HealthPartners

Continuity of Care Document

Specifications/Input:

File Type: .txt
Delimiter: "|" (pipe)
Header: N/A

Field Number	Field Name	Format	Description	Required?
1	Patient ID	########	[insert plan] patient ID number	Y
2	First Name	Char Text	The First Name of the patient that is associated with the record	Y
3	Last Name	Char Text	The Last Name of the patient that is associated with the record	Y
4	Birth Date	MM/DD/YYYY	The DOB of the patient that is associated with the record	Y
5	Pharmacist NPI	##########	Type 1 NPI of Pharmacist that provided MTM service	Y
6	Record Type	###	A three digit number used to describe the type of record being transmitted (see Code Set – Record Type)	Y

Record Type

Record Code	Record Type	Description
001	Lab	Patient's Lab and Lab Result Information
002	Prescriber Intervention	Count of Physician Outreaches and Drug Therapy Problems Identified
003	Assessment	Assessment information
004	Smoking History	Patient's smoking history
005	Blood Pressure	Patient Blood pressure

File Specification – Lab Segment (001): Note – Lab segments are not required segments, however, all available lab data that indicates drug indication, efficacy, and safety should have the most recent values (as of the date that the CCD is created)

Field Number	Field Name	Format	Description	Required?
7	Date	MM/DD/YYYY	The date of the Lab that was completed	Y – if lab segment is sent
8	Lab Type	##	The Lab type completed See below table (* Lab Types) (EX. 1 = total cholesterol)	Y – if lab segment is sent
9	Lab Value		The Value of the lab completed See below table (* Lab Types) (EX. 1 = total cholesterol= mg/dl)	Y – if lab segment is sent

* Lab Types

Corresponding Lab Type #	Lab Type	Value
1	Total Cholesterol (TC)	mg/dl
2	HDL	mg/dl
3	LDL	mg/dl
4	TG(triglycerides)	mg/dl
5	HbA1c	%
6	Hgb (hemoglobin)	g/dl
7	SCr (Creatinine)	mg/dl
8	AST	IU/L
9	ALT	IU/L
10	Alk (Alkaline Phos.)	U/L
11	Phosphorus (Phos)	mg/dl
12	Thyroid Stimulating Hormone (TSH)	mIU/ml

File Specification – Prescriber Intervention Segment (002): This is a required segment

Field Number	Field Name	Format	Description	Required?
7	Date	MM/DD/YYYY	Date the recommendation was made	Y
8	# of Medication Therapy Problems identified	##	Number of Medication Therapy Problems identified by provider on specified date	Y
9	# of Medication Therapy Problem Resolutions	##	Number of medication therapy problem resolutions (from 1 day after last assessment through day that # of drug therapy problem resolutions is recorded)	Y

File Specification – Assessment Segment (003): This is a required segment

Field Number	Field Name	Format	Description	Required?
7	Date	MM/DD/YYYY	Date of assessment/visit	Y
8	Recipient of assessment	##	01- Beneficiary 02- Beneficiary's Prescriber 03- Caregiver 04- Other	Y
9	Method of Delivery of assessment	##	01- Face to face 02- Telephone 03- Telehealth consultation 04- Other	Y
10	Cognitive Status	Y, N, U	Patient cognitively impaired? Y = Yes N = No U = Unknown	Y If N: Recipient of assessment must be 01- Beneficiary If U: Recipient of assessment must be 01- Beneficiary
11	CMS Standardized summary	MM/DD/YYYY	Date CMS standardized summary delivered	N – only required if patient has Medicare insurance AND received CMS Standardized summary; May be left blank for TMR services
12	Is the patient in a nursing home at the time of the visit?	Y, N, U	Y = Yes N = No U = Unknown	N - optional

13	Service Location NPI	##########	NPI of the service location in which the provider completed the visit	N - optional

File Specification – Tobacco Use History Segment (004): Not a required segment. If sending tobacco use history segment, please send the most recent assessment date as of the date the CCD record is created. If no tobacco use assessment exists, no tobacco use history segment should be sent.

Field Number	Field Name	Format	Description	Required?
7	Date	MM/DD/YYYY	Date tobacco status assessed	Y
8	Current Tobacco User?	Y, N, U	States if patient is a current smoker or smokeless tobacco user Y = Yes N = No U = Unknown	Y

File Specification – Blood Pressure Segment (005): Not a required segment. If sending a blood pressure value, please send the most recent blood pressure on record as of the date the CCD record was created. If no blood pressure value exists, no blood pressure segment should be sent.

Field Number	Field Name	Format	Description	Required?
7	Date	MM/DD/YYYY	Date of blood pressure Reading	Y
8	Systolic	### (max 3 digits, 2 digits ok)	Measure of blood pressure when heart is beating - Top number of blood pressure	N- required if field 10 not populated
9	Diastolic	### (max 3 digits, 2 digits ok)	Measure of blood pressure when heart is relaxed – bottom number of blood pressure	N – required if field 10 not populated
10	Systolic/Diastolic combined	###/### (max 3 digits, 2 digits ok)	Alternative reporting of BP if can't report as a separate systolic and diastolic value	N – required if fields 8 and 9 not populated