

CALINX Rx 2.0 Data Standard Toolkit

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1. Introduction

In the spring of 2004, members of the California health care community established the California Clinical Data Project: Setting Standards initiative. Setting Standards is a collaborative composed of provider organizations, health plans, commercial labs, hospitals, community clinics, purchasers, and state government dedicated to establishing uniform pharmacy and laboratory data exchange standards. These standards are intended to facilitate the exchange of clinical data and provide clinicians with greater access to timely clinical data. Find additional information on the Setting Standards initiative's goals and objectives at www.calinxstandards.org.

Most provider organizations in the state do not pay claims for prescriptions filled by their patients at pharmacies. Providers write prescriptions for their patients, and claims are paid by the health plan or the health plan's pharmacy billing management (PBM) company. Short of asking each patient individually, providers have no reliable way of knowing whether those prescriptions were filled, and if their patients are taking the medications they were prescribed.

The CALINX Rx 2.0 pharmacy data standard is the first product of Setting Standards. Six state and national health plans—Aetna, Blue Cross, Blue Shield, Cigna, Health Net, and PacifiCare—have agreed to provide pharmacy data to provider organization partners on a monthly basis using the CALINX Rx 2.0 format. CALINX Rx 2.0 is based on the CALINX Pharmacy Data Standard Version 1.1, parts of which have been used by health plans and provider organizations in California for the past four years.

Any time a health plan member uses their pharmacy benefit to fill and pay for a prescription, the health plan pays the claim on behalf of that patient to the dispensing pharmacy. The CALINX Rx 2.0 standard is a file format that describes these events. Each record in the CALINX Rx 2.0 standard represents a single prescription fill. Fields within the standard identify the patient, the pharmaceutical dispensed, and the prescribing clinician. The standard is intended to be used by health plans and PBMs to develop and send these prescription data files to contracted provider groups, and by provider organizations to interpret and load these prescription data into their own data repositories. A copy of the CALINX Rx 2.0 Standard and Implementation Guide can be found in Appendix A.

Using the new CALINX Rx 2.0 standard, health plans can provide prescription fill information to provider organizations on a regular basis. Groups can then build reports and deliver them to treating physicians, which gives the physicians more accurate, up-to-date prescription records for their patients. This gives treating providers the vital clinical information they need to treat their patients with chronic illnesses. Groups can also use pharmacy data to self-report Pay-for-Performance clinical measures (e.g., appropriate medication for people with asthma), incorporate pharmacy information into disease registries or electronic health records, or use the data for internal quality improvement or disease management programs.

2. What's New in CALINX Rx 2.0

The CALINX Rx 2.0 standard is very similar to the original CALINX 1.1 format. (Note: If you received pharmacy data prior to January 2005, it was likely being sent in the CALINX 1.1 format or a similar NCPDP format.) Most of the health plans implemented CALINX 1.1 a little differently, which resulted in files with different data structures and variations. This may have complicated the use of those data for provider organizations receiving files from more than one health plan.

The CALINX Rx 2.0 standard has improved field placement notation and expanded field definitions. The implementation guide and notes section located at the end of the CALINX Rx 2.0 standard has been expanded considerably. These sections answer questions about field values and how certain fields may be reported. This is the first place you should look if you need help interpreting your pharmacy data file.

CALINX Rx 2.0 has new fields that are intended to address common problems, like patient identification and prescription fill reversals. The new fields are:

1. **Health Plan Name:** CALINX 1.1 only provided a code; this adds the health plan name to the file to simplify health plan identification.
2. **Health Plan ID:** This field now represents a four-digit code assigned by the California Department of Managed Health Care.
3. **Record indicator:** This field indicates if each record in your file is either: new; a record that should overwrite an existing record (one sent in a previous batch); or a record that should delete a record received in a previous batch.
4. **Alternate Patient ID Qualifier and Alternate Patient ID:** These fields represent alternate patient identifiers that may be used by the health plans. This is intended to give provider organizations additional identifiers (if the plan has them) to facilitate patient matching.
5. **Brand Name:** This field is populated with the brand name of the drug or left null if a generic is used.
6. **Refill Number:** This field indicates the number of refills. In CALINX 1.1, this was combined with the previous field (**New/Refill Code**) which often did not indicate the number of refills, but only whether the drug was new or a refill.

Changes to existing fields include:

1. **Quantity Dispensed:** Expanded from 9 to 11 digits to be more consistent with NCPDP standards
2. **Place of Service:** New field value options added
3. **Pharmacy ID_NCPDP Code:** Name changed from **Pharmacy ID-NABP Code**
4. **Product Type:** Name changed from **Plan Type**
5. **Prescriber ID:** Name changed from **Prescriber ID #**
6. **PCP ID Qualifier:** Name changed from **PCP ID # Qualifier**
7. **PCP ID:** Name changed from **PCP ID code**
8. **Product Line Category Code:** Changed from **Commercial/Senior code**

3. Frequently Asked Questions

1. What is CALINX?

CALINX (which stands for CALifornia INformation eXchange) is a standard file format for exchanging batches of pharmacy records. The standard provides information about patient medication dispensing events and prescriber information, and can be used for disease registries, electronic health records, disease management, and Pay-for-Performance initiatives.

2. Was there an old standard? What was wrong with it?

The new CALINX Version 2.0 is the second iteration of the CALINX standard; the first version (1.1) was released in 2000 and was partially adopted by six health plans in California. The biggest problem with the standard was that it was interpreted differently by most of the adopting health plans. This led to slight variations of file formats, making integration of the data difficult for provider organizations receiving files from multiple health plan partners.

3. What's the difference between the old standard (CALINX 1.1) and the new standard (CALINX Rx 2.0)?

Most of the changes to the CALINX standard are relatively minor. There are additional patient identifier fields to help with internal patient matching efforts, and there is better functionality to handle reversals or changes. The Implementation Guide has also been revised and updated. For a complete review of changes to the standard, refer to Section 2, "What's New in CALINX Rx 2.0."

4. How does CALINX Rx 2.0 differ from NCPDP?

CALINX Rx 2.0 is based on the NCPDP batch transaction standard, version 1.1, which uses NCPDP version 5.1 as its base. CALINX Rx 2.0 has added some features specific to California (Health Plan ID based on the California Department of Managed Health Care code for example), as well as new functionality to enhance back-out and change capabilities. The biggest difference between the two standards is their intended purpose: The NCPDP standards are intended to be used for claims transaction purposes, while the CALINX standard is intended to be used for disease management and quality improvement purposes.

5. What does the Pharmacy Data Verification Tool do?

The pharmacy data verification tool's primary function is to allow you to confirm that pharmacy files you receive adheres to the CALINX Rx 2.0 standard. The tool also provides detailed reports on any detected errors, will allow for some error corrections, and can transform the files you receive into a variety of formats.

6. Who can I talk to about getting pharmacy data?

To inquire about receiving pharmacy data for your members, you can speak with your contracted health plan partners listed in Section 6, "For More Information."

7. Do we need to have pharmacy risk to receive pharmacy data from health plans?

No, you do not have to have pharmacy risk in order to receive pharmacy data from health plans. Most provider groups in California no longer have pharmacy risk, and many receive pharmacy files from their health plan partners.

8. Is this new standard HIPAA compliant?

The new CALINX Rx 2.0 standard does not fall under the HIPAA transaction standard rule. CALINX Rx 2.0 is intended for the transmission of health care information for quality and health improvement purposes, NOT for payment purposes. Because CALINX Rx 2.0 data has protection health information (PHI) such as patient names and dates of birth, it does fall under HIPAA privacy and security rules, and must be exchanged accordingly (between covered entities and business associates in a secure manner). Additional information can be found in Section 5, "CALINX Rx 2.0 and HIPAA."

9. Will the toolkit or data validation software help with member matching?

Unfortunately neither the new toolkit nor the data validation software has member matching capabilities.

In August 2004, the California HealthCare Foundation published a buyer's guide to patient data-matching software. The guide identified four relatively inexpensive software options available on the market and evaluated the products based on importing capabilities, matching capabilities, post-match processing, and price. You can download it at <http://www.chcf.org/topics/view.cfm?itemID=104595>.

10. Sometimes I get a file where all the patient identifiers are null, or masked and unreadable. Why is this and can it be corrected?

Some health plans may mask member identifiers for their own employees or for members who have asked that their patient identifiers be kept confidential. If you receive records with masked identifiers you may inquire if they can be identified, but it is unlikely that those records will be decrypted by the health plans.

4. Pharmacy Data Verification Tool

The CALINX Rx VERIFY software tool is designed to assist users who wish to verify that a pharmacy file conforms to the CALINX Rx 2.0 standard, and convert pharmacy data files that are in the CALINX Rx 2.0 format. The application can be used to perform two main functions:

1. **Verification.** The application can be used to verify that CALINX Rx 2.0 files are in the correct format. It will detect all verification errors and report the number and types of errors found at the file, record, and field level.
2. **Conversion.** The application will convert selected fields that contain dates and numbers in the CALINX Rx 2.0 format to more standard formats that can be interpreted easily by applications such as spreadsheets and databases.

The software will be available for download without charge at www.calinxstandards.org in early 2005.

5. CALINX Rx 2.0 and HIPAA

CALINX Rx 2.0 pharmacy data is intended to help improve access to more accurate and timely pharmacy data. CALINX Rx 2.0 pharmacy data is only intended to be exchanged between contracted entities, or between “covered entities” and “business associates” as defined in the Health Insurance Portability and Accountability Act of 1996, or HIPAA.

The HIPAA transaction standard requires that only standards recognized in the *Federal Register* be used for *financial* and *administrative transactions* to enable health information to be exchanged electronically. Standards are required for the following transactions:

1. Health care claims or equivalent encounter information
2. Health care payment and remittance advice
3. Coordination of benefits
4. Health care claim status
5. Enrollment and disenrollment in a health plan
6. Eligibility for a health plan
7. Health plan premium payments
8. Referral certification and authorization
9. First report of injury
10. Health claims attachments
11. Other transactions that the Secretary may prescribe by regulation

A transaction is defined in §160.103 of the *Final Rule*¹ as the exchange of data for one of the enumerated specific purposes. For example, one type of health care claim or equivalent encounter information transaction is the exchange of information between a health care provider and a health plan about services provided to a patient *to obtain payment*. Data submissions or exchanges for purposes other than those designated in this regulation are *not transactions* and therefore *do not require use of the standards*.

The regulations define a claim or encounter transaction as the transmission of:

- a. A request to obtain payment, and the necessary accompanying information from a health care provider to a health plan for health care; or
- b. If there is no direct claim, because the reimbursement contract is based on a mechanism other than charges or reimbursement rates for specific services (e.g., capitation), the transaction is the transmission of encounter information for the purpose of reporting health care.

CALINX Rx 2.0 is NOT a request for payment of any kind; it is a file format for transmitting clinical information to providers of care. As such, the CALINX Rx 2.0 standard does not fall under the transaction rule of HIPAA. The Privacy and Security regulations of HIPAA must however still be observed to maintain patient confidentiality.

¹ Federal Register, Vol. 65, No. 160, August 17, 2000, Rules and Regulations.

6. For More Information

If you have additional questions about managing pharmacy data that are not answered in this toolkit, you may find answers to these or other questions on the Web at www.calinxstandards.org.

If you have any questions about the CALINX Rx 2.0 standard or the pharmacy data validation tool, contact CALINX-Rx@sujansky.com. Sujansky & Associates are managing many aspects of this project for the California HealthCare Foundation.

If you have questions specific to pharmacy utilization data or a pharmacy file from one of your contracted health plan partners (for example, you wish to start receiving pharmacy data, didn't receive a file, etc.), contact the appropriate health plan contact below.

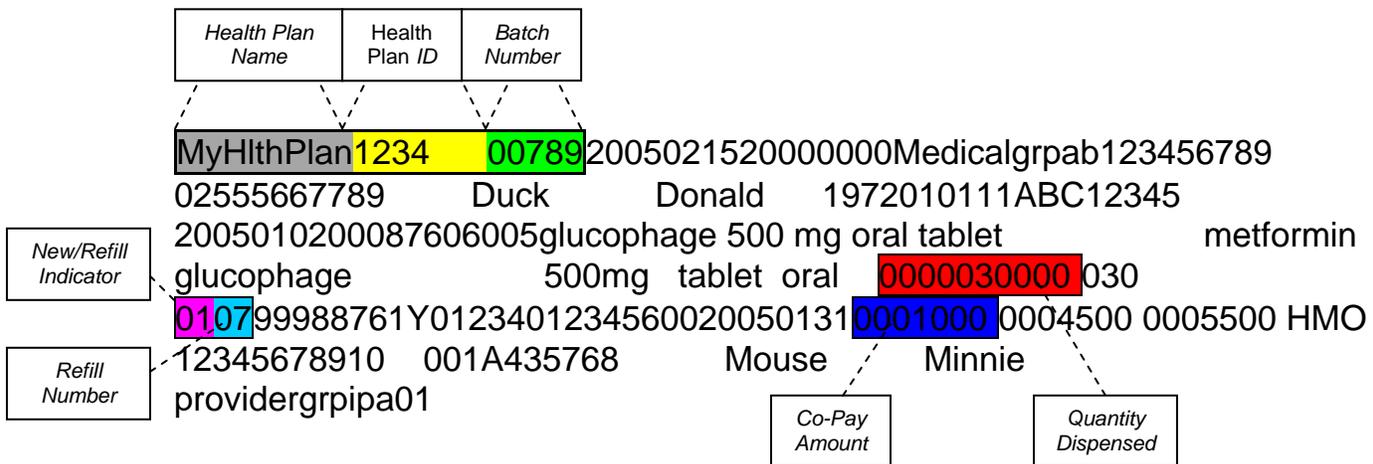
Organization	Name	Email	Phone
Sujansky & Associates	Walter Sujansky	CALINX-Rx @ sujansky.com	NA
Aetna	Mitch Nagao	NagaoM @ aetna.com	925-543-9777
Blue Cross	Martin Souverbielle	Martin.Souverbielle @ wellpoint.com	818-234-3974
Blue Shield	Adam Mattson	adam.mattson @ blueshieldca.com	916-350-6253
CIGNA	Janet Helm, Nancy Ho	Janet.Helm @ cigna.com nancy.ho @ cigna.com	818-500-6372 818-500-6459
Health Net	Ken Harada	ken.harada @ healthnet.com	818-676-8942
PacifiCare	Carolyn Iteen	carolyn.iteen @ phs.com	714-226-6772

7. Making Sense of Your Pharmacy Utilization File

CALINX Rx 2.0 files are fixed-width flat files. Each line or “record” in a file represents a single prescription dispensing event and has unique identifiers for patients, insurance carriers, prescribing clinicians, pharmaceutical agents, and prescription fill dates. Each line may also represent a back-out or replacement record if a prescription that the health plan previously reported as filled was either not picked up, or was changed. Special attention should be paid to managing back-outs and adjustments, as they will require that you replace, change, or delete records you may have already loaded into your pharmacy database. Section 8, “Managing CALINX Rx 2.0 Pharmacy Data,” describes how these records can be effectively managed.

7.1. Sample Record

You can view your pharmacy file, using a simple text editor, such as Microsoft Notepad. Opening your file using Notepad, each record may look something like this (without the shading, or the callout boxes indicating field names):



Fixed width files have no delimiters such as commas (,) or pipes (|) between fields. Instead, fields fit within a defined range of “columns” where each character is represented by a single column. In the above example, the **Health Plan Name** field is located in the first 10 columns, followed by the **Health Plan ID** field in the following 10 columns, and the **Batch Number** field in the following five. While each field is not delimited, each **record** in the file is delimited with a standard delimiter, such as a carriage return + line feed. This makes it easy to see where one record ends and another begins.

7.2. Field Formats

Notice in the sample record that there are blanks after the four digits of **Health Plan ID**. When the observation (in this case, 1234) is smaller than the space provided by the standard (10 columns) and the field is alphanumeric, the spaces to the right of the observation will be left blank. These fields are “left justified” because their observations are aligned with the left most column of the field. Numeric fields such as the **Batch Number** field above, are “right justified” and “zero filled”; they are aligned with the right most column of the field and empty spaces to the **left** of the reported value are filled with zeros. In this example, the two empty spaces to the left of the value 789 are filled with zeros.

Signed decimal and signed numeric fields are also right justified. However, they may be positive or negative, and this will be indicated in the field’s right-most column. A blank column indicates a positive record, while a negative (–) sign indicates a negative record. In the above example, the signed decimal field **Co-Pay Amount** is positive, as the right most column of the blue shaded box is blank.

Signed decimal fields also have an “implied” decimal placement. That means that the CALINX Rx 2.0 specification will indicate where the decimal should be placed in the field when loading your pharmacy file. This information is indicated in the **Definition of Field Value/Comments** column in the specification. In the case of the **Co-Pay Amount** field, the CALINX Rx 2.0 specification indicates the following:

Amount paid by patient \$\$\$\$\$ccS

The trailing “S” indicates the sign of the field, which will be either positive (blank) or negative (–). Counting from the left of this right-justified field, (and making sure to count the zeros), the decimal should be placed between the fifth and sixth column; or between the five “\$” columns and the two “c” columns. The output of this field is therefore \$10.00.

Signed decimal fields that are not currency will indicate the placement of the decimal with a “v.” In the above sample record, the value of **Quantity Dispensed** is 0000030000_ (the underscore is added here to represent the blank column, indicating a positive record). The CALINX Rx 2.0 **Definition of Field Value/Comments** for **Quantity Dispensed** indicates the following:

Metric Decimal quantity of product dispensed (9999999v999S)

Counting from the left of this right-justified field, the decimal should be placed between the seventh and eighth column; making sure to count any leading zeros. The output of this field is therefore 30.000 (or just 30).

7.3. Required, Optional, and Conditional Fields

The CALINX Rx 2.0 standard designates each field as being **Required**, **Optional**, or **Conditional**. This is indicated in the **Status** column of the standard with an R, O, or C respectively. **Required** fields must be populated with non-blank values in order for your file to be considered compliant with the CALINX Rx 2.0 standard. Examples of required fields include **Patient ID**, **Date of Birth**, and **NDC** code. Files missing required fields may be difficult or impossible to use appropriately. If you receive files with missing required fields, you should notify your health plan or PBM trading partner and have them send you a file with records updated accordingly.

Optional fields may be populated, but may also be left blank. If they are populated, they should conform to the standard field specification. If optional fields are populated with zeros (i.e., they are not left blank) then those fields should be considered valid data.

Conditional fields may be required if a related field is populated. Conditional fields are therefore dependent on the value of other fields in the CALINX Rx 2.0 standard. For example, the conditional field **Refill Number** and has the following condition:

Required if field 31, **New Refill Indicator** = 01

In the sample record above, the **New/Refill Indicator** is 01. According to the CALINX Rx 2.0 standard, this indicates that the prescription is a refill and that the **Refill Number** field is now required. In the above sample record, the **Refill Number** is 07, which means it is the seventh refill dispensed to the member.

8. Managing Pharmacy Data

Having a unified data exchange standard simplifies the integration and loading of pharmacy data from multiple health plans and PBMs into a single database. However, there are still a number of steps you must take to effectively manage the flow of pharmacy data into your organization. These steps will become your data loading programs or “routines” and should include the programming you use to match patient records to internal eligibility files, checks on file size and content, and updates you will use to load data into your pharmacy database.

Patient matching is one of the more difficult tasks provider groups face with their pharmacy files. The identity of the members in your pharmacy data files must be matched with your provider organization’s internal eligibility records. This can either be done with your own internally developed programming, or with readily available software (please see Additional Resources for more information on available software tools). After you have processed a few files from each plan, you should start to build some checks into your loading routines to count the number of records you receive in each batch and alert you if that number is suspiciously higher or lower than what you have recently seen. Your patient matching rate should also be a summary statistic you review as part of your loading programs.

Your loading programs will also have to take into account changes to previously reported prescriptions. Occasionally prescription records need to be adjusted if errors were made, or prescriptions that the payer believed filled were, in fact, not. These complications can be managed as long as you are aware of the coding methodologies used in the CALINX Rx 2.0 standard and make the appropriate adjustments to your own internal loading programs. Changes can take place either at the **record** level, where only a change to a previously reported prescription record are required; or at the **batch** level, where an entire batch must be adjusted. The following sections describe steps you can take to build your loading programs accordingly.

8.1. Action Code

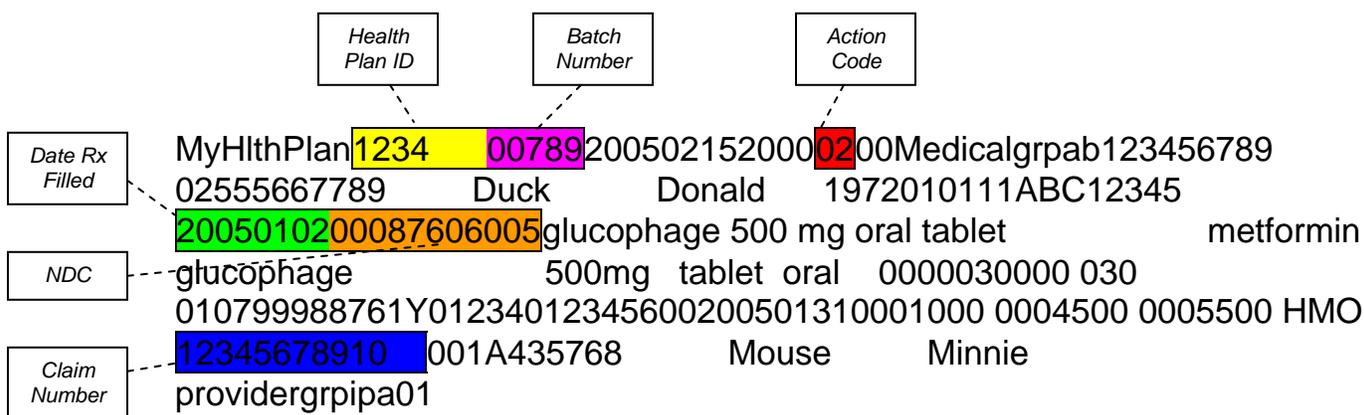
The **Action Code** field indicates how you should manage and process each **batch** of records you receive. This field should be set at the batch level; this means that all records you receive in that batch should have the same **Action Code**. For the majority of batches you receive, the value will be 00 indicating an original submission of pharmacy claims. Occasionally, you may receive a batch with an **Action Code** of 02 or 03 (see Appendix A for definitions of Action Code Values). These values require that you make changes to previous batches you have received and may have already loaded into your pharmacy database.

Before loading records from a new batch file into your pharmacy database, you need to check the **Action Code** value. If the value is 00, you may continue with other routines you run before loading your new batch of claims. If the value is 02 or 03, you need to

match all the records from the new batch with records you have loaded into your pharmacy claims database.

To identify the claims you need to change, search through all records in your pharmacy database and match them with records in your batch using the following fields:

- **Health Plan ID**
- **Batch Number**
- **Date Rx Filled**
- **NDC**
- **Claim Number**



Once those claims have been identified and matched, you need to take action. If the value of the **Action Code** field is 02 you should delete the records in your pharmacy database and replace them with the records in your new batch file. If the value is 03 you should delete all matching records from your pharmacy database. Some database administrators do not like to delete records out of their system; in that case, you may want to create a delete “flag,” and flag those identified records.

8.2. Record Indicator

The **Record Indicator** field is conditional on an **Action Code** value of 00 and is used to make corrections only to specific records from previous batches. It essentially works like the **Action Code** field except it operates at the record level instead of the batch level.

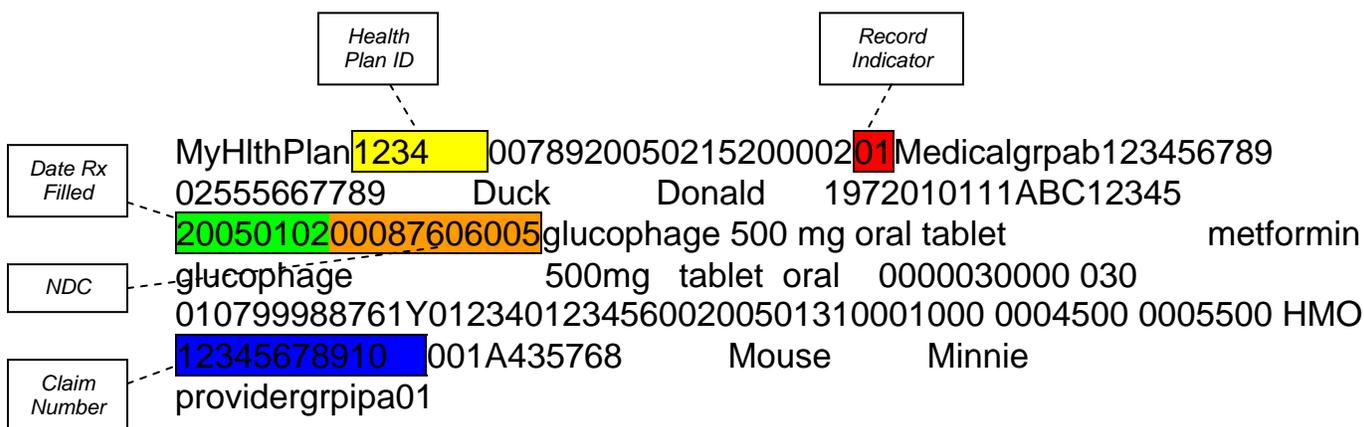
The majority of records you receive will have a value of 00 indicating a new record. Occasionally, you may receive a record with a **Record Indicator** of 01 or 02. These values require that you make changes to a record you received in a previous batch and may have already loaded into your pharmacy database.

Before loading records from a new batch file into your claims database, you need to check the **Record Indicator** value for each claim in your batch. If the value is 00, you may continue with other routines you run before loading your new batch of claims. If any

claims have values of 01 or 02, you need to match all the records with these values from your new batch with records you have loaded into your pharmacy database.

To identify the claims you need to change, you should search through all records in your pharmacy database and match them with records in your batch having non-00 values using the following fields:

- **Health Plan ID**
- **Date Rx Filled**
- **NDC**
- **Claim Number**

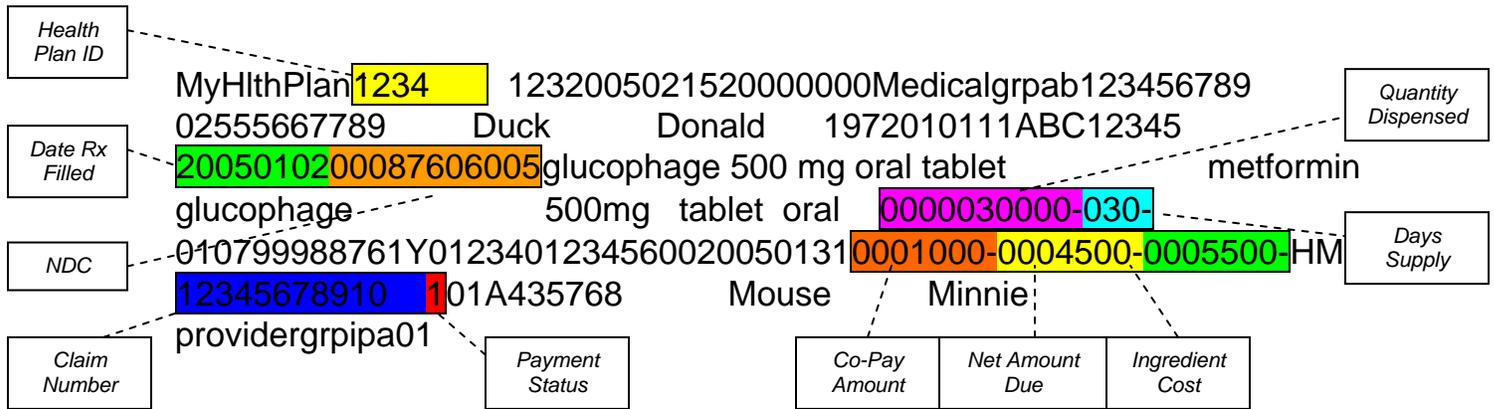


Once those claims have been identified and matched, you need to take action. For records with **Record Indicator** values of 01, you should delete the records in your pharmacy database and replace them with the records in the new batch file. For records with a value of 03, you should delete all matching records from your database.

8.3. Payment Status

The **Payment Status** also operates at the **record level** and indicates whether an individual claim for a prescription was paid (00) or reversed (01). Reversed claims are also commonly referred to as “back-outs.” The majority of claims in files you receive will be paid and the records can be loaded into your pharmacy database accordingly. However in some cases your file will have reversed records, which indicate prescriptions that were either not picked up by the patient; were refunded; or were returned to stock at the pharmacy. These records can be a headache to manage as they will typically show up in one reporting period as paid (00) and then show up in a subsequent reporting period as reversed (01). If the original claims have been loaded into your pharmacy database, you will need to locate and flag them, indicating that they were never picked up by the member.

Reversed claims have other important features. The example below highlights significant properties of reversed claims:



The **Payment Status** field = 01 and the **Quantity Dispensed, Days Supply, Co-Pay Amount, Net Amount Due, and Ingredient Cost** will all be negative. You should have received a similar claim in a previous batch (or possibly, but rarely, in the same batch). That claim should have a **Payment Status** = 0, and the fields listed above should all be identical, except that they will be positive.

For every pharmacy file you receive in the CALINX Rx 2.0 standard, you should run a routine that looks for reversed claims before loading these into your system. The routine should check for and list all claims in your batch with a **Payment Status** = 1. Once those have been identified (if there are any), you should search through your pharmacy database (and the new batch) for the identical claim that was reported as paid.

To find the paid claim, you should search all records and match on the following fields:

- **Health Plan ID**
- **Date Rx Filled**
- **NDC**
- **Claim Number**

Check to make sure that the matched claims have a **Payment Status** of 0 and that all the quantity fields listed above are the same (but positive) as the reversed claim. Once those claims have been identified and matched, you need to flag them. Remember, these weren't actually paid or picked up by the member, but they were reported as such. The best way to flag them is to change the **Payment Status** on the original claim from 0 to 1. Some database administrators don't like to alter original data; in that case, you may want to create a custom field and flag the original and reversed claim using the new field. It is not recommended that you delete either the original or reversed claim.

Depending on how comfortable you are with your system and the technical expertise available to you, these loading programs can all be automated. You should at least review an output file that lists all the claims that were flagged, just to make sure your routines worked as expected. It never hurts to do a final check.

Appendix A. The CALINX Rx 2.0 Standard

Version 2.0 is based on Version 1.1 of the California Information Exchange (CALINX) Pharmacy Data Standard Specification published in January 2000. Version 2.0 represents an industry review of Version 1.1 and includes field updates and clarifications. The industry review included health plan, provider organization, and vendor participation. Questions and comments regarding the specification and its implementation should be directed to the California HealthCare Foundation.

The CALINX Rx 2.0 Standard is presented in three parts:

1. A table of all of the fields that includes the field number, name, format, length, location, definition and comments, and status notation.
2. Additional notes for some fields that require further explanation.
3. An implementation guide that explains file conventions, field format types, and the status notation.

As you review Part 1, refer to Part 3 for complete definitions of the following items.

The Field Format types:

- A/N = Alpha-numeric
- N = Numeric
- SD = Signed decimal
- SN = Signed numeric

The Status notation:

- R = Required
- O = Optional
- C = Conditional. The condition is provided in the Definition column.

In addition to these three parts, the Toolkit includes an Import Specification. The Import Specification is a pre-loaded format that recognizes CALINX Rx 2.0 pharmacy data files and can be used to easily import CALINX Rx 2.0 pharmacy data directly into a Microsoft Access[®] database. Appendix B provides step-by-step instructions describing how the Import Specification can be used to load CALINX Rx 2.0 data.

Appendix A1. Data Standard Specification

Field	Field Name	Field Format	Field Length	Field Location	Field Definition & Comments	Status
1	Health Plan Name	A/N	10	1 – 10	Name of health plan See note for Field 1	R
2	Health Plan ID	A/N	10	11 – 20	Health plan identifier. For California, use Department of Managed Health Care assigned codes See note for Field 2	R
3	Batch Number	N	5	21 – 25	Identifier assigned by process/sender See note for Field 3	R
4	Run Date	N	8	26 – 33	Date on which file/tape/disk was created Use date format: CCYYMMDD	R
5	Version/Release #	A/N	2	34 – 35	CALINX version and release number 20 = Version 2, Release 0	R
6	Submission Number	A/N	2	36 – 37	00 = Original Submission 01 = First resubmission, etc. See note for Field 6	R
7	Action Code	A/N	2	38 – 39	00 = Original submission (new) 02 = Correction or adjustment to a previous batch 03 = Deletion of a previous batch 05 = Replacement of a previous batch (delete followed by add) See note for Field 7	R
8	Record Indicator	A/N	2	40 – 41	00 = New record 01 = Overwrite existing record 02 = Delete existing record <i>Condition: Required if Field 7 (Action Code) is 00 for Original Submission.</i> See note for Field 8	C
9	Recipient ID	A/N	10	42 – 51	Identification of group to whom data are being sent (assigned by sender)	O
10	Patient ID	A/N	18	52 – 69	Identification number assigned to patient by health plan, as appearing in the pharmacy claim See note for Field 10	R

Field	Field Name	Field Format	Field Length	Field Location	Field Definition & Comments	Status
11	Alternate Patient ID Qualifier	A/N	2	70 – 71	00 = Not defined 01 = Non-SSN-based patient ID assigned by health plan 02 = SSN-based patient ID assigned by health plan 03 = Patient SSN 99 = Other <i>Condition: Required if Field 12 (Alternate Patient ID) is populated.</i> See note for Field 11	C
12	Alternate Patient ID	A/N	18	72 – 89	Alternate identification number assigned to patient by health plan See note for Field 12	O
13	Patient Last Name	A/N	15	90 – 104	Patient's last name	R
14	Patient First Name	A/N	12	105 – 116	Patient's first name	R
15	Date of Birth	N	8	117 – 124	Patient's date of birth Use date format: CCYYMMDD	R
16	Patient Gender	A/N	1	125	0 = Not specified 1 = Male 2 = Female	R
17	Patient Relation	A/N	1	126	Patient's relationship to cardholder (insured) 0 = Not specified 1 = Cardholder 2 = Spouse 3 = Male child 4 = Female child 5 = Covered minor dependent of cardholder 6 = Covered adult dependent (not spouse) 7 = Previous spouse of cardholder 8 = No card used 9 = Other (not included above)	R
18	Patient Employer	A/N	15	127 – 141	Identification code assigned to cardholder employer group (by health plan)	O
19	Date Rx Filled	N	8	142 – 149	Date the prescription was filled or service rendered Use date format: CCYYMMDD	R

Field	Field Name	Field Format	Field Length	Field Location	Field Definition & Comments	Status
20	NDC	A/N	11	150 – 160	National Drug Code Use 11-digit format as follows: 5 digits = Manufacturer 4 digits = Product 2 digits = Package size See note for Field 20	R
21	Label Name	A/N	30	161 – 190	Product or service description. Use name of medication as it appears on label. See note for Field 21	R
22	Alternate Product Code ID Qualifier	A/N	2	191 – 192	00 = Not defined 01 = GPI 02 = AHFS 03 = GCN 04 = SMART Key 97 = Trading Partner Defined 99 = Other <i>Condition: Required if Field 23 (Alternate Product ID) is populated.</i>	C
23	Alternate Product ID	A/N	18	193 – 210	Alternate product ID code	O
24	Generic Name	A/N	30	211 – 240	Name of generic equivalent See note for Field 24	O
25	Brand Name	A/N	30	241 – 270	Drug brand name See note for Field 25	O
26	Strength	A/N	8	271 – 278	Drug product strength (value and units)	O
27	Dosage Form	A/N	8	279 – 286	Dosage form for product dispensed	O
28	Route of Administration	A/N	8	287 – 294	Route of administration of product See note for Field 28	O
29	Quantity Dispensed	SD	11	295 – 305	Metric decimal quantity of product dispensed Use SD format: 9999999v999S	R
30	Days Supply	SN	4	306 – 309	Estimated number of days the prescription will last Use SN format: 999S	R
31	New/Refill Indicator	A/N	2	310 – 311	00 = New 01 = Refill	R

Field	Field Name	Field Format	Field Length	Field Location	Field Definition & Comments	Status
32	Refill Number	N	2	312 – 313	0 = Unknown 1–99 = Refill number <i>Condition: Required if Field 31 (New Refill Indicator) is 01.</i> See note for Field 32	C
33	Prescription #	A/N	7	314 – 320	Number assigned by pharmacy to transaction provided	R
34	Drug Type	A/N	1	321	Drug type as defined by health plan: 0 = Not specified 1 = Single source brand 2 = Branded generic cross-licensed brand 3 = Generic 4 = OTC 5 = Multi-source brand (branded drug with generic available) See note for Field 34	R
35	Formulary Status	A/N	1	322	Y = Yes N = No Z = Unknown or not classified	O
36	Pharmacy ID_Chain Code	A/N	5	323 – 327	Chain identification assigned by NCPDP	O
37	Pharmacy ID_NCPDP Code	A/N	7	328 – 334	Individual pharmacy identification assigned by NCPDP	O
38	Place of Service	A/N	2	335 – 336	00 = Not specified 01 = Home 02 = Inter-care 03 = Nursing care 04 = Long-term care 05 = Rest home 06 = Boarding home 07 = Skilled care facility 08 = Sub-acute care facility 09 = Acute care facility 10 = Outpatient/Ambulatory 11 = Hospice 99 = Other not included in above	O
39	Date Billed	N	8	337 – 344	Ending date of financial period Use date format: CCYYMMDD	O
40	Co-Pay Amount	SD	8	345 – 352	Amount paid by patient Use SD format: \$\$\$\$ccS See note for Field 40	R

Field	Field Name	Field Format	Field Length	Field Location	Field Definition & Comments	Status
41	Net Amount Due	SD	8	353 – 360	Amount paid to pharmacy (net cost to plan) Use SD format: \$\$\$\$ccS See note for Field 41	R
42	Ingredient Cost	SD	8	361 – 368	Drug ingredient cost included in total amount due Use SD format: \$\$\$\$ccS See note for Field 42	R
43	Product Type	A/N	4	369 – 372	Insurance product type, as specified by the health plan (line of business code). This field may not be consistently populated across health plans. See also Field 56: Product Line Category Code. See note for Field 43	R
44	Claim Number	A/N	15	373 – 387	Unique claim identification number assigned by health plan or the ID number on the original claim	R
45	Payment Status	A/N	1	388	0 = Paid 1 = Reversed See note for Field 45	R
46	Prescriber ID Qualifier	A/N	2	389 – 390	00 = Not defined 01 = DEA number 02 = State license number 03 = National Prescriber ID number 04 = Tax ID number 05 = SS number 06 = HIN 07 = Health plan assigned ID number 99 = Other See note for Field 46	R
47	Prescriber ID	A/N	18	391 – 408	ID assigned to prescriber (in form defined by qualifier in Field 46)	R
48	Provider Last Name	A/N	15	409 – 423	Last name of prescribing provider	O
49	Provider First Name	A/N	12	424 – 435	First name of prescribing provider (or initial)	O

Field	Field Name	Field Format	Field Length	Field Location	Field Definition & Comments	Status
50	PCP ID Qualifier	A/N	2	436 – 437	00 = Not defined 01 = DEA number 02 = State license number 03 = National Prescriber ID number 04 = Tax ID number 05 = SS number 06 = HIN 07 = Health plan assigned ID number 99 = Other <i>Condition: Required if Field 51 (PCP ID) is populated.</i> See note for Field 50	C
51	PCP ID	A/N	18	438 – 455	Identification assigned to the patient's primary care provider (in form defined by qualifier in Field 50)	O
52	PCP Last Name	A/N	15	456 – 470	Last name of primary care provider	O
53	PCP First Name	A/N	15	471 – 485	First name of primary care provider	O
54	Provider Group	A/N	14	486 – 499	ID assigned to patient's medical group <i>Condition: Required if Field 56 (Product Line Category Code) is 1 – 6 (i.e., if prescription is for a managed-care patient).</i>	C
55	PSC/DAW	A/N	1	500	Product Selection Code / Dispense as Written (0–9) 0 = No product selection indicated 1 = Substitution not allowed by prescriber 2 = Substitution allowed—patient requested product dispensed 3 = Substitution allowed—pharmacist selected product dispensed 4 = Substitution allowed—generic drug not in stock 5 = Substitution allowed—brand drug dispensed as a generic 6 = Override 7 = Substitution not allowed—brand drug mandated by law 8 = Substitution allowed—generic drug not available in marketplace 9 = Payer-defined exemption	O

Field	Field Name	Field Format	Field Length	Field Location	Field Definition & Comments	Status
56	Product Line Category Code	A/N	1	501	0 = Unknown 1 = Commercial (HMO/POS) 2 = Medicare Risk 3 = Senior – Other 4 = Medi-Cal 5 = Healthy Families 6 = Other Government	R
57	Blank	A/N	30	502 – 531	Reserved for future expansion by CALINX See note for Field 57	O
58	Filler	A/N	81	532 – 612	Used for additional data specific to trading partners See note for Field 58	O

Appendix A2. Notes for Select Fields

Field 1: Health Plan Name

This is the text name of the health plan sending the data. It is self-assigned by the health plan and does not necessarily conform to any consistent naming standards.

Field 2: Health Plan ID

This field contains a unique identifier of the health plan sending the data. For reporting specific to California, use the California Department of Managed Health Care codes as noted in the “List of All Licensed Plans” (<http://www.dmhca.ca.gov/library/reports/>). These are four-digit codes assigned by DMHC for health insurance companies operating in California. If the CALINX Rx 2.0 standard is used in other states or across states to report pharmacy claims activity, please use an appropriate identifier as agreed upon by all sending and receiving parties.

Field 3: Batch Number

All records in a data set should have the same batch number. The batch number should be unique for a given health plan or other sender of pharmacy claims data (e.g., PBM). The batch number should only be reused to tie a replacement or a changed or deleted record back to the original batch (see note for [Field 6](#): Submission Number for more information). Many health plans use the “Julian” representation of the report date (YYDDD) as the batch number, but this is not required.

Field 6: Submission Number

The submission number is a two-digit code that indicates the number of times a data set has been resent (for example, owing to errors). All records in the data set should have the same submission number. Subsequent recreations of the same data set (“resubmissions”) should have the previous submission number increased by 1.

Note: The batch number (Field 2) in any resubmission should be the same as the batch number in the original submission. Maintaining the same batch number across submissions and resubmissions will help organizations identify records that need to be corrected or replaced when resubmissions are sent.

Field 7: Action Code

The action code is a two-digit code that instructs the receiver of the data set as to how the data are to be processed. The values are defined as follows:

- **00 = Original submission (new):** Represents an original or “new” batch submission. This code is used in most cases.

- **02 = Correction/adjustment to previous batch:** Represents a correction or adjustment to specific records sent in a previous corresponding batch. The record or records that are sent with an 02 Action Code in this batch should replace the corresponding records in the previous batch.
- **03 = Deletion of previous batch:** Represents a deletion of an entire previously sent batch. If an 03 is sent, all records sent in the previous corresponding batch should be deleted.
- **05 = Replacement of previous batch (delete followed by add):** Represents a full replacement of a previous batch. If an 05 is sent, all records sent in the previous corresponding batch should be deleted and replaced with all records sent in this batch.

Note that a record with a submission number of 00 *must* have an action code of 00. A record with a submission number of 01 or greater *cannot* have an action code of 00. A record with an action code of 01 or greater cannot have a submission number of 00. If the action code is not 00, the sender should alert the receiver to ensure correct processing.

Field 8: Record Indicator

Use of this field is reserved for the case when an original submission is sent (Action Code = 00) and the batch includes a small number of corrections/deletions to previously sent records. This field allows data to be flagged on a record-by-record basis so that the receiving organization can understand what action to take on each record. This field is conditional, and should be populated only if the Action Code (Field 7) is 00 (original submission). The allowed values are:

- **00 = New record:** Insert new record (this value should be assigned to most records in an original submission, i.e. those records that represent new data and are *not* corrections/adjustments to previously sent records).
- **01 = Overwrite existing record:** An error was discovered in a previously sent version of this record; therefore the receiver should delete the previously sent version and replace it with this record. Note: The previously sent version may be identified by the health plan ID, claim number, prescription number, and payment status data.
- **02 = Delete existing record:** This record was previously sent in error; therefore the receiver should delete the previously sent version of this record. There is no corresponding replacement record.

Note: Claim reversals should be treated as new records. When a claim is reversed, Payment Status (Field 45) should be 1 and Record Indicator should be 00 to allow for the dollar and quantity amounts to be correctly negated.

Field 10: Patient ID

This field is the health plan–assigned ID of the patient as it appears in the pharmacy claim. This field does not use a qualifier because there is no industrywide coding standard to represent member/patient identification.

Field 11: Alternate Patient ID Qualifier

This field contains a two-digit code describing the type of identifier in the Alternate Patient ID field that follows. It is a conditional field and must be populated if and only if there is an Alternate Patient ID included in the record. Alternate IDs are sometimes used by the health plan as an additional way to identify the patient. Explanations of each type follow:

00 - Not defined: Type of ID is unknown.

01 - Non SSN-based patient ID assigned by: This is the “new” identifier assigned by health plans to replace any previous identifier that may have included the subscriber’s social security number. Sample: J57889394948 (a meaningless number).

02 - SSN-based patient ID assigned by health plan: This is the “old” identifier previously used by many health plans, which includes the subscriber’s social security number. Sample: XJK123456789-01 (if the subscriber’s SSN is 123-45-6789).

03 - Patient SSN: The patient’s actual SSN. Sample: 123456789 (from above).

99 - Other: Type of ID not among listed options.

Field 12: Alternate Patient ID

This field represents the alternate IDs that are sometimes used by the health plan to identify the patient. These IDs vary by health plan and can be proprietary, be SSN-based, or be the patient's SSN (see Field 11).

Field 20: NDC

This field is the eleven-digit National Drug Code (NDC). The eleven digits represent the following: first 5 digits, manufacturer; next 4 digits, product; and last 2 digits, package size.

Field 21: Label Name

The medication name as it appears on the label should be entered in this field. Label name includes drug name, drug strength (value and units), and dosage form.

Field 24: Generic Drug Name

This field should be populated with the generic equivalent (except for compounded drugs and non-drug items in which case this field will be left blank). Please note that for compounded drugs, the field should be populated, if possible, with the generic name of the most prominent ingredient.

Field 25: Brand Name

This field should be populated with the brand name of the drug. This field is blank filled if the medication is a generic drug.

Field 28: Route of Administration

There are no established standard values for this field. For analytic purposes, the route of administration may be derived through the use of the NDC code and a reference drug database.

Field 32: Refill Number

This field represents the sequence number of the refill (if known). For example, 01 is the first refill, 02 is the second refill, etc. If the prescription is a refill, but the sequence number is unknown, 00 should be used. If the prescription is not a refill (i.e., if Field 31 is 00), then this field should be left blank.

Field 34: Drug Type

Health plans generally use this field to report how the drug is classified *for payment purposes*. This field does not necessarily report the actual brand/generic status of the drug. For example, it is possible that a brand drug may be reported as generic in this field, if the drug has a favorable status on the health plan formulary. If an organization wants to know the *actual* brand/generic status of the prescribed medication, this information may be referenced from a proprietary drug database via the reported NDC code (Field 20).

Field 40: Co-pay Amount

The co-pay amount represents the portion of the total claim amount paid by the member or the patient.

Field 41: Net Amount Due

The net amount due represents the dollar amount paid by the health plan to the pharmacy. The formula for calculating this field is as follows: Net Amount Due = Ingredient Cost + Dispensing Fee + Sales Tax - Co-pay – Deductible.

Field 42: Ingredient Cost

The ingredient cost field represents that portion of the total payment that is assigned specifically to the product or service and is independent of any professional fee or tax.

Field 43: Product Type

This field represents the member's insurance plan type as specified by the health plan. Examples include "Commercial," "Medicare," etc. This field is included because financial budgets are often based on this value. Note that the values in this field are not necessarily consistent across health plans (i.e., health plans may use different values to represent the same product types). For consistently coded product types, see Field 56: Product Line Category Code. Product Type is included for backward compatibility only.

Field 45: Payment Status

There are times when a prescription is filled and initially billed by the pharmacy, but subsequently the prescription is not picked up by the patient or is returned to stock for another reason. When this type of event occurs, the claim is reversed by the pharmacy and the reported payment status is 1 for that record. In these cases, the quantity field and all currency fields should be negative (see below).

The standard specification is designed to accommodate claims and subsequent reversals through the use of the claim number, the payment status, and the related financial fields, as described below. An example of how to encode claims and reversals follows:

Initial transmission (initial claim):

Unique claim number assigned to prescription, for example: 99999999999999

Payment status is "paid" = 0

Date script filled: 20040101

Ingredient cost: Sign is Positive (b)

Quantity dispensed: Sign is Positive (b)

Co-pay amount: Sign is Positive (b)

Days supplied: Sign is Positive (b)

Net amount due: Sign is Positive (b)

Reversal ("cancellation" of claim by pharmacy):

Same unique claim number for prescription, for example: 99999999999999

Payment status is "reversed" = 1

Date script filled is same: 20040101

Ingredient cost: Sign is Negative (-), magnitude is same as in initial claim

Quantity dispensed: Sign is Negative (-), magnitude is same as in initial claim

Co-pay amount: Sign is Negative (-), magnitude is same as in initial claim

Days supplied: Sign is Negative (-), magnitude is same as in initial claim

Net amount due: Sign is Negative (-), magnitude is same as in initial claim

Re-transmission, if any (submission of new claim for the same prescription):

New unique claim number for script, example: 88888888888888

Payment status is "paid" = 0

Date script filled may be different: 20040102

Ingredient cost: Sign is Positive (b)

Quantity dispensed: Sign is Positive (b)

Co-pay amount: Sign is Positive (b)
Days supplied: Sign is Positive (b)
Net amount due: Sign is Positive (b)

Some health plans “cancel out” (delete) claims and reversal records in their database if both are entered during the same reporting period. In this case, neither record appears in the data reported to the provider organizations, which is fine. However, if a claim is reported in one reporting period and later reversed in a subsequent reporting period, the two records should not be deleted. It is important that the reversal be retained and sent for the appropriate reporting period, so that the provider organization can accurately reconcile it with the claim that was reported earlier.

Field 46: Prescriber ID Qualifier

Because there are several coding schemes available to identify providers, a qualifier code is included to inform the receiver what coding scheme is being used to identify the prescriber.

Qualifiers include:

- **00 = Not defined:** Type of ID is unknown
- **01 = DEA number:** Unique number assigned by the Drug Enforcement Agency to prescribing clinicians. If a plan does not have a DEA number (a rare occurrence), they may populate this with a dummy DEA number (see note below).
- **02 = State License number**
- **03 = National Prescriber ID number**
- **04 = Tax ID number**
- **05 = Social Security number**
- **06 = HIN:** The Health Industry Number (HIN) is a unique identifier for enumerating services and activities throughout the health industry. The HIN enumerates prescribers by location, provider establishments, and all other entities in the health industry supply chain. The HIN database is maintained by the Health Industry Business Communications Council (HIBCC).
- **07 = Health plan assigned number:** ID assigned and maintained by health plan
- **99 = Other:** Type of ID not included in the above

NOTE: In certain cases, a “dummy” (invalid) DEA number may be transmitted from the pharmacy to the health plan (for example, when the prescriber has no DEA number or the DEA number is unknown). In these cases, the prescriber ID received by the health plan will be formatted identically as a valid DEA number and the health plan will be unable to distinguish it from a valid DEA number. Therefore, the health plan will encode the prescriber ID as a DEA number in this field (value 01), although the identifier may not be valid.

Field 50: PCP ID Qualifier

Because there are several coding schemes available to identify providers, a qualifier code is included to inform the receiver what coding scheme is being used to identify the PCP.

Qualifiers include:

- **00 = Not defined:** Type of ID is unknown
- **01 = DEA number:** Unique number assigned by the Drug Enforcement Agency to prescribing clinicians
- **02 = State license number**
- **03 = National Prescriber ID number**
- **04 = Tax ID number**
- **05 = Social Security number**
- **06 = HIN:** The Health Industry Number (HIN) is a unique identifier for enumerating services and activities throughout the health industry. The HIN enumerates prescribers by location, provider establishments, and all other entities in the health industry supply chain. The HIN database is maintained by the Health Industry Business Communications Council (HIBCC).
- **07 = Health plan assigned number:** ID assigned and maintained by health plan
- **99 = Other:** Type of ID not included in the above

Field 57: Blank

This field is reserved for future expansion of the CALINX standard.

Field 58: Filler

This field is blank filler and is intended for custom use by individual trading partners. Use of this space by trading partners will not be affected by future revisions of the format.

Appendix A3. Implementation Guide

Background and Purpose

Version 2.0 is based on Version 1.1 of the California Information Exchange (CALINX) Pharmacy Data Standard Format Specification published in January 2000. Version 2.0 represents an industry review of Version 1.1 and includes field updates and clarifications. The industry review included health plan, provider organization, and vendor participation. The review and regular maintenance of the specification is supported by the California HealthCare Foundation (CHCF). Questions and comments regarding the specification and its implementation should be directed to CHCF.

The implementation guide is a reference document to ensure consistent implementation of the standard format by health plans and/or their agents and consistent interpretation of the standard format by physician organizations in California. The implementation guide provides directions and instructions for the health plan and/or PBM agent for the creation of the data specification and for the medical group/provider organization in the interpretation and use of the data.

Out of Scope

The specific use of optional fields by trading partners is not addressed here. Use of these fields should be defined by contract terms between trading partners. The inclusion of optional fields should not be interpreted as a recommendation for their use. Contract negotiations and maintenance of contract terms are not addressed in the standard.

Record Guidelines

The flat file format is designed for use on a mainframe, mid-range or PC/LAN computer system.

- Records are fixed length. Fields are fixed width and NOT delimited.
 - To signify the end of a record and the beginning of the next record within a file, a standard delimiter (carriage return + line feed) is used.
 - Each record within a file has a header section that applies to the entire data file (i.e., the values of the fields in the header section should be the same for all records). The header portion of the record identifies the sender, the receiver, the date the file was created, and other general information.
 - All multiple configuration fields have a qualifier.
-
- All dates are represented as 8 digits, following the format CCYYMMDD. For example, June 8, 2004 is represented as "20040608."

Field Formats

Field formats are Numeric, Alpha-numeric, Signed Decimal, or Signed Numeric and are defined as follows:

- **Numeric (N)** fields are right justified and zero filled. They may contain only the digits 0–9. Zero is a valid value and does not mean “not reported.” If there is no value for a Numeric field, the entire field should be blank filled.
- **Alpha-numeric (A/N)** fields are left justified and blank filled. They may contain only the characters 0–9, a–z, A–Z, or other printable ASCII character. If no value is available, the entire field should be blank filled.
- **Signed Decimal (SD)** fields are right justified and zero filled. They are often used for currency values or quantities. They may contain only the digits 0–9, plus the space character (ASCII 32) or the minus character (ASCII 45) in the rightmost position to denote a positive or negative value, respectively. It is important to highlight that positive values are *not* denoted with the plus character (+) but rather by a space character (ASCII 32).

SD fields use implied decimal positioning, such that the position of the decimal point is specified in a character mask that is defined for each Signed Decimal field. For example, the mask 99999v99s denotes that there is an implied decimal point three positions from the right, and a sign character in the rightmost position. *Signed Decimal fields do not actually contain a decimal point.*

Some example values follow (note that in these examples, a space character [ASCII 32] is denoted by the character “b”).

<u>Field Length</u>	<u>Mask</u>	<u>Value</u>	<u>Meaning</u>
8	99999v99s	0015000b	\$150.00
6	999v99s	02550-	-\$25.50

- **Signed Numeric (SN)** fields are right justified and zero filled. They may contain only the digits 0–9, plus the space character (ASCII 32) or the minus character (ASCII 45) in the rightmost position to denote a positive or negative value, respectively. It is important to highlight that positive values are *not* denoted with the plus character (+) but rather by a space character (ASCII 32).

Example values:

<u>Field Length</u>	<u>Value</u>	<u>Meaning</u>
4	010b	10
8	0000450-	-450

Field Status

Each field is designated with a field status of R (Required), O (Optional), or C (Conditional), defined as follows:

- **Required** fields must be populated with a non-blank value for the record to be compliant with the standard.
- **Optional** fields may be populated, but need not be. If an optional field is populated, its value should conform to the standard specification for the field. Optional fields that do not contain data should be blank filled. For the purpose of this specification, zeros appearing in Numeric, Signed Numeric, and Signed Decimal fields are to be considered valid data.
- **Conditional** fields may need to be populated based on the status of related fields. Comments accompanying each conditional field specify conditions under which the fields must be populated. If the conditions are met, the field must be populated (i.e., is a required field). If the conditions are not met, the field should not be populated (i.e., it should be blank filled).

Qualifier Fields

ID Code Qualifier fields are used to eliminate the need for creating individual fields for all possible value types. For example, see Field 42 – Prescriber ID Qualifier. The prescriber may be identified by the HIN number, the DEA number, the TAX ID number, or other agreed-upon code. In general, the qualifier field is used to indicate to the recipient what type of code is being submitted in the corresponding field. Qualifier fields are Conditional and are only required if data are supplied in the accompanying ID Code field.

Other and Not Defined Values

Many coded fields include values for "Other" and/or "Not Defined." "Other" denotes any type of code that is not enumerated in the provided list of codes. "Not defined" denotes that the reporting party did not indicate the type of code being supplied.

Appendix A4: Rules of Exchange

Background

The *California Clinical Data Project: Setting Standards* has developed a standard for sharing pharmacy data among health plans and physician organizations with the goals defined for all participants as clinical evaluation, disease management, and utilization management.

Version 2.0 of the data specification is based on Version 1.1 of the California Information Exchange (CALINX) Pharmacy Data Standard Format Specification published in January 2000. The specification strives to align with the NCPDP (National Council for Prescription Drug Programs) electronic data standard used currently to transmit claims from retail pharmacies to payers or pharmacy benefit managers (PBMs).

CALINX Rx 2.0 resulted from an industry review of CALINX 1.1 and includes field updates and clarifications. The industry review included health plan, provider organization, and vendor participation.

Frequency and Implementation Date

By the first quarter of 2005, health plans and PBMs will make available to requesting provider organizations electronic pharmacy data based on the CALINX Rx 2.0 data specification and the following rules of exchange:

- Data formatted per the CALINX Rx 2.0 specification will be provided to contracting physician organizations at monthly (30-day) intervals by health plans and by PBMs with pharmacy carve-out contracts. The reporting interval may be longer than 30 days for physician organizations that specifically request it.
- The lag time for pharmacy reporting by the health plans or PBMs to the providers should not be longer than 30 days from the last date of service in the reporting period.
- The 30-day maximum lag time for reporting should be based on the “Date Rx Filled” field (#17). For clarification, it should *not* be based on the “Run Date” field (#4).

Data Accuracy and Completeness

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

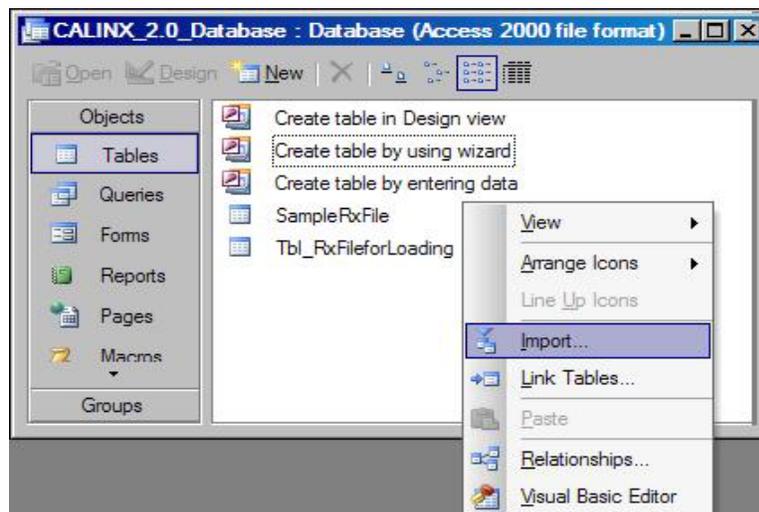
Appendix B. Importing Records

Many provider organizations use Microsoft Access to import and scrub pharmacy files. Microsoft Access is a relatively inexpensive and effective way to import and analyze large data sets, and to normalize data sets for loading into a data warehouse. The following import specification can be used to load your pharmacy data into a Microsoft Access database. You should first consider using the Pharmacy Data Validation Tool, to verify adherence to the CALINX Rx 2.0 standard. That tool also has functionality to identify errors or problems with your file, and to normalize and export the file into many different file formats.

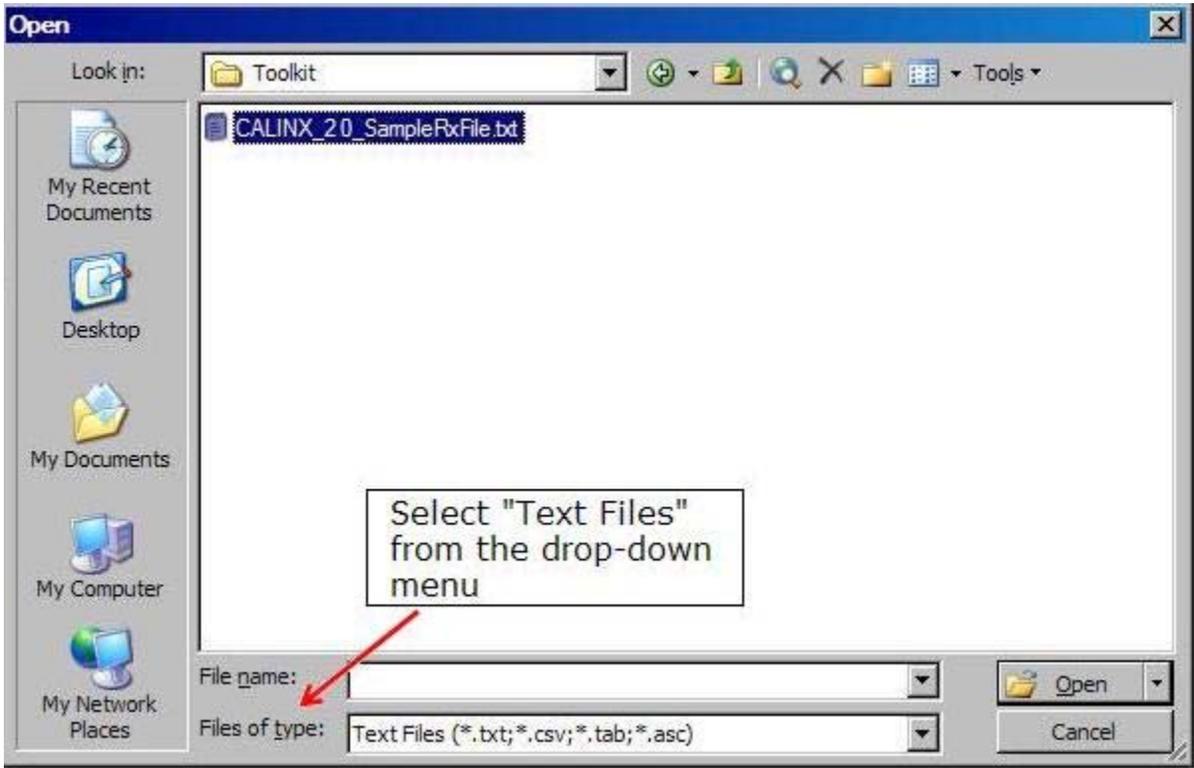
It's important to note that when using this import specification **Quantity Dispensed** and **Days Supply** are imported as text fields (see the **Field Format** column). The CALINX Rx 2.0 specification indicates that these are *signed decimal* and *signed numeric* fields respectively. If you use this import specification (or the import specification pre-loaded into the sample database), you will also need to “update” these two fields, and the three currency fields. A query is provided in the sample database which converts these fields.

The California HealthCare Foundation will provide a sample database and CALINX Rx 2.0 sample text file at www.calinxstandards.org which you can use along with these step-by-step instructions to see how records can be imported and updated using Microsoft Access.

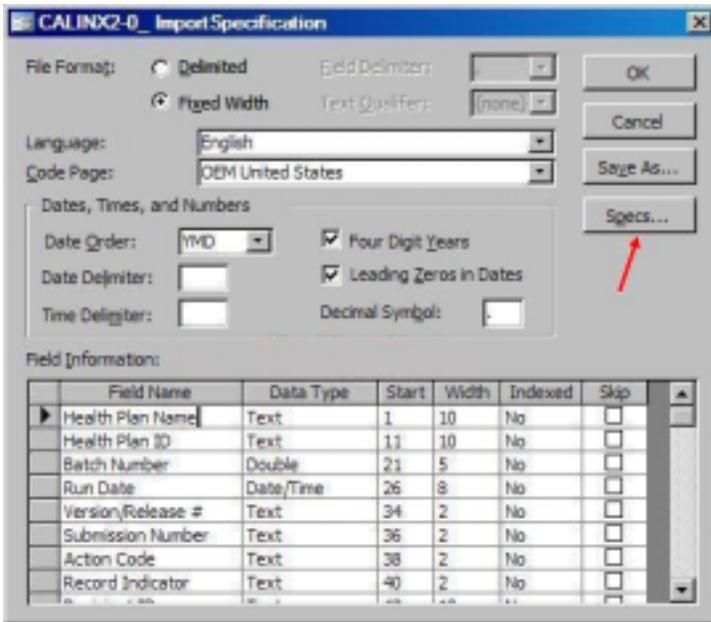
1. Open the sample database: “CALINX_2.0_Database.mdb.”
2. With your cursor in the database section, right click and select “import” from the drop-down menu:



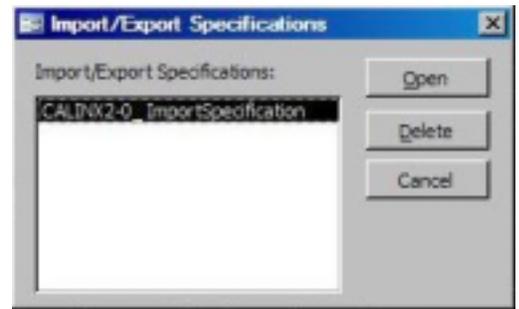
3. In the new dialogue box that opens, go to the “Files of Type” drop down menu, and select “Text Files” from the list of options. Locate the sample pharmacy file “CALINX_20_SampleRxFile.txt” and click the “Open” button.



4. The “Import Text Wizard” dialogue box should now open. Select the “Advanced” button near the lower left hand side of the box.



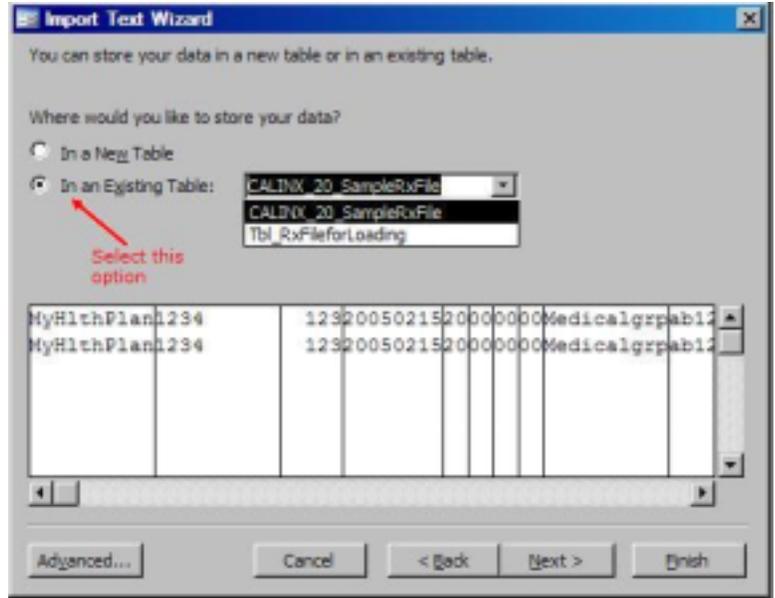
5. Use the import specification (see Appendix B.1 below) by clicking on the “Specs...” button and selecting the CALINX Rx 2.0 Import Specification. Click OK when you’re done.



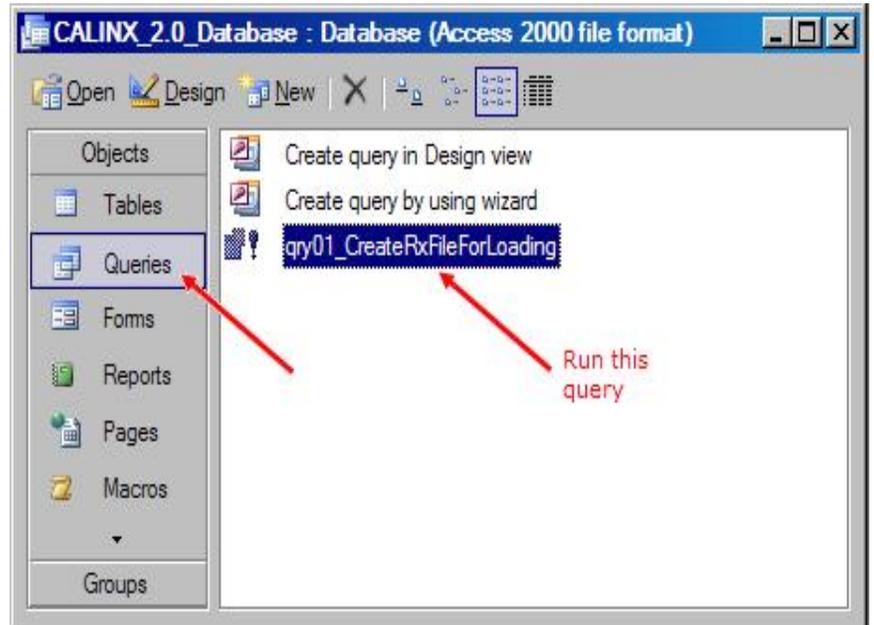
6. Click the Next button twice. Access will then ask you if you want to store the data in a new or existing

table. Select the “In an Existing Table” option, and select the table *CALINX_20_SampleRxFile*.

7. Click finish. The data should have been imported into the new table where you can view it.



8. You have one more step left before your data is ready. Click on "Queries." You should see one query. Run it by double clicking it. By running this query, you will be creating the table: *Tbl_RxFileForLoading*. You can now begin running your pre-load routines. (See Managing CALINX Rx 2.0 Pharmacy Data.)



Appendix B1. CALINX Rx 2.0 Import Specification

Field Name	Data Type	Start	Width	Indexed	Skip
Health Plan Name	Text	1	10	No	0
Health Plan ID	Text	11	10	No	0
Batch Number	Double	21	5	No	0
Run Date	Date/Time	26	8	No	0
Version/Release #	Text	34	2	No	0
Submission Number	Text	36	2	No	0
Action Code	Text	38	2	No	0
Record Indicator	Text	40	2	No	0
Recipient ID	Text	42	10	No	0
Patient ID	Text	52	18	No	0
Alternate Patient ID Qualifier	Text	70	2	No	0
Alternate Patient ID	Text	72	18	No	0
Patient Last Name	Text	90	15	No	0
Patient First Name	Text	105	12	No	0
Date of Birth	Date/Time	117	8	No	0
Patient Gender	Text	125	1	No	0
Patient Relation	Text	126	1	No	0
Patient Employer	Text	127	15	No	0
Date Rx Filled	Date/Time	142	8	No	0
NDC	Text	150	11	No	0
Label Name	Text	161	30	No	0
Alternate Product Code ID Qualifier	Text	191	2	No	0
Alternate Product ID	Text	193	18	No	0
Generic Name	Text	211	30	No	0
Brand Name	Text	241	30	No	0
Strength	Text	271	8	No	0
Dosage Form	Text	279	8	No	0
Route of Administration	Text	287	8	No	0
QuantityDispensed	Text	295	11	No	0
DaysSupply	Text	306	4	No	0
New/Refill Indicator	Text	310	2	No	0

Field Name	Data Type	Start	Width	Indexed	Skip
Refill Number	Double	312	2	No	0
Prescription #	Text	314	7	No	0
Drug Type	Text	321	1	No	0
Formulary status	Text	322	1	No	0
Pharmacy ID_Chain Code	Text	323	5	No	0
Pharmacy ID_NCPDP Code	Text	328	7	No	0
Place of service	Text	335	2	No	0
Date Billed	Date/Time	337	8	No	0
Co-payAmount	Text	345	8	No	0
NetAmountDue	Text	353	8	No	0
IngredientCost	Text	361	8	No	0
Product Type	Text	369	4	No	0
Claim Number	Text	373	15	No	0
Payment Status	Text	388	1	No	0
Prescriber ID Qualifier	Text	389	2	No	0
Prescriber ID	Text	391	18	No	0
Provider Last Name	Text	409	15	No	0
Provider First Name	Text	424	12	No	0
PCP ID Qualifier	Text	436	2	No	0
PCP ID	Text	438	18	No	0
PCP Last Name	Text	456	15	No	0
PCP First Name	Text	471	15	No	0
Provider group	Text	486	14	No	0
PSC/DAW	Text	500	1	No	0
Product Line Category Code	Text	501	1	No	0
Blank	Text	502	30	No	0
Filler	Text	532	81	No	0



CALINX Rx 2.0 Pharmacy Data Standard

What Is CALINX Rx 2.0?

CALINX Rx 2.0 is a standardized file format for electronically transmitting pharmacy data. A CALINX Rx 2.0 file contains a batch of records and each record represents a single dispensed prescription paid for by a health plan or other payer on behalf of its members. These batch files are intended to be sent monthly between contracted entities.

The CALINX Rx 2.0 file format is “fixed width.” There are no delimiters such as commas (,) or pipes (|) between fields; instead, fields fit within a defined range of columns. Each record has unique identifiers for patients, insurance, prescribing clinicians, dispensed medication, and prescription fill dates.

Why Is CALINX Rx 2.0 Needed?

The goal is to enable the efficient use of pharmacy data to improve care and avoid medical errors in California.

CALINX Rx 2.0 replaces CALINX 1.1, a file format that was first released in 2000. The original file format had not been updated for four years and was not consistently adopted in California.

Without a uniform standard, provider groups have been receiving pharmacy data

in a variety of formats, making it challenging to use and integrate. By adopting and strictly adhering to a single standard for transmitting pharmacy data electronically, providers groups will have better access to more timely and accurate pharmacy utilization data.

How Will CALINX Rx 2.0 Data Be Used?

Pharmacy data can be forwarded to treating physicians to provide them with a more complete picture of a patient’s prescription history, which can lead to better decision making. Pharmacy data can also be used for a number of administrative functions including:

- Self-reporting of Pay for Performance clinical measures to help maximize health plan quality bonuses.
- Integrating pharmacy data into clinical data repositories and disease registries to help manage patient populations.

Pharmacy data can also be used in conjunction with disease management and quality improvement programs by providing case managers and health educators with important prescription histories for the patients they treat.

FACT SHEET

DECEMBER
2004

Who Will Use CALINX Rx 2.0?

Six large California health plans have agreed to adopt the CALINX Rx 2.0 standard:

- Aetna
- CIGNA
- Blue Cross
- Health Net
- Blue Shield
- PacifiCare

Approximately 180 provider groups in California currently receiving pharmacy data electronically from any of the above plans can request pharmacy data in the new format.

How Was CALINX Rx 2.0 Developed?

CALINX Rx 2.0 was developed by the California Clinical Data Project: Setting Standards initiative. The initiative is convened by the California HealthCare Foundation and overseen by an executive committee representing provider organizations, health plans, commercial labs, hospitals, community clinics, purchasers, and state government.

Workgroups made up of technical experts from executive committee organizations developed CALINX Rx 2.0. The standard will be supported with validation software and toolkits, technical assistance, and a governance body to oversee maintenance and future updates to the standard.

Where Can I Learn More?

The CALINX Rx 2.0 standard, software tools, toolkits, and more are available on the CALINX Web site: www.calinxstandards.org.