VERSION NUMBER: 10~~9~~ Date: ~~TBD6/5/17~~2018	
SUPERCEDEDS VERSION NUMBER: 9~~8~~ DATE: 6/5/17~~31/16~~	

CENTER FOR IMPROVING VALUE IN HEALTH CARE (CIVHC)

Colorado All-Payer Claims Database DATA SUBMISSION GUIDE

Version 10 2018~~9 2017~~

REVISION HISTORY

Date	Version	Description	Author
2/2011	A/B	Initial draft; Added section on Data Quality Requirements and added Employer Name to the Eligibility Data File. Added Provider File and Pharmacy Eligibility File, with placeholder for Plan Details File.	A. Graziano
3/1/2011	C/D	General revisions and updates Added section numbering and data elements to insurance plan file. Added decisions reached during payer weekly DSG meeting	A. Graziano
4/27/2011	0	Incorporated decisions reached during payer weekly meetings including a revision to submission timelines, modification to data element definitions	A. Graziano
6/10/2011	0	Final adjustments made based on feedback from Cigna and United Healthcare. Modified timeline for data submission.	A. Graziano
7/14/11	1	Removed elements that are stated in the rule and removed certain data values in several data elements that are not relevant. Included the requirement to filter claims based on CRS 10-16-104(5)(d)(I)	A. Graziano
8/11	2/3/4d	Modified data element types, removed reference to small group plan types and filtering of mental health related claims. Provided definitions for field types. Corrected minor typos throughout the document and clarified the purpose of the header and trailer records. Incorporated decisions reached at the rules hearing on 8/23/11.	A. Graziano
1/22/13	4d	Added IP Procedure Code/Date, Present on Admission (POA), Dental columns, File Naming Convention Updates based on phase 1A and 1B experience.	S. Murphy
1/23/13	5 Draft	Added clarifications to required fields	L. Green
3/11/13	5 Draft	Final DSG approved at rules hearing	T. Campbell
2/14/2014	6 Draft	Added Address two, Provider Telephone Number, Added clarification to required and optional fields.	E. Perry
7/29/2015	7 Draft	Added new fields for the incorporation of self-funded claims.	E. Perry
4/1/2016	8 Draft	Amended the definition of SMG to align with federal regulation.	E. Perry
3/27/2017	9 Draft	Several changes made to fields to improve the comprehensiveness of the data.	E. Perry M. Tahir

Date	Version	Description	Author
5/1/2017	9 Draft	Final DSG 9 approved at rules hearing	E. Perry M. Tahir
5/25/2018	10 Draft	Added provision for the collection of additional data elements including: alternative payment models and prescription rebate information. Also added the collection of Medicare Beneficiary Identifiers and corrected typos.	
8/24/2018	10 Draft	Revisions on new data elements including APM and table B.1.J, corrected typos.	J. Tremaroli

Table of Contents

1.0 DATA SUBMISSION REQUIREMENTS - GENERAL

Data submissions detailed below will include eligibility, medical claims, pharmacy claims, ~~and~~ provider data (Health Care Data), Alternative Payments and Drug Rebates.~~).~~ Field definitions and other relevant data associated with these submissions are specified in Exhibit A. These datasets have been developed by the APCD Council in collaboration with stakeholders across the nation. Refer to APCD Rule 0615 for definitions and other requirements.

Each payer will be required to submit to administrator documentation supporting their standard data extract files that will include a data dictionary mapping internal system data elements to the data elements defined in this DSG. The documentation should include a detailed description of how the data extracts are created and how the requirements of this DSG and the rule are accomplished, including specifications on what data is being excluded and the parameters that define that excluded data.

Any thresholds regarding the number of enrolled lives, as related to payer data submissions (or a payer's third-party administrator or administrative services only organization ("TPA/ASO"), should be calculated by the payer (or its TPA/ASO) on a minimum annual basis, reflecting a 12-month average. The method for calculating any such thresholds, and the results, must be provided in any payer supporting documentation or upon the administrator's request.

1.1 DATA TO BE SUBMITTED

1.1~~2~~.1 MEDICAL CLAIMS DATA

a) Payers shall report health care service paid claims and encounters for all Colorado resident members. Payers may be required to identify encounters corresponding to a capitation payment (Exhibit A-2).
b) A Colorado resident is defined as any eligible member whose residence is within the State of Colorado, and all covered dependents. An exception to this is subscribers covered under a student plan. In this case, any student enrolled in a student plan for a Colorado college/university would be considered a Colorado resident regardless of their address of record.
c) Payers must provide information to identify the type of service and setting in which the service was provided. Each submitted data file shall have control totals and transmission control data as defined in the Header and Trailer Record for each defined file. (see Exhibit A for specifics).

   Claim data is required for submission for each month during which some action has ~~`~~been taken on that claim (i.e. payment, adjustment or other modification). Any claims that have been "soft" denied (denied for incompleteness, being incorrect or for other administrative reasons) which the data supplier expects to be resubmitted upon correction, do not have to be submitted until corrections have been completed and the claim paid. It is desirable that payers provide a reference that links the original claim to all subsequent actions associated with that claim (see Exhibit A-2 for specifics).

d) ICD-9/ICD-10 Diagnosis and Procedure Codes are required to accurately report risk factors related to the Episode of Care. CPT/HCPCS codes are also required.

e) For historical data submitted during the onboarding process, payers shall provide, as a separate report, monthly totals of covered members (Colorado residents) for the periods associated with the Historical Data.

f) Dental Claims: Standalone dental carriers should provide contact information to the Colorado APCD when these rules become effective. The Colorado APCD will notify standalone dental carriers of the process for submitting test files and regular updates. The process will include opportunities to discuss submission requirements prior to due dates.

~~1.~~1.1.2~~.2~~ Pharmacy Claims

a) Health Care Payers must provide data for all pharmacy paid claims for prescriptions that were actually dispensed to members and paid (Exhibit A-3).

b) If your health plan allows for medical coverage without pharmacy (or vice versa), ME018 - ME020 in Exhibit A-1 provides data elements in which such options must be identified in order to effectively and accurately aggregate claims based on Episodes of Care.

c) Claim data is required for submission for each month during which some action has been taken on that claim (i.e. payment, adjustment or other modification).

1.1~~2~~.3 Member Eligibility Data

a) Health Care Payers must provide a data set that contains information on every covered plan member who is a Colorado resident (see paragraph 1.2.1.b above) whether or not the member utilized services during the reporting period. The file must include member identifiers, subscriber name and identifier, member relationship to subscriber, residence, age, race, ethnicity and language, and other required fields to allow retrieval of related information from pharmacy and medical claims data sets (Exhibit A).

b) If dual coverage exists, send coverage of eligible members where payer insurance is primary or tertiary. ME028 is a flag to indicate whether this insurance is primary or tertiary coverage.

1.1~~2~~.4 Provider Data

a) Health Care Payers must provide a data set that contains information on every provider for whom claims were adjudicated during the targeted reporting period.

b) In the event the same provider delivered and was reimbursed for services rendered from two different physical locations, than the provider data file shall contain two separate records for that same provider reflecting each of those physical locations. One record shall be provided for each unique physical location for a provider.

1.2~~3~~ Coordination of Submissions

a) In the event that the health plan contracts with a pharmacy benefits manager or other service entity that manages claims for Colorado residents, the health plan shall be responsible for ensuring that complete and accurate files are submitted to the CO APCD by the subcontractor. The health plan shall ensure that the member identification information on the subcontractor's file(s) is consistent with the member identification information on the health plan's eligibility, medical claims and dental claims files. The health plan shall include utilization and cost information for all services provided to members under any financial arrangement, including subcapitated, bundled and global payment arrangements.

1.3~~4~~ Test, Historical and Partial Year Initial Submission

For payers required to begin submitting files to the CO APCD, the administrator will identify:

(1) the calendar month to be reported in test files;
(2) the specific full calendar years of data to be reported in the historical submission; and
(3) at the administrator's direction, a partial year submission for the current calendar year.

2.0 File Submission Methods

2.1 SFTP - Secure File Transport Protocol involves logging on to the appropriate FTP site and sending or receiving files using the SFTP client.

2.2 Web Upload - This method allows the sending and receiving of files and messages without the installation of additional software. This method requires internet access, a username and password.

3.0 Data Quality Requirements

3.1 The data elements in Exhibit A provide, in addition to field definitions, an indicator regarding data elements that are required. A data element that is required must contain a value unless an override is put in place with a specific payer who is unable to provide that data element due to system limitations. A data element marked as "TH" means that a % of all records must have a value in this field based on the expected frequency that this data element is available. Data files that do not achieve this threshold percentage for that data element may be rejected or require follow up prior to load into the CO

APCD. A data element marked as "O" is an optional data element that should be provided when available, but otherwise may contain a null value.

3.2 Data validation and quality edits will be developed in collaboration with payers and refined as test data and production data is brought into the CO APCD. Data files missing required fields, or when claim line/record line totals don't match, may be rejected on submission. Other data elements will be validated against established ranges as the database is populated and may require manual intervention in order to ensure the data is correct.

The objective is to populate the CO APCD with quality data and each payer will need to work interactively with CIVHC to develop data extracts that achieve validation and quality specifications. This is the purpose of test data submissions early in the implementation process. Overrides may be granted, at the discretion of CIVHC, for data variances that cannot be corrected due to systematic issues that require substantial effort to correct.

4.0 FILE FORMAT

4.1 All files submitted to the CO APCD will be formatted as standard text file.

Text files all comply with the following standards:

a) Always one line item per row; No single line item of data may contain carriage return or line feed characters.
b) All rows delimited by the carriage return + line feed character combination.
c) All fields are variable field length, delimited using the pipe character (ASCII=124). It is imperative that no pipes ('|') appear in the data itself. If your data contains pipes, either remove them or discuss using an alternate delimiter character.
d) Text fields are *never* demarcated or enclosed in single or double quotes. Any quotes detected are regarded as a part of the actual data.
e) The first row *always* contains the names of data columns.
f) Unless otherwise stipulated, numbers (e.g. ID numbers, account numbers, etc.) do not contain spaces, hyphens or other punctuation marks.
g) Text fields are never padded with leading or trailing spaces or tabs.
h) Numeric fields are never padded with leading or trailing zeroes.
i) If a field is not available, or is not applicable, leave it blank. 'Blank' means do not supply any value at all between pipes (including quotes or other characters).

4.2 File Naming Convention - All files submitted to the CO APCD shall have a naming convention developed to facilitate file management without requiring access to the contents.

All files names will follow the template:

TESTorPROD_PayerID_PeriodEndingDateFileTypeVersionNumber.txt

a. Examples
   i. TEST_0000_201606MEv01.txt
   ii. PROD_0000_201606MEv02.txt

- TEST or PROD - TEST for test files; PROD for production files
- PayerID - This is the payer ID assigned to each submitter
- Period ending date expressed as CCYYMM (four-digit calendar year and two-digit month; for example, 201403 indicates a March 2014 end date).
- File Type - Member Eligibility (ME), Medical Claims (MC), Pharmacy Claims (PC), Provider (MP), Specialty Crosswalk(SC), APM File (AM), Control Total (CT), Drug Rebate (DR).~~)~~
- Version number: This is used to differentiate multiple submissions of the same file. This will be important if a file needs to be resubmitted to resolve an issue such as a validation failure. The letter v should be used, followed by two digits, starting with v01. You must include the leading zero. Original submissions of all files should be labeled v01. The Portal will not accept files that have the same name as an existing file.
- File extension (.txt)

5.0 DATA ELEMENT TYPES

date - date data type for dates from 1/1/0001 through 12/31/9999

int - integer (whole number)

decimal/numeric - fixed precision and scale numeric data

char - fixed length non-unicode data with a max of 8,000 characters

varchar - variable length non-unicode data with a maximum of 8,000 characters text - variable length non-unicode data with a maximum of 2^31 -1 characters

year- 4 digit Year for which eligibility is reported in this submission

month- month for which eligibility is reported in this submission expressed numerical from 01 to 12

time- time expressed in military time = HHMM

6.0 DATES FOR DATA SUBMISSION

30 days after the end of the reporting month.

Date That Supplier Must Submit Data to CO APCD	Period Begin date of Paid Claims Data	Period End date of Paid Claims Data	Period Begin date of Eligibility Data	Period End date of Eligibility Data
By March 1	*January 1*	*January 31*	*January 1*	*January 31*
By April1	*February 1*	*February 28/29*	*February 1*	*February 28/29*
By May 1	*March 1*	*March 31*	*March 1*	*March 31*
By June 1	*April 1*	*April 30*	*April 1*	*April 30*
By July 1	*May 1*	*May 31*	*May 1*	*May 31*
By August 1	*June 1*	*June 30*	*June 1*	*June 30*
By September 1	*July 1*	*July 31*	*July 1*	*July 31*
By October 1	*August 1*	*August 31*	*August 1*	*August 31*
By November 1	*September 1*	*September 30*	*September 1*	*September 30*
By December 1	*October 1*	*October 31*	*October 1*	*October 31*
By January 1	*November 1*	*November 30*	*November 1*	*November 31*
By February 1	*December 1*	*December 31*	*December 1*	*December 31*

EXHIBIT A~~A~~ - DATA ELEMENTS

A-1 ELIGIBILITY FOR MEDICAL CLAIMS DATA

Frequency: Monthly Upload via FTP or Web Portal

It is extremely important that the member ID (Member Suffix or Sequence Number) is unique to an individual and that this unique identifier in the eligibility file is consistent with the unique identifier in the medical claims/pharmacy file. This provides linkage between medical and pharmacy claims during established coverage periods and is critical for the implementation of Episode of Care reporting.

For Historic Data collected, eligibility is to be reported for all Colorado residents who were covered members during that reporting month. In the event historical address data is not available, eligibility data for historical months shall be reported based on member's last known or current address. It is acknowledged that for some payers there may not be an eligibility record for each member identified in the medical claims file for that same period. In order to reconcile the total number of Colorado resident covered members for this 3 year period, each payer is to submit a summary report that totals the number of Colorado resident covered members for each month for Historic Data.

Additional formatting requirements:

- Eligibility files are formatted to provide one record per member per month. Member is either the Subscriber or the Subscriber's dependents.
- Data for administration fees, premiums, and capitation fees is contained on the eligibility file is pre-allocated (i.e. broken out by employee by month) to match the eligibility data
- Payers submit data in a single, consistent format for each data type.

MEDICAL ELIGIBILITY FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	ME
HD002	Payer Code	varchar	8	Distributed by CIVHC
HD003	Payer Name	varchar	75	Distributed by CIVHC
HD004	Beginning Month	date	6	CCYYMM
HD005	Ending Month	date	6	CCYYMM
HD006	Record count	int	10	Total number of records submitted in the medical eligibility file, excluding header and trailer records

MEDICAL ELIGIBILITY FILE TRAILER RECORD

Data Element #	Date Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	ME
TR002	Payer Code	varchar	8	Distributed by CIVHC
TR003	Payer Name	varchar	75	Distributed by CIVHC
TR004	Beginning Month	date	6	CCYYMM
TR005	Ending Month	date	6	CCYYMM
TR006	Extraction Date	date	8	CCYYMMDD

A-1.1 MEDICAL ELIGIBILITY FILE

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME001	N/A	Payer Code	varchar	8	Distributed by CIVHC	R
ME002	N/A	Payer Name	varchar	30	Distributed by CIVHC	R
ME003	271/2110C /EB/ /04, 271/2110D /EB/ /04	Insurance Type Code/Product	char	2	See Lookup Table B-1.A	R
ME004	N/A	Year	year~~int~~	4	4 digit Year for which eligibility is reported in this submission	R
ME005	N/A	Month	month~~char~~	2	Month for which eligibility is reported in this submission expressed numerical from 01 to 12.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME006	271/2100C/REF/1L/02, 271/2100C/REF/IG/02, 271/2100C/REF/6P/02, 271/2100D/REF/1L/02, 271/2100D/REF/IG/02, 271/2100D/REF/6P/02	Insured Group or Policy Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber	R
ME007	271/2110C/EB/ /02, 271/2110D/EB/ /02	Coverage Level Code	char	3	See Lookup Table B.1. I	R
ME008	271/2100C/NM1/MI/09	Subscriber Social Security Number	varchar	9	Subscriber’s social security number; Set as null if unavailable	O

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME009	271/2100C/NM1/MI/09	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract number; may~~Set as null if contract number = subscriber's social security number or~~ use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber.	R
ME010	N/A	Member Number	varchar	128	Unique number of the member within the contract. Must be an identifier that is unique to the member. May include a combination of contract number and suffix number in order to be unique. This column is the unique identifying column for membership and related medical and pharmacy claims. Only one record per eligibility month. ME010 = MC009; PC009	R
ME011	271/2100C/NM1/MI/09, 271/2100D/NM1/MI/09	Member Identification Code	varchar	9	Member's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member.	O
ME012	271/2100C/INS/Y/02, 271/2100D/INS/N/02	Individual Relationship Code	char	2	Member's relationship to insured - see Lookup Table B.1.B	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME013	271/2100C /DMG/ /03, 271/2100D /DMG/ /03	Member Gender	char	1	M = Male F = Female U = UNKNOWN	R
ME014	271/2100C /DMG/D8/ 02, 271/2100D /DMG/D8/ 02	Member Date of Birth	date	8	CCYYMMDD	R
ME015	271/2100C /N4/ /01, 271/2100D /N4/ /01	Member City Name of Residence	varchar	30	City name of member residence	R
ME016	271/2100C /N4/ /02, 271/2100D /N4/ /02	Member State or Province	char	2	As defined by the US Postal Service	R
ME017	271/2100C /N4/ /03, 271/2100D /N4/ /03	Member ZIP Code	varchar	11	ZIP Code of member - may include non-US codes. Do not include dash. Plus 4 optional but desired.	R
ME018	N/A	Medical Coverage	char	1	Y = YES N = NO 3 = UNKNOWN	R
ME019	N/A	Prescription Drug Coverage	char	1	Y = YES N = NO 3 = UNKNOWN	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME020	N/A	Dental Coverage	char	1	Y = YES N = NO 3 = UNKNOWN	R
ME123	N/A	Behavioral Health	char	1	Y = YES N = NO 3 = UNKNOWN	R
ME021	N/A	Race 1	varchar	6		O
					R1 American Indian/Alaska Native	
					R2 Asian	
					R3 Black/African American	
					R4 Native Hawaiian or other Pacific Islander	
					R5 White	
					R9 Other Race	
					UNKNOW Unknown/Not Specified	
ME022	N/A	Race 2	varchar	6	See code set for ME021.	O
ME023	N/A	Other Race	varchar	15	List race if MC021 or MC022 are coded as R9.	O
ME024	N/A	Hispanic Indicator	char	1		O
					Y = Patient is Hispanic/Latino/Spanish	
					N = Patient is not Hispanic/Latino/Spanish	
					U = Unknown	
ME025	N/A	Ethnicity 1	varchar	6		O
					2182-4 Cuban	
					2184-0 Dominican	
					2148-5 Mexican, Mexican American, Chicano	

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					2180-8 Puerto Rican	
					2161-8 Salvadoran	
					2155-0 Central American (not otherwise specified)	
					2165-9 South American (not otherwise specified)	
					2060-2 African	
					2058-6 African American	
					AMERCN American	
					2028-9 Asian	
					2029-7 Asian Indian	
					BRAZIL Brazilian	
					2033-9 Cambodian	
					CVERDN Cape Verdean	
					CARIBI Caribbean Island	
					2034-7 Chinese	
					2169-1 Columbian	
					2108-9 European	
					2036-2 Filipino	
					2157-6 Guatemalan	
					2071-9 Haitian	
					2158-4 Honduran	
					2039-6 Japanese	
					2040-4 Korean	
					2041-2 Laotian	
					2118-8 Middle Eastern	
					PORTUG Portuguese	

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					RUSSIA Russian	
					EASTEU Eastern European	
					2047-9 Vietnamese	
					OTHER Other Ethnicity	
					UNKNOW Unknown/Not Specified	
ME026	N/A	Ethnicity 2	varchar	6	See code set for ME025.	O
ME027	N/A	Other Ethnicity	varchar	20	List ethnicity if MC025 or MC026 are coded as OTHER.	O
ME028	N/A	Primary Insurance Indicator	char	1	Y - Yes, primary insurance N - No, secondary or tertiary insurance	R
ME029	N/A	Coverage Type	char	3	This field identifies which entity holds the risk: ASW = Self-funded plans administered by a TPA, where the employer has purchased stop-loss, or group excess insurance coverage ASO = Self-funded plans administered by a TPA, where the employer has not purchased stop-loss, or group excess insurance coverage STN = Short-term, non-renewable health insurance (e.g., COBRA) UND = Plans underwritten by the insurer (fully insured group and individual policies) MEW = Associations/Trusts and Multiple Employer Welfare Arrangements OTH = Any other plan (for example- student health plan). Insurers using this code shall obtain prior approval ---	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME030	N/A	Market Category Code	varchar	4		R
					IND -= policies sold and issued directly to individuals (non-group)	
					LGS -= policies and issued directly to employers having 101 or more employees	
					GSA -= policies sold and issued directly to small employers through a qualified association trust	
					OTH -= policies sold to other types of entities. Insurers using this market code shall obtain prior approval.	
					SGS = Policies sold and issued to employers having 2 - 100 employees	
					MED = Medicare and Retiree products.	
					SFP -= Self-insured plans	
ME032	N/A	Employer Tax ID	varchar	50	Employer tax ID	R for group plans and Self-insured plans
ME043	N/A	Member Street Address	varchar	50	Physical street address of the covered member	R
ME044	N/A	Employer Group Name	varchar	128	Employer Group Name or Name of the Purchaser/Client IND for individual Policies	R
ME101	271/2100C /NM1/ /03	Subscriber Last Name	varchar	128	The subscriber last name	R
ME102	271/2100C /NM1/ /04	Subscriber First Name	varchar	128	The subscriber first name	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME103	271/2100C /NM1/ /05	Subscriber Middle Initial	char	1	The subscriber middle initial	O
ME104	271/2100D /NM1/ /03	Member Last Name	varchar	128	The member last name	R
ME105	271/2100D /NM1/ /04	Member First Name	varchar	128	The member first name	R
ME897	N/A	Plan Effective Date	date	8	CCYYMMDD Date eligibility started for this member under this plan type. The purpose of this data element is to maintain eligibility span for each member.	R
ME045		Exchange Offering	char	1	Identifies whether or not a policy was purchased through the Colorado Health Benefits Exchange (COHBE~~COBHE~~). Y = Commercial small or non-group QHP purchased through the Exchange N = Commercial small or non-group QHP purchased outside the Exchange U = Not applicable (plan/product is not offered in the commercial small or non-group market or grandfathered)	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME106		Group Size	char	1	Code indicating Group Size consistent with Colorado Insurance Law and Regulation A = 1 D = 101+ E = 2 to 100 Required only for plans sold in the commercial large, small and non-group markets. The following plan/products do not need to report this value: Student plans Medicare supplemental Medicaid-funded plans Stand-alone behavioral health Dental Vision	R Required only for plans sold in the commercial large, small and non-group markets.
ME107		Risk Basis	char	1	S = Self-insured F = Fully insured Default to “F” for grandfathered Plans	R
ME108		High Deductible/ Health Savings Account Plan	char	1	Y = Plan is High Deductible/HSA eligible N = Plan is not High Deductible/HSA eligible Default to “N” for grandfathered Plans	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME120		Actuarial Value	decimal	6	Report value as calculated in the most recent version of the HHS Actuarial Value Calculator available at http://cciio.cms.gov/resources/regulations/index.html Size includes decimal point. Required for small group and non-group (individual) plans sold inside or outside the Exchange. Default to “0” for Grandfathered plans	R for plans where ME 106 = A or E; otherwise Optional

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME121		Metallic Value	int	1	Metal Level (percentage of Actuarial Value) per federal regulations. Valid values are: 1 = Platinum 2 = Gold 3 = Silver 4 = Bronze 0 = Not Applicable Required for small group and non-group (individual) plans sold inside or outside the Exchange. Use values provided in the most recent version of the HHS Actuarial Value Calculator available at http://cciio.cms.gov/resources/regulations/index.html Default to “0” for Grandfathered plans	R if coverage is sold in the Small Group Market (ME106 = A or E); otherwise Optional

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME122		Grandfather Status	char	1	See definition of "grandfathered plans" in HHS rules CFR 147.140 Y= Yes N = No Required for small group and non-group (individual) plans sold inside or outside the Exchange.	Required if coverage is sold in the Small Group Market (ME106 = A or E); Otherwise Optional
ME124		PCP NPI	char	10	NPI of Member's PCP NA = if the eligibility does not require a PCP Unknown = if PCP is unknown	R
ME125		Medicare Beneficiary Identifier (MBI)	char	11	Medicare Beneficiary Identifier Required for Medicare, Set as null if unavailable	O
ME126		NAIC ID	char	5	Report the NAIC Code associated with the entity that maintains this product. Leave blank if entity does not have a NAIC Code.	R
ME899	N/A	Record Type	char	2	Value = ME	R

A-2 MEDICAL CLAIMS DATA

Frequency: Monthly Upload via FTP or Web Portal

Additional formatting requirements:

- Claims are paid claims. Non-covered or denied claims (e.g. duplicate or patient ineligible claims) are not included.
- Payers submit data in a single, consistent format for each data type.

MEDICAL CLAIMS FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	MC
HD002	Payer Code	varchar	8	Distributed by CIVHC
HD003	Payer Name	varchar	75	Distributed by CIVHC
HD004	Beginning Month	date	6	CCYYMM
HD005	Ending Month	date	6	CCYYMM
HD006	Record count	int	10	Total number of records submitted in the medical claims file, excluding header and trailer records

MEDICAL CLAIMS FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	MC
TR002	Payer Code	varchar	8	Distributed by CIVHC
TR003	Payer Name	varchar	75	Distributed by CIVHC
TR004	Beginning Month	date	6	CCYYMM
TR005	Ending Month	date	6	CCYYMM
TR006	Extraction Date	date	8	CCYYMMDD

A-2.1 MEDICAL CLAIMS FILE

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC001	N/A	Payer Code	varchar	8	Distributed by CIVHC	R
MC002	N/A	Payer Name	varchar	30	Distributed by CIVHC	R
MC003	837/2000B/SBR/ /09	Insurance Type/Product Code	char	2	See Lookup Table B.1.A	R
MC004	835/2100/CLP/ /07	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system. No partial claims. Only paid (or partially paid) claims	R
MC005	837/2400/LX/ /01	Line Counter	int	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim. All claims must contain a line 1.	R
MC005A	N/A	Version Number	int	4	The version number of this claim service line. The original claim will have a version number of 0, with the next version being assigned a 1, and each subsequent version being incremented by 1 for that service line. Plans that cannot increment this column may opt to use YYMM as the version number.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC006	837/2000B/SBR/ /03	Insured Group or Policy Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber.	R
MC007	835/2100/NM1/34/09	Subscriber Social Security Number	varchar	9	Subscriber's social security number; Set as null if unavailable	O
MC008	835/2100/NM1/HN/09	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract number; may~~Set as null if contract number = subscriber's social security number or~~ use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber.	R
MC009	N/A	Member Number	varchar	128	Unique number of the member within the contract. Must be an identifier that is unique to the member. May include a combination of contract number and suffix number in order to be unique. This column is the unique identifying column for membership and related medical and pharmacy claims. Only one record per eligibility month per Eligibility year. MC009 = ME010; PC009	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC010	835/2100/NM1/MI/0~~8~~9	Member Identification Code (patient)	varchar	9	Member's social security number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member.	O
MC011	837/2000B/SBR/ /02, 837/2000C/PAT/ /01, 837/2320/SBR/ /02	Individual Relationship Code	char	2	Member's relationship to insured - payers will map their available codes to those listed in Lookup Table B.1.B	R
MC012	837/2010CA/DMG/ /03	Member Gender	char	1	M = Male F = Female U = Unknown	R
MC013	837/2010CA/DMG/D8/02	Member Date of Birth	date	8	CCYYMMDD	R
MC014	837/2010CA/N4/ /01	Member City Name of Residence	varchar	30	City name of member of residence	R
MC107		Member Street Address	varchar	50	Physical street address of the covered member	TH
MC015	837/2010CA/N4/ /02	Member State or Province	char	2	As defined by the US Postal Service	R
MC016	837/2010CA/N4/ /03	Member ZIP Code	varchar	11	ZIP Code of member - may include non-US codes. Do not include dash. Plus 4 optional but desired.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC017	N/A	Date Service Approved/Accounts Payable Date/Actual Paid Date	date	8	CCYYMMDD	R
MC018	837/2300/DTP/435/03	Admission Date	date	8	Required for all inpatient claims. CCYYMMDD	O (inpatient claims only)
MC019	837/2300/DTP/435/03	Admission Hour	char	4	Required for all inpatient claims. Time is expressed in military time - HHMM	O (inpatient claims only)
MC020	837/2300/CL1//01	Admission Type	int	1	Required for all inpatient claims (SOURCE: National Uniform Billing Data Element Specifications)	O (inpatient claims only)
					1 Emergency	
					2 Urgent	
					3 Elective	
					4 Newborn	
					5 Trauma Center	
					9 Information not available	
MC021	837/2300/CL1//02	Admission Source	char	1	Required for all inpatient claims (SOURCE: National Uniform Billing Data Element Specifications)	O (inpatient claims only)
MC022	837/2300/DTP/096/03	Discharge Hour	time~~int~~	4	Time expressed in military time = HHMM	R for all inpatient claims O for outpatient

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC023	837/2300/CL1/ /03	Discharge Status	char	2	Required for all inpatient claims. defaults: IP: default ‘00’ = unknown OP: default ‘01’ = home See Lookup Table B.1.C	R for all inpatient claims O for outpatient
MC024	835/2100/NM1/BD/09, 835/2100/NM1/BS/09, 835/2100/NM1/MC/09, 835/2100/NM1/PC/09	Service Provider Number	varchar	30	Payer assigned service provider number. Submit facility for institutional claims; physician or healthcare professional for professional claims.	R
MC025	835/2100/NM1/FI/09	Service Provider Tax ID Number	varchar	10	Federal taxpayer's identification number	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC026	professional: 837/2420A/NM1/XX/09; 837/2310B/NM1/XX/09; institutional: 837/2420A/NM1/XX/09; 837/2420C/NM1/XX/09; 837/2310A/NM1/XX/09	Service National Provider ID	varchar	20	National Provider ID. This data element pertains to the entity or individual directly providing the service.	R
MC027	professional: 837/2420A/NM1/82/02; 837/2310B/NM1/82/02; institutional: 837/2420A/NM1/72/02; 837/2420C/NM1/82/02; 837/2310A/NM1/71/02	Service Provider Entity Type Qualifier	char	1	HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a “person”, and these shall be coded as a person. Health care claims processors shall code according to:	R
					1 Person	
					2 Non-Person Entity	

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC028	professional: 837/2420A/NM1/82/04; 837/2310B/NM1/82/04; institutional: 837/2420A/NM1/72/04; 837/2420C/NM1/82/04; 837/2310A/NM1/71/04	Service Provider First Name	varchar	25	Individual first name. Set to null if provider is a facility or organization.	R
MC029	professional: 837/2420A/NM1/82/05; 837/2310B/NM1/82/05; institutional: 837/2420A/NM1/72/05; 837/2420C/NM1/82/05; 837/2310A/NM1/71/05	Service Provider Middle Name	varchar	25	Individual middle name or initial. Set to null if provider is a facility or organization.	O

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC030	professional: 837/2420A/NM1/82/03; 837/2310B/NM1/82/03; institutional: 837/2420A/NM1/72/03; 837/2420C/NM1/82/03; 837/2310A/NM1/71/03	Service Provider Last Name or Organization Name	varchar	60	Full name of provider organization or last name of individual provider	R
MC031	professional: 837/2420A/NM1/82/07; 837/2310B/NM1/82/07; institutional: 837/2420A/NM1/72/07; 837/2420C/NM1/82/07; 837/2310A/NM1/71/07	Service Provider Suffix	varchar	10	Suffix to individual name. Set to null if provider is a facility or organization. The service provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III), if applicable, rather than the clinician's degree (e.g., MD, LCSW).	O

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC032	professional: 837/2420A/PRV/PE/03; 837/2310B/PRV/PE/03; institutional: 837/2310A/PRV/AT/03	Service Provider Specialty	varchar	10	Prefer CMS specialty or taxonomy codes. Homegrown codes can be used but a lookup is required. A Dictionary for homegrown codes must be supplied during testing.	R
MC108		Service Provider Street Address	varchar	50	Physical practice location street address of the provider administering the services	R
MC033	professional: 837/2420C/N4//01; 837/2310C/N4//01; institutional: 837/2310E/N4//01	Service Provider City Name	varchar	30	City name of provider - preferably practice location	R
MC034	professional: 837/2420C/N4//02; 837/2310C/N4//02; institutional: 837/2310E/N4//02	Service Provider State or Province	char	2	As defined by the US Postal Service	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC035	professional: 837/2420C/N4/ /03; 837/2310C/N4/ /03; institutional: 837/2310E/N4/ /03	Service Provider ZIP Code	varchar	11	ZIP Code of provider - may include non-US codes; do not include dash. Plus 4 optional but desired.	R
MC036	837/2300/CLM/ /05-1	Type of Bill - Institutional	char	3	Required for institutional claims; Not to be used for professional claims See Lookup Table B.1.D	R (institutional claims only)
MC037	837/2300/CLM/ /05-1	Place of Service	char	2	Required for professional claims. Not to be used for institutional claims. Map where you can and default to “99” for all others. See Lookup Table B.1.E	R (professional claims only)
MC038	835/2100/CLP/ /02	Claim Status	char	2	See Lookup Table B.1.F	R
MC039	837/2300/HI/BJ/0~~2~~1-2	Admitting Diagnosis	varchar	7	Required on all inpatient admission claims and encounters. ICD-9-CM or ICD-10-CM. Do not code decimal point.	R- inpatient claims O- outpatient
MC898	N/A	ICD-9 / ICD-10 Flag	char	1	0 This claim contains ICD-9-CM codes 1 This claim contains ICD-10-CM codes The purpose of this field is to identify which code set is being utilized.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC040	837/2300/HI/BN/0~~3~~1-2	E-Code	varchar	7	Describes an injury, poisoning or adverse effect. ICD-9-CM or ICD-10-CM. Do not code decimal point.	O
MC041	837/2300/HI/BK/01-2	Principal Diagnosis	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	R
MC042	837/2300/HI/BF/01-2	Other Diagnosis - 1	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC043	837/2300/HI/BF/02-2	Other Diagnosis - 2	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC044	837/2300/HI/BF/03-2	Other Diagnosis - 3	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC045	837/2300/HI/BF/04-2	Other Diagnosis - 4	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC046	837/2300/HI/BF/05-2	Other Diagnosis - 5	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC047	837/2300/HI/BF/06-2	Other Diagnosis - 6	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC048	837/2300/HI/BF/07-2	Other Diagnosis - 7	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC049	837/2300/HI/BF/08-2	Other Diagnosis - 8	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC050	837/2300/HI/BF/09-2	Other Diagnosis - 9	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC051	837/2300/HI/BF/10-2	Other Diagnosis - 10	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC052	837/2300/HI/BF/11-2	Other Diagnosis - 11	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC053	837/2300/HI/BF/12-2	Other Diagnosis - 12	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC054	835/2110/SVC/NU/01-2	Revenue Code	char	4	National Uniform Billing Committee Codes. Code using leading zeroes, left justified, and four digits.	R for Institutional Claims only, otherwise leave blank
MC055	835/2110/SVC/HC/01-2	Outpatient Procedure Code	varchar	10	Health Care Common Procedural Coding System (HCPCS); this includes the CPT codes of the American Medical Association. Required for Outpatient and Professional claims only.	R for Outpatient and Professional Claims only; otherwise leave blank
MC056	835/2110/SVC/HC/01-3	Procedure Modifier - 1	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. Required for Outpatient and Professional claims only.	R for Outpatient and Professional Claims only; otherwise leave blank

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC057	835/2110/SVC/HC/01-4	Procedure Modifier - 2	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. Required for Outpatient and Professional claims only.	R for Outpatient and Professional Claims only; otherwise leave blank
MC058	835/2110/SVC/ID/01-2	ICD-9-CM or ICD-10 Procedure Code	char	7	Primary procedure code for this line of service. Do not code decimal point. Default to Blank	R for Inpatient Claims only; otherwise leave blank
MC059	835/2110/DTM/150/02	Date of Service - From	date	8	First date of service for this service line. CCYYMMDD	R
MC060	835/2110/DTM/151/02	Date of Service - Thru	date	8	Last date of service for this service line. CCYYMMDD	R
MC061	835/2110/SVC//05	Quantity	dec	12	Count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay. Do code decimal point when applicable.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC062	835/2110/SVC/ /02	Charge Amount	int	10	Do not code decimal point or provide any punctuation where $1,000.00 converted to 100000 Same for all financial data that follows.	R
MC063	835/2110/SVC/ /03	Paid Amount	int	10	Includes any withhold amounts. Do not code decimal point. For capitated claims set to zero.	R
MC064	N/A	Prepaid Amount	int	10	For capitated services, the fee for service equivalent amount. Do not code decimal point.	R
MC065	N/A	Co-pay Amount	int	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.	R
MC066	N/A	Coinsurance Amount	int	10	The dollar amount an individual is responsible for - not the percentage. Do not code decimal point.	R
MC067	N/A	Deductible Amount	int	10	Do not code decimal point.	R
MC068	837/2300/CLM/ /01	Patient Account/Control Number	varchar	20	Number assigned by hospital	O
MC069	N/A	Discharge Date	date	8	Date patient discharged. Required for all inpatient claims. CCYYMMDD	R for all inpatient Claims O for Outpatient
MC070	N/A	Service Provider Country Name	varchar	30	Code US for United States.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC071	837/2300/HI/DR/01-2	DRG	varchar	10	Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to DRGs transmitted from the hospital provider. When the CMS methodology for DRGs is not available, but the DRG system is used, the insurer shall format the DRG and the complexity level within the same field with an “A” prefix, and with a hyphen separating the DRG and the complexity level (e.g. AXXX-XX).	O
MC072	N/A	DRG Version	char	2	Version number of the grouper used	O
MC073	835/2110/REF/APC/02	APC	char	4	Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to APCs transmitted from the health care provider.	O
MC074	N/A	APC Version	char	2	Version number of the grouper used	O
MC075	837/2410/LIN/N4/03	NDC Drug Code	varchar	11	Report the NDC code used only when a medication is paid for as part of a medical claim or when a DME device has an NDC code. J codes should be submitted under procedure code (MC055), and have a procedure code type of ‘HCPCS.	R; Set as null if unavailable

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC076	837/2010AA/NM1 /ID/09	Billing Provider Number	varchar	30	Payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change.	R
MC077	837/2010AA/NM1 /XX/09	National Billing Provider ID	varchar	20	National Provider ID	R
MC078	837/2010AA/NM1 / /03	Billing Provider Last Name or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.	R
MC101	837/2010BA/NM1 / /03	Subscriber Last Name	varchar	128	Subscriber last name	R
MC102	837/2010BA/NM1 / /04	Subscriber First Name	varchar	128	Subscriber first name	R
MC103	837/2010BA/NM1 / /05	Subscriber Middle Initial	char	1	Subscriber middle initial	O
MC104	837/2010CA/NM1 / /03	Member Last Name	varchar	128		R
MC105	837/2010CA/NM1 / /04	Member First Name	varchar	128		R
MC106	837/2010CA/NM1 / /05	Member Middle Initial	char	1		O
MC201A		Present on Admission - PDX	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC201B		Present on Admission - DX1	varchar	1	Code indicating the presence of diagnosis at the time of admission for MC201A See Table B.1.G for valid values.	R if 201A has a value (Inpatient only, otherwise leave blank)
MC201C		Present on Admission - DX2	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201D		Present on Admission - DX3	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201E		Present on Admission - DX4	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201F		Present on Admission - DX5	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC201G		Present on Admission - DX6	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201H		Present on Admission - DX7	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201I		Present on Admission - DX8	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201J		Present on Admission - DX9	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201K		Present on Admission - DX10	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC201L		Present on Admission - DX11	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201M		Present on Admission - DX12	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC202	837D/2400/TOO/02	Tooth Number	char	20	Tooth Number or Letter Identification	R for Dental Claims only
MC203	837D/2400/SV/304 1-5	Dental Quadrant	char	2	Dental Quadrant	R for Dental Claims only
MC204	837D/2400/TOO/03 1 -5	Tooth Surface	char	10	Tooth Surface Identification	R for Dental Claims only
MC205		ICD-9-CM or ICD-10-CM Procedure Date	date	8	Date MC058 was performed	R
MC058A	835/2110/SVC/ID/01-2	ICD-9-CM Procedure Code or ICD-10-CM Procedure code	char	7	Secondary procedure code for this line of service. Do not code decimal point.	R Inpatient only, optional for O/P Default to blank

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC205A		ICD-9-CM or ICD-10-CM Procedure Date	date	8	Date MC058A was performed	R when MC058A is populated Default to blank if not present
MC058B	835/2110/SVC/ID/ 01-2	ICD-9-CM Procedure Code or ICD-10-CM Procedure code	char	7	Secondary procedure code for this line of service. Do not code decimal point.	R Inpatient Only, optional for O/P Default to blank if not present
MC205B		ICD-9-CM or ICD-10-CM Procedure Date	date	8	Date MC058B was performed	R when MC058B is populated Default to blank if not present
MC058C	835/2110/SVC/ID/ 01-2	ICD-9-CM Procedure Code or ICD-10-CM Procedure code	char	7	Secondary procedure code for this line of service. Do not code decimal point.	R Inpatient Only, optional for O/P Default to blank if not present

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC205C		ICD-9-CM or ICD-10-CM Procedure Date	date	8	Date MC058C was performed	R when MC058C is populated Default to blank if not present
MC058D	835/2110/SVC/ID/ 01-2	ICD-9-CM Procedure Code or ICD-10-CM Procedure code	char	7	Secondary procedure code for this line of service. Do not code decimal point.	R Inpatient Only, optional for O/P Default to blank if not present
MC205D		ICD-9-CM or ICD-10-CM Procedure Date	date	8	Date MC058E was performed	R when MC058D is populated Default to blank if not present
MC058E	835/2110/SVC/ID/ 01-2	ICD-9-CM Procedure Code or ICD-10-CM Procedure code	char	7	Secondary procedure code for this line of service. Do not code decimal point.	R Inpatient Only, optional for O/P Default to blank if not present

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC205E		ICD-9-CM or ICD-10-CM Procedure Date	date	8	Date MC058E was performed	R when MC058E is populated Default to blank if not present
MC206	N/A	Capitated Service Indicator	char	1	Y = services are paid under a capitated arrangement N = services are not paid under a capitated arrangement U = unknown	R
MC207		Provider network indicator	char	1	Servicing provider is a participating provider. Y = Yes N = No U = unknown	R
MC208		Self-Funded Claim Indicator	char	1	Y = Yes, Self-Funded claim N = No, Other	R
MC209		Dental Claim Indicator	char	1	Y = Yes, Dental claim N = No, Other	R
MC210		Medicare Beneficiary Identifier (MBI)	char	11	Medicare Beneficiary Identifier Required for Medicare, Set as null if unavailable	O
MC211		NAIC ID	char	5	Report the NAIC Code associated with the entity that maintains this product. Leave blank if entity does not have a NAIC Code.	R
MC899	N/A	Record Type	char	2	Value = MC	

A-3 PHARMACY CLAIMS DATA

Frequency: Monthly Upload via FTP or Web Portal

Additional formatting requirements:

- Payers submit data in a single, consistent format for each data type.

PHARMACY CLAIMS FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	PC
HD002	Payer Code	char	8	Distributed by CIVHC
HD003	Payer Name	char	75	Distributed by CIVHC
HD004	Beginning Month	date	6	CCYYMM
HD005	Ending Month	date	6	CCYYMM
HD006	Record count	int	10	Total number of records submitted in the Pharmacy claims file, excluding header and trailer records

PHARMACY CLAIMS FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	PC
TR002	Payer Code	varchar	8	Distributed by CIVHC
TR003	Payer Name	varchar	75	Distributed by CIVHC
TR004	Beginning Month	date	6	CCYYMM
TR005	Ending Month	date	6	CCYYMM
TR006	Extraction Date	date	8	CCYYMMDD

A-3.1 PHARMACY CLAIMS FILE

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC001	N/A	Payer Code	varchar	8	Distributed by CIVHC	R
PC002	N/A	Payer Name	varchar	30	Distributed by CIVHC	R
PC003	N/A	Insurance Type/Product Code	char	2	See lookup table B.1.A	R
PC004	N/A	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system.	R
PC005	N/A	Line Counter	int	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.	R

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC006	301-C1	Insured Group or Policy Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber	R
PC007	302-C2	Subscriber Social Security Number	varchar	9	Subscriber's social security number; Set as null if unavailable	O
PC008	N/A	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract number; may~~Set as null if contract number = subscriber's social security number or~~ use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber.	R
PC009	303-C3	Member Number	varchar	128	Unique number of the member within the contract. Must be an identifier that is unique to the member. May include a combination of contract number and suffix number in order to be unique. This column is the unique identifying column for membership and related medical and pharmacy claims. Only one record per eligibility month per eligibility year. PC009 = ME010 and MC009	R
PC010	302-C2	Member Identification Code	varchar	128	Member's social security number; Set as null if contract number = subscriber's social security number or use an alternate unique	O

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
					identifier such as Medicaid ID. Must be an identifier that is unique to the member.	
PC011	N/A	Individual Relationship Code	char	2	Member's relationship to insured Use Lookup Table B.1.B	R
PC012	305-C5	Member Gender	char	1	M = Male F = Female U = UNKNOWN	R
PC013	304-C4	Member Date of Birth	Date	8	CCYYMMDD	R
PC014	N/A	Member City Name of Residence	varchar	50	City name of member	R
PC015	N/A	Member State or Province	char	2	As defined by the US Postal Service	R
PC016	N/A	Member ZIP Code	varchar	11	ZIP Code of member - may include non-US codes. Do not include dash. Plus 4 optional but desired.	R
PC017	N/A	Date Service Approved (AP Date)	date	8	CCYYMMDD - date claim paid if available, otherwise set to Date Prescription Filled	R
PC018	201-B1	Pharmacy Number	varchar	30	Payer assigned pharmacy number. AHFS number is acceptable.	O
PC019	N/A	Pharmacy Tax ID Number	varchar	10	Federal taxpayer's identification number coded with no punctuation (carriers that contract with outside PBM's will not have this)	TH
PC020	833-5P	Pharmacy Name	varchar	50	Name of pharmacy	R

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC021	N/A	National Provider ID Number	varchar	20	National Provider ID. This data element pertains to the entity or individual directly providing the service.	R
PC048	N/A	Pharmacy Location Street Address	varchar	50~~30~~	Street address of pharmacy	O
PC022	831-5N	Pharmacy Location City	varchar	30	City name of pharmacy - preferably pharmacy location (if mail order null)	R
PC023	832-5O	Pharmacy Location State	char	2	As defined by the US Postal Service (if mail order null)	R
PC024	835-5R	Pharmacy ZIP Code	varchar	10	ZIP Code of pharmacy - may include non-US codes. Do not include dash. Plus 4 optional but desired (if mail order null)	R
PC024d	N/A	Pharmacy Country Name	varchar	30	Code US for United States	R
PC025	N/A	Claim Status	char	2	See Lookup Table B.1.F	R
PC026	407-D7	NDC Drug Code	varchar	11	NDC Code	R
PC027	516-FG	Drug Name	varchar	80	Text name of drug	R
PC028	403-D3	New Prescription or Refill	varchar	2	Older systems provide only an “N” for new or an “R” for refill, otherwise provide refill #	R
					01 = New prescription	
					02 = Refill	
PC029	425-DP	Generic Drug Indicator	char	2		R
					01 = branded drug	
					02 = generic drug	

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC030	408-D8	Dispense as Written Code	char	1	Please use Table B.1.H	R
PC031	406-D6	Compound Drug Indicator	char	1		O
					N = Non-compound drug	
					Y = Compound drug	
					U = Non-specified drug compound	
PC032	401-D1	Date Prescription Filled	date	8	CCYYMMDD	R
PC033	404-D4	Quantity Dispensed	int	5	Number of metric units of medication dispensed	R
PC034	405-D5	Days Supply	int	4~~3~~	Estimated number of days the prescription will last	R
PC035	804-5B	Charge Amount	int	10	Do not code decimal point or provide any punctuation where $1,000.00 converted to 100000 Same for all financial data that follows.	R
PC036	876-4B	Paid Amount	int	10	Includes all health plan payments and excludes all member payments. Do not code decimal point.	R
PC037	506-F6	Ingredient Cost/List Price	int	10	Cost of the drug dispensed. Do not code decimal point.	R
PC038	428-DS	Postage Amount Claimed	int	10	Do not code decimal point. Not typically captured.	O
PC039	412-DC	Dispensing Fee	int	10	Do not code decimal point.	R

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC040	817-5E	Co-pay Amount	int	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.	R
PC041	N/A	Coinsurance Amount	int	10	The dollar amount an individual is responsible for - not the percentage. Do not code decimal point.	R
PC042	N/A	Deductible Amount	int	10	Do not code decimal point.	R
PC043	N/A	Unassigned			Reserved for assignment	O
PC044	N/A	Prescribing Physician First Name	varchar	25	Physician first name.	O if PC047 is filled with DEA #
PC045	N/A	Prescribing Physician Middle Name	varchar	25	Physician middle name or initial.	O if PC047 is filled with DEA #
PC046	427-DR	Prescribing Physician Last Name	varchar	60	Physician last name	O if PC047 is filled with DEA #; R if PC047 is not filled or contains NPI number

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC047	421-DZ	Prescribing Physician NPI	varchar	20	NPI number for prescribing physician	R
PC049		Member Street Address	varchar	50	Physical street address of the covered member	R
PC101	313-CD	Subscriber Last Name	varchar	128		R
PC102	312-CC	Subscriber First Name	varchar	128		R
PC103	N/A	Subscriber Middle Initial	char	1		O
PC104	311-CB	Member Last Name	varchar	128		R
PC105	310-CA	Member First Name	varchar	128		R
PC106	N/A	Member Middle Initial	char	1		O
PC201	N/A	Version Number	int	4	The version number of this claim service line. The original claim will have a version number of 0, with the next version being assigned a 1, and each subsequent version being incremented by 1 for that service line. Required Default YYMM	R
PC202	N/A	Prescription Written Date	date	8	Date Prescription was written	R
PC047a	421-DZ	Prescribing Physician Provider ID	varchar	30	Provider ID for the prescribing physician	R
PC047b	421-DZ	Prescribing Physician DEA	varchar	20	DEA number for prescribing physician	O
PC050		Medicare Beneficiary Identifier (MBI)	char	11	Medicare Beneficiary Identifier Required for Medicare, set as null if unavailable	O

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC051		NAIC ID	char	5	Report the NAIC Code associated with the entity that maintains this product. For each claim, use the NAIC code of the carrier when a PBM processes claims on behalf of the carrier. Leave blank if entity does not have a NAIC Code.	R
PC899	N/A	Record Type	char	2	PC	R

A-4 Provider Data

Frequency: Monthly Upload via FTP or Web Portal

Additional formatting requirements:

- Payers submit data in a single, consistent format for each data type.
- A provider means a health care facility, health care practitioner, health product manufacturer, health product vendor or pharmacy.
- A billing provider means a provider or other entity that submits claims to health care claims processors for health care services directly or provided to a subscriber or member by a service provider.
- A service provider means the provider who directly performed or provided a health care service to a subscriber of member.
- One record submitted for each provider for each unique physical address.

PROVIDER FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	MP
HD002	Payer Code	varchar	8	Distributed by CIVHC
HD003	Payer Name	varchar	75	Distributed by CIVHC
HD004	Beginning Month	Date	6	CCYYMM (Example: 200801)
HD005	Ending Month	Date	6	CCYYMM (Example: 200812)
HD006	Record count	int	10	Total number of records submitted in the Provider file, excluding header and trailer records

PROVIDER FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	MP
TR002	Payer Code	varchar	8	Distributed by CIVHC
TR003	Payer Name	varchar	75	Distributed by CIVHC
TR004	Beginning Month	date	6	CCYYMM (Example: 200801)
TR005	Ending Month	date	6	CCYYMM (Example: 200812)
TR006	Extraction Date	date	8	CCYYMMDD

A-4.1 PROVIDER FILE

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MP001A	N/A	Payer Code	varchar	8	Distributed by CIVHC	R
MP001B	N/A	Year	year	4	4 digit Year for which the provider is reported in this submission	R
MP001C	N/A	Month	month	2	Month for which the provider is reported in this submission expressed numerical from 01 to 12.	R
MP001	N/A	Provider ID	varchar	30	A unique identifier for the provider as assigned by the reporting entity. Needs to be unique within the MP file. One unique ID Per Provider. May include a unique combination of NPI and tax ID. MP001= MC024, PC047A	R
MP002	N/A	Provider Tax ID	varchar	10	Tax ID of the provider. Do not code punctuation.	R
MP003	N/A	Provider Entity	char	1	F = Facility G = Provider group I = IPA P = Practitioner	R
MP004	N/A	Provider First Name	varchar	25	Individual first name. Set to null if provider is a facility or organization.	R
MP005	N/A	Provider Middle Name or Initial	varchar	25		O

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MP006	N/A	Provider Last Name or Organization Name	varchar	60	Full name of provider organization or last name of individual provider	R
MP007	N/A	Provider Suffix	varchar	10	Example: Jr.; NULL if provider is an organization. Do not use credentials such as MD or PhD	O
MP008	N/A	Provider Specialty	varchar	50	Report the HIPAA-compliant health care provider taxonomy code. Code set is freely available at the National Uniform Claims Committee's web site at http://www.nucc.org/	R
MP009	N/A	Provider Office Street Address	varchar	50	Physical address - address where provider delivers health care services	R
MP010	N/A	Provider Office City	varchar	30	Physical address - address where provider delivers health care services	R
MP011	N/A	Provider Office State	char	2	Physical address - address where provider delivers health care services. Use postal service standard 2 letter abbreviations.	R
MP012	N/A	Provider Office Zip	varchar	11	Physical address - address where provider delivers health care services. Minimum 5 digit code.	R
MP013	N/A	Provider DEA Number	varchar	12		TH
MP014	N/A	Provider NPI	varchar	20		TH

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MP015	N/A	Provider State License Number	varchar	30~~20~~	Prefix with two-character state of licensure with no punctuation. Example COLL12345	TH
MP016	N/A	Provider office Address	varchar	50~~10~~	Physical address - address where provider delivers health care services: Suite number, floor number, Unit number, etc.	O
MP017	N/A	Provider Office phone number	varchar	10	Provider Office number: Telephone number where provider delivers health care services.	O
MP899	N/A	Record Type	char	2	MP	R

A-5 Annual Supplemental Provider Level Alternative Payment Model (APM) Data

Frequency: Annually Upload via SFTP by September 30th of each year

Additional formatting requirements:

Initially, payers shall submit complete and accurate historical data for the most recent three calendar-year periods to the administrator. These submissions must conform to submission guide requirements and be received by no later than 120 days after the effective date of the rule. On a yearly basis thereafter, Payers will transmit complete and accurate APM data for the most recent and complete three calendar-year periods by no later than September 30th of the following year. Please see an example of the timeline below.

Date That Supplier Must Submit APM file to CO APCD	**Period Begin date**	**Period End date**
120 days after the effective date of the rule	*January 1, 2015*	*December 31, 2017*
September 30, 2019	*January 1, 2016*	*December 31, 2018*
September 30, 2020	*January 1, 2017*	*December 31, 2019*
September 30, 2021	*January 1, 2018*	*December 1 2020*
September 30, 2022	*January 1, 2019*	*January 1, 2021*

All definitions for APM types are included in look up table B.1.J

- Payers submit data in a single, consistent format for each data type.
- Include all payments made related to care during the previous calendar year. Payments related to care include:
    - Pay for Performance/Payment Penalty
    - Shared Savings/Shared Risk
    - Global Budget
    - Limited Budget
    - Capitation - Unspecified
    - Bundled/Episode-Based
    - Integrated Delivery System
    - Patient-Centered Medical Home; and
    - Other, Non-FFS

APM File Header Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	AM
HD002	Payer Code	varchar	8	Distributed by CIVHC
HD003	Payer Name	varchar	75	Distributed by CIVHC
HD004	Beginning Month	Date	6	CCYYMM (Example: 200801)
HD005	Ending Month	Date	6	CCYYMM (Example: 200812)
HD006	Record count	int	10	Total number of records submitted in the Provider file, excluding header and trailer records

APM File Trailer Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	AM
TR002	Payer Code	varchar	8	Distributed by CIVHC
TR003	Payer Name	varchar	75	Distributed by CIVHC
TR004	Beginning Month	date	6	CCYYMM (Example: 200801)
TR005	Ending Month	date	6	CCYYMM (Example: 200812)
TR006	Extraction Date	date	8	CCYYMMDD

A 5.1 - APM File

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM001	N/A	Billing Provider Number	varchar	30	Payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. This number should align with billing provider numbers in the MC file.	R
AM002	N/A	National Billing Provider ID	varchar	20	National Provider ID	R
AM003	N/A	Billing Provider Tax ID	Varchar	10	Tax ID of billing provider. Do not code punctuation.	
AM004	N/A	Billing Provider Last Name or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM005	N/A	Billing Provider Entity	Char	1	F = Facility G = Provider group I = IPA P = Practitioner	r
AM006	N/A	Payment Arrangement Category	Text	2	See look up table B.1.J Payment arrangement type reported. If there is more than one payment arrangement type with a billing provider/organization, then separately report each payment arrangement type.	R
AM007	N/A	Performance Period Start Date	Date	8	Effective date of performance period for reported Insurance Line of Business and Payment Arrangement Type. CCYYMMDD If varying performance periods apply to a billing provider or organization (for a particular line of business and payment arrangement type), report results on separate lines.	R
AM008	N/A	Performance Period End Date	Date	8	End date of performance period for reported Insurance Line of Business and Payment. Arrangement Type. CCYYMMDD. If varying performance periods apply to a billing provider or organization (for a particular line of business and payment arrangement type), report results on separate lines.	R
AM009	N/A	Member Months	INT	7	Total number of members in reported stratification that participate in the reported payment arrangement, expressed in months of membership	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					No decimal places; round to nearest integer. Example: 12345	
AM010	N/A	Total Primary Care Claims Payments	INT	12	Sum of all associated claims payments, including patient cost-sharing amounts that pertain to primary care. Primary Care Services are to be identified based on Provider Taxonomy Codes listed in Lookup Table B.1.K and Procedure and Diagnosis Codes listed in Lookup Table B.1.L. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter O if no primary care claims payments made. This value should never exceed the amount of Total Claims Payments (AM010).	R
AM011	N/A	Total Primary Care Non-Claims Payments	INT	12	Sum of all associated non-claims payments that pertain to primary care. Primary Care Services are to be identified based on Provider Taxonomy Codes listed in Lookup Table B.1.K and Procedure and Diagnosis Codes listed in Lookup Table B.1.L. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter O if no primary care non-claims payments made.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					This value should never exceed the amount of Total Non-Claims Payments (AM011).	
AM012	N/A	Total Claims Payments	INT		Sum of all associated claims payments, including patient cost-sharing amounts Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter O if no claims payments made	R
AM013	N/A	Total Non-Claims Payments	INT	12	Sum of all associated non-claims payments Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter O if no non- claims payments made	R
AM014	N/A	Billing Provider Office Street Address	varchar	50	Physical address	R
AM015	N/A	Billing Provider Office City	varchar	30	Physical address	R
AM016	N/A	Billing Provider Office State	char	2	Physical address - Use postal service standard 2 letter abbreviations.	R
AM017	N/A	Billing Provider Office Zip	varchar	11	Physical address - Minimum 5-digit code.	R
AM018	N/A	Billing Provider DEA Number	varchar	12		TH

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM019	N/A	Billing Provider NPI	varchar	20		TH
AM020	N/A	Billing Provider State License Number	varchar	20	Prefix with two-character state of licensure with no punctuation. Example COLL12345	TH
AM021	N/A	Billing Provider office Address	varchar	10	Physical address - Suite number, floor number, Unit number, etc.	O
AM022	N/A	Billing Provider Office phone number	varchar	10	Provider Office number: Telephone number where provider delivers health care services.	O
AM023	N/A	Record Type	char	2	AM	R

A-6 CONTROLS TOTALS FOR ANNUAL SUPPLEMENTAL PROVIDER LEVEL APM SUMMARY

Frequency: Annually Upload via SFTP

Initially, payers shall submit complete and accurate historical data for the most recent three calendar-year periods to the administrator. These submissions must conform to submission guide requirements and be received by no later than 120 days after the effective date of the rule. On a yearly basis thereafter, Payers will transmit complete and accurate historical data for the most recent, complete three calendar-year periods to the administrator that conforms to the submission guide requirements by no later than September 30th of the following year. Please see an example of the timeline below.

Date That Supplier Must Submit file to CO APCD	**Period Begin date**	**Period End date**
120 days after the effective date of the rule	*January 1, 2015*	*December 31, 2017*
September 30, 2019	*January 1, 2016*	*December 31, 2018*
September 30, 2020	*January 1, 2017*	*December 31, 2019*
September 30, 2021	*January 1, 2018*	*December 1, 2020*
September 30, 2022	*January 1, 2019*	*January 1, 2021*

Control Totals File Header Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	AM
HD002	Payer Code	varchar	8	Distributed by CIVHC
HD003	Payer Name	varchar	75	Distributed by CIVHC
HD004	Beginning Month	Date	6	CCYYMM (Example: 200801)
HD005	Ending Month	Date	6	CCYYMM (Example: 200812)
HD006	Record count	int	10	Total number of records submitted in the Provider file, excluding header and trailer records

Control Totals File Trailer Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	AM
TR002	Payer Code	varchar	8	Distributed by CIVHC
TR003	Payer Name	varchar	75	Distributed by CIVHC
TR004	Beginning Month	date	6	CCYYMM (Example: 200801)
TR005	Ending Month	date	6	CCYYMM (Example: 200812)
TR006	Extraction Date	date	8	CCYYMMDD

A 6.1 - APM File Control Record

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
CT001	N/A	Payer Code	varchar	8	Distributed by CIVHC	R
CT002	N/A	Payer Name	varchar	30	Distributed by CIVHC	R
CT003	N/A	Submitted File	Text	60	File name of the APM file	R
CT004	N/A	Data Rows	Numeric	10	Number of data rows in the submitted file	R
CT005	N/A	All Member Months	Numeric	10	Total enrollment during the previous calendar year No decimal places; round to nearest integer. Example: 12345 Enrollment should be reported (in de-duplicated member months) for insurance policies included in annual NAIC/SERFF filings, and should only be reported for those members for whom the mandatory reporter was the primary payer	R
CT006	N/A	Alternative Arrangement Member Months	Numeric	10	Total enrollment in alternative payment arrangements during the previous calendar year No decimal places; round to nearest integer Example: 12345 Enrollment should be reported (in de-duplicated member months) for insurance policies included in annual NAIC/SERFF filings, and should only be	R

					reported for those members for whom the mandatory reporter was the primary payer	
CT007	N/A	Total Primary Care Claims Payments	Numeric	12	Sum of Total Primary Care Claims Payments, as reported in AM file	R
CT008	N/A	Total Primary Care Non-Claims Payments	Numeric	12	Sum of Total Primary Care Non-Claims Payments, as reported in AM file	R
CT009	N/A	Total Claims Payments	Numeric	12	Sum of Total Claims Payments	R
CT010	N/A	Total Non-Claims Payments	Numeric	12	Sum of Total Non-Claims Payments	R
CT011	N/A	Record Type	Char	2	CT	R

A-7 Annual Prescription Drug Rebate Data File

Frequency: Submit annually to CIVHC via email by September 30th of each year. Data should be submitted to Submissions@civhc.org.

Additional formatting requirements:

- Payers submit aggregate level data in a single, consistent format for each data type.
- Include the total amount of any prescription drug rebates and other pharmaceutical manufacturer price concessions paid by pharmaceutical manufacturers to a payer or their pharmacy benefit manager(s) during the previous three calendar years. Data elements to be included in the prescription drug rebate file include:

Initially, payers shall submit complete and accurate historical data for the most recent three calendar-year periods to the administrator. These submissions must conform to submission guide requirements and be received by no later than 120 days after the effective date of the rule. On a yearly basis thereafter, Payers will transmit a complete and accurate Annual Prescription Drug Rebate data file for the most recent, complete three calendar-year periods by no later than September 30th of the following year. Please see an example of the timeline below.

Date That Supplier Must Submit file to CO APCD	**Period Begin date**	**Period End date**
120 days after the effective date of the rule	*January 1, 2015*	*December 31, 2017*
September 30, 2019	*January 1, 2016*	*December 31, 2018*
September 30, 2020	*January 1, 2017*	*December 31, 2019*
September 30, 2021	*January 1, 2018*	*December 1 2020*
September 30, 2022	*January 1, 2019*	*January 1, 2021*

A 7.1 ANNUAL PRESCRIPTION DRUG REBATE DATA

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
DR001	Payer Code	varchar	8	Distributed by CIVHC	R
DR002	Payer Name	varchar	30	Distributed by CIVHC	R
DR003	Insurance Type Code/Product	char	2	See Lookup Table B-1.A	R
DR004	Calendar Year	Year	4	4 digit Year for the most recent calendar year time period reported in this submission	R
DR005	Member population	Int		The population of covered members for all data provided in this data filing. Payers should only include information pertaining to members for which they are the primary payer, and exclude information for members for which they were the secondary or tertiary payer. All Colorado resident members for whom a payer provides primary coverage should be included in the member population, regardless of product or funding type.	R
DR006	Member Months	Int		The number of members receiving primary health insurance coverage by a plan over the specified period of time expressed in months of membership. The member months provided in this field should correspond to the patient population identified in Member Population. All members in the defined member population must be counted in the member month value. Sum of member months. No decimal places; round to nearest integer. Example: 12345	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
DR007	Total Pharmacy Expenditure Amount			The sum of all incurred claim allowed payment amounts to pharmacies for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit in a given calendar year. This amount shall include member cost sharing amounts. This shall also include all incurred claims for individuals included in the member population regardless of where the prescription drugs are dispensed (i.e., includes claims from in-state and out-of-state providers). Claims should be attributed to a calendar year based on the date of fill. (allowed amount should include direct drug costs and exclude non-claim costs. This amount will not reflect prescription drug rebates in any way)	R
DR008	Pharmacy Expenditure Amount: Specialty Drugs			The total expenditure for a specialty drug. Specialty drug expenditure and rebate amounts should be mutually exclusive from non-specialty brand drug and non-specialty generic drug expenditure and rebate amounts. Drug defined as a specialty drug under the terms of a payer's contract with its PBM.	R
DR009	Pharmacy Expenditure Amount: Non-Specialty Brand Drugs			The total expenditure for Non-Specialty Brand Drugs. Non-specialty brand drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty generic drug expenditure and rebate amounts.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				A drug defined as a non-specialty brand drug under the terms of a payer's contract with its PBM.	
DR010	Pharmacy Expenditure Amount: Non-Specialty Generic Drugs			The total expenditure for Non-Specialty Generic Drugs. Non-specialty generic drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty brand drug expenditure and rebate amounts. A drug defined as a non-specialty generic drug under the terms of a payer's contract with its PBM.	R
DR011	Total Prescription Drug Rebate Amount			Total rebates, and other price concessions (including concessions from price protection and hold harmless contract clauses) provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, excluding manufacturer-provided, fair market value, bona fide service fees.	R
DR012	Prescription Drug Rebate Amount: Specialty Drugs			The total rebate amount for all specialty drugs. Specialty drug expenditure and rebate amounts should be mutually exclusive from non-specialty brand drug and non-specialty generic drug expenditure and rebate amounts. Drug defined as a specialty drug under the terms of a payer's contract with its PBM.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
DR013	Prescription Drug Rebate Amount: Non-Specialty Brand Drugs			The total rebate amount for all Non-Specialty Brand Drugs. Non-specialty brand drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty generic drug expenditure and rebate amounts. A drug defined as a non-specialty brand drug under the terms of a payer's contract with its PBM.	R
DR014	Prescription Drug Rebate Amount: Non-Specialty Generic Drugs			The total rebate amount for all Non-Specialty Generic Drugs. Non-specialty generic drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty brand drug expenditure and rebate amounts. A drug defined as a non-specialty generic drug under the terms of a payer's contract with its PBM.	R
DR015	Per Member Per Month Pharmacy Expenditure Amount			Calculated as the Total Pharmacy Expenditure Amount (DR007) divided by Member Months (DR006)	R
DR016	Per Member Per Month Prescription Drug Rebate Amount			Calculated as the Total Prescription Drug Rebate Amount (DR011) divided by Member Months (DR006)	R
DR017	Combined Rebate Identifier			If rebate data is only available to a payer at an aggregated level and cannot be separated to	

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				provide unique information for each of the insurance categories for which the payer has business, the payer shall report data at the most granular level available. In such instances, the payer shall report a separate observation with all required data elements for each insurance category.	
DR018	Comments				O
DR019	Record Type	Char	2	DR	R

EXHIBIT B – LOOKUP TABLES

B.1.A INSURANCE TYPE

12 Preferred Provider Organization (PPO)
13 Point of Service (POS)
15 Indemnity Insurance
16 Health Maintenance Organization (HMO) Medicare Advantage
17 Dental Maintenance Organization (DMO)
CI Commercial Insurance Company
DN Dental
HM Health Maintenance Organization
HN HMO Medicare Risk/ Medicare Part C
MA Medicare Part A
MB Medicare Part B
MC Medicaid
MD Medicare Part D
MP Medicare Primary
QM Qualified Medicare Beneficiary
TV Title V
99 Other
SP Medicare Supplemental (Medi-gap) plan
CP Medicaid CHIP
MS Medicaid Fee for service
MM Medicaid Managed care
CS Commercial Supplemental plan
SF Self-Funded

B.1.B Relationship Codes

01	Spouse
04	Grandfather or Grandmother
05	Grandson or Granddaughter
07	Nephew or Niece
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
19	Child
20	Employee/Self
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
29	Significant Other
32	Mother
33	Father
36	Emancipated Minor
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
53	Life Partner
76	Dependent

B.1.C Discharge Status

01	Discharged to home or self-care
02	Discharged/transferred to another short term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to nursing facility (NF)
05	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a Home IV provider
09	Admitted as an inpatient to this hospital
20	Expired
21	Discharged/transferred to court/law enforcement
30	Still patient or expected to return for outpatient services
40	Expired at home
41	Expired in a medical facility
42	Expired, place unknown
43	Discharged/ transferred to a Federal Hospital
50	Hospice – ~~-~~ home
51	Hospice - medical facility
61	Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital
63	Discharged/transferred to a long-term care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital

66 Discharged/transferred to a Critical Access Hospital (CAH)
69 Discharged/transferred to a designated disaster alternative care site (effective 10/1/13)
70 Discharged/transferred to another type of health care institution not defined elsewhere in this code list
81 Discharged to home or self care with a planned acute care hospital inpatient readmission (effective 10/1/13)
82 Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission (effective 10/1/13)
83 Discharged/transferred to a Skilled Nursing Facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (effective 10/1/13)
84 Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (effective 10/1/13)
85 Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
86 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care with a planned acute care hospital inpatient readmission (effective 10/1/13)
87 Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission (effective 10/1/13)
88 Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission (effective 10/1/13)
89 Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission (effective 10/1/13)
90 Discharged/transferred to an Inpatient Rehabilitation Facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
91 Discharged/transferred to a Medicare Certified Long Term Care Hospital (LTCH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
92 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (effective 10/1/13)
93 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
94 Discharged/transferred to a Critical Access Hospital (CAH) with a planned acute care hospital inpatient readmission (effective 10/1/13)

95 Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission (effective 10/1/13)
OP: default ‘01’ = home
P: default ‘00’ = unknown

B.1.D TYPE OF BILL (INSTITUTIONAL CLAIMS ONLY)

Type of Facility First Digit	Bill Classification (Second digit if first is 1-6)	Bill Classification (Second Digit if First Digit = 7)	Bill Classification (Second Digit if First Digit = 8)	Frequency (Third digit)
1 Hospital	1 Inpatient (Including Medicare Part A)	1 Rural Health	1 Hospice (Non-Hospital Based)	1 admit through discharge
2 Skilled Nursing	2 Inpatient (Medicare Part B Only)	2 Hospital Based or Independent Renal Dialysis Center	2 Hospice (Hospital-Based)	2 interim - first claim used for the…
3 Home Health	3 Outpatient	3 Free Standing Outpatient Rehabilitation Facility (ORF)	3 Ambulatory Surgery Center	3 interim - continuing claims
4 Christian Science Hospital	4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)	5 Comprehensive Outpatient Rehabilitation Facilities (CORFs)	4 Free Standing Birthing Center	4 interim - last claim
5 Christian Science Extended Care	5 Nursing Facility Level I	6 Community Mental Health Center	9 Other	5 late charge only
6 Intermediate Care	6 Nursing Facility Level II	9 Other		7 replacement of prior claim
7 Clinic	7 Intermediate Care - Level III Nursing Facility			8 void/cancel of a prior claim
8 Special Facility	8 Swing Beds			9 final claim for a home

B.1.E Place of Service

01 Pharmacy
02 Tele-health
03 School
04 Homeless Shelter
05 Indian Health Service Free-standing Facility
06 Indian Health Service Provider-based Facility
07 Tribal 638 Free-standing Facility
08 Tribal 638 Provider-based Facility
09 Prison/Correctional Facility
11 Office
12 Home
13 Assisted Living Facility
14 Group Home
15 Mobile Unit
16 Temporary Lodging
17 Walk-in Retail Health Clinic
18 Place of Employment-Worksite
19 Off Campus-Outpatient Hospital
20 Urgent care Facility
21 Inpatient Hospital

22 On Campus-Outpatient Hospital
23 Emergency Room –~~-~~ Hospital
24 Ambulatory Surgery Center
25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
32 Nursing Facility
33 Custodial Care Facility
34 Hospice
41 Ambulance –~~-~~ Land
42 Ambulance - Air or Water
49 Independent Clinic
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
57 Non-residential Substance Abuse Treatment Facility
60 Mass Immunization Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End Stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Unlisted Facility

B.1.F CLAIM STATUS

01	Processed as primary
02	Processed as secondary
03	Processed as tertiary
19	Processed as primary, forwarded to additional payer(s)
20	Processed as secondary, forwarded to additional payer(s)
21	Processed as tertiary, forwarded to additional payer(s)
22	Reversal of previous payment

B.1.G PRESENT ON ADMISSION CODES

POA_Code	POA_Desc
3	Unknown
1	Exempt for POA reporting
E	Exempt for POA reporting
N	Diagnosis was not present at time of inpatient admission
U	Documentation insufficient to determine if condition was present at time of inpatient admission
W	Clinically undetermined
Y	Diagnosis was present at time of inpatient admission

B.1.H Dispense as Written Code

0	Not Dispensed as written
1	Physician dispense as written
2	Member dispense as written
3	Pharmacy dispense as written
4	No generic available
5	Brand dispensed as generic
6	Override
7	Substitution not allowed - brand drug mandated by law
8	Substitution allowed - generic drug not available in marketplace
9	Other

B.1.I Benefit Coverage Level

CHD	Children Only
DEP	Dependents Only
ECH	Employee and Children EMP/CH, EC, EE/CH
EPN	Employee plus N where N equals the number of other covered dependents
ELF	Employee and Life Partner
EMP	Employee Only E, EE, EO
ESP	Employee and Spouse EMP/SP, ES, EE/SP
FAM	Family ESC

IND	Individual
SPC	Spouse and Children
SPO	Spouse Only

B.1.J Alternative Payment Model (APM) Category Definitions

Code	Value	Definition/Example
PP	Pay for Performance/Payment Penalty	Annual payments or penalties made to a billing provider for performance against non-financial goals (quality and utilization metrics) during reporting year.
SH	Shared Savings/Shared Risk	Annual payments or penalties made to the billing provider for performance against spending targets during reporting year.
GB	Global Budget	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for either a: • Comprehensive set of services for a broadly defined population • Defined set of services, where certain benefits such as BH or Rx are carved out and not part of the budget Must, at a minimum, include physician services and IP/OP hospital services.
LB	Limited Budget	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for a non-comprehensive set of services to be delivered by a single provider organization (e.g. capitated primary care or oncology services)
CU	Capitation – Unspecified	Payments made to a billing provider, where the budgets were set either prospectively or retrospectively, for a set of services for a defined population, for which it cannot be determined if the arrangement is a global budget or limited budget arrangement.
BU	Bundled/Episode-Based	Payments made to a billing provider where a set budget was set for a defined episode of care for a specific condition (e.g. knee replacement) delivered by providers across multiple provider types
ID	Integrated Delivery System	One or more legal entities encompassing financing and delivery of a full-spectrum of healthcare services under a mutually exclusive contract agreement. Resources and decision-making rights are shared across entities, and reimbursement is not dependent on services provided.
PC	Patient-Centered Primary Care Home/ Patient-Centered Medical Home	Payment for recognition as a Patient-Centered Primary Care Home (PCPCH) or other type of Patient-Centered Medical Home (PCMH), including recognition under a proprietary PCMH initiative. Only reported for payments exclusively for PCPCH or other PCMH recognition. FFS, pay-for-performance, shared savings, and capitation

Code	Value	Definition/Example
		payments made for members in a PCPCH or other PCMH should be reported under those payment arrangement categories.
OT	Other, Non-FFS	All other payments made to a billing provider which are not based on a FFS model, including payments for health information technology structural changes; payments or expenses for supplemental staff or supplemental activities integrated into the practice, such as practice coaches, patient educators, or patient navigators; and other infrastructure payments.
FS	FFS	Payments made to a billing provider under a traditional fee-for-service model, where each service rendered to a patient is separately reimbursed. FFS includes: Diagnosis Related Groups (DRGs), per-diem payments, fixed procedure code-based fee schedule (e.g. Medicare's Ambulatory Payment Classifications (APCs), claims-based payments adjusted by performance measures, and discounted charges-based payments.

B.1.K Primary Care Provider Taxonomy Codes

Taxonomy code	Description
261QF0400X	Federally Qualified Health Center
261QP2300X	Primary care clinic
261QR1300X	Rural Health Center
207Q00000X	Physician, family medicine
207R00000X	Physician, general internal medicine
175F00000X	Naturopathic medicine
208000000X	Physician, pediatrics
2084P0800X	Physician, general psychiatry
2084P0804X	Physician, child and adolescent psychiatry
207V00000X	Physician, obstetrics and gynecology
207VG0400X	Physician, gynecology

208D00000X	Physician, general practice
363L00000X	Nurse practitioner
363LA2200X	Nurse practitioner, adult health
363LF0000X	Nurse practitioner, family
363LP0200X	Nurse practitioner, pediatrics
363LP0808X	Nurse practitioner, psychiatric
363LP2300X	Nurse practitioner, primary care
363LW0102X	Nurse practitioner, women's health
363LX0001X	Nurse practitioner, obstetrics and gynecology
363A00000X	Physician's assistant
363AM0700X	Physician's assistant, medical
207RG0300X	Physician, geriatric medicine
175L00000X	Homeopathic medicine
2083P0500X	Physician, preventive medicine
364S00000X	Certified clinical nurse specialist
163W00000X	Nurse, non-practitioner

B.1.L Primary Care Procedure and Diagnosis Codes

CPT Codes	Description
99205	Office or outpatient visit for a new patient
99211-99215	Office or outpatient visit for an established patient
99241-99245	Office or other outpatient consultations
99341-99345	Home visit for a new patient
99347-99350	Home visit for an established patient
99381-99385	Preventive medicine initial evaluation
99391-99395	Preventive medicine periodic reevaluation
99401-99404	Preventive medicine counsel and/or risk reduction intervention
99411-99412	Group prev. medicine counsel and/or risk reduction intervention
99420	Administration and interpretation of health risk assessments
99429	Unlisted preventive medicine service
59400	Routine obstetric care incl. vaginal delivery
59510	Routine obstetric care incl. cesarean delivery
59610	Routine obstetric care incl. VBAC delivery
59618	Routine obs. care incl. attempted VBAC
90460-90461	Immunization through age 18, including provider consult
90471-90472	Immunization by injection
90473-90474	Immunization by oral or intranasal route
99386-99387	Initial preventive medicine evaluation
99396-99397	Periodic preventive medicine reevaluation
G0402	Welcome to Medicare visit
G0438-G4039	Annual wellness visit
T1015	Clinic visit, all-inclusive

Primary ICD-10 code	Description
Z00	Encounter for general exam w/o complaint, susp or reprtd dx
Z000	Encounter for general adult medical examination
Z0000	Encounter for general adult medical exam w/o abnormal findings
Z0001	Encounter for general adult medical exam w abnormal findings
Z001	Encounter for newborn, infant and child health examinations
Z0011	Newborn health examination
Z00110	Health examination for newborn under 8 days old
Z00111	Health examination for newborn 8 to 28 days old
Z0012	Encounter for routine child health examination
Z00121	Encounter for routine child health exam w abnormal findings
Z00129	Encounter for routine child health exam w/o abnormal findings
Z008	Encounter for other general examination
Z014	Encounter for gynecological examination
Z0141	Encounter for routine gynecological examination
Z01411	Encounter for gyn exam (general) (routine) w abnormal findings
Z01419	Encounter for gyn exam (general) (routine) w/o abn findings