

PAS AND AFTER HOURS SURVEY DATA FILE SPECIFICATIONS

**DATA FILE DUE TO SURVEY VENDOR BETWEEN NOVEMBER 2 TO NOVEMBER 20, 2009.
DATA FILE SPECIFICATIONS REMAIN IDENTICAL TO LAST YEAR**

BACKGROUND

Each participating medical group is to submit three unique fixed-length ASCII text files to the survey vendor using the file specifications detailed below. (The technical specifications begin on page 8). This format assumes one data record per line of text. The three files are:

Table A) Patient Visit File: Contains records of every eligible encounter for eligible patients between January 1, 2009 to October 31, 2009.

Table B) Patient File: Contains a unique record for each patient who had at least one eligible encounter. All patients in this file should be matched to one or more records in the visit file based on their patient ID.

Table C) Active Provider File: Contains a unique record for each provider. This table should include records for all active providers of the specialty types defined in Appendix 1, even if there is no match between the provider and an eligible patient visit.

The Center for the Study of Services (CSS), the data vendor for the project, will match the three files to develop the sample frame to be used for the 2010 Patient Assessment Survey (PAS). The three files are linked together using the Patient IDs and the Physician IDs. The information contained in these files will be used to draw the sample for the Group Survey and the Doctor Survey (for participating groups).

For the Group Survey, CSS will draw a total sample of 900 patients. CSS will first randomly select 450 patients who had visits with their assigned PCP. The group will note each patient's assigned PCP in the data submission. If the Assigned PCP field is blank, CSS will assign a PCP based on the primary care provider most frequently visited by the patient. CSS will then draw an additional sample of 450 patients who had visits with a specialist — regardless of whether the patient had an assigned PCP.

After Hours Survey

For groups who choose to participate in the After Hours Survey, the after hours contact information is collected in the Active Provider File (Table C). Please fill in these if you choose to participate. (The After Hours Survey is a separate survey project but given the overlap in group participation we are including these fields in the PAS submission to consolidate data collection.)

File Naming Convention

The naming convention for the three files should be Table_[A/B/C]_[5-digit DMHC Code]. For example a medical group with DMHC Code 10001 would submit the following set of files:

Table_A_10001.txt, Table_B_10001.txt and Table_C_10001.txt for Patient Visits, Patients and Active Providers respectively.

Technical note: the file name extension (e.g., .txt, .dat, etc.) will be ignored and may be any extension or may be excluded altogether. However, the format of the files must be fixed length ASCII text. No other format will be accepted.

Due Dates and Re-Submissions

PAS is going to strictly enforce deadlines for receipt of data file submissions this year.

- First submissions must occur between **November 2 and November 20, 2009**.
- Groups will receive data quality reports via email within two business days of the submission.
- Final corrections must occur no later than **December 4**, so early submissions are encouraged.
- Groups that cannot make file corrections resulting in an approved file will **not be permitted to participate** in the 2010 project, and will **forfeit their eligibility for Pay for Performance bonuses** tied to the PAS project.

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Contacts

Jeff Burkeen of CSS for questions around the data specifications and file submissions (jburkeen@cssresearch.org or 202-454-3005).

Julie France of PBGH for PAS group and doctor survey information on project participation, survey options and fees (jfrance@pbgh.org 714.735.8754).

Cathie Markow of PBGH for information on Provider After Hours Access Survey participation (cmarkow@pbgh or 415 615-6359).

Generating an Accurate Data Submission

There will be no source code audit for 2010. However, in order to ensure that comparable samples are being drawn from each medical group, CSS will apply a Quality Assurance (QA) process after receipt of your data submission between November 2 and November 20, 2009. The QA system will use a series of data quality checks to determine if your submission is meeting the core parameters of the project. **Groups will be excluded from participation if their final data submission does not meet the criteria listed below labeled “required”. Such exclusion will preclude eligibility for the PAS portion of financial bonuses awarded through the Pay for Performance program.**

- **Required Flag.** Groups must pass all data quality checks labeled as “required”. Failure to pass required checks will result in exclusion from participating in the 2010 PAS Project.
- **Investigate Further Flag.** This is a warning flag that something may be wrong with the data. Groups will be asked to explore any issues that resulted in the flag and submit corrected data if an error in the data collection process is discovered.

Data Quality Criteria	Statistic
Patient Visits (Table A)	
All required visit <u>categories</u> . Illness, preventive care, outpatient, ophthalmology and obstetric visits should all be represented in the visit file.	Required. There should be visits in each of the following visit categories, per the defined CPT codes (or internal codes converted to the defined CPT codes): <ul style="list-style-type: none">▪ Illness▪ Preventive care▪ Outpatient▪ Ophthalmology▪ Obstetric
All eligible visits. Include <u>every</u> visit for each eligible patient. There should be a record for every patient visit—so that some patients will have <u>multiple</u> visit records in the Patient Visit File (and not just the most recent visit per patient).	Required. For each group, the ratio of visits to patients (the number of visit records divided by the number of patients) should be greater than 2.0 but fewer than 10.0 (A ratio larger than 10 may indicate too few patients submitted) Investigate Further. If there is unequal distribution of visits across periods: Visits will be divided into 3 periods: January-March, April-June, July-October. No single period should have more than 45% of submitted visits.
Visits with required specialty types.	Required. Per Appendix 1, there must be valid visits linked to providers representing <u>all</u> required specialty types listed in Appendix 1.
POS insured visits	Required. If the group indicated they had POS insured patients during the registration process, there must also be visits coded with commercial POS insurance in the patient visit file (Table A, Field 11).

Patients (Table B)	
All commercial HMO and POS patients 18 years and older with eligible visits must be included in the data submission.	Required. The number of valid patient-doctor relationships represented in the data should be 20% or more of the overall adult commercial enrollment.
	Investigate Further. If more than 35% of submitted patients are not assigned to a PCP included in the Active Provider file.
Active Providers (Table C)	
All providers of the required specialty types must be included. Include only active providers.	Required. Per Appendix 1, all of the required specialty types listed must be represented in the Active Provider file (Table C, Field 11) and be linked to valid patient visits.
	Required. At least 65% of providers who are listed on the group's roster (Table C, Field 15) should be linked to valid patient visits.
	Required. Family Practice and Internal Medicine physicians should make up at least 90% of the set of physicians flagged as PCPs (Table C, Field 10).
	Investigate Further. If anyone <i>non-PCP</i> specialty type makes up more than 20% of valid providers (with visits).
Additional data quality checks	
Missing data	To Be Invalidated. Any records with missing data that is needed to evaluate the file criteria (e.g., patient age, date of visit, insurance coverage, physician specialty, etc.) will be invalidated. Out-of-range values in these required fields (e.g., a gender entry that is not 'M' or 'F', a month of birth that is not 1-12, etc.) will also invalidate the affected records.
	Investigate Further: If more than 30% of addresses or more than 60% of phone numbers are missing or unusable.
Duplicate Patient IDs in the patient file or duplicate Provider IDs in the provider file.	To Be Invalidated. Records with duplicate IDs in the patient file (Table B, Field 7) or the provider file (Table C, Field 9) will be invalidated. However patient and provider IDs are expected to appear multiple times in the visit file (Table A) to reflect multiple patient visits with the same provider.
Use of PCP Flag	To Be Invalidated. Providers whose specialty is Family/General Practice, Internal Medicine, Nurse Practitioner or Physician Assistant and serve as PCPs with assigned panels of patients are required to be flagged as PCPs (Table C, Field 10). These provider types will be invalidated if this flag is missing or if they are coded as non-PCPs.

Legitimate Exemptions

The Online Survey of Data Procedures, to be completed prior to data submission, allows groups to indicate whether they cannot provide specific categories of patient visits or provide visit data for all required specialties. Project managers will follow up with groups and grant exemptions on a case-by-case basis. (In some cases, the data can be obtained by conversion or other means.)

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If a group believes they cannot meet any of the other requirements listed in the table above, the group should contact Jeff Burkeen at jburkeen@cssresearch.org or 202-454-3005 preferably prior to the start of the data submission period which commences November 2. The group should provide an explanation as to why it cannot meet the criteria and note if this was an issue in the previous PAS survey.

Essential Final Checks Prior to Data Submission

1. Before exporting the files into the final text format, make sure that the patient and provider IDs, respectively, have a consistent format across all three tables so that CSS will be able to link the tables together based on these IDs. Specifically, run the following checks:
 - Link (join) Table A (Patient Visits) with Table B (Patients) on the Patient ID and count the number of visit records in which there is a match with a patient ID (should be close to 100%).
 - Link (join) Table A (Patient Visits) with Table C (Active Providers) on the Provider ID and count the visit records in which there is a match with a provider ID (should be close to 100%).
 - Link (join) Table B (Patients) with Table C (Active Providers) to make sure the PCP ID in Table B matches a Provider ID in Table C. The percentage of matches should meet your expectations based on your PCP assignment policies – if nearly all of your adult patients are assigned a PCP then the match should be close to 100%.
 - If IDs do not match in suggested percentages, then check for missing patient and provider records and/or check that the IDs are formatted consistently and that the ID field lengths are correct.
2. A format checking tool will be available beginning October 1, 2009 on both the CSS and CCHRI web sites. It is highly recommended that you download and install the tool and check your files prior to submitting them for the full quality assurance (QA) process. The QA system is automated and will not process files that do not meet the format/length/naming specifications.

The format checking tool will also be available www.cchri.org/programs/programs_pas.html. The tool will also be available from the main menu at www.cssresearch.org/pas (after you log in with your DMHC Code and passcode).

Instructions for Submitting Data Files

Web site option

This will be the preferred means of submitting data for the 2010 PAS. The Web page for uploading data will create a secure connection between the CSS Web site and your Web browser using Secure Socket Layer (SSL) encryption (the same encryption used by commercial web sites for placing orders, viewing accounts, paying bills, etc.). After the files are selected and uploaded, they will be automatically transferred to the CSS internal network, behind the CSS network firewall. No part of the data files will reside on the Web site.

Once the data is in the CSS network, then the QA system will automatically check the data and generate a data quality report, which will inform each group if its data has been accepted for the PAS or if the data failed to meet specific data quality criteria and thus needs to be corrected. No part of the enrollment data will be included in the reports sent back to the group, only summary information to help identify and correct any issues that may be discovered. The reports will be sent via email with 2 business days of data submission. A data submission link will become available on the main menu of the CSS web page beginning Nov. 2, 2009 (requires a log in with your DMHC Code and passcode).

Web Link: www.cssresearch.org/pas

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E-mail or Surface Mail Options

Groups will still have the option of submitting data via email or by CD if they prefer, however the generation of QA reports may be delayed by an additional day from the day of receipt. Once CSS staff receive the data files they will load them into the QA system via the secure Web site and the QA system will then generate the QA report.

- *E-mail via encrypted e-mail:* CSS will work with groups to accept encrypted e-mail attachments through services such as Zixmail. Please contact CSS to work out the details of using this approach.
- *E-mail via standard e-mail:* If a group chooses to submit via standard e-mail then the file should be compressed (zipped), password protected, and attached to an email to data@cssresearch.org. The password to the zipped file should be sent in a separate email to jburkeen@cssresearch.org.
- *Surface Mail:* To mail the files by CD, please send the CD to the following address after November 2, 2009:
Jeff Burkeen
CSS - 8th Floor
1625 K ST NW
Washington, DC 20006

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Summary Data Requirements

✓	Survey Options	Information Needs	Table A Patient Visit Table	Table B Patient Demographic Table	Table C Provider Table
	Group Survey Must participate to be eligible for health plan bonuses under IHA P4P Program		A unique record for <u>all</u> patient visits: <ul style="list-style-type: none"> ▪ Made between 1/1/09 and 10/31/09 ▪ By HMO and POS members ▪ By members age 18 and older on 10/31/09 ▪ For defined visit types (see page 8) 	A unique record for <u>all</u> members that are: <ul style="list-style-type: none"> ▪ 18 years or older as of 10/31/09 ▪ Enrolled in HMO and POS ▪ Enrolled in Commercial product ▪ Enrolled with provider group on 10/ 31/09 ▪ Had <u>one or more eligible encounters</u> from 1/1/09 to 10/31/09 	A unique record for <u>all</u> provider types <u>active</u> as of 10/31/09: <ul style="list-style-type: none"> ▪ All active providers with required specialty types (see Appendix 1). ▪ Includes staff, network and contract providers.
	Alternative Language Surveying Is the medical group planning to survey its members in a language other than English? If so:	Identify the language(s); Will the alternative language survey be provided to <u>all</u> patients chosen for the survey, or <u>only patients of select physicians</u>? If the latter, obtain a list of the doctors whose patients will be surveyed in each language			If alternate languages will only be provided to patients of selected physicians, use Field 14 to indicate the language option for each provider. Each provider may be coded with any one of the four alt. language options.
	After Hours Survey Is the medical group participating in the After Hours Survey? If so:	Make sure you include pediatricians in Table C, the Active Provider File.			Include Pediatricians and fill in the optional After Hours contact information (fields 16-19).
	Sub-Unit Reporting Is the medical group going to sample and report results for subunits? If so:	Which subunits does the medical group want to report on separately? Groups can identify subunits in the Visit Table <u>or</u> the Provider Table depending on whether individual physicians deliver care across multiple subunits (use Visit Table) or if each physician is accountable for delivering care at one subunit only (use Provider Table).	Complete Field 9 Allows sampling of visits for a single physician across multiple subunits.		Complete Field 2 All sampled visits are associated with the provider's assigned subunit only.

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✓	Survey Options	Information Needs	Table A Patient Visit Table	Table B Patient Demographic Table	Table C Provider Table
	<p>Doctor Survey Is the medical group participating in the Doctor Survey (in addition to the Group Survey?) If so:</p>	<p>Obtain the list of doctors your group wants included in the Doctor Survey.</p> <p>Does your group want to survey members with PPO or Medicare coverage (in addition to HMO & POS)?</p> <p>Does your group want to enlarge the doctor sample size from 100 to 135?</p>	<p>May also include (by group choice):</p> <ul style="list-style-type: none"> ▪ Pediatric visits by members under 14 ▪ Visits by PPO or Indemnity members ▪ Visits by Medicare patients 	<p>May also include (by group choice):</p> <ul style="list-style-type: none"> ▪ Pediatric patients under 14 ▪ PPO or Indemnity members ▪ Medicare members 	<p>Use Field 12 to flag physicians participating in Doctor Survey and to denote sample size of 100 or 135 for physicians participating in Doctor Survey</p> <p>Fill in physician <i>practice/location</i> in Field 13.</p>

TABLE A: PATIENT VISIT FILE

Includes:

1. A separate record for **every** eligible visit. For example, if a member had three visits to Physician Smith and two visits to Physician Jones there should be five visit records in the file for that member.
2. Visits that meet ALL of the following criteria:
 - Visits made between January 1, 2009 and October 31, 2009.
 - Visits made by members with Commercial HMO or POS coverage
 - Visits made by members who are age 18 or older as of October 31, 2009.
 - Visits of each type listed below, including those documented in your system using internal or proprietary coding. You should include all of the visit codes below in your visit queries. If your group uses additional or different codes to represent the required visit types, you must convert them to the comparable standard CPT code and include them in the data submission. If you're not sure whether other codes should be converted, please contact Julie France at jfrance@pbgh.org 714.735.8754.

Visit Type	CPT Codes Typically Used	Internal Codes (notes section)
Illness office visits	99201-99205, 99211-99215	
Preventive care visits	99385-99387, 99395-99397, 99401-99404, 99411-99412, 99420, 99429 (Doctor Survey participants choosing to include Pediatricians should also include codes 99381-99384, 99391-99394)	
Outpatient consults	99241-99245	
Ophthalmology visits	92002-92014	
Obstetric visits	59400, 59510, 59610, 59618	

Doctor Survey Participant Notes

Groups participating in the Doctor Survey may choose to include the following for their Doctor Survey samples only. Check with the PAS project contact or Medical Director of your group to determine whether to include the visit types listed below.

- Visits made by patients under the age of 14 (if surveying Pediatricians)
- Visits made by PPO or Indemnity patients
- Visits made by Medicare patients

Reminders:

- If your group uses internal codes to represent the required visit types (illness, outpatient consult, preventive care, ophthalmology, obstetric), you will need to convert your internal codes to at least one of the standard CPT codes listed above in each category or they will be invalidated.
- Do not filter by place-of-service code. The survey vendor will be responsible for further screenings and exclusions.
- Before exporting the files into the final text format, make sure that the patient and provider IDs in the visit file match the correct records in the patient and provider tables, respectively. (See Essential Final Checks on Page 4).

- Large groups with subunits (excludes most groups) whose physicians provide services across subunits should use Field 2 to identify the subunit at the visit level. (Groups who wish to associate each provider with one subunit only should code the subunit in Table C – Providers instead.)

Table A – Patient Visit File Data Layout

Field #	Variable	Specifications	Data Format
1	Medical Group ID (DMHC - Department of Managed Health Care)	Medical Group's CA DMHC Code. Used to organize data by participating medical groups. Use 5 digit DMHC code.	Columns: 1 - 5 Width: 5 Type: Numeric Code
2	Medical Group Name	Name of Medical Group. Used as quick reference; will not be used in cover letters or reports and may be abbreviated	Columns: 6 - 35 Width: 30 Type: Alpha
3	Visit Service Code	CPT 5-digit code; if other codes are used for required visit types, they must be converted to corresponding CPT codes.	Columns: 36 - 40 Width: 5 Type: Numeric Code
4	Physician ID for Patient Visit	Physician identifier for provider with whom patient had visit. Used to match visits to the provider record in the Active Provider file. (Table A and Table C are linked together by CSS using the Physician ID)	Columns: 41 - 70 Width: 30 Type: Alpha-Numeric
5	Date of Visit – Month (Patient visit with physician listed in Field 4)	Visits January 1, 2009 – October 31, 2009. Use 2 digit Month codes (e.g. 01-10). Used to identify a unique visit.	Columns: 71 - 72 Width: 2 Type: Numeric Code
6	Date of Visit – Day (Patient visit with physician listed in Field 4)	Visits January 1, 2009 – October 31, 2009. Use 2 digit Day codes (e.g. 01-31). Used to identify a unique visit.	Columns: 73 - 74 Width: 2 Type: Numeric Code
7	Date of Visit – Year (Patient visit with physician listed in Field 4)	Visits January 1, 2009 – October 31, 2009. Use 4 digit Year Codes (2009). Used to identify a unique visit.	Columns: 75 - 78 Width: 4 Type: Numeric Code
8	Patient ID or Record Number	Patient identifier assigned by Medical Group. Used to match visits to the patient record in the Patient Demographic file. (Table A and Table B are linked together by CSS using the Patient ID.)	Columns: 79 - 93 Width: 15 Type: Alpha-Numeric

Table A – Patient Visit File Data Layout (cont.)

Field #	Variable	Specifications	Data Format
9	Medical Group Subunit Code	Group subunit where the visit took place. <u>Optional field</u> for groups who have registered for multiple subunit samples and wish to identify subunits at the visit level. Assign numeric code for each subunit (e.g., 01, 02, 03, ...). Leave blank if not applicable.	Columns: 94 - 95 Width: 2 Type: Numeric Code
10	Health Plan Used for Visit	Name of health plan covering visit. Use legal name of health plan. Do not use acronyms or aliases. If using numeric codes, convert the codes to plan names. Used to evaluate results by health plan.	Columns: 96 - 135 Width: 40 Type: Alpha
11	Insurance Product Used for Visit	Use the following codes: 1 = HMO 2 = POS 3 = PPO 4 = Indemnity/Other Categories 1 (HMO) or 2 (POS) are the only eligible categories for the PAS Group Survey reporting. Categories 3 and 4 may be used for Doctor Survey only.	Columns: 136 Width: 1 Type: Numeric Code
12	Type of Coverage	Use the following codes: 1 = Commercial 2 = Medicare Category 1 (Commercial) is the only eligible category for the PAS Group Survey. Category 2 may be used for Doctor Survey only.	Columns: 137 Width: 1 Type: Numeric Code
13	Place of Service Code*	2-digit CMS place of service indicator (e.g., 11=office, 21=inpatient hospital).	Columns: 138 - 139 Width: 2 Type: Numeric Code
14	Primary Diagnosis of Encounter	ICD-9** code that reflects the primary diagnosis made during the encounter. If not available, leave blank.	Columns: 140 - 149 Width: 10 Type: Alpha-Numeric
15	Secondary Diagnosis of Encounter	ICD-9** code that reflects the secondary diagnosis made during the encounter. If not available, leave blank.	Columns: 150 - 159 Width: 10 Type: Alpha-Numeric

*A complete list of Place of Service Codes are available from CMS. Go to the following Web site and choose "POS Database":
www.cms.hhs.gov/PlaceofServiceCodes/

** ICD-9: International Classification of Diseases, Ninth Revision

TABLE B: PATIENT FILE

Includes:

Members who meet **ALL** of the following criteria:

- Had one or more encounters from January 1, 2009 to October 31, 2009. (Patients who match one or more visits in Table A, based on the Patient ID)
- 18 years or older as of October 31, 2009
- Enrolled in HMO or POS
- Enrolled in Commercial products
- Enrolled with provider group on October 31, 2009

Excludes Members:

- Without any visits between January 1, 2009 and October 31, 2009. (No matches in Table A.)

Doctor Survey Participant Notes

Groups participating in the Doctor Survey may choose to include the following members, who will be included in the Doctor Survey samples only. Check with the PAS project contact or Medical Director of your group to determine whether to include the members types listed below. Note that visits for these patients should also be included in Table A.

- Patients under the age of 14 (if surveying Pediatricians)
- PPO-only or Indemnity-only patients
- Medicare patients

Reminders:

- Include all members based on the above eligibility criteria. The survey vendor will be responsible for further screenings and exclusions.
- Patients with dual insurance coverage may be included, as long as at least one visit was covered under an HMO or POS product.
- **There should be one unique record and one unique Patient ID for each patient. If there are multiple attributes for a patient (e.g., multiple addresses) provide the primary attribute for the patient. Duplicate patient records with the same patient ID will be excluded from the survey.**

Table B – Patient File Data Layout

Field #	Variable	Specifications	Data Format
1	Medical Group ID (DMHC – Department of Managed Health Care)	Medical Group’s CA DMHC Code. Used to organize data by participating medical groups. Use 5 digit DMHC code.	Columns: 1 – 5 Width: 5 Type: Numeric Code
2	Medical Group Name	Name of Medical Group. Used as quick reference; will not be used in cover letters or reports and may be abbreviated	Columns: 6 – 35 Width: 30 Type: Alpha
3	Last Name (Patient)	Include last name only. Exclude first name or middle initial. Used for addressing correspondence to patients.	Columns: 36 – 65 Width: 30 Type: Alpha
4	First Name (Patient)	Include first name only. Exclude middle name or initial. Used for addressing correspondence to patients.	Columns: 66 – 95 Width: 30 Type: Alpha
5	Middle Initial (Patient)	Include middle initial only. Used for addressing correspondence to patients.	Columns: 96 Width: 1 Type: Alpha
6	Suffix (Patient, If Any)	Include any degrees, titles, Sr. Jr., etc. Exclude any part of name. Used for addressing correspondence to patients.	Columns: 97 – 106 Width: 10 Type: Alpha
7	Patient ID or Record Number	Unique patient identifier assigned by Medical Group -- not an episode identifier. <u>Must</u> <u>match Patient IDs in Table B.</u> Used by CSS to match patient record to Patient Visit file.	Columns: 107 - 121 Width: 15 Type: Alpha-Numeric
8	Mailing Address Line 1 (Patient)	First line of patient’s primary mailing address (e.g.100 Main St, Apt 2). Survey will be mailed to this address. (Apartment numbers can be in either line 1 or 2)	Columns: 122 - 151 Width: 30 Type: Alpha-Numeric

Table B – Patient File Data Layout (cont.)

Field #	Variable	Specifications	Data Format
9	Mailing Address Line 2 (Patient)	Use if necessary for apartment or for a long address, otherwise leave blank; do <u>not</u> duplicate information in line 1.	Columns: 152 - 181 Width: 30 Type: Alpha-Numeric
10	City (Patient)	Use full name of city as recognized by Postal Service.	Columns: 182 - 211 Width: 30 Type: Alpha
11	State (Patient)	Use standard US Postal Service abbreviation (e.g., CA)	Columns: 212 - 213 Width: 2 Type: Alpha
12	Zip code (Patient)	5-digit zip code. (Use leading zeros as appropriate.)	Columns: 214 - 218 Width: 5 Type: Numeric Code
13	Home Phone (Patient)	Include area code. Provide full telephone number without any punctuation. (e.g. 4159991212) Used for follow-up phone survey with patients who are mail non-respondents.	Columns: 219 – 228 Width: 10 Type: Numeric Code
14	Date of Birth – Month (Patient)	Use 2 digit Month codes (e.g. 01-12) Used to confirm patient eligibility.	Columns: 229 - 230 Width: 2 Type: Numeric Code
15	Date of Birth – Day (Patient)	Use 2 digit Day codes (e.g. 01-31) Used to confirm patient eligibility.	Columns: 231 - 232 Width: 2 Type: Numeric Code
16	Date of Birth – Year (Patient)	Use 4 digit Year Codes (e.g. 1970) Used to confirm patient eligibility.	Columns: 233 - 236 Width: 4 Type: Numeric Code
17	Gender (Patient)	Use the following codes: F = female M = male; Used for salutation in patient correspondence	Columns: 237 Width: 1 Type: Alpha
18	Primary Care Physician (PCP) ID	Patient's PCP as of October 31, 2009. Use physician ID used in provider table (Table C). If patient is not assigned to PCP, leave blank and CSS will make PCP assignment based on most frequently visited PCP.	Columns: 238 - 267 Width: 30 Type: Alpha-Numeric

TABLE C. ACTIVE PROVIDER FILE

Please see Appendix 1 for the defined set of specialty types that must be represented in the data submission and their associated codes. **The submission will not pass the Quality Assurance process if the complete set of required specialty types is not included.**

Includes:

All providers (including contract providers) who practice one of the required specialties and were active as of October 31, 2009, regardless of whether there is a match with a patient visit.

Note: Providers who have not had an encounter in the past 3 years are not considered “Active” for the PAS and should not be included.

Excludes:

Providers whose primary specialty is:

- Pediatric subspecialty
- Hospital-based physicians: radiologists, pathologists, anesthesiologists, emergency medicine

Doctor Survey Participant Notes:

Determine the following with the PAS project contact or Medical Director for your group:

- Flag participating physicians in Field 12.
- Pediatricians may be included in the Doctor Survey. Include their patients (under 14) and visits in table A and B.
- Larger sample: to increase the doctor sample size from 100 to 135 (for an additional fee), use code 2 in Field 12.
- Physician practice/location in Field 13 is required.
- If you plan to include a doctor who has dual specialties (see note in reminders), we recommend you choose just one of the specialties for purposes of the Doctor Survey. Flagging both records is highly likely to result in insufficient patient sample size for both specialties.

Reminders:

- Multiple attributes: There should be one unique physician ID for each record in Table C. Duplicate provider records with the same physician ID will be invalidated. For other attributes (e.g., two practice locations), enter the primary attribute for the provider in a single record. (Dual specialty status is the only rationale for including two records for any one provider and each specialty record will require a separate, unique ID - see note on next page).
- New Affiliation Codes: Use Field 15 to code each provider’s affiliation based on whether the provider is typically included in your group roster (as provided to health plans, for example). This replaces the staff/network/contract coding scheme used last year.
- PCPs: Use Field 10 to flag all PCPs that have assigned panels of patients. Providers with specialties Family Practice (07), Internal medicine (09), Nurse Practitioner (14) or Physician Assistant (24) should be flagged as PCPs or they will be invalidated.

- Alternative Language: Use Field 14 to flag providers whose patients are to receive alternative language surveys (group must have registered for alternative language option). Each provider may be coded with any one of the four alternative language options. Groups who registered to have all patients in the sample receive an alternative language do not need to code providers.
- After Hours participants: Fill in optional contact information and include pediatricians.
- Large groups with subunits (excludes most groups): use Field 2 if you wish to associate each provider with one subunit only. (Groups whose physicians provide services across multiple subunits and want to capture that mobility should code the subunit in Table A – Visits instead.)
- Practices: If necessary, provider records may be included with the name of a practice abbreviated to 30 characters in the Last Name field (leave First Name blank). Groups are required to identify individual physicians if possible.
- Dual Specialties: If any providers have dual specialties, you may submit separate records for each specialty. However, each record must have a unique physician ID (e.g. Dr. Jones specializes in Family Practice and Pulmonology. Her unique physician ID for Family Practice is 12345 and her physician ID for Pulmonology is 12345A. In the provider file there would be two records for Dr. Jones, one with ID “12345” and Specialty “07”, the other record would have ID “12345A” and Specialty “26”.) Note that each ID must have corresponding visit records in Table A for each specialty to be represented in the sample. (Continuing the example, some visit records with Provider ID 12345 and some with Provider ID 12345A.) If one of the specialties serves as a PCP, make sure to flag the correct physician ID with the PCP flag.
- Physician Last Name: In field 4 please delete any unnecessary text appended to the last name, such as “Smith, a medical corporation” or “Jones, License # ...” as this will get printed on the surveys sent to their patients
- Groups not participating in the After Hours survey: fields 16 through 19 do not need to be included in Table C You may either fill those columns with blanks or end the provider file at the end of Field 15 (at position 184).

Table C – Active Provider File Data Layout

Field #	Variable	Specifications	Data Format
1	Medical Group ID (DMHC - Department of Managed Health Care)	Medical Group's CA DMHC Code. Used to organize data by participating medical groups. Use 5 digit DMHC code.	Columns: 1 - 5 Width: 5 Type: Numeric Code
2	Medical Group Subunit Code	Group subunit to which the doctor is assigned. <u>Optional field</u> for groups who have registered for multiple subunit samples and wish to associate each provider with a specific subunit. Assign numeric code for each subunit (e.g., 01, 02, 03, ...). Leave blank if not applicable.	Columns: 6 - 7 Width: 2 Type: Numeric Code
3	Medical Group Name	Name of Medical Group. Used as quick reference; will not be used in cover letters or reports and may be abbreviated.	Columns: 8 - 37 Width: 30 Type: Alpha
4	Physician Last Name (or abbreviated practice name)	Include last name only. Do not include professional suffix (MD, DO, etc.) Delete any unnecessary text appended to the last name. (If a practice name, abbreviate to 30 characters.)	Columns: 38 - 67 Width: 30 Type: Alpha
5	Physician First Name	Include first name only. Exclude middle initial. (If a practice name, leave blank – enter abbreviated practice in field 4.)	Columns: 68 - 97 Width: 30 Type: Alpha
6	Physician Middle Initial	Include middle initial only.	Columns: 98 Width: 1 Type: Alpha
7	Physician Name Suffix	Include any Sr. Jr., etc.	Columns: 99 - 108 Width: 10 Type: Alpha
8	Physician Professional Suffix	Include MD, DO, etc.	Columns: 109 - 118 Width: 10 Type: Alpha

Table C – Active Provider File Data Layout (cont.)

Field #	Variable	Specifications	Data Format
9	Physician ID	Unique physician identifier. Used to match physician record with visit records (Table A, Field 5) and patients' PCP assignment (Table B, Field 18).	Columns: 119 - 148 Width: 30 Type: Alpha-Numeric
10	PCP Indicator	Use the following codes: PCP = 1 Non-PCP = 2 Flag to indicate if physician serves as a primary care provider (PCP) with assigned panel of members. FP and IM doctors, NPs and PAs not flagged as PCPs will be invalidated.	Columns: 149 Width: 1 Type: Numeric Code
11	Physician Specialty	Use 2-digit specialty code only from Appendix 1. Used to analyze medical group and project-wide results by PCP/specialist categories and for case-mix adjustment.	Columns: 150 - 151 Width: 2 Type: Numeric Code
12	Doctor Survey Participant	<u>Doctor Survey participants.</u> Use the following codes to indicate which physicians will participate in the Doctor Survey: 1 = Include physician in Doctor Survey at 100 sample size 2 = Include physician in Doctor Survey at 135 sample size Blank = Physician will <u>not</u> be included in Doctor Survey If not applicable, leave blank.	Columns: 152 Width: 1 Type: Numeric Code
13	Physician Practice/Location	<u>Doctor Survey participants.</u> Name of physician's practice or location. <u>Required</u> for physicians who are flagged for participation in the Doctor Survey. If not applicable, leave blank.	Columns: 153 - 182 Width: 30 Type: Alpha-Numeric

Table C – Active Provider File Data Layout (cont.)

Field #	Variable	Specifications	Data Format
14	Alternative Language Survey to be included in addition to English Survey	If you registered for an <u>optional alternative language</u> survey at the provider level, indicate which language should be included for patients of each provider. Codes: Spanish=1, Chinese=2, Vietnamese=3. If not applicable, leave blank.	Columns: 183 Width: 1 Type: Numeric Code
15	Provider Affiliation with Medical Group/IPA	Use the following codes: 1 = Provider is included in group roster 2 = Provider is <u>not</u> included in group roster. (Applies to providers affiliated by a letter of understanding.) Provider Flag to identify each provider's affiliation with the medical group.	Columns: 184 Width: 1 Type: Numeric Code
16*	City (Provider)	<u>After Hours Participants:</u> Use full name of city recognized by Postal Service.	Columns: 185 - 214 Width: 30 Type: alpha
17*	State (Provider)	<u>After Hours Participants:</u> Use full name of city recognized by Postal Service.	Columns: 215 - 216 Width: 2 Type: alpha
18*	Zip code (Provider)	<u>After Hours Participants:</u> 5-digit zip code. Use leading zeros as appropriate.	Columns: 217 - 221 Width: 5 Type: Numeric Code
19*	Phone Number (Provider)	<u>After Hours Participants:</u> 10-digit number including area code. Do not include formatting characters such as parenthesis, dashes or spaces. (e.g. 7149940540)	Columns: 222 - 231 Width: 10 Type: Numeric Code

*Regarding optional After Hours fields: Groups who are not participating in the After Hours survey do not need to include fields 16 through 19. Either these columns can be included and filled with blanks, or the table can end at field 15 (position 184). (Note: other optional fields in the *middle* of any file must be filled with blanks if not applicable.)

Appendix 1: List of Required Specialties

For 2010, all of the *Required Specialty Types* listed below must be represented in the Table C data submission, using the codes in the left column. (For pairs of specialties highlighted in yellow, either code will meet the requirement.) In addition, all required specialty types should be represented with visits in Table A. **The submission will not pass the Quality Assurance process if the required specialty types are not included.**

Required Specialty Types		
01	Allergy/Immunology	
03	Cardiology	
05	Dermatology	
06	Endocrinology	
07	Family/General Practice	
08	Gastroenterology	
09	Internal Medicine	
10	Infectious Disease	
12	Nephrology	
13	Neurology	
15	Obstetrics/Gynecology	Quality check will ascertain if group has either OB/GYNs or Gynecologists only, but group should continue to use the two distinct codes for each specialty type.
41	Gynecology Only	
16	Oncology/Hematology	
17	Ophthalmology	
19	Orthopedist	Quality check will ascertain if group has either Orthopedic Surgeons or Orthopedists, but group should continue to use the two distinct codes for each specialty type.
32	Surgery Orthopedics	
20	Otolaryngology (ENT)	
25	Podiatry	
26	Pulmonology	
27	Rheumatology	
29	Surgery General	
30	Surgery Cardiac/Thoracic	Quality check will ascertain if group has any among following surgical types: Cardiac, Thoracic or Vascular, but group should continue to use the two distinct codes for each specialty type.
36	Surgery Vascular	
33	Surgery Plastic/Reconstructive	
34	Surgery Neurological	
37	Urology	
Optional Specialty Types *		
14	Nurse Practitioner (NP)	
24	Physician Assistant (PA)	
49	NP or PA working in OB/GYN	
50	NP or PA working in Pediatrics	May be included for Doctor Survey only
21	Pediatrician / Adolescent Medicine	For After Hours and Doctor Survey Only

* These specialty types may be included, but are not required.

Specialty Types Excluded from Group Survey**		
2010 Code	Specialty Type	
38	Acupuncture	May be included for Doctor Survey only
--	Addiction Medicine	
--	Anesthesiologists	
--	Audiology	
02	Behavioral Medicine	May be included for Doctor Survey only
04	Chiropractor	May be included for Doctor Survey only
--	Counselor	
48	Dental	May be included for Doctor Survey only
47	Emergency Medicine	May be included for Doctor Survey only
40	Genetics	May be included for Doctor Survey only
39	Geriatric Medicine	May be included for Doctor Survey only
42	Infertility/Reproductive Endocrinology.	May be included for Doctor Survey only
11	Neonatal Care	May be included for Doctor Survey only
--	Nuclear Medicine	
--	Nutrition	
46	Occupational Medicine	May be included for Doctor Survey only
18	Optometry	May be included for Doctor Survey only
43	Oral-maxillofacial Surgery	May be included for Doctor Survey only
44	Pain Management	May be included for Doctor Survey only
--	Pathologists	
--	Pediatric Subspecialists	
22	Perinatology	May be included for Doctor Survey only
23	Physical Medicine	May be included for Doctor Survey only
--	Psychiatry	
--	Public Health	
45	Radiation Oncology	May be included for Doctor Survey only
--	Radiologists	
--	Rehabilitation Medicine	
--	Sleep Medicine	
28	Social Worker	May be included for Doctor Survey only
--	Speech Therapy	
31	Surgery Colon/Rectal	May be included for Doctor Survey only
35	Surgery Transplant	May be included for Doctor Survey only
99	Urgent Care	

** These specialty types will not be included in the Group Survey sample for 2010. Specific specialties may be included in the Doctor Survey as indicated above. Groups may include all specialties in the submission, and the Survey Vendor will remove them if necessary.