Title of Rule:	Revision to the Executive Director of Health Care Policy and Financing Rule Concerning the All-Payer Claims Database, 10 CCR 2505-5, Sections 1.200.1, 1.200.2 1.200.3
Rule Number:	ED 15-02-11-A
Division / Contact / Phone:	Health Care Policy and Financing/Health Information Office/Joel Dalzell/303-720-2095, CIVHC-Tracey Campbell/ 720-242-7683

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

Currently, only fully insured and Public payers are submitting data to the CO APCD.
The purpose of this rule is to include additional insured Coloradans in the CO APCD in order to establish a comprehensive resource for all Colorado stakeholders for health care improvement initiates that support the Triple Aim.
This rule changes makes two sets of amendments

1: Update the DSG with a new version for housekeeping changes to align with carrier claims data and to improve provider claims identification and to allow for the inclusion of Self-funded Employer-sponsored health plan submissions.

2: Self-insured employer-sponsored health plans will be added to the definition of "private payer" and required to submit monthly files in the same format as fully insured companies. The ERISA organizations may opt-out of the claims data submission process for 2015 and 2016 claims submissions. Beginning in 2017 these claims data submissions will become mandatory.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   §25.5-1-108, C.R.S. (2014);

Title of Rule:	Revision to the Executive Director of Health Care Policy and Financing Rule Concerning the All-Payer Claims Database, 10 CCR 2505-5, Sections 1.200.1, 1.200.2 1.200.3
Rule Number:	ED 15-02-11-A
Division / Contact / Phone:	Health Care Policy and Financing/Health Information Office/Joel Dalzell/303-720-2095, CIVHC-Tracey Campbell/ 720-242-7683

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

The revised rule affects "private health care payers" as defined in Section 1.200.1.

This amendment would change the definition of "private health care payer" under 1.200.1 to include "a self-insured employer-sponsored health plan." Additionally, this amendment would change the Data Submission Guide in effect under 1.200.1 to Data Submission Guide version 7, 2015. The amendment will also add Mandatory Data Reporting guidelines for 1.200.3.A, 1.200.3.B. and 1.200.3.C.

The proposed amendment will also add an opt out clause in 1.200.2.B to read as: A private health care payer subject to the provisions of the federal Employee Retirement Income Security Act of 1974, as codified at 29 U.S.C. Chap. 18 (an "ERISA Entity") may opt-out of the data submission otherwise required under this rule for data files related to claims data for calendar years 2015 and 2016 only. To avoid the penalties, as defined at Section 1.200.6, such ERISA Entity, must declare that it has elected to "opt out" from data submission for calendar year 2015, calendar year 2016 or both calendar years' claims data by submitting the opt out form identified by the administrator, or its equivalent, via certified mail sent to the administrator within 160 calendar days after the effective date of this rule. Such ERISA Entity, may revoke its opt out decision at any time, by providing written notice to the administrator.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

CIVHC will work collaboratively with all private health payers to meet the requirements of the revised submission guide, including using the established waiver process to provide a short term relaxed data standard or an extended timeline to submit conforming data. United Health Care provided one question, 4/13/15, regarding the DSG which CIVHC answered 4/14/15.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

The APCD is not state funded; this amendment will have no impact on state appropriations.

Title of Rule:	Revision to the Executive Director of Health Care Policy and Financing Rule Concerning the All-Payer Claims Database, 10 CCR 2505-5, Sections 1.200.1, 1.200.2 1.200.3
Rule Number:	ED 15-02-11-A
Division / Contact / Phone:	Health Care Policy and Financing/Health Information Office/Joel Dalzell/303-720-2095, CIVHC-Tracey Campbell/ 720-242-7683

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   The state will not incur any costs due to action or inaction. The state would benefit from this rule change because the additional information would add to the collaborative understanding of health system performance now underway such as the State Innovation Model (SIM) project and other state based projects.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no other less costly or intrusive strategies to achieve the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   None

1.200 ALL-PAYERS CLAIMS DATABASE

1.200.1 Definitions

"administrator" means the administrator of the APCD appointed by the director of the department.

"APCD" means the Colorado All-Payer Claims Database.

"department" means the Colorado Department of Health Care Policy and Financing.

"director" means the Executive Director of the department.

"eligibility data file" means a file that includes data about a person who receives health care coverage from a payer, according to the requirements contained in the submission guide.

"HIPAA" means the Health Insurance Portability and Accountability Act, .S.C. § 1320d – 1320d-8, and its implementing regulations, 45 C.F.R. Parts 160, 162 and 164, as may be amended.

"historic data" means eligibility data file(s), medical claims data file(s), pharmacy file(s) and provider file(s) for the period commencing January 1, 2009 through December 31, ~~2011.~~ 2014 (except in the case of a self-insured employer-sponsored health plan, in which case, "historic data" shall mean, at minimum, such data file(s) for the period commencing January 1, 2015 through December 31, 2015).

"medical claims data file" means a file that includes data about medical claims and other encounter information, according to the requirements contained in the submission guide.

"payer" means a private health care payer and a public health care payer.

"pharmacy file" means a file that includes data about prescription medications and claims filed by pharmacies, according to the requirements contained in the submission guide.

"private health care payer" means an insurance carrier as defined in C.R.S. § 10-16-102(8) covering an aggregate of 1,000 or more enrolled lives in health coverage plans as defined in CRS 10-16-102(~~22.5~~34).). For purposes, of this regulation, "private health care payer" includes carriers offering health benefits plans under C.R.S. 10-16-102(~~21~~32)(a) and dental, vision, limited benefit health insurance, and short-term limited-duration health insurance. For the purposes of this regulation, a "private health care payer" also means a self-insured employer-sponsored health plan covering an aggregate of 100 or more enrolled lives in Colorado. It does not include a self-insured employer-sponsored health plan, if such health plan is administered by a third-party administrator or administrative services only organization ("TPA/ASO") that services less than an aggregate of 1,000 enrolled lives in Colorado; ~~It does not include~~ carriers offering ~~only~~ accident ~~liability~~ only: credit; benefits for long term care, home health care, community-based care, or any combination thereof under Article 19 of Title 10; disability income insurance; liability insurance including general liability insurance and automobile liability insurance; coverage issued as a supplement to liability insurance; worker's compensation or similar insurance; or automobile medical payment insurance, specified disease, or hospital ~~confinement~~ indemnity and other fixed indemnity insurance.

"provider file" means a file that includes additional information about the individuals and entities that submitted claims that are included in the medical claims file; and is submitted according to the requirements contained in the submission guide.

"public health care payer" means the Colorado Medicaid program established under articles 4, 5 and 6 of title 25.5, C.R.S., the children's basic health plan established under article 8 of title 25.5, C.R.S. and CoverColorado established under part 5 article 8 of title 10, C.R.S.

"submission guide" means the document entitled "Colorado All-Payer Claims Database Data Submission Guide" developed by the administrator that sets forth the required schedules, data file format, record specifications, data elements, definitions, code tables and edit specifications for payer submission of eligibility data files, medical and pharmacy claims data files and provider data files to the APCD dated ~~March~~ June 2015 version ~~6~~7, which document is hereby incorporated by reference.

1.200.2 Reporting Requirements

1.200.2.A Payers shall submit complete and accurate eligibility data files, medical and pharmacy claims data files and provider files to the APCD pursuant to the submission guide. The administrator may amend the submission guide and shall provide notice of the revisions to payers. Any revision to the submission guide will be effective only when incorporated into this rule and issued in compliance with the requirements of C.R.S. § 24-4-103(12.5). Reports submitted 120 days following the effective date of the revision of this rule and the submission guide shall follow the revised submission guide.

1.200.2.B. A private health care payer subject to the provisions of the federal Employee Retirement Income Security Act of 1974, as codified at 29 U.S.C. Chap. 18 (an "ERISA entity") may opt out of the data submission otherwise required under this rule for data files related to claims data for calendar years 2015 and 2016 only. Such ERISA entity must declare that it has elected to "opt out" from (*i.e.*, decline) data submission for calendar year 2015, calendar year 2016 or both calendar years' claims data no later than 120 calendar days after the effective date of this rule. Such declaration shall be deemed effective upon receipt, by the administrator, of the opt out form identified by the administrator, or its equivalent. Such opt out decision may be revoked at any time, by providing written notice to the administrator.

1.200.3 Schedule for Mandatory Data Reporting

1.200.3.A. Payers shall submit a test file of its eligibility data, medical and pharmacy claims data and provider files for a consecutive twelve month period to the administrator by no later than March 31, 2012 or no later than 160 calendar days after the effective date of this rule, whichever is later (unless a payer has chosen to opt out in accordance with section 1.200.2.B, in which case such payer shall submit its test file following the opt out period, as specified by the administrator).

1.200.3.B. Payers shall submit complete and accurate historic data to the administrator that conforms to submission guide requirements by no later than June 30, 2012, or no later than 250 calendar days after the effective date of this rule, whichever is later. This section 1.200.3.B does not apply to a payer that has chosen to opt out in accordance with 1.200.2.B.

1.200.3.C. Payers will transmit complete and accurate eligibility data, medical and pharmacy claims data and provider files covering the period from January 1, 2012 and ending June 30, 2012 to the administrator by no later than August 15, 2012, or for the period as specified by the administrator no later than 305 days after the effective date of this rule, whichever is later (unless a payer has

chosen to opt out in accordance with section 1.200.2.B, in which case such payer shall submit its eligibility data, medical and pharmacy claims data and provider files following the opt out period, as specified by the administrator).

1.200.3.D. On a monthly basis thereafter, payers will transmit complete and accurate monthly eligibility data, medical and pharmacy claims data, and provider files to the administrator. These data files for the period ending July 31, 2012, shall be submitted no later than September 15, 2012, or for the period as specified by the administrator, no later than 305 days after the effective date of this rule, whichever is later (unless a payer has chosen to opt out in accordance with section 1.200.2.B, in which case such payer shall submit its files following the opt out period, as specified by the administrator). For each month thereafter, files shall be submitted no later than ten (10) business days of the second month following the end of the reporting month. Any time extension shall be provided to payers in writing by administrator at least 30 days prior to established deadlines

1.200.4 APCD Reports

1.200.4.A. The administrator shall, at a minimum, issue reports from the APCD data at an aggregate level to describe patterns of incidence and variation of targeted medical conditions, state and regional cost patterns and utilization of services.

1.200.4.B. The APCD reports shall be available to the public on consumer facing websites and shall provide aggregate and summary reports to achieve the purposes of the APCD. Any such reports shall protect patient identity in accordance with HIPAA's standard for the de-identification of protected health information.

1.200.5 Requests for Data and Reports

1.200.5.A. A state agency or private entity engaged in efforts to improve health care or public health outcomes for Colorado residents may request a specialized report from the APCD by submitting to the administrator a written request detailing the purpose of the project, the methodology, the qualifications of the research entity, and by executing a data use agreement, to comply with the requirements of HIPAA.

1.200.5.B. A data release review committee shall review the request and advise the administrator on whether release of the data is consistent with the statutory purpose of the APCD, will contribute to efforts to improve health care for Colorado residents and complies with the requirements of HIPAA. The administrator shall include a representative of a physician organization, hospital organization, non-physician provider organization and a payer organization on the data release review committee.

1.200.5.C. The administrator may charge a reasonable fee to provide the requested data.

1.200.6 Penalties

1.200.6.A. If any payer fails to submit required data to the APCD in a timely basis, or fails to correct submissions rejected because of errors, the administrator shall provide written notice to the payer. The administrator may grant an extension of time for just cause. If the payer fails to provide the required information within thirty days following receipt of said written notice, the administrator shall provide the payer with notice of the failure to report and will notify the director of the payer's failure to report. The director shall assess a penalty of up to $1,000 per week for each week that a payer fails to provide the required data to the APCD up to a maximum penalty

of $50,000. In determining whether to impose a penalty, the director may consider mitigating factors such as the size and sophistication of a payer, the reasons for the failure to report and the detrimental impact upon the public purpose served by the APCD.

1.200.6.B The penalties, as specified in section 1.200.6.A, shall not be levied against any private health care payer that is a self-insured employer-sponsored health plan for data submissions related to claims data for calendar years 2015 and 2016 only, unless such private health care payer is an ERISA entity and willfully neglects to submit an opt out form in accordance with section 1.200.2.B.

1.200.7 Interagency Agreement

1.200.7.A. The director may enter into an Interagency Agreement on behalf of the APCD and the administrator with the Division of Insurance in the Colorado Department of Regulatory Agencies to assist in the enforcement of these regulations and under the Divisions' authority in Title 10 of the Colorado Revised Statues.

1.200.8 Privacy and Confidentiality

1.200.8.A. Pursuant to C.R.S. § 24-72-204(3)(a)(I) medical and other health care data on individual persons is not an open record and the department shall deny any open records request for such information.

1.200.8.B. Certain aggregate and de-identified data reports from the APCD shall be available to the public pursuant to C.R.S. § 25.5-1-204(7) when disclosed in a form and manner that ensures the privacy and security of personal health information in compliance with HIPAA.

1.200.8.C. The administrator shall institute appropriate administrative, physical and technical safeguards to ensure that the APCD, its operations, data collection and storage, and reporting disclosures are in compliance with the requirements of HIPAA. All eligibility claims data and medical claims data shall be transmitted to the APCD and stored by the APCD in a secure manner compliant with HIPAA.

1.200.9 Incorporation by Reference

1.200.9A The rules incorporate by reference (as indicated within) material originally published elsewhere. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department of Health Care Policy and Financing maintains copies of the incorporated texts in their entirety which shall be available for public inspection during regular business hours at:

Colorado Department of Health Care Policy and Financing

Medical Services Board Coordinator

1570 Grant Street

Denver, CO 80203

Copies of material shall be provided by the department, at cost, upon request.

THE FOLLOWING DOCUMENT IS THE APCD DATA SUBMISSION GUIDE THAT WILL BE INCORPORATED BY REFERENCE AS A RESULT OF THIS RULE. IT IS PROVIDED AS SUPPORTING DOCUMENTATION ONLY AND WILL NOT BE SUBMITTED TO THE SECRETARY OF STATE FOR PUBLICATION IN THE CODE OF COLORADO REGULATIONS

CENTER FOR IMPROVING VALUE IN HEALTH CARE (CIVHC)

Colorado All-Payer Claims Database DATA SUBMISSION GUIDE

Version 7 DRAFT ~~6~~
~~March~~ June ~~2014~~2015

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	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
6/29/2015	7		

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). 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

1.2.1 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 (ie payment, adjustment or other modification). Any claims that have been "soft" denied (denied for incompleteness, incorrect or 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. ~~(1/1/2009 through 12/31/2011 2014).~~

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.

1.2.2 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.

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.

1.2.4 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.

1.3 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 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.

a)

1.4 Test, Historical and Partial Year Initial Submission

For payers required to begin submitting files to the 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 a waiver 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 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 each payer and refined as test data and production data is brought into the 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 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. Waivers 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 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 (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 zeros.
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 APCD shall have a naming convention developed to facilitate file management without requiring access to the contents.

All files names will follow the template:

COAPCD_PayerID_TestorProd_EntityAbreviation_SubmisionDate_CoveragePeriodDate.txt

- PayerID – This is the payer ID assigned to each submitter
- TestorProd – Test for test files; Prod for production
- EntityAbbreviation – ME,MC,PC,MP
- SubmissionDate – Date File was produced. This date should be in the YYYYMMDD format.
- CoveragePeriodDate – The coverage period for the transmission. This date should be in the YYYYMMDD format.

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

EXHIBIT 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	YYYYMMDD

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	~~O~~R
ME003	271/2110C /EB/ /04, 271/2110D /EB/ /04	Insurance Type Code/Product	char	2	See Lookup Table B-1.A 2013 changes: Required field; codes added to Lookup Table.	R
ME004	N/A	Year	int	4	4 digit Year for which eligibility is reported in this submission	R
ME005	N/A	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	Benefit coverage level	R
					CHD Children Only	
					DEP Dependents Only	
					ECH Employee and Children	
					EPN Employee plus N where N equals the number of other covered dependents	
					ELF Employee and Life Partner	
					EMP Employee Only	

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					ESP Employee and Spouse	
					FAM Family	
					IND Individual	
					SPC Spouse and Children	
					SPO Spouse Only	
ME008	271/2100C /NM1/MI/ 09	Subscriber Social Security Number	varchar	9	Subscriber's social security number; Set as null if unavailable	O
ME009	271/2100C /NM1/MI/ 09	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract 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 subscriber.	R
ME010	N/A	Member Suffix or Sequence 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. ME-010 = MC-009; ME-010 = PC-009	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME011	271/2100C /NM1/MI/ 09, 271/2100D /NM1/MI/ 09	Member Identification Code	varchar	9	~~Member's social security number; Set as null if contract number = subscriber's~~ 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
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	char	8	YYYYMMDD	R
ME015	271/2100C /N4/ /01, 271/2100D /N4/ /01	Member City Name	varchar	30	City location of member	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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
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	

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					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 MC021or 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	
					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	

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					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	
					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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME029	N/A	Coverage Type	char	3	STN – short-term, non-renewable health insurance (ie COBRA) UND – plans underwritten by the insurer OTH – any other plan. Insurers using this code shall obtain prior approval.	R
ME030	N/A	Market Category Code	varchar	4		~~O~~R
					IND – policies sold and issued directly to individuals (non-group)	
					FCH – policies sold and issued directly to individuals on a franchise basis	
					GS3 – policies sold and issued directly to employers having 50 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.	
					SMG- Policies sold and issued to employers having ~~less than~~ 2 - 50 employees	
					MED- Medicare and Retiree products.	
					SFP – Self-insured plans	

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME032	N/A	Employer Tax ID	varchar	50	Employer tax ID	R for group plans ~~only~~ and Self-insured plans
ME043	N/A	Member Street Address	varchar	50	Street address of member	R
ME044	N/A	Employer Group Name	varchar	128	Employer Group Name or Name of the Purchaser/Client IND for individual Policies	R ~~O~~
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
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	char	8	YYYYMMDD **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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME045		Exchange Offering	char	1	Identifies whether or not a policy was purchased through the Colorado Health Benefits Exchange (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 ~~As of January 1, 2014~~

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME106		Group Size	char	2	Code indicating Group Size consistent with Colorado Insurance Law and Regulation A – 1 B – 2 to 50 C – 51 – 100 D – 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 and 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 ~~as of January 1, 2014~~ 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 B; 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 as of January 1, 2014 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 B); 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 as of January 1, 2014 for small group and non-group (individual) plans sold inside or outside the Exchange. Default to "0" for Grandfathered plans	Required if coverage is sold in the Small Group Market (ME106 = A or B); Otherwise Optional
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	YYYYMMDD

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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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
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; 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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC009	N/A	Member Suffix or Sequence Number	varchar	20	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. MC-009=ME-010; PC-009 MC-009=ME-010; PC-009Unique number of the member within the contract. Must be an identifier that is unique to the member.	R
MC010	835/2100/NM1/MI/089	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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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	char	8	YYYYMMDD	R
MC014	837/2010CA/N4/ /01	Member City Name	varchar	30	City name of member	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. Plus 4 optional but desired.	R
MC017	N/A	Date Service Approved/Accounts Payable Date/Actual Paid Date	char	8	YYYYMMDD	R
MC018	837/2300/DTP/435/ 03	Admission Date	char	8	Required for all inpatient claims. YYYYMMDD	O (inpatient claims only)

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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	int	4	Time expressed in military time – HHMM	~~O~~ R for all inpatient claims O for outpatient ~~(inpatient claims only)~~

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.EC	R for all inpatient claims O for outpatient O (inpatient claims only)
					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	

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					09- Admitted as an inpatient to this hospital	
					20- Expired	
					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	

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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	TH
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.	TH

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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:	TH
					1 Person	
					2 Non-Person Entity	
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.	O

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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
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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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
MC032	professional: 837/2420A/PRV/PE/03; 837/2310B/PRV/PE/03; institutional: 837/2310A/PRV/AT/03	Service Provider Specialty	varchar	10	~~As defined by payer. Dictionary for specialty code values must be supplied during testing~~. 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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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
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.FD	R (institutional claims only)
					Type of Facility – First Digit	
					1 Hospital	
					2 Skilled Nursing	
					3 Home Health	
					4 Christian Science Hospital	
					5 Christian Science Extended Care	
					6 Intermediate Care	
					7 Clinic	
					8 Special Facility	
					Bill Classification – Second Digit if First Digit = 1-6	
					1 Inpatient (Including Medicare Part A)	

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					2- Inpatient (Medicare Part B Only)	
					3- Outpatient	
					4- Other (for hospital referenced diagnostic services or home health not under a plan of treatment)	
					5- Nursing Facility Level I	
					6- Nursing Facility Level II	
					7- Intermediate Care - Level III Nursing Facility	
					8- Swing Beds	
					Bill Classification - Second Digit if First Digit = 7	
					1- Rural Health	
					2- Hospital Based or Independent Renal Dialysis Center	
					3- Free Standing Outpatient Rehabilitation Facility (ORF)	
					5- Comprehensive Outpatient Rehabilitation Facilities (CORFs)	
					6- Community Mental Health Center	
					9- Other	
					Bill Classification - Second Digit if First Digit = 8	
					1- Hospice (Non-Hospital Based)	
					2- Hospice (Hospital-Based)	
					3- Ambulatory Surgery Center	

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					4 Free Standing Birthing Center	
					9 Other	
					Frequency - third digit	
					1 admit through discharge	
					2 interim - first claim used for the…	
					3 interim - continuing claims	
					4 interim - last claim	
					5 late charge only	
					7 replacement of prior claim	
					8 void/cancel of a prior claim	
					9 final claim for a home	
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.GE	R (professional claims only)
-	-	-	-	-	11 Office	
-	-	-	-	-	12 Home	
-	-	-	-	-	21 Inpatient Hospital	
-	-	-	-	-	22 Outpatient Hospital	
-	-	-	-	-	23 Emergency Room - Hospital	
-	-	-	-	-	24 Ambulatory Surgery Center	
-	-	-	-	-	25 Birthing Center	
-	-	-	-	-	26 Military Treatment Facility	
-	-	-	-	-	31 Skilled Nursing Facility	

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
-	-	-	-	-	32 Nursing Facility	
-	-	-	-	-	33 Custodial Care Facility	
-	-	-	-	-	34 Hospice	
-	-	-	-	-	35 Boarding Home	
-	-	-	-	-	41 Ambulance - Land	
-	-	-	-	-	42 Ambulance - Air or Water	
-	-	-	-	-	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	
-	-	-	-	-	50 Federally Qualified Center	
-	-	-	-	-	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	

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
-	-	-	-	-	81 Independent Laboratory	
-	-	-	-	-	99 Other Unlisted Facility	
MC038	835/2100/CLP/ /02	Claim Status	char	2	See Lookup Table B-1.FC	R
MC039	837/2300/HI/BJ/021-2	Admitting Diagnosis	varchar	7	Required on all inpatient admission claims and encounters. ICD-9-CM or ICD-10-CM. Do not code decimal point.	O (inpatient claims and encounters only)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
MC040	837/2300/HI/BN/031-2	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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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
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	10	National Uniform Billing Committee Codes. Code using leading zeroes, left justified, and four digits.	R for Institutional Claims only, otherwise leave blank

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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
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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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. YYYYMMDD	R
MC060	835/2110/DTM/151/02	Date of Service – Thru	Date	8	Last date of service for this service line. YYYYMMDD	R
MC061	835/2110/SVC/ /05	Quantity	int	3	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.	R
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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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. YYYYMMDD	R for all inpatient Claims O for Outpatient ~~O (inpatient claims only)~~
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	Drug Code	varchar	11	An NDC code used only when a medication is paid for as part of a medical claim.	O

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.	TH
MC077	837/2010AA/NM1/XX/09	National Billing Provider ID	varchar	20	National Provider ID	TH
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.	TH
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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC201A		Present on Admission – PDX	Varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B-1. D G for valid values.	R (Inpatient Only, otherwise leave blank)
MC201B		Present on Admission – DX1	Varchar	1	Code indicating the presence of diagnosis at the time of admission for MC201 See Table B-1. D 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. D 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. D 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 D for valid values.	R (Inpatient Only, otherwise leave blank

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC201F		Present on Admission – DX5	Varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B-1. D G for valid values.	R (Inpatient Only, otherwise leave blank
MC201G		Present on Admission – DX6	Varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B-1. D 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. D 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. D 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. D 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. D 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.~~D~~ 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.~~D~~ 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	1	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/0 1-2	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
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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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
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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC207		Provider network indicator	char	1	Servicing provider is a participating provider. Y = Yes N = No U = unknown	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 ~~medical~~ 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	YYYYMMDD

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	PayerName	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
PC006	301-C1	Insured Group 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; 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 ~~Suffix or Sequence~~ Number	varchar	20	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. PC-009= ME-010 and MC-009~~Unique number of the member within the contract. Must be an identifier that is unique to the member.~~	R
PC010	302-C2	Member Identification	varchar	128	Member's social security number; Set as	O

		Code			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.	
PC011	306-C6	Individual Relationship Code	char	2	Member's relationship to insured See 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	YYYYMMDD	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	YYYYMMDD – 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

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	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.FC.	R O
PC026	407-D7	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	
PC030	408-D8	Dispense as Written Code	char	1	Payers able to map available codes to those belowPlease use Table B.1.H	R
					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~~	
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	YYYYMMDD	R
PC033	404-D4	Quantity Dispensed	int	5	Number of metric units of medication dispensed	O
PC034	405-D5	Days Supply	int	3	Estimated number of days the prescription will last	R ~~O~~
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
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
PC047	421-DZ	Prescribing Physician NPI	varchar	20	NPI number for prescribing physician	O
PC049		Member Street Address	varchar	50	Street address of 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	~~O~~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
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 ~~medical eligibility~~ 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	YYYYMMDD

A-4.1 PROVIDER FILE

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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. Unique identified for the provider as assigned by the reporting entity. Needs to be unique within the MP file. One Unique ID Provider. A combination of NPI and tax ID. MP-001= MC-024, PC-047, PC-018, 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

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
MP015	N/A	Provider State License Number	varchar	20	Prefix with two-character state of licensure with no punctuation. Example COLL12345	TH
MP016	N/A	Provider office	Varchar	10	Physical address – address where	O

		Address			provider delivers health care services: Suite number, floor number, Unit number, etc.	
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

B-1 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
~~SP Supplemental Policy~~
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.CE~~E~~ 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
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
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

11 Office
12 Home
20 Urgent care Facility
21 Inpatient Hospital
22 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
35 Boarding Home
41 Ambulance - Land
42 Ambulance - Air or Water
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
50 Federally Qualified Center
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