Alberta Health

H-Link Electronic Claims Submission
Specifications

Health Information Technology and Systems Division

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I INFORMATION ABOUT THIS MANUAL

This manual outlines the technical and business requirements that must be met in order for individuals or organizations (a group of practitioners or an Accredited H-Link Submitter) to become a "submitter" for sending claim transactions in electronic format to Alberta Health and receive files from Alberta Health.

The first portion of this manual deals with the "Business Accreditation" process pertaining to becoming a submitter. This includes what documentation must be completed, what the submitter responsibilities are prior to and after accreditation.

The latter part of this manual describes the "Technical Accreditation" information such as hardware and software requirements, claim submission and retrieval formats and the communication process with the Alberta Health mainframe computer utilizing communications software.

II INTRODUCTION

This document describes the accreditation process and criteria for Submitters (Accredited H-Link Submitters including Service Providers) wishing to submit claims electronically to Alberta Health The recommended software utilized for this process is a web browser called Internet Explorer. The communication network that allows a remote personal computer (PC) to communicate with Alberta Health's mainframe is referred to as the "H-Link" communications system.

H-Link is available to any Stakeholder registered with Alberta Health who has a need to transmit and receive claim information to and from Alberta Health. Authorized Stakeholders are granted a Submitter role, which allows the Alberta Health processing system to accept and process their transmissions. Accredited H-Link Submitters and Practitioner's Offices must apply for the Submitter role before they can use H-Link. From this point forward, the term 'Submitters' refers to submitters who are third parties and practitioners with/requesting the submitter role.

Prospective Submitters must pass an accreditation process required for the Submitter role. The accreditation process accredits a submitter to allow for the transmission and retrieval of claim data between the submitter and Alberta Health. The accreditation process does not accredit billing and reconciliation software, NOR does it accredit the data content of claim files transmitted to Alberta Health. Data is reviewed for correct format, but the validity of the data itself is not determined. The Service Provider providing the service is responsible for verification of billing and reconciliation software.

As a Submitter, you must have a Personal Computer (PC) to process transactions and a modem to connect your PC to a data communication line. This communication line would transmit your claims data to Alberta Health's Mainframe computer via H-Link that will in turn process the claim transactions and make the results available for you to retrieve.

Under the *Health Information Act,* as a Submitter you are an affiliate of the Custodian for whom you are submitting claims. Custodians are responsible for any access to, collection, use, or disclosure of health information by their affiliates. Custodians must ensure that affiliates, in this case submitters, only have access to the health information needed for an authorized purpose under the *Health Information Act* and have appropriate legal arrangements with affiliates including, where appropriate, Information Manager Agreements.

The accreditation process:

- ☐ Provides you, the Submitter, with a Submitter Prefix ID
- ☐ Gives you the ability to transmit and retrieve files to and from Alberta Health
- ☐ Allows you to submit specific types of transactions first in a Test Environment, then in the Production Environment
- ☐ Identifies which reports, letters and other data you can retrieve electronically from Alberta Health

The data that you communicate to Alberta Health must be in the specified format that meets the technical specifications described in this manual.

All costs associated with the electronic data communications are your responsibility.

All initial communication regarding the electronic claim submission process should be directed to:

Alberta Health
Health Information Technology and Systems Division
Information Technology Operations Branch
Application Maintenance and Data Services
Box 1360, Edmonton, Alberta T5J 2N3

Attention: H-Link Application Support

III GLOSSARY OF TERMS

ACCREDITATION (OF SUBMITTER)

An established process of recognizing a Service Provider or Accredited H-Link Submitter meeting an official standard to provide claim submission services based on predetermined requirements.

ACCREDITED SUBMITTER

An Accredited H-Link Submitter, Service Provider, or group of Service Providers permitted to submit claims and/or associated text electronically to and receive the results electronically from Alberta Health. Under the *Health Information Act*, a Submitter is an affiliate of the Custodian for whom they are submitting claims. Submitters are required to follow through with the duties and responsibilities of an affiliate as outlined in the *Health Information Act*. If a Submitter fails to follow through, the Submitter will lose accreditation, and may face other legal consequences.

ACTION CODE

The action that a specific transaction accomplishes. Allowed values are:

A - Add, used when submitting a new claim.
C - Change, used when changing an existing claim that has previously been accepted by Alberta Health.
D - Delete, used to delete an existing claim that has previously been accepted by Alberta Health.
R - Reassess, used to cause a previously assessed claim to be reassessed with text reviewed. Normally, except for specific situations, text is ignored when a claim is assessed initially.

ADDITIONAL COMPENSATION

Additional Compensation, previously known as Extraordinary Medical Services Assessment Fund, applies to Physicians only. Allows service Providers in Alberta to request compensation greater than the fee indicated in the medical schedule, when the level of medical care provided to an Alberta resident is deemed to be extraordinary.

AGREEMENT

A contract between an Accredited Submitter and a Service Provider, if the Service Provider utilizes an Accredited H-Link Submitter to submit claims on their behalf. This agreement should outline the affiliate-custodian relationship between a Submitter and Service Provider.

BATCH BALANCE REPORT

An on-line report summarizing the processing results for a file of one or more batches submitted. This report is the output file response to the Submitter once the Claim Submission file is initially processed by Alberta Health.

BUSINESS ARRANGEMENT

An agreement between a Service Provider and Alberta Health covering payment arrangements for health services provided. The Business Arrangement defines the contract holder, the service providers and the payee, all of whom could be the same or different stakeholders. All Service Providers in Alberta must have or be part of a Business Arrangement registered with Alberta Health in order to claim for services. Some Service Providers may have and/or may be part of more than one Business Arrangement.

CANADIAN CLASSIFICATION OF SURGICAL, THERAPEUTIC AND DIAGNOSTIC PROCEDURES CCP (CANADIAN CLINICAL PROCEDURES)

A catalogue of procedures used by Statistics Canada for analysis of health services provided to Canadians. The majority of Alberta Health's Health Service Codes are based on CCP. A specific CCP code is the same across specialties, and the amount to be paid for that service code is determined based on the applicable skill codes and fee modifiers.

CLAIM

A communication from a Service Provider requesting payment for services delivered or from a Service Recipient requesting reimbursement for services received (e.g. the submission of an office visit for payment).

DISCIPLINE

A specific branch or field of study in which a practitioner has been licensed to practice (e.g. medical, dentistry, etc.)

ENCOUNTER NUMBER

Pertains to the number of separate times the practitioner sees the same patient on the same day.

Each separate encounter with a Service Recipient on the same day by the same Service Provider must be given a unique Encounter Number. All services performed during the same encounter with the Service Recipient must be given the same Encounter Number.

FACILITY/DELIVERY SITE

A physical location (e.g. hospital, clinic, and doctor's office) where health services are routinely performed. All facilities/Delivery Sites that are formally recognized or accredited will be placed on the Alberta Health Stakeholder Registry.

FACILITY NUMBER

The unique number of the facility, which has been assigned within the Alberta Health Stakeholder Registry.

FEE MODIFIERS

Conditions which contribute to the determination of the amount payable under the benefit.

There are two types of modifiers:

- Explicit - Must be manually entered in the Fee Modifiers 1, 2 and 3 fields on the claim.

- Implicit - Fee Modifiers derived by the Claims Processing System from other claim fields or from data stored on the Alberta Health system.

Examples of Fee Modifiers are:

An Explicit modifier is provided by the Service Provider; e.g. Role Modifier - When a Service Provider acts as an Anaesthesiologist the role modifier "ANE or ANEST" is used.

An Implicit modifier is provided by Alberta Health during processing of the claim transaction; e.g. Age Modifier; when a claim transaction for a service is paid a different rate according to the patients age (e.g. Other non-operative bronchoscopy HSC 01.09). Alberta Health checks the service recipient's information and applies the appropriate age modifier to the claim transaction.

FUNCTIONAL CENTRE

The specific Functional Centre within the Facility where the service was performed. Functional Centre may have restrictions as to the Health Services that can be performed at them.

Examples of Functional Centre are: Neonatal Intensive Care Unit, Surgical and Emergency.

HEALTH PROCEDURES INFORMATION

Health Service Codes

Health Service Codes identify services/procedures performed by a Service Provider to a Service Recipient. These Health Service Codes are listed in the Health Service Codes Procedure List within the Schedule of Benefits. There is a Procedure List for each discipline.

Schedule of Benefits

The Schedule of Benefits for each discipline contains a Procedures List, Price List and Governing Rules List. The Explanatory Code List and Fee Modifier Definitions List are all common to the Schedule of Benefits.

The Procedures List contains all health service codes for services that can be claimed, their description, the base amount that applies and the listed anaesthetic benefit. This information is in report format.

The Price List contains the health service code, base amount, modifier codes and amounts, and the category code This information is in report format.

The Governing Rules List contains all Governing Rules that apply to that discipline. These rules provide guidelines on how a practitioner may bill for services and the restrictions and considerations that must take place when billing for these services. This information is in report format.

The Explanatory Code List Report provides a list of codes and their explanation. These codes explain why a claim has been reduced, paid at zero, refused or changed in some other manner. This information is in report format.

The Fee Modifier Definitions provides the modifier code definitions. These codes are used on a claim in conjunction with a procedure code which contributes to the determination of the amount payable. Refer to Fee Modifiers (above) for details. This information is in report format.

LOCATION CODE

For services not performed at a Registered Facility, the Location Code is required. Currently only three non-facility location codes are applicable - HOME (Service Recipient's Residence), SCHL (School) and OTHR.

ORIGINATING FACILITY

The Facility where the encounter with a Service Recipient occurred when different from the Facility where the service was performed (e.g. specimen/procedure (e.g. blood sample/ECG/xray) taken in one Facility and tested/interpreted in another).

PAYEE

A Stakeholder who will receive payment for a claim. For non-subscriber claims, the Business Arrangement defines the payee. For subscriber claims, the payee can be the Service Recipient, the contract holder of the Service Recipient's Alberta Health registration or a designated Stakeholder.

SEGMENT TYPES

A transaction can consist of one or more segments, and the segment type is used to identify a specific segment within a transaction. Each segment contains a header portion and a data portion. An In-Province Service Provider Claim (CIP1) can include one or more of the following segments:

CIB1 - In-Province Service Provider Base Claim segment (1 only).
CPD1 - Claim Person Data segments (multiple as needed).
CST1 - Claim Supporting Text segments (up to 500).
CTX1 - Supporting Text Cross-Reference segment (as required).

The use of each segment type is dependent upon the Action Code being used.

SERVICE ALBERTA

The external agency contracted by Alberta Health to provide a full service data centre and technical support.

SERVICE PROVIDER (aka Physician, Practitioner, Clinic)

A Person or Organization who delivers a service to or on behalf of the health system.

SERVICE PROVIDER NUMBER (Practitioner ID)

The practitioner number that Alberta Health assigns to each Health Care professional authorized to provide services or provide a referral for claims submitted to Alberta Health. This number must be coded on each claim transaction. This number is also referred to as PRID.

SERVICE RECIPIENT (aka Patient, Registrant, Subscriber)

A person who has received, or potentially may receive, a service from the health system. Service Recipients include all Alberta residents, plus out of province individuals receiving services in Alberta through Medical Reciprocal (e.g. A person receiving their annual check-up or an out of province visitor who is hospitalized).

SKILL

The abilities or proficiencies of a Service Provider which are of interest to the health service delivery system.

Designates the Service Provider's discipline and skill (specialty/accreditation) that the service was performed under such as Dermatology, Neuropathology, Echocardiography, Optometry etc. Skills may be used to determine the applicable payment amount (e.g. a specialist may be paid a different rate for a visit than a GP).

STATEMENT OF ASSESSMENT

A report of all claims received and assessed by Alberta Health and a summary of all claims processed to date, since the last Statement Of Assessment. This report is produced on a weekly basis. This information is also available to submitters on a data file basis.

STATEMENT OF ACCOUNT

A report outlining the amounts Alberta Health has released for payment based on claims assessed. The payment amount would be net of applicable deductions such as Revenue Canada Assignments, charges for schedules/handbooks, etc.

SUBMITTER PREFIX ID

A three-character code(s) assigned by Alberta Health to identify each Accredited Submitter, and must accompany all transmissions.

TRANSACTION NUMBER

The transaction number is a unique identifier for all transactions within the CLASS (Claims) system, and in the case of claims transactions, this is also the claim number. This 15 digit number is composed of Submitter Prefix (3) as assigned by Alberta Health, Current Year (2), Source Code (2), Sequence Number (7) and a Check Digit (1).

TRANSACTION TYPES

Identifies a specific type of transaction submitted to Alberta Health. A type of transaction can contain multiple records called segments. At this time only CIP1 (In-province Service Provider Claim) is used for all claims by Service Providers within Alberta. This includes reciprocal claims for services to Out of Province (OOP) service recipients who are registered with another provincial (except Quebec) Health Plan. This transaction does not include Hospital Reciprocal claims.

CHAPTER 1 ACCREDITATION

1.1 Accreditation Process

The accreditation process is the responsibility of the Information Technology Operations Branch, Health Information Technology and Systems Division.

The application for accreditation will be reviewed according to predetermined accreditation requirements which must be satisfied before you can be granted the submitter role.

The sequence of events for the accreditation process is as follows:

1. Party interested in becoming a submitter contacts Alberta Health, Information Technology Operations Branch, Application Maintenance and Data Services (AMDS) for information and application forms (phone 780-644-7643).

2. AMDS sends out the Application for Submitter Role (AH2210), External User ID Application Request (AHC2209), Access Administrator Application, Agreement and Authorization (AHC2208), and the H-Link Information Letter.

3. The applicant (submitter) completes the forms and returns them to AMDS. The fax number is 780-422-7248.

4. AMDS will review these forms for completeness. AMDS then assigns a Submitter Prefix Code and makes arrangements for a Security Card package to be sent to the applicant.

5. AMDS advises submitter of prefix code and assigns an organization ULI to the new Accredited H-Link Submitter or new group of practitioners that wish to become a submitter. Individual practitioners wanting to submit direct to Alberta Health will already have a PRID. The practitioner is then given the "role" of submitter and the Submitter/Service Provider relationships are established.

6. When a software developer wishes to accredit new submissions software, they contact AMDS. Testing is performed in the UAT environment and access is provided to allow the software vendor to test their program for compatibility. Access to the test environment is available for both the H-Link portal and via SFTP.

7. AMDS will contact the submitter to coordinate testing schedule and discuss results.

8. The software developer submits the test file. Alberta Health provides support for the tests. Test output is reviewed by the developer/submitter and AMDS. If the tests are successful and if the user retrieves the output files successfully, then a date is established by AMDS to start production submissions.

9. AMDS will assign the role of Submitter and ensures that the Submitter/Service Provider relationships are entered in production. IBM Production Support sets up production files.

10. A confirmation letter notifying the submitter of their accreditation and submission start date is sent by AMDS.

11. Alberta Health will monitor submissions to ensure accreditation criteria and submission specifications continue to be met. Failure to comply with accreditation criteria and submission specifications may result in immediate termination of accreditation privileges.

1.2 ACCREDITATION RESPONSIBILITIES

1.2.1 Submitter (Service Provider and/or Accredited H-Link Submitter)

To obtain and maintain accreditation, the Submitter must comply with the following:

Documents/Communication

- Applicant for accredited submitter status must file the appropriate forms with Alberta Health at least **four weeks prior** to the proposed effective date of the client.

- An established submitter must, in conjunction with the Service Provider, or Business Arrangement Contact Holder, file with Alberta Health a completed Access Administration Application, Agreement and Authorization for each new client at least two weeks prior to the proposed effective date for that client.

- Submitter must advise Alberta Health at least two weeks in advance whenever the submitter terminates an agreement with a Service Provider.

- Submitter is responsible for communicating information, such as specification changes or early cut-off dates, provided by Alberta Health to service providers, billing agents and software vendor partners.

Data

- Submitter must submit correctly formatted data to Alberta Health as per the specifications outlined in Chapter 2 Claim Preparation and Submission.

- An Accredited H-Link Submitter must **not alter** any original data received from a Service Provider or Business Arrangement Contract Holder unless authorized by the Service Provider and substantiated by an audit trail.

- An Accredited H-Link Submitter must not create "original" data.

- Submitter must ensure that the billing software provides the functionality to capture all data fields for all disciplines (when applicable).

- An Accredited H-Link Submitter must return **all** claims processing results (data files, reports) to the Service Provider unless otherwise authorized in writing by the Service Provider.

- Submitter must return claims data which cannot be processed by the submitter, resulting from incomplete or incorrect data or claims refused or rejected by Alberta Health, to the Service Provider for correction.

- Submitter must comply with the understanding that all data and associated documentation is the property of the Service Recipient, Service Provider and/or Alberta Health.

- An Accredited H-Link Submitter must be able to provide for correction and resubmission of claims originally sent by a Service Provider's former submitter.

- Submitter must be able to distribute claim results received from Alberta Health for claims originally submitted under a Service Provider's former submitter.

- Submitter is responsible for ensuring staff are adequately trained in submission and retrieval procedures and billing software.

- Submitter is responsible for providing training and support for Service Provider clients with respect to software use.

- Submitter is responsible for all testing with its agencies or sites once testing with Alberta Health is complete and claims are being submitted for payment. Testing of batches through H-LINK can **ONLY** be performed in the H-LINK test environment. If testing is required after submitter is production ready they must contact Alberta Health and request further access to the test environment.

Security

- An Accredited H-Link Submitter must protect the confidentiality and security of any data received from Alberta Health or any data handled on behalf of Service Providers in accordance with the Freedom of Information and Privacy (FOIP) act and the *Health Information Act* (HIA).
- An Accredited H-Link Submitter must not release any information to third parties without written permission from Alberta Health and the Service Provider(s) concerned.
- Submitter cannot use data for Business Arrangement comparison or analysis, without the written agreement of all Business Arrangements involved.
- Submitter must maintain a secure environment and electronic back-up for at least seven submissions and recovery procedures to meet the business needs of the Service Provider and Alberta Health.
- Submitter agrees not to use Alberta Health's User ID and password for any other purpose than the submission and retrieval of Service Provider's and Alberta Health's data.
- Submitter must not divulge, share or compromise the password and User ID assigned by Alberta Health.

Software

- Submitter agrees that any modifications or problems with Accredited Submitter software operating system or telecommunications are the responsibility of the submitter.

Charges and Costs

- Submitter acknowledges that operational charges incurred by the Accredited Submitter or Service Provider as a result of legislative, policy or other changes will be at no cost to Alberta Health.
- An Accredited H-Link Submitter must include the method of charging Service Providers for Accredited Submitter services in any agreement between the Accredited Submitter and the Service Provider/Business arrangement Contract Holder.
- Submitter agrees not to charge for services on a commission or percentage basis nor on the basis of gross dollar value of claims.
- Submitter acknowledges that all costs associated with electronic data communications are the responsibility of the submitter.

- Submitter acknowledges that all costs for providing data required in the course of an examination of records or in testing are the responsibility of the submitter and/or Service Provider.

- Submitter must retain, and consent to examination upon 24 hours notice by an authorized representative of Alberta Health, on-site documentation including:

  - claim process and verification procedures
  - reconciliation procedures and audit trails maintained
  - samples of all statistical reports being generated and corresponding distribution list
  - agreements between Accredited Submitter and Service Provider for up to two years following termination.

Termination

- Submitter acknowledges that any breach or non-compliance of any condition may result in immediate and unconditional withdrawal of accreditation privileges by Alberta Health.

- Submitter must inform Alberta Health of any violations by the Service Provider(s) of the Alberta Health Electronic Claim Submission accreditation requirements and technical specifications, or of the Alberta Health Care Insurance Act and Regulations.

- Failure to comply with the *Health Information Act* will result in the termination of the Submitter. Failure to comply may also result in fines and/or investigation by the Office of the Information and Privacy Commissioner (OIPC).

1.2.2 Service Provider Utilizing An Accredited H-Link Submitter

The Service Provider or Business Arrangement Contract Holder must comply with the following:

Documents/Communication

- Service Provider must file with Alberta Health a completed Submitter/Client Relationship for Electronic Claim Submission Form.

- Service Provider must advise Alberta Health at least two weeks in advance of any change from one Accredited Submitter to another or of the use of any additional Accredited Submitters. A new Submitter/Client Relationship for Electronic Claims Submission form must be filed.

- Service Provider must advise Submitters when they no longer wish to retain their services.

Data

- Service Provider must ensure that data submitted through the Accredited Submitter is in accordance with the Alberta Health Care Insurance Act and Regulations.

- Service Provider must ensure that the Accredited Submitter keeps confidential and secure any data from Alberta Health or any data processed on his/her behalf. No information may be compiled or released by the Accredited Submitter to any third party without written permission from the Service Provider(s) concerned and Alberta Health.

- Service Provider acknowledges that all documents and data used in claiming and reconciliation of payments are the property of the Service Provider, Alberta Health and/or Service Recipient.

- Service Provider is responsible for ensuring that billing and reconciliation software is adequate and accurate.

Volumes

- Submitter must supply prospective client Business Arrangement Numbers for claim volume analysis upon application for accreditation.
- Submitters must not exceed a reject rate of 6% over 1 month, 3% over 3 months.
- Submitters must submit daily if transmitting over 25,000 claims per week.

Security

- Service Providers have a duty to protect health information, and must maintain the security, validity and accuracy of all claim submissions to the Alberta Health Care Insurance Plan. As part of this responsibility, the Service Provider must ensure the Accredited Submitter has adequate processes and procedures in place to record, protect and recreate, if necessary, any data submitted on his/her behalf.
- Service Provider must inform Alberta Health of any violations or inconsistencies by the Accredited Submitter.

Payment

- Service Provider acknowledges that payments by the Alberta Health Care Insurance Plan will only be made to the Service Provider, Service Provider's authorized designate, Service Recipient or Service Recipient's authorized designate.

Audit

- Service Provider must retain, and consent to examination upon 24 hours notice by an authorized representative of Alberta Health, original charge documents and records (other than medical records), wherever they are maintained, as per Section 34 of the Alberta Health Care Insurance Act, and Section 22(3) of the Alberta Health Care Insurance Regulations.
- Service Provider acknowledges that all costs for providing data required in the course of an examination of records are the responsibility of the Service Provider and/or Accredited Submitter.

1.2.3 Alberta Health

Alberta Health must comply with the following:

Accreditation

- Alberta Health must accredit new Submitters to transmit and receive claim data based on their ability to meet the accreditation criteria specified in this document.

- Alberta Health, in conjunction with CGI, must monitor Accredited Submitter transmissions to ensure accreditation requirements are maintained. Any problems identified through the Accreditation Process by Alberta Health or CGI will be brought to the attention of the Accredited Submitter.

- Alberta Health must provide specifications, a Submitter Prefix code, Security Card and password granting Conditional Accreditation to new Submitters to perform the testing required to meet the accreditation requirements.

- Alberta Health must provide assessment information to the Accredited Submitter in the output format specified in this manual.

- Alberta Health must provide electronic files as defined under Accredited Submitter Functions for Accredited Submitter retrieval.

- Alberta Health must provide, on request, Claim Number and Service Provider Stakeholder ULI Number check digit formulas.

Notification

- Alberta Health will inform all Accredited Submitters of any operational changes via Alberta Health Bulletins as far in advance as possible. Legislative changes affecting both Alberta Health and Accredited Submitters may not have advance warning. The communication will include the Alberta Health target implementation date, timeframes for Accredited Submitters to comply with the changes and testing requirements.

- Alberta Health must provide confirmation to the Accredited Submitter when accreditation is granted.

- Alberta Health will provide notification and/or replacements to the Schedule of Benefits components on electronic medium as updates occur.

- Alberta Health must inform the Accredited Submitter of the implementation date upon successful completion of accreditation test requirements.

- Alberta Health must inform the Accredited Submitter of any operational problems during the accreditation period or while in production.

Security

- Alberta Health must keep technology information captured on the Electronic Submitter application for Accreditation confidential.

Payment

- Payments by Alberta Health will only be made to the Service Provider, Service Provider's authorized designate, Service Recipient or Service Recipient's authorized designate.

Audit

- Alberta Health may periodically schedule on-site inspections of the Accredited Submitter site, providing 24 hours notice.

- Alberta Health must notify the Accredited Submitter, and the Service Providers/Business Arrangement Contract Holders affected, in writing two weeks in advance if accreditation privileges are being withdrawn.

There are a number of reasons that termination of accreditation may occur outside of Alberta Health's control.

These may be voluntary withdrawals resulting from:

☐ Loss of Service

☐ Loss of Service Providers

☐ Bankruptcy

The reasons under which Alberta Health will terminate accreditation are as follows:

☐ Alteration of original data was detected and not substantiated with an audit trail or reconciliation showing evidence of Service Provider approval

☐ On-site inspection not satisfactory

☐ Specifications continually violated

☐ Evidence of breach of confidentiality

☐ Evidence of fraudulent collusion between Accredited Submitter and Service Provider(s) Business Arrangement Contract Holder

A verbal notification followed by a written notification will be issued two weeks in advance when terminating accreditation. Affected Service Providers/Business Arrangement Contract Holder will also be notified.

1.3 Accreditation Application Forms

There are two application forms required for accreditation.

1. Application for Submitter Role (AHC2210)
   -used by the prospective submitter to apply for initial accreditation

2. Submitter/Client Relationship for Electronic Claim Submission (AHC2096)
   -used by Service Provider/Business Arrangement Contract Holder to designate their authorization for an Accredited Submitter to submit claims on their behalf.

   All fields on the forms must be completed.

A sample and the detailed description of each form follows.

1.3.1 Application for Submitter Role (AHC2210)

The Submitter, requesting approval to become accredited for the role of Submitter, completes this application form. Details on how to complete the form follow. All fields are mandatory.

The first section (Section A) of the form covers the details pertaining to the Submitter and the following information must be provided:

- ☐ Name (Practitioner/organization)
- ☐ Practitioner ID/Organization ID
- ☐ Business Phone / Business Fax / Business E-mail
- ☐ Mailing Address
- ☐ Physical Address

The second section (Section B) of the form to be completed is the submitter Technical Software Contact information:

- ☐ Name of Technical Software Contacts (software vendor/company name)
- ☐ Telephone Numbers (of the contacts)

The third section (Section C) of the form to be completed is the Submitter Agreement information:

- ☐ Authorization Name(s)
- ☐ Authorization Signature(s)
- ☐ Date of Application Authorization

The technology information captured on the Electronic Submitter application for Accreditation will be kept confidential and will not be shared with any other Accredited Submitters. Alberta Health will use this information when considering technology changes.

A copy of the form and any supporting information can be forwarded to:

Alberta Health
Health Information Technology and Systems Division
Information Technology Operations Branch
Application Maintenance and Data Services
Box 1360, Edmonton, Alberta T5J 2N3

Attention: H-Link Application Support

Or faxed directly to 780-422-7248

1.3.2 Submitter/Client Relationship for Electronic Claim Submission (AHC2096)

This form is completed by the Service Provider/Business Arrangement Contract Holder and signed jointly with the Accredited Submitter and provides authorization for the Accredited Submitter to submit claims on behalf of the Service Provider or Business Arrangement Contract Holder. The details on how to complete the form are as follows.

The first section of the form covers the Service Provider details and the following information must be provided:

- ☐ Name
- ☐ Business Address
- ☐ Business Arrangement Numbers to be connected to the submitter
- ☐ Service Provider PRID or Business Arrangement Contract Holder ULI (as issued by Alberta Health)
- ☐ Proposed Commencement Date (for the initial submission)
- ☐ Contact name (of the Service Provider or Business Arrangement contract Holder delegated representative with whom Alberta Health will communicate)
- ☐ Telephone Number (of the contact)

The next section of the form covers the Accredited Submitter details including:

- ☐ Accredited Submitter Name
- ☐ PHN/PRID
- ☐ Submitter's Prefix I.D. Number (as assigned by Alberta Health)
- ☐ Proposed Submission Date

The last section of the form to be completed is the Certifications and Agreements for the Service Provider or Business Arrangement contract Holder and the Accredited Submitter including:

- ☐ Authorization Signature(s)
- ☐ Authorization Name(s)
- ☐ Dates of Application Authorizations

A copy can be retained by the Service Provider or Business Arrangement Contract Holder and the Accredited Submitter. The original is to be forwarded to:

Alberta Health
Health Care Insurance Plan Administration Division
Claims Management Branch
Practitioner and Facility Registries Unit
Box 1360, Edmonton, Alberta T5J 2N3

Or faxed direct to 780-422-3552

1.4 Software Requirements

- The software to be used to perform electronic claims submission is a web browser.

- Internet Explorer for Windows 7 or Windows versions later than 7 (i.e. Windows 8, Windows 8.1) A copy of the latest version of IE can be downloaded from Microsoft (http://www.microsoft.com).

1.5 Hardware Requirements

This is the **minimum** configuration required.

- A personal computer running at least a 3.0 gigahertz processor and either Windows 7 or higher Windows versions. The computer must have sufficient memory and disk space to run Internet Explorer. A minimum of 3 GB of RAM is recommended.

- A High-speed internet connection (DSL or Cable).

- A FOB (secure logon device) used for logging into the H-Link Network.

CHAPTER 2 CLAIM PREPARATION AND SUBMISSION

2.1 Introduction

The Claims Assessment System is designed to allow for the processing of claims on a daily basis, however we currently only process claims Tuesdays, Wednesdays and Thursdays. An additional run on Friday or a weekend is optional based on volumes and Alberta Health's operational requirements. Due to the large volumes of claims involved, submitters transmitting large volumes (e.g. 25,000) need to balance volumes over the three daily runs.

Every file of transactions submitted to the Alberta Health Claims Assessment System (CLASS) is validated. The validation will insure:

- the Submitter is accredited to submit production transactions.

- each Batch Header record is the correct format with valid field values and the Batch Trailer Transaction Totals match actual batch values.

- each transaction segment is the correct format based on the Transaction and Segment Type.

Claims' processing is a two-step process. Batches are first edited (validated) and balanced before the transactions are processed for payment. At this edit stage, if a transaction within a batch is in error, the transaction is refused. It can also be refused if there is an issue with the header, footer or submitter information. Valid transactions are then passed to the claims assessment system for further processing. Any assessment related problems detected at this point will result in only the affected transactions being refused or held for manual review/assessment. Refused batches and transactions must be corrected and re-submitted to Alberta Health to be re-processed. Error codes in the Batch and Field Edit checking are found in Appendix B.

NOTE: Certain special characters are not to be used within submitted claims because of their potential to conflict with characters that are used in the telecommunications aspect of transmitting claim data. **CAUTION** should be used for the following types of characters which can create problems in converting data for transmission: ', ¢, [ ], and binary zeroes. Do not use these characters in your text records or in the claim transaction fields.

Three record types make-up a batch of claims for submission - a batch header, one or more transactions, and a batch trailer. Each record type is described in this Chapter. Electronic claims must be batched in a specific format for transmission to the claims processing system. More than one batch can be transferred within one submission. The batch process involves the following basic steps for each batch.

STEP	COMMENT/RESULT
1. Collect and batch claim records	Max.99999 claims/batch
2. Precede batch with a Header Record	See this Section for details
3. Follow batch with a Trailer Record	See this Section for details

2.2 Transaction Types

Identifies a specific type of transaction submitted to Alberta Health. A type of transaction can contain multiple records called segments. At this time Service Providers within Alberta use only CIP1 (In-province Service Provider Claim) for all claims. This includes reciprocal claims for services to Out of Province (OOP) service recipients who are registered with another provincial (except Quebec) Health Plan. This transaction does not include Hospital Reciprocal claims.

2.3 Segment Types

A transaction can consist of one or more segments, and the segment type is used to identify a specific segment within a transaction. Each segment contains a header portion and a data portion. An In-Province Service Provider Claim (CIP1) can include one or more of the following segments:

CIB1 - In-Province Service Provider Base Claim segment (1 only).
CPD1 - Claim Person Data segments (multiple as needed).
CST1 - Claim Supporting Text segments (up to 500).
CTX1 - Supporting Text cross-reference segment (as required).

The use of each segment type is dependent upon the Action Code being used.

2.4 Action Codes

An Action Code tells the system whether a claim is being added, changed, deleted, or re-assessed. The valid action codes that can be coded for this transaction are:

A - Add Claim

Used when adding a new claim. The Claim Number (Submitter Prefix, Current Year, Source Code, Sequential Number, Check Digit combination) cannot have previously been sent.

There must be a Base Claim segment (CIB1) provided. If a person data is required, person data segments (CPD1) must be included. If supporting text is required, then supporting text segments (CST1) must be included. If the same text is to be used by other claims, a supporting text cross-reference segment (CTX1) must be included.

C - Change Claim

Used when changing an existing claim that has previously been accepted by Alberta Health. A Claim is considered accepted if already assessed and applied. If the previous Claim transaction for this Claim Number had been refused by Alberta Health, then a change cannot be accepted.

Person data segments (CPD1) can be included if required based on the data provided on the base claim data segment.

Any text segments (CST1) included will add an additional text block to any text blocks already existing for the claim and to any text blocks already existing for any claims referenced in an included text cross-reference segment.

If a text cross-reference segment (CTX1) is included, any text included with the change will be connected to the referenced claims.

R - Reassess Claim

Used to cause a previously assessed claim to be re-assessed with text taken into consideration. Normally, except for specific situations (e.g. claim for unlisted procedure, EMSAF claim), text is ignored when a claim is initially assessed and results in payment.

A Base Claim segment (CIB1) may be included (an 'R' and 'D' may have a CIB1 segment).

Text segments (CST1) must be included and will add an additional text block to any text blocks already existing for the claim.

If a text cross-reference segment (CTX1) is included, any text included will be connected to the referenced claims.

D - Delete Claim

Used to delete an existing claim that has previously been accepted by Alberta Health. No segment data is required. The segment type (C1B1) in the transaction header should be blank if no segment is sent - but the segment count must still be 0001. A CIB1 is allowed for a 'D' and when sent is the only segment required.

If a Change, Reassess or Delete transaction is refused, the initial applied claim that was to be changed/reassessed/deleted is left as is.

2.5 Preparing A Batch Header

Every transmitted file or "batch" must begin with a **Batch Header Record**, contain one or more claim transactions, and end with a Batch Trailer Record. Each of these records is divided into "data fields". Each data field must comply with predefined syntax, conditions, values, ranges etc. This enables the computer to correctly locate, edit, and process the data.

The Batch Header is recognized by the system by a record type "2" in the first position. The Submitter of the batch is identified by their Submitter Prefix code. The batch number uniquely identifies the batch.

The following table describes the format of the Batch Header record. It contains four columns that: describes a data field, indicates the starting and ending position of each data field, the number of characters allotted to the field (size), whether the field is alphabetic or numeric, and provides a comment or special instruction pertaining to the field.

Example: 2ABC000001

BATCH HEADER DATA FIELD	FIELD POSITION	FIELD SIZE	COMMENTS
Record Type	01-01	N(01)	Constant value = "2"
Submitter Prefix	02-04	A(03)	As given by Alberta Health
Batch Number	05-10	N(06)	This must be unique across all batches in all files submitted by the submitter within the last 720 days. It should be assigned sequentially starting at 1 and can restart at 1 once 999,999 is reached.
(not used)	11-255	A(244)	Leave blank

2.6 Preparing a Claim Transaction

Claim transactions follow the Batch Header. **A Transaction** is composed of two parts. The first part is the transaction header and the second part is the segment. The transaction header contains identifier fields. It identifies the transaction record type (always type "3") and is followed by a claim number. **A claim number is also the transaction number** and is composed of the Submitter Prefix, which is usually the same as in the header and trailer records, the current year; a source code to identify the originating source of the claim (e.g. practitioner's office), and the location to where the processed results will be returned; a unique sequence number; and a check digit that helps to detect an inadvertent transposed or changed sequence number. The Claim number in the Header is followed by the Transaction Type; Segment Type; Segment Sequence, and Action Code.

The following is an example of claims transaction.

3XXXYYSS1234567DCIP1CIB10001 A ---Segment Data-----

The layout of the claim transaction is as follows:

Header Portion

'3'	=	Record Type
XXX	=	Submitter Prefix
YY	=	Current Year
SS	=	Source Code (unique alphanumeric number assigned to a Service Provider by the Submitter to distinguish Service Provider data)
1234567	=	Sequence Number (assigned sequentially starting at 1.)
D	=	Check Digit
CIP1	=	Transaction Type that identifies the purpose of the transaction.
CIB1	=	Segment Type (other possible values are CST1, CPD1, and CTX1)
0001	=	Segment Sequence

Note: If other segments are required for the same transaction, then the segment sequence increases according to number of segments (e.g. CIB1=001, CPD1= 0002, CST1= 0003).

A	=	Action Code (**A**dd, **C**hange, **D**elete, **R**e-assess) C, D & R are only allowed for previously accepted claims.
Filler	=	Blank
Segment Type	=	following the Transaction Type is the Segment Type.

There are four (4) basic segments types associated with a transaction. Each is used for a different purpose. The first part of a transaction (the header) must always be repeated for each segment type associated with that transaction to ensure segments are kept together. All segments within a transaction must have a unique sequence number. For each new transaction, start the segment sequence at one (1) and increment by one (1) (e.g. text segments must be kept in sequence to ensure text lines are kept in the proper sequence).

1. CIB1 - In Province Provider Base Claim. This is the first segment type. A "CIB1" segment must always be present on a Claim with an 'A' (Add) Action since it provides the base data for claims by in-province Service Providers and thus forms the basis of a transaction. Only one "CIB1" segment is allowed per transaction. Other segment types are conditional for Add transactions.

2. CPD1 - Claim Person data segment. The second segment type "CPD1", in addition to the mandatory first segment "CIB1" for an Add, is required for each person referenced on a claim where:

   - ☐ the Service Recipient (person receiving a service from a Service Provider) does not have a Unique Lifetime Identifier (ULI) and;
   - ☐ a Payee not already identified by the Pay to ULI, where the Pay to Code = OTHR.
   - ☐ an out of province Referring Service Provider

   This segment is necessary to document the name, address, and other pertinent information so processing may be completed.

3. CST1 - Claim Supporting Text segments. The third segment "CST1" is used when supporting text is required for a claim. Up to 500 "CST1" segments can be used.

4. CTX1 - Supporting Text cross-reference. The fourth segment "CTX1" is used where the supporting text in segments "CST1" above is also used for other claims. This segment can include up to fourteen (14) Claim Numbers that use the same supporting text. Only one (1) "CTX1" segment can be used per transaction.

Where a specific transaction has multiple segments, the segment types must be in the following sequence within a unique transaction.

- CIB1 segment
- CPD1 segments
- CST1 segments
- CTX1 segments

Segment Portion

Contains the Segment Data pertinent to the segment provided.

Details of the data fields required for each segment type are provided in this Chapter.

A claim transaction consists of the header portion that identifies the type of transaction and the type of segment.

The total size of a record, including header and data portion is 254 bytes.

The following describes the format of the header portion of the CIP1 (generic claim) transaction record.

TRANSACTION FIRST PART DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Record Type	01-01	N(01)	This is always the number "3". Transaction Records are placed between a Batch Header (record type 2) and Batch Trailer Record (record type 4).
Submitter Prefix As assigned by Alberta Health (part of claim #)	02-04	A(03)	A three-character code as assigned by Alberta Health that uniquely identifies a submitter. Only the 'A' Add transaction must have a Prefix = to the current Submitter. For C, D and R transactions, the original claim number must be used (it may have a different submitter prefix). Forms part of the Claim Number.
Current Year (part of claim #)	05-06	N(02)	The year the transaction was created (captured) by the Submitter.
Source Code (part of claim #)	07-08	A(02)	For Submitter use. Can be used to differentiate transactions from different sources (e.g. Service Provider). This field cannot have a space in it. Examples of how the Source code can be used are:

TRANSACTION FIRST PART DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
			-a lone practitioner who works from a single facility may choose to always use the same source code -clinics with many practitioners may choose to use a different source code to identify each practitioner -organizations with several facilities or departments may choose to use different sources codes to identify each location
Sequence Number (part of claim #)	09-15	N(07)	A unique number within each transaction. No two transactions can have the same SUBMITTER PREFIX, SOURCE CODE, CURRENT YEAR and SEQUENCE NUMBER except when a claim that was previously sent is to be changed, deleted, or reassessed. These fields must be the same as on the original claim addition transaction. In the case of claim transactions, the SUBMITTER PREFIX, CURRENT YEAR, SOURCE CODE, SEQUENCE NUMBER and CHECK DIGIT will form the Claim Number.
Check Digit (part of claim #)	16-16	N(01)	Calculated from Sequence Number using modulus 10 formula.
Transaction Type	17-20	A(04)	Within record type "3' there is a transaction code that tells the system the type of transaction being submitted (e.g. In-Province claims). At this time only one transaction type code (CIP1) is being used for In-Province (IPC) and Out-of-Province (OOP) claims. Out-of-Province claims are for services to Out-of-Province recipients who are registered with another Provincial (except Quebec) Health Plan. This transaction excludes Hospital reciprocal claims.
Segment Type	21-24	A(04)	A transaction can contain one or more segments and each segment, must be uniquely identified by a segment type. The header portion of the transaction identifies the type of transaction and type of segment. The following segment types exist (depending on the Action code). CIB1 - In-Province Provider Base Claim segment (one only).

TRANSACTION FIRST PART DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
			CPD1 - Claim Person Data segments (maximum of three per transaction; one each for Service Recipient, Payee and OOP Referring Service Provider. CST1 - Claim Supporting Text segments (up to 500 segments). CTX1 - Supporting Text cross-reference segment - can include a maximum of 14 cross-referenced claims that use the supporting text in segments "CPD1" or "CST1". The transaction header and segment portion data together cannot exceed 254 characters.
Segment Sequence	25-28	N(04)	The unique sequence of a segment within a transaction. This is required for text segments to ensure text lines are kept in the proper sequence. Each segment within a transaction must have a unique sequence number - usually starting at one (1).
Action Code	29-29	A(01)	The Action Code tells the system whether a claim is being added, changed, deleted, or re-assessed. The valid action codes that can be coded for this transaction are A, C, R, and D. All segments within a transaction must have the same action code. See Action Definitions described earlier in this Section.
Unused	30-35	A(06)	Unused - leave blank.
SEGMENT (data portion)	36-254	A(219)	Segment part of transaction and contents depends on the type of segment being completed. If a specific transaction includes multiple segments, the segments must be in the following sequence (alphabetic): - CIB1 segment - CPD1 segments - CST1 segments - CTX1 segments

2.6.1 **Format and Content of Base Claim Segment (CIB1)**

The following identifies the fields in the segment portion of a transaction.

This segment contains the base data for claims by in-province Service Providers. Most in-province Service providers will only require this segment. **Transaction header fields must be completed before completing segment CIB1.**

SEGMENT TYPE - CIB1

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Transaction data entered here	1-35		Transaction data is entered in column's 1-35 (see previous section for description).
Claim Type	36-39	A(04)	Use type "RGLR" for all In-Province Service Provider claims.
Service Provider PRID	40-48	N(09)	A nine digit Practitioner Identifier. All Service Providers will have a unique PRID, which must be coded on each claim. All PRID's have a check digit in the 5th position, which can be calculated using the Modulus 10 formula.
Skill Code	49-52	A(04)	Designates the Service Provider's discipline and specialty/accreditation that the service was performed under. The valid Skills for each Service Provider will be registered in the Alberta Health Stakeholder Registry. This field need only be populated when the Service Provider has more than one SKILL and the HEALTH SERVICE can be performed by more than one of those SKILLS and the default SKILL for the BUSINESS ARRANGEMENT is not to be used.
Service Recipient ULI	53-61	N(09)	All persons in Alberta will have a ULI/PHN (Personal Health Number). If the claim is being submitted as a Good Faith claim, this field and the Service Recipient Registration Number field should be spaces/blanks. A person data segment (CPD1) must accompany the transaction. If this is a Newborn claim this field and the Service Recipient Registration Number field could be spaces. All ULIs have a check digit in the 5th position, which can be calculated using the Modulus 10 formula.
Service Recipient Registration	62-73	A(12)	If this is a Medical Reciprocal claim this field contains the other province Health Plan

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Number			Registration Number. **Note: If the other province's health plan number and the PHN are known, a person data segment is not required.** The Registration Number must pass check digit validation of the respective province (see Recovery Code field that follows). The validation routine depends on the province.
Health Service Code	74-80	A(07)	Indicates the health service performed. The Health Service Code must be a valid code within the Schedule of Benefits applicable to the discipline of the Service Provider. Procedures claimed under the Miscellaneous category (e.g. Unlisted procedures 99.09 and all other by-assessment items) must have supporting documentation (with the exception of 99.09T). The claimed amount must also be indicated. The Health Service must be claimed in accordance with the Governing Rules applicable to the discipline of the Service Provider. The Health Service Code must be allowable for the Service Provider based on the Service Provider's Skill and any service restrictions. The Health Service Code must be allowable for the Service Recipient's gender, age and other biological characteristics. The Health Service code must be allowable for the Facility/Functional Centre/Location. The Health Service Code must be allowable for the Diagnostic code(s). The Health Service Code may be submitted in compressed format. (No embedded spaces). Alberta Health will decompress. (E.g. Input: E1 or E _ _ 1 will be allowed). Alberta Health's external format of the Health Service codes will be in decompressed format only. (E.g. Output:E _ _ 1).

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Service Start Date	81-88	N(08)	YYYYMMDD - Indicates the day the health service was performed. In the case of hospital visits (03.03D), the date of the first day of consecutive hospital visit days is coded and the CALLS field must indicate the number of consecutive days.
Encounter Number	89-89	N(01)	Indicates if the service was performed during the first, second, third, etc. time the Service Provider has seen the Service Recipient on the same day.
Diagnosis Code 1	90-95	A(06)	Primary diagnosis (ICD-9 format) The Diagnostic Code must be valid for the Health Service Code entered. Diagnostic Code 1 is used for the primary diagnosis. Diagnostic Codes 2 and 3 are used for any secondary diagnosis, if applicable.
Diagnosis Code 2	96-101	A(06)	Secondary diagnosis code - if necessary (ICD-9 format).
Diagnosis Code 3	102-107	A(06)	Tertiary diagnosis code - if necessary (ICD-9 format).
Calls	108-110	N(03)	This field is used to indicate either the number of consecutive hospital visit days (03.03D), the number of services performed or the number of units (e.g. 15 minute time blocks) required. The Price List defines the meaning of this field for each applicable Health Service Code and defines the maximum calls allowed for the Health Service Code.
Explicit Fee Modifier 1	111-116	A(06)	The Explicit Fee Modifier fields are used to enter explicit modifiers required to further identify the nature of the service for payment purposes. Explicit Fee Modifiers are those that cannot be derived from other data on the claim. An example of an Explicit Fee Modifier is the Role modifier, which indicates the role (e.g. surgical assist or anaesthetist) that the Service Provider was performing for the service. The Fee Modifier Definitions List indicates if a modifier is explicit (required on the claim) or implicit (derived)

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
			Fee Modifiers affect how much Alberta Health will pay for a Health Service Code. The applicable derived and the allowable explicit Fee Modifiers are described in the Price List.
Explicit Fee Modifier 2	117-122	A(06)	Used if more than one Explicit Fee Modifier is required. An example of two modifiers could be "role" and "services unscheduled" for any service where payment is affected by the role of the Service Provider (e.g. surgical assistant) and by the time block (e.g. at night) the service was performed.
Explicit Fee Modifier 3	123-128	A(06)	Used if more than two Explicit Fee Modifiers are required.
Facility Number	129-134	N(06)	The specific Facility where the service was performed as per the Alberta Health Stakeholder Registry. If the service was not performed at a registered Facility, the LOCATION CODE field must be coded instead.
Functional Centre	135-138	A(04	The specific Functional Centre within the Facility where the service was performed. An example is the Neonatal Intensive Care Functional Centre within the University Hospital. The Alberta Health Stakeholder Registry details the valid Functional Centres for each registered Facility. This field is only required if the service was performed at a registered Facility and that Facility requires a Functional Centre to be coded. Some Facility/Functional Centres will have restrictions as to the Health Services that can be performed at them.
Location Code	139-142	A(04)	If the service was not performed at a Registered Facility, the Location Code is required. Values are "HOME" (e.g. the Service Recipient's home), “SCHL” (School) and "OTHR".

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Originating Facility	143-148	N(06)	Used to indicate the Facility where the encounter with the Service Recipient occurred, for those types of services, where the encounter can be at a different Facility from where the service was performed (e.g. when a specimen/procedure (blood sample/ECG/xray) is taken in one facility and tested/interpreted in another).
Originating Location	149-152	A(04)	Valid values are; 'SCHL' for School, 'OTHR' for Other, and 'HOME' for Home. This field should only be used if the encounter with the patient occurred at somewhere other than where the service occurred, and that location is **NOT** a recognized facility. The Originating Facility and Originating Location cannot both be used on a single claim. If the code "OTHR" is used, then the exact location must be provided in the text.
Business Arrangement	153-159	N(07)	The Service Provider's Business Arrangement that the Service Provider is claiming under. Business Arrangements are agreements between one or more Stakeholders and Alberta Health for provision and payment of Health services. The Business Arrangement describes the Service Providers that can provide services, the Contract Holder that the Service Providers are contracted to, and the payee that is to be paid for any claims. In some cases the above will all be the same Stakeholder. All Service Providers in Alberta must have or be part of a Business Arrangement registered with Alberta Health in order to claim for services. Some Service Providers may have and/or may be part of more than one Business Arrangement. Some Business Arrangements will have restrictions as to the Health Services that can be claimed. The Business Arrangement or the Contract Holder of the Business Arrangement must be

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
			registered to submit via the Submitter that has submitted the transaction. An exception to this would be if the practitioner is acting as a locum. If the practitioner is using a Business Arrangement for their locum practice, then the locum Business Arrangement either must be associated with the Submitter or if using submitter for service provider he is replacing their BA must be coded on the claim.
Pay To Code	160-163	A(04)	Indicates to what person or organization the payment is to be made. Normally, the Pay To Code will indicate "Business Arrangement" which results in the payee defined for the Business Arrangement to be paid. If Pay To Code indicates Service Recipient, or Contract Holder (CONT) (for example, pay to the parent Contract Holder if the service recipient is a child), or Other (OTHR), then the claim is considered a Subscriber claim. If Pay To Code indicates "OTHR", the Pay To ULI or a Person Segment for Payee must be coded. The Pay to Code "OTHR" should only be used when the Pay to ULI does not act in any of the roles identified by the other Pay to Codes. The valid codes are: - "CONT" (Contract Holder) - "RECP" (Service Recipient) - "BAPY" (Business Arrangement), or - "OTHR" (Other) - "PRVD" (Service Provider)
Pay to ULI	164-172	N(09)	If Pay To Code indicates "other" and the ULI of the other person is known, code the ULI here. If ULI of the other person is not known, a Person Segment for Payee is required. All ULIs have a check digit in the 5th position.
Locum Arrangement Business	173-179	N(07)	If the Service Provider is performing the Service as a result of a Locum arrangement with a second Service Provider and the claims

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Arrangement			are to be submitted via the first Service Provider's Submitter, then the first Service Provider's Business Arrangement must be coded.
Referral ID	180-188	A(09)	If the Service was a referred service, the referring Service Provider's PRAC ID must be coded. If the service was referred from an OOP Service Provider, this field can be blank but the OOP REFERRAL IND must be set to Y, and the person data segment must be completed.
OOP Referral Indicator	189-189	A(01)	"Y" indicates that the service was referred from an OOP Service Provider. A person data segment for the OOP Referring Service Provider must be included. **Note: Leave this field blank for Medical Reciprocal claims referred from an OOP Service Provider.**
Recovery Code	190-193	A(04)	If the claim is for services provided to a Service Recipient registered in another provincial health plan as per the Medical Reciprocal Agreement, the other province code (e.g. SK) is coded in this field. A Medical Reciprocal Claim requires the OOP Registration Number to be coded in the SERVICE RECIPIENT REGN NO. FIELD and also requires a Person Data segment for Service Recipient. The valid codes are: - any valid province abbreviation (except Quebec) for Medical Reciprocal claims.
Chart Number	194-207	A(14)	Free format field. This is a clinic use field, which can be used for any source reference number.
Claimed Amount	208-216	N(09)	This field is used in conjunction with the Claimed Amount Indicator.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
			If the CLAIMED AMOUNT INDICATOR is not "Y", the Claimed Amount is ignored but will be returned on the Assessment Result Details File List and Statement of Assessments for reconciliation purposes. If the Service Provider wishes to claim an amount less than the normal amount to be paid for the service then the Claimed Amount Indicator can be set to "Y". If the Claimed Amount is less than the amount assessed by Alberta Health, the Claimed Amount will be paid. If the Claimed Amount Indicator is "Y" and the Claimed Amount is more than the Alberta Health Assessed Amount, the Claimed Amount will be ignored.
Claimed Amount Indicator	217-217	A(01)	"Y" indicates that the Service Provider is claiming an amount less than the normal amount to be paid for the service.
Intercept Reason	218-221	A(04)	If the payment for the claim is to be intercepted by Alberta Health (e.g. not to be mailed directly to the payee), the reason for the intercept must be coded. The valid codes are: - "PKUP"(Hold for pickup). **NOTE:** This code cannot be used if the pay to code is “BAPY”.
Confidential Indicator	222-222	A(01)	"Y" indicates that the Service Recipient indicated that the service is to be confidential.
Good Faith Indicator	223-223	A(01)	"Y" indicates that the Service Provider is submitting the claim as a Good Faith claim as per the Alberta Health Good Faith policy. If the claim is submitted as a Good Faith claim, a Person Data Segment for the Service Recipient is required.
Newborn Code	224-227	A(04)	Indicates Service Recipient is new-born without an Alberta Health ULI. If Newborn, a Person Segment for the Service

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
			Recipient is required. Valid codes are: - "ADOP" (Adoption) - "LVBR" (Live birth) - "STBN" (Still Born) - "MULT" (Multiple Birth)
EMSAF Indicator (Extraordinary Medical Services Assessment Fund)	228-228	A(01)	"Y" indicates that the Service Provider is submitting the claim as an EMSAF claim as per the Alberta Health EMSAF policy. If the claim is submitted as an EMSAF claim, Supporting Text is required. The extra amount claimed must be indicated in the Supporting Text. Program is now called Additional Compensation however the field name remains unchanged.
Paper Supporting Documentation Indicator	229-229	A(01)	Indicates that supporting documentation is being sent on paper (e.g. not as electronic text). Supporting documentation should only be sent on paper if graphics are required. The paper supporting documentation must reference the Claim Number.
Hospital Admission /Originating Encounter Date	230-237	N(08)	YYYYMMDD format. If the service performed is a hospital visit (03.03D), the date the Service Recipient was admitted to hospital must be indicated on each hospital visit claim. When the Originating Facility field is entered on a claim, the "Originating Encounter Date" may also be used.
Tooth Code	238-239	A(02)	As per Dental Procedures List.
Tooth Surface 1	240-241	A(02)	As per Dental Procedures List.
Tooth Surface 2	242-243	A(02)	As per Dental Procedures List.
Tooth Surface 3	244-245	A(02)	As per Dental Procedures List.
Tooth Surface 4	246-247	A(02)	As per Dental Procedures List.
Tooth Surface 5	248-249	A(02)	As per Dental Procedures List.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Unused	250-254	A(09)	

2.6.2 Format of Claim Person Data Segment (CPD1)

This segment is required for each person referenced on a claim where the person's ULI is not known. The only persons that this segment is allowed for are **Service Recipient**, and **Payee** (see Glossary for definition). There can be multiple Person Data Segments for the same transaction, as required.

A Claim Person Data Segment (CPD1) applies to the following situations:

A) The claim is submitted as Good Faith. (Not allowed on claims from Opticians, Denturists, or any EHB services from Dentists or Optometrists.)

B) The Service Recipient is a Newborn and the ULI is unknown. (Allowable on claims for the Medical discipline only.)

C) The Service Recipient is from out-of-province, eligible for Medical Reciprocal Services. (Allowable on claims for the Medical discipline only.)

D) The Referring Service Provider is Out-Of-Province. (Allowable on claims for Medical, Dental, Optometry and Podiatrists disciplines only.)

E) The Pay To Code is set at "OTHR" and the Pay To ULI is blank. (Allowable on all claims.)

(Check in the Handbook for Claim Submissions for further details).

The following describes the transaction segment data for the CPD1 segment.

SEGMENT CPD1 DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Enter Transaction data here	1-35		See transaction data requirements in this document.
Person Type	36-39	A(04)	Indicates if person segment is for Service Recipient, or Payee, or OOP Referring Service Provider. Valid codes are: - "RECP" (Service Recipient) - "PYST" (Payee) and - "RFRC" (OOP Referring Service Provider)
Surname	40-69	A(30)	
Middle Name	70-81	A(12)	
First Name	82-93	A(12)	Do not use wording such as Baby Boy, Infant Girl in this field for new-borns. If a baby's name is not known, this field must be left blank.
Birth Date	94-101	N(08)	YYYYMMDD format.
Gender Code	102-102	A(01)	Valid values are M and F.
Address Line 1	103-127	A(25)	Should contain non-address data (e.g. company name) if applicable, otherwise the street or mailing address should be here. The apartment or unit number is to be placed at the end of the street address. No symbols (#,-) are to be placed before the number.
Address line 2	128-152	A(25)	
Address Line 3	153-177	A(25)	
City Name	178-207	A(30)	Full name or abbreviations for Alberta cities allowed by Alberta Health (provided as one of the Validation files available for Submitter retrieval).
Postal Code	208-213	A(06)	

SEGMENT CPD1 DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Province/ State Code	214-215	A(02)	
Country Code	216-219	A(04)	
Guardian/ Parent Code (ULI)	220-228	N(09)	Used when Service Recipient is a Newborn. All ULIs have a check digit in the 5th position, which can be calculated using the Modulus 10 formula located in Appendix D.
Guardian/ Parent Registration No.	229-240	A(12)	Used if Guardian/Parent ULI is not known and the Guardian/Parent Registration Number is known.
Unused	241-254	A(14)	Leave blank.

Some of the fields indicated on the person segment may not be required depending on the Person Type and the reason for the person segment.

2.6.3 Format of Claim Supporting Text Data Segment (CST1)

This segment is used when supporting text is required for a claim. Up to 500 segments, each containing 3 text lines, can be included for one claim.

The following describes the transaction segment data for the CST1 segment.

SEGMENT TYPE - CST1

SEGMENT CST1 DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Enter Transaction data here	1-35		See transaction data requirements section in this document.
Text Line 1	36-108	A(73)	
Text Line 2	109-181	A(73)	
Text Line 3	182-254	A(73)	

2.6.4 Format of Claim Supporting Text Cross Reference Segment(CTX1)

This segment is used when the supporting text for the claim is also used for other claims. Only 1 segment can be included to indicate up to 14 claims that use the same supporting text. This segment can only be included if CST1 segments are also included.

The following describes the transaction segment data for the CTX1 segment.

SEGMENT CTX1

SEGMENT CTX1 DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Enter Transaction data here	1-35		See transaction data requirements section in this document.
Claim Number	36-245	A(15) X 14	Occurs up to 14 times.
Unused	246-254	A(09)	Leave blank.

2.6.5 Keeping Transaction Segments In Sequence

The header of each claim transaction contains the same data with exception of segment type and segment sequence number. All segments within the same transaction must have the same Action Code.

The following table illustrates how transaction segments are held together in sequence in a transaction.

Transaction Type	Transaction Number	Check Digit	Segment Type	Segment Sequence	Action Code
Transaction #1					
3 CIP1	AAA95CC0000211	2	CIB1	0001	A
3 CIP1	AAA95CC0000211	2	CPD1	0002	A
3 CIP1	AAA95CC0000211	2	CPD1	0003	A
3 CIP1	AAA95CC0000211	2	CST1	0004	A
3 CIP1	AAA95CC0000211	2	CST1	0005	A
3 CIP1	AAA95CC0000211	2	CTX1	0006	A
Transaction #2					
3 CIP1	AAA95CC0000212	6	CIB1	0001	A
3 CIP1	AAA95CC0000212	6	CPD1	0002	A
Transaction #3					
3 CIP1	AAA95CC0000213	3	CIB1	0001	C
3 CIP1	AAA95CC0000213	3	CST1	0002	C

2.7 Preparing a Batch Trailer

The **Batch Trailer Record** is similar to the batch header record. The batch trailer is a record type "4"; it contains the Submitter Prefix code assigned to a Submitter by Alberta Health, and, a batch number (same as Header Record). In addition, it contains the total of all transactions in the batch, excluding the header and trailer records. It also contains a count of all segments in all transactions (explained below). These latter two counts are used to help ensure that transactions and their respective segments are not lost during a transmission and help to ensure batches are all accounted for.

The following table describes the batch trailer in detail.

BATCH TRAILER DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Record Type	01-01	N(01)	Constant value = "4".
Submitter Prefix	02-04	A(03)	As given by Alberta Health.
Batch Number	05-10	N(06)	Same as the Batch Header Number. Must be unique within the Submitter Prefix starting at 1 and re-started after 999999 for all batches in all files submitted within the last 720 days.
Total TXN's	11-15	N(05)	Total number of transactions in the batch (excludes Header and Trailer records). A batch can have a maximum of 99999 transactions, although Alberta Health recommends that batches have between 100-500 transactions. Total number of transactions should include leading zeros. Do not leave blanks.
Total Segments	16-23	N(08)	The total of all segments in all transactions. Total number of transactions should include leading zeros. Do not leave blanks.
Unused	24-254	A(231)	Leave blank.

CHAPTER 3 CLAIM AND DATA FILE RETRIEVAL

Every file of transactions submitted to the Alberta Health Claims Assessment System (CLASS) will be validated. The validation will insure that:

- The submitter is accredited to submit production transactions
- Each Batch Header record is the correct format with valid field values and that the Batch Trailer Transaction Totals match actual batch values
- Each transaction segment is the correct format based on the Transaction and Segment Type and the Submitter is accredited to send each type of transaction

Once the validation process is completed, the transactions from accepted complete and partial batches will be made available to the individual transaction processing sub-systems within the Alberta Health CLASS System. Any problems detected after this point will result in only the affected transactions being either refused or held for manual review/assessment.

Essentially, two output files are used to store claims processing results.

3.1 Batch Balance Retrieval

Batches transmitted to Alberta Health are edited and balanced within one-hour of receipt. The Batch Balance is the on-line response to a claim submission. The Batch Balance response is automatic and returns an immediate response to the submitted claims.

The Batch Balance file is submitter specific and provides one detail line for each processed batch. The Batch Balance report will display accepted and rejected batch numbers and any claim errors or rejections from the edit check process. The detail record indicates whether the batch was accepted or refused or if only a partial batch was accepted.

If the number of claims accepted equals the number of claims submitted, then all the claims in the batch have been accepted. If the number of claims accepted does not equal the number of claims submitted, then either the batch has been partially accepted (e.g. birth date invalid somewhere within the batch) or rejected (e.g. missing header) dependant upon the problem. These claim errors will appear in the same format as an ARD record at the end of your Batch Balance. Only rejected claims or batches need to be resubmitted.

If the batch is refused, the report also provides an error code describing the problem. If the refusal was caused by a transaction, the report identifies the transaction that was in error. Any refused batches and/or transactions must be re-submitted in order for Alberta Health to reprocess. For a list of Batch and Reject messages, refer to Appendix B.

An example of a Batch Balance report:

H-link: STX

ALBERTA HEALTH
Claims Assessment
Batch Results
Date: 2010/11/25

Batch Number	First Transaction ID	Last Transaction ID	Status Code	Reason Code
XCC123212	XCC98MN00039056	XCC98MN00039056	PART	
XCC123213	XCC98MU00039056	XCC98MU00039056	PART	

H-link :ETX More data follows? Y
21998/11/28 13:37:38.400000 0153 HEADER
3XCC98MN00039056CIP1CIB10001A 37B
3XCC98MN00039056CIP1CST10001A
3XCC98MU00039056CIP1CIB10001C 39DA
4000000002000000003 TRAILER

Transaction Summary Section:

•H-Link : STX = Indicates the Start of the Transaction Summary Section.
•H-Link : ETX = Indicates the End of the Transaction Summary Section.
•More data follows = "Y", if at least one batch has been partially refused.
"N", if all batches have been either accepted or rejected.

Note: Since this report will only be distributed electronically, no page breaks will be enforced and therefore the Title Information will be printed only once at the beginning of the report.

Transaction Detail Section:

Header Record

Pos. 1	=	"2" (Constant for Record Type "Header").
Pos. 2 - 27	=	Timestamp of Report Creation.
Pos. 29 - 32	=	Generation Number of GDG created.
Pos. 34 - 39	=	"HEADER" (Constant).

Transaction Record

Pos. 1	=	"3" (Constant for Record Type "Data").
Pos. 2 - 36	=	Transaction Header: - Claim Number - Transaction Type - Segment Type - Segment Number - Action Code - Filler
Pos. 37 - 40	=	Explanatory Code.

Trailer Record

Pos. 1	=	"4" (Constant for Record Type "Trailer").
Pos. 2 - 10	=	Number of Transaction Refused.
Pos. 11 - 19	=	Number of Segments Refused.
Pos. 25 - 31	=	"TRAILER" (Constant).

3.2 Assessment Results Detail (ARD)

The Assessment Results Detail file contains assessment information after the Claim Submission process. Claim errors can be identified in the Batch Balance Response via the discrepancy between the total claims submitted and the total claims accepted and the error details displayed at the end of the batch Balance.

This file is submitter specific and contains the results of all claims processed. The submitter will be supplied with any and all ARD files that are available. New ARD files are created weekly. The Submitter can use these details for any processing needs (e.g. reconciliation of input files). The processed results can be applied (e.g. paid, reduced), refused or held. The output file consists of records 234 characters long and is usually available for retrieval on Monday morning.

Detail records are in order by Date of Service within Service Provider, within Business Arrangement order as defined in the Record Formats section.

Each File contains detail records pertaining to one or more Business Arrangement Numbers.

If a claim transaction is being held by Alberta Health for review, the assessment result outcome for the transaction will indicate held and a subsequent assessment result detail record will be sent when the final outcome of the transaction has been determined.

If a previously processed claim was internally re-assessed with a resulting change in the assessed amount, an assessment result detail record will be sent to the Service Provider/Business Arrangement via the appropriate Submitter.

It is possible for a Submitter to receive Assessment Result Details for claims that were not initiated by the Submitter. If a Business Arrangement changes submitter, any re-assessments of claims sent by the old Submitter will have resulting Assessment Result Details sent to the new Submitter. As well, unique circumstances may arise where Alberta Health may initiate creation, deletion or reassessment of claims. If the Submitter Prefix of any claim transactions received in your ARD file does not match yours, the source code on the transaction will be unreliable in determining where to send the assessment results. Use the Business Arrangement number for routing these transaction results to the appropriate client.

The following fields are contained on the Assessment Results Detail file:

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Claim Number	01-15	A(15)	The Claim Number is a combination of the Submitter Prefix, Current Year, Source Code, Sequence Number, and Check Digit fields as input on the originating transaction.
Transaction Tag Number	16-19	N(04)	Set to 0000 for the initial transaction that created a claim and then incremented by 1 for every transaction/re-assessment against the claim. It is possible to have gaps in the sequence of Tag Numbers.(e.g. Tag Number 3 could be the first change/delete/reassessment for the claim).
Transaction Action Code	20-20	A(01)	A - indicates the assessment result is for the originating claim add C - indicates the assessment result is for a change transaction D - indicates the assessment result is for a delete transaction R - indicates the assessment result is for a re-assessment transaction
Transaction Re-assess Reason	21-24	A(04)	If the assessment result detail is for a re-assessment of a claim, this indicates the reason for the re-assessment. Examples of reasons that the code represents are: SRLE - HSC retro-active change RTRO - Service Provider retro-active change CHEL - Service Recipient retro-active change ARUL - Affected by another Service - etc.
Assessment Result Action	25-25	A(01)	Indicates the outcome of the assessment process. The outcome can be one of: R - Indicates transaction refused. The Explanation Codes indicate the reason for refusal. Refused add transactions must be re-submitted as a new claim with a new claim number once the correct information is determined. If a change or delete transaction is refused, the claim with Alberta Health is left unchanged. H - Indicates transaction is currently being

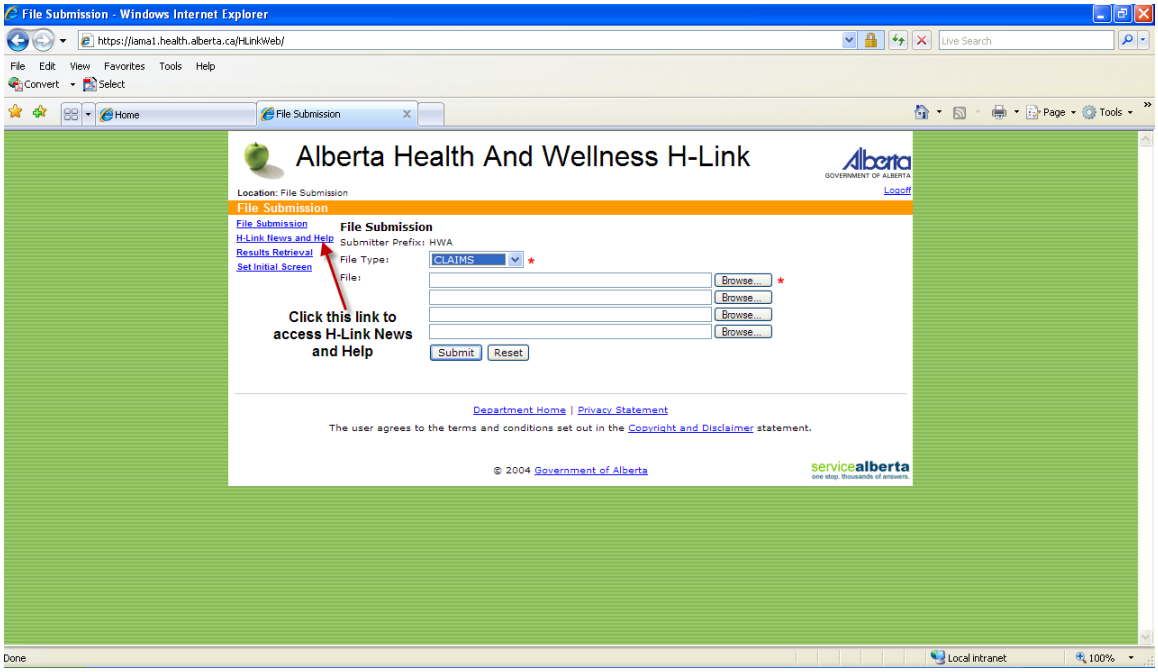
DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
			held for review by Alberta Health. Final outcome will be provided on a subsequent assessment result detail. A - Indicates transaction was applied and an assessed amount has been determined. The amount could be a reduced amount or could be 0.00. In these cases, the Explanation Codes indicate the reason for reduction. An applied claim can later be re-assessed, deleted, or changed.
Assessment Result Action	26-26	A(01)	"R" indicates the record is a reversal of a previous assessment result for the claim. "space" indicates the current assessment result. If the Assessment Outcome is A (applied) and the Transaction Action Code is a C (change) or R (reassessment), two Assessment Result Detail records will be created; the first is a reversal of the old assessed amount and the second is the new assessed amount. Both records will have the same Transaction Number. If the Assessment Outcome is A (applied) and the Transaction Action Code is A (add) or the Assessment Outcome is R (refused) or H (held), only a current assessment result record will be created. If the Assessment Outcome is A (applied) and the Transaction Action Code is a D (delete), only a reversal record will be created.
Chart Number	27-40	A(14)	As originally coded on the submitted claim. This field can be used for any type of record keeping and is not restricted to chart number.
Service Recipient ULI	41-49	N(09)	
Service Recipient Registration No.	50-61	N(12)	
Statement of Assessment Reference Number	62-70	N(09)	The Statement of Assessment that the result is reported on. Statements of Assessment are sent to the originating Business Arrangements. Each

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
			Statement has a unique reference number.
Expected Payment Date	71-78	N(08)	YYYYMMDD The expected date of the cheque or direct deposit that the payment/adjustment amount will be included on.
Assessment Date	79-86	N(08)	YYYYMMDD The date the assessment result was determined by CLASS
Final Assessed Amount	87-95	N(09)	9999999V99 The amount that has been assessed for the claim. The difference between the Final Assessed Amount on the current and reversal records will be the payment/adjustment amount for the claim transaction. These fields will not have commas or decimal points in them. The format will be 9999999V99, where the V designates an implied decimal point. If you were to look at the physical file you would see '999999999'.
Claimed Amount	96-104	N(09)	9999999V99 The claimed amount as coded on the submitted transaction. These fields will not have commas or decimal points in them. The format will be 9999999V99, where the V designates an implied decimal point. If you were to look at the physical file you would see '999999999'.
Claimed Amount Indicator	105-105	A(01)	As coded on the submitted transaction.
Explanation Codes	106-135	A(05) X6	Occurs six times (30 positions) If the assessed amount is not the normal amount to be paid for the HSC/Fee Modifiers, the Explanation Codes provide the reduction reason(s). If the claim has been refused, the Explanation Codes provide the refuse reason(s).
EMSAF Status	136-139	A(04)	If the claim is an EMSAF claim, this indicates the status of the EMSAF portion of the claim. The status can be: - SUBM Submitted

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
			- PPAY Partial Payment - FPAY Full Payment - SENT Sent to Committee - DEND Denied
Fee Modifiers Used	140-199	A(06) X 10	Occurs 8 times (48 positions) The list of derived and explicit fee modifiers that were used to determine the assessed amount. If the assessed amount was manually determined, either due to a manual assessment or an EMSAF assessment, then this area will not contain any data.
FR Reference Number	188-196	N(09)	Unique number assigned to the Financial Request information produced from the assessment of the claim.
Unused	197-199	A(03)	Leave blank.
Business Arrangement Number	200-206	N(07)	From original claim.
Service Provider ULI	207-215	N(09)	From original claim.
Service Date	216-223	N(08)	From original claim
Service Code	224-230	A(07)	From original claim.
Pay to Code	231-234	A(04)	From original claim.

3.3 Data Files Download for Viewing and/or Downloading

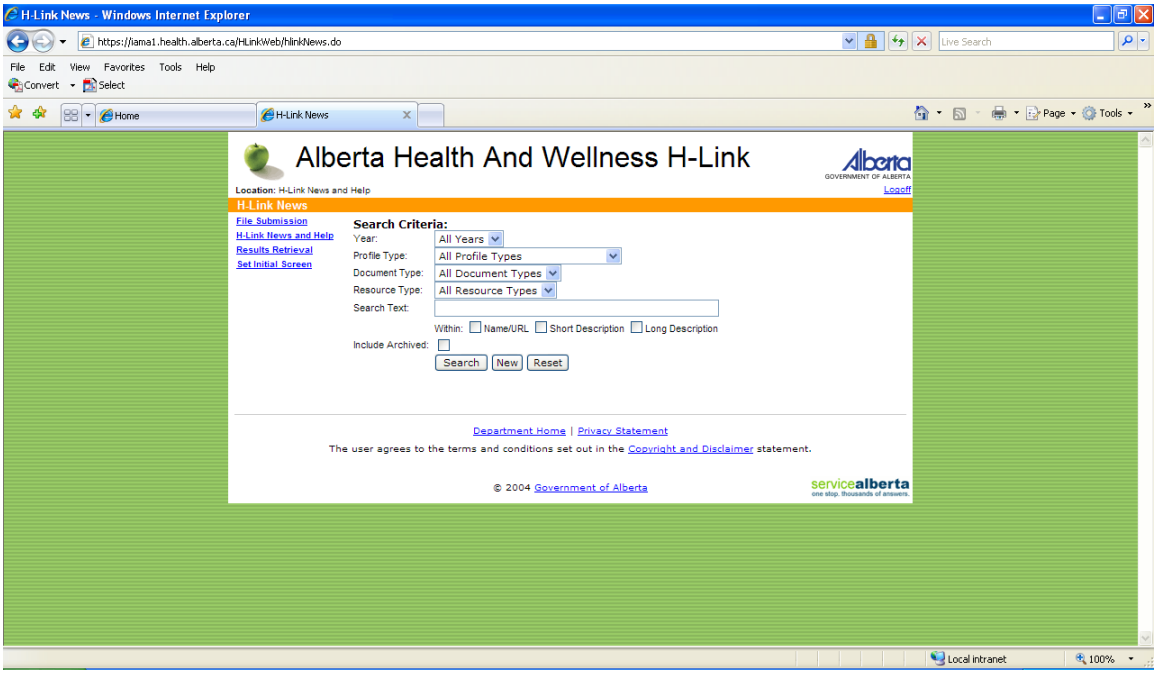
In addition to the Batch Balance Results File and the Assessment Result Details Output File, there are a number of files that you can view online and download into your system. The files are available under the H-Link News and help page.



Search Criteria

This is the first screen that will appear when you select the H-Link News and Help link.

This page consists of a number of search parameters which allow the user to specify the year, profile type, document type and resource type. The user can also enter in text to be searched on, as well as specify where the text is expected (i.e. within the name or URL, short description or long description).



Year: documents are available for a number of years. If All Years is specified, all available documents for the criteria specified will be displayed.

Profile Type: available profile types include Claims Allied, Claims Chiropractor, Claims Claim, Claims Dental Mechanic/Dentist, Claims Dentistry, Claims Medical, Claims Midwives, Claims Optician, Claims Optometry, Claims Podiatry, EAP Collections, EAP Employer and Submitter.

Document Type: these include Bulletin, Help, Download File and Letter.

Resource Type: the choices for Resource Type are Document, Link or All Resource Types.

Search Text: this is a free-format field. One of the three 'Within' boxes below the field must be specified when using this field.

Combination(s) of these fields will enable the user to narrow the search results.

3.3.1 Download Files

Files available for download are all in ZIP formats	**DESCRIPTION**
SCHEDULE.ZIP	Includes all TXT. Files Miscellaneous as well as Organized by Discipline and Program.

HPCT.VALID.CITY.NAME.LST.ZIP	
HPCT.VALID.DIAG.CODE.LST.ZIP	
HPCT.VALID.FACLTY.NUM.LST.ZIP	
HPCT.VALID.FUNCTR.CODE.LST.ZIP	
HPCT.VALID.SKILL.CODE.LST.ZIP	
HPCT.SCFMPROC.MEDDS.BASC.D980715.ZIP	
HPCT.SCFMPROC.OPTODS.BASC.D980501.ZIP	
HPCT.SCFMPROC.OPTODS.OPTCDS.EHB.D980101.ZIP	
HPCT.SCFMPROC.PODDS.PALL.D980101.ZIP	
etc ...	
FILE NAMES INSIDE ZIP FILES	
Miscellaneous Files:	
cityname.txt City Names	
diagcode.txt Diagnostic Codes	
facltyno.txt Facility Numbers	
funccode.txt Functional Centres	
skilcode.txt Skill Codes	
efeemodr.txt Modifiers (Extract)	
eexpcode.txt Explanatory Codes (Extract)	
ffeemodr.txt Modifiers (Formatted)	
fexpcode.txt Explanatory Codes (Formatted)	
FILE TYPE	
City Names	List of valid city names within Alberta.
Diagnostic Codes	List of diagnostic codes in table format.
Facility Numbers	List of facility codes in table format.
Functional Centers	List of functional center in table format.
Skill Codes	Valid skill code listing.
Fee Modifiers (Formatted)	List of fee modifier in table format.
Explanatory Codes (Formatted)	List of explanatory code in table format.
Fee Modifiers (Extract)	List of modifier codes as they appear in the Schedule of Benefits.
Explanatory Codes (Extract)	List of explanatory codes as they appear in the Schedule of Benefits.

Files Organized by Discipline and Program:	
ETTDDDPP.txt	
where:	
E	
e = Extract	
f = Formatted	
TT	
gv = Governing Rules	
hs = Health Service Codes	
pb = Plan Benefit	
pc = Price List	
po = Procedure List	
di = Section D - Price List	
do = Section D - Procedure List	
DDD	
all = All Disciplines	
chi = Chiroprators	
den = Dental	
ddm = Dental & Dental Mechanic	
med = Medical	
opm = Optometry	
oom = Optometry & Optician	
phy = Physical Therapy	
pod = Podiatry	
PP	
al = All Programs	
bc = Basic	
eb = Extended Health Benefits	
hp = Hospital	
rb = Recipical Billing	
us = Uninsured Health Service Codes	
fpopodal.txt 44,394 07-13-98	Formatted Procedure List Podiatry All Programs
fpooomeb.txt 3,553 07-13-98	Formatted Procedure List Optometry/Optician Medical
fpoopmbc.txt 3,729 07-13-98	Formatted Procedure List Optometry Basic
fpomedbc.txt 697,790 07-13-98	Formatted Procedure List Medical Basic
fpoddmeb.txt 52,023 07-13-98	Formatted Procedure List Dentistry/Dental Mechanic EHB
fpodenbc.txt 43,457 07-13-98	Formatted Procedure List Dentistry Basic
fpochial.txt 2,571 07-13-98	Formatted Procedure List Chiropractic All Programs
fpcpodal.txt 211,769 07-13-98	Formatted Price List Podiatry All Programs
fpcoomeb.txt 4,967 07-13-98	Formatted Price List Optometry/Optician EHB
fpcopmbc.txt 4,420 07-13-98	Formatted Price List Optometry Basic
fpcmedbc.txt 3,932,760 07-13-98	Formatted Price List Medical Basic
fpcddmeb.txt 70,946 07-13-98	Formatted Price List Dentistry/Dental Mechanic EHB
fpcdenbc.txt 274,174 07-13-98	Formatted Price List Dentistry Basic
fpcchial.txt 2,837 07-13-98	Formatted Price List Chiropractic All Programs
fgvpodal.txt 35,697 07-13-98	Formatted Governing Rules Podiatry All Programs
fgvopmbc.txt 8,225 07-13-98	Formatted Governing Rules Optometry Basic

fgvmedbc.txt 112,964 07-13-98	Formatted Governing Rules Medical Basic
fgvdenbc.txt 17,903 07-13-98	Formatted Governing Rules Dentistry Basic
fgvchial.txt 7,490 07-13-98	Formatted Governing Rules Chiropractic All Programs
epcpodal.txt 140,004 07-13-98	Extract Price List Podiatry All Programs
epcoomeb.txt 1,800 07-13-98	Extract Price List Optometry/Optician EHB
epcopmbc.txt 1,836 07-13-98	Extract Price List Optometry Basic
epcmedbc.txt 2,672,073 07-13-98	Extract Price List Medical Basic
epcddmeb.txt 26,712 07-13-98	Extract Price List Dentistry/Dental Mechanic EHB
epcdenbc.txt 198,675 07-13-98	Extract Price List Dentistry Basic
epcchial.txt 432 07-13-98	Extract Price List Chiropractic All Programs
epbpodal.txt 4,512 07-13-98	Extract Plan Benefit All Programs
epboomeb.txt 256 07-13-98	Extract Plan Benefit Optometry/Optician EHB
epbopmbc.txt 384 07-13-98	Extract Plan Benefit Optometry Basic
epbmedbc.txt 90,272 07-13-98	Extract Plan Benefit Medical Basic
epbddmeb.txt 7,712 07-13-98	Extract Plan Benefit Dentistry/Dental Mechanic EHB
epbdenbc.txt 5,248 07-13-98	Extract Plan Benefit Dentistry Basic
epbchial.txt 192 07-13-98	Extract Plan Benefit Chiropractic All Programs
ehspodal.txt 26,091 07-13-98	Extract Health Service Codes Podiatry All Programs
ehsoomeb.txt 2,925 07-13-98	Extract Health Service Codes Optometry/Optician EHB
ehsopmbc.txt 1,404 07-13-98	Extract Health Service Codes Optometry Basic
ehsmedbc.txt 336,843 07-13-98	Extract Health Service Codes Medical Basic
ehsddmeb.txt 129,987 07-13-98	Extract Health Service Codes Dentistry/Dental Mechanic EHB
ehsdenbc.txt 24,219 07-13-98	Extract Health Service Codes Dentistry Basic
ehschial.txt 702 07-13-98	Extract Health Service Codes Chiropractic
fdopodal.doc 51,712 08-17-98	Formatted Section D - Procedure List Podiatry All Programs
fdipodal.doc 197,120 08-17-98	Formatted Section D - Price List Podiatry All Programs
fdodenal.doc 74,752..08-17-98	Formatted Section D - Procedure List Dental All Programs
fdidenal.doc 281,600 08-17-98	Formatted Section D - Price List Dental All Programs
readme.txt 1,350..08-17-98	List Containing Miscellaneous Files & Files Organized by Discipline and Program
FILE TYPES	
Procedure List	Health procedure list.
Price List (Formatted)	Price list as it appears in the Schedule of Benefits.
Section D - Anaesthetic Rates (Formatted)	Schedule of Medical Benefits for Anaesthetic Rates for Podiatry and Dental Service Codes
Governing Rules (Formatted)	Governing rules list.
Health Service Code (Extract)	Health service code listing.
Plan Benefit (Extract)	The AHW plan benefit document.
Price List (Extract)	Price list in table format.
DISCIPLINES	
All Discipline	List of all Discipline files.
Chiropractors	List of Chiropractors.
Dental	List of Dental.
Dental/Dental Mechanic	List of Dental/Dental Mechanic.
Medical	List of Medical.
Optometry	List of Optometry.
Optometry/Optician	List of Optometry/Optician.

Physical Therapy	List of Physical Therapy.
Podiatry	List of Podiatry.

3.3.2 Valid City Name Codes

This data file contains the table of valid city name codes that can be used for any Alberta addresses. This file will be refreshed on a periodic basis by Alberta Health and can be retrieved by a Submitter at any time.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
City Name	01-30	A(30)	
City Full Name	31-60	A(30)	

EXAMPLE:

City Name A (30)	City Full Name A (30)
Edgerton	Edgerton
Edmonton	Edmonton
Edson	Edson
Egremont	Egremont
Eleske Reserve	Eleske Reserve
Elk Point	Elk Point
Elkwater	Elkwater
Ellscott	Ellscott
Elmworth	Elmworth
Elnora	Elnora
Empress	Empress

3.3.3 Valid Diagnostic Codes

This data file contains the table of valid diagnostic codes that can be coded on a claim.

This file will be refreshed on a periodic basis by Alberta Health and can be retrieved by a Submitter at any time.

The Diagnostic Codes are timed, thus a specific Diagnostic Code is valid only during the Effective and End dates given based on the Service Date on the claim.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Diagnostic Code	01-06	A(06)	
Diagnostic Description	07-66	A(60)	
Effective Date	67-74	N(08)	YYYYMMDD
End Date	75-82	N(08)	YYYYMMDD

EXAMPLE:

Diag Code A (6)	**Description A (60)**	**Eff Date N (8)**	**End Date N (8)**
264	Vitamin A deficiency	20100401	20110331
264.0	With conjunctival xerosis	20100401	20110331
264.1	With bitots spot and conjunctival xerosis	20100401	20110331
V26	Procreative Management	20100401	20110331
V26.0	Tuboplasty or vasoplasty after previous sterilization	20100401	20110331

NOTE: These are examples only.

3.3.4 Valid Facility Numbers

This data file contains the table of valid Facility Numbers that can be coded on a claim.

This file will be refreshed on a periodic basis by Alberta Health and can be retrieved by a Submitter at any time.

The Facilities are versioned, thus a specific Facility can have one or more versions in the table. Each version is applicable only during the Effective and End dates given based on the Service Date on the claim.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Facility Number	01-06	N(06)	
Facility Name	07-36	A(30)	
Facility Type	37-40	A(04)	
Functional Centre Required on Claim Indicator	41-41	A(01)	
Effective Date	42-49	N(08)	YYYYMMDD
End Date	50-57	N(08)	YYYYMMDD

A Facility can be a Hospital, Doctor's Office, Clinic, Lab, etc.

EXAMPLE:

VALID FACILITY NUMBERS

Fac Number N (6)	Facility Name A (30)	Fac Type A (4)	Funct Center Reg'd on Claim A (1)	Eff Dat N (8)	End Date N (8)
123456	Dr. R. Jones Office	OFFC	N	19900401	
100001	Dr. L. Smith Office	OFFC	N	19900401	19930814
102483	Baker Clinic - -Edmonton West	OFFC	N	19900401	
43	Royal Alexander Hospital - Edm.	ACT	Y	19900401	
231062	Hanson Lab - Edm. Northgate	DIAG	N	19900401	
143612	ABC Lab - Edm. Lessard	DIAG	N	19900401	19940422

3.3.5 Valid Functional Centre Codes

This data file contains the table of valid Functional Centers.

This file will be refreshed on a periodic basis by Alberta Health and can be retrieved by a Submitter at any time.

The Functional Centers are timed, thus a specific Functional Centre is valid only during the Effective and End dates given, based on the Service Date on the claim.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Functional Centre Code	01-04	A(04)	
Functional Centre Name	05-34	A(30)	
Effective Date	35-42	N(08)	YYYYMMDD
End Date	43-50	N(08)	YYYYMMDD

NOTE: A Functional Centre Code may be a valid when validated against the table of codes however it could be invalid for the specified facility. Alberta Health does not provide cross-reference table to validate each Functional Code to a particular Facility.

EXAMPLE: Valid Functional Centre Codes

Effective and End dates are examples only.

CODE (4)	DESCRIPTION (30)	FUNCT CNTR TYPE (04)	EFFECTIVE DATE (08)	End Date (08)
CLAB	Clinical Laboratory	DGTS	19920401	19950401
CLNC	Clinic	AMBU	19920401	19950401
D/N	Day/Night Care	AMBU	19920401	19950401
DIMG	Diagnostic Imaging	DGTS	19910701	19950601
ELEC	Electrodiagnosis	DGTS		
EMRG	Emergency	AMBU		
EXRM	Examination Room	POFF		
ICN1	ICU Neonatal - Level 1	IPSR		
ICN2	ICU Neonatal - Level 2	IPSR		
ICN3	ICU Neonatal - Level 3	IPSR		
IC01	ICU Obstetrics - Level 1	IPSR		
IC02	ICU Obstetrics - Level 2	IPSR		
IC03	ICU Obstetrics - Level 3	IPSR		
ICU1	Intensive Care Unit - Level 1	IPSR		
ICU2	Intensive Care Unit - Level 2	IPSR		
ICU3	Intensive Care Unit - Level 3	IPSR		
LBER	Clinical Lab/Examination Room	POFF		
LSSE	Clin Lab/Surg Suite/Exam Room	POFF		
LTC	Long Term Care	IPSR		
MED	Medical	IPSR		
OLAB	Other Diagnostic Laboratory	DGTS		
PHYS	Physical Therapy	IPSR		
RDON	Radiation Oncology	DGTS		
SGSU	Surgical Suite/Examination Room	POFF		

CODE (4)	DESCRIPTION (30)	FUNCT CNTR TYPE (04)	EFFECTIVE DATE (08)	End Date (08)
SURG	Surgical	IPSR		

3.3.6 Valid Health Service Codes

This data file contains the table of valid Health Service Codes (HSC) that can be coded on a claim. This file will be refreshed on a periodic basis by Alberta Health and can be retrieved by a Submitter at any time.

The Health Service Codes are versioned, thus a specific Health Service Code can have one or more versions in the table. Each version is applicable only during the Effective and End dates given based on the Service Date on the claim.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Health Service Code	01-07	A(07)	Health Service Code(HSC)
Health Service Short Description	08-83	A(76)	Short Description
Diagnostic Code required Indicator	84-84	A(01)	"Y" indicates that a Diagnostic Code must be coded on the claim when the HSC is used.
Gender Restriction Code	85-85	A(01)	If a gender is indicated, the HSC can only be performed on a Service Recipient of that gender.
Age Restriction From	86-91	N(06)	If a restriction is indicated, the HSC can only be performed on a Service Recipient who is older than the "From Age". Partial years are calculated by dividing 365 into 1 plus the difference between date of service date and last birthdate. The decimal point is implicit.
Age Restriction To	92-97	N(06)	If a restriction is indicated, the HSC can only be performed on a Service Recipient who is younger than the "To Age".
Tooth Code Required Indicator	98-98	A(01)	"Y" indicates that the applicable Tooth Code must be provided.
Tooth Surface required Indicator	99-99	A(01)	"Y" indicates that the applicable Tooth Surface(s) must be provided.
Effective date	100-107	N(08)	YYYYMMDD
End Date	108-115	N(08)	YYYYMMDD

EXAMPLE: **VALID HEALTH SERVICE CODES**

Health Service Code A(7)	Short Description A(76)	Diag Code Req'd A(1)	Gender Restr. A(1)	Age Restr. From N(6)	Age Restr. To N(6)	Tooth Code Req'd A(1)	Tooth Surf. Req'dN(8) A(1)	Eff Date N(8)	End Date
01.01	Removal of	Y	M	-	-	N	N	19900401	19920331
02.18	Injection of	Y	F	000000	012000	N	N	19900401	19920331
13672	Extraction of Molar	N		-	-	Y	N	19900401	19920331

3.3.7 Valid Explicit Fee Modifier Codes

This data file contains the Fee Modifier Code Table entries that can be coded on a claim in any one of the Explicit Fee Modifier fields.

This file will be refreshed on a periodic basis by Alberta Health and can be retrieved by a Submitter at any time.

The Fee Modifiers are timed, thus a specific Fee Modifier is valid only during the Effective and End dates given based on the Service Date on the claim.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Fee Modifier Code	01-06	A(06)	
Fee Modifier Description	07-82	A(76)	
Fee Modifier Type	83-86	A(04)	Indicates the Type of Fee Modifier (e.g. Role, Skill, Tray, etc.)
Effective Date	87-94	N(08)	YYYYMMDD
End Date	95-102	N(08)	YYYYMMDD

EXAMPLE:

VALID EXPLICIT FEE MODIFIER CODES

Fee Mod Code	Fee Mod Description	Fee Mod Type	Effective Date	End Date
EV	Evening (5pm - 11 pm)	SURC	20100401	
LVP75	Indicate lesser value procedure	LVP	20100401	
COMPLT	Done through previous incision	REDO	20100401	
UNDP	Procedure was undisplaced	UNDP	20100401	
TSAR	Two surgeons diff specialties	TSAR	20100401	
BNEV	Indicates time of day	SUBD	20100401	
STEREO	Indicates stereo exam done	XRAY	20100401	

3.3.8 Explanatory Codes

This data file provides the full description of the Explanation Codes given on Statements of Assessment and Assessment Result Details. It will be refreshed on a periodic basis by Alberta Health and can be retrieved by a Submitter at any time.

Each Explanatory Code can have multiple text lines. The first text line (Sequence Number 0001) for each Explanatory Code contains the short description.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Explanatory Code	01-05	A(05)	
Text Line Sequence Number	06-09	N(04)	This field is zero filled.
Text Line	10-85	A(76)	

EXAMPLE: <u>EXPLANATORY CODES</u>

Expl. Code A(5)	Text Line Seq# N(4)	Text Line A(76)
30	1	Address Format Invalid
30AA	1	City Code Invalid for AB
35M	1	Your Claim has been refused as .....
35M	2	(a) invalid
39A	1	Your claim has been refused .....

3.3.9 Plan Benefit Codes

This data file provides the information required for Referral and Supporting documentation requirements.

This file will be available for retrieval by a submitter at any time.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Health Service Code	01-07	A(07)	
Referral	08-08	A(01)	
Support Documentation	09-09	A(01)	
Program End Type	10-13	A(04)	
Effective Date	14-21	N(08)	YYYYMMDD
End Date	22-29	N(08)	YYYYMMDD
Ases with Supporting Doc	30-30	A(1)	

PLAN BENEFIT TABLE

This table will provide the information required to edit Referral and Supporting Documentation requirements.

HSC	Referral	*Support Doc.	Program	Eff.	End	Ases with Supp.
A(7)	Required A(1)	Required A(1)	Type A(4)	Date A(8)	Date A(8)	Doc A(1)
23.61	C	Y	EHB	19900401	19920331	N
41.18	S	Y	HOSP	19900401		N
67.60		N	BASC	19900401		N
11246	M	N	RCIP	19900401		Y
13612	D	N	EHB	19900401		Y

NOTE: When set to "Y", the claim must include a Supporting Text Segment -or- set the "Paper Support Documentation Indicator" to "Y".

Example:

Plan Benefit Referral Table As of May 1st, 2012		
Plan Benefit Referral Identifier Code	**Effective**	**Description**
A	2001/04/01	Referral Req'd by Med, Pod, Midwife, can't be self
B	2005/10/01	Req'd Med,Pod,Dent,NurPrac,Chiro,Midwife,Opto can't be Self-
C	1800/01/01	Referral Req'd by Med, Dental, Podiatry, chiro
D	2012/05/01	RefReqd MEDDS,CHIRDS,DENTDS,PODDS,NRPR,PHTH,SelfRef
E	1800/01/01	Referral required by Med or Dental
F	1998/07/01	Ref Req'd by Med, Dent, Pod, Midwife, can be self
G	1998/07/01	Req'd Med,Midwife,NurPrac,Chiro-can't be Self-Ref
H	2000/06/01	Req'd Med,Midwife,NurPrac,Chiro-can't be Self-Ref
I	2005/02/28	Req'd Med,NurPrac,Chiro-can't be Self-Ref
J	2011/10/01	Req'd by COCTH PSCH SCWK PSNR SLPT can't be self
K	2003/04/01	Req'd Med,Pod,Dent,NurPrac,Midwife,Chiro-can't be Self-Ref
L	2005/10/01	Referral Req'd by Med, Optomery, can't be self
M	1800/01/01	Referral Req'd by Medical, can't be self
N	1800/01/01	No Referral Required
O	1992/07/01	Referral Prac must have OTOL, NEUR, or NUSG skill
P	1800/01/01	Ref Req'd Med,Dent,NursePrac,Pod, HSC is Med can be self-ref
Q	2004/04/01	Ref Req'd Medical,Nurse Practitioner, Midwife - self ref OK
R	2009/04/01	Reqd Med,Pod,Dent,NurPrac,Chiro,Midwife,Opto,Phys can't self
S	1800/01/01	Referral Required - Self Referral is allowed
T	1800/01/01	Referral Req'd by Podiatry - HSC must be Podiatry
U	1995/07/01	Referral Req'd by Med, Podiatry, can't be self
V	2010/07/01	Req'd Med,Pod,Dent,NurPrac,Midwife,Chiro,Phys-can't be self
W	1800/01/01	Ref Req'd Medds,Dentds,NursePrac,Podds,Chirds -Self ref OK
X	1800/01/01	Ref Req'd Med,Chiro,NursePrac,Pod-HSC is Med,can be self-ref
Y	2012/05/01	RefReqd MEDDS,CHIRDS,PODDS HSC-EDDSonly,NRPR,PHTH,SelfRef
Z	2011/03/31	Referral Required, Nurse Practitioner, can be self-ref

Program Type Codes:

EHB - Extended Health Benefits
BASC - Basic
HOSP - Hospital
RCIP - Reciprocal Billing
UNIN - Uninsured HSC

3.3.10 Valid Skill Codes

The Valid Skill Codes are versioned, thus a specific Skill Code can have one or more versions in the table. Each version is applicable only during the Effective and End dates given based on the Service Date on the claim.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Skill Code	01-04	A(04)	
Description	05-64	A(60)	
Effective Date	65-72	N(08)	YYYYMMDD
End Date	73-80	N(08)	YYYYMMDD

Valid Skill Codes Table (example)

Code A(4)	Description A(60)	Eff Date N(8)	End Date N(8)
ANES	Anesthesiology	20110401	
ANPA	Anatomical Pathology	20110401	
CAC	Computer Assessed Certification	20110401	
CARD	Cardiology	20110401	
CLIM	Clinical Immunology	20110401	
CMCE	Community Medicine-Certification	20110401	
CMSP	Community Medicine-Specialty	20110401	
VSSG	Vascular Surgery	20110401	

3.3.11 Valid Health Service Procedures

The following is the report format of all HSC definitions etc. as listed in the Schedule of Benefits.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Procedure List Detail Line	1-115	A(115)	

3.3.12 Valid Health Service Prices (Formatted)

The following is the report format of all Base and Modified Prices for each HSC as listed in the Schedule of Benefits.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Price List Detail Line	1-106	A(106)	

3.3.13 Valid Health Service Prices (Extracted)

The following is the extracted version of the Health Service Price List.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Price List Detail Line	1-79	A(79)	

3.3.14 Valid Health Service Governing Rules

The following is the report format of all Rules that govern payment policy as listed in the Schedule of Benefits.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Governing Rule Report Line	1-89	A(89)	

3.3.15 Valid Explanatory Code Listing

The following is the report format of all explanatory codes as listed in the Schedule of Benefits.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Explanatory Code List	01-99	A(99)	

3.3.16 Modifier Code Listing

The following is the report format of all modifier codes as listed in the Schedule of Benefits.

DATA FIELD	FIELD POSITION	FIELD SIZE	NOTES
Modifier Code List	01-99	A(99)	

CHAPTER 4 H-LINK COMMUNICATION PROCESS

4.1 Introduction

"H-Link" is the electronic communication system that gives an application running on a remote PC access to information stored on Alberta Health's Mainframe databases and datasets. Electronic Claim Submission is one of the services offered by this system.

H-Link uses the same web browser technology as the Internet. It is important to not confuse H-Link with the Internet even though it looks and feels like the Internet. H-Link is a private network and is not connected to the Internet. What this means to an H-Link user is that communication within the H-Link network is secure and web pages normally found out on the Internet are not present on the H-Link web server. This type of private network is often referred to as an "Intranet".

4.2 H-Link Components

Components making up H-Link:

- **Web Browser** - A tool used in navigating the H-Link application and serve as the user interface to on-line services offered by Alberta Health.

- **Internet Connection** - Routes network packets to the appropriate destinations. It connects remote PC to the H-Link network by DSL or Cable.

- **Security Service** - An application that runs on the H-Link workstation. It is used to authenticate users connecting to H-Link through their Internet Service Provider (ISP). The security system is based on a keychain size security FOB. H-Link users connecting via the internet will be prompted for a user name and a pass code. The pass **code** is a numerical password made up of a fixed four-digit pin number assigned by Alberta Health and a dynamically changing six-digit number generated by a security FOB.

- **H-Link Web Server** - Interfaces with H-Link users' web browsers and handles all web requests made by the browser. Alberta Health's on-line electronic services are provided in this way through web pages.

- **H-Link FTP Site** - A site containing H-Link user personal mainframe datasets (claim files, batch balance reports, assessment reports and letters). It is the location where all file transfers, uploads and downloads are performed.

- **Mainframe CLASS System** - Where H-Link users' datasets and CLASS database tables are stored and processed.

4.3 Submission Process

The following is a brief description of the submission process.

1. Submitters can come into H-Link by asynchronous modem. The H-Link user connects to the internet via a web browser. The user navigates to the security server for authentication. After successfully passing authentication, the H-Link user is presented with the H-Link logon page.

2. Once the H-Link user is connected to the H-Link logon page, a userid and password are required. When they have been entered and validated, the H-Link user can use any of the on-line services that he/she is authorized to use.

3. Claim files uploaded onto CLASS are automatically validated by a batch balance program running on the Mainframe and a batch balance report is produced. Transactions that pass the batch balance process are submitted to CLASS daily assessment runs. Any problems detected after this point will result in only the affected transactions being either refused or held for manual review/assessment. Two reports are generated by the assessment run: Assessment Results Detail (ARD) and Statement of Assessment Report (Report).

4. To log off H-Link, simply click the logoff link.

For a more detail description of the submission process, refer to "H-Link Intranet Installation Guide and User Guide" manual.

CHAPTER 5 TROUBLESHOOTING

Occasionally questions with respect to your claim submissions and the retrieval of data will arise. The nature of the questions, whether it is business related or technical will determine what area they should be directed to.

5.1 Business Issues

Alberta Health – Information Technology Operations, Application Maintenance and Data Services 780-644-7643

Typical Questions:

- ☐ I'm missing data from electronic files (e.g. Statement of Assessments)
- ☐ I don't understand the record layout on the files.
- ☐ What are the weekly processing cycles in relationship to claims receipts, claims assessment, payment processing, Statements of Assessment, Statements of Account and actual payment?
- ☐ Why does my Report File reflect multiple Statements of Assessment with only a few lines on them?
- ☐ How often should I retrieve the Report File (Statement of Assessment)?
- ☐ Why was a claim reduced/refused as indicated on the Assessment Results Detail File?
- ☐ What are the turnaround timeframes for batch balance claims assessment or payment?
- ☐ Interpretation/explanation of Batch/Transaction processing errors.
- ☐ Practitioner problem with a Submitter.
- ☐ Transaction Actions and their relationship to previous submitted and processed claims.
- ☐ Transaction Actions and their relationship to segments and batch trailer record.
- ☐ Accredit new submitters.
- ☐ What limitations are there for transactions within a batch? (e.g. number of transactions, segments, transaction prefix identifiers, number of practitioners, business arrangements, etc.).

- ☐ Maintenance of the Electronic Claims Submission Specifications Manual.
- ☐ Interpretation/clarification of design, file/field/character use, definitions, technical specifications.
- ☐ How to change submitters.
- ☐ Where to get information about the claims submission requirements (e.g. record layouts and field definitions).

5.2 Technical Issues

Single Point of Contact Help Desk – 1-877-931-1638

NOTE: All submitters should report their retrieval problems **IMMEDIATELY.**

☐ Problems installing Internet Explorer.

☐☐ Submitter fails to authenticate on the H-Link security server.

☐ Unable to retrieve the H-Link web server home page "https://iam2.health.alberta.ca/idm/user".

☐ Submitter's mainframe datasets missing or not listed in H-Link.

☐ Submitter can't download or retrieve files.

☐ Claim files submitted but no batch balance report produced.

☎ Missing assessment files.

APPENDIX A BATCH EDIT CHECKING

These edits will be performed prior to any edits on transaction level. The following two edits indicate the whole batch or a portion of the batch has been accepted.

ERROR	EDIT/<VALID VALUES>	ERROR CODE
Accepted	No errors found	ACPT
Partially Accepted	No batch errors found, but transaction edit errors encountered	PART

If any of the following edits fail, then the complete batch will be rejected.

ERROR	EDIT/<VALID VALUES>	ERROR CODE
Submitter not valid	Submitter prefix used on input file has to be on STKH_SUBMTR table. NOTE: The Error Code "SNVL" will only show in the field "Submission Reject Reason Code" on the Submission Log table. The Batch Balance report will show "SBRJ".	SNVL
Empty File	No data in input file.	EMFI
Unidentified Record Type	<2, 3, 4>	URTP
Header Not Found	Header record was expected, but a Data Segment has been received.	HNFD
Batch Trailer Out of Order	Header record was expected, but a Batch Trailer has been received.	BTOO
Trailer Not Found	Trailer record was expected, but a Header Record has been received.	TNFD
Batch Header Out of Order	First Data Segment was expected, but a Batch Header has been received.	BHOO
No Transactions	First Data Segment was expected, but a Batch Trailer has been received.	NOTX
Invalid Batch Number	Batch Number on Header must be in Format "AAANNNNNN".	IBNO
Accredited Submitter Prefix Not Valid	Submitter Prefix on Batch Header must be the same as Submitter Prefix used on input file.	IPFX
Duplicate Batch	Same Batch has already been accepted previously.	DUPB

ERROR	EDIT/<VALID VALUES>	ERROR CODE
Base Claim Segment missing	Batch has an "ADD" or "CHANGE" transaction without a "C1B1" segment.	BCSM
Batch Number not consistent	Batch Number on Trailer does not match Batch Number on Header.	BNNC
Invalid Batch Trailer	Total Number of Segments in Batch Trailer must be in format "NNNNNNNN".	ISTF
Invalid Batch Trailer	Total Number of Transactions on Batch Trailer must be in format "NNNNN".	ITTF
Invalid Batch Trailer	Total Number of Segments indicated on Batch Trailer does not match actual Number of Segments received in batch.	ITSC
Invalid Batch Trailer	Total Number of Transactions indicated on Batch Trailer does not match actual Number of transactions received in batch.	ITTC
Submission	Submission Rejected (refer to -->Submission Edits)	SBRJ
Refused Transactions in Batch	If Status Code is set to "PART", then the Reason Code will be set to "TX".	TX

FIELD EDIT CHECKING

*AC - Printable ASCII check. NC-Numeric check. DC - Date check. RSWZ - Replace spaces with leading zeros. S - Can be spaces.

FIELD NAME	EDIT/<VALID VALUES>	ERROR CODE
TRANSACTION HEADER		
Record Type	No Edit required	N/A
Claim Number - Submitter	Must be equal to Submitter Prefix on Batch Header, if Action is = "ADD": otherwise; AC	35FA
Claim Number - Current Year	NC	34AA
Claim Number - source Code	Letter or Number, cannot have blanks	34EB
Claim Number - Sequence Number	NC	34AB
Claim Number - Check Digit	NC, Mod 10 Checksum	34AC
Transaction Type	<C1P1>	34DA
Segment Type	<C1B1, CPD1, CST1, CTX1>, Blank allowed if Action = "Delete"	34DB
Segment Sequence	NC	34DC
Action Code	<A, C, R, D> space not allowed	35
Filler	No edit performed	N/A

FIELD NAME	EDIT CHECK/<VALID VALUES>	ERROR CODE
CIB1 SEGMENT		
Claim Type	<RGLR>	35D
Service Provider ULI	Valid ULI format, Mod 10 checksum (if not blank or 0)	37A
Skill Code	AC	37B
Service Recipient ULI	<Blank, 0>; valid ULI format; Mod 10 checksum (if not blank or 0)	05BB
Service Recipient Registration#	<Blank>, Provincial checksum (if not blank)	05BA
Health Service code	AC; cannot be blank	39B
Service Start Date	DC	39
Encounter Number	NC, RSWZ	45B
Diagnostic Code (1-3)	AC	39E
Number of Calls	NC, RSWZ	39C
Explicit Fee Modifier Codes (1-3)	AC	39G
Facility Number	S, NC, RSWZ	39DA
Functional Center Code	AC	39DB
Location Code	AC	39D
Originating Facility Number	S, NC, RSWZ	39DC
Originating Location Code	AC	39DD
Business Arrangement Number	<Blank, 0>, RSWZ, Mod 10 checksum (if not space or 0)	37
Pay to Code	AC	35K
Pay to ULI	<Blank, 0>; valid ULI format; Mod 10 checksum (if not blank or 0)	35L
Locum Arrangement BA Number	<Blank,0>,RSWZ, Mod 10 checksum (if not space or 0)	36
Referral ULI	<Blank, 0, Alpha 8>; valid ULI format Mod 10 checksum (if not blank or 0)	45

FIELD NAME	EDIT CHECK/<VALID VALUES>	ERROR CODE
OOP Referral Indicator	<Y,N,blank>	45A
Recovery Code	<blank>, Valid Recovery Code on SERECOVY_V table	35B
Chart Number	AC	34F
Claimed Amount	NC, RSWZ	39FA
Claimed Amount Indicator	<Y,N,blank>	39F
Intercept Reason Code	AC	35A
Confidentiality Indicator	<Y,N,blank>	35E
Good Faith Indicator	<Y,N,blank>	35G
Newborn Code	AC	35M
EMSAF Indicator	<Y,N,blank>	34B
Supporting Document Indicator	<Y,N,blank>	35H
Hospital Admission Date	S, RSWZ, DC	42
Tooth Code	AC	70EB
Tooth Surface Codes (1-5)	AC	70EB
Filler	No edit performed	N/A

FIELD NAME	EDIT CHECK/<VALID VALUES>	ERROR CODE
CPD1 SEGMENT		
Person Type	<RECP< PYST, RFRC>	30F
Surname	AC	30E
Middle Name	AC	30EB
First Name	AC	30EA
Birth Date	S, DC, RSWZ, Century must be <18, 19, 20>	30B
Gender Code	<M,F,blank>	30BA
Address Lines (1-3)	AC	30
City Name	AC	30AA
Postal Code	AC	30AC
Province/State Code	AC	30A
Country Code	AC	30AB
Guardian/Parent ULI	<Blank,0>; valid ULI format; Mod 10 checksum (if not blank or 0)	30G
Guardian/Parent Registration Number	AC	30H
Filler	No edit performed	N/A

FIELD NAME	EDIT CHECK/<VALID VALUES>	ERROR CODE
CST1 SEGMENT		
Text Lines (1-3)	AC	34EA
CTX1 Segment		
Claim Number	<Not Blank>, valid claim number format (if not blank)	34EC

Additional Edits	
Maximum Number of "CST1" segments for a transaction is 500	34DE
If Action = "Reassess", then at least 1 "CST1" segment is required	34DD
If a "CTX1" segment passed, then at least 1 "CST1" segment is required	34ED
If Action = "Delete", then only a "CIB1" segment is allowed	34DF
If Action = "Reassess", then "CPD1" segment is not allowed	34DG
Segment numbers for a transaction must be incremental, starting with 1	34DC
Order of Segment Types: "CIB1", "CPD1", "CST1", "CTX1"	34DB
Transaction cannot have more than 1 person data segment of each person type (e.g. duplicate person types)	34DH
Same claim submitted in multiple transactions within same batch	34AD