UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION

In the Matter of	
North Texas Specialty Physicians, Respondent	Docket No. 9312

MOTION TO SUPPLEMENT

Non-party Blue Cross Blue Shield of Texas ("BCBSTX"), a division of Health Care Service Corporation, a mutual legal reserve company, files the following Motion to Supplement.

I.

On January 6, 2004, BCBSTX submitted a Motion to Quash and/or Limit Subpoena Duces Tecum, and explained in the motion that it intended to submit evidence in support of the motion but was unable to do so because of the unexpected unavailability of an employee witness. BCBSTX now submits the attached affidavit (Exhibit A) in support of its Motion to Quash and/or Limit Subpoena Duces Tecum and respectfully requests the Administrative Law Judge consider the attached affidavit when he considers that Motion.

II.

Counsel for BCBSTX has called counsel for North Texas Specialty Physicians, which requested the Subpoena Duces Tecum, to inquire whether this motion is opposed. That call has not been returned.

WHEREFORE, PREMISES CONSIDERED, non-party Blue Cross Blue Shield of Texas respectfully requests the Administrative Law Judge consider the attached

Exhibit A when considering BCBSTX's previously filed Motion to Quash and/or Limit Subpoena Duces Tecum. BCBSTX further requests such other relief, both legal and equitable, to which it may show itself justly entitled.

Respectfully submitted,

HULL HENRICKS & MacRAE LLP
Bank One Tower
221 West 6th Street, Suite 2000
Austin, Texas 78701
(512) 472-4554
(512) 494-0022 (Facsimile)

By: _____
MICHAEL S. HULL
State Bar No. 10253400
ANDREW F. MacRAE
State Bar No. 00784510

ATTORNEYS FOR BLUE CROSS
BLUE SHIELD OF TEXAS

CERTIFICATE OF SERVICE

I hereby certify that the foregoing document has been sent to the following counsel of record via overnight delivery on this 8 day of January 2004.

Honorable D. Michael Chappell
Administrative Law Judge
Federal Trade Commission
Room H-104
600 Pennsylvania Avenue, NW
Washington, DC 20580

Michael Bloom
Senior Counsel to the Northeast Region
Federal Trade Commission
One Bowling Green, Suite 318
New York, NY 10004

Gregory D. Binns
Thompson & Knight LLP
1700 Pacific Ave., Suite 3300
Dallas, TX 75201

Michael S. Hull / Andrew F. MacRae

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION

In the Matter of	)	
	)	Docket No. 9312
North Texas Specialty Physicians,	)	
Respondent	)	

AFFIDAVIT OF RICK HADDOCK

STATE OF TEXAS §
§
COUNTY OF DALLAS §

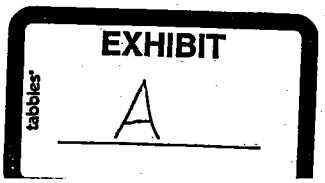
BEFORE ME, the undersigned authority, personally appeared Rick Haddock, who, being by me duly sworn on oath, deposed and stated as follows:

"My name is Rick Haddock. I am over the age of twenty-one (21) years and am competent in all respects to make this Affidavit. I am currently the Regional Director for the Professional Provider Network department for Blue Cross Blue Shield of Texas ("BCBSTX"), a division of Health Care Service Corporation ("HCSC"), a Mutual Legal Reserve Company. All the facts recited here in are within my personal knowledge and are true and correct.

"On December 23, 2003, BCBSTX, which is not a party to this proceeding, received a Subpoena Duces Tecum ("Subpoena"), a copy of which is attached to the Motion to Quash and/or Limit Subpoena Duces Tecum filed by BCBSTX as Exhibit A. The Subpoena, issued at the behest of North Texas Specialty Physicians ("NTSP") requires production of documents and information responsive to the following categories:

1. All documents previously produced or otherwise sent to the Federal Trade Commission concerning your business relationships with healthcare providers in the State of Texas.

2. All documents previously produced or otherwise sent to the Office of the Attorney General of the State of Texas concerning business relationships with healthcare providers



in the State of Texas, including specifically but without limitation the documents provided in response to the Written Notice of Intent to Inspect, Examine and Copy Corporate Documents served in or about March 2002 (a sample of such Written Notice is attached hereto as Appendix A). [At your option, check registers as described in Class 6 of Exhibit C need not be produced]. Such documents should be provided in electronic form only.

3. Documents for the time period January 1, 2000 to June 30, 2002 described in Exhibits A through C of the above-referenced Written Notice of Intent to Inspect, Examine and Copy Corporate Documents to the extent such documents are not produced in response to Request No. 2 above. [At your option, check registers as described in Class 6 of Exhibit C need not be produced]. Such documents should be provided in electronic form only.

4. All internal and external correspondence, memoranda, and messages concerning or relating to NTSP.

5. All documents comparing the cost or quality of medical service provided by any physician provider listed on Appendix B and any other physician providers.

6. Documents sufficient to show the rate (as expressed in terms of a % of RBRVS or otherwise) paid to each physician provider by you, the period for which that rate was paid, whether the rate was for a risk or non-risk contract, whether the rate was for a HMO or PPO or other contract, who the contracting parties were for the contract setting the rate, and which physicians were covered by such contract.

7. All documents concerning or relating to comparisons of the cost of physician services, hospital care, pharmacy cost, or cost of health insurance in the State of Texas.

8. Documents sufficient to show your policies, rules, and access standards establishing the geographic areas to be serviced by physician providers in the State of Texas.

9. A sample contract used for each contracting entity involving more than 75 physicians in the Counties of Dallas and/or Tarrant and any amendments, revisions, or replacements thereof.

As Regional Director for BCBSTX, I am familiar with the production of documents to the Office of the Attorney General of the State of Texas (categories nos. 2 and 3 above). I am also familiar with the types of documents that might be responsive to the broad categories of documents identified in requests nos. 4-9 above.

"With respect to the information requested in categories nos. 2 and 3 in the Subpoena, I have knowledge of the information sent to the Attorney General of Texas in response to a Civil

Investigative Demand similar to Appendix A to the Subpoena. (A copy of the demand sent to BCBSTX is attached to this Affidavit as Exhibit 1.) The information, which was produced in the form of six computer hard-drives, 21 CD-Roms, e-mails and paper documents, was provided only after prolonged negotiation and cooperation with the Attorney General, and required approximately 1459 person-hours. It was estimated at the time of production that the Information Technology department cost alone was approximately $110,000.00, not including the time of other people in other areas of the company who assisted with the project.

"The information submitted in response to the Civil Investigative Demand includes sensitive financial information, which BCBSTX considers confidential and does not disclose to anyone outside BCBSTX or HCSC. However, it is my understanding that documents provided the Attorney General in response to a Civil Investigative Demand are deemed confidential by statute, and on page two of the Civil Investigative Demand to BCBSTX (Exhibit 1), the Attorney General stated: "CPD [Consumer Protection Division] shall return all documents, and all copies of documents, produced by BCBS[TX] pursuant to this inspection and examination prior to closing this investigation. In the meantime, it is CPD's position that such documents are not subject to production pursuant to an open records request as provided by Art. 1302-5.04 of the Texas Miscellaneous Corporation Laws Act." (Exhibit 1, p. 2.) Moreover, the Attorney General stated that it "does not intend to use these documents in any pending litigation between the State of Texas and BCBS." (*Id.*) Accordingly, BCBSTX provided information to the Attorney General with the understanding that the information would be treated as confidential by the Attorney General, would be returned to BCBSTX following the Attorney General's investigation and would not be used at any other time, by any other person, for any other purpose. In my opinion, if the information provided the Attorney General were to be produced in any other setting,

including this proceeding, it would cause irreparable harm to BCBSTX. If healthcare providers, health maintenance organizations, managed care plans, ERISA plans and the like were to have access to internal BCBSTX confidential information, BCBSTX would be placed at a significant competitive disadvantage.

"Further, if BCBSTX were forced to provide to NTSP the information provided to the Attorney General, in a format usable to NTSP, it would incur considerable time and expense. It is estimated that to produce all the requested information, which would number well into the thousands of documents, and probably millions, would require at least 9000 in person-hours. At a rate of $20 per hour, the average pay of BCBSTX personnel who would be assigned to this task, BCBSTX would incur at least $684,000 in labor, copying and other expenses. (This is not including hard drives, CD Rom's etc. as indicated in Nos. 2 and 3 above, or the operational disruption and harm potentially caused to BCBSTX by the diversion of employees from their routine job assignments.)

"Category no. 4 calls for the production of "all internal and external correspondence, memoranda, and messages concerning or relating to NTSP." The request is not otherwise limited by subject matter, and literal compliance would require BCBSTX to sort through correspondence, memoranda and data to determine whether something "concerned or related to" NTSP. Moreover, BCBSTX and NTSP are in active negotiations regarding NTSP becoming an "at-risk" provider within the BCBSTX HMO network. BCBSTX' internal communications during those negotiations have not been disclosed to NTSP, as disclosure would compromise BCBSTX' position during negotiations. To the extent category no. 4 seeks internal communications about those negotiations, in my opinion production of that information would give NTSP an unfair advantage in negotiations.

"Category no. 6 calls for the production of "Documents sufficient to show the rate (as expressed in terms of a % of RBRVS or otherwise) paid to each physician provider by you, the period for which that rate was paid, whether the rate was for a risk or non-risk contract, whether the rate was for a HMO or PPO or other contract, who the contracting parties were for the contract setting the rate, and which physicians were covered by such contract." This request appears to call for the production of contracts between BCBSTX and healthcare providers in Texas and the disclosure of the compensation paid those providers by BCBSTX. BCBSTX considers all contracts with medical care providers to be confidential and proprietary. Indeed, the contracts themselves provide that they are confidential and proprietary, and both BCBSTX and the contracting providers are bound to maintain the confidentiality of the contracts. The reimbursement rates paid to physicians are an integral part of the contracts and are specifically included within the confidentiality provisions. Thus, medical care providers have the justified expectation that their contracts with BCBSTX will not be produced to the world at large. If confidential financial information were to be disclosed in response to the Subpoena, in my opinion it could cause harm to BCBSTX. If healthcare providers, health maintenance organizations, managed care plans, ERISA plans and the like were to determine the financial reimbursement paid by BCBSTX to its contracting providers, BCBSTX would be placed at a significant competitive disadvantage. Moreover, BCBSTX and NTSP are in active negotiations regarding NTSP becoming an "at-risk" provider within the BCBSTX HMO network. In my opinion, production of this information would give NTSP an unfair advantage in negotiations.

"As set forth in the Motion to Quash and/or Limit Subpoena Duces Tecum, document categories nos. 5 and 7 are broad and non-specific. However, they appear to call for the production of documents BCBSTX considers proprietary trade secrets. Specifically, categories 5

and 7 appear to require disclosure of documents comparing the cost or quality of medical service provided by physicians; and concerning or relating to comparisons of the cost of physician services, hospital care, pharmacy cost, or cost of health insurance in the State of Texas. Documents that appear to be responsive to these categories include formulas, patterns and compilations of information used in BCBSTXs' business, which present BCBSTX an opportunity to obtain an advantage over its competitors. Indeed, some of the documents responsive to these categories go to the core of BCBSTXs' business and business model. Again, if such documents were to be produced, then BCBSTX would be placed at a significant competitive disadvantage.

"Category no. 9 of the documents sought by the Subpoena calls for the production of: "A sample contract used for each contracting entity involving more than 75 physicians in the Counties of Dallas and/or Tarrant and any amendments, revisions, or replacements thereof." To the extent this category calls for the production of financial information, I refer to my testimony regarding categories nos. 4 and 6 above.

"Finally, the Subpoena requires production of documents for the time period from January 1, 1998 through the present, or almost exactly six years. It is difficult to accurately quantify the time and expense that would be incurred in responding to the Subpoena. However, the time and expense necessary to respond to the Subpoena necessarily grows in proportion to the length of time covered by the Subpoena. Older records may be stored off-site, thus further increasing the time, effort and expense necessary to respond.

"On January 6, 2004, I underwent a series of tests at Medical Center of Plano and was out of my office and unable to execute this Affidavit. I am executing this Affidavit on the first day I am back in my office following the hospital testing."

RICK HADDOCK

SUBSCRIBED AND SWORN to before me by the said Rick Haddock this 7 day of January, 2004.

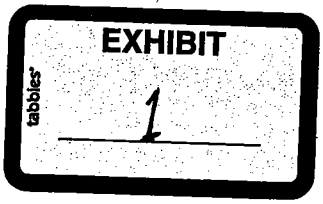
Carolina Cullum
Notary Public, State of Texas

1/14/04
My Commission Expires:

Carolina Cullum
Printed Name

COPY

OFFICE OF THE ATTORNEY GENERAL · STATE OF TEXAS
JOHN CORNYN



March 29, 2002

Attention Corporate Officers and Agents
Health Care Service Corporation d/b/a Blue Cross and Blue Shield of Texas
Mr. Ronald Taylor
901 South Central Expressway
Richardson, Texas 75080 VIA Certified Mail #7001 2510 0007 0331 9052

Re: Written Notice of Intent to Inspect, Examine and Copy Corporate Documents pursuant to Art. 1302-5.02 of the Texas Miscellaneous Corporation Laws Act. Health Maintenance Organization Documents

Attention Corporate Officers and Agents of Health Care Service Corporation d/b/a Blue Cross and Blue Shield of Texas (hereafter, "BCBS"):

Please be advised that the Texas Attorney General has authorized and directed that the Consumer Protection Division (hereafter, "CPD") inspect, examine and review certain books, records and other documents related to BCBS's Texas Health Maintenance Organization (hereafter, "HMO") business pursuant to the Texas Miscellaneous Corporation Laws Act, TEX. REV. CIV. STAT. ANN. Art. 1302-5.01 - Art. 1302-5.06. Therefore, CPD requests that BCBS produce the books, records and other documents as specified in the attached Exhibits A, B and C within the next thirty days. If BCBS chooses to cooperate with this request, these documents should be produced to Assistant Attorney General Robert C. Robinson, III, Consumer Protection Division, 300 West 15th Street, Suite 900, Austin, Texas 78701.

As an alternative to producing the electronic file copies of the requested documents according to the terms specified in the attached Exhibits A, B and C, please notify CPD of the dates BCBS will make its electronic databases and systems that contain the requested electronic data accessible to CPD for inspection, examination and copying at BCBS's offices. If BCBS chooses this option, such electronic databases and systems shall be made available for inspection, examination and copying beginning no later than April 29, 2002, and continuing until such inspection, examination and copying is complete. Upon arrival at BCBS's offices, the Attorney General's assistants and representatives shall present BCBS with a letter confirming that each is authorized to conduct the inspection, examination and copying of BCBS's books, records and other documents.

The documents specified in the attached Exhibits A, B and C are requested as part of the Attorney General's investigation of possible violations of Section 17.46(a) of the Deceptive Trade Practices Act and Section 3 of the Unfair Competition and Unfair Practices Act, Texas Insurance Code, Article 21.21. The documents as specified in the attached Exhibits A, B and C may show or tend to show that BCBS has been or is engaged in acts or conduct in violation of its charter rights and privileges, or in violation of the laws of this State.

The Attorney General does not intend to use these documents in any pending litigation between the State of Texas and BCBS.

CPD shall return all documents, and all copies of documents, produced by BCBS pursuant to this inspection and examination prior to closing this investigation. In the meantime, it is CPD's position that such documents are not subject to production pursuant to an open records request as provided by Art. 1302-5.04 of the Texas Miscellaneous Corporation Laws Act. CPD is not requesting confidential patient information.

If it is easier to do so, the documents responsive to this request to inspect, examine, and copy documents may be produced in coordination with the documents to be produced in response to the separate request issued today for records related to BCBS's PPO business in Texas.

Please be advised that any corporation that fails or refuses to permit the Attorney General or his authorized assistants or representatives to examine or to take copies of any of its said books, records or other documents pursuant to the Texas Miscellaneous Corporation Laws Act, "shall thereby forfeit its right to do business in this State; and its permit or charter shall be canceled or forfeited." Art. 1302-5.05.A. Additionally, any officer or agent of a corporation who fails or refuses to permit the Attorney General or his authorized assistants or representatives to examine or to take copies of any of its books, records or other documents pursuant to the Texas Miscellaneous Corporation Laws Act, "shall be fined not less than one hundred dollars nor more than one thousand dollars, and be imprisoned in jail not less than thirty nor more than one hundred days. Each day of such failure or refusal is a separate offense." Art. 1302-5.05.B.

Should you have any questions regarding production of the requested documents according to the terms specified in the attached Exhibits A, B and C, or any interest in discussing this matter further, please contact me at (512) 475-4360, or by fax at (512) 322-0578. CPD is confident that BCBS shares the Attorney General's interest and desire to resolve these allegations of improper payment practices, and we look forward to BCBS's cooperation in this endeavor.

Yours truly,

Robert C. Robinson, III
Assistant Attorney General
Consumer Protection Division

c: Mr. Michael S. Hull
Hull, Henricks & MacRae, L.L.P.
Via Facsimile: (512) 494-0022

HMO DOCUMENT EXAMINATION, EXHIBIT A
DEFINITIONS

1. "Company," "you," "your," "your company," and "BCBS" mean each entity to which this Examination is addressed; its parent; and its merged, consolidated, or acquired predecessors, divisions, subsidiaries, and/or affiliates. These terms include any and all directors, officers, equity owners, representatives, employees, agents, attorneys, successors, and assigns of BCBS. The terms also include all natural persons and entities acting or purporting to act for the above, and any predecessor, successor, affiliate, subsidiary or wholly owned or controlled entity. The phrase will be construed to include present and former officers, agents, employees, directors, representatives, consultants, attorneys, associates and all other persons acting or purporting to act for you, and any predecessor, successor, affiliate, or subsidiary entity or person(s), including all present and former officers, agents, employees and all other persons exercising or purporting to exercise discretion, to make policy, or to make decisions.

2. Without limiting the term, a document is deemed to be within your "control" if you have ownership, possession, or custody of the document, or superior right to secure the document or copy of it from any person or public or private entity having physical possession of it.

3. "Any" means all.

4. "Claim" means any health care provider's request for payment for emergency, medical or other health care services, supplies or equipment furnished to an individual patient recipient. For the purposes of the six classes of electronic document claim records requested by Exhibit C, a single claim may have multiple suffixes and claim lines, and each claim line will have multiple fields.

5. "CMS" means Centers for Medicare and Medicaid Services.

6. "Code" means any code, edit and/or modifier used to specify, to sequence or otherwise to describe the services for which the provider is submitting a claim..

7. "Correct Coding Initiative," "CCI" and "NCCI" mean the CMS National Correct Coding Initiative system for codes, edits and modifiers that is utilized nationally by all Medicare carriers in the claims processing systems those Medicare carriers use to determine payments to providers. CMS developed CCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Medicare Part B claims. CMS developed its CCI coding policies based on coding conventions such as those defined in the American Medical Association's (hereafter, "AMA") Current Procedural Terminology ("CPT") manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices and a review of current coding practices.

8. "CPT" code or "CPT code" means any Current Procedural Technology code as defined and licensed by the AMA.

9. "Database" - In addition to its common meaning, the term "database" shall include the terms "data bank" and shall mean and refer to any structured collection of electronic information organized into records or rows, together with all other electronic data whose presence is needed to analyze and view the information in a full and meaningful way. This Examination requests electronic data documentation from your databases and/or data banks that contain information about any and all claims by any health care provider that provides services to your members with all codes and/or programming instructions and other materials necessary to understand and use such electronic data documentation.

10. "Document" means and includes all written, printed, recorded and graphic matter, regardless of authorship, both originals and nonidentical copies, in your possession, custody or control, or known by you to exist, despite whether the writing was intended for or transmitted internally by you, or intended for or transmitted to any other person or entity. It includes communications in words, symbols, pictures, photographs, sounds, films and tapes, and information stored in or accessible through computer or other information storage and retrieval systems, with all codes and/or programming instructions and other materials necessary to understand and use such systems.

11. "Examination" means this Written Notice of Intent (and Request) to Inspect, Examine and Copy Corporate Documents as issued at the direction of the Attorney General pursuant to Art. 1302-5.02 of the Texas Miscellaneous Corporation Laws Act.

12. "HCPCS" means the Health Care Finance Administration (CMS) Common Procedure Coding System for all providers and medical suppliers to code professional services, procedures and supplies for Medicare.

13. "Health Care Provider" includes any "physician" as that term is defined by TEX. INS. CODE Art. 20A.02(r) and also includes any "provider" as that term is defined by TEX. INS. CODE Art. 20A.02(t) as amended by *Act of 1997, 75th Leg., ch. 1026, Sec. 3.*

14. "ICD-9-CM" and "ICD9" code(s) means any International Classification of Diseases-9th revision-Clinical Modification codes used to classify morbidity and mortality information as such codes are approved by the American Hospital Association ("AHA"), CMS and the National Center for Health Care Statistics.

15. "Industry Standard Code(s)" include any and all codes, code edits, modifiers or coding methods as such codes and coding methods are specifically defined, required and/or used for claim submission compliance with the NCCI. Terms and definitions applicable to the NCCI standards may be found at www.hcfa/medlearn/ncci.html. For coding methods not required by CCI or HCPCS, the term "industry standard code(s)" includes, but is not limited to, any and all CPT codes as licensed by the AMA, any and all ICD-9-CM codes as revised and approved by the AHA, CMS, and the National Center for Health Care Statistics.

16. "Member" includes any patient as the term patient is defined at TEX. INS. CODE Art. 21.58A, Section 2(16) (West 2002).

17. "PC Compatible" means an American Standard Code for Information Interchange (hereafter, "ASCII") text file that can be read by a personal computer. Data in each PC compatible file should be fixed width.

18. "Provider" for purposes of this Examination shall have the same meaning as "Health Care Provider" unless otherwise specified.

19. "Relates to," "relating to," "regarding," and "connected to" mean and include any and all information that in any manner or form is relevant in any way to the subject matter in question, including without limitation all information that, directly or indirectly, contains, records, reflects, summarizes, evaluates, refers to, indicates, comments on, or discusses the subject matter, or that in any manner states the background of, or was the basis or were the bases for, or that record, evaluate, comment on, relate to or were referred to, relied on, utilized, generated, transmitted or received in arriving at your conclusion(s), opinion(s), estimate(s), position(s), decision(s), belief(s) or assertion(s) concerning the subject matter in question.

20. "Service(s)" means any emergency, medical or other health care services, procedures, supplies or equipment for which BCBS receives a claim for payment from a health care provider.

HMO DOCUMENT EXAMINATION, EXHIBIT B
INSTRUCTIONS

A. Unless otherwise stated, the scope of this Examination relates to all specified books, data documents and records existing or created at any time during the period from January 1, 2000, to March 28, 2002, related to BCBS's Texas HMO business.

B. The electronic data document files requested in Exhibit C should be produced in PC Compatible format. Each file should be an ASCII text file that can be read by a personal computer. Data in each file should be fixed width. A sample demonstrating how the requested electronic files shall appear when printed in table format is attached as Exhibit D.

C. Any failure to provide document(s) is not acceptable if you can obtain the document(s) from persons reasonably available to you or under your control.

D. In any situation in which it is not clear in which capacity you are responding, you are to designate all relevant capacities.

E. It is your responsibility to clearly designate which, if any, of the documents contain trade secrets according to § 17.61(f) of the TEX. BUS. & COM. CODE.

F. Documents produced shall be complete and not redacted, submitted as originally prepared or as found in your files. You may submit legible copies instead of original documents.

G. Documents should be numbered consecutively and marked with a BCBS or personal identification and a unique consecutive control number.

H. All documents and/or other data compilations that relate to the subject matter of this Examination shall be preserved and any ongoing process of document destruction involving such documents and/or data compilations should cease.

I. Documents responsive to this Examination shall be produced according to the instructions and definitions outlined in Exhibit A, Exhibit B and Exhibit C.

J. This Examination does not request data for Medicare plans. However, the meaning of each term used within Exhibits A, B, and C is to be defined and interpreted consistent with that term's definition as used by CMS, HCPCS and the NCCI. If you believe there is a direct contradiction between the meaning specifically given to a term within Exhibit A, B or C and the meaning given to that term as the term is used by CMS and the NCCI, please notify CPD of such belief and proceed with the understanding that the definition within Exhibit A, B, and C shall control.

K. If BCBS uses a broader definition of any term(s) defined or used within this Examination, please provide a written copy of the broader definition of such term(s).

L. If BCBS does not have the requested information for a specific field of any particular individual record stored within any database, and/or BCBS does not otherwise have access to the requested information for any specific field of the given record, please leave the field blank to indicate that BCBS does not have access to the requested information for the specific field of the particular record produced.

M. As used herein, the words "and" and "or" should be construed either conjunctively or disjunctively as required by the context to bring within the scope of the request any answer, response or document that might be deemed outside its scope by another construction.

N. All currency amounts requested for electronic data document data elements (fields) should be represented as dollars and cents with a plus or minus sign to indicate positive or negative amounts. The plus or minus sign should be the first character in the currency field. Currency amounts should be presented with the next eight digits for dollars and the last two for cents (without a decimal point).

O. All dates for electronic data document data elements (fields) should be mmddyyyy format without spaces, "_", or "/".

P. All text for electronic data document data elements (fields) should be left justified without leading spaces.

Q. Place of service, type of service, CPT codes, and ICD9 codes should be industry standard codes. If industry standard codes are not used (e.g., if there is no applicable industry standard code as the term industry code is defined in Exhibit A), or if the codes used include any variations from industry standard codes, an electronic file containing any and all applicable lookup tables and/or data dictionaries should be provided. The electronic file containing the lookup table(s) and/or data dictionary(ies) shall include each non-industry standard code, each variation from an industry standard code and a description of each. The layout of the lookup table(s) and/or data dictionary(ies) should also be provided in the electronic data file. As with all electronic file copies requested by this Examination, this electronic file should be PC Compatible. Each file should be an ASCII text file that can be read by a personal computer. Data in the electronic data file should be fixed width delimited. The electronic data file produced in response to this Instruction Q should be labeled as responsive to Instruction Q.

HMO DOCUMENT EXAMINATION, EXHIBIT C
Electronic Data Documents

CPD requests the six classes of electronic data documents as follows:

Class 1 Eligibility
Class 2 Authorizations/Referrals
Class 3 Claims/Encounters
Class 4 Capitation
Class 5 Adjudication Rules
Class 6 Check Register

HMO DOCUMENT EXAMINATION, EXHIBIT C

Specific Electronic Data Document Class 1
Eligibility

To assure that BCBS understands the data elements requested regarding Document Class 1, specific instructions and definitions for production of Class 1 documents are detailed below.

Two electronic data document files are requested for each of the 26 (twenty-six) months specified within Class 1 below. For each of the 26 (twenty-six) months, please provide one electronic data file showing eligibility information for each person who was a BCBS member during that month as such information was available to the provider, from BCBS, during that month the service was provided, and one electronic data file showing eligibility for each person who was a BCBS member during that month as eligibility for that month exists with all retroactive additions, deletions and other adjustments incorporated as of March 28, 2002.

Please provide the two separate files for each month showing all members eligible during that month. Please label the 52 separate eligibility files as shown below.

1) Eligibility information as it was available to the provider, from BCBS, during that month. Example: jan2000.txt will contain eligibility information, as it was available to the provider in January of 2000 for members to whom the provider furnished services in January 2000.

Jan2000.txt	Jan2001.txt	Jan2002.txt
Feb2000.txt	Feb2001.txt	Feb2002.txt
Mar2000.txt	Mar2001.txt	
Apr2000.txt	Apr2001.txt	
May2000.txt	May2001.txt	
Jun2000.txt	Jun2001.txt	
Jul2000.txt	Jul2001.txt	
Aug2000.txt	Aug2001.txt	
Sep2000.txt	Sep2001.txt	
Oct2000.txt	Oct2001.txt	
Nov2000.txt	Nov2001.txt	
Dec2000.txt	Dec2001.txt	

2) Eligibility with all retroactive additions, deletions and other adjustments as of March 28, 2002.

Jan2000a.txt	Jan2001a.txt	Jan2002a.txt
Feb2000a.txt	Feb2001a.txt	Feb2002a.txt
Mar2000a.txt	Mar2001a.txt	
Apr2000a.txt	Apr2001a.txt	
May2000a.txt	May2001a.txt	
Jun2000a.txt	Jun2001a.txt	
Jul2000a.txt	Jul2001a.txt	
Aug2000a.txt	Aug2001a.txt	
Sep2000a.txt	Sep2001a.txt	
Oct2000a.txt	Oct2001a.txt	
Nov2000a.txt	Nov2001a.txt	

The following Electronic Data Elements (Fields) are requested for each of the 52 Class 1 Electronic Data Document Files described above:

Name	Description	Data Type	Length
Month	Month eligibility is for	Text	8 (mmddyyyy)
Mbr_id	Member ID	Text	25
Mbr_Age	Member Age on first day of month	Text	4
Mbr_Sex	Member Sex (M, F, U)	Text	2
Mbr_DOB	Member Date of Birth	Text	8 (mmddyyyy)
PCP_last	Primary Care Physician Last Name	Text	25
PCP_first	Primary Care Physician First Name	Text	25
PCP_ID	Primary Care Physician ID	Text	25
CapIPA_ID	ID for IPA/GROUP paid by capitation	Text	25
IPAName	IPA OR GROUP Name	Text	25
Tot_premium	Total Premium	Text	11
PCP_Percent	PCP Percent of Premium	Text	11
Specialist_Percent	Specialist Percent of Premium	Text	11
Facility_percent	Facility percent of Premium	Text	11
Pharmacy_percent	Pharmacy Percent of Premium	Text	11
PCP_adjmbr	PCP adjusted member count	Text	11
Specialist_adjmbr	Specialist adjusted member count	Text	11
Facility_adjmbr	Facility adjusted member count	Text	11
Pharm_adjmbr	Pharmacy adjusted member count	Text	11
Product		Text	25
Plan		Text	25
LOB	Line of Business	Text	25
Benefit	Benefit Set	Text	25
Employer_ID	Employer ID	Text	25
Employer_name	Employer Name	Text	25

HMO DOCUMENT EXAMINATION, EXHIBIT C

Specific Electronic Data Document Class 2
Authorizations/Referrals

To assure that BCBS understands the data elements requested regarding Class 2 Electronic Data Documents, below are specific additional instructions and definitions for production of Class 2 documents.

Authorization Number is the number assigned to any authorization.
Referral Number is the number assigned to any referral.
Provider ID is the BCBS identification number for the provider approved to perform service.
Member ID is the BCBS identification number for the member.
Requested by is the name of the physician requesting the authorization number.
Number of visits authorized is the number of visits approved of as part of the authorization.
Authorization for describes the type of service authorized.
Authorized from date is the first date for which the authorization is valid.
Authorized to date is the last date for which the authorization is valid.
Comments documented comments associated with an authorization.

Please provide one file for each month showing authorizations created during that month.
Please provide 26 separate authorization files labeled as shown below.

Jan00auth.txt	Jan01auth.txt	Jan02auth.txt
Feb00auth.txt	Feb01auth.txt	Feb02auth.txt
Mar00auth.txt	Mar01auth.txt	
Apr00auth.txt	Apr01auth.txt	
May00auth.txt	May01auth.txt	
Jun00auth.txt	Jun01auth.txt	
Jul00auth.txt	Jul01auth.txt	
Aug00auth.txt	Aug01auth.txt	
Sep00auth.txt	Sep01auth.txt	
Oct00auth.txt	Oct01auth.txt	
Nov00auth.txt	Nov01auth.txt	
Dec00auth.txt	Dec01auth.txt	

Each field provided in each Class 2 record should correspond to the authorization number for that record.

The following Electronic Data Elements (Fields) are requested for each record of the 26 Class 2 Electronic Data Document Files described above:

Name	Description	Data Type	Length
Authorization_Nbr	Authorization Number	Text	25
Referral_Nbr	Referral Number	Text	25
Provider_id	Provider Identification Number	Text	25
Member_id	Member Identification Number	Text	25
Requested_by	Requested by	Text	25
Authorization_for	Services approved	Text	255
Visits	Number of visits	Text	3
From_date	First date authorization valid	Text	8 (mmddyyyy)
To_date	Last date authorization valid	Text	8 (mmddyyyy)
Comments	Comments	Text	1024

HMO DOCUMENT EXAMINATION, EXHIBIT C

Specific Electronic Data Document Class 3
Claims/Encounters

To assure that BCBS understands the data elements requested in Electronic Data Document Class 3, below are specific instructions and definitions for production of Class 3 documents.

For purposes of this Electronic Data Document Class 3, the term ***claim*** means ***submitted claims*** and ***encounters***.

It is CPD's understanding that disposition of submitted claims or encounters is dependent upon a number of factors including member eligibility, authorization, covered benefits, co-pay, deductible, co-insurance, applicable fee schedule and provider contracts. A single claim or encounter may have to be re-processed multiple times if errors are made during processing. Each time a claim or encounter is re-processed a new suffix number is assigned to the claim.

Document Class 3 includes both paid and denied claims. There should be one document file for each month showing each claim and each encounter entered during that month. Each of the Class 3 electronic document files should include all encounter information entered that month on each claim and each encounter paid via a capitation contract or delegated claims payment.

Example: Jan00claim.txt should include all claims entered in January 2000 regardless of the date of service or the date paid.

There should be 26 separate Class 3 claims/encounters document files labeled as follows:

Jan00claim.txt	Jan01claim.txt	Jan02claim.txt
Feb00claim.txt	Feb01claim.txt	Feb02claim.txt
Mar00claim.txt	Mar01claim.txt	
Apr00claim.txt	Apr01claim.txt	
May00claim.txt	May01claim.txt	
Jun00claim.txt	Jun01claim.txt	
Jul00claim.txt	Jul01claim.txt	
Aug00claim.txt	Aug01claim.txt	
Sep00claim.txt	Sep01claim.txt	
Oct00claim.txt	Oct01claim.txt	
Nov00claim.txt	Nov01claim.txt	
Dec00claim.txt	Dec01claim.txt	

Each field provided in each Class 3 record should correlate to the claim number, line number and claim suffix for that record.

Below are definitions of data elements (fields) to be included in Class 3 Electronic Data Document Files.

The ***claim number*** is used like an invoice number to track a provider's request for payment.

If a provider performs multiple services for the same patient on the same day, each service is given a separate ***claim line number***. Each time a claim or encounter is re-processed a new ***claim suffix number*** is assigned to the claim. The Class 3 electronic data files should include each ***claim suffix number*** assigned to the claim.

The health plan assigns a unique number to each member (covered life), the ***Member ID***. This number is usually comprised of a subscriber number for the primary insured and a two-digit extension for the family member.

Member Date of Birth is the date when the covered life was born.
Member Age is the age of the member on the date of service.
Employer ID is a unique number assigned by BCBS to identify each BCBS employer contract.
Employer Name is assigned by BCBS to identify the BCBS employer contract.
PCP ID is the unique identification number assigned by BCBS for the Primary Care Physician. A single physician may have multiple ID numbers corresponding to locations, contracts and tax IDs.
PCP Name is the full name of the Primary Care Physician.
PCP Specialty is the Specialty of the Primary Care Physician (General Practice, Family Practice, Internal Medicine, OBGYN).
Place of Service is the industry standard CMS code noting the place where service was performed.
Type of Service is the industry standard CMS code indicating the type of service performed.
Date Admitted is the first day of service for procedures performed over multiple days. (e.g., inpatient stays, observation and rehabilitation).
Date Discharged is the last day of service for procedures performed over multiple days. (e.g., inpatient stays, observation and rehabilitation).
Discharge Status is the patient condition at the point of discharge from an inpatient stay.
ICD91 is the first level code assigned by the physician indicating the patient's diagnosis and/or co-morbid conditions.
ICD92 is the second level code assigned by the physician indicating the patient's diagnosis and/or co-morbid conditions.
ICD93 is the third level code assigned by the physician indicating the patient's diagnosis and/or co-morbid conditions.
ICD94 is the fourth level code assigned by the physician indicating the patient's diagnosis and/or co-morbid conditions.
ICD9 Procedure1 is a code used by some facilities to describe the first multiple procedure performed in conjunction with an inpatient stay.
ICD9 Procedure2 is a code used by some facilities to describe multiple procedures performed in conjunction with an inpatient stay.
ICD9 Procedure3 is a code used by some facilities to describe multiple procedures performed in conjunction with an inpatient stay.
ICD9 Procedure4 is a code used by some facilities to describe multiple procedures performed in conjunction with an inpatient stay.
Modifier 1 is a two-digit code used to describe variations impacting the payment of a CPT or HCPCS code. The modifier is used to indicate that a service or procedure that has been performed has been altered by some specific circumstance, but has not changed in its definition or CPT/HCPCS code.
Modifier 2 is a two-digit code used to describe variations impacting the payment of a CPT/HCPCS code. The modifier is used to indicate that a service or procedure that has been performed has been altered by some specific circumstance, but has not changed in its definition or CPT/HCPCS code.

DRG is a code used to describe procedures performed in conjunction with inpatient care. (Inpatient claims)
RevCode is a code used to describe the revenue codes (e.g., semi-private room) used for inpatient stays. (Inpatient claims)
Quantity is used to indicate multiple prescriptions, tests, injections or procedures.
Unit measure is the unit of measurement applicable to health care services provided in units (e.g., milligrams)
Date Paid is the date claim adjudication was completed.
Date Received is the date the claim was received by BCBS.
Date Entered is the date the claim was entered into the BCBS system.
Check Number is the financial institution issued number on the check supplied to the provider as payment.
Amount Submitted is the amount submitted by the provider as their standard charge for the services provided.
Amount Paid is the amount paid by BCBS to the provider.
Amount Co-pay is the amount paid for the claim by the member(patient) to the provider.
Amount Withhold is the amount that BCBS withholds for possible future payment to the provider if the provider meets given criteria. For contracted providers, this amount should be determined according to the payment terms of BCBS's contract with the provider.
Amount Allowed is the total amount, including co-pays, determined by BCBS as the amount due the provider. For contracted providers, this amount should be determined according to the payment terms of BCBS's contract with the provider.
Capitation Allowed is the total amount, including co-pays, determined by BCBS as the amount BCBS would have paid the provider if the-furnished service was paid as a Fee for Service claim. For contracted providers, this amount should be determined according to the payment terms of BCBS's contract with the provider.
Amount Co-insurance is an amount received by a secondary HMO/insurer that reduces the amount due to the provider from the primary HMO/insurer.
Denial Code is a code assigned by BCBS to indicate why a claim was denied.
Denial Message is a description of why the claim was denied.
Cap or FFS indication of whether a claim was paid asa fee for service claim or capitation encounter.
Fee Schedule Amount is the total amount, including co-pays, corresponding to the fee schedule used by BCBS to pay the claim. For contracted providers, this amount should be determined according to the fee schedule and other payment terms of BCBS contract with the provider. This amount should be determined consistent with member benefits and procedures performed on the date of service.
Provider ID is a unique identification number assigned by BCBS to identify a specific provider, provider contract, tax ID number and location.
Provider First Name is the provider's first name.
Provider Last Name is the provider's last name.
Provider UPIN Number is the number assigned to the provider by CMS.
Provider Federal Tax ID is the provider's federal tax identifier number assigned by the IRS.
Provider State License Number is the number assigned to the provider by the state board of medical examiners.
Provider Specialty is the medical specialty of the provider.
Authorization Number is the number assigned to the authorization.
Entity Processing Claim is the name of the company processing the claim, whether BCBS or a company delegated to pay claims on behalf of BCBS.
Per Diem indication as to whether claim payment is either procedure based (e.g., DRG) or per day (per diem) based.
Code Change indication that the code submitted by the provider has been changed and/or the code paid was different than the code submitted.

Re-Bundled Claim indication that a code(s) submitted on the claim has/have been consolidated and paid as a single procedure, or single set of procedures, instead of paid as separate codes as submitted.

The following Data Elements (Fields) are requested for each record of the 26 Class 3 Electronic Data Document Files deserbed above:

Name	Description	Data Type	Length
Claim_number	Claim Number	Text	25
Line	Claim Line Number	Text	25
Suffix	Claim Suffix	Text	25
Member_ID	Member Identification	Text	25
Member_DOB	Member Date of Birth	Text	8(mmddyyyy)
Member_AGE	Member Age on date of claim	Text	3
Member_sex	Member Sex(M,F,U)	Text	2
Provider_ID	Provider ID	Text	25
Provider_First_Name	Provider first name	Text	25
Provider_Last_Name	Provider last name or company name	Text	25
Provider_specialty	Provider Specialty (AMA Code)	Text	25
Place_of_service	Place of Service	Text	25
Type_of_service	Type of Service	Text	25
Date_of_service	Date of Service	Text	8 (mmddyyyy)
Date_admitted	Date Admitted	Text	8 (mmddyyyy)
Date_discharged	Date Discharged	Text	8 (mmddyyyy)
Discharge_status	Discharge Status	Text	25
ICD91	First ICD9 diagnosis	Text	8
ICD92	Second ICD9 diagnosis	Text	8
ICD93	Third ICD9 diagnosis	Text	8
ICD94	Fourth ICD9 diagnosis	Text	8
ICD9_Procedure1	First ICD9 procedure	Text	8
ICD9_Procedure2	Second ICD9 procedure	Text	8
ICD9_Procedure3	Third ICD9 procedure	Text	8
ICD9_Procedure4	Fourth ICD9 procedure	Text	8
CPT	CPT code (submitted)	Text	10
CPT_paid	CPT code (paid)	Text	10
Modifier1	First modifier	Text	2
Modifier2	Second modifier	Text	2
DRG	DRG	Text	25
Revcode	Revenue Code	Text	5
Quantity	Number of units	Text	5
Unit_measure	Basis unit of measure	Text	25
Authorization_Nbr	Authorization number	Text	25
Date_Paid	Date paid	Text	8 (mmddyyyy)
Amount_Submitted	Amount of claim submitted by provider	Text	11
Date_Received	Date claim received by BCBS	Text	8 (mmddyyyy)

Date_Entered	Date claim entered by BCBS	Text	8 (mmddyyyy)
Check Number	Financial institution issued number of the check that included payment for the claim	Text	25
Amount_ClaimPaid	Amount paid for the claim	Text	11
Amount_Co-pay	Amount co-pay by employee	Text	11
Amount_Withhold	Amount withheld	Text	11
Amount_Deductible	Amount of deductible	Text	11
Amount_Allowed	Amount allowed	Text	11
Amount_Co-ins	Amount paid by secondary carrier	Text	11
Fee_Amount	Fee Schedule amount	Text	11
Denial_code	Code for why claim was denied	Text	25
Denial_message	Description of why claim was denied	Text	255
Product		Text	25
Plan		Text	25
LOB	Line of business	Text	25
Employer_ID	Employer ID	Text	25
Employer	Employer Name	Text	25
PCP_ID	PCP ID	Text	25
PCP_Name	PCP Name	Text	25
PCP_Specialty	PCP Specialty (AMA Code)	Text	25
Provider_UPIN	Provider UPIN number	Text	10
Provider_Tax_ID	Provider federal tax identification	Text	15
Provider_License	Provider Texas license number	Text	25
Entity_processing	Name of Entity that processed claim (e.g. BCBS, name of TPA or delegated entity)	Text	25
Cap_FFS	Is claim paid via capitation or FFS?	Text	4
Code_change	Was/Were code(s) changed between the time of submission and time of claim payment?	Text	2 (Y/N)
Re-Bundled_claim	Was/Were submitted code(s) re-bundled with other claim lines?	Text	2 (Y/N)
Per_Diem	Was claim paid on per diem basis?	Text	2 (Y/N)

HMO DOCUMENT EXAMINATION, EXHIBIT C

Specific Electronic Data Document Class 4
Capitation

To assure that BCBS understands the data elements requested in Document Class 4, below are specific instructions and descriptions for production of Class 4 documents.

It is CPD's understanding that the detail data and documentation used to calculate the monthly capitation payment to the provider for capitated services should include a record for each member (covered life) covered by the capitation payment; the member age/sex/benefits data; any and all other data used to determine the member count, capitation rate (Per Member Per Month); and the actual amount paid. Although capitation and eligibility are related files, eligibility data seldom matches the capitation data or the capitation check amount because they are run at different times.

Two electronic data document capitation files are required for each of the months specified in Class 4 below; one file showing information as it was available to the provider, from BCBS, during that month, and one file showing information as it exists with all retroactive additions, deletions and adjustments incorporated as of March 28, 2002. Each of the two files for a particular month should contain the same data elements for each record.

There should be two separate files for each month showing each member (covered life) for whom the provider(s) was/were paid capitation for that month. The 52 separate files should be labeled as follows:

1) Capitation as it was available to the provider, from BCBS, during that month.
Example: jan2000cap.txt will contain requested capitation information as it was available to the provider, from BCBS, in January of 2000.

Jan2000cap.txt	Jan2001cap.txt	Jan2002cap.txt
Feb2000cap.txt	Feb2001cap.txt	Feb2002cap.txt
Mar2000cap.txt	Mar2001cap.txt	
Apr2000cap.txt	Apr2001cap.txt	
May2000cap.txt	May2001cap.txt	
Jun2000cap.txt	Jun2001cap.txt	
Jul2000cap.txt	Jul2001cap.txt	
Aug2000cap.txt	Aug2001cap.txt	
Sep2000cap.txt	Sep2001cap.txt	
Oct2000cap.txt	Oct2001cap.txt	
Nov2000cap.txt	Nov2001cap.txt	
Dec2000cap.txt	Dec2001cap.txt	

2) Capitation as it exists with all retroactive adjustments as of March 28, 2002.

Jan2000acap.txt	Jan2001acap.txt	Jan2002acap.txt
Feb2000acap.txt	Feb2001acap.txt	Feb2002acap.txt
Mar2000acap.txt	Mar2001acap.txt	
Apr2000acap.txt	Apr2001acap.txt	
May2000acap.txt	May2001acap.txt	
Jun2000acap.txt	Jun2001acap.txt	
Jul2000acap.txt	Jul2001acap.txt	
Aug2000acap.txt	Aug2001acap.txt	
Sep2000acap.txt	Sep2001acap.txt	
Oct2000acap.txt	Oct2001acap.txt	
Nov2000acap.txt	Nov2001acap.txt	
Dec2000acap.txt	Dec2001acap.txt	

Adjusted count – if the capitation amount is adjusted for age/sex/benefit (hereafter, "ASB"), severity, morbidity, or other factors, please include documentation describing how the adjusted count is determined. Also include an electronic file with any look up tables and/or data dictionaries, or similar information, necessary to calculate adjustment to the count and/or the percent of premium payment. The layout of the look up table(s) and/or data dictionary(ies) should also be provided in the electronic file. As with all electronic files requested, this electronic file should be PC Compatible.

The following Data Elements (Fields) are requested for each record of the 52 Class 4 Electronic Data Document Files described above:

Name	Description	Data Type	Length
Month	Month capitation payment is for	Text	8 (mmddyyyy)
Mbr_ID	Member ID	Text	25
Mbr_Age	Member Age on first day of month	Text	3
Mbr_Sex	Member Sex (M, F, U)	Text	2
Mbr_DOB	Member Date of Birth	Text	8 (mmddyyyy)
PCP_ID	Primary Care Physician ID	Text	25
CapIPA_ID	ID for IPA/GROUP paid by capitation	Text	25
IPAName	IPA OR GROUP Name	Text	25
Adjusted_count	see definition and instructions above	Text	8
Retro_add	Record of member added as retro adjustment	Text	2 (Y/N)
Retro_delete	Record of member deleted as retro adjustment	Text	2 (Y/N)
Cap_CheckNbr	Financial institution issued number of check used to pay capitation to each provider	Text	20
Cap_CheckAmt	Amount of Capitation check for month	Text	11
Cap_Date_Paid	Date Capitation check was issued	Text	8 (mmddyyyy)
Product		Text	25
Plan		Text	25
LOB	Line of Business	Text	25
Benefit	Benefit Set	Text	25
Withhold_amt	Amount withheld	Text	11

HMO DOCUMENT EXAMINATION, EXHIBIT C

Specific Electronic Data Document Class 5
Adjudication Logic

For Electronic Data Document Class 5, produce an electronically formatted, PC compatible electronic file copy of any logic or rules used to value or pay claims in any manner other than a direct lookup of the fee schedule amount corresponding to the procedure on: 1) the submitted claim; 2) the provider contract; and 3) the member plan.

This request includes any and all logic and/or other rules:

1. used to process or pay claims submitted for/with multiple procedures, or assistant surgeon(s), or modifiers; or

2. used to upcode, downcode, bundle, or re-bundle claims; or

3. used to process out of area claims; or

4. used to process out of network claims; or

5. used to process and/or calculate rates and/or discounts applied to payment of any particular claim(s).

HMO DOCUMENT EXAMINATION, EXHIBIT C

Specific Computer Based Document Class 6
Check Register

To assure that BCBS understands the data elements requested in document Class 6, below are specific additional instructions and definitions for production of Class 6 documents.

Class 6 requests the Register record of each check issued to an IPA/Group, or other provider, to pay any and all claim(s) for services. This information includes a list of each claim, covered by each check. If a prior claim is reversed or overpaid, and that reversed or overpaid amount is deducted from a check issued to pay another claim(s), the file should include the number(s) of the "Recoup_ClaimNmbr" for the claim being recouped and the "Recoup_ClaimAmt" deducted as recoupment for that particular prior claim(s).

There should be one file for each month with information for each check issued that month to pay any claim(s) or capitation. **Example**: Jan00check.txt should include all checks issued in January 2000 regardless of the date of service.

There should be 26 separate check register files labeled as follows:

Jan00check.txt	Jan01check.txt	Jan02check.txt
Feb00check.txt	Feb01check.txt	Feb02check.txt
Mar00check.txt	Mar01check.txt	
Apr00check.txt	Apr01check.txt	
May00check .txt	May01check.txt	
Jun00check.txt	Jun01check.txt	
Jul00check.txt	Jul01check.txt	
Aug00check.txt	Aug01check.txt	
Sep00check.txt	Sep01check.txt	
Oct00check.txt	Oct01check.txt	
Nov00check.txt	Nov01check.txt	
Dec00check.txt	Dec01check.txt	

Each field provided for each Class 6 record should correlate to the check number for that record.

The following Data Elements (Fields) are requested for each record of the 26 Class 6 Electronic Data Document Files described above:

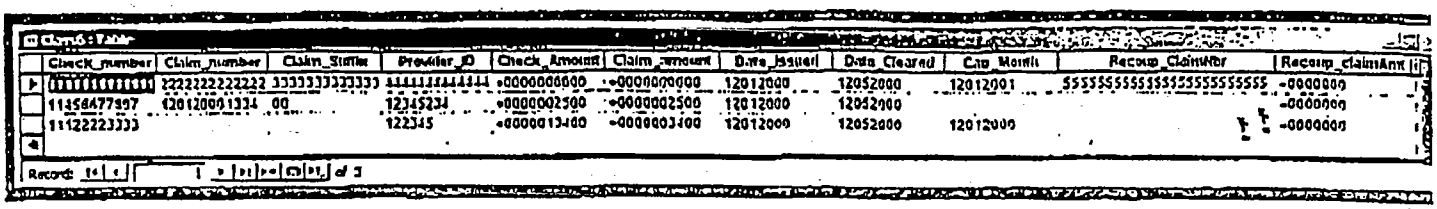
Name	Description	Data Type	Length
Check Number	Financial institution issued number on check	Text	25
Claim_Number	Claim Number	Text	25
Claim_Suffix	Claim Suffix	Text	25
Provider_ID	Provider ID	Text	25
CapIPA_ID	ID for IPA/Group paid by capitation	Text	25
Check_amount	Total amount of check	Text	11
Amount_ClaimPaid	Amount of check applied to the claim number	Text	11
Date Issued	Date check issued	Text	8 (mmddyyyy)
Date Cleared	Date check cleared bank	Text	8 (mmddyyyy)
Cap_Month	Month capitation amount applies to	Text	8 (mmddyyyy)
Recoup_ClaimNbr		Text	25
Recoup_ClaimAmt		Text	11

HMO DOCUMENT EXAMINATION, EXHIBIT D

This sample format indicates how the electronic data files produced for

Exhibit C
Class 6
Check Register

should appear if printed out (in table format) from the electronic data file.



Claim$: Table

Check_number	Claim_number	Claim_Status	Provider_ID	Check_Amount	Claim_amount	Date_Issued	Date_Cleared	Cap_Month	Recomp_ClaimNbr	Recomp_claimAmt
1111111111111	2222222222222	3333333333333	4444444444444	+00000000000	+00000000000	12012000	12052000	12012001	555555555555555555555555	-0000000
11456477997	120120001334	00	12345234	+00000002500	+00000002500	12012000	12052000			-0000000
11122223333			122345	+00000013400	+00000013400	12012000	12052000	12012000		-0000000

Record: 1 of 3

FILE

The Office of the Attorney General
State of Texas
Consumer Protection Division

-TO:	Mike Hull FAX: (512) 494-0022
From:	Robert C. Robinson, III Assistant Attorney General
Company:	Office of the Attorney General
Phone:	(512) 475-4360
FAX:	(512) 322-0578
Date:	March 29, 2002
Pages including this cover:	25

Re: Written Notice of Intent to Inspect, Examine and Copy Corporate Documents pursuant to Art. 1302-5.02 of the Texas Miscellaneous Corporation Laws Act. Issued to Health Care Service Corporation d/b/a Blue Cross and Blue Shield of Texas, for HMO Documents

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION

In the Matter of	)	
	)	Docket No. 9312
North Texas Specialty Physicians,	)	
Respondent	)	

ORDER GRANTING MOTION TO QUASH AND/OR LIMIT SUBPOENA DUCES TECUM

Before the Administrative Law Judge is the Motion to Quash and/or Limit Subpoena Duces Tecum submitted by non-party Blue Cross Blue Shield of Texas. The Administrative Law Judge, having considered the motion and supporting evidence, the response, if any, by Respondent North Texas Specialty Physicians, and the arguments of counsel, finds that the motion should be, and hereby is, GRANTED.

IT IS THEREFORE ORDERED that the Motion to Quash and/or Limit Subpoena Duces Tecum filed by non-party Blue Cross Blue Shield of Texas is granted in all respects, and the Subpoena Duces Tecum is quashed in its entirety.

IT IS FURTHER ORDERED that Respondent North Texas Specialty Physicians shall reimburse Blue Cross Blue Shield of Texas for its attorney's fees and costs incurred in filing the Motion to Quash and/or Limit Subpoena Duces Tecum.

Signed this _____ day of January, 2004.

Honorable D. Michael Chappell
Administrative Law Judge

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION

In the Matter of	)	
	)	Docket No. 9312
North Texas Specialty Physicians,	)	
Respondent	)	

ORDER GRANTING MOTION TO SUPPLEMENT

Before the Administrative Law Judge is the Motion to Supplement filed by non-party Blue Cross Blue Shield of Texas. The Administrative Law Judge finds that the motion should be, and hereby is, GRANTED.

IT IS THEREFORE ORDERED that the Motion to Supplement is granted, and the Affidavit of Rick Haddock attached to the Motion to Supplement, including the Exhibit 1 attached to the affidavit, will be considered in support of the Motion to Quash and/or Limit Subpoena Duces Tecum previously filed by Blue Cross Blue Shield of Texas.

Signed this _____ day of January, 2004.

Honorable D. Michael Chappell
Administrative Law Judge