insurance co. code
42	OTH_POLICY2	175	20	Policy number
43	OTHER-INSURER3	195	2	Insurance co. code
44	OTH_POLICY3	197	20	Policy number
45	GROUP-IDENT	217	2	"06" - ELA, "02" - Veteran, "22" - Small Bus. Zero fill, right justify.
46	ODSI-FAMILY-NO	219	11	"Gx"+HOH SSN for ELA (x=0,1,2 ... by subscription period)
47	ELA-ERRORS	230	10	5 2-digit error codes for ELA-SB-Vet
48	AGENCY	240	5	Agency # for ELA / Group Num for SB. Zero fill, right justify.
49	***MASTER PATIENT INDEX (MPI)***	***245***	***13***	
50	***MEMBER CERTIFICATION DATE***	***258***	***8***	***MMDDYYYY***
51	***CONTRACT NUMBER***	***266***	***13***	***Include Suffix***
52	***MEMBER PRIMARY CENTER***	***279***	***4***	
53	***MEMBER PRIMARY CENTER EFFECTIVE DATE***	***283***	***8***	***MMDDYYYY***
54	***MEMBER NEW PRIMARY CENTER***	***291***	***4***	
55	***MEMBER NEW PRIMARY CENTER EFFECTIVE DATE***	***295***	***8***	***MMDDYYYY***
56	***PCP1***	***303***	***15***	
57	***PCP1 EFFECTIVE DATE***	***318***	***8***	***MMDDYYYY***
58	***PCP2***	***326***	***15***	
59	***PCP2 EFFECTIVE DATE***	***341***	***8***	***MMDDYYYY***
60	***NEW PCP1***	***349***	***15***	
61	***NEW PCP1 EFFECTIVE DATE***	***364***	***8***	***MMDDYYYY***
62	***NEW PCP2***	***372***	***15***	



CARRIER ELIGIBILITY FILE
MEMBERS RECORD

CARRIER ELIGIBLITY OUTPUT FILE

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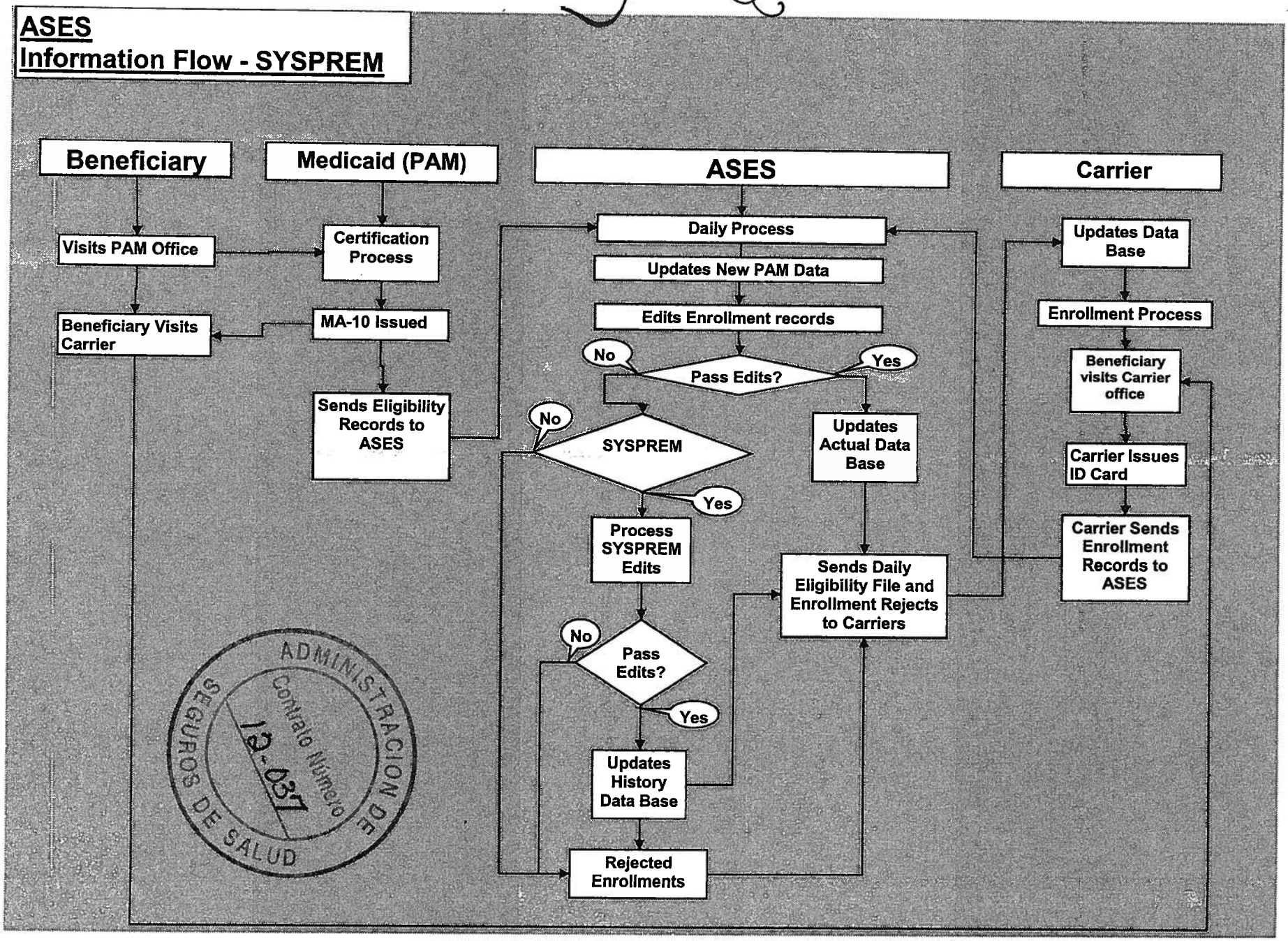
# Field	Record Fields	Position	Size	Notes
63	NEW PCP2 EFFECTIVE DATE	387	8	MMDDYYYY
64	CARD ID NUMBER	395	15	
65	CARD ID DATE	410	8	MMDDYYYY
66	ELA INDICATOR	418	1	1=NO PREMIUM 2=PREMIUM Spaces when not ELA.
67	PRIMARY CENTER PCP CHANGE REASON	419	2	Basado en tabla de Codigo de Razon.
68	MEDICAID INDICATOR	421	1	1=Medicaid Federal, 2=SCHIPS 3=Estatal 4= Estatal otros
69	MEDICARE INDICATOR	422	1	1=A&B, 3=A, 9=B
70	CARRIER	423	2	
71	CARRIER_EFF_DATE	425	8	MMDDYYYY
72	NEW_CARRIER	433	2	
73	NEW_CARRIER_EFF_DATE	435	8	MMDDYYYY
74	PLAN_TYPE	443	2	"bb"=elegible no suscrito, Ver tabla Plan Type
75	PLAN_TYPE_EFF_DATE	445	8	MMDDYYYY
76	PLAN_VERSION	453	3	Version del plan MA suscrito
77	PLAN_VERSION_EFF_DATE	456	8	MMDDYYYY
78	NEW_PLAN_TYPE	464	2	
79	NEW_PLAN_TYPE_EFF_DATE	466	8	MMDDYYYY
80	NEW_PLAN_VERSION	474	3	
81	NEW_PLAN_VERSION_EFF_DATE	477	8	MMDDYYYY
82	INSTITUTIONAL_STATUS	485	1	Y or N
83	HIC NUMBER MA	486	12	
84	AUTO_ENROLL_INDICATOR	498	1	0 = Not Auto; >0 = Auto Enroll
85	AUTO_ENROLL_DATE	499	8	MMDDYYYY
86	IPA_ESPECIAL	507	1	1 = IPA Especial
87	CMS_Cert_Status	508	2	Status de Certificación en CMS
88	Coverage_Code	510	3	001 - Traditional GHIP (ends 10/31/2006) 010 – Traditional GHIP with deductible level 0 011- Traditional GHIP with deductible level 1 012 - Traditional GHIP with deductible level 2 013 - Traditional GHIP with deductible level 3 310 - State with income <= 100% of FPL 320 – State with income > 100% of FPL
89	New Contract Number	513	13	
	Special_Enroll	526	1	E = Emergency N = New Born
90	FILLER	527	13	
		540		

*** All are Text Fields

Addendum – e

Flow Diagram


ASES
Information Flow - SYSPREM
Beneficiary
Medicaid (PAM)
ASES
Carrier
Visits PAM Office
Certification Process
Beneficiary Visits Carrier
MA-10 Issued
Sends Eligibility Records to ASES
Daily Process
Updates New PAM Data
Edits Enrollment records
No
Pass Edits?
Yes
No
SYSPREM
Yes
Updates Actual Data Base
Process SYSPREM Edits
No
Pass Edits?
Yes
Updates History Data Base
Rejected Enrollments
Sends Daily Eligibility File and Enrollment Rejects to Carriers
Updates Data Base
Enrollment Process
Beneficiary visits Carrier office
Carrier Issues ID Card
Carrier Sends Enrollment Records to ASES
ADMINISTRACION DE SEGUROS DE SALUD
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2. ASES 820 Mapping

ASES - 820 Mapping Sheet

HIPAA Field Name- 820 Premium PaymentTransaction	Segment Require-ment	Element Require-ment	HIPAA Loop Repeat	HIPAA Loop ID	HIPAA Segment ID	HIPAA Data Element Number	HIPAA Imple-mentation Guide Page	HIPAA Field Type	HIPAA Field Length Min/Max	CARRIER PAYMENT FILE	Notes
										Legend - RED - "Hard Coded" Values Blue - New Data Elements Gray - Data Element NOT SENT	
Interchange Control Header	R		1								
Authorization Information Qualifier		R			ISA01	I01		ID	2 / 2	00	No Authorization Information Present (No Meaningful Information in I02)
Authorization Information		R			ISA02	I02		AN	10 / 10	SPACES(10)	
Security Information Qualifier		R			ISA03	I03		ID	2 / 2	00	No Security Information Present (No Meaningful Information in I04)
Security Information		R			ISA04	I04		AN	10 / 10	SPACES(10)	
Interchange ID Qualifier		R			ISA05	I05		ID	2 / 2	ZZ	
Interchange Sender ID		R			ISA06	I06		AN	15 / 15	ASES+SPACES(11)	
Interchange ID Qualifier		R			ISA07	I05		ID	2 / 2	ZZ	
Interchange Receiver ID		R			ISA08	I07		AN	15 / 15	NEW	MCO/MBHO/COSVI name - up to 15 characters - padded with spaces to a fixed length of 15
Interchange Date		R			ISA09	I08		DT	6 / 6	NEW	System Date - YYMMDD
Interchange Time		R			ISA10	I09		TM	4 / 4	NEW	System Time - HHMM
Interchange Control Standards Identifier		R			ISA11	I10		ID	1 / 1	U	U.S. EDI Community of ASC X12, TDCC, and UCS
Interchange Control Version Number		R			ISA12	I11		ID	5 / 5	00401	
Interchange Control Number		R			ISA13	I12		NO	9 / 9	NEW	System Date (YYMMDD)+Sequence Number (3 digits)
Acknowledgment Requested		R			ISA14	I13		ID	1 / 1	0	No Acknowledgment Requested
Production Data		R			ISA15	I14		ID	1 / 1	P	Production Data
Component Element Separator		R			ISA16	I15			1 / 1	|	Pipe
Functional Group Header	R										
Functional Identifier Code		R			GS01	479		ID	2 / 2	RA	Payment Order/Remittance Advice (820)
Application Sender's Code		R			GS02	142		AN	2 / 15	ASES	

ASES - 820 Mapping Sheet

HIPAA Field Name- 820 Premium Payment Transaction	Segment Require-ment	Element Require-ment	HIPAA Loop Repeat	HIPAA Loop ID	HIPAA Segment ID	HIPAA Data Element Number	HIPAA Imple-mentation Guide Page	HIPAA Field Type	HIPAA Field Length Min/Max	CARRIER PAYMENT FILE	Notes
Application Receiver's Code		R			GS03	124		AN	2 / 15	NEW	MCO/MBHO/COSVI name - up to 15 characters
Date		R			GS04	373		DT	8 / 8	NEW	System Date - CCYYMMDD
Time		R			GS05	337		TM	4 / 8	NEW	System Time - HHMM
Group Control Number		R			GS06	28		NO	1 / 9	NEW	Sequence Number, starting at 1 incremented by 1,+System Date (YYMMDD)
Responsible Agency Code		R			GS07	455		ID	1 / 2	X	
Version / Release / Industry Identifier Code		R			GS08	480		AN	1 / 12	004010X061A1	
Transaction Set Header	R		1								
Transaction Set Identifier Code		R			ST01	143	34	ID	3 / 3	820	
Transaction Set Control Number		R			ST02	329	34	AN	4 / 9	NEW	Tracking number unique to this ST-SE pair. Recommend - "YYMM+CARRIER_ID+REGION+PLAN" Plan Type (Reform, MA or PDP) Added for Medicare Project
Financial Information	R		1								
Transaction Handling Code		R			BPR01	305	36	ID	1 / 2	I	Remittance Information Only - Use this code to indicate to the payee that the remittance detail is moving separately from the payment.
Total Premium Payment Amount		R			BPR02	782	37	R	1 / 18	NEW	Sum of CALC_AMOUNT for entire Carrier/Region/Plan_Type
Credit or Debit Flag Code		R			BPR03	478	37	ID	1 / 1	C	Credit - If Payment is EFT, this indicates a credit to the payee's account, and a debit to the Payer's account. This code should also be used if payment is by check.

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ASES - 820 Mapping Sheet

HIPAA Field Name- 820 Premium PaymentTransaction	Segment Require-ment	Element Require-ment	HIPAA Loop Repeat	HIPAA Loop ID	HIPAA Segment ID	HIPAA Data Element Number	HIPAA Imple-mentation Guide Page	HIPAA Field Type	HIPAA Field Length Min/Max	CARRIER PAYMENT FILE	Notes
Payment Method Code		R			BPR04	591	37	ID	3 / 3	CHK	Check - Use this code to indicate that a check has been issued for payment.
Payment Format Code		S			BPR05	812	38	ID	1 / 10		
Depository Financial Institution (DFI) Identification Number Qualifier		S			BPR06	506	39	ID	2 / 2		
Originating Depository Financial Institution (DFI) Identifier		S			BPR07	507	39	AN	3 / 12		
Account Number Qualifier		S			BPR08	569	39	ID	1 / 3		
Sender Bank Account Number		S			BPR09	508	40	AN	1 / 35		
Originating Company Identifier		S			BPR10	509	40	AN	10 / 10		
Originating Company Supplemental Code		S			BPR11	510	40	AN	9 / 9		
Depository Financial Institution (DFI) Identification Number Qualifier		S			BPR12	506	40	ID	2 / 2		
Receiving Depository Financial Institution (DFI) Identifier		S			BPR13	507	41	AN	3 / 12		
Account Number Qualifier-		S			BPR14	569	41	ID	1 / 3		
Receiver Bank Account Number		S			BPR15	508	41	AN	1 / 35		
Check Issue or EFT Effective Date		R			BPR16	373	41	DT	8 / 8	NEW	Check Issurance Date
Reassociation Key	R		1								
Trace Type Code		R			TRN01	481	43	ID	1 / 2	3	Financial Reassociation Trace Number - The payment and remittance information have been separated and need to be reassociated by the receiver.
Check or EFT Trace Number		R			TRN02	127	44	AN	1 / 30	NEW	Check Number
Originating Company Identifier		S			TRN03	509	44	AN	10 / 10		
Originating Company Supplemental Code- NO		S			TRN04	127	44	AN	1 / 30		
Non-US Dollars Currency	S										
Entity Identifier Code		R			CUR01	98	46	ID	2 / 3		
Currency Code		R			CUR02	100	46	ID	3 / 3		
Exchange Rate		S			CUR03	280	47	R	4 / 10		
Premium Receiver Identification Key	S		>1								

ADMINISTRACION DE SEGUROS DE SALUD
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ASES - 820 Mapping Sheet

HIPAA Field Name- 820 Premium PaymentTransaction	Segment Requirement	Element Requirement	HIPAA Loop Repeat	HIPAA Loop ID	HIPAA Segment ID	HIPAA Data Element Number	HIPAA Implementation Guide Page	HIPAA Field Type	HIPAA Field Length Min/Max	CARRIER PAYMENT FILE	Notes
Reference Identification Qualifier		R			REF01	128	48	ID	2 / 3	14	Master Account Number - For HIPAA Health Premium Payments this element is REQUIRED.
Premium Receiver Reference Identifier		R			REF02	127	49	AN	1 / 30	CARRIER+REGION-ID	
Process Date	S										
Date Time Qualifier		R			DTM01	374	50	ID	3 / 3		
Payer Process Date		R			DTM02	373	50	DT	8 / 8		
Delivery Date	S										
Date Time Qualifier		R			DTM01	374	52	ID	3 / 3		
Premium Delivery Date		R			DTM02	373	53	DT	8 / 8		
Coverage Period	S		1								
Date Time Qualifier		R			DTM01	374	54	ID	3 / 3		
Date Time Period Format Qualifier		R			DTM05	1250	55	ID	2 / 3		
Coverage Period		R			DTM06	1251	55	AN	1 / 35		
Premium Receiver's Name	R		1								
Entity Identifier Code		R		1000A	N101	98	56	ID	2 / 3	PE	Payee
Information Receiver Last or Organization Name		R		1000A	N102	93	57	AN	1 / 60	NEW	MCO/MBHO Name
Identification Code Qualifier		R		1000A	N103	66	57	ID	1 / 2	FI	Federal Taxpayer's Identification Number
Receiver Identifier		R		1000A	N104	67	57	AN	2 / 80	NEW	MCO/MBHO Federal Tax ID
Premium Receiver's Additional Name	S										
Receiver Additional Name		R		1000A	N201	93	58	AN	1 / 60		
Premium Receiver's Address	S										
Receiver Address Line		R		1000A	N301	166	59	AN	1 / 55		
Receiver Address Line		S		1000A	N302	166	59	AN	1 / 55		
Premium Receiver's City, State, Zip	S										
Information Receiver City Name		R		1000A	N401	19	60	AN	2 / 30		
Information Receiver State Code		R		1000A	N402	156	60	ID	2 / 2		
Information Receiver Postal Zone or ZIP Code		R		1000A	N403	116	61	ID	3 / 15		
Country Code		S		1000A	N404	26	61	ID	2 / 3		
Premium Payer's Name	R		1								
Entity Identifier Code		R		1000B	N101	98	62	ID	2 / 3	PR	Payer
Premium Payer Name		R		1000B	N102	93	63	AN	1 / 60	NEW	ASES Name
Identification Code Qualifier		S		1000B	N103	66	63	ID	1 / 2	FI	Federal Taxpayer's Identification Number

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ASES - 820 Mapping Sheet

HIPAA Field Name- 820 Premium PaymentTransaction	Segment Requirement	Element Requirement	HIPAA Loop Repeat	HIPAA Loop ID	HIPAA Segment ID	HIPAA Data Element Number	HIPAA Implementation Guide Page	HIPAA Field Type	HIPAA Field Length Min/Max	CARRIER PAYMENT FILE	Notes
Premium Payer Identifier		S		1000B	N104	67	63	AN	2 / 80	NEW	ASES Federal TAX ID
Premium Payer's Additional Name	S										
Premium Payer Additional Name		R		1000B	N201	93	65	AN	1 / 60		
Premium Payer's Address	S										
Premium Payer Address Line		R		1000B	N301	166	66	AN	1 / 55		
Premium Payer Address Line		S		1000B	N302	166	66	AN	1 / 55		
Premium Payer's City State Zip	S										
Premium Payer City Name		R		1000B	N401	19	67	AN	2 / 30		
Premium Payer State Code		R		1000B	N402	156	67	ID	2 / 2		
Premium Payer Postal Zone or ZIP Code		R		1000B	N403	116	68	ID	3 / 15		
Country Code		S		1000B	N404	26	68	ID	2 / 3		
Premium Payer's Administrative Contact	S		>1								
Contact Function Code		R		1000B	PER01	366	70	ID	2 / 2		
Premium Payer Contact Name		R		1000B	PER02	93	70	AN	1 / 60		
Communication Number Qualifier		S		1000B	PER03	365	70	ID	2 / 2		
Communication Number		S		1000B	PER04	364	70	AN	1 / 80		
Communication Number Qualifier		S		1000B	PER05	365	70	ID	2 / 2		
Communication Number		S		1000B	PER06	364	71	AN	1 / 80		
Communication Number Qualifier		S		1000B	PER07	365	71	ID	2 / 2		
Communication Number		S		1000B	PER08	364	71	AN	1 / 80		
Organization Summary Remittance	S		1								
Assigned Number		R		2000A	ENT01	554	73	N0	1 / 6		
Entity Identifier Code		R		2000A	ENT02	98	73	ID	2 / 3		
Identification Code Qualifier		S		2000A	ENT03	66	73	ID	1 / 2		
Organization Identification Code		S		2000A	ENT04	67	73	AN	2 / 80		
Organization Summary Remittance Detail	SR		1								
Reference Identification Qualifier		R		2300A	RMR01	128	75	ID	2 / 3		
Contract, Invoice, Account, Group, or Policy Number		R		2300A	RMR02	127	75	AN	1 / 30		
Payment Action Code		S		2300A	RMR03	482	75	ID	2 / 2		
Detail Premium Payment Amount		R		2300A	RMR04	782	76	R	1 / 18		
Billed Premium Amount		S		2300A	RMR05	782	76	R	1 / 18		
Summary Line Item	S		1								

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ASES - 820 Mapping Sheet

HIPAA Field Name- 820 Premium PaymentTransaction	Segment Requirement	Element Requirement	HIPAA Loop Repeat	HIPAA Loop ID	HIPAA Segment ID	HIPAA Data Element Number	HIPAA Implementation Guide Page	HIPAA Field Type	HIPAA Field Length Min/Max	CARRIER PAYMENT FILE	Notes
Line Item Control Number		R		2310a	IT101	350	78	AN	1 / 20		
Member Count	S		>1								
Line Item Control Number		R		2315A	SLN01	350	81	AN	1 / 20		
Information Only Indicator		R		2315A	SLN03	662	82	ID	1 / 1		
Head Count		R		2315A	SLN04	380	82	R	1 / 15		
Unit or Basis for Measurement Code		R		2315A	SLN05	355	82	ID	2 / 2		
Organization Summary Remittance Level Adj.	S		>1								
Adjustment Amount		R		2320A	ADX01	782	85	R	1 / 18		
Adjustment Reason Code		R		2320A	ADX02	426	85	ID	2 / 2		
Individual Remittance	S		>1								
Assigned Number		R		2000B	ENT01	554	87	N0	1 / 6	NEW	Sequence Number starting at 1 incremented by 1, reset back to 1 at next ST segment
Entity Identifier Code		R		2000B	ENT02	98	87	ID	2 / 3	2J	Individual
Identification Code Qualifier		R		2000B	ENT03	66	87	ID	1 / 2	34	
Receiver's Individual Identifier		R		2000B	ENT04	67	87	AN	2 / 80	MEMBER Social Security Number	
Individual Name	S		>1								
Entity Identifier Code		R		2100B	NM101	98	88	ID	2 / 3	QE	Policyholder
Entity Type Qualifier		R		2100B	NM102	1065	89	ID	1 / 1	1	Person
Individual Last Name		S		2100B	NM103	1035	89	AN	1 / 35	MEMBER_LAST_NAME_1	
Individual First Name		S		2100B	NM104	1036	89	AN	1 / 25		
Individual Middle Name		S		2100B	NM105	1037	89	AN	1 / 25		
Individual Name Prefix		S		2100B	NM106	1038	89	AN	1 / 10		
Individual Name Suffix		S		2100B	NM107	1039	89	AN	1 / 10		
Identification Code Qualifier		S		2100B	NM108	66	89	ID	1 / 2		
Individual Identifier		S		2100B	NM109	67	90	AN	2 / 80		
Individual Premium Remittance Detail - See Notes on Worksheet - RMR Usage	S		>1								
Reference Identification Qualifier		R		2300B	RMR01	128	92	ID	2 / 3	11	Account Number
Insurance Remittance Reference Number		R		2300B	RMR02	127	92	AN	1 / 30	NEW	FAMILY_ID+Member_Suffix+MPI+Municipio Replaced CALC_MEMBERS by MPI Added Member_suffix for Medicare Proyect

ASES - 820 Mapping Sheet

HIPAA Field Name- 820 Premium PaymentTransaction	Segment Require-ment	Element Require-ment	HIPAA Loop Repeat	HIPAA Loop ID	HIPAA Segment ID	HIPAA Data Element Number	HIPAA Imple-mentation Guide Page	HIPAA Field Type	HIPAA Field Length Min/Max	CARRIER PAYMENT FILE	Notes
Payment Action Code		S		2300B	RMR03	482	92	ID	2 / 2		
Detail Premium Payment Amount		R		2300B	RMR04	782	93	R	1 / 18	CALC_AMOUNT	
Billed Premium Amount		S		2300B	RMR05	782	93	R	1 / 18	BILLED_AMOUNT	
Reference Identification Qualifier		R		2300B	RMR01	128	92	ID	2 / 3	IK	Difference for adjustment
Insurance Remittance Reference Number		R		2300B	RMR02	127	92	AN	1 / 30	NEW	CARRIER ID+REGION+BILLING DATE
Payment Action Code		S		2300B	RMR03	482	92	ID	2 / 2		
Detail Premium Payment Amount		R		2300B	RMR04	782	93	R	1 / 18	CALC_AMOUNT	
Billed Premium Amount		S		2300B	RMR05	782	93	R	1 / 18	BILLED_AMOUNT	
Reference Identification Qualifier		R		2300B	RMR01	128	92	ID	2 / 3	KW	Errors
Insurance Remittance Reference Number		R		2300B	RMR02	127	92	AN	1 / 30	NEW	ERROR CODES
Payment Action Code		S		2300B	RMR03	482	92	ID	2 / 2		
Detail Premium Payment Amount		R		2300B	RMR04	782	93	R	1 / 18	CALC_AMOUNT	
Billed Premium Amount		S		2300B	RMR05	782	93	R	1 / 18	BILLED_AMOUNT	0
Individual Coverage Period	S		1								
Date Time Qualifier		R		2300B	DTM01	374	94	ID	3 / 3	582	Report Period
Date Time Period Format Qualifier		R		2300B	DTM05	1250	95	ID	2 / 3	RD8	Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
Coverage Period		R		2300B	DTM06	1251	95	AN	1 / 35	NEW	Starting Date of Coverage-Ending Date of Coverage based upon CALC_DAYS. Use Accounting date for retro & adjustments.
Individual Premium Adjustment	S		>1								
Adjustment Amount		R		2320B	ADX01	782	96	R	1 / 18	NEW	**(CALC_AMOUNT minus BILLED_AMOUNT)+adjustment carrier code**
Adjustment Reason Code		R		2320B	ADX02	426	97	ID	2 / 2	IA	
Trailer	R		1								

ASES - 820 Mapping Sheet

HIPAA Field Name- 820 Premium PaymentTransaction	Segment Require-ment	Element Require-ment	HIPAA Loop Repeat	HIPAA Loop ID	HIPAA Segment ID	HIPAA Data Element Number	HIPAA Imple-mentation Guide Page	HIPAA Field Type	HIPAA Field Length Min/Max	CARRIER PAYMENT FILE	Notes
Transaction Segment Count		R			SE01	96	98	N0	1 / 10	NEW	Count of number of total segments, including ST and SE
Transaction Set Control Number		R			SE02	329	98	AN	4 / 9	NEW	Tracking number unique to the ST-SE pair. Recommend - "YYMM+CARRIER_ID+REGION+PLAN" Plan Type (Reform, MA or PDP) Added for Medicare Project"
Functional Group Trailer	R										
Number of Transaction Sets Included		R			GE01	97		NO	1 / 6	1	
Group Control Number		R			GE02	28		NO	1 / 9	NEW	Sequence Number, starting at 1 incremented by 1,+System Date (YYMMDD)
Interchange Control Trailer	R										
Number of Included Functional Groups		R			IEA01	I16		NO	1 / 5	1	
Interchange Control Number		R			IEA02	I12		NO	9 / 9	NEW	System Date (YYMMDD)+Sequence Number (3 digits)

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3. ASES Query Process

ASES QUERY FILE

ELIGIBILITY QUERY FILE LAYOUT

August 1, 2008

This file is produced by Medicare Platino Carriers and sent to ASES to verify the elegibility of Medicare Beneficiaries in the GHIP (Reforma).

Query Record

# Field	Record Fields	Position	Size	Notes
1	RECORD_TYPE	1	1	"Q" for Query
2	PROCESS_DATE	2	8	YYYYMMDD
3	BENEFICARY SSN	10	9	
4	1ST_LAST_NAME	19	15	
5	2ND_LAST_NAME	34	15	
6	FIRST_NAME	49	20	
7	SEX	69	1	1 = Male, 2 = Female
8	DATE OF BIRTH	70	8	YYYYMMDD
9	REGION	78	1	
10	CARRIER	79	2	Carrier Code
11	FECHA DE EFECTIVIDAD	81	8	Para uso en queries historicos. Entrar fecha en que comienza la suscripcion del Beneficiario. Formato YYYYMMDD. El dia debe ser primero de mes. Si el query no es historico se deja en blanco.
12	FILLER	89	11	
		100		

*** All are Text Fields

ADMINISTRACION DE SEGUROS DE SALUD
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ASES QUERY RESPONSE FILE

QUERY RESPONSE FILE LAYOUT

October 20, 2008

This file is sent by ASES to Carriers as a response to query records. The Response Record informs if a Beneficiary is elegible for GHIP (Reform) coverage. It provides the key data elements which the Carrier will use to notify enrollment to ASES once approved by CMS.

Query Response Record

# Field	Record Fields	Position	Size	Notes
1	RECORD_TYPE	1	1	"R" for Response
2	CARRIER_PROCESS_DATE	2	8	YYYYMMDD
3	**BENEFICARY SSN**	10	9	
4	CARRIER_1ST_LAST_NAME	19	15	
5	CARRIER_2ND_LAST_NAME	34	15	
6	CARRIER_FIRST_NAME	49	20	
7	CARRIER_SEX	69	1	1 = Male, 2 = Female
8	CARRIER_DATE OF BIRTH	70	8	YYYYMMDD
9	CARRIER_REGION	78	1	
10	CARRIER	79	2	Carrier Code
11	ASES_1ST_LAST_NAME	81	15	
12	ASES_2ND_LAST_NAME	96	15	
13	ASES_FIRST_NAME	111	20	
14	ASES_SEX	131	1	1 = Male, 2 = Female
15	ASES_DATE OF BIRTH	132	8	YYYYMMDD
16	**ASES_REGION**	140	1	
17	ELEGIBILITY_INDICATOR	141	1	**Y or N**
18	**ODSI_FAMILY_ID**	142	11	
19	**MEMBER_SUFFIX**	153	2	
20	**MPI**	155	13	Alpha-numeric ej.-"0080012345678"
21	MEDICAID_INDICATOR	168	1	**1 = Federal Medicaid**
22	ELEGIBILITY_EFFECTIVE_DATE	169	8	YYYYMMDD
23	ELEGIBILITY_EXPIRATION_DATE	177	8	YYYYMMDD
24	ASES_PROCESS_DATE	185	8	YYYYMMDD
25	MESSAGE_CODE	193	6	Spaces= no errors, 01=SSN no match, 02=Sex no match, 03=DOB no match, 04=Region no match, 05=Miembro de municipio no contratado por Carrier, 06=Empleado ELA, 07=SSN no match (history records)
26	ASES_DEDUCTIBLE_LEVEL	199	1	
27	MUNICIPIO	200	4	Código Municipio en ASES
28	FECHA DE EFECTIVIDAD	204	8	Para uso en queries historicos. Formato YYYYMMDD.
29	CODIGO DE CUBIERTA	212	3	Código de Cubierta (Coverage Code)
30	FILLER	215	5	
		220		

*** All are Text Fields

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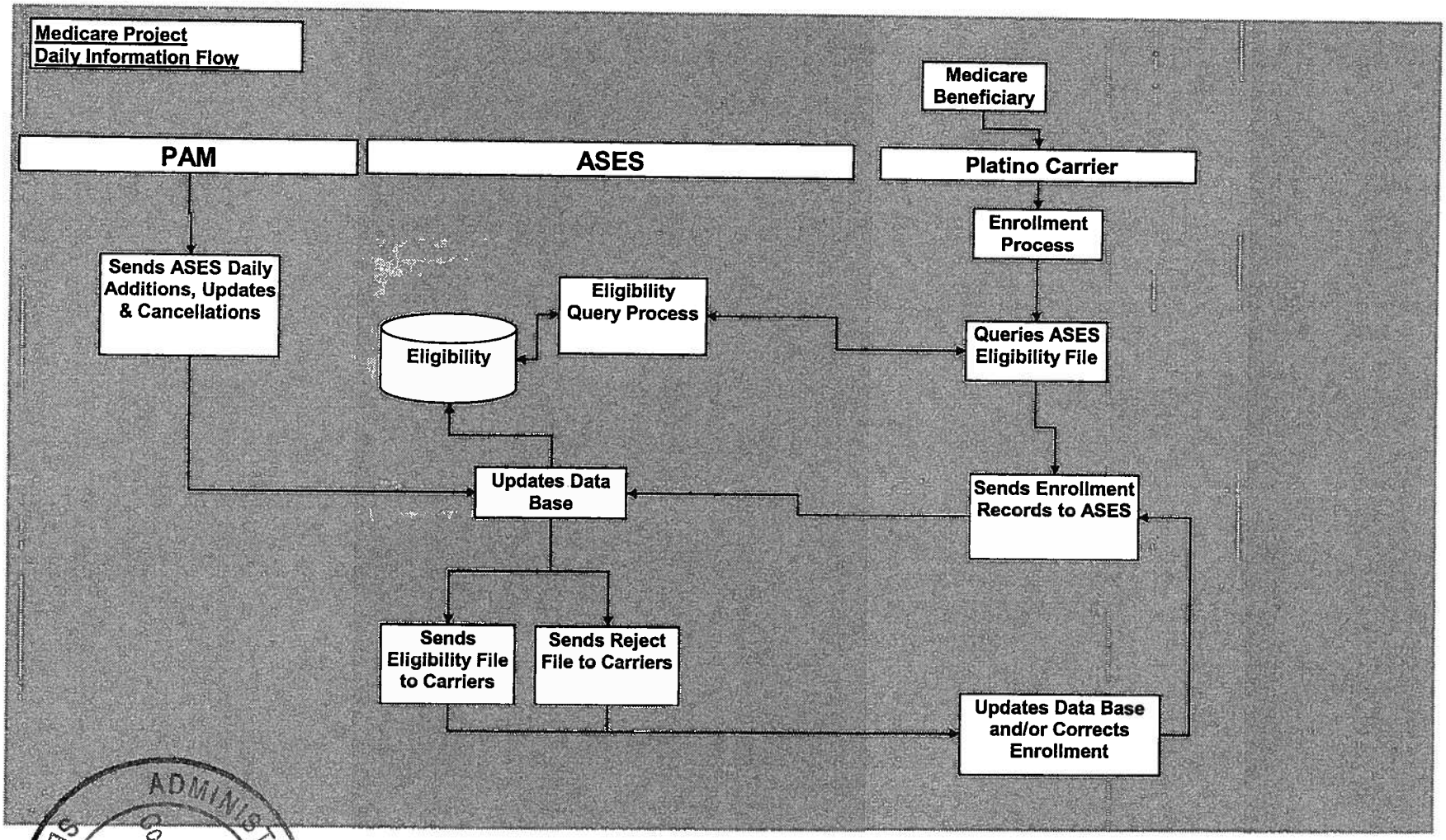
4. Current Layout for Claims & Encounters

ASES QUERY PROCESS FLOW



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PUERTO RICO HEALTH INSURANCE ADMINISTRATION
Claims and Encounter Input File Layout

Field	*Description*	*Value*	*Type-Size*	*Position*
***Transaction Code**	Identify the action to be taken with the record. 'A' and 'D' should NOT match any existing record (on Internal Control Number). 'C' and 'E' should match an existing record (on Internal Control Number).	**A** – Addition **C** – Change **D** – Deny **E** – Eliminate	A – 1	1
***Carrier Code**	Value that identifies carrier. Must be a valid code.	**01** – Triple SSS **02** – Humana **17** – MCS **25** – Cruz Azul **55** – COSVI **64** – MC-21 **76** – MBHP **83** – APS **95** – FHC	N – 2	2
***Internal Control Number**	Insurance company's Internal claim identification. This number is used to avoid duplicated Claims. Transactions with the same Internal Control Number would be considered a duplicate and will be rejected.		AN – 15	4
***Region Code**	Identifies regions. Must be a valid code.	**A** – Arecibo (N) **B** – Bayamon (M-N) **E** – Este (E) **F** – Fajardo (N-E) **G** – Guayama (S-E) **J** - San Juan **S** – Suroeste (S-W) **Z** – Mayaguez (W)	A – 1	19
***Municipality Residence**	Identify the beneficiary's municipality of residence. The residence municipality must be a valid code and reside in the correct region.	**Appendix I**	N – 4	20
Municipality Service	Identify the municipality where the beneficiary received the service. Must be a valid code.	**Appendix I**	N – 4	24
***HOH Social Security**	The nine digits Social Security Number (non zeroes) of the Head of Household.		N – 9	28
***Patient Social Security**	The nine digits Social Security Number (non zeroes) of the beneficiary.		N – 9	37
***ASES Member Suffix**	Identifies the beneficiary within the family group. Should be the same as supplied by ASES from the Eligibility Process.	01 – Head of Household 02-99 - Dependants	N – 2	46
***Sex Code**	Sex of the beneficiary.	**M** – Male **F** – Female	A – 1	48
***Patient Age**	Age of the beneficiary as of the service from date. Ex: 9 years will be 009 (Zero fill, right justify).		N – 3	49
***Birth Date**	Must be a Valid Date. Format - yyyymmdd Ex. March 15, 2002 will be 20020315.		N – 8	52
***Accident Date**	Date when the accident was reported or services was received. Must be a Valid Date. The accident date must be before or the same as the Service From Date. Format – yyyymmdd Ex. March 15, 2002 will be 20020315.		N – 8	60
***Service From Date**	Begin date of the treatment. Date Service From must be before or the same as the Date Service To. Must be a Valid Date. Format – yyyymmdd Ex. March 15, 2002 will be 20020315.		N – 8	68

Field	*Description*	*Value*	*Type-Size*	*Position*
***Service To Date**	End date of the treatment. Must be a Valid Date. Format - yyyymmdd Ex. March 16, 2002 will be 20020316.		N – 8	76
***Payment Date**	For the encounter – the process dates. For fee for service – the payment date. The payment date must be after or equal to the service to date. Must be a Valid Date. Format - yyyymmdd Ex. March 17, 2002 will be 20020317.		N – 8	84
Number of Services or Daily Doses	For Claim Type F or H, Number of Services received by the beneficiary must be numeric and greater than zeroes. If Claim Type is H (Hospital) it will be the days in the hospital or F (Pharmacy) will be the daily doses in tablets or liquids. Ex. 5 days will be 00005 (Zero fill, right justify)		N – 5	92
Number of Session	Number of sessions of psychiatric services. Ex. 5 sessions will be 00005 (Zero fill, right justify)		N – 5	97
Prescription Days	If claim type is F (Pharmacy), then the prescription days must be greater than 0. Ex. 5 days will be 00005 (Zero fill, right justify)		N – 5	102
***Diagnostic Code**	Must be a valid ICD-9 or DSM-4 code. If the code, appears with a dot, it should be coded that way. Diagnostic Codes must pass validity tests with Sex and Age. Example: An ICD-9 of 174 (Malignant Neoplasm in Female Breast) will be on a claim with a sex of 'F'.	**ICD-9, DSM-4**	AN – 6	107
***Claim Type**	Identify the Claim Type. Must be a valid code.	**A** - Ambulance **D** - Dental **E** - Emergency **F** - Pharmacy **H** - Hospital **L** - Laboratory **M** - Medic	A – 1	113
***IN / OUT Patient**	Specify if the service was giving as Inpatient or Outpatient. Must be a valid value.	**I** - In-patient **O** - Out-patient	A – 1	114
***Encounter or Fee**	Must be a valid value.	**E** - Encounter **F** - Fee for Service	A – 1	115
***Service Type**	Specify what type of services the beneficiary received. Must be a valid code.	**Appendix IV**	AN – 1	116
***Procedure Code**	This code should conform to Common Procedure Terminology (CPT), National Drug Code (NDC), HCPCS, Revenue Code or Common Dental Terminology (CDT) appropriate to the Claim Type.	**CPT, NDC, HCPCS, CDT, Revenue Code**	AN – 15	117
***Tooth Code**	If Claim type is D, Tooth Code is required for certain CDT codes.	**Appendix II**	AN – 3	132
***Superficies Code**	If Claim type is D, Tooth Superficies is required for certain CDT codes.	**Appendix II**	AN – 7	135
Case Type	Specify if the beneficiary received Surgical Intervention.	**1** – Surgical **2** - Non Surgical	N – 1	142
Case Code	Specify the beneficiary's condition at the time of service.	**A-** Alcoholism **C-** Cardiovascular **D-** Dental **E-** Diabetes	A – 1	143

Field	*Description*	*Value*	*Type-Size*	*Position*
		I- Intensive Care **M-** Maternity **N-** Pre-Natal **O-** Oncology **P-** Psychiatric **Q-** Drugs **R-** Respiratory **S-** SIDA **T-** Tuberculosis **X-** Other		
Reason Code	Treatment reason.	**1-** Work Accident **2-** Vehicle Accident **3-** Other Accident **4-** Sickness **5-** Other	N – 1	144
***COB Code**	Identify if the beneficiary has other Health Insurance. Must be a valid code.	**Y** - Yes **N** - No	A – 1	145
Primary Center	Identify the Care Center or IPA of the beneficiary. Primary Center is required.		AN – 10	146
Service Center	Identify the Care Center or IPA, where the claim was produced. Service Center is required.		AN – 10	156
Contract Type	Identify the contract type of the beneficiary. First Position Health Plan Insurance **1-** Reform Second Position Contract Type **1-** Family **2-** Individual	The required combinations are: • **11** • **12**	N – 2	166
***Place of Service**	Must be a valid code. For a claim type 'H' and IN / OUT Patient 'I', the place of service must be '21', '31', '51', or '61'. For a claim type 'H' and IN / OUT Patient 'O', the place of service must be '22', '52', or '62'. For a claim type 'F', the place of service must be '98'. For a claim type 'A', the place of service must be '41' or '42'.	**Appendix V**	AN – 2	168
Primary Provider License	Primary Provider License should be a valid Physician's License.		AN – 10	170
Primary Provider Specialty	Specify the specialty of Beneficiary's Primary Provider.	**Appendix III**	AN – 3	180
Service Provider License	Service Provider License should be a valid Physician's License.		AN – 10	183
Service Provider Specialty	Specify the specialty of the Doctor who gave services to the beneficiary.	**Appendix III**	AN – 3	193
HIC Code	Indicate the Medicare Number of the specified beneficiary.		AN – 12	196
Referred Provider License	Specify the license of Doctor who referred the case.		AN – 10	208
Referred Provider Specialty	Specify the specialty of the Doctor who referred the beneficiary's case.	**Appendix III**	AN – 3	218
***Submitted Charge**	Indicate the cost of the services. Ex. A charge of $14.50 will be 000001450 (zero fill, right justify). (Non Negative Values)		N – 9	221
***Deductible**	Ex. A deductible of $1.00 will be 000000100		N – 9	230

Field	*Description*	*Value*	*Type-Size*	*Position*
	(zero fill, right justify and Non Negative Values).			
***Co-Pay**	Ex. A Co-Pay of $1.25 will be 000000125 (zero fill, right justify and Non Negative Values).		N – 9	239
***Drugstore Dispense**	For Claim Type of F (Pharmacy), indicate the dispensing fee. Ex. A Co-Pay of $1.25 will be 000000125 (zero fill, right justify and Non Negative Values).		N – 9	248
***Net Payment**	For an Encounter the net payment must be zero. For Fee for Service, the net payment must be greater than zero. Ex. A payment of $11.25 will be 000001125 (zero fill, right justify and Non Negative Values).		N – 9	257
Filler	Space.		AN – 1	266
Patient Name	Format – First Name 'space' LastName1 'space' LastName2.		AN – 30	267
***ASES Family ID**	Number assigned by ASES to the beneficiary's family. The Family ID must be 11 characters long.		AN – 11	297
Provider Number	Provider Number of the Doctor that gave the service.		AN – 10	308
MPI Number	Is the Master Patient Index. Is the unique patient identifier.		AN – 13	318
Contract Number	Is used by Insurance Companies like a Patient Support Number and awarding claims.		AN – 13	331
Receive Date	Specify when the Insurance Company receives the Claim or Encounter. Must be a Valid Date. Format – yyyymmdd Ex. March 15, 2002 will be 20020315.		AN – 8	344
*Plan Type	Identify the plan type contracted by ASES to provided Health Services to a beneficiary. Must be a valid code.	**01** – Plan de Salud del Gobierno (PSG (Reforma)) **02** – MA-SNP **03** – MA_PD	AN – 2	352
*Plan Version	Used to identify version of Plan within PLAN_TYPE (if needed). Must be a valid code.		AN – 3	354
Cost Applied to	Identifies to which coverage the cost of the Claim is applied. If the amount is split between both covers then the amounts are entered in the field provided below.	1 – Advantage Coverage 2 – Wrap Around Coverage 3 – Split Cost Application	AN – 1	357
Wrap Around Split Amount	Ex. An amount of $11.25 will be 000001125 (zero fill, right justify and Non Negative Values).		N – 9	358
Advantage Split Amount	Ex. An amount of $11.25 will be 000001125 (zero fill, right justify and Non Negative Values).		N – 9	367
Filler			AN – 24	376 400

Field	*Description*	*Value*	*Type-Size*	*Position*

The file must be of fixed length (ASCII).

* Required Fields
A – Alpha (alphabets only)
AN – Alpha Numeric (can be alphabets and/or numbers)
N – Numeric (numbers only)

Changes due the Medicare Project

APPENDIX I
Municipality Code

Code	Municipality	Region	Code	Municipality	Region
0004	Adjuntas	S	0168	Lares	A
0008	Aguada	Z	0172	Las Marias	Z
0012	Aguadilla	Z	0176	Las Piedras	E
0016	Aguas Buenas	E	0180	Loiza	F
0020	Aibonito	G	0184	Luquillo	F
0024	Añasco	Z	0188	Manatí	A
0028	Arecibo	A	0192	Maricao	Z
0032	Arroyo	G	0196	Maunabo	G
0036	Barceloneta	A	0200	Mayagüez	Z
0040	Barranquitas	G	0204	Moca	Z
0044	Bayamón	B	0208	Morovis	A
0048	Cabo Rojo	Z	0212	Naguabo	E
0052	Caguas	E	0216	Naranjito	B
0056	Camuy	A	0220	Orocovis	G
0060	Canovanas	F	0224	Patillas	G
0064	Carolina	F	0228	Peñuelas	S
0068	Cataño	B	0232	Ponce	S
0072	Cayey	E	0236	Quebradillas	A
0076	Ceiba	F	0240	Rincon	Z
0080	Ciales	A	0244	Rio Grande	F
0084	Cidra	E	0248	Sabana Grande	Z
0088	Coamo	G	0252	Salinas	G
0092	Comerio	B	0256	San German	Z
0096	Corozal	B	0264	Puerta de Tierra	J
0100	Culebra	F	0266	San Juan	J
0104	Dorado	B	0270	Puerto Nuevo	J
0108	Fajardo	F	0272	Rio Piedras	J
0112	Florida	A	0274	San José	J
0116	Guanica	S	0276	San Lorenzo	E
0120	Guayama	G	0280	San Sebastian	Z
0124	Guayanilla	S	0284	Santa Isabel	G
0128	Guaynabo	B	0288	Toa Alta	B
0132	Gurabo	E	0292	Toa Baja	B
0136	Hatillo	A	0296	Trujillo Alto	F
0140	Hormigueros	Z	0300	Utuado	A
0144	Humacao	E	0304	Vega Alta	B
0148	Isabela	Z	0308	Vega Baja	A
0152	Jayuya	S	0312	Vieques	F
0156	Juana Diaz	G	0316	Villalba	G
0160	Juncos	E	0320	Yabucoa	E
0164	Lajas	Z	0324	Yauco	S

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APPENDIX II
Dental Codes

Category	Code	Description	Tooth	Surface
Endodontics	D3310	Anterior (Endo)	Y	N
	D3320	Bicuspid (Endo)	Y	N
	D3322	Bicuspid - Two or More Canals	Y	N
Oral Surgery	D7110	Single Tooth	Y	N
	D7120	Each Additional Tooth	Y	N
	D7130	Root Removal-Exposed Roots	Y	N
	D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap	Y	N
	D7220	Removal of Impacted Tooth-Soft Tissue	Y	N
	D7230	Removal of Impacted Tooth-Partially	Y	N
	D7240	Removal of Impacted Tooth-Compl-Bony	Y	N
	D7241	Removal of Impacted Tooth-Compl-Bony-With Unusual Surgical Complications	Y	N
	D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	Y	N
Palliative	D2940	Sedative Filling	Y	N
	D9110	Palliative Treatment	Y	N
Preventive	D1351	Sealant-Per Tooth	Y	N
Restorative	D2110	Amalgam-One Surface, Primary	Y	Y
	D2120	Amalgam-Two Surfaces, Primary	Y	Y
	D2130	Amalgam-Three Surfaces, Primary	Y	Y
	D2131	Amalgam-Four or More Surfaces, Primary	Y	Y
	D2140	Amalgam-One Surface, Permanent	Y	Y
	D2150	Amalgam-Two Surfaces, Permanent	Y	Y
	D2160	Amalgam-Three Surfaces, Permanent	Y	Y
	D2161	Amalgam-Four or More Surfaces, Permanent	Y	Y
	D2330	Resin-One Surface, Anterior	Y	Y
	D2331	Resin-Two Surfaces, Anterior	Y	Y
	D2332	Resin-Three Surfaces, Anterior	Y	Y
	D2335	Resin-Four or More Surfaces or Involving Incisal Angle	Y	Y

APPENDIX III

Codificación de Proveedores

A. Médicos

Código	Especialidad	Código	Especialidad	Código	Especialidad
001	General Practice	022	Pathology	051	Orthopedic Surgery
002	General Surgery	025	Physical Medicine / Rehabilitation	053	Preventive Medicine
003	Allergy/Immunology	026	Psychiatry	066	Rheumatology
004	Otolaryngology	027	Occupational Medicine	076	Peripheral Vascular Disease
005	Anesthesiology	028	Colorectal Surgery / Proctology	077	Vascular Surgery
006	Cardiology	029	Pulmonary Diseases	078	Cardiac Surgery
007	Dermatology	030	Diagnostic Radiology	079	Pediatric Surgery
008	Family Practice	033	Thoracic Surgery	085	Maxillofacial Surgery
010	Gastroenterology	034	Urology	086	Neuropsychiatry
011	Internal Medicine	036	Nuclear Medicine	088	Hematology
012	Geneticist	037	Pediatrics	090	Medical Oncology
013	Neurology	038	Geriatrics	091	Surgical Oncology
014	Neurosurgery	039	Nephrology	092	Radiation Oncology
015	Neonatology	040	Hand Surgery	093	Emergency Medicine
016	Obstetrics / Gynecology	044	Infectious Diseases	094	Intervention Radiology
017	Perinatology	046	Endocrinology		
018	Ophthalmology	048	Plastic & Reconstructive Surgery		

B. Otros Proveedores Individuales

Código	Especialidad	Código	Especialidad	Código	Especialidad
AU	Audiologist	OP	Optometrist	PS	Psycologist
DD	Dentist	OR	Orthotist	PT	Physical Therapist
DI	Dietician	OS	Oral Surgery (Dentist)	RT	Respiratory Therapist
EN	Endodontist	OT	Occupational Therapist	ST	Speech Therapist
HE	Health Educator	PD	Podiatrist	SW	Social Worker
HN	Home Health Nurse	PR	Prosthetist		
NU	Nutricionist	PE	Periodontist		

C. Codificación de Proveedores que no sean Individuos

Código	Especialidad	Código	Especialidad	Código	Especialidad
AF	Ambulatory Surgery Facility	HV	HIV Ambulatory Antibiotic Facility	PP	Private Psychiatric Hospitalization
AM	Ambulance	HO	Hospice	PS	Psychiatric Partial Hospitalization
BB	Blood Bank	IC	Intensive Care Unit	SH	State Hospital
CL	Clinical Laboratory	IT	Infusion Therapy	SN	Skilled Nursing Facility
CV	Cardiac Catheterization Facility	LI	Lithotripsy	SP	State Psychiatric Hospital
DF	Dialysis Facility	NI	Neonatal ICU	XR	X-ray Facility
EC	Emergency Care Facility	OP	Optical	Z4	Cardiovascular Surgery Program
FA	Pharmacy	PC	Clinic – Primary Level		
HC	Home Health Care	PH	Private Hospitalization		

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APPENDIX IV
Service Type

Type	Description
1	Medical Care
2	Surgery
3	Consultation
4	Diagnostic Radiology
5	Diagnostic Laboratory
6	Therapeutic Radiology
7	Anesthesia
8	Assistant at Surgery
9	Other Medical Items or Services (Will be use for Dental Transactions)
0	Whole blood or packed red cells
A	Used durable medical equipment
B	High risk screening mammography
C	Low risk screening mammography
D	Ambulance
E	Enteral / parenteral nutrients/supplies
F	Ambulatory medical center (facility usage for surgical services)
G	Immunosuppressive drugs
H	Hospice services
I	Purchase of DME (installment basis)
J	Diabetic shoes
K	Hearing items and services
L	ESRD supplies (renal supplier in the home)
M	Monthly capitation payment for dialysis
N	Kidney donor
P	Lump sum purchase of dme, prosthetics, orthotics
Q	Vision items or services
R	Rental of DME
S	Surgical dressings or other medical supplies
T	Psychological therapy
U	Occupational therapy
V	Pneumococcal/flu vaccine Pneumococcal/flu/ hepatitis b vaccine
W	Physical therapy
Y	Second opinion on elective surgery
Z	Pharmacy

APPENDIX V
Place of Service

Code	Name	Description
00-10	Unassigned	N/A
11	Office	Location, other than a hospital, Skilled Nursing Facility (SNF), military treatment facility, community health center, State or local public health clinic, or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13-20	Unassigned	N/A
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital, which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room - Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility, which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.

APPENDIX V
Place of Service

Code	Name	Description
42	Ambulance - Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-49	Unassigned	N/A
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: • Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility. • 24 hour a day emergency cares services. • Day treatment, other partial hospitalization services, or psychosocial rehabilitation services. • Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission. • Consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility, which provides treatment for substance (alcohol and drug) abuse to live-in residents who, does not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care, which provides a total 24-hour therapeutically, planned and professionally staffed group living and learning environment.
57-59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.

APPENDIX V
Place of Service

Code	Name	Description
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66-70	Unassigned	N/A
71	State or Local Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility, which is located in a rural medically, underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-97	Unassigned	N/A
98	Pharmacy	A Drugstore didn't include desktop medicine.
99	Other Unlisted Facility	Other service facilities not specified above.

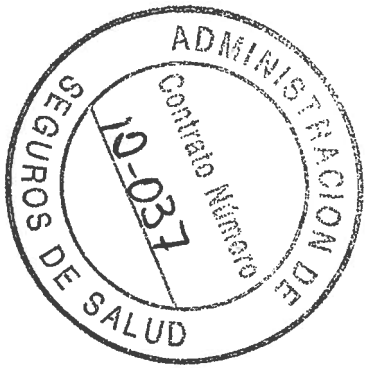
5. Carrier to ASES Data Submissions – Version 1.7B

Carrier to ASES Data Submissions

New File Layouts

Version 1.7C

March 07, 2011



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Version Changes

Version 1.7C

CLAIMS Input File Layout -

New codes for Plan Type and Plan Version and Region to include Government Employee claims.
Substitution of content on field MPI with Contract Number for Government Employee Only.
New field #19 Network Provider.
Changed the size for all 6 diagnosis codes from 6 to 8.

NOTE THAT THE LENGTH OF THE CLAIMS INPUT FILE LAYOUT HAS CHANGED – LENGTH IS NOW 267.

SERVICES Input File Layout -

New field #34 Coverage Code.

PROVIDER Input File Layout -

New field #22 Network Provider.

CAPITATION Input File Layout -

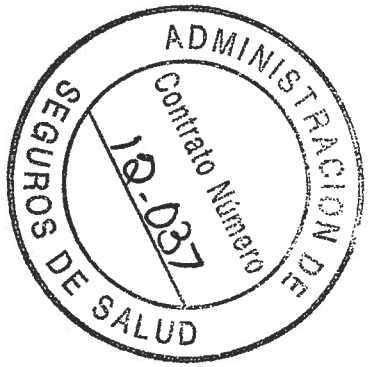
Capitation Type updated to include type "F" for fixed payment capitations.

ATTACHMENTS –

Attachment II – Carrier Codes: Updated.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
Carrier to ASES Data Submissions
File Layouts

Version 1.7B



SERVICES Input File Layout -

Validation Rules clarified.

ERROR CODES Table -

Error codes C413.2 and C418.5 added.

ATTACHMENTS –

Attachment I --	Value added to table Notes added to end of table.
Attachment II –	Carrier Codes: Updated.

Numerous updates have been made throughout the layouts to adjust, complete, or expand descriptions and validation rules. Field numbers and the text are highlighted to indicate these changes in BLUE

Version 1.7A

NOTES

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
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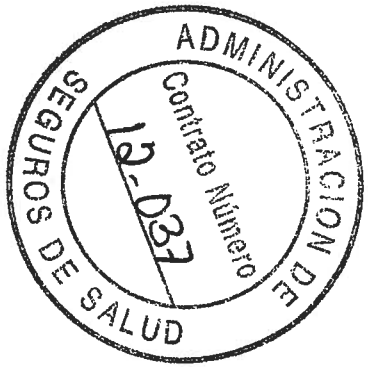
Changes and Additions in Data File Layouts

Initial wording has been updated.
UPDATED: Validation Process
UPDATED: General notes on data files updated.

File Naming Convention

INSERTED: Code for region SPECIAL
INSERTED: Notes on naming conventions when files are ZIPped.



CLAIMS Input File Layout -

MODIFIED: field 9 description updated to include code for region SPECIAL.

CAPITATION Input File Layout -

MODIFIED: field 8 description updated to include code for region SPECIAL.

ATTACHMENTS –

Attachment I –	Value added to table Notes added to end of table.
Attachment II –	Carrier Codes: Updated.

Numerous updates have been made throughout the layouts to adjust, complete, or expand descriptions and validation rules. Field numbers and the text are highlighted to indicate these changes in BLUE

Version 1.7

NOTES

Changes and Additions and Data File Layouts

UPDATED: Validation Process
INSERTED: Provider File Changes

PROVIDER Input File Layout -

MODIFIED: field 22 has been redefined as filler, replacing pcp_prov.
MODIFIED: field 23 has been redefined as filler, replacing pcp_ipa.

Version 1.6

NOTES

Changes and Additions and Data File Layouts

INSERTED: Validation Process
INSERTED: Primary Carrier ID
INSERTED: IPA codes and Provider codes
INSERTED: Attending Provider

GENERAL Notes on data layouts requirements

INSERTED: MIP Numbers in fields.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
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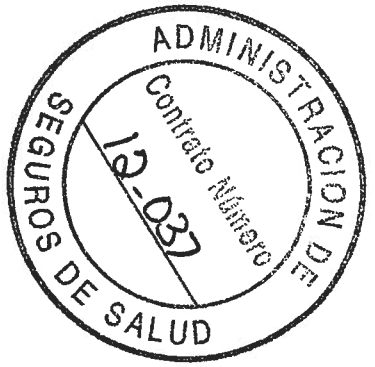

SERVICES Input File Layout -

MODIFIED: field 19 has been redefined as filler, replacing tos_code.
MODIFIED: field 34 has been redefined as filler, replacing rx_form.
MODIFIED: Risk Type is allowed to be "UNK" for Unknown on PBM submitted files.
MODIFIED: Stop Loss Flag should be set to "N" on PBM submitted files.

CLAIMS Input File Layout -

MODIFIED: field 19 has been redefined as filler, replacing age.
INSERTED: Primary Carrier ID has been added as a required field

NOTE THAT THE LENGTH OF THE CLAIMS INPUT FILE LAYOUT HAS CHANGED – LENGTH IS NOW 253.

CAPITATION Input File Layout -

INSERTED: MPI Number has been added and as a required field.

NOTE THAT THE LENGTH OF THE CAPITATION INPUT FILE LAYOUT HAS CHANGED – LENGTH IS NOW 128.

Version 1.5

NOTES

Changes and Additions and Data File Layouts

INSERTED: Pharmacy Provider IDs
INSERTED: Provider telephone numbers

INSERTED: Capitation amount
INSERTED: Capitation adjustments
INSERTED: Claims / Services File Handling
INSERTED: Other File Handlin

GENERAL Notes on data layouts requirements

INSERTED: Justification and Filling of Fields
INSERTED: References to CMS 1500 and UB-92

File Naming Convention –

Added notes on the naming of the ERROR Return Files.

SERVICES Input File Layout -

MODIFIED: Prescription Days has been redefined to be 999 (3 digits in length)
INSERTED: Total Quantity Dispensed has been added and should be filled for Pharmacy claims

NOTE THAT THE LENGTH OF THE SERVICE INPUT FILE LAYOUT HAS CHANGED – LENGTH IS NOW 279.

ERROR RETURN File Layout –

MODIFIED: Error Code field expanded to 600 bytes to allow for maximum possible error codes.

ATTACHMENTS –

Attachment II – Carrier Codes: Updated and corrected

Attachment VII – Claims / Services Basic Flow Overview: Added

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Version 1.4

NOTES – File Naming Convention -

INSERTED:

ERROR RETURN File Layout -

INSERTED:

ERROR CODES Table -

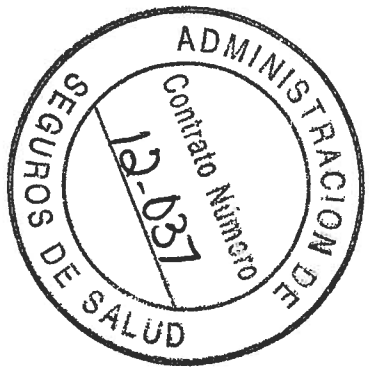
INSERTED:

WARNING CODES Table –

INSERTED:

ATTACHMENTS –

Attachment II – Carrier Codes: Updated



Version 1.3

NOTES - Changes and additions in data file layouts -

ADDED: Explanation of Provider ID and the functioning of the ID on the Provider table.

NOTES - General Notes on data layout requirements -

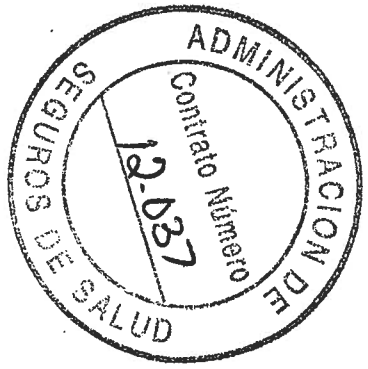
MODIFIED: Amount fields

SERVICES Input File Layout -

INSERTED: Encounter Type (moved from Claims Input File Layout)
REMOVED: Primary Center (moved to Claims Input File Layout)
REMOVED: Service Center

CLAIMS Input File Layout -

REMOVED: Encounter Type (moved to Services Input File Layout)
INSERTED: Primary Center (moved from Services Input File Layout)
REMOVED: Service Provider Specialty



PROVIDERS Input File Layout -

INSERTED: Prov Telephone

IPA Input File Layout -

MODIFIED: IPA Code
REMOVED: Service Provider Specialty

PUERTO RICO HEALTH INSURANCE ADMINISTRATION
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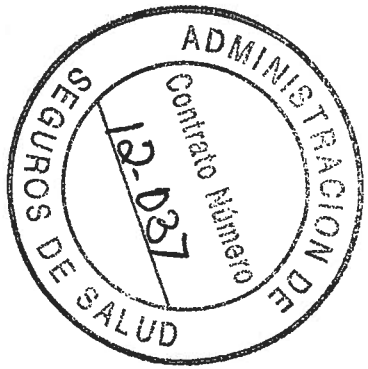
CAPITATION Input File Layout -

INSERTED: Family ID
MODIFIED: Capitation Amount

ATTACHMENTS -

INSERTED: Attachment I – Municipality Codes
INSERTED: Attachment II – Carrier Codes
INSERTED: Attachment III – Specialty Codes
INSERTED: Attachment IV – Place of Service Codes
INSERTED: Attachment V – Type of Service Codes
INSERTED: Attachment VI – Provider Type Codes



NOTES

Changes and Additions in Data File Layouts

ASES new file layouts for submission by Carriers for data generated from October 1, 2006 forward.

The following data layouts will be discontinued after the Data Layouts have been established in production and their use is stabilized:

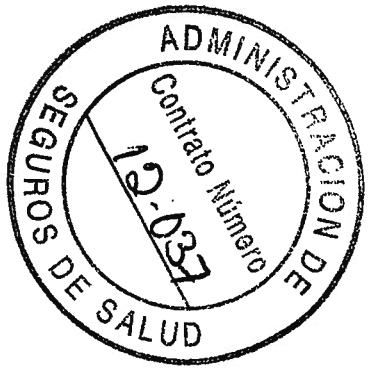
Claims and Encounter Input File Layout

The following data layouts will be used with the submission of data from October 2006:

Services Input File Layout
Claims Input File Layout

New data layouts will be required from October 2006 as follows:

Provider Input File Layout
IPA Input File Layout
Capitation Input File Layout



Administrative Expenses - Table M from current monthly report will be use as a basis for gathering administrative expense data. Some expansion to include FTE data will be developed.

The Provider and IPA files will be used to build and maintain reference files within ASES's systems for Providers, PCPs and IPA/HCOs. At implementation carriers will be required to supply full files and every month thereafter to submit files of additions and changes to maintain these in an up-to-date status.

Provider ID - ASES will not try to specify the format or construction of Provider IDs and will accept on incoming data the codes used by the delivering entity. Internally within the ASES database system, a single ID will be generated for each provider. The ASES system will be developed to match the carrier's provider data to ASES's stored provider data and therefore map IDs between the systems. It is expected therefore that an actual provider who has multiple IDs across several of the carriers will still resolve to a single Provider ID in ASES. The key to this will be the matching of records supplied to maintain the Provider file, which has been put into practice by Milliman in similar MedInsight projects in which multiple source entities are involved.

To implement this strategy, ASES requires that carriers provide accurate and timely provider files on a monthly basis. The Provider file maintained in ASES from this data will be used to validate the Provider ID fields on the other data files being submitted, especially for Claims & Encounters and for Capitation.

PHARMACY PROVIDER IDs –

After considering situations presented by various carriers with regard to the coding of the Provider ID field on claims and in the Provider Input File for pharmacy claims we have decided to make the following change to the layout definitions and instructions.

For pharmacy claims only

If the carrier includes all PBM providers (pharmacies) in its own provider file and these are part of the Provider Input File delivered to ASES then the carrier has no problem and should continue to handle the data in this way. This assumes that in coding pharmacy providers into the Provider Input File for ASES the carrier is capable of filling all the required fields and the records will pass validation and be accepted. When claims are validated the Billing Provider on the claim record will be validated against the Provider file and will be matched even if the provider is unique for the carrier.

For carriers who do not include PBM providers in their own Provider File - the claims must be coded with the Provider ID supplied by the PBM. This ID in turn must be a valid NABP/NCPDP number identifying the pharmacy uniquely regardless of which PBM sourced the data. The carrier will not include these pharmacy providers in their Provider Input File to ASES avoiding the problems created by their not having all the details required for the providers contracted by the PBM and not the carrier. On Claims the carrier

will use this same Provider ID from the PBM for the Billing Provider which will be matched during the validation against pharmacy providers loaded from PBM Provider Input File submissions to ASES. The carrier's records will still be found to fail validation if this provider number cannot be validated.

PROVIDER telephone numbers –

Prov Telephone remains a required field on the Provider Input Layout. In the event, and as an exception, if the carrier does not have the actual provider's telephone number they should insert their own (Carrier's) telephone number. This also applies to the IPA Work Phone field in the same way.

Note that all telephone number fields must be filled using only numbers. No spaces or ()- characters should be included. For example, the telephone number (939) 123-4567 will be coded in the data field as 9391234567

CAPITATION AMOUNT –

The amount to be reported on capitation records must be a net amount that represents any costs associated with providing services which are not reported in claims and encounters. This may come from formal contracts with providers such as HCO/PCPs, or any other financial arrangement or allocation of costs.

The number should represent a calculation which includes the earned capitation for the period less claims paid amounts, if any, chargeable against the provider risk. Other types of deductions which may be taken out of the provider's payment such as repayment of advances, retentions for reserves should not be included in the calculation.

CAPITATION ADJUSTMENTS –

There may be circumstances in which capitation payments which have already been reported, need in a later month to be adjusted or even reversed. To accomplish this, the Capitation records will behave differently than Claims and Services. The carrier will send a new record for the provider / member / experience date with an amount to be added or subtracted from the previously reported

amount. If a capitation of $10.00 is to be reversed then the new record should contain the same information as the original but with a new Capitation Date and a Capitation Amount of -$10.00. Inside MedInsight the capitation for that Provider / Member for that particular date will be the aggregate of all the records and this example will result in $0.00.

Note that, as Capitation net amounts for any particular record may be negative, a reversal in such a case would be a positive amount.

CLAIMS / SERVICES File Handling –

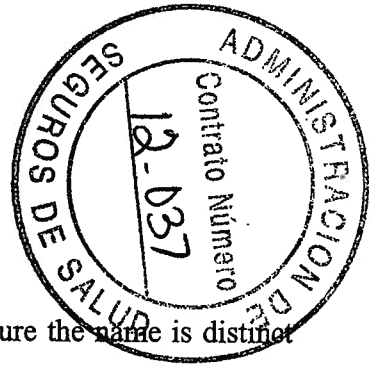
Claims and Services files will be handled as related data sets in that a Claim must be associated with one or more Services. While each type of file will have its own validation process, the relationship between claims records and services records will also be part of the validation process.

For new record sets, a Claim record, which validates successfully for all its data elements, will be rejected if there is not at least one valid Service record with a corresponding Carrier and Claim-ID. Similarly, a Service record, which validates on all its data elements, will be rejected if there is not a valid claim record with a corresponding Carrier and Claim-ID.

"I" transactions may represent new claims in which case the relationship between Claim and Service records must be within the Claims Input File and Services Input File in the same submission. When "I" records represent an update to records submitted in prior periods then a Claim record or a Service record may be submitted by itself provided it corresponds respectively to valid Service or Claim records matching on Carrier and Claims-ID already loaded in the database.

Claims and Services file will pass through a validation process as shown in Attachment VII. Pre-validation will check the basic structure of the file and its records and may result in a file being rejected without proceeding to full record validation. Such rejections may be caused for example, by – file names which fail to follow the naming convention, a file containing wrong length records or other basic tests.

A file which is processed through full validation may also be rejected if it fails to meet the error threshold level. All files which are rejected will be notified to the carrier with an explanation of why the file is rejected. No records from such a file will be retained in the system and the carrier will be required to re-submit the rejected file in its entirety before the next months files become due. Such



re-submitted files must be carefully named using the sequence number part of the naming convention to ensure the name is distinct from the rejected file and is named in the correct order.

If a file is accepted after validation, any records with errors will be returned in an Error Return file. Only the individual records which are rejected must be corrected and re-submitted and not the entire file. Such re-submitted records are to be included with the following month's file.

OTHER File Handling –

For files other than Claims and Services, the handling in terms of file rejection and record rejection will be similar to that described above for the Claims and Services. IPA, Provider and Capitation files will be validated individually without relationship to other files.

VALIDATION PROCESS –

The processing of files will take place on an individual file basis with first a Pre-Validation step in which files may be rejected if they fail structurally, cannot be read or are misnamed. A file rejection report will indicate the cause of the rejection and the file must be corrected and re-submitted immediately.

On files which pass Pre-Validation there will be a two step validation process. First, validation will take place on individual files to determine the compliance of each field with the validation rules. Records marked in error will then be removed and files will be passed to a staging area at which point cross-file validation will take place.

In the staging area, files will be checked for fields which depend on other files or previously loaded data. Such validations include the requirement for claims records to have at least one matching, valid service record and for service records that have a valid matching claim. Also, fields on service records which are particular to the type of claim will be validated after matching to a claim record and the type of claim can be determined from Bill Type (e.g. Pharmacy field on service records will be validated after matching to a claim record with a Bill Type of "P"). Any records marked in error at this stage will also be removed.

Files will be tested for error threshold compliance. Those files which fail to achieve an error rate below the threshold will be rejected. In such cases, the rejected records will not be placed on the Held Records table and the rejected file will need to be re-submitted after

correction in its entirety, but an Error Return file will be created and retuned to the carrier with the details of the records which were marked in error.

Error records from accepted files will be placed on the Held Records table and the corresponding Error Return file will be given back to the carrier. These rejected records need to be corrected and included in the following month's submission.

Carriers need to distinguish error return files as being for file rejects or record records and process them accordingly. The Claims/Services Basic Flow diagram in Attachment VII has been updated to reflect this process.

A Claims Processing Summary File will be generated which will contain a record for each file in a processing period (including expected files which were not received). The layout of this file is contained in the section of tables defining each of the file layouts. This file is an electronic "report" on the validation process and will be placed with the error-return files on the FTP server for the carriers to download.

Primary Carrier ID –

A field for the Primary Carrier ID has been added to the Claims Input Layout to recognize the MCO or TPA which enrolls the member and assigns IPA and PCP Provider IDs. The Carrier ID filed will carry the ID of the carrier generating the Claims Input File. These files will contain the same value when the reporting carrier is an MCO or TPA. When the reporting carrier is an MBHO or PBM the Carrier ID will contain the code of the MBHO or PBM and the Primary Carrier ID will contain the code of the MCO or TPA of the member.

IPA codes and Provider codes –

The Primary Carrier ID field has been added to be able to distinguish the validation of IPA and Provider codes by carrier. The Primary Carrier ID will carry the code of the MCO or TPA which contracts the members IPA and PCP Provider. In Claims records the codes for IPA and PCP Provider will be those created by the MCO/TPA and delivered to the MBHOs and PBMs in eligibility/enrollment data exchanges.

Attending Provider –

The validation rules for Attending Provider have been changes to remove the requirement that the value match a valid provider (i.e. a provider code reported by the carrier in its Provider file. The field is still required.

Municipality Service –

Recognizing that claims may be processed for services outside of Puerto Rico, code 0666 has been added to the list of Municipality Codes. This value is valid only for use in the field Municipality Service on the Claims Input File. This value should be used only when services are paid for outside of Puerto Rico.

PROVIDER FILE CHANGES –

The PCP Flag and IPA Code fields have been removed from the Provider Input File Layout. It has become obvious through the experience gained in testing so far, that the value of these fields on the provider file is overwhelming outweighed by the complexities produced. PCP and IPA codes will still be required on claims and these will be validated to ensure that they are valid Provider codes and IPA codes but no attempt will be made in validation to cross check that the PCP Provider on claims has been flagged as a PCP on the Provider table or that there is a correlation between PCP and IPA in the provider table. With this change there should be no need for carriers to report providers on multiple records.

These fields have been eliminated from the Provider file and the validations rules in other files have been adjusted accordingly. These changes do not affect the record length of the Provider Input Layout.

General Notes on data layout requirements

Date Fields - All date fields in the following data layout are defined to the same size and format as YYYYMMDD. An 8 byte field where YYYY = 4 digit year, MM = 2 digit month and DD = 2 digit day. 1 digit month and day values must always have the leading zero (0). Date fields must contain a valid date with months between 01 and 12 and days between 01 and maximum day in month. July 1, 2006 will be coded as 20060701.

Amount Fields – All amount fields representing money must be numeric and are defined as 9 bytes in the format 9(7)v99 where v represents and implied decimal point. This allows a maximum of 7 digits for dollars plus the last two digits for cents. These numbers are always right justified and zero filled to the left. As examples:

$1.23 will be coded as	000000123
$100.00 will be coded as	000010000

All amount fields are positive and follow the above definition unless clearly specified otherwise.
End of Record Filler – All file layouts have been designed to end with a filler field of 1 byte which must always be coded as an "*" character. This is done to avoid issues between different systems when generating and transferring ASCII files in which ending field may be empty. The fixed End of Record Filler guarantees that all records in a file can be constructed to the fixed length format as defined in the layouts.

Justification and filling of Fields – The layouts have all been specified to provide fixed length fields and fixed length records. While other methods can be used, it is felt that this provides the best common ground for working with multiple entities each of which uses varying systems. To be sure everyone understands the same about the comments on justification and filling the following examples are given to help keep this concept clear.

All numeric fields must be filled completely with numeric digits. If there are exceptions these are clearly spelled out in the documentation of the layouts. Typically numeric field are right justified and to keep them numeric must be zero filled. In a field specified as numeric such a 9(7)v99 where v represents an implied decimal the following examples illustrate how data will look in the field –

Value	Field
12.50	000001250
101	000010100
1,234.56	000123456
1,000,000	100000000

All alphanumeric fields must be filled completely. If the value of data in the field is less than the width of the field then care must be taken to ensure that the field is filled with blanks. Allowing "NULLS" or other special characters through may cause unexpected results and make reading, loading and validation of the data difficult. Typically alphanumeric field are left justified and filled to the right with blanks to complete the field. In a field specified as alphanumeric such a X(20) the following examples illustrate how data will look in the field where the [ ] characters represent the start and end of the field –

Value	Field
P.R.	[P.R.]
José Rivera	[José Rivera]
blanks	[ ]
(Metro-North Region)	[(Metro-North Region)]

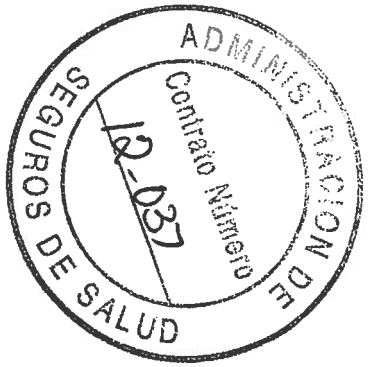
References to CMS 1500 and UB-92 – All references to CMS 1500 or UB-92 in this document are for convenience and correspond equally to equivalent electronic formats and will apply equally to the next version of CMS 1500 or the UB-04 when implemented.

MPI Number fields – In all files in which MIP Number is required, carriers should code all 9s if the MPI is unknown. This should not be true for any current beneficiary. This exception will continue until such time as ASES determines that the issue of MPI being unavailable has disappeared from historical data. For Government Employee MPI should be filled with Contract Number.

File Naming Convention

All files to be delivered to ASES by the carriers must follow the naming conventions below. Files which do not fit the naming convention will be ignored and the carrier deemed to have failed in delivery of such a file.

File names must adhere strictly to this naming convention as the structure includes information for identification of the carrier, region, dates and file type. If not named correctly the file cannot be processed properly.



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The general format of file names will be –

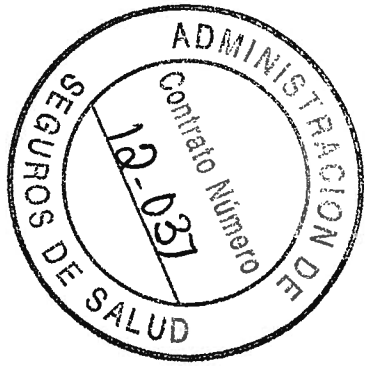
Dccrymms.fff

Where:

Character 1			Always "**D**"
Characters 2-3		**cc**	= Carrier Code (See attachment II)
Character 4		**r**	= Region as defined by ASES
	A =		Arecibo / North Region
	B =		Bayamón / Metro-North Region
	E =		Este / East Region
	F =		Fajardo / North-East Region
	G =		Guayama / South-East Region
	J =		Sanjuan / San Juan Region
	L =		Aguadilla / North-West Region (used for historical purposes only)
	M =		Montaña / Central Region (used for historical purposes only)
	S =		Suroeste / South-West Region
	Z =		Mayaguez / West Region
	P =		SPECIAL / SPECIAL pseudo region
	Y =		Government Employee
Character 5		**y**	= Last digit of year
Characters 6-7		**mm**	= Month
Character 8		**s**	= sequence number of file submission.

All submission start with s = 0 and continue in numeric if files are re-submitted to 9
If files must be re-submitted beyond 9, then alphabetic characters will be used a, b, c …

Character 9		Always "."
Characters 1-12		Extension code identifying type of file
	SRV for	SERVICES
	CLM for	CLAIMS
	PRV for	PROVIDERS
	IPA for	IPA
	CAP for	CAPITATIONS



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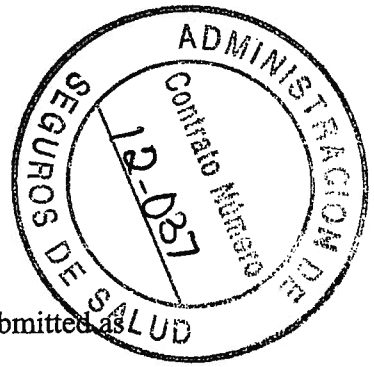
Files are always dated for the month being reported. For example, when sending claims paid in September 2009 the **ymm** part of the file name will be **909** while the file will be sent to ASES in October.

When a file which is common for multiple regions is sent, the region code may be set as "X". This can only apply to files such as Provider and IPA. Claims, Services and Capitation must be sent for their individual regions.

Examples of completing this naming convention are –

For imaginary carrier 96 in the Metro-North region files for services and payments in April 2008 will be named as follows –

Services	D96B8040.SRV
Claims	D96B8040.CLM
Providers	D96B8040.PRV
IPA	D96B8040.IPA
Capitation	D96B8040.CAP



When the Capitation file is rejected, the corrected file will be re-submitted as
D96B8041.CAP

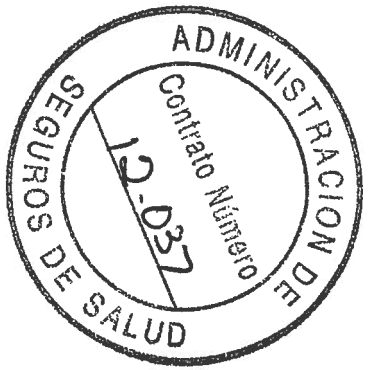
If providers for carrier 96 are common with other contracted regions the file may have been submitted as
D96X8040.PRV

ERROR Return Files will be named by replacing the first character of the input file (the "D") with an "E". For example, when a capitation file is delivered with the name D96G7111.CAP the ERROR Return file which contains all the errors for this capitation file will be named E96G7111.CAP.

ZIP Files will be accepted when named to the following standard. Use the file name as defined above, convert the "." Between the body of the file name and the file extension to "_" and add the extension ".ZIP". For Instance, using examples above -

Services file	D96B8040.SRV would become zipped as	D96B8040_SRV.ZIP
Claims file	D96B8040.CLM would become zipped as	D96B8040_CLM.ZIP
Providers	D96B8040.PRV would become zipped as	D96B8040_PRV.ZIP
IPA	D96B8040.IPA would become zipped as	D96B8040_IPA.ZIP
Capitation	D96B8040.CAP would become zipped as	D96B8040_CAP.ZIP

Return files to carriers will be zipped in a similar fashion when their size justifies it.



PUERTO RICO HEALTH INSURANCE ADMINISTRATION

SERVICES INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	trans_code	varchar(1)	**Transaction Code**	Identify the action to be taken with the record. I for Insert or E for Delete.	**X**	Required Must equal "I" or "E"
2	pmt_stat	varchar(1)	**Payment Status**	Indicates payment action on the service represented by this record. P for Paid or D for Denied	**X**	Required Must equal "P" or "D"
3	carrier_id	varchar(2)	**Carrier ID**	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II.	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
4	claim_id	varchar(20)	**Claim ID**	Unique identification number within Carrier. May be Carrier's Internal Claim Identification number. This number is used to avoid duplicated Claims, but allows multiple service lines within the same claim.	**X(20)**	Required Left justified, blank filled to 20 characters if value is less than 20 characters. Claim ID on Service must match with a Claim ID on a Claim record.
5	Sv_line	smallint()	**Service Line Number**	Number identifying individual service within a given claim.	**99**	Required Must be a 2 digit un-duplicated ID of the Service Line within the Claim ID. (line numbers less than 10 must be zero filled right justified) Duplicates within Claim ID on the same submission will be considered errors (the combination of the claim_id plus the service_line_no must be unique within the carrier). If Transaction Code is "E" then the key (Carrier ID, Claim ID, Service Line Number) must exist.
6	enc_type	varchar(20)	**Encounter Type**	Indicates whether service is reimbursed to the Billing Provider or is covered under a capitation arrangement. Valid values are – "FFS" for fee for service "CAP" for capitated. If value is "CAP", service will have zero Paid Amount.	**X(20)**	Required for Transaction Code "I" Must be a valid value Must be left justified and blank filled Not required for Transaction Code "E"
7	from_date	datetime()	**Service From Date**	Begin date of the treatment.	**YYYYMMDD**	Required for Transaction Code "I" Must be a valid date. Not required for Transaction Code "E"

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SERVICES INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
8	to_date	datetime()	**Service To Date**	End date of the treatment.	**YYYYMMDD**	Required for Transaction Code "I" Must be a valid date Must be on or after Service From Date Not required for Transaction Code "E"
9	paid_date	datetime()	**Payment Date**	For an Encounter, this will be the date the transaction is processed by the carrier. For non-encounters, this will be the date of payment for paid claims or the process date for denied claims.	**YYYYMMDD**	Required for Transaction Code "I" Must be a valid date Must be on or after Service To Date Not required for Transaction Code "E"
10	Filler_10	n/a	**Filler**		**X**	
11	proc_code	varchar(15)	**Procedure Code**	For non-Pharmacy Standard procedure code conforming to HCPCS/CPT or HCSPC/CDT as appropriate	**X(15)**	Allowed for Transaction Code "I" For claims from CMS1500 / UB92, when present must be a HCPCS/CPT code. For Dental claims must be a valid dental HCPCS/CDT code For Pharmacy claims this must be all blanks Not required for Transaction Code "E"
12	cpt_mod	varchar(2)	**Procedure Modifier Code**	Modifier code valid for the Procedure Code	**XX**	Allowed for Transaction Code "I" Can only be present when Procedure Code is present and allows a modifier code. Must be valid as a modifier for the Procedure code Not required for Transaction Code "E"
13	rev_code	varchar(5)	**Revenue Code**	For UB92 Claims NUBC Revenue Code	**X(5)**	Allowed for Transaction Code "I" For UB92 claims. When present it must be a valid Revenue code. Must be left justified, blank filled to the right Not required for Transaction Code "E"
14	rx_ndc	varchar(11)	**National Drug Code**	For Pharmacy only. National Drug Code value for prescribed drug in 5 4 2 format	**X(11)**	Allowed for Transaction Code "I" Required on Pharmacy claims Must be a valid NDC code in 5 4 2 format filling all 11 bytes For non-Pharmacy claims must be blank Not required for Transaction Code "E"

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SERVICES INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
15	tooth_code	varchar(3)	**Tooth Code**	For Dental only ADA standard tooth number as required by CDT code when procedure directly affects a tooth.	**XXX**	Allowed for Transaction Code "I" Must be present on Dental claims when Procedure code requires Tooth Code Must be a valid Tooth Code when present Must be left justified and blank filled to complete the field For non-Dental claims must be blank Not required for Transaction Code "E"
16	surface_code	varchar(7)	**Surface Code**	For Dental only ADA standard surface code as required by CDT code when procedure directly affects one or more surfaces.	**X(7)**	Allowed for Transaction Code "I" Must be present on Dental claims when procedure code requires Surface Code Must be a valid Surface Code Must be left justified and blank filled to complete the field For non-Dental claims must be blank Not required for Transaction Code "E"
17	cob_code	varchar(1)	**COB Code**	Identify if the beneficiary has other Health Insurance for this service. "Y if member has other health insurance, "N" otherwise	**X**	Required for Transaction Code "I" Must be "Y" or "N" Not required for Transaction Code "E"
18	pos_code	varchar(2)	**Place of Service**	Place of Service Code identifying the place in which the service is delivered. See POS Code List in Attachment IV	**XX**	Required for Transaction Code "I" Must be a valid Place of service Code Not required for Transaction Code "E"
19	amt_billed	money()	**Billed Amount**	For non-Pharmacy Cost of service as billed by the provider.	**9(7)v99**	Allowed for Transaction Code "I" Required for non-Pharmacy claims. Must be a number on all records Cannot be left blank Not required for Transaction Code "E"
20	amt_allowed	money()	**Allowed Amount**	For non-Pharmacy Amount allowed for the service by the carrier	**9(7)v99**	Allowed for Transaction Code "I" Required for non-Pharmacy claims. Must be a number on all records Cannot be left blank For pmt_stat "P" (Payment Status = "paid") this must be greater than zero. Not required for Transaction Code "E"
21	Deduct	money()	**Deductible**	Amount paid by member before payments by the carrier begin for this service	**9(7)v99**	Required for Transaction Code "I" Must be a number on all records Cannot be left blank Not required for Transaction Code "E"

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	Field	Internal Type, Size	Name	Description	Deliverable Data Format	Validation Rules
22	Copay	money()	**Co-Pay**	Amount paid by member as dollar co-payment for this service	**9(7)v99**	Required for Transaction Code "I" Must be a number on all records Cannot be left blank Not required for Transaction Code "E"
23	Cob	money()	**COB Amount**	Amount paid by other Health Insurance attributable to this service.	**9(7)v99**	Required for Transaction Code "I" Must be a number on all records Cannot be left blank Not required for Transaction Code "E"
24	Coins	money()	**Coinsurance Amount**	Amount paid by member as percentage of cost for this service	**9(7)v99**	Required for Transaction Code "I" Must be a number on all records Cannot be left blank Not required for Transaction Code "E"
25	amt_paid	money()	**Paid Amount**	Amount paid by carrier for this service	**9(7)v99**	Required for Transaction Code "I" Must be zero for encounters Must be zero for Services with Payment Status of "D" For Services with pmt_stat = "P" (Payment Status = Paid) one of the following calculations must be valid within a record – <u>For non-Pharmacy:</u> amt_paid = amt_allowed - deduct - copay - cob - coins <u>For Pharmacy:</u> amt_paid = rx_ingr_cost - deduct - copay - cob - coins + rx_disp_fee **For Plan Type "02" or "03" only** - amt_paid may be zero if the appropriate calculation above results in 0.00. For Plan Type "01" the amt_paid must be greater than zero. Not required for Transaction Code "E"

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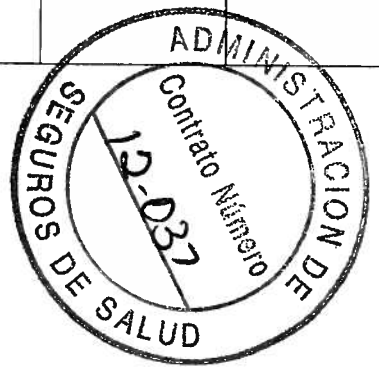
	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
26	rx_disc	money()	**Drug Discount**	For Pharmacy only Amount Discounted at the Pharmacy This is the discount given from AWP to get the Ingredient Cost When drug is paid from a MAC list the discount amount will be Zero (0) This field does not form part of the calculation to get Amount Paid but can be used with Ingredient Cost to work back to AWP.	**9(7)v99**	Allowed for Transaction Code "I" Required on Pharmacy claims On non-Pharmacy claims must be blank Not required for Transaction Code "E"
27	rx_ingr_cost	money()	**Ingredient Cost**	For Pharmacy only Cost of ingredient(s) dispensed for this Service	**9(7)v99**	Allowed for Transaction Code "I" Required on Pharmacy claims Must be greater than zero On non-Pharmacy claims must be blank Not required for Transaction Code "E"
28	rx_disp_fee	money()	**Dispensing Fee**	For Pharmacy only Dispensing fee charged by pharmacy	**9(7)v99**	Allowed for Transaction Code "I" Required on Pharmacy claims Must be a number On non-Pharmacy claims must be blank Not required for Transaction Code "E"
29	rx_days_supply	smallint()	**Prescription Days**	For Pharmacy only Number of days prescribed and dispensed	**999**	Allowed for Transaction Code "I" Required on Pharmacy claims Must be greater than zero On non-Pharmacy claims must be blank Not required for Transaction Code "E"
30	rx_drug_type	varchar(2)	**Drug Type Code**	For Pharmacy only Code identifying type of drug on pharmacy claims Valid codes are - 01=Generic 02=SSB 03=MSB	**XX**	Allowed for Transaction Code "I" Required on Pharmacy claims When present it must be one of the valid codes. On non-Pharmacy claims must be blank Not required for Transaction Code "E"



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SERVICES INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
31	rx_daw	varchar(6)	**Dispensed As Written**	For Pharmacy only Code indicating "Dispense as written" status of the prescription on pharmacy claims Valid Codes are – 0 - NO DISPENSE AS WRITTEN (Substitution Allowed) (or no product selection indicated) 1 - PHYSICIAN writes DISPENSE AS WRITTEN 2 - PATIENT REQUESTED 3 - PHARMACIST SELECTED BRAND 4 - GENERIC NOT IN STOCK 5 - BRAND DISPENSED, PRICED AS GENERIC 6 - OVERRIDE 7 - SUBSTITUTION NOT ALLOWED; BRAND MANDATED BY LAW 8 - GENERIC NOT AVAILABLE 9 - OTHER	**X(6)**	Allowed for Transaction Code "I" Required on Pharmacy claims When present it must be one of the valid codes. On non-Pharmacy claims must be blank Not required for Transaction Code "E"
32	rx_refill_cnt	varchar(6)	**Refill Count**	For Pharmacy only The number of refills specified by the physician writing the prescription on pharmacy claims	**9(6)**	Allowed for Transaction Code "I" Required on Pharmacy claims When present must be a number On non-Pharmacy claims must be blank Not required for Transaction Code "E"
33	rx_par	varchar(7)	**Participating Pharmacy Flag**	For Pharmacy only Indicates whether prescription was dispensed by a participating pharmacy on pharmacy claims Valid values – "Y" = participating pharmacy "N" = non-participating pharmacy	**X(7)**	Allowed for Transaction Code "I" Required on Pharmacy claims Left justified, blank filled Must be "Y" or "N" On non-Pharmacy claims must be blank Not required for Transaction Code "E"
34	Cov_Code	Varchar(3)	**Covarage Code**	For government employee only Indicates the coverage applied on the service.	**X(3)**	Allowed for Transaction Code "I" Required for government employee claims Left justified, blank filled On non-government employee claims must be blank Not required for Transaction Code "E"
35	filler_34	n/a	**Filler**		**X(4)**	

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	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
36	risk_type	varchar(3)	**Risk Type**	Distinguishes for this service whether risk belongs to PCP(/Group) or carrier. If cost should be charged to PCP(/Group) then value = "PCP" Otherwise value = "CAR" (Carrier). Where there is no risk sharing the value should be entered as "CAR". PBM ONLY – when a PBM is submitting this file this field should be coded as "UNK" for Unknown.	**XXX**	Required for Transaction Code "I" Must be filled Must be "PCP" or "CAR" For PBM only value can be "UNK" Not required for Transaction Code "E"
37	stop_loss_flag	Varchar(1)	**Stop Loss Flag**	When Risk Type is "PCP", set to "Y" if stop loss for PCP(/Group) has been reached for PCP on member Otherwise "N" . When Risk Type is "CAR", set to "N" PBM ONLY – set to "N"	**X**	Required for Transaction Code "I" Must be filled ""Y" or "N" Not required for Transaction Code "E"
38	applied_cost	varchar(1)	**Cost Applied To**	For Medicare Platino, defines whether service is part of the ASES coverage, the CMS (MA) coverage or both. When filled the valid values are – 1=ASES 2=CMS 3=BOTH (SPLIT)	**X**	Required for Transaction Code "I" for Plan Type "02" and "03" (Medicare Platino) Must be filled and be a valid value Not required for Transaction Code "I" for Plan Type "01" Not required for Transaction Code "E"
39	ases_split_amt	money()	**ASES Split Amount**	For Medicare Platino, indicates the part of the Paid Amount allocated to ASES coverage.	**9(7)v99**	Required for Transaction Code "I" for Plan Type "02" and "03" (Medicare Platino) Must be filled if Cost Applied To = 1 or 3 Not required for Transaction Code "I" for Plan Type "01" Not required for Transaction Code "E"
40	cms_split_amt	money()	**CMS Split Amount**	For Medicare Platino, indicates the part of the Paid Amount allocated to CMS (MA) coverage.	**9(7)v99**	Required for Transaction Code "I" for Plan Type "02" and "03" (Medicare Platino) Must be filled if Cost Applied To = 2 or 3 Not required for Transaction Code "I" for Plan Type "01" Not required for Transaction Code "E"
41	extract_date	datetime()	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Services Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record

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SERVICES INPUT FILE LAYOUT

	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
42	rx_total_disp	Float()	**Total Quantity Dispensed**	For Pharmacy only Total quantity of drug dispensed by pharmacy.	**9(7)v99**	Allowed for Transaction Code "I" Required on Pharmacy claims Must be a number, right justified, zero filled On non-Pharmacy claims must be blank Not required for Transaction Code "E"
43	Filler	n/a	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
				RECORD LENGTH	**279**	

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CLAIMS INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	trans_code	varchar(1)	**Transaction Code**	Identify the action to be taken with the record. I for Insert or E for Delete.	**X**	Required Must equal "I" or "E"
2	carrier_id	varchar(2)	**Carrier ID**	Value that identifies carrier which is reporting claims. Must be a valid code. See Carrier Code List in Attachment II	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
3	claim_id	varchar(20)	**Claim ID**	Unique Identification number within Carrier. May be Carrier's Internal Claim Identification number. This number is used to avoid duplicated Claims, but allows multiple service lines within the same claim.	**X(20)**	Required Left justified, blank filled to the right Treated as a unique key within Carrier ID. When trans_code = "E", Carrier_ID + Claim_ID must already exist.
4	plan_type	varchar(2)	**Plan Type**	ASES defined Plan Type 01 = GHIP 02 = MA-SNP 03 = MA-PD 04 = State Agency 05 = Municipality 06 = Public Corporation	**XX**	Required for Transaction Code "I" Must equal "01", "02" , "03","04","05"or "06" Value "01' must correspond to a GHIP carrier or to an MBHO, PBM, or other assigned carrier code which is not Medicare Platino. Values of "02" or "03" must correspond to Medicare Platino Carrier ID Values of "04","05"or "06"must correspond to government employees carrier ID. Not required for Transaction Code "E"
5	plan_version	varchar(3)	**Plan Version**	Plan Version to distinguish multiple plans within Plan Type. Always three numeric characters, e.g. 001 For government employee claims indicates contract type: 001 = Family 002 = Couple 003 = Individual 004 = Optional Dependent	**XXX**	Required for Transaction Code "I" Must be a 3 digit Plan Version Code Carrier ID, Plan Type and Plan Version must validate with a plan definition contracted with ASES Not required for Transaction Code "E"
6	bill_type	varchar(1)	**Bill Type**	Originating bill type – U=UB-92 / Institutional H=HCFA/CMS1500 / Individual / Professional, P=Pharmacy Claim, D=Dental Claim.	**X**	Required for Transaction Code "I" Must equal "U", "H", "P" or "D" Not required for Transaction Code "E"
7	adm_date	datetime()	**Admit Date**	For UB-92 claims this is the date of admission. For other claims this is the Service From Date of the earliest service.	**YYYYMMDD**	Required for Transaction Code "I" Must be a valid date Not required for Transaction Code "E"

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CLAIMS INPUT FILE LAYOUT

	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
8	dis_date	datetime()	**Discharge Date**	For UB-92 claims this is the date of discharge. For other claims this is the Service To date of the latest service.	**YYYYMMDD**	Required for Transaction Code "I" Must be a valid date Must be equal or later than Admit Date Not required for Transaction Code "E"
9	region_code	varchar(1)	**Region Code**	Region of member as defined by ASES Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West "P" = SPECIAL	**X**	Required for Transaction Code "I" Must be valid ASES Region code Not required for Transaction Code "E"
10	municipality_res	varchar(4)	**Municipality Residence**	Municipality of residence of member. See Municipality Codes in Attachment I.	**XXXX**	Required for Transaction Code "I" Must be a valid ASES Municipality Code All numeric, right justified, zero filled Must correspond to a municipality within Region Code Not required for Transaction Code "E"
11	municipality_code	varchar(4)	**Municipality Service**	Municipality in which services are provided based on provider address. See municipality Codes in Attachment I	**XXXX**	Required for Transaction Code "I" Must be a valid ASES Municipality Code All numeric, right justified, zero filled Not required for Transaction Code "E"
12	ssn_mainh	varchar(9)	**HOH Social Security**	Social Security number of Head of Household (HOH) of family. This is available from the Family record in ASES eligibility data sent to carriers.	**9(9)**	Required for Transaction Code "I" Must be all numeric Must be a full 9 digits Not required for Transaction Code "E"
13	ssn	varchar(9)	**Patient Social Security**	Social Security Number of member	**9(9)**	Required for Transaction Code "I" Must be all numeric Must be a full 9 digits Not required for Transaction Code "E"
14	member_suffix	varchar(2)	**ASES Member Suffix**	Identifies the beneficiary within the family group. Must be the two digit member suffix as supplied in ASES Eligibility data.	**99**	Required for Transaction Code "I" Must be ASES Assigned member suffix All numeric value 01 to 99 Not required for Transaction Code "E"
15	patient_name	varchar(30)	**Patient Name**	Member Name	**X(30)**	Required for Transaction Code "I" Must be left justified, blank filled to the right Not required for Transaction Code "E"

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CLAIMS INPUT FILE LAYOUT

	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
16	family_id	varchar(11)	**ASES Family ID**	Family ID as supplied in ASES Eligibility data.	**X(11)**	Required for Transaction Code "I" ASES / ODSI Family ID Alphanumeric full 11 characters For government employee use SSN Main Holder . Must be left justified, blank filled to the right Not required for Transaction Code "E"
17	mpi	Varchar(13)	**MPI Number**	Master Patient Index (MPI) As supplied in ASES Eligibility Data For government employee contract number	**X(13)**	Required for Transaction Code "I" Must be a valid MPI number For government employee contract number Must be left justified, blank filled to the right Not required for Transaction Code "E"
18	sex	varchar(1)	**Sex Code**	Gender of member M = Male F = Female	**X**	Required for Transaction Code "I" Must equal "M" or "F" Not required for Transaction Code "E"
19	Network_Specialist	Varchar(1)	**Network Specialist**	Indicates if the service provider is a participating specialist of the preferred network in the PMG Y = Yes N = No	**X**	Allowed for Transaction Code "I" Must be "Y" or "N" Not required for Transaction Code "E"
20	filler_19	n/a	**Filler**		**XX**	
21	birth_date	datetime()	**Birth Date**	Member Date of Birth in YYYYMMDD format	**YYYYMMDD**	Required for Transaction Code "I" Must be a valid date Cannot be in the future compared to Extract Date Cannot be greater than 150 years ago compared to Extract Date Must be equal or earlier than Admit Date Not required for Transaction Code "E"
22	primary_center	varchar(10)	**Primary Center**	Identify the Primary Care Center (IPA/HCO) of the member. Code as assigned by the carrier.	**X(10)**	Allowed for Transaction Code "I" Must be present on all claims of Plan Type 01 May be present on claims of other Plan Types When present it indicates the Primary center (IPA/HCO etc.) of the member. Must be left justified and blank filled to complete the field. Must be found on the IPA table matched by Primary Carrier ID and IPA Not required for Transaction Code "E"

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CLAIMS INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
23	date_accident	datetime()	**Accident Date**	Accident Date in YYYYMMDD format when claim corresponds to services provided as the result of an accident. From CMS 1500 field 14, required if due to an accident. From UB-92 Occurrence date fields if Occurrence code indicates and accident.	**YYYYMMDD**	Allowed for Transaction Code "I" When present, must be a valid date Must be equal or greater than Birth Date Must be equal or earlier than Admit Date Not required for Transaction Code "E"
24	rec_date	datetime()	**Received Date**	Date when claim was received in carrier in YYYYMMDD format	**YYYYMMDD**	Required for Transaction Code "I" Must be a valid date Must be equal or greater than Discharge Date Not required for Transaction Code "E"
25	entry_date	datetime()	**Entry Date**	Date when claim was entered into the carrier's system. YYYYMMDD format.	**YYYYMMDD**	Required for Transaction Code "I" Must be a valid date Must be equal or greater than Received Date Not required for Transaction Code "E"
26	icd_diag_01	varchar(8)	**Primary ICD diagnosis code**	Non-Pharmacy/Dental Principal diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	**X(8)**	Allowed for Transaction Code "I" Not required for Pharmacy and Dental claims Required field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code Not required for Transaction Code "E"
27	icd_diag_02	varchar(8)	**Second ICD diagnosis code**	Non-Pharmacy/Dental Other diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	**X(8)**	Allowed for Transaction Code "I" Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code Not required for Transaction Code "E"
28	icd_diag_03	varchar(8)	**Third ICD diagnosis code**	Non-Pharmacy/Dental Other diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	**X(8)**	Allowed for Transaction Code "I" Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code Not required for Transaction Code "E"
29	icd_diag_04	varchar(8)	**Fourth ICD diagnosis code**	Non-Pharmacy/Dental Other diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	**X(8)**	Allowed for Transaction Code "I" Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code Not required for Transaction Code "E"

CLAIMS INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
30	icd_diag_05	varchar(8)	**Fifth ICD diagnosis code**	Non-Pharmacy/Dental Other diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	**X(8)**	Allowed for Transaction Code "I" Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code Not required for Transaction Code "E"
31	icd_diag_06	varchar(8)	**Sixth ICD diagnosis code**	Non-Pharmacy/Dental Other diagnosis code. Must be a valid ICD or DSM IV diagnosis code. Diagnosis codes must be carried to their highest degree of detail. Left justified, blank filled.	**X(8)**	Allowed for Transaction Code "I" Not required for Pharmacy and Dental claims Allowed field for claims other than Pharmacy or Dental Must be a valid ICD/DSM IV code Not required for Transaction Code "E"
32	pcp_prov	varchar(10)	**PCP Provider**	Provider ID of member's PCP. Defined by Primary Carrier. MBHOs and PBMs use data supplied on eligibility/enrollment data from MCO/TPA	**X(10)**	Allowed for Transaction Code "I" Required for Plan Type "01" claims Must be found on the Provider table matched by Primary Carrier ID and Provider ID Not required for Transaction Code "E"
33	att_prov	varchar(10)	**Attending Provider**	Provider ID of the provider delivering the service. If not directly available from the claim it should be filled from the Billing Provider. On pharmacy claims this is the prescribing physician	**X(10)**	Required for Transaction Code "I" Must be filled with a value Not required for Transaction Code "E"
34	bill_prov	varchar(10)	**Billing Provider**	Provider ID of Provider billing services On pharmacy claims this is the dispensing pharmacy	**X(10)**	Required for Transaction Code "I" Must be a valid Provider ID Not required for Transaction Code "E"
35	dis_stat	varchar(2)	**Discharge Status Code**	On UB-92 claims, Patient Status Code at discharge.	**XX**	Allowed for Transaction Code "I" Required for UB-92 claims When present, it must not contain blanks Not required for Transaction Code "E"
36	extract_date	datetime()	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Claims Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
37	primary_carrier_id	varchar(2)	**Primary Carrier ID**	Value that identifies the primary carrier – MCO or TPA. Must be a valid code. See Carrier Code List in Attachment II	**XX**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES
38	icd_ver	varchar(2)	**Diagnosis Code Version**	Version of ICD code that is used on this claim. Can be either 9 or 10.	**XX**	Required for Transaction Code "I" when diagnosis code is ICD code. Must be '9' or '10'

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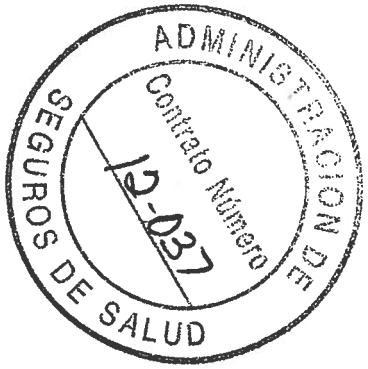
PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMS INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
39	Filler	n/a	**End of Record Filler**	Fixed filler with "*"	X	Required Must be = "*"
				RECORD LENGTH	267	



PUERTO RICO HEALTH INSURANCE ADMINISTRATION

PROVIDERS INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	prov_carrier	varchar(2)	**Prov Carrier ID**	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	prov_id	varchar(20)	**Prov ID**	Provider ID as assigned by carrier *SEE NOTES – Changes and Additions in Data File Layouts: PHARMACY PROVIDER IDs*	**X(20)**	Required Must be left justified and blank filled to the right
3	prov_lname	varchar(50)	**Prov Lname**	For an individual, Last Names (Apellidos) For an entity (other than an individual), the entity name	**X(50)**	Required Must be left justified, blank filled to the right
4	prov_fname	varchar(30)	**Prov Fname**	For an individual, First Name (Nombre)	**X(30)**	Optional Must be left justified, blank filled to the right
5	prov_mname	varchar(30)	**Prov Mname**	For an individual, Middle Name	**X(30)**	Optional Must be left justified, blank filled to the right
6	prov_addr1	varchar(45)	**Prov Addr1**	First line of provider's address	**X(45)**	Required Must be left justified, blank filled to the right
7	prov_addr2	varchar(45)	**Prov Addr2**	Second line of provider's address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
8	prov_addr3	varchar(45)	**Prov Addr3**	Third Line of provider's address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
9	prov_city	varchar(45)	**Prov City**	Provider's city	**X(45)**	Required Must be left justified, blank filled to the right
10	prov_state	varchar(45)	**Prov State**	Provider's state	**X(45)**	Required Must be left justified, blank filled to the right
11	prov_zip	varchar(9)	**Prov Zip**	Provider's Zip code Either 5 digit or plus 4 format without dashes	**X(9)**	Required Must be left justified, blank filled to the right Significant characters must be numeric and 5 or 9 digits in length
12	prov_country	varchar(45)	**Prov Country**	Provider's country	**X(45)**	Required Must be left justified, blank filled to the right
13	Prov_tel	Varchar(20)	**Prov Telephone**	Provider's telephone number. *SEE NOTES – Changes and Additions in Data File Layouts: PROVIDER telephone numbers*	**X(20)**	Required Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
14	prov_ext	varchar(20)	**Prov Ext**	Provider's telephone extension	**X(20)**	Optional Must be left justified, blank filled to the right

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PROVIDERS INPUT FILE LAYOUT

	Field	Internal Type-Size	Name	Description	Deliverable Data Format	Validation Rules
15	prov_email	varchar(40)	**Prov Email**	Provider's e-mail address	**X(40)**	Optional If supplied it must fit e-mail address format rules Must be left justified, blank filled to the right
16	prov_contact	varchar(50)	**Prov Contact**	Name of contact person if provider is not an individual	**X(50)**	Optional Must be left justified, blank filled to the right
17	prov_type	varchar(20)	**Prov Type**	Type of provider. See Provider Type Codes in Attachment VI	**X(20)**	Required Must be left justified, blank filled to the right Must be a valid Provider Type Code
18	spec1	varchar(20)	**Spec1**	Provider Specialty (first). See Specialty Code in Attachment III	**X(20)**	Required Must be left justified, blank filled to the right Must be a valid Specialty Code
19	spec2	varchar(20)	**Spec2**	Provider Specialty (second). See Specialty Code in Attachment III	**X(20)**	Optional Must be left justified, blank filled to the right Must be a valid Specialty Code
20	spec3	varchar(20)	**Spec3**	Provider Specialty (third). See Specialty Code in Attachment III	**X(20)**	Optional Must be left justified, blank filled to the right Must be a valid Specialty Code
21	spec4	varchar(20)	**Spec4**	Provider Specialty (fourth). See Specialty Code in Attachment III	**X(20)**	Optional Must be left justified, blank filled to the right Must be a valid Specialty Code
22	network_specialist	Varchar(01)	**Preferred Network Specialists**	Indicates if the service provider is a participating specialist of the preferred network in the PMG	**X**	Required Must be "Y" or "N"
23	filler_23	n/a	**Filler**		**X(20)**	
24	federal_tax_id	varchar(20)	**Federal Tax ID**	SSN for individuals, EIN for entities.	**X(20)**	Required Left justified, blank filled to the right Must be 9 digits in significant positions
25	licence_number	varchar(15)	**License Number**	State License Number	**X(15)**	Optional Should be supplied when available Must be left justified, blank filled to the right
26	upin	varchar(15)	**UPIN**	Physician's UPIN	**X(15)**	Optional Should be supplied when available Must be left justified, blank filled to the right
27	dea_number	varchar(20)	**DEA Number**	DEA number	**X(20)**	Optional Should be supplied when available Must be left justified, blank filled to the right
28	medicare_number	varchar(20)	**Medicare Number**		**X(20)**	Optional Must be left justified, blank filled to the right

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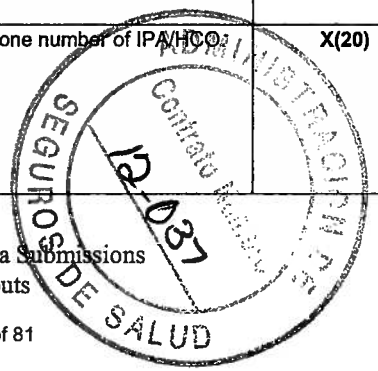
PROVIDERS INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
29	medicaid_number	varchar(20)	**Medicaid Number**		**X(20)**	Optional Must be left justified, blank filled to the right
30	extract_date	datetime()	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Provider Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
31	Filler	n/a	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
				RECORD LENGTH	**781**	

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

IPA INPUT FILE LAYOUT

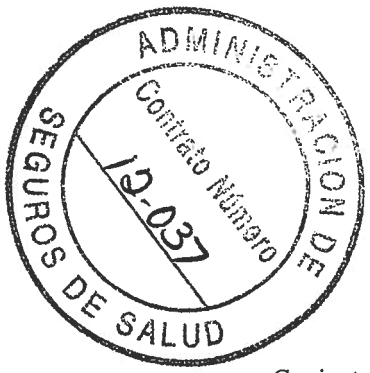
	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier_id	varchar(2)	**Carrier ID**	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II.	**99**	Required Must be two (2) digits (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	ipa	varchar(4)	**IPA Code**	Code assigned by carrier to identify IPA/HCO. Maximum of 4 characters.	**X(4)**	Required IPA/HCO code assigned by Carrier Must be left justified, blank filled to the right
3	ipa_desc	varchar(80)	**IPA Description**	Name of IPA/HCO	**X(80)**	Required Must be left justified, blank filled to the right
4	ipa_addr1	varchar(45)	**IPA Addr1**	IPA/HCO's first line of address	**X(45)**	Required Must be left justified, blank filled to the right
5	ipa_addr2	varchar(45)	**IPA Addr2**	IPA/HCO's second line of address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
6	ipa_addr3	varchar(45)	**IPA Addr3**	IPA/HCO's third line of address (if required)	**X(45)**	Optional Must be left justified, blank filled to the right
7	ipa_city	varchar(45)	**IPA City**	IPA/HCO's city	**X(45)**	Required Must be left justified, blank filled to the right
8	ipa_state	varchar(45)	**IPA State**	IPA/HCO's state	**X(45)**	Required Must be left justified, blank filled to the right
9	ipa_zip	varchar(9)	**IPA Zip**	IPA/HCO's zip code. Either 5 digit or plus 4 format without dashes	**X(9)**	Required Must be left justified, blank filled to the right Significant characters must be numeric. Must be 5 or 9 digits in length.
10	ipa_country	varchar(45)	**IPA Country**	IPA/HCO's country	**X(45)**	Required Must be left justified, blank filled to the right
11	ipa_home_phone	varchar(20)	**IPA Home Phone**	Home telephone number of contact person for IPA/HCO	**X(20)**	Optional Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567
12	ipa_work_phone	varchar(20)	**IPA Work Phone**	Principal work telephone number of IPA/HCO.	**X(20)**	Required Must be left justified, blank filled to the right Must include only numbers with no spaces or ()- characters. Must include area code Example – (787) 123-4567 will be coded as 7871234567



PUERTO RICO HEALTH INSURANCE ADMINISTRATION

IPA INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
13	ipa_ext	varchar(20)	**IPA Ext**	Telephone extension at IPA Work Phone for contact person	**X(20)**	Optional Must be left justified, blank filled to the right
14	federal_tax_id	varchar20)	**Federal Tax ID**	EIN of IPA	**X(20)**	Required Must be left justified and blank filled to the right Significant characters must be numeric and 9 digits in length
15	extract_date	datetime()	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the IPA Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
16	Filler	n/a	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
				RECORD LENGTH	**454**	



PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CAPITATION INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
1	carrier_id	varchar(2)	**Carrier ID**	Value that identifies carrier. Must be a valid code. See Carrier Code List in Attachment II.	**99**	Required Must be two (2) digit s (numeric). Must equal a valid Carrier ID as assigned by ASES.
2	cap_id	varchar(20)	**Capitation ID**	Capitation payment ID must be a unique ID within carrier.	**X(20)**	Required Must be left justified, blank filled to the right Must be a unique ID within Carrier
3	cap_type	varchar(1)	**Capitation Type**	Capitation type code defined as: "P"=PCP "S"=specialty "F"=Fixed Payment	**X**	Required Must be "P", "S" or "F"
4	cap_date	datetime	**Capitation Date**	Date capitation paid.	**YYYYMMDD**	Required Must be a valid date
5	expr_date	datetime	**Experience Date**	Experience date of capitation payment. This is the date for which the capitation payment applies.	**YYYYMMDD**	Required Must be a valid date
6	prov	varchar(20)	**Provider ID**	Carrier assigned Provider ID of the provider to which the capitation payment is made.	**X(20)**	Required Must be a valid Provider ID
7	ipa	varchar(10)	**IPA ID**	Carrier assigned ID of IPA/HCO. This must be filled when Capitation type is PCP and IPA/HCO is involved (Must always be filled for Plan Type 01 by MCOs/TPAs when capitation payment is for PCP services)	**X(10)**	Required If Capitation Type is "P" and Carrier ID corresponds to Plan Type "01" Must be a valid IPA Code for the Carrier
8	region_code	varchar(1)	**Region**	Region of member Regions are identified as: "A" = North "B" = Metro-North "E" = East "F" = North-East "G" = South-East "Z" = West "J" = San Juan "S" = South-West 'P" = SPECIAL	**X**	Required Must be valid ASES Region code
9	municipality_code	varchar(4)	**Municipality**	Municipality of residence of member. See Municipality Code in Attachment I.	**XXXX**	Required Must be ASES Municipality Code All numeric, right justified, zero filled Must correspond to a municipality within Region Code

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CAPITATION INPUT FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*	*Validation Rules*
10	member_ssn	varchar(9)	**Member SSN**	Social Security Number of member	**9(9)**	Required Must be 9 digits (numeric)
11	family_id	varchar(11)	**ASES Family ID**	Family ID as supplied in ASES Eligibility data.	**X(11)**	Required ASES / ODSI Family ID Alphanumeric full 11 characters
12	member_suffix	varchar(2)	**Member Suffix**	Identifies the beneficiary within the family group. Must be the two digit member suffix as supplied in ASES Eligibility data.	**99**	Required Must be 2 digits (numeric)
13	cap_amt	money	**Capitation Amount**	Capitation amount paid to provider **MAY BE NEGATIVE** *SEE NOTES – Changes and Additions in Data File Layouts: CAPITATION AMOUNT*	**S9(7)v99**	Required Must be a number Signed, may be negative 10 byte field Sign must appear in leftmost byte, other 9 bytes must be numeric If the value is negative the sign byte must be a "-", otherwise it must be blank.
14	extract_date	datetime()	**Extract Date**	Date on which record is originally extracted from Carrier's system to create the Capitation Input File.	**YYYYMMDD**	Required Must be a valid date Must be later or equal to any other date field on record
15	mpi	Varchar(13)	**MPI Number**	Master Patient Index (MPI) As supplied in ASES Eligibility Data	**X(13)**	Required Must be a valid MPI number
16	filler	n/a	**End of Record Filler**	Fixed filler with "*"	**X**	Required Must be = "*"
				RECORD LENGTH	**128**	

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

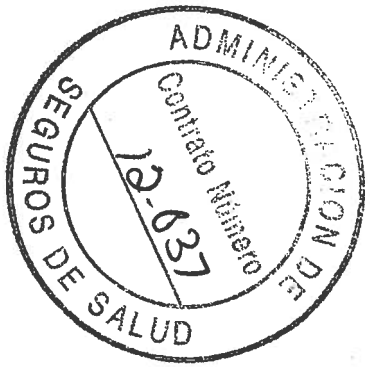
ERROR RETURN FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*
1	Input_record	*	**Input Record**	A complete copy of the record from the carrier input file	*
2	Errors	varchar(600)	**Error Codes**	Codes for all errors found on record during validation. Each error will be separated by a comma.	**X(600)**
3	Process_date	datetime	**Process Date**	Date file/record was processed by MedInsight validation	**YYYYMMDD**
4	Filler	n/a	**End of Record Filler**	Fixed filler with "*"	**X**
				RECORD LENGTH	*

- Size varies with Input Record. The specific error file will be dependent on the Input File being reported but the general structure will be as shown above.

*	For	.SRV	record length =	888
		.CLM	record length =	862
		.PRV	record length =	1,390
		.IPA	record length =	1,063
		.CAP	record length =	737

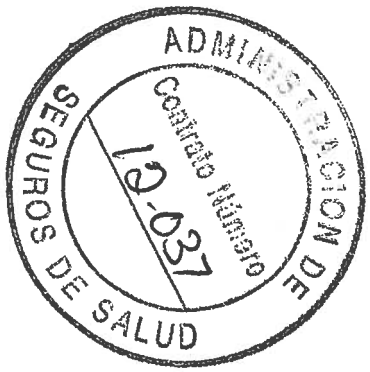
- Processing, error and warning codes for each input file type are listed in the following tables



PUERTO RICO HEALTH INSURANCE ADMINISTRATION

CLAIMS PROCESSING SUMMARY FILE LAYOUT

	Field	*Internal Type-Size*	*Name*	*Description*	*Deliverable Data Format*
1	sub_filename	varchar(12)	**Submitted File Name**	The name of the file that was submitted from the carrier.	**X(12)**
2	err_filename	varchar(12)	**Error File Name**	The name of the file with error records and error codes created by ASES. If no error file exists, then this will be blank.	**X(12)**
3	process_code	varchar(6)	**Processing Status Code**	Processing code that identifies the status of file being processed. (SEE FILE PROCESSING CODES TABLE).	**X(9)**
4	process_desc	varchar(50)	**Processing Status Description**	Description of the status of the file being processed.	**X(20)**
5	notes	varchar(50)	**Processing Notes**	Any additional notes including the number of critical and warning errors found in the file.	**X(50)**
				RECORD LENGTH	103

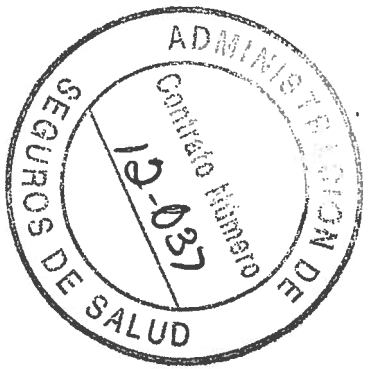


PUERTO RICO HEALTH INSURANCE ADMINISTRATION

File Processing CODES

CODE	ERROR DESCRIPTION
	GENERAL FILE PROCESSING CODES
G000	PASSED PREPROCESSING
G100	FILE IS EMPTY.
G105	UNABLE TO OPEN FILE OR FILE CORRUPTED.
G110	FILE CONTAINS ONE OR MORE WRONG LENGTH RECORDS.
G120	INVALID FILE NAME.
G125	FILE NAME PREVIOUSLY SUBMITTED.
G130	EXPECTED FILE MISSING FOR CURRENT RECORD LOAD.
G135	FILE EXCEEDED ERROR THRESHOLD
G199	FILE ACCEPTED

NOTE G000 - PASSED PREPROCESSING: such files have passed the pre-processing stage of validation but were **not** sent to full validation because of other issues. For example a .SRV file may be held because its corresponding .CLM file has a G110 error and failed pre-processing



PUERTO RICO HEALTH INSURANCE ADMINISTRATION

File Validation ERROR CODES

CODE	ERROR DESCRIPTION
	SERVICES FILE ERRORS
C400	TRANS_CODE INVALID. THIS IS A REQUIRED FIELD AND MUST BE 'I' OR 'E'.
C401	PMT_STAT INVALID. THIS IS A REQUIRED FIELD AND MUST BE 'P' OR 'D'.
C402	CARRIER_ID INVALID. THIS IS A REQUIRED FIELD AND MUST BE A VALID CARRIER ID AS ASSIGNED BY ASES.
C403	CLAIM_ID MISSING. THIS IS A REQUIRED FIELD.
C403.2	CLAIM_ID INVALID. DOES NOT MATCH WITH A CLAIM_ID ON A VALID CLAIM RECORD.
C404	SV_LINE MISSING. THIS IS A REQUIRED FIELD.
C404.2	SV_LINE DUPLICATE WITHIN THE SAME CLAIM ID. (CARRIER_ID+CLAIM_ID+SV_LINE MUST BE UNIQUE)
C404.3	SV_LINE DOES NOT EXIST. FOR A TRANS_CODE E RECORD THE CARRIER_ID+CLAIM_ID+SV_LINE MUST ALREADY EXIST.
C405	ENC_TYPE INVALID. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C406	FROM_DATE MISSING. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C407	TO_DATE MISSING. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C407.2	TO_DATE INVALID. MUST BE EQUAL OR LATER THAN FROM_DATE. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C408	PAID_DATE MISSING. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C408.2	PAID_DATE INVALID. MUST BE EQUAL OR LATER THAN TO_DATE. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C410	COB_CODE INVALID. MUST BE EITHER 'Y' OR 'N' WHEN TRANS_CODE IS I
C411	POS_CODE INVALID. MUST BE A VALID PLACE OF SERVICE CODE. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C412	AMT_BILLED INVALID. THIS IS A REQUIRED FIELD FOR NON-PHARMACY CLAIMS.
C413	AMT_ALLOWED INVALID. THIS IS A REQUIRED FIELD FOR NON-PHARMACY CLAIMS.
C413.2	AMT_ALLOWED INVALID. MUST BE GREATER THAN ZERO FOR PAID CLAIMS.
C414	DEDUCT INVALID. MUST BE A NUMBER ON ALL THE RECORDS WITH TRANS_CODE = I.
C415	COPAY INVALID. MUST BE A NUMBER ON ALL THE RECORDS WITH TRANS_CODE = I.
C416	COB INVALID. MUST BE A NUMBER ON ALL THE RECORDS WITH TRANS_CODE = I.
C417	COINS INVALID. MUST BE A NUMBER ON ALL THE RECORDS WITH TRANS_CODE = I.
C418	AMT_PAID INVALID. MUST BE ZERO FOR ENCOUNTERS
C418.2	AMT_PAID INVALID. MUST BE ZERO FOR PAYMENT STATUS 'D'.
C418.3	AMT_PAID INVALID. MUST BE EQUAL TO AMT_ALLOWED - DEDUCT - COPAY - COB - COINS (NON-PHARMACY CLAIMS)

File Validation ERROR CODES

C418.4	AMT_PAID INVALID. MUST BE EQUAL TO RX_INGR_COST - DEDUCT - COPAY - COB - COINS + RX_DISP_FEE (PHARMACY CLAIMS).
C418.5	AMT_PAID INVALID. MUST BE GREATER THAN ZERO FOR PLAN_TYPE = "01" CLAIMS.
C419	RX_DISC INVALID. THIS IS A REQUIRED FIELD FOR PHARMACY CLAIMS.
C420	RX_INGR_COST INVALID. THIS IS A REQUIRED FIELD FOR PHARMACY CLAIMS.
C421	RX_DISP_FEE INVALID. THIS FIELD IS REQUIRED FOR PHARMACY CLAIMS.
C422	RX_DAYS_SUPPLY INVALID. THIS IS A REQUIRED FIELD FOR PHARMACY CLAIMS.
C423	RX_DRUG_TYPE INVALID. THIS IS A REQUIRED FIELD FOR PHARMACY CLAIMS.
C424	RX_DAW INVALID. MUST BE ONE OF THE VALID CODES. THIS IS A REQUIRED FIELD FOR PHARMACY CLAIMS.
C425	RX_REFILL_CNT INVALID. THIS IS A REQUIRED FIELD FOR PHARMACY CLAIMS.
C426	RX_PAR INVALID. IT MUST BE EITHER 'Y' OR 'N' ON PHARMACY CLAIMS.
C428	RISK_TYPE INVALID. IT MUST BE EITHER 'PCP' OR 'CAR' (OR 'UNK" FOR PHARAMCY). THIS IS A REQUIRE FIELD FOR TRANS_CODE I.
C429	STOP_LOSS_FLAG INVALID. MUST BE 'Y' OR 'N'. THIS IS A REQUIRED FIELD FOR TRANS_CODE = I.
C430	APPLIED_COST INVALID. THIS IS A REQUIRED FIELD FOR TRANS_CODE = I WHEN PLAN TYPE = '02' OR '03'.
C431	ASES_SPLIT_AMT INVALID. THIS IS A REQUIRED FIELD FOR TRANS_CODE = I WHEN PLAN TYPE = '02' OR '03' AND APPLIED_COST = '1' OR '3'.
C432	CMS_SPLIT_AMT INVALID. THIS IS A REQUIRED FIELD FOR TRANS_CODE = I WHEN PLAN TYPE = '02' OR '03' AND APPLIED_COST = '2' OR '3'.
C433	EXTRACT DATE MISSING. THIS IS A REQUIRED FIELD.
C433.2	EXTRACT DATE INVALID. MUST BE LATER OR EQUAL THAN FROM_DATE
C433.3	EXTRACT DATE INVALID. MUST BE LATER OR EQUAL THAN TO_DATE
C433.4	EXTRACT DATE INVALID. MUST BE LATER OR EQUAL THAN PAID_DATE
C434	FILLER INVALID. MUST BE '*' ON ALL RECORDS.
C435	RX_TOTAL_DISP INVALID. THIS IS A REQUIRED FIELD FOR PHARMACY CLAIMS.
	CLAIMS FILE ERRORS:
C300	TRANS_CODE INVALID. THIS IS A REQUIRED FIELD AND MUST BE 'I' OR 'E'.
C301	CARRIER_ID INVALID. THIS IS A REQUIRED FIELD AND MUST BE A VALID CARRIER ID AS ASSIGNED BY ASES.
C302	CLAIM_ID MISSING. THIS IS A REQUIRED FIELD.
C302.2	CLAIM_ID INVALID. CLAIM_ID CANNOT BE DUPLICATED. THIS IS A REQUIRED FIELD.

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File Validation ERROR CODES

C302.3	CLAIM_ID DOES NOT EXIST. FOR A TRANS_CODE E RECORD THE CARRIER_ID + CLAIM_ID MUST ALREADY EXIST.
C303	PLAN_TYPE INVALID. MUST BE '01', '02' OR '03'. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C303.2	PLAN_TYPE INVALID. '02' OR '03' MUST CORRESPOND TO A MEDICARE PLATINO CARRIER_ID.
C303.3	PLAN_TYPE INVALID. '01' MUST CORRESPOND TO A GHIP CARRIER, MBHO, PBM OR OTHER ASSIGNED CARRIER CODE WHICH IS NOT MEDICARE PLATINO.
C304	PLAN_VERSION MISSING. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C304.2	PLAN_VERSION MUST BE A 3 DIGIT CODE. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C304.3	PLAN_VERSION INVALID. CARRIER_ID + PLAN_TYPE + PLAN_VERSION MUST CORRESPOND TO A PLAN DEFINITION CONTRACTED WITH ASES. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C305	BILL_TYPE INVALID. MUST BE 'U', 'H', 'P' OR 'D'. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C306	ADM_DATE MISSING. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C307	DIS_DATE MISSING. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C307.2	DIS_DATE INVALID. MUST BE EQUAL OR LATER THAN ADM_DATE. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C308	REGION_CODE INVALID. MUST BE 'A', 'B', 'E', 'F', 'G', 'Z', 'J' or 'S'. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C309	MUNICIPALITY_RES INVALID. MUST CORRESPOND TO A VALID ASES MUNICIPALITY CODE AND BE WITHIN THE REGION IDENTIFIED BY REGION_CODE. REQUIRED FIELD WHEN TRANS_CODE IS I.
C310	MUNICIPALITY_CODE INVALID. MUST BE A VALID ASES MUNICIPALITY CODE. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C311	SSN_MAINH INVALID. MUST BE 9 DIGITS. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C312	SSN_INVALID. MUST BE 9 DIGITS. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C313	MEMBER_SUFFIX MISSING OR INVALID. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C314	PATIENT_NAME MISSING. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C315	FAMILY_ID INVALID. THIS MUST BE ALPHANUMERIC FULL 11 CHARACTERS. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C316	MPI INVALID OR MISSING. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C317	SEX INVALID. MUST BE 'M' OR 'F'. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C319	BIRTH_DATE MISSING. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C319.2	BIRTH_DATE INVALID. IT CANNOT BE IN THE FUTURE BASED ON EXTRACT DATE.
C319.3	BIRTH_DATE INVALID. IT CANNOT BE GREATER THAN 150 YEARS AGO BASED ON EXTRACT DATE.
C319.4	BIRTH_DATE INVALID. IT MUST BE EQUAL OR EARLIER THAN ADM_DATE.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

File Validation ERROR CODES

C320	PRIMARY_CENTER MISSING. MUST BE PRESENT ON CLAIMS OF PLAN TYPE 01.
C320.2	PRIMARY_CENTER INVALID. MUST MATCH A VALID ENTRY ON IPA TABLE.
C321	DATE_ACCIDENT INVALID. MUST BE EQUAL OR GREATER THAN BIRTH_DATE.
C321.2	DATE_ACCIDENT INVALID. MUST BE EQUAL OR EARLIER THAN ADM_DATE.
C322	REC_DATE MISSING. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C322.2	REC_DATE INVALID. MUST BE EQUAL OR GREATER THAN DIS_DATE.
C323	ENTRY_DATE MISSING. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C323.2	ENTRY_DATE INVALID. MUST BE EQUAL OR GREATER THAN REC_DATE.
C324	PCP_PROV MISSING. REQUIRED WHEN PLAN_TYPE = '01'.
C324.2	PCP_PROV INVALID. MUST BE A VALID PROVIDER_ID FOR PRIMARY CARRIER.
C325	ATT_PROV MISSING. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C326	BILL_PROV MISSING. THIS IS A REQUIRED FIELD WHEN TRANS_CODE IS I.
C326.2	BILL_PROV INVALID. MUST BE A VALID PROVIDER_ID FOR CARRIER.
C328	EXTRACT_DATE MISSING. THIS IS A REQUIRED FIELD.
C328.2	EXTRACT_DATE INVALID. MUST BE LATER OR EQUAL THAN ADM_DATE.
C328.3	EXTRACT_DATE INVALID. MUST BE LATER OR EQUAL THAN DIS_DATE.
C328.4	EXTRACT_DATE INVALID. MUST BE LATER OR EQUAL THAN DATE_ACCIDENT.
C328.5	EXTRACT_DATE INVALID. MUST BE LATER OR EQUAL THAN REC_DATE.
C328.6	EXTRACT_DATE INVALID. MUST BE LATER OR EQUAL THAN ENTRY_DATE.
C329	FILLER INVALID. MUST BE '*' ON ALL RECORDS.
C330	PRIMARY_CARRIER_ID INVALID. THIS IS A REQUIRED FIELD AND MUST BE A VALID CARRIER ID AS ASSIGNED BY ASES.
C331	CLAIM FOUND WITHOUT A CORRESPONDING VALID SERVICE. EVERY CLAIM MUST HAVE AT LEAST ONE SERVICE.
C332	DIS_STAT MISSING OR INVALID. THIS IS A REQUIRED FIELD ON UB-92 CLAIMS.
	PROVIDER FILE ERRORS
C200	PROV_CARRIER MISSING OR INVALID. THIS IS A REQUIRED FIELD AND MUST BE A VALID CARRIER ID AS ASSIGNED BY ASES.
C201	PROV_ID MISSING. THIS IS A REQUIRED FIELD.
C202	PROV_LNAME MISSING. THIS IS A REQUIRED FIELD ON ALL RECORDS.
C203	PROV_ADDR1 MISSING. THIS IS A REQUIRED FIELD.

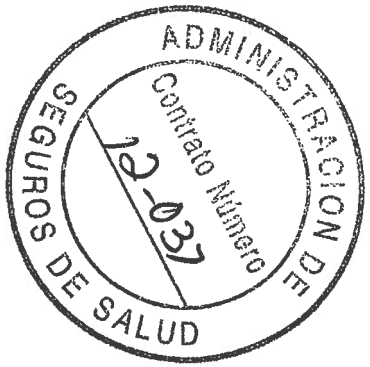
File Validation ERROR CODES

C204	PROV_CITY MISSING. THIS IS A REQUIRED FIELD.
C205	PROV_STATE MISSING. THIS IS A REQUIRED FIELD.
C206	PROV_ZIP MISSING. THIS IS A REQUIRED FIELD.
C207	PROV_COUNTRY MISSING. THIS IS A REQUIRED FIELD.
C208	PROV_TEL MISSING OR WRONG LENGTH. THIS IS A REQUIRED FIELD.
C209	PROV_TYPE INVALID. THIS IS A REQUIRED FIELD AND MUST BE A VALID PROVIDER TYPE CODE.
C210	PROV_SPEC1 INVALID. THIS IS A REQUIRED FIELD AND MUST BE A VALID SPECIALTY CODE.
C213	FEDERAL_TAX_ID MISSING OR WRONG LENGTH. THIS IS A REQUIRED 9 DIGIT FIELD.
C214	EXTRACT_DATE MISSING. THIS IS A REQUIRED FIELD.
C215	FILLER INVALID. MUST BE '*' ON ALL RECORDS.
	IPA FILE ERRORS
C100	CARRIER_ID MISSING OR INVALID. THIS IS A REQUIRED FIELD AND MUST BE A VALID CARRIER ID AS ASSIGNED BY ASES.
C101	IPA MISSING. THIS IS A REQUIRED FIELD.
C102	IPA_DESC MISSING. THIS IS A REQUIRED FIELD.
C103	IPA_ADDR1 MISSING. THIS IS A REQUIRED FIELD.
C104	IPA_CITY MISSING. THIS IS A REQUIRED FIELD.
C105	IPA_STATE MISSING. THIS IS A REQUIRED FIELD.
C106	IPA_ZIP MISSING. THIS IS A REQUIRED FIELD.
C107	IPA_COUNTRY MISSING. THIS IS A REQUIRED FIELD.
C108	IPA_WORK_PHONE MISSING OR WRONG LENGTH. THIS IS A REQUIRED FIELD.
C109	FEDERAL_TAX_ID MISSING OR WRONG LENGTH. THIS IS A REQUIRED 9 DIGIT FIELD.
C110	EXTRACT DATE MISSING. THIS IS A REQUIRED FIELD.
C111	FILLER INVALID. MUST BE '*' ON ALL RECORDS.
	CAPITATION FILE ERRORS
C500	CARRIER_ID MISSING OR INVALID. THIS IS A REQUIRED FIELD AND MUST BE A VALID CARRIER ID AS ASSIGNED BY ASES.
C501	CAP_ID INVALID. THIS IS A REQUIRED FIELD.
C501.2	CAP_ID INVALID. CAP_ID CANNOT BE DUPLICATED. THIS IS A REQUIRED FIELD.
C502	CAP_TYPE INVALID. MUST BE 'P' OR 'S'. THIS IS A REQUIRED FIELD.
C503	CAP_DATE INVALID. THIS IS A REQUIRED FIELD.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

File Validation ERROR CODES

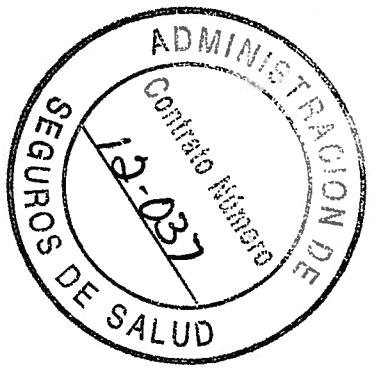
C504	EXPR_DATE INVALID. THIS IS A REQUIRED FIELD.
C505	PROV INVALID. MUST BE A VALID PROVIDER FOR THIS CARRIER. THIS IS A REQUIRED FIELD.
C506	IPA MISSING. THIS IS A REQUIRED FIELD IF CAP_TYPE = 'P' AND CARRIER_ID CORRESPONDS TO PLAN TYPE '01'
C506.2	IPA INVALID. THIS MUST BE A VALID IPA CODE.
C507	REGION_CODE INVALID. MUST BE ONE = 'A', 'B', 'E', 'F', 'G', 'Z', 'J' OR 'S'. THIS IS A REQUIRED FIELD.
C508	MUNICIPALITY_CODE INVALID. MUST CORRESPOND TO A VALID ASES MUNICIPALITY CODE AND BE WITHIN THE REGION IDENTIFIED BY REGION_CODE. THIS IS A REQUIRED FIELD.
C509	MEMBER_SSN INVALID. IT MUST BE 9 DIGITS. THIS IS A REQUIRED FIELD.
C510	FAMILY_ID INVALID. THIS HAS TO BE ALPHANUMERIC FULL 11 CHARACTERS. THIS IS A REQUIRED FIELD.
C511	MEMBER_SUFFIX INVALID. IT MUST BE 2 DIGITS. THIS IS A REQUIRED FIELD.
C512	CAP_AMT INVALID. IT MUST BE NUMERIC. THIS IS A REQUIRED FIELD.
C513	EXTRACT_DATE MISSING. THIS IS A REQUIRED FIELD.
C513.2	EXTRACT_DATE INVALID. MUST BE EQUAL TO OR LATER THAN CAP_DATE.
C513.3	EXTRACT_DATE INVALID. MUST BE EQUAL TO OR LATER THAN EXPR_DATE
C514	FILLER INVALID. MUST BE '*' ON ALL RECORDS.
C515	MPI INVALID OR MISSING. THIS IS A REQUIRED FIELD.
C516	INCONSISTENCY BETWEEN TWO OR MORE RECORDS. IF CARRIER_ID, CAP_TYPE, EXPR_DATE, PROV, FAMILY_ID & MEMBER_SUFFIX MATCH BETWEEN MULTIPLE RECORDS, THERE IS AN INCONSISTENCY IF IPA OR REGION_CODE OR MEMBER_SSN OR MPI DO NOT MATCH.



PUERTO RICO HEALTH INSURANCE ADMINISTRATION

File Validation WARNING CODES

CODE	WARNING DESCRIPTION
	SERVICES FILE WARNINGS
W400	PROC_CODE MUST BE A VALID HCPCS/CPT CODE. (CMS1500 / UB92 CLAIMS).
W400.2	PROC_CODE FOR DENTAL CLAIMS MUST BE A VALID DENTAL HCPCS/CDT CODE. (DENTAL CLAIMS)
W400.3	PROC_CODE FOR PHARMACY CLAIMS MUST BE BLANK. (PHARMACY CLAIMS)
W401	CPT_MOD INVALID.
W402	REV_CODE MUST BE A VALID REVENUE CODE. (UB92 CLAIMS)
W403	RX_NDC MUST BE A VALID NDC CODE (PHARMACY CLAIMS)
	CLAIMS FILE WARNINGS
W300	ICD_DIAG_01 MUST BE A VALID ICD OR DSM IV DIAGNOSIS CODE. (MUST CARRY HIGHEST DEGREE OF DETAIL 4TH OR 5TH DIGIT). (NOT PHARMACY OR DENTAL).
W301	ICD_DIAG_02 MUST BE A VALID ICD OR DSM IV DIAGNOSIS CODE. (MUST CARRY HIGHEST DEGREE OF DETAIL 4TH OR 5TH DIGIT). (NOT PHARMACY OR DENTAL).
W302	ICD_DIAG_03 MUST BE A VALID ICD OR DSM IV DIAGNOSIS CODE. (MUST CARRY HIGHEST DEGREE OF DETAIL 4TH OR 5TH DIGIT). (NOT PHARMACY OR DENTAL).
W303	ICD_DIAG_04 MUST BE A VALID ICD OR DSM IV DIAGNOSIS CODE. (MUST CARRY HIGHEST DEGREE OF DETAIL 4TH OR 5TH DIGIT). (NOT PHARMACY OR DENTAL).
W304	ICD_DIAG_05 MUST BE A VALID ICD OR DSM IV DIAGNOSIS CODE. (MUST CARRY HIGHEST DEGREE OF DETAIL 4TH OR 5TH DIGIT). (NOT PHARMACY OR DENTAL).
W305	ICD_DIAG_06 MUST BE A VALID ICD OR DSM IV DIAGNOSIS CODE. (MUST CARRY HIGHEST DEGREE OF DETAIL 4TH OR 5TH DIGIT). (NOT PHARMACY OR DENTAL).
W327	DIS_STAT MISSING OR INVALID. THIS IS A REQUIRED FIELD FOR UB-92 CLAIMS.
	PROVIDERS FILE WARNINGS
W200	PROV_FNAME MISSING. THIS IS AN EXPECTED FIELD FOR INDIVIDUAL PROVIDERS.



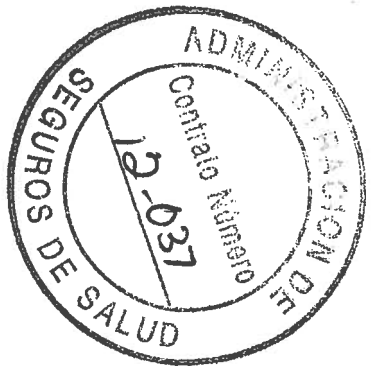
PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	REGION	CODE
Adjuntas	S	0004
Aguada	Z	0008
Aguadilla	Z	0012
Aguas Buenas	E	0016
Aibonito	G	0020
Añasco	Z	0024
Arecibo	A	0028
Arroyo	G	0032
Barceloneta	A	0036
Barranquitas	G	0040
Bayamón	B	0044
Cabo Rojo	Z	0048
Caguas	E	0052
Camuy	A	0056
Canovanas	F	0060
Carolina	F	0064
Cataño	B	0068
Cayey	E	0072
Ceiba	F	0076
Ciales	A	0080
Cidra	E	0084
Coamo	G	0088
Comerio	B	0092

Ordered By Code		
CODE	MUNICIPALITY	REGION
0004	Adjuntas	S
0008	Aguada	Z
0012	Aguadilla	Z
0016	Aguas Buenas	E
0020	Aibonito	G
0024	Añasco	Z
0028	Arecibo	A
0032	Arroyo	G
0036	Barceloneta	A
0040	Barranquitas	G
0044	Bayamón	B
0048	Cabo Rojo	Z
0052	Caguas	E
0056	Camuy	A
0060	Canovanas	F
0064	Carolina	F
0068	Cataño	B
0072	Cayey	E
0076	Ceiba	F
0080	Ciales	A
0084	Cidra	E
0088	Coamo	G
0092	Comerio	B

ATTACHMENTS



PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	REGION	CODE
Corozal	B	0096
Culebra	F	0100
Dorado	B	0104
Fajardo	F	0108
Florida	A	0112
Guanica	S	0116
Guayama	G	0120
Guayanilla	S	0124
Guaynabo	B	0128
Gurabo	E	0132
Hatillo	A	0136
Hormigueros	Z	0140
Humacao	E	0144
Isabela	Z	0148
Jayuya	S	0152
Juana Diaz	G	0156
Juncos	E	0160
Lajas	Z	0164
Lares	A	0168
Las Marias	Z	0172
Las Piedras	E	0176
Loiza	F	0180
Luquillo	F	0184

Ordered By Code		
CODE	MUNICIPALITY	REGION
0096	Corozal	B
0100	Culebra	F
0104	Dorado	B
0108	Fajardo	F
0112	Florida	A
0116	Guanica	S
0120	Guayama	G
0124	Guayanilla	S
0128	Guaynabo	B
0132	Gurabo	E
0136	Hatillo	A
0140	Hormigueros	Z
0144	Humacao	E
0148	Isabela	Z
0152	Jayuya	S
0156	Juana Diaz	G
0160	Juncos	E
0164	Lajas	Z
0168	Lares	A
0172	Las Marias	Z
0176	Las Piedras	E
0180	Loiza	F
0184	Luquillo	F

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality		
MUNICIPALITY	REGION	CODE
Manatí	A	0188
Maricao	Z	0192
Maunabo	G	0196
Mayagüez	Z	0200
Moca	Z	0204
Morovis	A	0208
Naguabo	E	0212
Naranjito	B	0216
Orocovis	G	0220
Patillas	G	0224
Peñuelas	S	0228
Ponce	S	0232
Puerta de Tierra	J	0264
Puerto Nuevo	J	0270
Quebradillas	A	0236
Rincon	Z	0240
Rio Grande	F	0244
Rio Piedras	J	0272
Sabana Grande	Z	0248
Salinas	G	0252
San German	Z	0256
San José	J	0274
San Juan	J	0266

Ordered By Code		
CODE	MUNICIPALITY	REGION
0188	Manatí	A
0192	Maricao	Z
0196	Maunabo	G
0200	Mayagüez	Z
0204	Moca	Z
0208	Morovis	A
0212	Naguabo	E
0216	Naranjito	B
0220	Orocovis	G
0224	Patillas	G
0228	Peñuelas	S
0232	Ponce	S
0236	Quebradillas	A
0240	Rincon	Z
0244	Rio Grande	F
0248	Sabana Grande	Z
0252	Salinas	G
0256	San German	Z
0264	Puerta de Tierra	J
0266	San Juan	J
0270	Puerto Nuevo	J
0272	Rio Piedras	J
0274	San José	J

ADMINISTRACION DE SERVICIOS DE SALUD
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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT I - MUNICIPALITY CODES

Alphabetical by Municipality				Ordered By Code		
MUNICIPALITY	REGION	CODE		CODE	MUNICIPALITY	REGION
San Lorenzo	E	0276		0276	San Lorenzo	E
San Sebastian	Z	0280		0280	San Sebastian	Z
Santa Isabel	G	0284		0284	Santa Isabel	G
Toa Alta	B	0288		0288	Toa Alta	B
Toa Baja	B	0292		0292	Toa Baja	B
Trujillo Alto	F	0296		0296	Trujillo Alto	F
Utuado	A	0300		0300	Utuado	A
Vega Alta	B	0304		0304	Vega Alta	B
Vega Baja	A	0308		0308	Vega Baja	A
Vieques	F	0312		0312	Vieques	F
Villalba	G	0316		0316	Villalba	G
Yabucoa	E	0320		0320	Yabucoa	E
Yauco	S	0324		0324	Yauco	S
Outside Puerto Rico	--	0666	*	0666	Outside Puerto Rico	--

* 0666 is valid only for use with Municipality Service on Claims Input File

NOTE: Any municipality code may appear in region SPECIAL.

ADMINISTRACION DE SEGUROS DE SALUD
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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

CODE	Carrier	Type
01	Triple S	MCO
03	(discontinued)	MCO
02	Humana	MCO
17	MCS	MCO
25	(discontinued)	MCO
27	MCS Life	Medicare Platino
28	Red Medica	Medicare Platino
29	Medicare y Mucho Mas	Medicare Platino
31	Triple S	Medicare Platino
33	Preferred Medicare Choice	Medicare Platino
34	MCS Advantage	Medicare Platino
35	COSVIMed	Medicare Platino
37	Salud Dorada con Medicare	Medicare Platino
39	MAPFRE	Medicare Platino
41	Health Medicare Ultra	Medicare Platino
42	Humana	Medicare Platino
44	Auxilio Platino	Medicare Platino
47	American Health	Medicare Platino
49	FirstPlus	Medicare Platino
51	Triple S	TPA – Direct Contract
52	Humana	TPA – Direct Contract
53	MCS	TPA – Direct Contract

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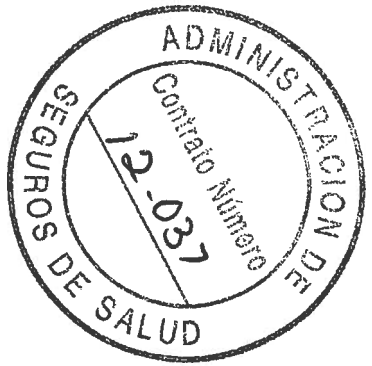
PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT II - CARRIER CODES

CODE	Carrier	Type
55	COSVI	TPA – Direct Contract
60	Caremark	PBM
64	MC-21	PBM
70	ASSMCA	Mental Health Pilot
71	Plan de Salud Hospital Menonita	Government Employee
72	MMM Healthcare,INC	Government Employee
73	National Life Insurance Company	Government Employee
74	Ryder Health Plan, Inc.	Government Employee
75	Triple-S Salud Inc.	Government Employee
76	(discontinued)	MBHO
77	Humana Health Plan of Puerto Rico, Inc.	Government Employee
78	Humana Insurance of Puerto Rico,Inc.	Government Employee
79	MCS Advantage,Inc.	Government Employee
80	MCS Life Insurance Company	Government Employee
81	Asociacion de Maestros de Puerto Rico	Government Employee
82	First Medical Health Plan, Inc.	Government Employee
83	APS	MBHO
95	FHC	MBHO



PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
Codes included in this table are designed for completeness and in no way imply coverage of services under the Government Health Insurance Plan	
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
09	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Therapy
13	Neurology
14	Neurosurgery
16	Obstetrics / Gynecology
18	Ophthalmology
19	Oral Surgery
20	Orthopedic Surgery
22	Pathology
24	Plastic and Reconstructive Surgery
25	Physical Medicine / Rehabilitation

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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
26	Psychiatry
28	Colorectal Surgery (Formerly Proctology)
29	Pulmonary Diseases
30	Diagnostic Radiology
32	Anesthesiologist Assistant
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometry
42	Certified Nurse Midwife
43	Certified Registered Nurse Assistant (CRNA)
44	Infectious Disease
45	Mammography Screening Center
46	Endocrinology
47	Independent Diagnostics Testing Facility
48	Podiatry
49	Ambulatory Surgical Center
50	Nurse Practitioner

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
51	Medical Supply Company with Orthotist
52	Medical Supply Company with Prosthetist
53	Medical Supply Company with Orthotist-Prosthetist
54	Other Medical Supply Company
55	Individual Certified Orthotist
56	Individual Certified Prosthetist
57	Individual Certified Orthotist-Prosthetist
58	Medical Supply Company with pharmacist
59	Ambulance Service Provider
60	Public Health and Welfare Agency
61	Voluntary Health or Charitable Agency
62	Psychologist
63	Portable X-ray Supplier
64	Audiologist
65	Physical Therapist
66	Rheumatology
67	Occupational Therapy
68	Clinical Psychologist
69	Clinical Laboratory
70	Multi-Specialty Clinic or Group Practice
71	Registered Dietician / Nutritional Professional
72	Pain Management
73	Mass Immunization Roster Billers

ADMINISTRACION DE SEGUROS DE SALUD Contrato Número 12-037

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
74	Radiation Therapy Center
75	Slide Preparation Facilities
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
80	Licensed Clinical Social Worker
81	Critical Care (Intensivists)
82	Hematology
83	Hematology / Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
87	All Other Suppliers
88	Unknown Supplier / Provider Specialty
89	Certified Clinical Nurse Specialist
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Intervention Radiology
96	Optician
97	Physician Assistant

ADMINISTRACION DE SEGUROS DE SALUD
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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
98	Gynecological Oncology
99	Unknown Physician Specialty
A1	Skilled Nursing Facility
A2	Intermediate Care Nursing Facility
A3	Other Nursing Facility
A4	Home Health Agency
A5	Pharmacy
A6	Medical Supply Company with Respiratory Therapist
A7	Department Store
A8	Grocery Store
DD	Dentist
EN	Endodontist
HE	Health Educator
HN	Home Health Nurse
PE	Periodontist
RT	Respiratory Therapist
ST	Speech Therapist
BB	Blood Bank
CV	Cardiac Catheterization Facility
DF	Dialysis Facility
EC	Emergency Care Facility
HV	HIV Ambulatory Antibiotic Facility
HO	Hospice

ADMINISTRACION DE SEGUROS DE SALUD
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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT III - SPECIALTY CODES

CODE	Specialty
IC	Intensive Care Unit
IT	Infusion Therapy
LI	Lithotripsy
NI	Neonatal ICU
OP	Optical
PC	Clinic – Primary Level
PH	Private Hospital
PP	Private Psychiatric Hospital
PS	Psychiatric Partial Hospital
SH	State Hospital
SP	State Psychiatric Hospital
XR	X-ray Facility
Z4	Cardiovascular Surgery Program
O1	Occupational Medicine
P1	Perinatology
N1	Neonatolgy
G1	Geneticist
P2	Pediatric Surgery

ADMINISTRACION DE SEGUROS DE SALUD
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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
Codes included in this table are designed for completeness and in no way imply coverage of services under the Government Health Insurance Plan		
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals.
05	Indian Health Service Free-standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization
06	Indian Health Service Provider-based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09-10	Unassigned	N/A

ADMINISTRACION DE SEGUROS DE SALUD
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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
11	Office	Location, other than a hospital, Skilled Nursing Facility (SNF), military treatment facility, community health center, State or local public health clinic, or Intermediate Care Facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services.
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16-19	Unassigned	N/A
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital, which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room - Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

ADMINISTRACION DE SEGUROS DE SALUD
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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
27-30	Unassigned	N/A
31	Skilled Nursing Facility	A facility, which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35-40	Unassigned	N/A
41	Ambulance - Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43-48	Unassigned	N/A

ADMINISTRACION DE SEGUROS DE Certificado Número 12-037

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
49	Independent Clinic	A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.
50	Federally Qualified Health Center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric Facility Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: • Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility. • 24 hour a day emergency cares services. • Day treatment, other partial hospitalization services, or psychosocial rehabilitation services. • Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission. • Consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.

ADMINISTRACION DE SEGUROS DE SALUD
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PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
55	Residential Substance Abuse Treatment Facility	A facility, which provides treatment for substance (alcohol and drug) abuse to live-in residents who, does not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care, which provides a total 24-hour therapeutically, planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
58-59	Unassigned	N/A
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63-64	Unassigned	N/A
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.

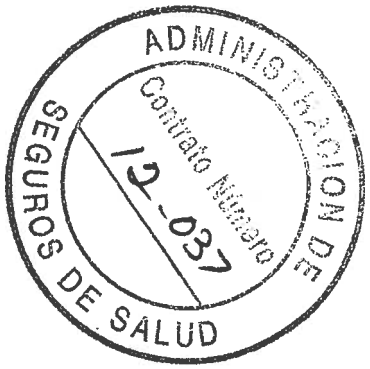
ATTACHMENT IV - PLACE OF SERVICE CODES

CODE	Name	Description
66-70	Unassigned	N/A
71	State or Local Public Health Clinic	A facility maintained by either State or local health departments that provide ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility, which is located in a rural medically, underserved area that provides ambulatory primary medical care under the general direction of a physician.
73-80	Unassigned	N/A
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82-98	Unassigned	N/A
99	Other Place of Service	Other service facilities not specified above.

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT V

THIS ATTACHMENT HAS BEEN REMOVED



PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VI - PROVIDER TYPE CODES

CODE	Description
Codes included in this table are designed for completeness and in no way imply coverage of services under the Government Health Insurance Plan	
AM	Ambulance
AS	Ambulatory Surgical Center
BB	Blood Bank
CL	Clinical Facility
DE	Dentist
DM	Durable Medical Equipment (DME)
EM	Emergency Facility
HH	Home Health Agency
HO	Hospital
HS	Hospice
LA	Laboratory
MD	Medical Doctor (Physician)
RX	Pharmacy
SN	Skilled Nursing Facility (SNF)
UF	Urgent Care facility
XR	Radiology Facility
ZZ	Other

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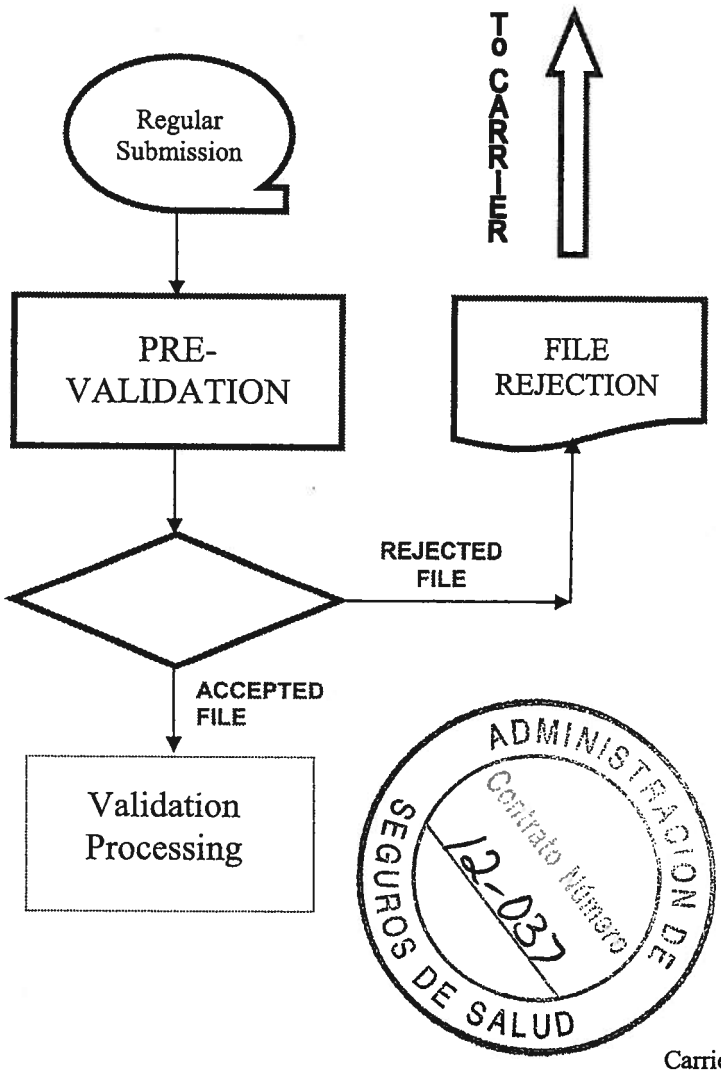
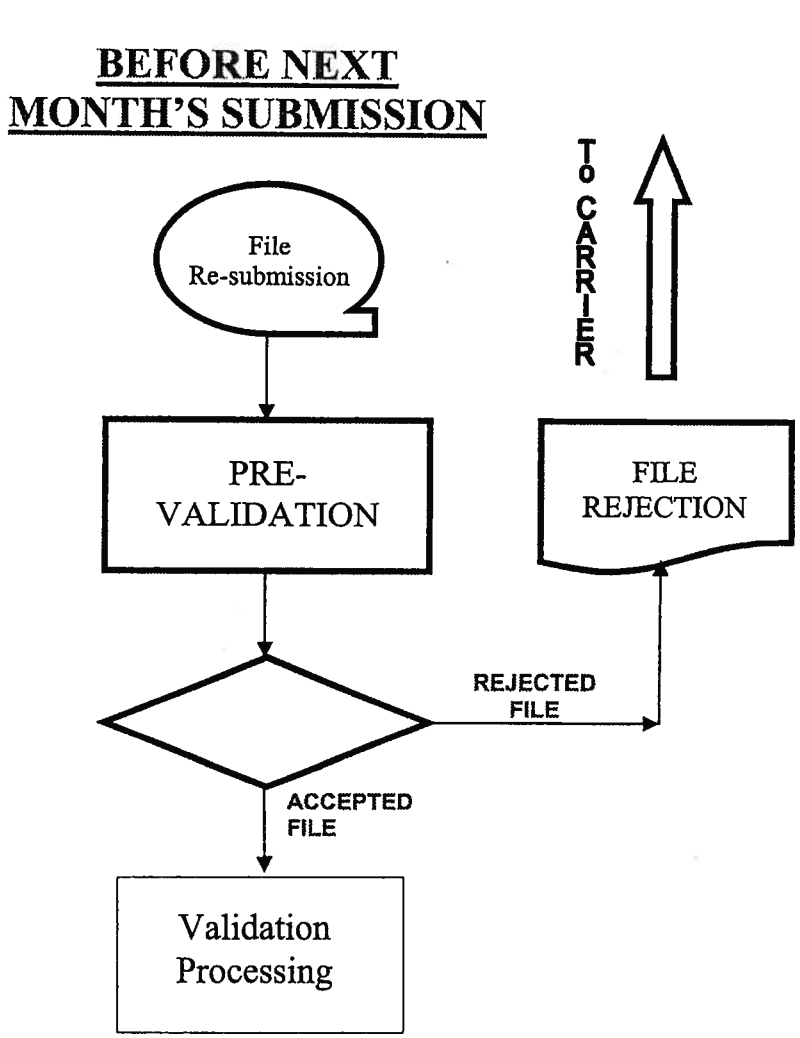
PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VII - CLAIMS / SERVICES BASIC FLOW OVERVIEW

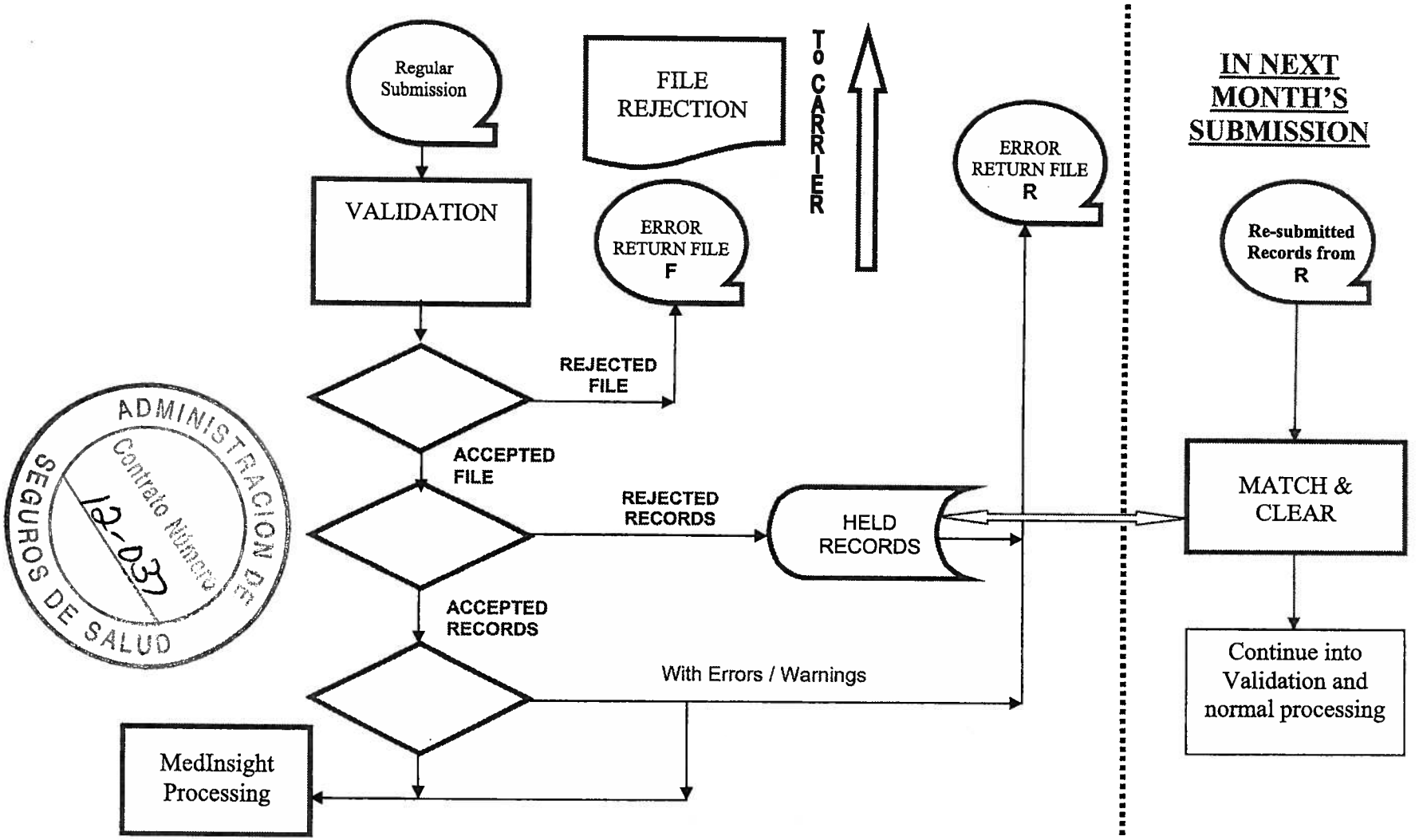




Carrier to ASES Data Submissions
File Layouts

PUERTO RICO HEALTH INSURANCE ADMINISTRATION

ATTACHMENT VII - CLAIMS / SERVICES BASIC FLOW OVERVIEW

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ATTACHMENT #10

Projected Medical Costs by Region: November 1, 2011 - June 30, 2012

	West	Metro North	North	San Juan	Northeast
	With Plan Changes	With Plan Changes	With Plan Changes	With Plan Changes	With Plan Changes
Facility	$ 35.19	$ 45.75	$ 37.55	$ 52.65	$ 37.24
Professional	$ 31.25	$ 39.70	$ 28.05	$ 49.54	$ 45.01
Dental	$ 3.00	$ 4.07	$ 3.85	$ 4.53	$ 4.31
Drugs	$ 11.74	$ 14.97	$ 12.66	$ 21.78	$ 15.99
Other	$ 6.31	$ 7.08	$ 5.94	$ 9.59	$ 7.65
	$ 87.49	$ 111.57	$ 88.05	$ 138.09	$ 110.20

Developed by ASES' actuaries
Attachment # 10

ATTACHMENT 10A

ATTACHMENT 10A

Calculation of Threshold Per Member Per Month (PMPM)

November 2011 - June 2012

	West	Metro North	North	San Juan	Northeast	Threshold*
Projected Medical Cost PMPM	$ 87.49	$ 111.57	$ 88.05	$ 138.09	$ 110.20	$ 102.25
June 2011 Membership	225,038	196,267	200,616	92,198	130,114	

*Threshold is calculated as weighted average projected medical PMPM cost. The threshold will be recalculated based on actual membership for November 2011 - June 2012 at the end of the contract period.

Rev. 10.17.2011

ATTACHMENT #11

ATTACHMENT 11

ADMINISTRATIVE FEES PER MEMBER PER MONTH PER REGION

Region	Per Member Per Month Administrative Fee
North	$7.80
Metro North	$8.17
San Juan	$11.42
Northeast	$8.64
West	$7.15
Virtual	Included above

Annual Budget for Administration of Quality Incentive Program: $1,000,000
Annual Retention Fund (5%): $50,000

ATTACHMENT #12

Administración de Seguros de Salud de Puerto Rico (ASES)
TPA Contract
Attachment 12
Deliverables

Section	Deliverable	Contractor delivery date
6.4.5	Enrollee Handbook - (Universal Guide)	November 1, 2011
6.6.6	Provider Directory	December 1, 2011
6.7.5	Front and back sample of Enrollee ID Card	October 20, 2011
6.8.13	Scripts addressing the questions expected to arise most often for both the Information Service and the Medical Advice Service	October 20, 2011
6.8.14	Tele *Mi Salud* Policies and Procedures, Quality Criteria and Protocols, Outreach Program, Scripts and Training materials for Tele *MI Salud* Call Center Employees	October 20, 2011
6.9.5	Website screenshots	December 1, 2011
6.10.2	Cultural Competency Plan	December 1, 2011
6.14.5.1	Marketing Plan and copies of all Marketing Materials (written and oral)	December 1, 2011
7.5.3.4.5	**Wellness Plan**	**December 1, 2011**
7.5.8.3.12	Pre-Natal and Maternal Wellness Plan	December 1, 2011
7.7.6.6	Summary of the Strategy for the identification of populations with special health care needs	November 15, 2011
7.7.6 & 9.14.2	Protocols for screening and registering Enrollees for Special Coverage	November 1, 2011
7.7.9.1	Coordination Plan with the MBHO to meet the integration requirements for autism.	October 17, 2011
7.8.2.6	Case Management Policies and Procedures	October 17, 2011
7.8.3.5	Disease Management Policies and Procedures	December 1, 2011
7.9.1.4	EPSDT Plan including procedures for follow-up of missed appointments, including missed Referral appointments for	October 17, 2011

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	problems identified through EPSDT screens and exams	
8.8	Integration Plan incorporating the elements in Article 8, to ensure cooperation between TPA and MBHO	October 17, 2011
9.6.1.6	Policies and procedures for Enrollee selection of PCP	October 17, 2011
9.11.3	**MBHO Policies and Procedures that ensure timely Access to Behavioral Services and integration of Care.**	**November 1, 2011**
9.14.2	Protocols for screening Enrollees for participation in Case Management and Disease Management Programs	October 17, 2011
9.19.4	Policies and procedures for determining the adequacy of Providers' available hours	December 1, 2011
9.21.3	Policies and procedures for monitoring (PPN) Provider performance, measuring access to care, and identifying Provider compliance issues	December 1, 2011
9.1.1; 9.22.1	**Assurances concerning adequacy of Provider Network**	**TBD - Certifications Due Upon Request**
10.1.6.1	Model for each type of Provider Contract	Upon Execution
10.1.6.1	Compact disk with copies of provider contract templates	Upon Execution
10.2.1.3	Provider Guidelines	October 17, 2011
10.2.2.1	Continuing Education Curriculum for Providers	December 1, 2011
10.5.1.5	**Capitation methodology**	**October 28, 2011**
10.8.1	Electronic file and a list of all participating providers, listed by municipality, indicating the capacity of each Provider, as well as the specialty or subspecialty of physicians	File Submission Weekly based on Contract Execution Date
10.8.5	Control sheet of provider files	File Submission Weekly based on Contract Execution Date
11.1.2	Utilization Management Policies and Procedures	October 17, 2011

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Administración de Seguros de Salud de Puerto Rico (ASES)
TPA Contract
Attachment 12
Deliverables

12.2.4; 12.5.1	QAPI Program	December 1, 2011
13.1.3	Fraud and Abuse Policies and Procedures, proposed compliance plan, and Program Integrity Plan	December 1, 2011
14.1.3	Grievance System Policies and Procedures	October 24, 2011
14.1.14	Grievance System Forms	October 24, 2011
15.3.2	Staff Training Plan and a current organizational chart	October 17, 2011
15.5.1-2	Implementation Plan	October 17, 2011
10.5.1.8; 16.5.1	Provider Payment Schedule	October 17, 2011
22.1.7	**Payment procedures and controls**	**December 1, 2011**
22.4.1.9	Plan for Routine Audits to prevent duplicate payments for third party billable services	December 1, 2011
28.2	**Certification that the Contractor does not contract with entities that have been under investigation for, accused of, convicted of, or sentenced to imprisonment, in Puerto Rico, the United States of America, or any other country, for any crime involving corruption, fraud, embezzlement, or unlawful appropriation of public funds, pursuant to Act 458, as amended, and Act 84 of 2002**	**October 17, 2011**
30.1	Insurance license issued by PRICO	October 17, 2011
31.1	**Certifications from government agencies, a list of Contractor's contracts with government agencies, and other documents relating to Contractor's compliance with federal and Puerto Rico law.**	**Within 15 days of execution of contract.**
38.2	**Conflict of Interest Disclosure Form**	**October 17, 2011**

ADMINISTRACION DE SALUD Contrato Número 12-637

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
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ATTACHMENT #13

ADMINISTRACION DE SEGUROS DE SALUD

ESTADO LIBRE ASOCIADO DE PUERTO RICO

ASES

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
12-037

Carta Circular
Núm. 10-10-06

Año Fiscal 2010-2011
6 de octubre de 2011

A los Secretarios, Directores de Dependencias y Alcaldes del Estado Libre Asociado de Puerto Rico

Asunto: Servicios Médicos Contratados para el Año 2011

Como parte del Plan de Reorganización Núm. 3 de 2010, las funciones antes ejercidas por el Área de Seguros Públicos del Departamento de Hacienda relacionadas a la Ley Núm. 95 del 29 de junio de 1963 pasaron a la Administración de Seguros de Salud (ASES), entiéndase la facultad de negociar, contratar y gestionar los beneficios de salud para los empleados públicos.

En la Carta Circular Núm. 1300-07-09, emitida por el Departamento de Hacienda, se establecen las instrucciones generales a seguir para el trámite y pago de los planes de servicios de salud del personal de Gobierno. De acuerdo con las disposiciones de la Ley Núm. 95, se formalizaron los contratos de servicios de salud para el **año 2011 con vigencia del 1 de enero al 31 de diciembre de 2011**.

DISPOSICIONES ESPECÍFICAS

1. Todo el personal elegible que interese ingresar a algún plan de servicios de salud contratado por la ASES deberá enviar el original de la solicitud de ingreso a la entidad aseguradora no más tarde del **30 de noviembre de 2010** con acuse de recibo. El empleado retendrá una copia como evidencia y enviará una copia a la Oficina de Recursos Humanos de su agencia El personal que se acoja a un plan de servicios de salud auspiciado por una organización de empleados, deberá tramitar su solicitud de ingreso a través de dicha organización. Ésta luego de verificar que el empleado pertenece a la organización, será responsable de enviar el original de la misma a la entidad aseguradora dentro de la fecha límite indicada. Será responsabilidad del asegurado pagar directamente a la entidad aseguradora la parte que le corresponda de la prima si entrega su solicitud después de la fecha límite establecida.

PO Box 195661, San Juan, P.R. 00919-5661 Tel. (787) 474-3300 Fax (787) 474-3346

2. **La Oficina de Recursos Humanos de la agencia será responsable de retener las copias de las solicitudes de ingreso del personal para verificar las facturas que reciba de la entidad aseguradora.**

3. El personal que tenga un nombramiento transitorio, cuyo contrato de nombramiento sea menor de seis meses, es elegible para ingresar a los planes de servicios de salud contratados por la ASES, pero no tendrá derecho a la aportación patronal establecida en la Carta Circular 1300-07-09. En estos casos, al llenar la solicitud de ingreso, deberán indicar en un área visible de la misma la frase **SIN DERECHO A LA APORTACIÓN PATRONAL.** Estas solicitudes deberán ser entregadas a la entidad aseguradora y copia a la Oficina de Recursos Humanos de su agencia.

   La Oficina de Recursos Humanos de cada agencia utilizará las copias de las solicitudes recibidas para preparar una lista del personal, por entidad aseguradora y organización de empleados. Dicha lista incluirá el nombre y seguro social del asegurado principal e **identificará al personal transitorio** sin derecho a la aportación patronal. Bajo ninguna circunstancia incluirán en los medios magnéticos a los empleados transitorios cuyo nombramiento sea menor de seis meses.

4. **Las entidades aseguradoras autorizadas a enviar los cambios directamente al Área de Tecnología de Información (ATI) de este Departamento en los diferentes** medios magnéticos tendrán hasta las 4:00 p.m. del **3 de diciembre de 2010** para entregarlos. Bajo ninguna circunstancia incluirán en los mismos a los empleados transitorios cuyo nombramiento sea menor de seis meses.

5. En el Anejo 1 se indican las claves asignadas por ATI para identificar los descuentos por concepto de servicios de salud a efectuarse a favor de las entidades aseguradoras y organizaciones de empleados bajo la Ley 95 contratadas por el Secretario de Hacienda. ATI usará estas claves para identificar en el registro de nómina, la entidad aseguradora u organización de empleados con la cual el funcionario tiene su seguro de servicios médicos.

6. **Las agencias interesadas en que ATI les procese los cambios automáticamente para la primera quincena del mes de enero 2011, lo solicitarán por escrito a ATI, antes del cierre para procesar los mismos. Las agencias tendrán hasta las 4:00 de la tarde del 3 de diciembre de 2010 para someter su solicitud y autorización para que ATI procese sus cambios automáticamente. De no participar en dicho proceso, la agencia será responsable de efectuar los cambios directamente en el sistema RHUM (Recursos Humanos Mecanizados). Las agencias serán responsables de**

entrar las transacciones del personal transitorio cuyo nombramiento sea menor de seis meses.

7. En los contratos formalizados con las organizaciones de empleados se acordó que el pago correspondiente a las primas se emitirá a nombre de la entidad aseguradora a través de la cual se prestarán los servicios. En el Anejo 1 le indicamos a favor de quién se emitirán los pagos correspondientes.

8. **No están autorizadas las renovaciones automáticas,** con excepción de las cubiertas *Advantage* y Parte D de *Medicare*. Todo pensionado con la Cubierta *Advantage* y Parte D de *Medicare* que no desee continuar con el plan médico luego de la renovación automática y aquellos que pertenecen a la Cubierta Complementaria de *Medicare* tendrán hasta el 7 de febrero de 2011 para cambiar de compañía o renovar su cubierta.

   De incurrir en el incumplimiento de este inciso el empleado notificará a la ASES y el Plan de servicios de salud quedará obligado al pago de una penalidad de cinco mil **($ 5,000.00) por ocurrencia pagadero a la ASES.**

9. **Cuando el funcionario entregue más de una copia de la solicitud de ingreso a la agencia gubernamental, dicha agencia reconocerá como válida la primera solicitud recibida.**

10. La entidad aseguradora deberá emitir las tarjetas de identificación al asegurado, la cual incluirá la fecha de efectividad del Plan, **no más tarde de 15 días** luego de recibir la solicitud del empleado. Como evidencia de que envió las tarjetas, **utilizará el Formulario PS Form 3877, Certificate of Mailing,** que provee la oficina de correo postal. En el mismo indicarán el nombre y la dirección del asegurado y deberá ser certificado por el funcionario del correo. En los casos donde no pueda cumplir con el envío de las referidas tarjetas, enviará una certificación de cubierta al asegurado, no más tarde de 15 días luego de recibir la solicitud, y completará el Formulario PS Form 3877, como evidencia del envío de las mismas.

    Cuando el asegurado no reciba las tarjetas o las certificaciones, se comunicará con la entidad aseguradora para solicitar el reembolso o la no-facturación del mes o los meses en que la entidad tarde en emitir las tarjetas o certificaciones. **En estos casos, deberá presentar evidencia de las gestiones de solicitud hechas por él a la entidad aseguradora.**

11. Los contratos de servicios de salud tendrán vigencia hasta el **31 de diciembre de 2011**. No obstante, aquellos funcionarios que interesen darse de baja por alguna razón **que no sea la de ingresar a otro plan,** podrán hacerlo en cualquier momento dentro de dicho período, mediante el Modelo SC 1330, Solicitud de Cancelación, (Anejo 2). **En estos casos, el empleado no podrá**

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Solicitud de Cancelación, (Anejo 2). **En estos casos, el empleado no podrá ingresar a otro plan de salud de los contratados por la ASES hasta la próxima negociación, ni la aportación patronal estará su disposición.**

El Modelo SC 1330 se completará en original y dos copias. Será responsabilidad del asegurado enviar original del referido Modelo a la entidad aseguradora para que tramite el mismo y la copia a la Oficina de Recursos Humanos del organismo para el cual trabaja. Retendrá la última copia como prueba de la solicitud.

12. **La única razón para que la entidad aseguradora no proceda a cancelar el contrato del plan médico será que el funcionario adeude primas. Tan pronto la entidad aseguradora reciba la Solicitud de Cancelación tendrá 5 días para notificarle al asegurado, si dicha cancelación no procede.**

    La entidad aseguradora le notificará al empleado que primero tiene que pagar para que proceda su cancelación. De lo contrario, tiene que permanecer en el plan hasta la vigencia del contrato.

13. Si durante la vigencia del contrato, el empleado o sus dependientes son elegibles para ingresar a otro plan médico grupal, podrá solicitar la baja del plan contratado por la ASES. En estos casos, la cancelación tendrá efectividad el día primero del mes siguiente si se somete en o antes del día 10. Si la solicitud de baja se efectúa después del día 10, la cancelación tendrá efectividad el día primero del mes subsiguiente al que se someta la solicitud.

14. Si durante la vigencia de este contrato, un empleado o sus dependientes dejan de ser elegibles a otro plan médico, podrá solicitar ingreso al plan contratado por la ASES. En este caso tendrá treinta (30) días a partir de la fecha de notificación de cancelación para solicitar el cambio. Deberá presentar evidencia de la fecha de efectividad de la cancelación. El ingreso en estos casos tendrá efectividad el día primero del mes siguiente a aquel en que se somete la misma, siempre que la persona la solicite antes del día diez (10) del mes. Si la persona somete la solicitud después del día diez (10) del mes, la misma tendrá efectividad el día primero del mes subsiguiente a aquel en que sometió la solicitud.

15. Las agencias tienen la obligación de enviar la documentación necesaria que justifique cualquier ajuste hecho en el pago a la aseguradora.

16. **Las agencias no podrán utilizar el Sistema RHUM para efectuar reembolso de planes de servicios de salud a empleados ni a entidades, una vez vencido su periodo de contratación.**

17. En los casos de aquellos empleados con licencia por enfermedad, las agencias vienen obligadas a pagar la aportación patronal tan pronto el plan médico facture y no esperar a que el empleado se reinstale en sus labores.

18. El plan familiar mancomunado no aplica al personal y sus familiares que pertenecen a la Asociación de Maestros de Puerto Rico. Tampoco aplica al personal de las corporaciones públicas o entidades gubernamentales cuyos servicios de salud no estén contratados bajo las disposiciones de la citada Ley Núm. 95. Sin embargo, para las uniones que contraten bajo la Ley Núm. 158 se permitirá la mancomunación.

LEY NÚM. 158 DEL 10 DE AGOSTO DE 2006

Dicha Ley dispone que las uniones que están bajo la Ley Núm. 45 del 25 de febrero de 1998, según enmendada, mejor conocida por Ley de Sindicalización de Empleados Públicos, tendrán derecho a que el representante exclusivo negocie directamente a nombre de éstos, todo lo concerniente a los beneficios relacionados al plan de servicio de salud. Para el año 2008 varias organizaciones presentaron al Secretario de Hacienda sus negociaciones con un plan único. Las agencias a las cuales les aplique dicha negociación tendrán que tomar las siguientes medidas:

1. La unión notificará oficialmente a la agencia y a sus unionados que se están acogiendo a dicha Ley Núm. 158 y el nombre del plan médico seleccionado.

2. La agencia solicitará a la unión copia de la solicitud de cada unionado acogido al plan. Dicha agencia no podrá ingresar en bloque a todos los unionados en dicho plan, solo ingresará aquellos que la Unión les presente copia de la solicitud.

3. La agencia acordará con la unión la forma en la cual se harán los descuentos. El pago de estos descuentos se hará a nombre de la entidad aseguradora o del Plan Médico.

4. La agencia acordará con la ASES la forma en que realizará los cambios y será responsable de enviar los mismos directamente a ATI en los diferentes medios magnéticos. Las normas, fechas y calendario a seguir se regirán por la Ley 95.

5. La unión velará que los descuentos y los servicios le sean prestados a los unionados.

6. El unionado gestionará toda querella o reclamación directamente con la unión.

7. El Plan Médico seleccionado será compulsorio para todos los unionados, exceptuando las siguientes condiciones:

    a. Que el empleado presente evidencia de desafiliación a la unión.

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b. Que el empleado pertenezca a Mi Salud como Médico Indigente o ELA Puro, (entiéndase que se acoge al Plan a través de su aportación patronal sin estar certificado por la Oficina del Programa de Asistencia Médica de su municipio de residencia). De estar interesado en ingresar al plan médico de la unión deberá darse de baja en la oficina del Programa de Asistencia Médica correspondiente ante de la fecha de efectividad del Plan seleccionado. Si el empleado público está en Mi Salud como médico indigente y pierde este beneficio fuera de las fechas establecidas debe completar su afiliación como ELA Puro hasta culminar tiempo de la cubierta. El empleado no podrá ingresar a ningún otro plan de los contratados por la ASES ni tendrás su aportación patronal a su disposición. Dicha cancelación será efectiva al 31 de diciembre del año contrato.

c. En un plan familiar o pareja mancomunado, que el unionado no sea el asegurado principal.

d. El empleado sea miembro de la Asociación de Maestros. De estar interesado en ingresar al plan médico de la unión, el empleado se comunicará con la Asociación de Maestros antes de llenar la solicitud de la unión para que éstos lo orienten sobre el proceso a seguir para la cancelación de su plan con la Asociación.

e. El empleado no desee acogerse al Plan Médico seleccionado. **De ser así, éste no podrá utilizar su aportación patronal para ningún otro Plan Médico contratado por la ASES.**

8. El empleado no podrá hacer cambios a otro Plan Médico durante el año.

9. Si durante la vigencia del contrato, el empleado es reclasificado de unionado a gerencial, éste dejará de ser elegible al Plan Médico bajo la Ley Núm. 158. En estos casos, el empleado tendrá 30 días a partir de la fecha en que tiene conocimiento del cambio para acogerse a uno de los planes contratados por la ASES bajo la Ley Núm. 95. Éste deberá presentar al plan médico una certificación de la agencia que indique que ya no es miembro de la unión bajo esta Ley.

   Aquel empleado gerencial que pertenezca a alguna Organización de Empleados bajo la Ley Núm. 158 y pase a ser unionado tendrá ~~también~~ 30 días para acogerse al plan que le corresponda a dicha Organización. Deberá presentar a la unión una certificación de la agencia que indique que ya no es empleado gerencial.

10. La vigencia de este contrato será igual a la fecha establecida por la ASES, así como cualquiera otra fecha establecida por su Director Ejecutivo.

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PROGRAMAS DE ADVANTAGE PARA PENSIONADOS

La efectividad de los planes contratados para los pensionados de Medicare con cubierta de Medicina 9.2, Medicare Parte D o Advantage será del 1 de enero de 2011 al 31 de diciembre del 2011.

ENTIDADES ASEGURADORAS PARA PROGRAMAS DE ADVANTAGE PARA PENSIONADOS AÑO 2011

Nombre	Código de deducción
FIRST MEDICAL HEALTH PLAN, INC	A27
HUMANA INSURANCE	A17
MCS LIFE INSURANCE	A14
MEDICARE Y MUCHO MAS	A35
TRIPLE S, INC.	A01

ENTIDADES ASEGURADORAS PARA PROGRAMAS MEDICINA PARTE-D PARA PENSIONADOS AÑO 2011

Nombre	Código de deducción
TRIPLE S, INC.	D01
MCS LIFE INSURANCE	D14
FIRST MEDICAL HEALTH PLAN, INC	D27

DISPOSICIONES GENERALES

1. Los aseguradores serán responsables de ofrecer orientaciones e información a sus representantes y a los funcionarios durante las campañas de orientación. Además, serán responsables de notificar a los asegurados los cambios que ocurran en la cubierta y mantener evidencia de estas.

2. El trámite y pago de los planes médicos se regirá por las disposiciones de la **Carta Circular Núm. 1300-07-09** emitida por el Departamento de Hacienda.

3. La Oficina de Recursos Humanos de cada agencia, solicitará el Certificado de Matrimonio actualizado.

4. Autorizamos a las agencias a reproducir el Modelo SC 1330, Solicitud de Cancelación en sus propias facilidades.

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Es importante que hagan llegar una copia del mismo a cada uno de los empleados de su agencia.

6. Próximamente se emitirá una Carta Circular para informarles las Organizaciones de Empleados bajo la Ley 95 y Ley 158 con las cuales la ASES formalizará contratos de Salud para el año 2011, así como las claves que identificarán las mismas.

Esta Carta Circular deroga la Carta Circular Núm. 1300-21-10 del 15 de enero de 2010.

El texto de esta carta circular está disponible en nuestra página de Internet en la dirección **www.ases.gobierno.pr/publicaciones/cartas_circulares_cont.html.**

Es responsabilidad de las agencias hacer llegar las disposiciones de esta Carta Circular a cada uno de su personal, especialmente a los de la Oficina de Recursos Humanos encargados de los planes médicos.

Cordialmente,

Domingo Nevárez-Ramírez, MHSA
Director Ejecutivo

Sr. Carlos Guzmán
Repesentante de Servicios

Anejos

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Anejo 1

CC 10-10-06
1 de octubre de 2010
Página 1

INFORMACIÓN PARA INGRESAR O RENOVAR PLANES MÉDICOS AÑO 2011

1. Las solicitudes de ingreso a los planes de salud deben llegar a la entidad aseguradora no más tarde del **30 de noviembre de 2010**, para garantizar la efectividad al **1 de enero de 2011.**

2. El personal que tenga un nombramiento transitorio cuyo contrato de nombramiento sea menor de seis meses es elegible para ingresar a los planes de servicios de salud, pero sin derecho a la aportación patronal. En este caso, indicará en su solicitud de ingreso la frase **SIN DERECHO A LA APORTACIÓN PATRONAL.**

3. El asegurado enviará la solicitud de ingreso a la entidad aseguradora y copia a la Oficina de Recursos Humanos de su agencia. El personal que se acoja a un plan de servicios de salud auspiciado por una organización de empleados tramitará su solicitud de ingreso a través de dicha organización.

4. La entidad aseguradora deberá emitir las tarjetas de identificación al asegurado y se compromete a trabajar las solicitudes de cancelaciones o bajas no más tarde de 15 días luego de recibir la solicitud del empleado.

5. De **no recibir** las tarjetas o las certificaciones de cubierta, dentro del período establecido en el punto 4, el asegurado deberá comunicarse con la entidad aseguradora. El asegurado podrá solicitar el reembolso o no facturación del mes o los meses en que la entidad tarde en emitir las tarjetas o certificaciones y presentará pruebas de las gestiones hechas por él a la entidad aseguradora.

6. Al llenar la solicitud de ingreso, deberá completar todas sus partes con la información, según aparece en la Agencia.

7. Cuando un empleado interese acogerse a un plan médico mancomunado y su cónyuge presta servicios en otro organismo llenará el Modelo SC 1335, **Certificación para Acogerse al Plan de Salud Mancomunado.** El plan familiar mancomunado no aplica al personal y sus familiares que pertenecen a la Asociación de Maestros de Puerto Rico. Tampoco aplica al personal de las corporaciones públicas u entidades gubernamentales cuyos servicios de salud no estén contratados bajo las disposiciones de la citada Ley Núm. 95. Sin embargo,

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para las uniones que contraten bajo la Ley Núm. 158 se permitirá la mancomunación.

La Oficina de Recursos Humanos de la agencia, solicitará copia del Certificado de Matrimonio actualizado.

8. Después del **30 de noviembre de 2010** no se tramitará solicitud de ingreso alguna, con las siguientes excepciones:

   a. Personal de nuevo nombramiento. Estos tendrán 60 días a partir de la fecha de efectividad de su nombramiento.

   b. Personal que ingrese en alguna de las organizaciones de empleados, con las cuales se haya contratado, con el fin de acogerse a los planes de salud que ofrecen dichas organizaciones.

   c. Personal que luego del 30 de noviembre se acoja a los beneficios de retiro, de cualquiera de los Sistemas de Retiro, que interesen continuar o ingresar en uno de los planes médicos contratados por el Secretario de Hacienda. Dichas solicitudes deberán tramitarse a la entidad aseguradora correspondiente con no menos de 60 días de antelación a la fecha en que cesará.

9. Si el asegurado cesa en sus funciones, tendrá la opción de continuar con su plan médico, mediante pago directo o no continuar con el mismo. De continuar con su plan médico, retendrá sus tarjetas, le informará su decisión al supervisor inmediato y al Área de Recursos Humanos de su agencia y completará el Modelo SC 1339, Certificación de Conversión de Plan Médico en Casos de Renuncia o Cesantía. **De no continuar con el plan médico el empleado es responsable de notificarlo a la entidad aseguradora.** Además, deberá entregar, a su supervisor inmediato, su tarjeta y la de sus dependientes, incluyendo la correspondiente a su cónyuge si tenía plan médico mancomunado. El supervisor enviará el Modelo SC 1339 y copia de la renuncia al Área de Recursos Humanos de la Agencia, quien a su vez la enviará a la entidad aseguradora.

10. **Cuando el asegurado principal cese, pero prestó servicios por un periodo menor de 15 días durante cualquier mes, excepto por razón de licencia autorizada, no se le contará dicho periodo como trabajado para los efectos del**

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pago de la aportación patronal. La prima será pagada en su totalidad por el asegurado.

11. El asegurado está obligado a notificar, por escrito, a su plan médico los siguientes cambios:

    a. **Destitución y suspensión de empleo o sueldo** - Indicará la fecha de efectividad de la destitución o suspensión y su dirección. En los casos de suspensión indicará, además, la fecha de vencimiento de la misma. Si tiene un plan médico mancomunado, le enviará copia de la comunicación a la dependencia donde preste servicios su cónyuge para la acción correspondiente. Al cónyuge del asegurado principal, se le hará el descuento del asegurado principal por el tiempo que dure dicha destitución o suspensión de empleo y sueldo.

    En caso de suspensión o destitución no confirmada, de continuar con el contrato, el funcionario hará sus pagos de primas, incluyendo la parte patronal, directamente a la entidad aseguradora u organización de empleados. Cuando el funcionario se reincorpore al trabajo, de continuar con el seguro, se harán los ajustes para reembolsarle la aportación patronal por el período de su cesantía o suspensión, de acuerdo con la Sección 9 (c) de la Ley Núm. 95. En los casos de planes mancomunados, cuando el cónyuge del asegurado principal se reincorpore al trabajo, la entidad aseguradora hará los ajustes para rebajar el descuento al asegurado principal y facturar a la dependencia donde preste servicios su cónyuge.

    b. **Licencia sin Sueldo, Licencia Militar sin Sueldo o Licencia Familiar y Médica (Modelo SC 1334)** – Indicará la fecha en que comienza y termina la misma y si continuará o no con el contrato. Además, si tiene un plan mancomunado, enviará copia de dicha comunicación a la dependencia donde preste servicios su cónyuge, para la acción correspondiente.

    Si continúa con el contrato, la cubierta continuará en vigor por un período que no excederá de un año para licencias bajo la Ley Núm. 95, o por un periodo que no excederá de 12 semanas en los casos de licencias bajo la Ley de Licencia Familiar y Médica de 1993, (Public Law 103-3), y tendrá derecho al pago de la aportación patronal correspondiente por el referido periodo. Si el funcionario se reintegra al servicio público luego de terminada

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la licencia y no está acogido a un plan médico, tendrá 60 días siguientes a la fecha de su reingreso para solicitar ingreso a uno de los planes médicos contratados por el Secretario de Hacienda.

Cuando un empleado suscrito a un plan de beneficios de salud se acoge a una licencia sin sueldo y determina continuar con el contrato de seguro, tendrá derecho al pago de la aportación patronal por un período que no excederá de 12 meses, siempre y cuando se reintegre al servicio público al finalizar dicho período. Si al cumplirse el año desde la fecha en que se le concede la licencia sin sueldo, el empleado no se ha reintegrado a sus labores, habiendo disfrutado del pago de la aportación del Gobierno al plan de beneficios de salud, vendrá obligado a reembolsar dicha cantidad a su agencia. Sin embargo, el Secretario de Hacienda podrá excluir de la obligación de reembolsar las aportaciones mencionadas, a todo aquel empleado que se acoja a los beneficios del retiro por una condición de salud.

Cuando un militar suscrito a un plan de beneficios de salud se acoge a una licencia militar sin sueldo y determina continuar con el contrato de seguros, deberá notificarle a la entidad aseguradora y a la Oficina de Recursos Humanos de su agencia. La licencia militar sin sueldo es hasta que la persona regrese y no tiene que devolver la aportación patronal siempre y cuando sea activado para una necesidad específica.

12. Los funcionarios tramitarán por escrito cualquier reclamación por errores en descuentos directamente a la entidad aseguradora u organización de empleados dentro de los 30 días siguientes de haber recibido el talonario o alguna notificación de cobro.

13. En los casos de renuncia del cónyuge del asegurado principal en un plan mancomunado, se procederá igual que en los casos de destitución.

14. Si durante la vigencia del contrato, el funcionario o sus dependientes son elegibles para ingresar a otro plan médico, podrá solicitar la baja del plan contratado por el Secretario de Hacienda. En estos casos, la cancelación tendrá efectividad el día primero del mes siguiente si se somete antes del día 10. Si la solicitud de baja se efectúa después del día 10, la cancelación tendrá efectividad el día primero del mes subsiguiente al que se someta la solicitud.

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15. Los funcionarios que se acojan a un plan médico auspiciado por una organización de empleados públicos deberán canalizar su solicitud de ingreso directamente a la organización que corresponda.

16. Las reclamaciones de servicios se tramitarán por escrito directamente a la entidad aseguradora u organización de empleados correspondiente, dentro de los 60 días siguientes de haber recibido algún servicio cubierto por la póliza.

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ESTADO LIBRE ASOCIADO DE PUERTO RICO

ASES

Carta Circular
Núm. 10-10-06-Enmendada

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Año Fiscal 2010-2011
2 de noviembre de 2010

A los Secretarios, Directores de Dependencias y Alcaldes del Estado Libre Asociado de Puerto Rico

Asunto: Servicios Médicos Contratados para el Año 2011

Esta carta tiene el propósito de enmendar la Carta Circular 10-10-06 del 6 de octubre de 2010. La referida carta seguirá en vigencia, excepto por las correcciones que se detallan a continuación en este comunicado.

Los cambios vienen como consecuencia de los cambios que sufre el calendario de trabajo para este año debido a la decisión de la ASES de extender el contrato existente hasta febrero 28 de 2011. Esto como medida para negociar de manera prudente tarifas y beneficios que hagan justicia al empleado público.

Las enmiendas son las siguientes:

- La fecha estipulada en el punto1 de la página 1 debe leer: "no más tarde del 28 de enero de 2011 con acuse de recibo."
- La fecha contenida en el punto 4 de la página 2 debe leer: "hasta las 2:30 pm del 2 de febrero de 2011. Esta información también puede ser sometida por adelantado, a través de correo electrónico, con atención a la Sra. Carmen García Ramos (cgr8346@hacienda.gobierno.pr), siempre y cuando el archivo no sea mayor de 2 MB en formato TXT. Esto no exime de que se entregue de manera física en la fecha antes estipulada."
- La fecha contenida en el punto 6 de la página 2 debe leer: "...para la primera quincena del mes de marzo de 2011, los solicitarán por escrito a ATI, antes del cierre para procesar los mismos. Las agencias tendrán hasta las 4:00 pm del 21 de enero de 2011 para someter su solicitud y autorización parta que ATI procese sus cambios automáticamente."
- La fecha en el punto 8 página 3 debe leer: "hasta el 5 de marzo de 2011"
- La fecha en el primer párrafo de la página 7 (Programas Advantage para pensionados) debe leer: "...del 1 de marzo de 2011 al 31 de diciembre de 2011."
- La fecha contenida en el punto 1 del anejo 1 debe leer: "no más tarde del 28 de enero de 2011, para garantizar la efectividad al 1 de marzo de 2011."
- La fecha en el punto 8 de la página 2 del anejo 1 debe leer: "Después del 28 de enero de 2011 no se tramitará solicitud de ingreso alguna..."

PO Box 195661, San Juan, P.R. 00919-5661 Tel. (787) 474-3300 Fax (787) 474-3346

- La fecha en el inciso c punto 8 de la página 2 del anejo 1 debe leer: "...que luego del 28 de enero se acoja a los beneficios de retiro..."

Además de los cambios ya establecidos, se incluye el nuevo calendario de trabajo establecido para los trámites de la suscripción al amparo de la Ley 95. Recordamos que este calendario también aplica a la Ley 63 del 21 de junio de 2010 y la Ley 158 del 10 de agosto de 2006.

Actividad	Fecha
Fecha de orientación y selección de planes	13 de diciembre de 2010 a enero 28 2011
Fecha límite de entrega de solicitudes a las agencias	enero 31, 2010
Fecha límite para entrega de cintas a ATI	Febrero 2, 2011. Debe ser en o antes de las 2:30pm. Esta información también puede ser sometida por adelantado, a través de correo electrónico, con atención a la Sra. Carmen García Ramos (cgr8346@hacienda.gobierno.pr), siempre y cuando el archivo no sea mayor de 2 MB en formato TXT. Esto no exime que se entregue de manera física en la fecha antes estipulada.
Emisión de nuevas tarjetas con los cambios de cubierta que apliquen	Febrero 15 de 2011
Vigencia del plan	Marzo 1 a Diciembre 31, 2011

Es responsabilidad de las agencias hacer llegar las disposiciones de esta Carta Circular a cada uno de su personal, especialmente a los de la Oficina de Recursos Humanos encargados de los planes médicos.

Se está coordinando una orientación general para todas las agencias y municipios para el 15 de diciembre de 2010 en el auditorio de la Lotería de Puerto Rico. Tan pronto se confirme la disponibilidad del local se estará confirmando la misma.

Cordialmente,

Domingo Nevárez Ramírez, MHSA
Director Ejecutivo de ASES

Carlos Guzmán
Representante de Servicios

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ADMINISTRACION DE SEGUROS DE SALUD
ESTADO LIBRE ASOCIADO DE PUERTO RICO

13 de febrero de 2004

A TODAS LAS ASEGURADORAS, COMPAÑIAS DE SERVICIOS DE SALUD MENTAL, ADMINISTRADOR DE SERVICIOS DE CONTRATACION DIRECTA, GRUPOS MEDICOS DEL DEMOSTRATIVO DE CONTRATACIÓN DIRECTA, CENTROS PRIMARIOS, ASOCIACIONES DE PRÁCTICA INDEPENDIENTE Y PROVEEDORES PARTICIPANTES DEL SEGURO DE SALUD DEL ESTADO LIBRE ASOCIADO DE PUERTO RICO

Lcdo. Enrique A. Vicéns Rivera
Director Ejecutivo

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Carta Normativa Núm. 04-0130

PAGO DE RECLAMACIONES EN SALAS DE EMERGENCIAS POR SERVICIOS DE SALUD FISICA Y MENTAL EN HOSPITALES MEDICO-QUIRURGICOS

Durante el transcurso del año fiscal 2003 y del corriente, la Administración de Seguros de Salud ("ASES") ha recibido una cantidad significativa de quejas provenientes de instituciones hospitalarias medico-quirúrgicas. En particular, dichas instituciones nos preguntan cuál es la entidad responsable del pago de reclamaciones por servicios rendidos en salas de emergencias de dichas instituciones cuando se hacen procedimientos físicos para estabilizar un beneficiario de salud mental o cuando se realizan exámenes y pruebas físicas de diagnóstico pero el diagnóstico final resulta ser uno cubierto por las compañías de servicios de salud mental ("MBHOs").

En aras de aclarar la confusión existente al respecto, esta Carta Normativa dispone la interpretación de la ASES al respecto, la cual ha sido comunicada anteriormente a "MBHOs" y Aseguradoras:

> Cuando un beneficiario es admitido en un hospital médico-quirúrgico o reciba servicios en salas de emergencias de dichos hospitales, las aseguradoras tramitarán el pago del fondo correspondiente por todo procedimiento físico que razonablemente se pueda realizar para estabilizar a un beneficiario independientemente de que el diagnóstico final sea uno de salud mental. Igualmente, las aseguradoras serán responsables de tramitar el pago del fondo correspondiente por exámenes y pruebas físicas de diagnóstico que razonablemente se puedan realizar a base de los síntomas con los que se presenta un beneficiario conforme a la definición de condición de emergencia medica en los contratos, la cual establece la

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reglamentación federal. Por ejemplo, es responsabilidad de la aseguradora pagar a proveedores por reclamaciones de lavado de estómago o suturarle las muñecas a un beneficiario con intento suicida. Simultáneamente, se tiene que contactar al "MBHO" de acuerdo a su protocolo para la consulta psiquiátrica y correspondiente referido.

De necesitarse una consulta o evaluación psiquiátrica, el hospital médico-quirúrgico o su sala de emergencia coordinará la misma utilizando los protocolos del "MBHO" y la Hoja Uniforme de Referido Para Servicios de Salud Mental. El "MBHO" será responsable solamente por el ofrecimiento de aquellos servicios de salud mental, servicios relacionados al tratamiento de alcoholismo y/o dependencia de sustancias controladas, los cuales excluyen procedimientos de estabilización física o de diagnóstico en dichas instituciones.

Conforme al contrato entre la ASES y los "MBHO's", estos tendrán disponibles psiquiatras con privilegios en hospitales médico-quirúrgicos, los cuales atenderán las consultas de beneficiarios admitidos en dichos hospitales. Si al momento de requerirse el servicio de salud mental en la unidad hospitalaria, el "MBHO" no tiene médicos disponibles, el beneficiario podrá recibir tratamiento para su condición por parte de los facultativos psiquiátricos coordinados a través del hospital y que cumplan con los requisitos de credenciales (usuales) para ese tipo de proveedor. Esto hasta que el paciente pueda ser transferido a una institución psiquiátrica, previa autorización del "MBHO". Es importante señalar que en estos casos aplicará la siguiente exclusión contemplada en nuestro acuerdo contractual (ASES y los "MBHO's"):

- Servicios ordenados y/o prestados por proveedores no participantes de servicios de salud mental, excepto en casos de real y comprobada emergencia o mediante previa autorización de la compañía de servicios de salud mental ("MBHO").

Para efectos de pago, el "MBHO" verificará las credenciales usuales del facultativo y compensará a éste por una cantidad que no será menor a la contratada con los proveedores del "MBHO" para ofrecer los servicios de consulta psiquiátrica en hospitales medico-quirúrgicos. En caso de que el paciénte sea beneficiario de Medicare y el Seguro de Salud, el reembolso al facultativo se efectuará de acuerdo al contrato con la ASES.

ESTADO LIBRE ASOCIADO DE PUERTO RICO

OFICINA DEL COMISIONADO DE SEGUROS

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
12-037

21 de febrero de 1991

CARTA NORMATIVA CA-I-2-1232-91

A TODAS LAS ORGANIZACIONES DE SERVICIOS DE SALUD
Y SUS PROVEEDORES

ASUNTO: Contratación Per Capita

Señores:

Mediante Carta Circular Núm. E-2-917-83 del 10 de febrero de 1983, esta Oficina prohibió a las distintas organizaciones de servicios de salud la contratación de proveedores de servicios de salud sobre una base per capita y/o de cantidades fijas.

La llamada base per capita, representa el pago fijo de determinada cantidad de dinero por suscritor hecho por la organización al proveedor, no importa que dicho suscritor utilice o no los servicios prestados por el proveedor.

Hemos reexaminado dicho concepto a la luz de las disposiciones del Código de Seguros de Puerto Rico y encontramos que una transferencia absoluta de riesgo bajo los términos más liberales que podría permitir un contrato per capita, constituye el ofrecimiento de un plan de cuidado de salud por parte de un proveedor de servicios, quien generalmente no está autorizado por esta Oficina a realizar tales negocios.

No obstante lo anterior, dentro de ciertas limitaciones se puede llevar a cabo un tipo de contratación per capita por parte del proveedor de servicios médicos, que no constituya negocio de seguros.

Las características esenciales de un contrato como el mencionado, son las siguientes: la organización de servicios de salud retiene la responsabilidad primaria hacia el suscritor y la transferencia del riesgo económico se hace en forma prudente y razonable, basada en la experiencia real de la utilización de los servicios. Debe proveer, además, las garantías necesarias de calidad y suficiencia en la prestación de los servicios.

A tales efectos esta Oficina permitirá contratación sobre bases fijas o per capita, siempre que se cumpla con las siguientes condiciones:

1) La Organización de servicios de salud podrá contratar en forma per capita aquellos servicios donde por su localización geográfica o área de servicio, no pueda contar con facilidades propias.

2) La Organización de servicios de salud podrá contratar con cualquier grupo médico-hospitalario, hospital, asegurador o corporación de servicios médicos, debidamente acreditados, la provisión de aquellos servicios que aparecen en su evidencia de cubierta en armonía con la capacidad y a tenor con las limitaciones de dicho proveedor para facilitar sus servicios. Todo contrato per capita prohibirá al proveedor que a su vez subcontrate en forma per capita.

3) El contrato per capita o sobre bases fijas requerirá al proveedor que suministre a la organización de servicios de salud datos estadísticos sobre la utilización, costos, días-pacientes, estadía promedio, etc., y facultará a ésta a velar razonablemente por la calidad de los servicios prestados a sus suscritores. La organización de servicios de salud tendrá derecho al acceso de los libros del proveedor con el propósito de auditar los mismos, en lo que respecta a la contratación entre ambos y tomará las providencias necesarias para corregir aquellos defectos o faltas relacionadas que encuentre al proveedor con lo contratado. El proveedor suministrará a la organización sus estados financieros anuales y cualquier información razonable y necesaria sobre costos y utilización.

4) El contrato per capita deberá requerir al proveedor que mantenga récords de todos los suscritores a los cuales presta servicios, clasificados éstos por cada organización de servicios de salud a las que provee servicios. Dicha información estará accesible a las organizaciones de servicios de salud y a cualquier instrumentalidad pública. El proveedor conservará dichos récords por el período que la organización de servicios de salud le requiera mediante el contrato, pero en ningún caso será por menos de cinco (5) años.

5) El proveedor será responsable y deberá tener la capacidad de prestar los servicios de cuidado de salud por un período no menor de 30 días en caso de que la organización se liquide, esté pendiente de liquidación o en un procedimiento de cobro.

6) Toda organización de servicios de salud someterá a la Oficina del Comisionado de Seguros copia de cada contrato para evaluación y aprobación tipo per capita o sobre bases fijas que

desee otorgar, con no menos de 60 días previo al otorgamiento del mismo, (incluyendo el pago de derechos por $250 pagaderos a nombre del Secretario de Hacienda) disponiéndose que el incumplimiento de esta directriz conllevará las sanciones que procedan conforme a lo establecido por las disposiciones del Código de Seguros de Puerto Rico.

Con el propósito de determinar si se está cumpliendo con las disposiciones del Código de Seguros de Puerto Rico y de esta carta normativa, esta Oficina evaluará el cumplimiento de los requisitos de esta carta dentro de sesenta (60) días contados a partir de la fecha en que se someta. Para llevar a cabo dicha evaluación, tanto el proveedor como la organización de servicios de salud, suministrarán información sobre las facilidades del proveedor, los servicios que ofrecerá su personal y la relación de costos por los últimos 2 años, así como cualquier otra información que esta Oficina le requiera.

7) El contrato per capita entre la Organización y el proveedor se formalizará por escrito y su duración no podrá ser por más de un (1) año. Contendrá, entre otras, las siguientes cláusulas y condiciones:

a) Una declaración sobre cuál es la capacidad del proveedor en términos de horas-pacientes, días-camas y otra unidad similar y que dicha capacidad esté acorde con la utilización esperada para el número de suscritores per capita que cubrirá el contrato.

b) La organización de servicios de salud someterá anualmente a esta Oficina, en o antes del 31 de marzo, un informe comparativo sobre la experiencia en la contratación per capita.

c) El contrato per capita deberá tener como mínimo 50 suscritores, sin exceder las capacidades del proveedor.

d) El proveedor habrá de rendir un servicio médico de excelencia, a la par con las normas de la tecnología médica en esta jurisdicción. La organización atenderá todas las querellas o quejas por la falta de servicios, incompetencia, mala calidad en el servicio y cualquier otra queja relacionada con la prestación de servicios que presenten los suscritores.

e) El proveedor se comprometerá a hacer accesible a esta Oficina datos estadísticos sobre la utilización, los costos, la estadía promedio de pacientes, los servicios a los suscritores, el personal, los estados financieros anuales, sus libros en lo que respecta a la contratación con la

organización y cualquier información razonable y necesaria sobre costos y utilización de servicios.

8) En el contrato per capita, la tasa per capita no será menor de la cantidad actuarialmente necesaria para cubrir el costo del servicio médico.

9) La contratación per capita no menoscabará la obligación de la organización para con el suscritor. El incumplimiento del proveedor será considerado como un incumplimiento de la organización.

10) La resolución o terminación de un contrato per capita sólo será efectiva mediante la notificación de un aviso escrito por cualquiera de las partes, con no menos de treinta (30) días de anticipación a la fecha de efectividad.

11) El proveedor per capita no podrá hacer mercadeo, suscripción o administración del plan de cuidado de salud a nombre de la organización de servicios de salud.

Se requiere, por la presente, estricto cumplimiento con lo dispuesto en esta carta normativa, la cual entrará en vigor de inmediato. Las organizaciones de servicios de salud tendrán hasta el 30 de junio de 1991, para finalizar cualquier acuerdo vigente que no esté conforme a lo aquí expresado y someterán evidencia al Comisionado de Seguros en o antes del 30 de agosto de 1991 del cumplimiento requerido por esta carta.

Cada organización de servicios de salud deberá presentar anualmente al Comisionado de Seguros, en o antes del 31 de marzo, un informe certificado y juramentado por el presidente de ésta. Dicho informe contendrá:

1. El nombre y la dirección de todos los proveedores per capita.

2. Un estado de costos y de ingresos de los contratos per capita.

3. Un estado de altas o bajas de suscritores y su utilización por cada contrato per capita.

4. Un estado de reclamaciones por pagar reportadas y no reportadas del proveedor per capita.

El archivo de este informe conlleva el pago de derechos por $50 pagaderos a nombre del Secretario de Hacienda.

De tener cualquier duda sobre el contenido de esta carta normativa, deberá comunicarse con esta Oficina de inmediato.

Atentamente,

Miguel A. Villafañe Neriz
Comisionado de Seguros

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
12-037

Departamento de Salud

21 JAN 2009

23 de diciembre de 2008

Lcda. Minerva Rivera
Directora Ejecutiva ASES

Johnny V. Rullán, MD.,FACPM
Secretario de Salud

LISTADO DE DIAGNÓSTICO DE NIÑOS CON NECESIDADES ESPECIALES DE SALUD (NNES)

El listado de Diagnósticos de Niños con Necesidades Especiales de Salud fue revisado respondiendo a su petición.

Es necesario señalar que en principio este listado fue provisto a ASES como una guía; por tanto, es importante que no se excluya de los beneficios de la cubierta de la Tarjeta de Salud del Gobierno de Puerto Rico a un niño que presente alguna condición que no esté en el listado. Si el niño cumple con la definición de Niños con Necesidades Especiales de Salud del Negociado para la Salud Materno Infantil, deberá recibir los servicios aún antes de que se establezca un diagnóstico.

Sometemos además nuestras recomendaciones para la identificación, diagnóstico y tratamiento de los niños y jóvenes con necesidades especiales de salud a manera de asegurar el acceso a los servicios que esta población necesita. Éstas tienen el propósito de asegurar unos servicios uniformes para todos los niños con necesidades especiales de salud sin importar la aseguradora.

Gracias por su atención a este asunto.

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
12-037

Listado de Diagnóstico de NNES
d/varios 2008-06

RECIBIDO
OFICINA DIRECTOR EJECUTIVO
ASES
2009 JAN 21 P 2:44

NIÑOS CON NECESIDADES ESPECIALES DE SALUD

DEFINICIÓN:

Niños que tienen o se encuentran en mayor riesgo de desarrollar una condición crónica física, de conducta, emocional o del desarrollo, que también necesitan servicios de salud y otros servicios relacionados de un tipo o en una cantidad que va más allá de lo que los niños necesitan por lo general.

ESTANDAR DE NECESIDAD MÉDICA ESPECÍFICO PARA NIÑOS

- Servicios médicamente necesarios son aquellos necesarios para la prevención y el mantenimiento de la salud o para el diagnóstico y tratamiento de una condición física o mental, o si fueran necesarios para prevenir el deterioro de esa condición o para promover el desarrollo o el mantenimiento del funcionamiento apropiado para la edad.

CUBIERTA ESPECIAL NNES

En la "Cubierta Especial" las Aseguradoras, con quien ASES contrata los servicios, asumen el riesgo de los servicios para las condiciones clasificadas con Diagnósticos de Condiciones de Niños con Necesidades Especiales. (Ver lista diagnósticos ASES)

En esta lista de condiciones se incluyen los diagnósticos más frecuentes, pero no limita o excluye otras condiciones que cumplan con la definición. Con este propósito se debe utilizar un instrumento de cernimiento (ver "Screener") para determinar su aplicabilidad.

Es responsabilidad del médico primario solicitar la cubierta, y registrar al asegurado utilizando el formulario correspondiente para Niños con Necesidades Especiales de Salud que se encuentra en el Manual del Proveedor. También el proceso de certificación puede ser iniciado por uno de los Centros Pediátricos del Departamento de Salud.

Para poder evaluar y certificar estos casos es necesario que se incluya junto al formulario la información necesaria: Ej

- Resumen de caso: Historial y físico actualizado
- Evaluaciones y consultas de especialistas.
- Resultados de procedimientos y pruebas diagnósticas
- Resultados de pruebas de laboratorio diagnósticas.
- Plan de seguimiento necesario.
- Plan de tratamiento

Esta información y el formulario de registro deben ser enviadas al Programa de Manejo de Casos (PMC) de la Aseguradora. El PMC evaluará la solicitud de certificación y la información documental incluida. Cada caso se evalúa individualmente por el Manejador de casos y consultando al equipo asesor del Programa. Esto dependerá de la cubierta negociada. El acuerdo con las aseguradoras debe ser uniforme y que obligue igual a todas las compañías.

Se le notifica directamente por carta a la familia y al médico primario si la solicitud para la inclusión de su paciente en el registro NNE ha sido aceptada o denegada; o si falta información para la consideración del caso. El médico y/o la familia podrá apelar por escrito cualquier decisión de denegación, con la información adicional necesaria.

ICD 9	Índice por Diagnóstico y Condición
	Desórdenes Metabólicos
270	**Desórdenes de metabolismo de amino-ácidos aromáticos**
270.0	Desórdenes de transporte de amino-ácidos
270.0	Cistinosis
270.0	Cistinuria
270.0	Fanconi
270.0	Hartnup's
270.0	Lowe's
270.1	Phenilketonuria (PKU)
270.2	Desórdenes de metabolismo de tirosina
270.2	Alcaptonuria
270.2	Hipertirosinemia
270.2	Ocronosis
270.2	Tirosinosis
270.2	Tirosinuria
270.2	Albinismo
270.3	Enfermedad de Maple-Syrup
270.3	Otros desórdenes de metabolismo de amino-ácidos en cadena
270.3	Hiperleucina-isoleucinemia
270.3	Hipervalinemia
270.3	Acidemia isovalérica
270.3	Acidemia metilmalónica
270.3	Acidemia propiónica
270.4	Desórdenes de metabolismo de amino-ácidos con sulfuro
270.4	Homocistinuria
270.4	Methionina
270.4	Deficiencia de oxidasa de sulfito
270.4	Homocistina cistationina
270.5	Otros desórdenes de metabolismo de amino-ácidos aromáticos.
270.5	Desorden de:
270.5	Metabolismo de histidina
270.5	Metabolismo de Triptófano
270.5	Desórdenes de metabolismo de amino-ácidos en cadena y ácido graso
270.6	Desórdenes de metabolismo del ciclo de urea Citrulinemia
270.6	Hiperamonemia
270.6	Ácido arginosuccinico
270.7	Desórdenes de metabolismo de lisina e hidroxilisina
270.7	Aciduria glutárica
270.7	Hidroxilisinemia
270.7	Hiperlisinemia
270.7	Desórdenes de metabolismo de glicina
270.7	Hiperglicinemia no cetósica
270.8	Desórdenes de metabolismo deornitina
270.8	Ornitinemia tipo I, II
270.8	Hiperhidroxiprolinemia
270.8	Hiperprolinemia tipos I, II
270.8	Sarcosinemia
270.8	Otros desórdenes específicos de metabolismo de amino-ácido
270.9	Otros desórdenes no específicos del metabolismo y transporte de amino-ácidos
271	**Desórdenes del transporte y metabolismo de carbohidratos**
271.0	Glicogenosis
271.0	Amilopectinosis
271.0	Deficiencia de glucosa-6-fosfatasa
271.0	Glicogenosis cardiaca

ICD 9	Índice por Diagnóstico y Condición
271.0	Enfermedad:
271.0	Andersen
271.0	Cori
271.0	Forbes
271.0	Hers
271.0	McArdle
271.0	Pompe
271.0	Tauri
271.0	Von Gierke
271.0	Deficiencia de fosforilasa hepática
271.1	Desorden de metabolismo de galactosa Galactosemia
271.2	Desorden de metabolismo de fructosa, Fructosemia
271.3	Intolerancia a lactosa
271.3	Otros desórdenes de absorción intestinal de carbohidratos
271.4	Otros desórdenes especifico de metabolismo de carbohidratos Pentosuria, Glicosuria renal
271.8	Desorden de metabolismo de piruvato y gluconeogénesis
271.8	Defectos en degradación de glicoproteina
271.9	Desorden no específico del transporte y metabolismo de carbohidratos
272	**Desórdenes del metabolismo de lipoides**
272.0	Hipercolesterolemia
272	Gangliosidosis
272.0	Hipercolesterolemia
272.1	Hiperglicerinemia
272.4	Otras hiperlipidemias no específicas
272.7	Otras ganglosidosis
272.7	Lipidosis
272.7	Anderson's
272.7	Fabry's
272.7	Gaucher's
272.7	Krabbe
272.7	Neimman-Pick
272.7	Faber's
272.7	Leukodistrofia metacromática
272.7	Mucopolisacaridosis, tipo I
272.7	Hurler's
272.7	Hurler-Scheie
272.7	Scheie
272.7	Mucopolisacaridosis, tipo II
272.7	Hunter's
272.7	Otros mucopolisacaridosis
272.7	Maroteaux-Lamy
272.7	Morquio's
272.7	Sanfilippo
273	Desórdenes de metabolismo de proteína de plasma
274.9	Gota inespecífica
275	**Desórdenes del metabolismo de minerales**
275.0	Desórdenes de metabolismo de hierro
275.1	Desórdenes de metabolismo de cobre
275.1	Wilson's
275.2	Desórdenes de metabolismo de magnesio
275.3	Desórdenes de metabolismo de fósforo
275.4	Desórdenes de metabolismo de calcio
275.9	otros Desórdenes del metabolismo de minerales
276.2	Acidosis Láctica
277	**Otros desórdenes del metabolismo**
277.00	Fibrosis Quistica

ICD_9	Índice por Diagnóstico y Condición
277.1	Desórdenes de metabolismo de purina y pirimidina
277.1	Porfiria eritropoiética hereditaria
277.2	Otros desórdenes de metabolismo de purina y pirimidina
277.2	Lesch-Nyhan
277.2	Xantinuria hereditaria
277.3	Amiloidosis
277.4	Gilbert's
277.4	Crigler-Najjar
277.4	Otros desórdenes de metabolismo de bilirrubina
277.4	Dubin-Johnson
277.4	Rotor's
277.6	Deficiencia antitripsina alpha-1
277.8	Otros desórdenes específicos del metabolismo
277.81	Deficiencia primaria de carnitina
277.82	Deficiencia de carnitina
277.85	Desórdenes de la oxidación de ácidos grasos
277.85	CPT1, CPT2, LCHAD, VLHAD, MCAD, SCAD
277.87	Desórdenes del metabolismo mitocondrial
277.89	Otros desórdenes específicos del metabolismo
277.89	Hans Schuller Christian, Histiocitosis, Histiocitosis
277.9	Otros desórdenes del metabolismo no específicos
	Enfermedades Hereditarias y degenerativas del Sistema Nervioso
330	Degeneración cerebral
330.0	Esfingolipidosis (Leucodistrofia)
330.1	Lipidosis cerebral
330.8	Otras degeneraciones cerebrales
330.8	Alper's
330.8	Leigh's
330.8	Encefalopatia necrotizante sub-aguda
331.4	Hidrocefalia obstructiva, adquirida
333.1	Temblor esenciales
333.2	Myoclonus
333.4	Huntington's chorea
334.0	Enfermedad espinocerebelar
334.0	Ataxia Hereditaria
334.0	Ataxia de Friedreich's
334.1	Paraplegia espástica hereditaria
334.2	Degeneración cerebelar primaria
334.2	Marie's
334.2	Sanger's-Brown
334.8	Ataxia-telangectacia
335	**Atrofia muscular espinal y síndromes afines**
335.0	Atrofia muscular espinal infantil, tipo I (Werdnig-Hoffman)
335.1	Otras atrofias musculares espinales hereditarias
335.10	Atrofia muscular espinal:
335.10	Infantil, tipo II
335.11	Juvenil, tipo II (Kugelberg-Welander)
340	Esclerosis múltiple
341	Otras enfermedades demielinizantes del sistema nervioso central
341.0	Neuromielitis óptica
341.1	Esclerosis difusa
341.1	Encefalitis periaxial
341.1	Enfermedad de Schilder
341.8	Otras enfermedades demielinizantes del sistema nervioso central
341.8	Demielinización central del cuerpo calloso
341.8	Mielinólisis central pontina

ICD_9	Índice por Diagnóstico y Condición
341.8	Mielitis transversa aguda en enfermedad desmielinizante del sistema nervioso central
341.8	Mielitis necrotizante subaguda
341.9	Enfermedades demielinizantes no específicas del sistema nervioso central
345	**Epilepsia**
345	Epilepsia generalizada sin convulsiones
345.1	Epilepsia generalizada con convulsiones
345.1	• clónicos
345.1	• mioclonicos
345.1	• tónicos
345.1	• tónico-clónicos
345.1	Síndrome de Lennox-Gastaut
345.2	Estado de pequeño mal epiléptico
345.3	Estado de gran mal epiléptico
345.3	Estado epiléptico tónico-clónico
345.4	Epilepsia parcial, con pérdida de conocimiento
345.4	Estado de ausencia epiléptica
345.4	Estado de mal epiléptico parcial complejo
345.5	Epilepsia parcial , sin pérdida conocimiento
345.6	Ataques de Salaam
345.6	Espasmos infantiles
345.7	Epilepsia parcial continua [Kozhevnikof]
345.8	Otros estados epilépticos
345.9	Estado de mal epiléptico de tipo no especificado
342.0	Hemiplejia flácida
342.1	Hemiplejia espástica
342.3	Monoplejia infantil
342.9	Hemiplejia, no especificada
343	**Parálisis cerebral infantil**
343.0	Diplejía espástica
343.1	Hemiplejia, congénita
343.2	Cuadriplejía, no especificada
343.4	Hemiplejia infantil
343.8	Parálisis (cerebral) espástica congénita
343.9	Parálisis cerebral infantil no específica
344	Otros síndromes de parálisis espástica infantil, no congénita
356	Neuropatía hereditaria motora y sensorial
356.0	Neuropatías hereditarias idiopáticas
356.0	Enfermedad de Dejerine-Sottas
356.1	Atrofia muscular peroneal, enfermedad de Charcot-Marie-Tooth
356.2	Neuropatía hereditaria sensorial, tipos I-IV
356.8	Síndrome de Roussy Levy
348	**Otras condiciones del cerebro**
348.0	Quistes cerebrales
348.30	Encefalopatía sin especificar
356.3	Enfermedad de Refsum
356.3	Neuropatía asociada con ataxia hereditaria
356.4	Neuropatía progresiva idiopática
356.8	Otras neuropatías hereditarias e idiopáticas
356.9	Neuropatía hereditaria e idiopática, sin otra especificación
357	Polineuropatía inflamatoria
357.0	Síndrome de Guillain-Barre
357.0	Polineuritis (post) infecciosa aguda
359	**Distrofia muscular y otras miopatías**
359.0	Distrofia muscular congénita hereditaria
359.1	Distrofia muscular hereditaria progresiva
359.1	• autosómica recesiva, tipo infantil, semejante a Duchenne o Becker

ICD_9	Índice por Diagnóstico y Condición
359.1	• benigna [Becker]
359.1	• cintura-pélvica
359.1	• distal
359.1	• escapuloperoneal
359.1	• escapuloperoneal benigna con contracturas precoces [Emery-Dreituss]
359.1	• fascioescapulohumeral
359.1	• grave [Duchenne]
359.1	• ocular
359.1	• oculofaríngea
359.2	**Desórdenes motónicos**
359.2	Distrofia miotónica [Steinert]
359.2	Miotonia congénita:
359.2	• dominante [Thomsen]
359.2	• recesiva [Becker]
359.9	Miopatías , sin especificar
	Desórdenes Músculo Esqueletales
723.5	Tortícolis, no específica
732.1	Osteocondritis juvenil de pelvis y cadera
732.1	Coxa plana
732.1	Legg-Calve-Perthes
732.1	Enfermedad de Scheuermann
732.4	Osteocondritis juvenil de la tibia y del peroné
732.4	Proximal de la tibia (Blount)
732.4	Tuberosidad de la tibia (Osgood-Schlatter)
732.4	Tibia vara
736.7	Otras deformidades adquiridas de los miembros
736.71	Deformidad "equinovarus" adquirida
736.79	Otras deformidades equina del pie, adquirida
737	**Curvatura de espina**
737.1	Cifosis adquirida
737.2	Lordosis adquirida
737.3	Escoliosis, idiopática
754.1	Tortícolis del músculo esternocleidomastoideo
	Anomalías Congénitas
	Anomalías congénitas del sistema nervioso
740.0	Anencefalia
740.1	Craneorraquisquisis
740.2	Iniencefalia
741	**Espina bífida**
741.00	Espina bífida con hidrocefalia, región no específica
741.01	Espina bífida con hidrocefalia, región cervical
741.02	Espina bífida con hidrocefalia, dorsal (toráxico)
741.03	Espina bífida con hidrocefalia, región lumbar
741.9	Espina bífida, no especificado
741.91	Espina bífida sin mencionar hidrocefalia, región cervical
741.92	Espina bífida sin hidrocefalia, región dorsal (toráxico)
74193	Espina bífida sin hidrocefalia, región lumbar
742.0	Encefalocele
742.1	Microcefalia
742.2	Malformaciones congénitas del cuerpo calloso
742.2	Agenesia del cuerpo calloso
742.2	Arrinencefalia
742.2	Holoprosencefalia
742.2	Otras anomalías hipoplásicas del encéfalo: Agenesia, hipoplasia, Lisencefalia...

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742.3	Hidrocefalia congénita
742.3	Malformaciones del acueducto de Silvio: Anomalía, estenosis , obstrucción
742.4	Otras malformaciones congénitas del encéfalo
742.4	Megalencefalia
742.4	Quistes cerebrales congénitos:
742.4	Esquicencefalia
742.4	Porencefalia
742.4	Macrogiria
742.51	Diastematomielia
742.53	Hydromielia
742.59	Otras anomalías congénitas del cordón espinal
742.8	Otras anomalías congénitas del cordón espinal, específicas
742.8	Otras anomalías congénitas del sistema nervioso
742.8	Síndrome de Arnold-Chiari
742.9	Anomalías congénitas del cerebro, cordón espinal y sistema nervioso, no específicas
743	**Malformaciones congénitas del ojo, del oído, de la cara y del cuello**
743	Anoftalmia, microftalmia y macroftalmia
743.03	Globo ocular quístico
743.1	Microftalmia
743.2	Buftalmos, glaucoma congénito
743.2	Glaucoma congénito
743.3	Malformaciones congénitas del cristalino
743.3	Catarata congénita
743.35	Afaquia congénita
743.36	Otras malformaciones congénitas del cristalino
743.37	Desplazamiento congénito del cristalino
743.39	Coloboma del cristalino
743.4	Malformaciones congénitas del segmento anterior del ojo
743.41	Anomalía del tamaño y forma de la cornea
743.42	Opacidad corneal congénita
743.43	Otras malformaciones congénitas de la cornea
743.44	Otras malformaciones congénitas del segmento anterior del ojo
743.44	Anomalía de Rieger
743.45	Ausencia del iris, Aniridia
743.46	Coloboma del iris
743.46	Otras malformaciones congénitas del iris
743.47	Esclerótica azul
743.48	Malformación congénita del segmento anterior del ojo, no especificada
743.51	Malformaciones congénitas del segmento posterior del ojo
743.51	Malformación congénita del humor vítreo
743.52	Otras malformaciones congénitas del segmento posterior del ojo
743.52	Coloboma del fondo del ojo
743.53	Malformación congénita de la coroides
743.56	Malformación congénita de la retina
743.57	Malformación congénita del disco óptico
743.57	Coloboma del disco óptico
743.59	Malformación congénita del segmento posterior del ojo, no especificada
743.6	Malformaciones congénitas de los párpados, del aparato lagrimal y de la orbita
743.61	Blefaroptosis congénita
743.62	Ectropion congénito
743.62	Entropion congénito
743.62	Otras malformaciones congénitas de los párpados
743.64	Ausencia y agenesia del aparato lagrimal
743.65	Estenosis y estrechez congénitas del conducto lagrimal
743.65	Otras malformaciones congénitas del aparato lagrimal
743.66	Malformación congénita de la orbita

ICD 9	Índice por Diagnóstico y Condición
743.8	Otras malformaciones congénitas del ojo, especificadas
743.9	Malformaciones congénitas del ojo, no especificadas
744	**Malformaciones congénitas del oído que causan alteración de la audición**
744.01	Ausencia congénita del pabellón (de la oreja)
744.02	Ausencia congénita, atresia o estrechez del conducto auditivo (externo)
744.03	Otras malformaciones congénitas del oído medio
744.04	Malformación congénita de los huesecillos del oído
744.04	Fusión de los huesecillos del oído
744.05	Malformación congénita del oído interno
744.09	Ausencia congénita del oído SAI
744.09	Ausencia congénita de lóbulo auricular
744.1	Aurícula accesoria
744.2	Otras malformaciones congénitas del oído
744.21	Otras malformaciones congénitas del oído, especificadas
744.22	Macrotia
744.23	Microtia
744.24	Ausencia de la trompa de Eustaquio
744.3	Malformación congénita del oído, no especificada
744.4	Seno, fístula o quiste de la hendidura branquial
744.43	Oreja cervical
744.47	Seno y quiste preauricular, Fístula:
744.49	Otras malformaciones de las hendiduras branquiales
744.5	Pterigion del cuello
744.8	Otras malformaciones congénitas especificadas de cara y cuello
744.81	Macroqueilia
744.82	Microqueilia
744.83	Macrostomia
744.84	Microstomia
744.9	Malformación congénita de la cara y del cuello, no especificada
745	**Malformaciones congénitas del sistema circulatorio**
745	**Malformaciones congénitas de las cámaras cardiacas y sus conexiones**
745.0	Tronco arterioso común
745.0	Persistencia del tronco arterioso
745.10	Transposición (completa) de los grandes vasos
745.11	Transposición de los grandes vasos en ventrículo derecho
745.11	Síndrome de Taussig-Bing
745.11	Transposición de los grandes vasos en ventrículo izquierdo
745.12	Transposición corregida
745.2	Tetralogía de Fallot
745.3	Ventrículo común
745.3	Ventrículo único
745.4	Defecto del tabique ventricular
745.4	Síndrome de Eisenmenger
745.5	Defecto del tabique auricular
745.5	Agujero Oval
745.5	Ostium secundum (tipo II)
745.6	Defecto del tabique auriculoventricular
745.6	Defecto de la almohadilla endocardica
745.61	Defecto del tabique auricular ostium primum (tipo I)
745.69	Canal auriculoventricular común
745.7	Corazón trilocular biauricular
745.8	Otras malformaciones congénitas de los tabiques cardiacos
745.9	Malformación congénita del tabique cardíaco, no especificada
746	**Malformaciones congénitas de las válvulas pulmonar y tricúspide**
746.00	Anomalía de la válvula pulmonar, sin especificar

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746.01	Atresia de la válvula pulmonar
746.02	Estenosis congénita de la válvula pulmonar
746.09	Insuficiencia congénita de la válvula pulmonar
746.1	Estenosis, atresia congénita de la válvula tricúspide
746.2	Anomalía de Ebstein
746.3	Estenosis congénita de la válvula aórtica
746.4	Insuficiencia congénita de la válvula aórtica
746.5	Estenosis mitral congénita
746.6	Insuficiencia mitral congénita
746.7	Síndrome de hipoplasia del corazón izquierdo
746.7	Síndrome de hipoplasia del corazón izquierdo
746.81	Estenosis subaórtica congénita
746.82	Corazón triauricular
746.83	Estenosis del infundíbulo pulmonar
746.84	Otras malformaciones congénitas del corazón, especificadas
746.85	Malformación de los vasos coronarios
746.86	Bloqueo cardíaco congénito
746.87	Otras malformaciones congénitas del corazón
746.87	Dextrocardia
746.87	Levocardia
746.89	Divertículo congénito del ventrículo izquierdo
746.9	Malformación congénita del corazón, no especificada
747	**Malformaciones congénitas de las grandes arterias**
747.0	Conducto arterioso permeable
747.0	Conducto [agujero] de Botal abierto
747.0	Persistencia del conducto arterioso
747.1	Coartación de la aorta
747.2	Otras anomalías de la aorta
747.21	Anomalía del arco aortico
747.22	Atresia y estenosis de la aorta
747.22	Ausencia de la aorta
747.22	Aplasia de la aorta
747.29	Otras malformaciones congénitas de la aorta
747.29	Aneurisma del seno de Valsalva (con ruptura)
747.29	Aneurisma congénito
747.3	Anomalías de la arteria pulmonar
747.40	Malformaciones congénitas de las grandes venas
747.41	Conexión anómala total de las venas pulmonares
747.42	Conexión anómala parcial de las venas pulmonares
747.49	Conexión anómala de las venas pulmonares, sin otra especificación
747.5	Ausencia e hipoplasia congénita de la arteria umbilical
747.5	Arteria umbilical única
747.60	Otras malformaciones congénitas del sistema vascular periférico
747.6	Malformación arteriovenosa periférica
747.62	Estenosis congénita de la arteria renal
747.62	Otras malformaciones congénitas de la arteria renal
747.8	Otras malformaciones congénitas del sistema vascular, especificadas
747.81	Anomalías del sistema cerebrovascular
747.82	Anomalía vascular espinal
747.83	Circulación fetal persistente
747.9	Malformación congénita del sistema vascular, no especificada
748	**Malformaciones congénitas del sistema respiratorio**
748	Malformaciones congénitas de la nariz
748.0	Atresia de las coanas
748.1	Agenesia o hipoplasia y otras malformaciones de la nariz
748.2	Pterigion de la laringe

ICD 9	Índice por Diagnóstico y Condición
748.3	Malformaciones congénitas de la laringe, traquea y bronquios
748.3	Broncomalacia congénita
748.4	Malformaciones congénitas del pulmón
748.4	Quiste pulmonar congénito
748.5	Agenesia, hipoplasia y displasia del pulmón
748.5	Secuestro del pulmón
748.5	Hipoplasia y displasia pulmonar
748.6	Otras malformaciones congénitas del pulmón
748.61	Bronquiectasia congénita
748.8	Otras Anomalías específicas del sistema respiratorio
749	**Fisura del paladar y labio leporino**
749.00	Fisura del paladar
749.01	Fisura del paladar, unilateral completo
749.02	Fisura del paladar unilateral, incompleto
749.03	Fisura del paladar bilateral completo
749.04	Fisura del paladar bilateral, incompleto
749.10	Labio leporino
749.11	Labio leporino unilateral completo
749.12	Labio leporino unilateral, incompleto
749.13	Labio leporino bilateral, completo
749.14	Labio leporino bilateral, incompleto
749.20	Fisura del paladar con labio leporino
749.21	Fisura del paladar duro con labio leporino, unilateral
749.21	Fisura del paladar duro y del paladar blando con labio
749.22	Fisura del paladar blando con labio leporino, unilateral
749.23	Fisura del paladar duro con labio leporino, bilateral
749.23	Fisura del paladar duro y del paladar blando con labio leporino, bilateral
749.24	Fisura del paladar blando con labio leporino, bilateral
749.25	Fisura del paladar con labio leporino, sin otra especificación
750	**Otras malformaciones congénitas del sistema digestivo**
750.0	Anquiloglosia, Frenillo lingual corto
750.1	Otras malformaciones congénitas de la lengua,
750.15	Macroglosia
750.2	Otras malformaciones congénitas de la boca y de la faringe
750.2	Malformaciones congénitas de las glándulas y de los conductos salivales
750.26	Otras malformaciones congénitas de la boca
750.27	Divertículo faringeo
750.29	Otras malformaciones congénitas de la faringe
750.3	Atresia del esófago sin mención de fistula
750.3	Atresia del esófago con fistula traqueoesofágica
750.3	Fistula traqueoesofágica congénita sin mención de atresia
750.3	Estrechez o estenosis congénita del esófago
750.4	Malformaciones congénitas del esófago
750.4	Pterigion del esófago,dilatación congénita del esófago, divertículo, duplicación.
750.5	Estenosis pylórica hipertrofica congénita
750.6	Hernia hiatal congénita
750.7	Otras malformaciones congénitas del estomago, especificadas
750.8	Otras malformaciones congénitas de la parte superior del tubo digestivo
751.0	Divertículo de Meckel, Persistencia del conducto:
751.1	Ausencia, atresia y estenosis congénita del intestino delgado
751.1	Ausencia, atresia y estenosis congénita del duodeno
751.1	Ausencia, atresia y estenosis congénita del yeyuno
751.2	Ausencia, atresia y estenosis congénita del intestino grueso, parte no especificada
751.2	Ausencia, atresia y estenosis congénita del recto y ano
751.3	Enfermedad de Hirschsprung, Aganglionosis, Megacolon congénito (aganglionar)
751.5	Otras malformaciones congénitas del intestino

ICD 9	Índice por Diagnóstico y Condición
751.6	Malformaciones congénitas de la vesícula biliar,de los conductos biliares y del hígado
751.61	Agenesia, aplasia e hipoplasia de la vesícula biliar
751.61	Atresia de los conductos biliares
751.62	Enfermedad quística del hígado
751.69	Quiste del colédoco
751.7	Agenesia, aplasia e hipoplasia del páncreas
751.7	Páncreas anular
751.7	Quiste congénito del páncreas
751.9	Otras malformaciones congénitas del sistema digestivo
752	**Malformaciones congénitas de los órganos genitales**
752.0	Anomalías y ausencia congénita de ovario
752.1	Malformaciones congénitas de las trompas de Falopio y de los ligamentos anchos
752.2	Malformaciones congénitas del útero
752.2	Duplicación del útero con duplicación del cuello uterino y de la vagina
752.3	Agenesia y aplasia del útero y Otras anomalías del útero
752.3	Otras malformaciones congénitas del útero
752.40	Anomalías del cuello uterino,vagina, y genitalia externa femenina
752.41	Quiste embrionario del cuello uterino
752.42	Hymen imperforado
752.49	Agenesia y aplasia del cuello uterino
752.49	Otras malformaciones congénitas de los órganos genitales femeninos
752.49	Ausencia congénita de la vagina
752.51	Cryptorquidia
752.6	Hipospadias, epispadias y otras anomalías del pene
752.64	Aplasia y ausencia congénita del pene
752.69	Otras malformaciones congénitas del pene
752.7	Sexo indeterminado y seudohermafroditismo
752.7	Sexo indeterminado, sin otra especificación, Genitales ambiguos
752.8	Otras malformaciones congénitas de los órganos genitales masculinos
752.8	Otras malformaciones congénitas de los conductos deferentes, del epididimo,
753	**Malformaciones congénitas del sistema urinario**
753.0	Agenesia renal y otras malformaciones hipoplásicas del riñón
753.0	Agenesia renal, unilateral
753.0	Agenesia renal, bilateral
753.0	Agenesia renal, sin otra especificación
753.0	Hipoplasia renal, unilateral
753.0	Hipoplasia renal, bilateral
753.0	Hipoplasia renal, no especificada
753.0	Síndrome de Potter
753.1	Riñón poliquístico, tipo infantil
753.11	Quiste renal solitario congénito
753.12	Riñón poliquístico, tipo no especificado
753.15	Displasia renal
753.16	Riñón quístico medular
753.17	Riñón espongioide SAI
753.19	Otras enfermedades renales quísticas
753.2	Defectos obstructivos congénitos de la pelvis, renal y malformaciones congénitas del uréter
753.23	Otros defectos obstructivos de la pelvis renal y del uréter
753.23	Ureterocele congénito
753.29	Hidronefrosis congénita
753.29	Atresia y estenosis del uréter
753.29	Megalouréter congénito
753.29	Agenesia del uréter
753.29	Duplicación del uréter

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753.29	Mala posición del uréter
753.29	Reflujo vésico-urétero-renal congénito
753.3	Otras malformaciones congénitas del riñón
753.3	Riñón supernumerario
753.3	Riñón lobulado, fusionado y en herradura
753.3	Riñón ectópico
753.3	Hiperplasia renal y riñón gigante
753.4	Otras anomalías específicas del uréter
753.5	Extrofia de la vejiga urinaria
753.6	Válvulas uretrales posteriores congénitas
753.6	Otras atresias y estenosis de la uretra y del cuello de la vejiga
753.7	Anomalías del uracho
753.8	Ausencia congénita de la vejiga y de la uretra
753.8	Divertículo congénito de la vejiga
753.8	Otras malformaciones congénitas de la vejiga y de la uretra
754	**Malformaciones y deformidades congénitas del sistema osteomuscular**
754.0	**Deformidades osteomusculares congénitas de la cabeza, de la cara**
754.0	Asimetría facial
754.0	Facies comprimida
754.0	Dolicocefalia
754.0	Plagiocefalia
754.0	Otras deformidades congénitas del cráneo, de la cara y dela mandíbula
754.0	Aplastamiento congénito de la nariz
754.0	Atrofia o hipertrofia hemifacial
754.0	Depresiones en el cráneo
754.0	Desviación congénita del tabique nasal
754.2	**Deformidad congénita de la columna vertebral**
754.2	Escoliosis congénita:
754.3	**Deformidades congénitas de la cadera**
754.30	Luxación congénita de la cadera, unilateral
754.3	Displasia acetabular congénita
754.31	Luxación congénita de la cadera, bilateral
754.32	Subluxación congénita de la cadera, unilateral
754.33	Subluxación congénita de la cadera, bilateral
754..35	Cadera inestable
754.4	**Deformidad congénita de la rodilla**
754.4	Genu recurvatum congénito
754.41	Luxación congénita de la rodilla
754.42	Curvatura congénita del fémur
754.43	Curvatura congénita de la tibia y del peroné
754.44	Curvatura congénita de hueso(s) largo(s) del miembro inferior, sin otra especificación
754.5	**Deformidades congénitas de los pies**
754.51	Talipes equinovarus
754.53	Metatarsus varus
754.59	Otras deformidades varus congénitas de los pies
754.61	Pie plano congénito
754.62	Talipes calcaneovalgus
754.69	Otras deformidades valgus congénitas de los pies
754.69	Metatarso valgus
754.71	Pie cavus
754.79	Talipes calcaneovarus
754.79	Hallux varus congénito
754.79	Otras deformidades congénitas de los pies
754.81	Tórax excavado
754.81	Tórax en embudo, congénito

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754.82	Tórax en quilla
754.82	Tórax de paloma, congénito
754.89	**Otras deformidades congénitas de las extremidades**
754.89	Artrogriposis múltiple congénita
754.89	Dedo deforme congénito
754.89	Mano en pala (congénita)
755.0	Polidactilia
755.02	Dedo(s) supernumerario(s) del pie
755.1	Sindactilia
755.13	Membrana interdigital del pie
755.14	Fusión de los dedos del pie
755.2	Defectos por reducción del miembro superior
755.21	Ausencia congénita completa del (de los) miembro(s)
755.23	Ausencia congénita del antebrazo y de la mano
755.26	Defecto por reducción longitudinal del radio
755.27	Defecto por reducción longitudinal del cubito
755.29	Ausencia congénita de la mano y el (los) dedo(s)
755.3	Defectos por reducción del miembro inferior
755.3	Otros defectos por reducción del (de los) miembro(s) inferior(es)
755.31	Ausencia congénita completa del (de los) miembro(s) inferior(es)
755.34	Defecto por reducción longitudinal del fémur
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ESTADO LIBRE ASOCIADO DE PUERTO RICO

28 de junio de 2010

TODAS LAS ENTIDADES ASEGURADORAS DE PLANES MEDICARE PLATINO

El contrato entre ASES y los Medicare Advantage Organizations (MAOs) establece en el Apéndice F, primer párrafo que; " los empleados públicos y retirados del ELA son elegibles por ley para obtener el Seguro de Salud de Gobierno. Por lo tanto, los empleados públicos y retirados que estén acogidos a los beneficios del Seguro de Salud y tengan cubierta de medicare pueden suscribirse a los servicios bajo el Programa Medicare Platino."

Sin embargo, se hace necesario aclarar que los beneficios de los planes Medicare Platino solamente están disponibles para aquellos beneficiarios que cualifiquen para los programas Medicare y Medicaid. Estos se conocen como "Dual Eligible Beneficiaries"

Es importante que todos los MAOs que tienen contrato de Medicare Platino con ASES revisen su base de datos, para identificar los asegurados en las redes de Medicare Platino que no cumplen con el requisito de doble elegibilidad, y se aseguren que los mismos pasen al producto o beneficio que les corresponda.

Enfatizamos que el beneficio de Platino está limitado a "Dual Eligibles" de Medicare y Medicaid y por lo tanto, aquellos beneficiarios que sean "estatales", pero no cumplan con los requisitos de elegibilidad de Medicaid, deberán pasar al beneficio que les corresponda.

La presente constituye una enmienda, por cambio de Ley, al Apéndice F del Contrato y entra en vigor inmediatamente.

Cordialmente,

Domingo Nevárez Ramírez, MHSA
Director Ejecutivo

c. Lcdo. Juan C. Fierres
Sra. Lourdes Pagán

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PO Box 195661, San Juan, P.R. 00919-5661 Tel. (787) 474-3300 Fax (787) 474-3346

ATTACHMENT #14

Commonwealth of Puerto Rico
Puerto Rico Medicaid Program/Puerto Rico Department of Health
Puerto Rico Health Insurance Administration

Guidelines for the Development of Program Integrity Plan

2011 – 2013

(This document is to be used by all contracted companies participating in the Commonwealth of Puerto Rico "Mi Salud". The purpose of sharing information with contracted companies is to provide them guidelines with minimum requirements to formulate their own Plan Integrity Program for the Health Care Delivery System sponsored by the Commonwealth of Puerto Rico)

The Insurer shall comply with the following Medicaid Integrity requirements:

A. 60 days after the dated of the agreement the Company must submit to ASES Compliance Office copy of the policies and procedures for identifying and tracking potential provider fraud cases, for conducting preliminary and full investigation and for referring cases of suspected fraud to an appropriate law enforcement agency. The Compliance Plan should be developed in accordance with 42 CFR 438.608.

B. Each company must submit to the Administration's Compliance Office on a quarterly basis a report with the following information: preliminary and full investigations, audits performed, administrative actions against providers, overpayments identified and providers referred to the Department of Justice (if not submit a certification signed by the Compliance Director and the President or CEO).

C. Each company must submit to the Compliance Office on a quarterly basis a report with the following information: fraud investigations pending, fraud investigations in process, fraud investigations finished and referrals to the Department of Justice or U.S. Attorney's Field Office (if there were no investigations, submit a certifications signed by the Compliance Director and the President or CEO).

D. Each Company has five (5) days to notify ASES about the referrals made to the US Attorney's Field Office and HHS-OIG.

E. Each company must submit to the Compliance Office a certification signed by the Compliance Director and the President or CEO indicating that all full investigations were made in accordance with 42 CFR 455.15.

F. Each Company has five (5) days to notify ASES about any adverse or negative action that the MCO has taken on provider application (upon initial application or application renewal) or actions which limit the ability of providers to participate in the program.

G. Each Company must review the credentialing forms of all providers and any fiscal agents they may use to ensure that they are in accordance with federal regulation 42 CFR 455.104.

H. Each Company must require providers to fill out a complete ownership and control disclosures form. The Company is responsible to ensure compliance with regulation.

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I. Each Company must review providers agreement to incorporate appropriate business transaction language to ensure accordance with federal regulation 42 CFR 455.105.

J. Each Company must request providers to fulfill a business transactions form and verify compliance with regulation.

K. Each Company must establish a method to capture criminal conviction information on owners, persons with control interest, agents, and managing employees of providers to ensure that is in accordance with federal regulation 42 CFR 455.106.

L. Each Company must review the enrollment packages for all provider types to request criminal conviction information as stated before.

M. Each Company should develop and implement procedures to report to HHS-OIG and ASES within 20 working days any criminal conviction disclosures made during the MCO credentialing process. Copy of the policies should be submitted to ASES Compliance Office.

N. Each Company must submit to the Compliance Office a certification signed by the Compliance Director and the President or CEO stating compliance with 42 CFR 455.106.

O. Each Company must comply with requirement in 42 CFR 455.20 and must document in a quarterly report compliance with regulation.

P. Each Company must comply with requirement in 42 CFR 455.101.

Q. Each Company must review the enrollment form and credentialing packages for all provider types to capture the identity of agents and managing employees.

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Introduction

Under the authority of Sec. 1102 of the Social Security Act (42 U.S.C. 1302); as detailed in the 43 FR 45262, Sept. 29, 1978, the Medicaid Program must have a program to detect and investigate fraud, waste and abuse.

The Commonwealth of Puerto Rico Department of Health and its Office for the Medically Indigent, acting as the single state agency are responsible for the management of the Medicaid and SCHIP grant funds. These funds are transferred to the Puerto Rico Health Insurance Administration (ASES), to be combined with state funds to provide health benefit coverage to the medically indigent population under a managed care fully capitated health plan. Acting as a sub-grantee to the Office for the Medically Indigent Medicaid program, ASES establishes contracts with insurance companies and other organizations to facilitate the beneficiaries' access to the benefit coverage through out their provider's networks.

Integrity Program Basis and Scope

This document sets forth guidelines with minimum criteria for the compliance with Program Integrity Policies and Procedures that each organization (grantee, sub-grantee, insurance companies) must have for the administration of the Commonwealth of Puerto Rico's Medicaid and State Health Plans. This document includes guidelines for the elaboration of the 3 main sections in the organizations Program Integrity Plan (PIP):

1. Fraud Detection and Investigation
2. Providers and Fiscal Agents Disclosure of Information on Ownership and Control
3. Integrity Program

Regulation Citation

Sections 1902(a)(4) [42 USC 1396(a)(4)1, (61)2, (64)3]; 1903(i)(2) [42 USC 1396(b)(i)(2)]4 1936[42 USC 1396u-6]5) and regulations at 42 CFR Parts 438, 455, 1001 and 1002

Overall Requirement

All providers/contractors are required to comply with the CMS Medicaid Integrity Group State Medicaid Director Letters #08-003 and #09-001, which explain what all states and contractors should do in terms of checking for excluded parties. The letters provide guidance on where to check for excluded individuals as well as the consequences of contracting with individuals and entities that have been excluded from participating in federally funded programs.

Companies are also required to notify to the Department of Health and Human Services-Office of Inspector General (HHS-OIG) of any action it takes to limit the ability of an individual or entity to participate in its program as stated in 42 CFR 1002.3.

Each contracted company must report actions it takes when it denies a provider enrollment based on program integrity concerns. Companies should report on each provider whom it has disenrolled, suspended, terminated or otherwise restricted from participation in the Medicaid program based on program integrity concerns. Companies are required to report affected providers directly to HHS-OIG while copying ASES.

Definitions

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider

Conviction or *Convicted* means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

Disclosing Entity means a Medicaid provider (other than an individual practitioner or group of practitioners) or a fiscal agent

Exclusion means that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit for him/her or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Furnished refers to items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a provider, or other supplier of services. (For purposes of denial of reimbursement within this part, it does not refer to services ordered by one party but billed for and provided by or under the supervision of another.)

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Health insuring organization (HIO) has the meaning specified in §438.2.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

(b) Any Medicare intermediary or carrier; and

(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Person with an ownership or control interest means a person or corporation that—

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(e) Is an officer or director of a disclosing entity that is organized as a corporation; or

(f) Is a partner in a disclosing entity that is organized as a partnership.

Practitioner means a physician or other individual licensed under State law to practice his or her profession.

Program Integrity Plan (PIP) means the program, process or policy that each contracted company has to comply with integrity requirements. The plan should be developed in accordance with federal regulation.

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Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means—

(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreeement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Stakeholder means the single state agency, the sub-grantee and all organizations contracted to provide health care management and services to Medicaid beneficiaries

Suspension means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

Termination means—

(1) For a—

(i) Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and

(ii) Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.

(2)(i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary.

(ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.

(3) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to—

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(i) Fraud;

(ii) Integrity; or

(iii) Quality.

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider

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Section A

Fraud Detection and Investigation sub part represents each one of the elements that must be included as part of the integrity program activities, although they are not necessarily the only elements that come into play.

All contracted plans must have an integrity program with their own structure, policies and procedures. Among other areas, they should have written policies and procedures on methods for the identification, investigation and referral of suspected cases; procedure to perform preliminary investigations as well as full investigations; procedures to address resolution of full investigations; procedures to comply with reporting requirements; provider's statements on claims form (if applicable); provider's statement on checks; cooperation with the Commonwealth of Puerto Rico Office for the Medically Indigent fraud control unit and procedure to withhold payments in case of fraud or willful misrepresentation. Contracted companies are required to submit to ASES Compliance Office copy of their integrity programs for evaluation. The plan should be developed in accordance with 42 CFR 438.608.

Each one of the Guidelines under section A includes the name or title of the guideline, scope, purpose, process and general information to identify the creation date, creator, and revisions or updates. This document will be attached to the contract each organization holds with the Puerto Rico Insurance Administration; while each one of the contracted organization should have at least a minimum set of policies and procedures to address the guidelines included.

The Program Integrity Plan (PIP) of each organization is to be monitored by the sub-grantee on periodic basis. An annual report will be issued reporting data and findings.

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Title SA1.1	State Plan Requirements
Scope	Applies to Single State Agency and Sub-Grantee
Purpose	This guideline describes the commitment of the single state agency and the sub-grantee in adhering to the statue rules and regulations and the implementation of a Program Integrity Plan for the Medicaid Program
General	The grantee and the sub-grantee will abide bye the following guidelines on how to manage the integrity program activities in the whole service delivery system.
Guidelines	1. The single state agency and sub-grantee acknowledge the need to adhere to a Medicaid Integrity Program as defined in the state plan. 2. The grantee and sub-grantee agree to establish a structure to manage Program Integrity Plan (PIP) activities. 3. The organization structure to perform above mentioned activities is furnished with a Program Integrity Plan (PIP) of members representing the single state agency, the sub-grantee and each contracted organization. 4. The PIP leads the efforts toward achieving compliance with state plan requirements regulation by establishing the minimum criteria of required PI program policies and procedures. 5. The PIP monitors contracted companies plan compliance on regular basis. 6. The PIP chairman develops the meeting calendar each year, develops the committee agenda, and keeps minutes of all meetings and call for meetings. 7. Sub-grantee facilitates the development and update of the Program Integrity Plan guidelines, reports and notification to guarantees its distribution and final acceptance among contracted companies and regulatory agencies. 8. Sub-grantee review performance of each organization, level of adherence to policies and recommend corrective action plan development for areas that must be improved. 9. Sub-grantee develops an annual report that is to be submitted to the Medicaid Program Integrity Group and to the CMS region 2. The report will include the areas and companies reviewed during the period and the findings of each company, if any. 10. The PIP provides guidance and guarantees that each contracted companies develop and implement policies and procedures in their organizations. 11. The PIP guidelines are integrated into each contracted organization Program Integrity Plan Policies and Procedures; and are assumed as a standard operating procedure to prevent fraud, waste and abuse in the management of Medicaid funds and health plan benefit coverage for the indigent population.

Title SA02.1	Methods for identification, investigation, and referral
Scope	Grantee, Sub-grantee and Contracted Organizations
Purpose	This guide describes what the organization must include in their PIP to guarantee the use of methods for the identification, investigation, and referral of suspected fraud and abuse cases.
General	The organization must establish methods for the identification, investigation and referral of suspected cases, that guarantees the use of a consistent and objective approach to address fraud, waste and abuse when performing PIP activities.
Guidelines	The PIP must include an explicit definition of methods to perform identification of cases suspected of fraud, waste and abuse a. what is fraud, waste and abuse b. how is detected fraud, waste and abuse c. who performs the identification d. when preliminary, full investigation and resolutions are done The PIP must have a detailed process to perform investigations on each suspected case guaranteeing objective methods to identify potential cases and perform investigations a. open and documents the case b. initiate data gathering process c. follow a protocol to verify information d. issue a report of findings e. refer case to next level f. close the case The PIP must include a variety of methods for the identification, investigation and referral of suspected cases, accepted in the industry and without infringing provider or beneficiary rights. Methods might include a. electronic data exchanges b. data mining c. claims registries / reconciliation d. targeted procedures e. profiling The PIP must include a systematic approach of data analysis by: a. flagging the case b. identifying cause for flagging (i.e. over-under payment) c. establishing actions and sanctions The PIP must have procedures in placed for referring suspect fraud cases to law enforcement officials, at a minimum:

Guidelines	a. an organizational structure to address the reports. b. a due process that includes but is not limited to: case identification, complete record with supporting materials, notification letter to suspect, notification letter to single state agency, documentation of entrance and exit interviews, and if necessary copy of referral letters and case resolution letter to and from legal authorities. c. a flowchart to work in cooperation with the grantee and sub-grantee as well as with the state legal authorities such as: Organization's Legal Affairs Department, ASES, Single State Agency – Department of Health Legal Department, State Department of Justice, and the Office of Inspector General. d. a follow up process to work with legal authorities each case of fraud, waste and abuse suspicion until final disposition and notification to the single state agency.

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Title SA03	Preliminary Investigations
Scope	Grantee, Sub-grantee and Contracted Organizations
Purpose	To provide guidance on how to perform a preliminary investigation when the agency receives a complaint of fraud or abuse from any source or identifies any questionable practices.
General	The organization must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.
Guidelines	The PIP defines a standard operating procedure to complete a preliminary investigation of all suspect cases of fraud, waste and abuse. The PIP identifies the requirements to complete the preliminary investigation when evaluating providers and beneficiaries. It should include at least: a. Source of information b. Identification method (how the case is detected) c. Cause for investigation d. Case documentation e. Analysis of Data and documents f. Report of Findings g. Action Taken (Recommended Action) The PIP includes a mechanism to keep tracking of all preliminary investigations and results. The PIP establishes a mechanism to report preliminary investigations activity to the sub-grantee (ASES) which will be in charge of reporting activity to the single state agency (Office for the Medically Indigent).

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Title SA04	Full Investigations
Scope	Grantee, Sub-grantee and Contracted Organizations
Purpose	To provide guidance and minimum set of elements in the PIP to perform full investigations on incidents of fraud and abuse.
General	If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occur in the Medicaid program, the organization must take the appropriate actions.
Guidelines	The PIP must define the process to conduct a full investigation and specify when a case requires the full investigation. Full investigations must be done in accordance with federal regulation and based in the company written policy. The company must submit copy of the written policies to ASES for review and approval. The PIP must define the process to refer the cases to the companies fraud liaison (i.e. companies compliance office), the appropriate law enforcement agency / sub-grantee when there is a reason: a. to suspect a provider has engaged in fraud or abuse of the program. b. to suspect a recipient is defrauding the program. c. to suspect a recipient has abused the Medicaid program. The PIP must have a mechanism to keep tracking of all full investigations performed in progress and closed. The PIP must have a mechanism to report the sub-grantee (ASES) informed full investigations in progress, conducted and results.

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Title SA05	Resolution of full investigation
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on minimum actions that must be taken in order to complete the process of a full investigation.
General	The full investigations must continue until the cases are referred, solved or closed.
Guidelines	The PIP must include the process to guarantee that a full investigation must continue until: a. appropriate legal action is initiated. b. the case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse. c. the matter is resolved between the organization and the provider or recipient ✓ the resolution may include but is not limited to: 1) Sending a warning letter to the provider or recipient, giving notice that continuation of the activity in question will result in further action; 2) Suspending or terminating the provider from participation in the Medicaid program; 3) Seeking recovery of payments made to the provider; or 4) Imposing other sanctions provided under the organization PIP plan. The PIP must guarantee that there is a mechanism to keep tracking of all full investigations until resolution.

Title SA06	Reporting Requirements
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on how to adhere to a minimum set of elements that must be included in the process to report fraud and abuse information to the appropriate organizations officials.
General	The organization must submit a progress report the fraud and abuse information and statistics to the appropriate department / grantee / sub-grantee on quarterly basis.
Guidelines	The PIP must describe the mechanism to report fraud and abuse data to the appropriate fraud liaison, organization structure, sub-grantee (ASES) and grantee (Office for the Medically Indigent). The PIP progress report must include at least the following information: a. # of complaints on fraud and abuse received. b. # of complaints that warrant preliminary investigation. c. Detailed information for each case of suspected provider fraud and abuse that warrants a full investigation: ✓ Provider's name and id number ✓ Source of the complaint ✓ Type of the provider ✓ Nature of the complaint ✓ Estimate amount of money involved ✓ Legal and administrative disposition of the case and actions taken by the law enforcement officials to whom the case has been referred. Suspected fraud cases must be reported immediately in a written format to ASES Compliance Office. The PIP reports must be submitted in electronic format to facilitate its inclusion in the Commonwealth of Puerto Rico Medicaid Program PI Annual Report.

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Title SA07	Provider's statements on claims forms
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on how to comply with regulation on provider's statements on claims forms.
General	The organization may print that all provider claims forms be imprinted in boldface type with the following statement, or with alternate wording that is approved by the Regional CMS Administration.
Guidelines	The PIP must include that providers are required to attest in the claim forms that they agree with the following statement: ✓ "This is to certify that the foregoing information is true accurate and complete". ✓ "I understand that payment of this claim will be from federal and state funds and that any falsification or concealment of a material fact maybe prosecutes under federal and state laws". For electronic claims, providers must attest that they agree with the following statements: ✓ "This is to certify the truthfulness of the foregoing information and certify that is true, accurate, complete and that the service was provided". The statements may be printed above the claimant's signature or, if they are printed on the revenue of the form, a reference to the statements must appear immediately preceding the claimant's signature.

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Title SA08	Provider's statements on check
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on how to comply with regulation on provider's statements on check.
General	The organization may print the following wording above the claimant's endorsement on the reverse of checks or warrants payable to each provider.
Guidelines	The PIP must include that providers are required to attest (in addition to the statements required in providers claims form) that they agree with the following statement either by having it written on checks or temporarily in a legal document as an affidavit: ✓ "I understand in endorsing or depositing this check that payment will be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws". The above attestation must be included in electronic and checks payment. The PIP must indicate frequency and responsible for conducting spot checks to guarantee the organization complies with the provider's statements and / or the provider signature appears on a legal document attesting compliance.

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Title SA09	Recipient verification procedure
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To verify that the services listed on claims forms have been rendered.
General	The organization must have a method for verifying with recipients whether services billed by providers were received.
Guidelines	The PIP must include a description of how the organization performs claims matches with medical records to guarantee adequacy of billing. The PIP must define the mechanism to monitor frequency of encounters and services rendered to patients billed by providers. The PIP will provide periodic up dates on reconciliation findings report to the sub-grantee and grantee. The sub-grantee will select a sample to perform independent reviews to verify that recipient's services billed by providers (as well as encounters under capitated environment) were indeed rendered. This review will be performed through confirmations to beneficiaries.

Note: All contracted companies are required to comply with Law 114 which require that the beneficiaries must receive an Evidence of Medical Benefits with a detailed of the services and expenses incurred during a quarter. ASES compliance office will review the compliance with the Law.

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Title SA10	Cooperation with Medicaid Fraud Control Units
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on how to communicate findings and to cooperate with any Puerto Rico or federal law enforcement agency. To request that all contracted companies must communicate preliminary findings to ASES.
General	The organization must have a mechanism to provide information to the regulatory and legal authorities on cases, investigations, schemes and any other activity where intention to commit fraud, abuse and waste of services occur.
Guidelines	The PIP must demonstrate it has an effective mechanism to cooperate with the Medicaid anti fraud unit as well as with other program divisions in charge of preventing and prosecuting cases related to fraud, waste and abuse of services under the Medicaid program. The PIP must establish a process to guarantee the organization complies with the following: ✓ All cases of suspected provider fraud are referred to the anti fraud / integrity organization's unit. ✓ If the anti fraud / integrity unit determines that it may be useful in carrying out the unit's responsibilities, promptly comply with a request from the unit for -- i. Access to, and free copies of, any records or information kept by the organization or its contractors; ii. Computerized data stored by the organization or its contractors. These data must be supplied without charge and in the form requested by the unit; iii. Access to any information kept by providers to which the organization is authorized access. In using this information, the unit must protect the privacy rights of recipients; ✓ Communicate to ASES preliminary findings; and ✓ On referral from the unit, coordinate with ASES or appropriate law enforcement agency before initiating any available administrative or judicial action to recover improper payments to a provider. The PIP must recommend the organization to have in the provider's contract a disclaimer that as a contracted provider any data related to services or payments provided must be available for review of the integrity staff.

Title SA11	Withholding of payments in cases of fraud or willful misrepresentations
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on elements to be considered when withholding of payments to providers who committed fraud or willful misrepresentation.
General	The organization should consider withholding payments to providers as a mechanism to prevent wrong disbursement of payments when suspect of fraud.
Guidelines	The PIP will establish a mechanism and adhere to the following recommendations when considering withholding of payments: (a) ***Basis for withholding***. The organization may withhold capitation or claims payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid program. The organization may withhold payments without first notifying the provider of its intention to withhold such payments. A provider may request, and must be granted, administrative review where State law so requires. (b) ***Notice of withholding***. The organization must send notice of its withholding of program payments within 5 days of taking such action. The notice must set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning its ongoing investigation. The notice must: ✓ State that payments are being withheld in accordance with this provision; ✓ State that the withholding is for a temporary period, and cite the circumstances under which withholding will be terminated; ✓ Specify, when appropriate, to which type or types of payment (capitation or claims) withholding is effective; and ✓ Inform the provider of the right to submit written evidence for consideration bye the agency. (c) ***Duration of withholding***. All withholding of payment actions under this section will be temporary and will not continue after: ✓ The agency or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation bye the provider; or ✓ Legal proceedings related to the provider's alleged fraud or willful misrepresentations are completed.

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Title SA12	Disclosure of Information by Providers and Fiscal Agents
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide definition of concepts in order to fully adhere to the regulation on providers control and ownership of facilities.
General	The organization must adhere to standard definitions when dealing with disclosure of information by providers and fiscal agents when establishing mechanism to regulate providers control and ownership of facilities.
Guidelines	The PIP will adhere to the following definitions of concepts to keep consistency with federal regulation and application of law: *Agent* means any person who has been delegated the authority to obligate or act on behalf of a provider. *Disclosing entity* means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent. *Other disclosing entity* means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the federal programs (Medicaid, SCHIP, FQHC's). This includes: (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII); (b) Any Medicare intermediary or carrier; and (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act. *Fiscal agent* means a contractor that processes or pays vendor claims on behalf of the Medicaid agency. *Group of practitioners* means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment). *Indirect ownership interest* means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Guideline	*Managing employee* means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. *Ownership interest* means the possession of equity in the capital, the stock, or the profits of the disclosing entity. *Person with an ownership or control interest* means a person or corporation that – (a) Has an ownership interest totaling 5 percent or more in a disclosing entity; (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity; (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity; (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured bye the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity; (e) Is an officer or director of a disclosing entity that is organized as a corporation; or (f) Is a partner in a disclosing entity that is organized as a partnership. *Significant business transaction* means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses. *Subcontractor* means – (a) An individual, agency or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or (b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement. *Supplier* means an individual, agency or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

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Guideline	*Wholly owned supplier* means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

Title SA13	Disclosure by disclosing entities: Information on ownership and control.
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidelines on what information must be disclosed by entities that have ownership and control over facilities.
General	The organization must have a mechanism to monitor on a timely manner the providers and fiscal agents that owns or control facilities where Medicaid beneficiaries receive services.
Guidelines	The PIP must require each disclosing entity to disclose the following information in a timely manner: (a) *Type of Information that must be disclosed.* ✓ The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more; ✓ Whether any of the persons named is related to another as spouse, parent, child, or sibling. ✓ The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must – (i) Keep copies of all these requests and the responses to them; (ii) Make them available to the Secretary or the Medicaid agency upon request; and (iii) Advise the Medicaid agency when there is no response to a request. (b) *Time and manner of disclosure.* ✓ Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information specified to the organization. ✓ Any disclosing entity that is not subject to periodic survey and certification and has not supplied the information specified. Updated information must be furnished to the Secretary or the State survey or Medicaid agency at intervals between recertification or contract renewals, within 35 days of a written request.

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Guidelines	(c) *Provider agreements and fiscal agent contracts.* The organization shall not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose ownership or control information as required by this section. The PIP will include the process to provide an annual report to the grantee and sub-grantee on above information and data.

Title SA14	Disclosure by providers: Information related to business transactions.
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	The organization must establish a mechanism to facilitate the providers disclose information related to their business transactions when own or control facilities where Medicaid beneficiaries received services.
Guidelines	The PIP must describe the mechanism to allow providers owning or controlling facilities disclose information related to business transactions. The PIP must attest the organization abide by the following regulation: (a) *Provider agreements.* The organization must enter into an agreement with each provider or provider group under which the provider agrees to furnish to it or to the grantee / sub-grantee on request, information related to business transactions. (b) *Information that must be submitted.* A provider must submit, within 35 days of the date on a request by the organization full and complete information about – ✓ The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and ✓ Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request. The PIP must include withholding of payment processes and procedures to enforce above guideline.

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Title SA15	Disclosure by providers: Information on persons convicted of crimes
Scope	Grantee, Sub-Grantee and Contracted Organizations
Purpose	To provide guidance on type of information providers must report in compliance with integrity program.
General	The organization is obliged to request providers to report any conviction of crimes or any other in the program integrity regulation.
Guidelines	The PIP must include a mechanism to confirm information included below is considered as part of the integrity activities.

(c) *Information that must be disclosed.* Before the organization enters into or renews a provider agreement, or at any time upon written request by the organization, the provider must disclose to the organization the identity of any person who:

(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

(b) *Notification to Inspector General.*

(1) The organization must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.

(2) The organization must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.

(c) *Denial or termination of provider participation.*

(1) The organization may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.

(2) The organization may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

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Miguel Negron Rivera
Executive Director of Medicaid
Puerto Rico Department of Health

Frank R. Diaz Gines
Executive Director
PR Health Insurance Administration

ATTACHMENT #15

ATTACHMENT 15
ELECTRONIC HEALTH RECORD SPECIFICATIONS

1. **Overview:** Primary Care Physicians (PCPs) and physician specialists within the Preferred Provider Network (PPN) shall have an operational Electronic Health Record ("EHR") system in their practice in place on or before July 1, 2012. The EHR system must be certified by (i) an Office of the National Coordinator Authorized Testing and Certification Body ("OCN-ATCB") and (ii) the Certification Commission for Healthcare Information Technology ("CCHIT") to participate in the MiSalud Program. The purpose of implementing an EHR is to: (i) become a Meaningful User of Health Information Technology (HIT); (ii) improve quality of care; (iii) maximize cost-efficiency; (iv) connect with a Health Information Exchange ("HIE") hub; and (v) allow patients to access their personal health information through a mechanism such as a Personal Health Record (PHR).

2. **EHR System Specifications:** To comply with technological as well as MiSalud model of care requirements, the EHR system shall:

Be certified by an ONC-ATCB

2.2 Be certified by the CCHIT

2.3 Be capable to perform SureScripts-certified ePrescribing

2.4 Be supported by one of the major drug-databases such as:

2.4.1.1 First DataBank;
2.4.1.2 MediSpan; or
2.4.1.3 Multum.

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2.5 Provide for ePrescribing Clinical Decision Support ("CDS") interaction checks.

2.6 Meet federal meaningful use objectives and measures in force at any given time. For example, during stage 1, must implement, at minimum, the capacity to detect drug-drug and drug-allergy interactions, as well as drug-formulary checks.

2.7 Support applicable (according to practice) federally mandated transactions and code-sets standards, as follows:

2.7.1 Transactions CCD, CDA, HL7, X12, NCPDP, and others.
2.7.2 Code-Sets ICD, CPT, HCPCS, NDC, CDT, LOINC, and SNOMED.

2.8 Be certified by, and connected to, the Puerto Rico Health Information Network ("PRHIN"), the ONC-supported and the state-designated entity or organization for HIE, as its services are made available. The EHR system must also be able to connect to other alternative hubs and be capable of reading and importing CCD files.

2.9 Support compliance and reporting of CMS quality measures.

2.10 Provide electronic copy of health information or clinical summaries to patients and other providers.

2.11 Support electronic submittal of public health and/or reportable-disease/conditions data as these capabilities are made available in Puerto Rico.

2.12 Be capable of quality monitoring.

2.13 Be capable of prospective-preventive services management.

2.14 Have mental and physical health integration capabilities.

2.15 Have screening capabilities according to age group, gender and risks factors.

2.16 Have an EPSDT prospective tracking system.

2.17 Have the capacity to register members on Special Coverage.

2.18 Have the capacity to generate an electronic referral.

2.19 Have the capacity to update MiSalud's drug formulary

2.20 Provide electronic referral to the Contractor's clinical programs

2.21 Document Enrollee's Advance Directives preferences

2.22 Document Enrollee's moral or religious objections

2.23 Generate a Prior Authorization request to the Contractor

2.24 Provide access to a Network Provider's education module

3 **Contractor's Certification Program:** The Contractor will develop and implement a Certification Program for Electronic Medical Records ("EMR") with technological requirements as well as MiSalud model of care requirements. Compliance with the established requirements will be taken into consideration to determine PCP qualification for the Physician Incentive Plan, as defined in Section 10.7 of the Contract.

ATTACHMENT #16

TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

ATTACHMENT 16

ADMINISTRACIÓN DE SEGUROS DE SALUD
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Procedimiento para incluir asegurados en cubierta especial e identificar los riesgos asumidos por ASES, en vigor a partir del 1ro. de noviembre de 2011 para los asegurados del Plan Mi Salud

Este documento define las condiciones y procedimientos donde ASES asume el riesgo económico de los serivicos ofrecidos a los asegurados de Mi Salud. A continuación se describen los criterios y procesos a seguir para la transferencia del riesgo económico a ASES de aquellos casos en que el asegurado es diagnosticado con alguna condición o se le realiza un procedimiento que es parte del riesgo económico asumido por la aseguradora.

Es de suma importancia que el médico primario continúe brindándole toda la atención médica necesaria a su paciente aún cuando el riesgo económico sea de ASES. El rol del médico primario de coordinar todos los servicios médicos del paciente asignado a su cuidado debe continuar independientemente de quien asuma el riesgo económico.

Si la solicitud de registro en la cubierta especial se realiza dentro de los primeros 120 días de efectuada la(s) prueba(s) y procedimientos que confirmaron el diagnóstico, la efectividad de la cubierta será a la fecha en que se confirmó el diagnóstico. Si la solicitud ocurre posterior a los 120 días de confirmado el diagnóstico, la efectividad será de 90 días previa a la solicitud.

La solicitud del registro de cubierta especial **debe ser enviada** a la dirección electrónica cubiertasespeciales@ssspr.com o por fax (787) 774-4835.

A continuación se detallan las condiciones médicas que pueden ser icluidas en la Cubierta Especial. Para cada condición se explican los criterios y el procedimiento a seguir para incluir un asegurado en la Cubierta Especial.

ANEMIA APLÁSTICA

Los servicios médicos relacionados a la condición de anemia aplástica serán riesgo financiero de ASES una vez realizado el diagnóstico y registrado el asegurado en la cubierta especial. Para registrar el asegurado se requiere certificación de la condición por hematólogo, así como evidencia del resultado de aspiración o biopsia de médula ósea y citogenética confirmando el diagnóstico. Se deben proveer resultados de contaje absoluto de neutrófilos, contaje de plaquetas, contaje de reticulositos. El médico primario, grupo médico primario o hematólogo podrán solicitar el registro de cubierta especial.

ARTRITIS REUMATOIDE

Los servicios médicos relacionados a la condición de artritis reumatoide serán riesgo financiero de ASES una vez realizado el diagnóstico y registrado el asegurado en la cubierta especial. Para registrar el asegurado se requiere enviar certificación de la condición por el reumatólogo, evidencia de resultado de ANA Test, ESR, CRP y/o radiografias pertinentes. Podrán se registrados por el médico primario, grupo médico primario o por el reumatólogo.

AUTISMO

Los servicios médicos relacionados a la condición de autismo serán riesgo económico de ASES una vez realizado el diagnóstico y registrado el asegurado en la cubierta especial. Para registrar estos asegurados se requiere evidencia de diagnóstico por neurólogo y/o psiquiatra. Se debe proveer el resultado o interpretación de los cuestionarios M-CHAT y *Ages and Stages*. El médico primario puede utilizar la prueba de cernimiento M-CHAT para realizar el diagnóstico presuntivo. La misma puede ser accesada a través de Internet por www.firstsigns.org. El referido para el registro podrá realizarlo el proveedor de salud físisca o salud mental.

CÁNCER

Los servicios cubiertos relacionados al tratamiento de cáncer para los asegurados con este diagnóstico comenzarán a considerarse riesgos de ASES desde el momento en que se realice la toma de la muestra que confirme el diagnóstico. La hospitalización y el procedimiento para realizar el diagnóstico se considerará riesgo de ASES. Esta cubierta dependerá de que el asegurado sea incluido en nuestro Registro de Cáncer y se extenderá hasta que se complete el tratamiento con quimioterapia y radioterapia. En casos donde no pueda obtenerse una confirmación del diagnóstico por patología ASES a través de Triple-S Salud tomará en consideración los estudios especializados realizados para la determinación de la cubierta especial.

Los diagnósticos de cáncer de piel y carcinoma in situ sólo se considerarán como cubierta especial al momento de la cirugía. Los casos de cáncer de piel como melanoma invasivo o los de células escamosas con evidencia de metástasis o que por su extensión requieran radioterapia y/o cirugía reconstructiva, serán incluidos en el registro de cubierta especial.

Una vez que el tumor se elimina, no exista evidencia de metástasis, haya remisión o no exista la necesidad de continuar con tratamientos de quimioterapia y radioterapia, los servicios dejarán de considerarse riesgos de ASES. Los casos de asegurados que hayan sido diagnosticados en el pasado con cáncer y estén libres de enfermedad al presente, no se consideran como riesgos de ASES (ej. asegurado con cáncer de colon en 1989, que se le practicó una colostomía). El seguimiento por el oncólogo, urólogo, etc. de asegurados en remisión, será riesgo del grupo médico primario aunque el asegurado podrá accesarlos sin necesidad de referido ya que serán parte de la red preferida.

Es necesario que al solicitar el registro de un asegurado con diagnóstico de cáncer, se envíe la hoja de registro completada con copia de los resultados de patología, otros estudios que confirmen el diagnóstico, la información del tratamiento recomendado y el tiempo que lo estará recibiendo. Si no se provee toda esta información, el asegurado se registrará temporalmente por cuatro (4) meses, mientras el grupo médico primario o el especialista nos envían la información necesaria para el registro definitivo. El registro puede ser solicitado por el médico primario, cirujano, ginecólogo, urólogo, oncólogo o radioterapeuta a cargo del asegurado.

Los casos de re-activación se registrarán a la fecha de la evidencia de reactivación de la condición (ej: evidencia de aparición de metástasis mediante biopsia o estudio que

confirme el diagnóstico) hasta un máximo de seis (6) meses previo a la fecha de solicitud, lo que sea menor.

El tratamiento de quimioterapia y radioterapia es riesgo de ASES, esté el asegurado registrado o no.

ENFERMEDAD RENAL CRÓNICA

Los casos de asegurados con enfermedad renal crónica son clasificados en etapas del 1 al 5 por su tasa filtrado glomerular (GFR, por sus siglas en inglés).

Nivel 1	GFR mayor de 90
Nivel 2	GFR entre 60 y 89
Nivel 3	GFR entre 30 y 59
Nivel 4	GFR entre 15 y 29
Nivel 5	GFR menor de 15

Los asegurados en los niveles 1 y 2 serán riesgo del grupo médico primario.

Los asegurados en los niveles 3, 4 y 5 serán riesgo de ASES, según se detalla a continuación:

- Para los asegurados en el nivel 3 y 4 sólo las visitas al nefrólogo y algunos laboratorios relacionados (urianálisis, colección de orina de 24 horas para proteínas y creatinina, albumina, bilirrubina, calcio, dióxido de carbono, cloro, creatinina, glucosa, fosfatasa alcalina, fósforo inorgánico, potasio, proteínas totales, sodio, enzimas hepáticas y BUN) son considerados riesgos de ASES.
- Los asegurados del nivel 5 serán suscritos a grupos primarios renales. Todos los servicios del asegurado en estos grupos primarios renales son riesgos de ASES.

Es importante el monitoreo continuo de los pacientes a riesgo de esta condición para la identificación temprana y registro de éstos, previo a comenzar la diálisis.

La cirugía necesaria para realizar la fístula requerida para la hemodiálisis y la inserción de catéteres para diálisis se consideran parte del riesgo de ASES, aún cuando el asegurado no esté registrado. Una vez realizada la fístula, aún cuando el asegurado no haya comenzado diálisis, puede ser suscrito en un grupo primario renal.

En los casos de fallo renal agudo que recuperan su función renal, sólo se considerará riesgo de ASES el procedimiento de diálisis peritoneal o hemodiálisis.

La diálisis peritoneal y la hemodiálisis se consideran riesgos de ASES, aún cuando el asegurado no haya sido registrado en un grupo primario renal.

Una vez se autoriza el ingreso a la cubierta especial por condición renal crónica, el asegurado recibe una notificación por correo, indicándole los cambios en su cubierta o el cambio de grupo médico primario a un grupo primario renal, con su nueva tarjeta. El cambio a dicho grupo será efectivo el mes en que se efectúa la solicitud del cambio. De este momento en adelante, el grupo médico primario cesa de recibir el pago per cápita correspondiente a este asegurado. Los servicios recibidos por el asegurado, previo al cambio al grupo primario renal o al registro del asegurado en la cubierta especial por

condición renal crónica, son riesgos del grupo médico primario, excepto los relacionados directamente con la diálisis. Los servicios ambulatorios fuera de la red preferida y no relacionados a la diálisis, que se les brinde a estos asegurados que pertenecen a un grupo primario renal, tienen que ser coordinados por el nefrólogo, quien pasará a ser el médico primario de estos asegurados.

Los requisitos para otorgar la cubierta renal dependen del GFR (tasa de filtración glomerular):

$$GFR = 186 \times (P_{Cr})^{-1.154} \times (age)^{-0.203} \times (0.742 \text{ if female}) \times (1.210 \text{ if black})$$

De necesitar información adicional con respecto a la fórmula, recomendamos la página electrónica del *National Kidney Foundation* (www.kidney.org).

Para registrar el asegurado se requiere copia de resultados de laboratorio que evidencie la creatinina, la edad y el sexo del asegurado. En caso de ser mujer y/o de raza negra se debe especificar, pues esta información se utiliza para calcular el GFR. En los casos que aplique puede acompañar copia de la forma HCFA #2728. El médico primario, el nefrólogo o el centro renal pueden completar el formulario de Registro de Cubierta Especial.

ESCLERODERMA

Los servicios médicos relacionados a la condición de escleroderma serán riesgo financiero de ASES una vez realizado el diagnóstico definitivo y registrado el asegurado en la cubierta especial. Para registrar el asegurado debe enviar evidencia del resultado de la prueba de ANA Test, reporte de la biopsia de piel, informe de consulta con dermatólogo y/o reumatólogo que confirmen la condición. El registro puede ser solicitado por el médico primario del asegurado o por el especialista a cargo de la condición.

ESCLEROSIS MÚLTIPLE

Los servicios médicos relacionados a la condición de esclerosis múltiple son riesgo financiero de ASES una vez realizado el diagnóstico definitivo y el asegurado sea incluido en el Registro de Cubierta Especial. Para registrar el asegurado se requiere resultados de MRI del cerebro y de ser necesario MRI de cordón espinal, resultado de punción lumbar, tipo de esclerosis múltiple certificada por neurólogo y pruebas de laboratorios que descartan otras enfermedades con síntomas similares. El registro puede ser solicitado por el médico primario del asegurado o por el neurólogo a cargo de la condición.

FIBROSIS QUÍSTICA

Todos los servicios médicos de asegurados con evidencia de diagnóstico de fibrosis quística registrados en cubierta especial se consideran riesgo financiero de ASES. Para registrar el asegurado se requiere prueba de sudor, tratamiento y/o certificación del neumólogo. Estos asegurados pueden ser registrados por el pneumólogo, pediatra o médico primario que le brinde los servicios médicos al asegurado. Por estos casos, el grupo médico primario no recibirá pago per cápita y su médico primario pasará a ser el neumólogo.

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HEMOFILIA

Los servicioe médicos relacionados y el tratamiento con factor antihemofilico para los asegurados con hemofilia se considera riesgo económico de ASES. Para el registro de estos asegurados se requiere certificación de las Clínicas de Hemofilia o por un hematólogo que evidencie la condición, así como resultados de los niveles de factores de coagulación.

LEPRA

Los servicios relacionados a la condición, visitas al infectólogo, medicamentos para la condición, cultivos, biopsias de seguimiento, asi como hospitalizaciones y procedimientos con el ICD-9/ICD-10 de la misma, serán riesgo de ASES a partir de la fecha del Registro de Cubierta Especial. Para registrar el asegurado se requiere evidencia de biopsias o cultivos positivos para la infección. El registro puede ser realizado por el médico primario o por el especialista a cargo de la condición. La vigencia del registro será basada en el tiempo de duración del tratamiento.

LUPUS ERITEMATOSO SISTEMICO

Los servicios médicos relacionados a la condición de lupus eritematoso sistémico son riesgo económico de ASES una vez realizado el diagnóstico definitivo y el asegurado sea incluido en el Registro de Cubierta Especial. Para registrar el asegurado se requiere evaluación de reumatología donde se certifique la condición, así como resultados de laboratorios de ANA Test, DS-DNA, Anti Sm y Anti Phospholipids Abs. La solicitud del la Cubierta Especial puede ser realzada por el médico primario o especialista.

NIÑOS CON NECESIDADES ESPECIALES DE SALUD

Todos los servicios médicos cubiertos para asegurados en el Registro de Niños con Necesidades Especiales de Salud son riesgo económico de ASES. El médico primario será responsable de proveerle al niño; el cuidado preventivo de acuerdo a la edad, recetas y precertificaciones. Estos asegurados no requieren referido para visitar a los especialistas. Sin embargo en caso de que el especialista, laboratorio o facilidad asi lo requiera, el médico primario será responsable de brindárselo y el servicio **no** será descontado del riesgo económico del grupo médico primario.

Para registrar el niño se requiere completar el Formulario de Registro de Niños con Necesidades Especiales de Salud con la siguiente información:

- Evidencia de condición médica de acuerdo a la lista de diagnósticos de niños con necesidades especiales de salud (Ver Anejo 1)
- Laboratorios pertinentes a la condición
- Cirugías pendientes para corregir la condición
- Tratamiento farmacológico actual

La determinación de incluir el niño en el registro se realizará tomando en consideración la edad (hasta los 21 años) y diagnósticos.

► Manejo de Casos para Niños con Necesidades Especiales

Triple-S Salud tiene disponible un Programa de Manejo de Casos para pacientes pediátricos que por sus diagnósticos no cualifican para la cubierta especial. El requisito para el programa es que tengan múltiples condiciones médicas que requieran visitas frecuentes a más de dos especialistas (4 o más visitas por especialista al año) o pacientes de alto riesgo para hospitalizaciones como la población pediátrica con Diabetes Mellitus Tipo 1. La enfermera encargada del manejo de esta población será responsable de garantizar el acceso del asegurado a los especialistas, pruebas diagnósticas y tratamiento médico necesario en comunicación con el médico primario. Se evaluará de acuerdo a la cubierta de beneficios del Plan Mi Salud y al Formulario de Medicamentos Preferidos (PDL, por sus siglas en inglés). El **riesgo económico** de los servicios ofrecidos a esta población será del grupo médico primario hasta alcanzar el *stop loss*.

OBSTETRICIA

Todos los servicios médicos, cubiertos, provistos a las beneficiarias de Mi Salud suscritas con Triple-S Salud y registradas en la cubierta especial de obstetricia, son riesgo económico de ASES. Triple-S cuenta con un proceso electrónico para el registro de embarazadas. Mediante este proceso el obstetra podrá realizar el registro a través de nuestra página de Internet www.ssspr.com/sesweb. Esto permitirá entregarle la carta de certificación de registro a la asegurada en la primera visita para que pueda realizarse las pruebas de laboratorio y buscar sus medicamentos sin necesidad de la autorización o referido del médico primario.

En caso de que el obstetra no tenga acceso a Internet, deberá completar el Formulario de Registro de Casos de Obstetricia y enviarlo al Área de Registros de Condiciones Especiales. Una vez se registra el caso, se enviará a la asegurada por correo una certificación de la cubierta especial.

El obstetra solo podrá recibir pago por la visita inicial obstétrica y no por las subsiguientes, si la asegurada no está registrada. Esta visita inicial se considerará siempre riesgo de ASES. El grupo médico primario no recibirá pago per cápita por esta asegurada durante el tiempo que esté registrada.

Los siguientes procedimientos obstétricos requieren ser precertificados a través del Centro de Llamadas de Precertificaciones de Triple-S Salud. (1-866-365-9024):

- Sonogramas obstétricos en oficina del obstetra
- "Biophysical profile"
- "Non-stress test" en oficina

Los medicamentos fuera del formulario de Obstetricia deben ser precertificados. Debe completar el formulario de solicitud y enviarlo al fax (787) 625-8698.

Las cirugías electivas durante el embarazo deben ser precertificadas. Debe completar el formulario de solicitud de precertificación y enviarlo vía fax al (787) 774-4835.

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Las esterilizaciones realizadas en admisiones separadas posteriores al parto o cesárea serán responsabilidad del grupo médico primario, por lo que requerirán referido del médico primario.

Los niños recién nacidos mientras tengan el contrato de la madre y hasta que termine el registro de obstetricia (41 días posteriores a la fecha estimada de parto) serán riesgos de ASES. Se pagará el pago per cápita del recién nacido una vez la madre salga del registro y/o el recién nacido sea certificado por la madre, lo que ocurra primero.

POST TRASPLANTES DE ÓRGANOS

Todos los servicios cubiertos a asegurados post trasplantes de órganos registrados en la Cubierta Especial son riesgos de ASES. Los asegurados post trasplantes de riñón serán incluidos en un grupo primario renal. Los asegurados post trasplantes de corazón, hígado, pulmón y médula ósea serán incluidos en un registro especial para trasplantados. Para registrar al asegurado, se requiere evidencia médica del trasplante y de los inmunosupresores que utiliza el asegurado. El registro puede ser realizado por el médico primario o especialista a cargo de la condición. El registro terminará cuando el asegurado no utilice más inmunosupresores.

Deben recordar que el procedimiento para realizar un trasplante de órgano no está cubierto por el Plan Mi Salud.

TUBERCULOSIS

Los servicios relacionados a la condición, visitas al neumólogo o infectólogo, antibióticos para la condición, cultivos, radiográficas de seguimiento, asi como hospitalizaciones y procedimientos con el ICD-9/ICD-10 de la misma, serán riesgo de ASES a partir de la fecha del Registro de Cubierta Especial. Para registrar el asegurado se requiere evidencia de radiografías o cultivos positivos para la infección o reporte de lavado bronquial o de biopsia del lugar afectada. El registro puede ser realizado por el médico primario o por el especialista a cargo de la condición.

La vigencia del registro será basada en el tiempo de duración del tratamiento.

VIH + / SIDA

Todos los servicios médicos cubiertos de asegurados con esta condición serán riesgo económico de ASES. Para registrar el asegurado se requiere:

- Evidencia de prueba de VIH positiva confirmada por la prueba de *Western Blot* para los asegurados VIH
- CD-4 menor de 200 o evidencia de enfermedad oportunista para los asegurados con SIDA

El registro puede ser realizado por el médico primario, especialista o personal de las Clínicas de Inmunología del Departamento de Salud u otros centros especializados en el tratamiento de la condición.

Los medicamentos antiretrovirales incluidos en la cubierta y las hospitalizaciones con los

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diagnósticos mencionados, serán asumidos bajo el riesgo económico de ASES, aún cuando el asegurado no haya sido registrado:

- Candidiasis esofágica o en bronquio, tráquea o pulmón
- Cáncer cervical invasivo
- Coccidioidomycosis diseminado o extrapulmonar
- Cryptococcosis extrapulmonar
- Cryptosporidiosis intestinal crónica (más de un mes de duración)
- Enfermedad por Cytomegalovirus en hígado, vasos o nódulos
- Retinitis por Cytomegalovirus con pérdida de visión
- Encefalopatía, relacionada a VIH
- Bronquitis, Pneumonitis o Esofagitis por Herpes Simple
- Histoplasmosis diseminado o extrapulmonar
- Isosporasis crónico intestinal (más de un mes de duración)
- Sarcoma de Kaposi
- Lymphoma Burkitt (o término equivalente)
- Lymphoma Inmunoblástico (o su término equivalente)
- Lymphoma primario de cerebro
- Mycobacterium Avium complex o Tipo M, Kanasii diseminado o extrapulmonar
- Mycobacterium tuberculosis (cualquier lugar pulmonar o extrapulmonar)
- Otras especies de Mycobacterium sin identificar, diseminado o extrapulmonar
- Pneumonía por pneumocystis carinii
- Pneumonía recurrente
- Leucoencefalopatía progresiva multifocal
- Toxoplasmosis del cerebro

Los asegurados en tratamiento con inhibidores de proteasa deben ser referidos a las Clínicas de Inmunología del Departamento de Salud para tratamiento, ya que éstos no están incluidos en la cubierta establecida por ASES para los asegurados del Plan Mi Salud.

Un niño se considera con diagnóstico definitivo de infección por VIH, si tiene evidencia de anticuerpos VIH después de los 18 meses de edad o tiene dos de las siguientes pruebas positivas: Antígeno P24, Prueba de Carga Viral y Cultivo de Virus. En los casos pediátricos, todo niño nacido de madre seropositiva debe considerarse infectado y requiere manejo, según el protocolo establecido para estos fines. Los casos de infantes mayores de 18 meses que no posean anticuerpos, cesarán de considerarse como riesgos de ASES

ASES asume otros riesgos financieros de acuerdo a lo establecido en la cubierta de beneficios de Mi Salud. No es requisito registrar a estos asegurados, ya que los mismos son identificados por medio de los códigos relacionados a la facturación. Las definiciones de estos otros riesgos se detallan a continuación:

ACCIDENTES CEREBROVASCULARES AGUDOS (CVA)

Los servicios prestados durante una hospitalización o visita a sala de emergencias de un asegurado con este diagnóstico serán riesgos de ASES El seguimiento médico y de rehabilitación de este asegurado, una vez es dado de alta del hospital, es riesgo de la IPA.

AFÉRESIS TERAPÉUTICA

Los procedimientos de aféresis terapéutica estarán incluidos en los riesgos asumidos por ASES. Estos procedimientos requieren precertificación, la solicitud puede ser enviada vía fax al (787) 774-4835.

AMBULANCIAS

Los servicios de ambulancia para transporte de emergencias, sea terrestre o aérea, son riesgos económicos asumidos de ASES y no requieren precertificación. El transporte de asegurados en ambulancias a citas médicas o al hogar cuando es dado de alta del hospital, **no** está cubierto por el Plan Mi Salud. Algunos casos son precertificados por excepción como por ejemplo; asegurados encamados, recibiendo servicios de terapia intravenosa (IVF) o con ventilación mecánica en el hogar. Los criterios utilizados para la precertificación serán detallados a través de carta circular.

La transportación de no emergencia en vehículos contratados no está considerado un beneficio dentro del Plan Mi Salud.

CÁMARA HIPERBÁRICA MULTIPLAZA

El pago por la utilización de la cámara hiperbárica multiplaza y el servicio médico asociado a ésta es un riesgo económico asumido por ASES. Este servicio requiere precertificación, la documentación médica justificando el uso del servicio puede ser enviada vía fax al (787) 774-4835. La solicitud de la precertificación de los servicios de emergencia podrá ser enviada posterior al servicio, el próximo día laborable.

CIRUGÍAS CARDIOVASCULARES

Los procedimientos invasivos como cateterismos, angioplastías, marcapasos y todas las cirugías cardiovasculares y periferovasculares, así como la porción de la hospitalización asociada a estos procedimientos se consideran riesgo económico de ASES. La hospitalización de un asegurado por un diagnóstico de infarto de miocardio que durante el 5to día se le realiza un cateterismo, solo el día asociado al cateterismo será riesgo de ASES. Una vez el cirujano da de alta al asegurado de sus servicios en el hospital donde fue realizado el procedimiento el riesgo económico pasa a ser del grupo médico primario.

El seguimiento ambulatorio por el cardiólogo una vez dado de alta el asegurado del hospital **no** es parte del riesgo económico asumido por ASES. Este seguimiento debe continuar a través del médico primario y del cardiólogo consultor.

Algunos de los procedimientos invasivos o cirugías cardiovasculares requieren pre-certificación a través del Programa de Precertificaciones de Triple-S Salud. En los casos electivos, esta precertificación debe gestionarla el médico primario del asegurado. El cirujano cardiovascular, el cardiólogo o el personal del hospital será quien gestionará la precertificación en aquellos casos en que, como resultado de una admisión hospitalaria, se desarrollen síntomas que requiere un procedimiento o una intervención quirúrgica. La precertificación puede ser tramitada a través del Centro de Llamadas de Pre-certificaciones de Triple S Salud al 1-866-365-9024.

CIRUGIAS MAXILARES

Los procedimientos realizados por los cirujanos maxilofaciales con códigos de CPT relacionados a reconstrucción de maloclusión dental o corrección de mordida, serán riesgo económico asumido por ASES y requieren precertificación a través del Departamento de Reclamaciones Dentales de Triple-S Salud. La solicitud y los documentos requeridos deben ser enviados al apartado postal 383628, San Juan, Puerto Rico 00936-3628 a la atención del Departamento indicado.

DENTAL Y MEDICAMENTOS DEL FORMULARIO DENTAL RECETADOS POR DENTISTAS

Los códigos definidos en el Manual CDT e incluidos en la cubierta dental definida por ASES asi como los medicamentos incluidos en el formulario dental que hayan sido recetados por un dentista serán riesgos de ASES. Estos medicamentos seguirán la regla establecida por el PBM de despacho de medicamentos por condiciones agudas.

EMERGENCIAS Y HOSPITALIZACIONES PARA EL TRATAMIENTO DE CONDICIONES RESULTANTES DE DAÑOS AUTOINFLIGIDOS O FELONÍAS REALIZADAS POR EL ASEGURADO

Los servicios de emergencia y hospitalizaciones resultantes de esta emergencia con códigos diagnósticos E950.0 a E989.0 son riesgo económico asumido por ASES. Los servicios de sala de emergencia y hospitalización de los casos rechazados por ACAA están incluidos bajo este riesgo.

ESTUDIOS DE MEDICINA NUCLEAR

Los estudios de Medicina Nuclear (códigos 78000 @ 79999) y los contrastes fármaco-radiológicos necesarios para realizar los estudios son riesgo económico asumido por ASES. El requisito de precertificar para algunos de estos estudios continuará a través del Programa de Precertificaciones de Triple-S Salud al 1-866-365-9024.

INTENSIVO NEONATAL (NICU)

Todos los casos de bebés con criterios de admisión a las Unidades de Cuidado Intensivo Neonatal (NICU), se consideran riesgos económico asumido por ASES. Una vez el niño sea dado de alta de NICU, cesa de considerarse riesgo de ASES. El seguimiento médico ambulatorio continuará a través de su médico primario y los otros profesionales especialistas y subespecialistas que sean consultados y será parte del riesgo económico asumido por el grupo médico primario.

INTENSIVO PEDIÁTRICO (PICU) Y DE ADULTOS (ICU)

Todos los servicios hospitalarios cubiertos a los asegurados en las unidades de Cuidado Intensivo de Pediátrico y de Adultos serán riesgo económico asumido por ASES. Una vez el asegurado cumple con los criterios médicos para ser trasladado a otro nivel de cuidado se considerará riesgo económico de el grupo médico primario.

LABORATORIOS DE CITOGENÉTICA

Los laboratorios de citogenética son riesgos económicos asumidos por ASES. Los códigos que corresponden a este tipo de laboratorios son 88230 @ 88299.

LITOTRICIA

El procedimiento de litotricia, tanto la parte institucional como la porción de servicios médicos, es un riesgo económico asumido por ASES. Este procedimiento requiere precertificación, la cual debe gestionarse a través del Centro de Llamadas de Precertificaciones de Triple-S Salud al 1-866-365-9024.

MA-10

ASES asumirá el riesgo económico de las reclamaciones incurridas por servicios prestados a aquellos asegurados certificados como elegibles por el Programa Medicaid y que a la fecha del servicio no han completado el proceso de suscripción con Triple-S Salud.

Un asegurado certificado por Mi Salud es aquel que ha completado el proceso de suscripción y tenga asignado un grupo médico primario y un médico primario. Cuando el asegurado complete este proceso, las reclamaciones comenzarán a ser riesgo del grupo médico primario de acuerdo a lo establecido en este documento.

MAMOGRAFIAS

Las mamografías de cernimiento y diagnósticas forman parte del riesgo asumido por ASES.

MEDICAMENTOS ESPECIALES

Los siguientes medicamentos forman parte del riesgo económico asumido por ASES:

Antivirales par HIV *
Quimioterapias para cáncer **
Medicamentos de Hemofilia
Sandostatina
Desmopresina (DDAVP)
Copaxone
Rebif
Betaseron
Extavia
Novantrone
Avonex
Hormona de Crecimiento
Botox
Eulexin
Hydrea *
Phoslo *
Sensipar
Rocaltrol
Tysabri
Tobi
Epogen
Procrit
Aranesp
Neupogen
Neulasta
Leukine
Syangis
Inmunosupresores
Carnitol*
Gammaglobulinas
Remicade
Pentamidine
Leucovorin*
Aromasin
Megace*
Arimidex*
Aromasin*
Femara
Nolvadex*
Calciferol*
Humira
Enbrel
Renvela

*No requieren precertificación
**Algunas de las quimioterapias requieren precertificación. La precertificación de los mismos debe gestionarse a través del fax (787) 625-8698.

NEUROCIRUGÍA

Todos los procedimientos de neurocirugía son clasificadas como riesgo económico asumido por ASES. Esta clasificación termina cuando el asegurado es dado de alta del hospital por el neurocirujano. El seguimiento médico de los profesionales y especialistas, posterior al alta del asegurado será riesgo económico del grupo médico primario y debe ser coordinado a través del médico primario.

La coordinación de los servicios para el asegurado que requiere un procedimiento de neurocirugía electiva le corresponde al médico primario. Esta coordinación debe incluir la emisión de los referidos necesarios para el proceso de pre-admisión y para la realización del procedimiento.

Los procedimientos de neurocirugía de asegurados admitidos a través de la sala de emergencia, se registran a través del SES WEB, como cualquier otra admisión a través de sala de emergencia.

PRÓTESIS

Las siguientes prótesis están cubiertas y forman parte del riesgo asumido por ASES:

- Marcapasos, Desfibriladores *
- Válvulas cardíacas y neuroquirúrgicas
- Bandeja ortopédica de instrumentación para fracturas, escoliosis, (tornillos, clavos y varillas) y reemplazo de articulaciones
- Prótesis de extremidades *
- Prótesis de ojo
- Hueso de cadáver *

* La precertificación de las mismas debe gestionarse a través del Centro de Llamadas de Precertificaciones de Triple-S Salud al 1-866-365-9024.

Triple-S Salud sólo reembolsará el costo de las bandejas y el material usado de las mismas al proveedor, por lo cual, la factura deberá estar acompañada de la evidencia de este costo, el reporte del cirujano y del material usado.

El cargo por el lente intraocular en las cirugías para remoción de cataratas se considera un riesgo económico del grupo médico primario. Este servicio es facturado directamente por el centro de cirugía ambulatoria.

RADIOCIRUGÍAS

El procedimiento de radiocirugía es riesgo económico asumido por ASES y requiere precertificación a través del Centro de Llamadas de Precertificaciones de Triple-S Salud al 1-866-365-9024. La precertificación puede ser gestionada por el médico primario, el neurocirujano o la facilidad que va a realizar el procedimiento.

Para la evaluación de los casos se requiere enviar:

- Consulta del radioterapeuta y/o neurocirujano
- Resultado de MRI que evidencie el tamaño de la lesión
- Resultado de venograma (si aplica)
- Escala de Karnofski (KPS)

SALUD MENTAL

Todos los servicios de proveedores de salud mental serán brindados por los proveedores del MBHO contratado por ASES. La evaluación de asegurados para descartar condiciones físicas será riesgo del grupo médico primario. Esto incluye laboratorios y estudios requeridos para las evaluaciones a niños con sospecha de ADD o hiperactividad, las evaluaciones de pacientes con sospecha de demencias, las evaluaciones de pacientes candidatos a detoxificación de sustancias controladas y las visitas a sala de emergencia de asegurados con síntomas físicos (ejemplo: dolor de pecho) en donde el diagnóstico final sea uno de salud mental o por intento suicida. En estos casos la intervención de la sala de emergencia u hospital se limita a descartar una condición de salud física y no está dirigida al tratamiento de la condición psiquiátrica. Las pruebas diagnosticas tales como: laboratorios, CT Scan, MRI, electroencefalogramas, serán riesgo del MBHO únicamente cuando son referidas por un siquiatra.

SALAS DE EMERGENCIA

El riesgo económico de sala de emergencia será 100% del grupo médico primario. Esto incluirá el pago por la facilidad y todos los servicios ofrecidos en el lugar de servicio 23.

SERVICIOS PREVENTIVOS

Los servicios preventivos identificados y que se incluyen en este procedimiento como anejo serán riesgo económico de ASES.

VACUNAS

El incentivo de $4.00 que se ofrece a los grupos médicos primarios por la administración de las vacunas indicadas en el esquema de vacunación del Departamento de Salud, es un riesgo económico asumido por ASES. Este servicio puede ofrecerse y facturarse a Triple-S Salud para cualquier suscriptor, irrespectivo del grupo médico primario a la que pertenezca y sin mediar referido médico. Se facturará la administración de una sola vacuna aunque ésta contenga varios antígenos (Ej. DPT).

El incentivo no aplica a los asegurados Medicare A y B, o Medicare Advantage ya que Medicare cubre el costo y la administración de las vacunas. Las vacunas que no son parte del esquema de vacunación del Departamento de Salud y son médicamente necesarios serán riesgo de la IPA.

Revisado el 14 de octubre de 2011.

TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

Anejo 2

CONDICIONES PARA INCLUIR PACIENTES EN EL REGISTRO DE NIÑOS CON NECESIDADES ESPECIALES DE SALUD

Diagnóstico Principal	Especificaciones	ICD-9
A. Desórdenes Metabólicos	1. Desórdenes específicos de amino ácidos	270.0 - 270.8
	2. Desorden no específico del metabolismo de los aminoácidos	270.9
	3. Desórdenes de transporte y metabolismo de carbohidratos	271.0 -271.9
	a. Glicogenosis	271.0
	b. Galactosemia	271.1
	c. Intolerancia a la fructosa	271.2
	d. Desórdenes específicos de transporte y metabolismo de carbohidratos	271.8
	e. Desórdenes no específicos de transporte y metabolismo de carbohidratos	271.9
	4. Desórdenes de metabolismo de lípidos	272.0 - 272.7
	a. Desórdenes de lipoproteínas	272.5
	b. Lipidosis	272.7
	5. Otros desórdenes de metabolismo no específicos	277.00 - 277.6
	a. Desórdenes de metabolismo de porfirina, purina y pirimidina	277.1 - 277.2
	b. Amiloidosis	277.30 -277.39
	c. Mucopolisacaridosis	277.5
	d. Deficiencia de enzimas de circulación	277.6
B. Enfermedades hereditarias y del sistema nervioso central	1. Degeneración cerebral	330
	a. Leucodistrofia	330.0
	b. Lipidosis cerebral	330.1 - 330.8
	2. Enfermedades espinocerebelares	334.0 - 334.9
	3. Enfermedades demielinizantes del sistema nervioso central	341.0 - 341.9
	4. Perlesía Cerebral	343.0 - 343.9
	5. Otros síndromes de parálisis	344.00 -344.09
	6. Neuropatías periferales hereditarias	356.0 - 356.9
	7. Distrofia Muscular y otras miopatías, desórdenes miotónicos	359.0 - 359.29
C. Desórdenes Músculo esqueletales	1. Tortícolis	723.5
	a. Espástica, congénita, tortícolis del músculo esternocleidomastoideo	754.1
	2. Osteocondritis juvenil de pelvis y cadera	732.1
	3. Ostocondritis juvenil de la extremidad inferior, excluye el pie	732.4
	4. Otras deformidades adquiridas de tobillo y pie	736.70 - 736.72
	5. Curvatura de espina	737.0 - 737.39
	6. Espina bífida	741.00 -741.03, 741.90 - 741.93
	7. Otras anomalías congénitas del sistema nervioso central	742.0 - 74.59, 742.8 - 742.9

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D. Anomalías Congénitas*	1. Anomalías congénitas del ojo	
	a. Anoftalmo	743.0-743.06,
	b. Microftalmo, Buftalmo	743.10 - 743.12, 743.20 - 743.22
	c. Cataratas congénitas y anomalía en el lente	743.30 - 743.39
	d. Coloboma y otras anomalías del segmento anterior del ojo	
	e. Anomalías congénitas del segmento posterior del ojo	743.51 - 743.59
	f. Anomalías congénitas del parpado, sistema lacrimal y órbita	743.61 - 743.9
	2. Anomalías congénitas del oído, cara y cuello	
	a. Anomalías auditivas	744.00 - 744.3
	b. Atresia congénita de coanas y otras anomalías congénitas de la nariz, laringe, traquea y bronquios	744.41 - 744.5, 744.81 - 744.9 748.0 - 748.9
	c. Paladar y labio hendido (Cleft lip and palate)	749.0 - 749.25
	d. Otras anomalías congénitas del tracto alimentario superior	750.0 - 750.9
	3. Deformidades musculoesqueletales congénitas	754.0 - 754.79 755.00, 755.21, 755.31,755.58 y 755.59
	4. Osteodistrofia Congénita	756.50 - 757.39
	5. Anomalías de los cromosomas	758.0 - 758.89, 759.5-759.9
E. Desórdenes en los órganos sensoriales	1. Pérdida auditiva conductiva	389.00 - 389.08
	2. Pérdida auditiva sensorineural	389.10 - 389.9
	3. Ceguera y visión pobre	369.00 - 369.04
	4. Estrabismo y otros desórdenes de movimiento ocular	378
	a. Esotropia	
	b. Exotropia	378.00 - 378.08
	c. Heterotropia intermitente	378.10 - 378.18 378.20 - 378.9
F. Quemaduras y Traumas	1. Quemadura con cicatrices incapacitantes	906.9
	2. Condiciones de cicatrices y filrosis de la piel	709.2
G. Desórdenes hematológicos severos**	1. Mielodisplasia	238.71 -238.74
	2. Anemia Aplástica	284.0 – 284.9
H. Enfermedades del colágeno**	1. Lupus eritematoso sistémico	710.0
	2. Artritis Reumatoidea Juvenil	714.0
I. Deficiencia de Hormona de Crecimiento		253.3

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* Las anomalías congénitas que requieran corrección quirúrgica permanecerán en el registro tres meses post-cirugía o hasta ser dados de alta por el médico que realizó la cirugía.

** Se evaluará cada caso individualmente de acuerdo al tratamiento y severidad de la condición.

Revisado 07 de octubre de 2011

TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

Subsidiaria de Triple-S Management Corporation
PO Box 363628 San Juan, PR 00922-3628
Tel: 749-4949, Fax: (787)-774-4835
cubiertasespeciales@ssspr.com

Anejo 3

FORMULARIO DE REGISTRO DE CUBIERTA ESPECIAL

INFORMACIÓN DEL ASEGURADO Y MÉDICOS QUE LE ATIENDEN

Nombre del asegurado:	Nombre del PCP:	Nombre del Especialista:
Número de Contrato:	Número de proveedor del PCP:	Número de proveedor del Especialista:
Número de telefónico del asegurado:	Tel. PCP:	Tel. Especialista:
	Fax PCP:	Fax Especialista:

DIAGNÓSTICOS

ANEMIA APLASTICA
Requisitos para evaluación:
- — Evidencia de resultado de biopsia o lavado de Médula Ósea
- — Citogenética confirmando el diagnóstico
- — Evaluación y certificación del hematólogo

ESCLERODERMA SISTÉMICA
Requisitos para evaluación:
- — Evidencia de ANA Test
- — Biopsia de Pie
- — Evauación de hematólogo y/o neumólgo

LUPUS ERITEMATOSO SISTÉMICO
Requisitos para evaluación:
- — Evaluación de reumatología
- — Laboratorios de *ANA Test, DS-DNA*, Anti-SM y Anti-Phospholipids Abs

ARTRITIS REUMATOIDE
Requisitos para evaluación:
- — Certificación de condición por Reumatólogo
- — Evidencia de resultado de ESR, CRP, ANA Test y radiografías pertinentes

ESCLEROSIS MÚLTIPLE
Requisitos para evaluación:
- — MRI de Cerebro
- — MRI de Cordón Espinal
- — Resultados de líquido espinal
- — Evaluación y certificación del neurólogo

TUBERCULOSIS
Requisitos para evaluación:
- — Radiografías o cultivos positivos para la infección o lavado bronquial o biopsia de lugar afectado
- — Certificación del neumólogo

AUTISMO
Requisitos para evaluación:
- Evidencia de diagnóstico por neurólogo y/o psiquiatra
  Interpretación M- Chat
- — Resultado del cuestionario Ages and Stages

FIBROSIS QUÍSTICA
Requisitos para evaluación:
- — Prueba de sudor
- — Certificación neumólogo sobre diagnóstico
- — Evidencia de medicamentos que utiliza para la condición

VIH+/SIDA
Requisitos para evaluación:
- — Contaje de CD4 (menos de 200) con historial de enfermedad oportunista
- — Prueba de Western Blot+

ENFERMEDAD RENAL CRÓNICA

Nivel 3	GFR entre 30 y 59
Nivel 4	GFR entre 15 y 29
Nivel 5	GFR menor de 15

Fecha de inicio diálisis: ____/____/____
Mes Día Año

- — Documento 2728
- — Laboratorio creatinina , BUN y edad
- — Indicación de raza y sexo
- — Lugar donde recibe tratamiento: _____
- — Evaluación del nefrólogo que indique nivel de enfermedad renal

POST TRASPLANTE
Requisitos que debe incluir con este formulario:

Tipo trasplante:_____ Fecha trasplante: ____/____/____
Mes Día Año

- — Evidencia médica del trasplante
- — Inmunosupresores utilizados

Indicar si asegurado tiene:
- — Medicare A
- — Medicare B
- — Medicare A y B

HEMOFILIA
- — Evaluación y certificación de hematólogo
- — Resultados de niveles de factores coagulativos
- — Tratamiento actual

LEPRA
- — Evidencia de biopsias o cultivos positivos para la infección

Comentarios adicionales:

ADMINISTRACIÓN DE SEGUROS DE SALUD
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12-037

Nota: Favor de enviar este formulario acompañado de toda la información pertinente, por fax al 774-4835 o vía correo electrónico a la siguiente dirección: cubiertasespeciales@ssspr.com.

isado: 12 de octubre de 2011

TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

Subsidiaria de Triple-S Management Corp
PO Box 363628 San Juan, PR 00922-3628
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REGISTRO DE NIÑOS CON NECESIDADES ESPECIALES

Anejo 4

INFORMACIÓN DEL SUSCRIPTOR Y MEDICOS QUE LE ATIENDEN

Nombre del suscriptor:	Edad:	Número de contrato:	Teléfono del suscriptor:	Núm. de GMP:
Dirección postal del suscriptor:		Nombre del PCP:		Núm. de Proveedor:
		Tel. PCP:	Fax PCP:	Núm. Expediente:
		Nombre del Especialista:		Núm. de Proveedor:
		Tel. Especialista	Fax Especialista	Núm. Expediente:

DIAGNÓSTICOS

DIAGNÓSTICOS		INDIQUE TRATAMIENTO
Diagnóstico (ICD9)	Fecha Diagnóstico: Mes / Día / Año	
Diagnóstico (ICD9)	Fecha Diagnóstico: Mes / Día / Año	
Diagnóstico (ICD9)	Fecha Diagnóstico: Mes / Día / Año	
Diagnóstico (ICD9)	Fecha Diagnóstico: Mes / Día / Año	

ADMINISTRACION DE SALUD
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INDIQUE CLÍNICAS ESPECIALIZADAS QUE VISITA Y LA FRECUENCIA DE LAS VISITAS

INDIQUE HOSPITALIZACIONES RECIENTES (SI ALGUNA)

FECHA	HOSPITAL

INDIQUE PROCEDIMIENTOS QUIRURGICOS RECIENTES Y/O PENDIENTES (SI ALGUNO)

PROCEDIMIENTOS QUIRURGICOS	DESCRIPCION	FECHA	CODIGO DE CPT	LUGAR DE SERVICIO

Nombre y firma de persona que completa este formulario: | Fecha:

Revisado: 13 de octubre de 2011

TRIPLE-S SALUD
BlueCross BlueShield of Puerto Rico

PO Box 363628 San Juan, PR 00922-3628
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FORMULARIO INICIAL DE REGISTRO DE ONCOLOGIA

Anejo 5

Parte A. Información del Asegurado

Nombre del Asegurado:	Número de contrato:
ICD9:	Estadío(TNM):
Fecha de Patología: _____/_____/_____	Teléfono del paciente:
Comorbilidad: ☐ Alergias _____ ☐ Diabetes ☐ Hipertensión ☐ Enfermedad Cardíaca ☐ Enfermedad Pulmonar ☐ Otros _____	

Comentarios: _____

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
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Parte B: Tratamientos Recibidos

Tratamiento	Fecha Aproximada	# Tratamientos	Descripción del Tratamiento
☐ Cirugía			
☐ Radioterapia			
☐ Terapia hormonal			
☐ Trasplante de médula ósea			

Quimioterapia /Agentes Hormonales	Fecha Aproximada	Dosis	Frecuencia	Duración

Ruta	Periferal	Línea Central	S/C	IM	PO
Anti-eméticos	Compazine	Decadron	Reglan	Zofran	Anzemet
Otros Medicamentos:					

Parte C: Proveedores

	Nombre	Número proveedor	Teléfono	Fax
☐ Cirujano				
☐ Radioterapeuta				
☐ Oncólogo				
☐ Otros				

Persona que documenta: _____ Fecha: _____

REGISTRO DE CASOS DE OBSTETRICIA Y REFERIDOS AL PROGRAMA EDUCATIVO

INFORMACIÓN DE LA PACIENTE

Nombre de la Paciente	Edad	GMP

Número de Contrato	Teléfonos de la Paciente

Fecha Primera Visita			Semana de Embarazo al Momento de Primera Visita	Fecha de Ultima Menstruación			Fecha estimada del Parto		
Mes	Día	Año		Mes	Día	Año	Mes	Día	Año

NFORMACIÓN DEL OBSTETRA

Nombre del Obstetra:	
Número de Proveedor	NPI
Teléfono de Oficina	Número de Fax

HISTORIAL CLINICO

Historial Gineco-Obstétrico				¿Abortos recientes? Si o No **Sí**, favor de llenar		
G	**P**	**A**	**SB**			
				Mes	Día	Año

Si es un embarazo de alto riesgo, escoja entre las siguientes indicando el orden de relevancia de las condiciones: (**1** Primario, **2** Secundario, **3** Terciario)

Diagnóstico:	**Relevancia:**
❑ Diabetes	____
❑ Condición respiratoria	____
❑ Hipertensión	____
❑ Cardiovascular	____
❑ Cáncer	____
❑ VIH	____
❑ Historial de parto prematuro	____
❑ Otro, especifique: _____	____

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
12-037

Comentarios:

Firma del Obstetra	Fecha
X	

Puede enviar este formulario al siguiente fax: 774-4835 o vía correo electrónico a la siguiente dirección: cubiertasespeciales@ssspr.com

Revisado: 13 de octubre de 2011

ATTACHMENT 17
LIST OF SUBCONTRACTORS

1. Jaye, Inc.
2. McKesson Health Solutions
3. Mercer Oliver Wyman Actuarial Consulting, Inc.
4. Uticorp
5. VIPS Healthcare Information Solutions
6. Telemedik

Rev. 10.17.2011

ATTACHMENT #17

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Rev. 10.17.2011