
UTAH APCD

Utah All-Payer Claims Database DATA SUBMISSION GUIDE

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REVISION HISTORY

| Date | Version | Description | Author |
|------------------|----------------|--------------------------------------|---------------|
| Oct 2013 | A | Initial draft | S. Murphy |
| Oct 2013 | B | Changes based on payer comments | D. Arcilesi |
| Sept 2014 | 2.1 | Incorporated changes approved by HDC | C. Hawley |
| Sept 2015 | 2.2 | Incorporated changes approved by HDC | C. Hawley |
| July 2016 | 3 | Proposed Changes | C Hawley |

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1.0 DATA SUBMISSION REQUIREMENTS - GENERAL

Data submissions detailed below will include eligibility, medical claims, pharmacy claims, and provider data. Field definitions and other relevant data associated with these submissions are specified in Exhibit A. These datasets were based on recommendations from the All-Payer Claims Databased (APCD) Council developed in collaboration with stakeholders across the nation.

1.1 DATA TO BE SUBMITTED

1.1.1 MEDICAL CLAIMS DATA

- a) Payers shall report health care service paid claims and encounters for all Utah resident members. Payers may be required to identify encounters corresponding to a capitated payment (Exhibit A-2).
- b) A Utah resident is defined as any eligible member whose residence is within the State of Utah, 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 Utah college/university would be considered a Utah 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.
- d) 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, 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).
- e) International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10) Diagnosis and Procedure Codes are required to accurately report risk factors related to the Episode of Care. Healthcare Common Procedural Coding System (HCPCS) and Current Procedural Terminology (CPT) codes are also required.
- f) Stand-alone dental carriers should provide contact information to OHCS as required by Utah Administrative Code (UAC) R428 and submit claims in compliance with this manual.

1.1.2 PHARMACY CLAIMS

- a) 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.

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1.1.3 MEMBER ELIGIBILITY DATA

- a) Payers must provide a data set that contains information on every covered plan member who is a Utah resident (see paragraph 1.1.1.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.
- c) As of the date of publication of this document, the Utah Insurance Department's (UID) rule UAC R590-270 requires data suppliers to provide additional information. All data suppliers are encouraged to review this rule for the current requirements.

1.1.4 PROVIDER DATA

- a) Payers must provide a data set that contains information on every health care provider for whom claims were adjudicated during the targeted reporting period.
- b) In the event the same health care provider delivered and was reimbursed for services rendered from two different physical locations, then 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 COORDINATION OF SUBMISSIONS

In the event that the health plan contracts with a pharmacy benefits manager or other service entity that manages claims for Utah 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.

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 percentage 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 be left blank.

- 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 containing mismatched claim line/record line totals 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 the Utah Department of Health (UDOH), Office of Health Care Statistics (OHCS) to develop data extracts that achieve validation and quality specifications. Waivers may be granted, at the discretion of OHCS, 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 files complying 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) 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.

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All file names will follow the template:

UTAPCD_PayerID_TestorProd_EntityAbreviation_SubmisionDate_CoveragePeriodDate.txt

- PayerID – This is the payer ID assigned to each submitter
- TestorProd – Test for test files; Prod for production
- EntityAbreviation – ME, MC, PC, MP (ME – Medical Enrollment, MC – Medical Claims, PC – Pharmacy Claims, MP – Medical Provider)
- 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 claims file. This provides linkage between medical and pharmacy claims during established coverage periods and is critical for the implementation of Episode of Care reporting.

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.
- In order to accurately capture eligibility end dates, payers will submit the previous three months, or a “rolling,” eligibility file monthly. This will provide run out to ensure ME005B is populated with a valid last day of eligibility for all members during the previous three months.
- Payers submit data in a single consistent format for each data type.

A-1.1 MEDICAL ELIGIBILITY FILE

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

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| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---|--------------------------------|---------|--------|---|----------|
| ME001 | N/A | Payer Code | varchar | 8 | Distributed by OHCS | R |
| ME002 | N/A | Payer Name | varchar | 30 | Distributed by OHCS | O |
| 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 | 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 Medicaid Fee for Service will populate this field with the Aid Category Code. | R |
| ME007 | 271/2110C /EB/ /02, 271/2110D /EB/ /02 | Coverage Level Code | char | 3 | Benefit coverage level. See Lookup Table B-1.B | R |
| ME008 | 271/2100C /NM1/MI/09 | Subscriber Social Security Number | varchar | 9 | Subscriber's Social Security Number; Leave blank if unavailable | TH |

| 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; Leave blank 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. This column is the unique identifying column for membership and related medical and pharmacy claims. Only one record per eligibility month. Must match MC009 and PC009. | R |
| ME011 | 271/2100C /NM1/MI/ 09, 271/2100D /NM1/MI/ 09 | Member Identification Code | varchar | 9 | Member's Social Security Number; Leave blank if unavailable. | TH |
| 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.C | R |
| ME013 | 271/2100C /DMG/ /03, 271/2100D /DMG/ /03 | Member Gender | char | 1 | M – Male F – Female U - UNKNOWN | R |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---|-------------------------------|---------|--------|--|----------|
| 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 |
| 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 |
| ME021 | N/A | Race 1 | varchar | 6 | See Lookup Table B-1.D | TH |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|-----------------------------|---------|--------|--|----------|
| ME022 | N/A | Race 2 | varchar | 6 | See Lookup Table B-1.D | TH |
| ME023 | N/A | Other Race | varchar | 15 | List race if MC021or MC022 are coded as R9. | O |
| ME024 | N/A | Hispanic Indicator | char | 1 | Y = Patient is Hispanic/Latino/Spanish N = Patient is not Hispanic/Latino/Spanish U = Unknown | TH |
| ME025 | N/A | Ethnicity 1 | varchar | 6 | See Lookup Table B-1.E | O |
| 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 | 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. AWS – Self-funded | R |
| ME030 | N/A | Market Category Code | varchar | 4 | | TH |
| | | | | | IND – policies sold and issued directly to individuals (non-group) | |
| | | | | | FCH – policies sold and issued directly to individuals on a franchise basis | |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---------------------|---------------------------|---------|--------|--|----------|
| | | | | | 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. | |
| ME032 | N/A | Group Name | varchar | 128 | Group name or IND for individual policies | O |
| ME043 | N/A | Member Street Address | varchar | 50 | Street address of member | R |
| ME044 | N/A | Employer Name | varchar | 50 | Name of the Employer, or if same as Group Name, leave blank | 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 |

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| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|---------------------|------|--------|---|----------|
| ME897 | N/A | Plan Effective Date | char | 8 | YYYYMMDD Date eligibility started for this <u>member</u> 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 Utah Health Benefits Exchange (UBHE). 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) | R |

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| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|--|------|--------|--|----------|
| ME106 | | Group Size | char | 2 | Code indicating Group Size consistent with Utah 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 |
| ME107 | | Risk Basis | char | 1 | S – Self-insured F – Fully insured | 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 | R |

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| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|-------------------|---------|--------|---|---|
| ME120 | | Actuarial Value | decimal | 6 | <p>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</p> <p>Size includes decimal point.</p> <p>Required as of January 1, 2014 for small group and non-group (individual) plans sold inside or outside the Exchange.</p> | <p>R - if ME106 = A ME106 = B</p> <p>O - Others</p> |

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| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|-------------------|------|--------|---|---|
| ME121 | | Metallic Value | int | 1 | <p>Metal Level (percentage of Actuarial Value) per federal regulations. Valid values are: 1 – Platinum 2--Gold 3 – Silver 4 – Bronze 5 – Catastrophic 0 – Not Applicable</p> <p>Required as of January 1, 2014 for small group and non-group (individual) plans sold inside or outside the Exchange.</p> <p>Use values provided in the most recent version of the HHS Actuarial Value Calculator available at : http://cciio.cms.gov/resources/regulations/index.html</p> | <p>R - if ME106 = A ME106 = B</p> <p>O - Others</p> |

| 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. | R - if ME106 = A ME106 = B O - Others |
| ME899 | N/A | Record Type | char | 2 | Value = ME | R |
| NOTE: At the time of publication, the following fields are required by R590-270, as outlined in <i>DSG 2.0 Additional Elements</i> and published by the UID. This information is included here for reference. | | | | | | |
| ME123 | | HIOS SCID | char | 17 | HIOS Standard Component ID with CSR variant e.g. 12345UT0010001-00 where 12345 is the unique Issuer HIOS ID UT is the state code for Utah 0010001 is Issuer defined and indicates a specific plan -00 is the cost sharing variant such that -00 off exchange -01 on exchange -02 zero cost sharing -03 limited cost sharing -04 73% AV Silver -05 87% AV Silver -06 94% AV Silver | R - if ACA Risk Adjustment Plans O - Others |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|---------------------------------------|------|--------|---|--|
| ME124 | | ACA Rating Area | int | 1 | Geographic rating areas associated with the plan premium. Value = 1, 2, 3, 4, 5, or 6 1 – Cache, Rich 2 – Box Elder, Morgan, Weber 3 – Davis, Salt Lake, Summit, Tooele, Wasatch 4 – Utah 5 – Iron, Washington 6 – Beaver, Carbon, Daggett, Duchesne, Emery, Garfield, Grand, Juab, Kane, Millard, Piute, San Juan, Sanpete, Sevier, Uintah, Wayne | R - if ACA Risk Adjustment Plans O - Others |
| ME125 | | Subscriber Premium | int | 10 | Monthly subscriber premium, include up to hundredths place, but do not code decimal point (e.g. for \$1,123.58 input 112358). Only subscriber records should show a premium amount other than 0. Code as 0 for records where ME012 Individual Relationship Code is not "20 Employee/Self." | R - if ACA Risk Adjustment Plans O - Others |
| ME005A | N/A | First day of eligibility in the month | Int | 2 | Day in the month when eligibility began. The first day in the month the member was eligible. Example: a member eligible for the entire month of February will have a value of 1. | R |

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| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|--------------------------------------|------|--------|--|----------|
| ME005B | N/A | Last day of eligibility in the month | Int | 2 | Day in the month when eligibility ends. The last day in the month the member was eligible. Example: a member eligible for the entire month of February will have a value of 28. | 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.
 - It is assumed that a complete snapshot of the claim is submitted at the time of final payment.
 - All claims lines submitted are processed as a unit.
 - Modifications to any previous submitted claim are submitted one of two ways:
 - Reversals - reverse the entire original claim (using MC038) and a new claim may be submitted as a replacement, or
 - Update with new version - replace the original claim with a new version (using MC005A).
- Financial amount data elements (MC062-MC067) assume the following:
 - The sum of all claim lines for a given data element will equal the total charge, paid, prepaid, co-pay, coinsurance, or deductible amounts for the entire claim.
 - The paid amount provided for each non-charge financial amount data element is mutually exclusive.
- Payers submit data in a single consistent format for each data type.

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 OHCS | R |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|-----------------------|--------------------|-----------------------------|-------------|---------------|--|-----------------|
| MC002 | N/A | Payer Name | varchar | 30 | Distributed by OHCS | 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 YYYY 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; Leave blank if unavailable | TH |
| MC008 | 835/2100/NM1/HN/09 | Plan Specific Contract Number | varchar | 128 | Plan assigned subscriber's contract number; Leave blank 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 Suffix or Sequence Number | varchar | 128 | Unique number of the member within the contract. Must be an identifier that is unique to the member. Must match ME010. | R |
| MC010 | 835/2100/NM1/MI/089 | Member Identification Code (patient) | varchar | 9 | Member's Social Security Number; Leave blank if unavailable. | TH |
| 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 |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|-----------------------|--------------------------|--|-------------|---------------|---|-------------------------|
| 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 | YYYYMMDD | R - Institutional Claim |
| MC019 | 837/2300/DTP/435/ 03 | Admission Hour | char | 4 | Time is expressed in military time - HHMM | R - Institutional Claim |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---|-------------------------|---------|--------|---|-------------------------|
| MC020 | 837/2300/CL1/ /01 | Admission Type | int | 1 | 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma Center 9 Information not available SOURCE: National Uniform Billing Data Element Specifications | R - Institutional Claim |
| MC021 | 837/2300/CL1/ /02 | Admission Source | char | 1 | SOURCE: National Uniform Billing Data Element Specifications | R - Institutional Claim |
| MC022 | 837/2300/DTP/096/03 | Discharge Hour | int | 4 | Time expressed in military time – HHMM | R - Institutional Claim |
| MC023 | 837/2300/CL1/ /03 | Discharge Status | char | 2 | See Lookup Table B-1.F | R - Institutional Claim |
| 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. Must match MP001. | R |

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

| 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. Leave blank if provider is a facility or organization. | TH |
| 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. Leave blank if provider is a facility or organization. | TH |

| 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. Leave blank 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 | 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 |
| 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 | Physical practice location city name | 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 |
| 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 |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|----------------------|------------------------------|---------|--------|---|------------------------------------|
| MC036 | 837/2300/CLM/ /05-1 | Type of Bill – Institutional | char | 3 | See Lookup Table B-1.G Do not use for professional claims | R - Institutional Claim |
| MC037 | 837/2300/CLM/ /05-1 | Facility Type - Professional | char | 2 | Use CMS Place of Service Codes for Professional Claims ADA Dental Claim Form Completion Instructions requests the same codes for Place of Treatment. Do not use for institutional claims. | R – Professional and Dental Claims |
| MC038 | 835/2100/CLP/ /02 | Claim Status | char | 2 | See Lookup Table B-1.H | R |
| MC039 | 837/2300/HI/BJ/021-2 | Admitting Diagnosis | varchar | 7 | ICD-10-CM. Do not code decimal point. | R - Institutional Claim |
| 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 and ICD-10-PCS codes | R |
| MC040 | 837/2300/HI/BN/031-2 | E-Code | varchar | 7 | Describes an injury, poisoning or adverse effect. Do not code decimal point. | O |
| MC041 | 837/2300/HI/BK/01-2 | Principal Diagnosis | varchar | 7 | ICD-10-CM. Do not code decimal point. | R O - Dental Claim |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|-----------------------|---------------------|--------------------------|-------------|---------------|---------------------------------------|----------------------------|
| MC042 | 837/2300/HI/BF/01-2 | Other Diagnosis – 1 | varchar | 7 | ICD-10-CM. Do not code decimal point. | TH O - Dental Claim |
| MC043 | 837/2300/HI/BF/02-2 | Other Diagnosis – 2 | varchar | 7 | ICD-10-CM. Do not code decimal point. | TH O - Dental Claim |
| MC044 | 837/2300/HI/BF/03-2 | Other Diagnosis – 3 | varchar | 7 | ICD-10-CM. Do not code decimal point. | TH O - Dental Claim |
| MC045 | 837/2300/HI/BF/04-2 | Other Diagnosis – 4 | varchar | 7 | ICD-10-CM. Do not code decimal point. | TH O - Dental Claim |
| MC046 | 837/2300/HI/BF/05-2 | Other Diagnosis – 5 | varchar | 7 | ICD-10-CM. Do not code decimal point. | TH O - Dental Claim |
| MC047 | 837/2300/HI/BF/06-2 | Other Diagnosis – 6 | varchar | 7 | ICD-10-CM. Do not code decimal point. | TH O - Dental Claim |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|-----------------------|---------------------|--------------------------|-------------|---------------|---------------------------------------|----------------------------|
| MC048 | 837/2300/HI/BF/07-2 | Other Diagnosis – 7 | varchar | 7 | ICD-10-CM. Do not code decimal point. | TH O - Dental Claim |
| MC049 | 837/2300/HI/BF/08-2 | Other Diagnosis – 8 | varchar | 7 | ICD-10-CM. Do not code decimal point. | TH O - Dental Claim |
| MC050 | 837/2300/HI/BF/09-2 | Other Diagnosis – 9 | varchar | 7 | ICD-10-CM. Do not code decimal point. | TH O - Dental Claim |
| MC051 | 837/2300/HI/BF/10-2 | Other Diagnosis – 10 | varchar | 7 | ICD-10-CM. Do not code decimal point. | TH O - Dental Claim |
| MC052 | 837/2300/HI/BF/11-2 | Other Diagnosis – 11 | varchar | 7 | ICD-10-CM. Do not code decimal point. | TH O - Dental Claim |
| MC053 | 837/2300/HI/BF/12-2 | Other Diagnosis – 12 | varchar | 7 | ICD-10-CM. Do not code decimal point. | TH O - Dental Claim |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|--------------------------|-----------------------------|---------|--------|---|-------------------------------|
| MC054 | 835/2110/SVC/NU/0 1-2 | Revenue Code | char | 10 | National Uniform Billing Committee Codes. Code using leading zeroes, left justified, and four digits. | R - Institutional Claim |
| MC055 | 835/2110/SVC/HC/0 1-2 | Professional Procedure Code | varchar | 10 | Procedure code for professional services. HCPCS including CPT codes of the American Medical Association, are valid entries. | R - Professional Claim |
| MC056 | 835/2110/SVC/HC/0 1-3 | Procedure Modifier – 1 | char | 2 | Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code (MC055). | R - Professional Claim |
| MC057 | 835/2110/SVC/HC/0 1-4 | Procedure Modifier – 2 | char | 2 | Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code (MC055). | R - Professional Claim |
| MC058 | 835/2110/SVC/ID/0 1-2 | ICD-10-PCS Procedure Code | char | 7 | Primary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim. | R - Institutional Claim |
| 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. | R |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-------------------|--------------------------------|---------|--------|---|-------------------------|
| MC062 | 835/2110/SVC/ /02 | Charge Amount | int | 10 | <u>Do not code decimal point or provide any punctuation.</u> For example, \$1,000.00 converted to 100000. Same format for all financial data that follows. | R |
| MC063 | 835/2110/SVC/ /03 | Paid Amount | int | 10 | Set to zero for capitated claims. Do not code decimal point. | 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. YYYYMMDD | R - Institutional Claim |
| 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. Must match MP001. | R |
| MC077 | 837/2010AA/NM1/XX/09 | Billing Provider NPI | 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 | Last name of member | R |
| MC105 | 837/2010CA/NM1/ /04 | Member First Name | varchar | 128 | First name of member | R |
| MC106 | 837/2010CA/NM1/ /05 | Member Middle Initial | char | 1 | Middle initial of member | 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 Lookup Table B-1.I for valid values. | R - if MC041 filled |
| MC201B | | Present on Admission – DX1 | varchar | 1 | Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values. | R - if MC042 filled |
| MC201C | | Present on Admission – DX2 | varchar | 1 | Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values. | R - if MC043 filled |
| MC201D | | Present on Admission – DX3 | varchar | 1 | Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values. | R - if MC044 filled |
| MC201E | | Present on Admission – DX4 | varchar | 1 | Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values. | R - if MC045 filled |
| MC201F | | Present on Admission – DX5 | varchar | 1 | Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values. | R - if MC046 filled |

| 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 Lookup Table B-1.I for valid values. | R - if MC047 filled |
| MC201H | | Present on Admission – DX7 | varchar | 1 | Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values. | R - if MC048 filled |
| MC201I | | Present on Admission – DX8 | varchar | 1 | Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values. | R - if MC049 filled |
| MC201J | | Present on Admission – DX9 | varchar | 1 | Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values. | R - if MC050 filled |
| MC201K | | Present on Admission – DX10 | varchar | 1 | Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values. | R - if MC051 filled |
| MC201L | | Present on Admission – DX11 | varchar | 1 | Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values. | R - if MC052 filled |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|-----------------------|--------------------------|-----------------------------|-------------|---------------|--|-------------------------|
| MC201M | | Present on Admission – DX12 | varchar | 1 | Code indicating the presence of diagnosis at the time of admission See Lookup Table B-1.I for valid values. | R - if MC053 filled |
| MC202 | 837D/2400/TOO/02 | Tooth Number | char | 20 | Tooth Number or Letter Identification | R - Dental Claim |
| MC203 | 837D/2400/SV/304 1-5 | Dental Quadrant | char | 2 | Dental Quadrant | R - Dental Claim |
| MC204 | 837D/2400/TOO/03 1 -5 | Tooth Surface | char | 10 | Tooth Surface Identification | R - Dental Claim |
| MC205 | | ICD-10-PCS Procedure Date | date | 8 | Date MC058 was performed Leave blank if not an institutional claim. | R – Institutional Claim |
| MC058A | 835/2110/SVC/ID/0 1-2 | ICD-10-PCS Procedure Code | char | 7 | Secondary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim. | R – Institutional Claim |
| MC205A | | ICD-10-PCS Procedure Date | date | 8 | Date MC058A was performed Leave blank if not an institutional claim. | R – Institutional Claim |
| MC058B | 835/2110/SVC/ID/0 1-2 | ICD-10-PCS Procedure Code | char | 7 | Secondary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim. | R – Institutional Claim |
| MC205B | | ICD-10-PCS Procedure Date | date | 8 | Date MC058B was performed Leave blank if not an institutional claim. | R – Institutional Claim |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|--------------------------|--------------------------------|------|--------|---|-------------------------------|
| MC058C | 835/2110/SVC/ID/0 1-2 | ICD-10-PCS Procedure Code | char | 7 | Secondary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim. | R – Institutional Claim |
| MC205C | | ICD-10-PCS Procedure Date | date | 8 | Date MC058C was performed Leave blank if not an institutional claim. | R – Institutional Claim |
| MC058D | 835/2110/SVC/ID/0 1-2 | ICD-10-PCS Procedure Code | char | 7 | Secondary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim. | R – Institutional Claim |
| MC205D | | ICD-10-PCS Procedure Date | date | 8 | Date MC058D was performed Leave blank if not an institutional claim. | R – Institutional Claim |
| MC058E | 835/2110/SVC/ID/0 1-2 | ICD-10-PCS Procedure Code | char | 7 | Secondary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim. | R – Institutional Claim |
| MC205E | | ICD-10-PCS Procedure Date | date | 8 | Date MC058E was performed Leave blank if not an institutional claim. | R – Institutional Claim |
| 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 |
| MC899 | N/A | Record Type | char | 2 | Value = MC | |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|----------------|------------------------|------|--------|---|------------------------|
| MC061A | 837/2400/SV103 | Unit of Measure | char | 2 | Unit of measure for MC061. Valid values are: DA – Days MJ – Minutes UN – Units Other standard ANSI values may be used with prior approval from OHCS. | R |
| MC901 | 2400 SV2 02-5 | Procedure Modifier – 3 | char | 2 | Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code (MC055). | R - Professional Claim |
| MC902 | 2400 SV2 02-6 | Procedure Modifier – 4 | char | 2 | Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code (MC055). | R - Professional Claim |

A-3 PHARMACY 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.
 - It is assumed that a complete snapshot of the claim is submitted at the time of final payment.
 - All claims lines submitted are processed as a unit.
 - Modifications to any previous submitted claim are submitted one of two ways:
 - Reversals - reverse the entire original claim (using PC025) and a new claim may be submitted as a replacement, or
 - Update with new version - replace the original claim with a new version (using PC201).
- Financial amount data elements (PC035-PC042) assume the following:
 - The sum of all claim lines for a given data element will equal the total charge, paid, ingredient cost, postage, dispensing fee, co-pay, coinsurance, or deductible amounts for the entire claim.
 - The paid amount provided for each non-charge financial amount data element is mutually exclusive.
- Payers submit data in a single, consistent format for each data type.

A-3.1 PHARMACY CLAIMS FILE

| Data Element # | NCPDP Field # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---------------|-------------------|---------|--------|---------------------------|----------|
| PC001 | N/A | Payer Code | varchar | 8 | Distributed by OHCS | R |
| PC002 | N/A | Payer Name | varchar | 30 | Distributed by OHCS | 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; Leave blank if unavailable | TH |
| PC008 | N/A | Plan Specific Contract Number | varchar | 128 | Plan assigned subscriber's contract number; Leave blank 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. Must match ME010. | R |
| PC010 | 302-C2 | Member Identification Code | varchar | 128 | Member's social security number; Leave blank 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. | TH |
| PC011 | 306-C6 | Individual Relationship Code | char | 2 | Member's relationship to insured See Lookup Table B-1.C | R |
| PC012 | 305-C5 | Member Gender | char | 1 | M – Male | R |

| | | | | | | |
|-------|--------|----------------------------------|---------|----|---|----|
| | | | | | F – Female U – UNKNOWN | |
| 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. Must match MP001. | 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 | Pharmacy NPI | varchar | 20 | Pharmacy's 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 | TH |
| PC022 | 831-5N | Pharmacy Location City | varchar | 30 | City name of pharmacy - preferably pharmacy location (if mail order leave blank) | R |

| | | | | | | |
|--------|--------|----------------------------|---------|----|--|---|
| PC023 | 832-5O | Pharmacy Location State | char | 2 | As defined by the US Postal Service (if mail order leave blank) | 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 leave blank) | 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.H. | 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 | 01 New prescription 02 – 99 Refill Count | R |
| PC029 | 425-DP | Generic Drug Indicator | char | 2 | 01 - branded drug 02 - generic drug | R |
| PC030 | 408-D8 | Dispense as Written Code | char | 1 | Payers able to map available codes to those below. See Lookup Table B-1.J | R |
| PC031 | 406-D6 | Compound Drug Indicator | char | 1 | N Non-compound drug Y Compound drug U Non-specified drug compound | O |
| 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 | O |
| PC035 | 804-5B | Charge Amount | int | 10 | <u>Do not code decimal point or provide any punctuation.</u> For example, \$1,000.00 converted to 100000. Same format for all financial data that | R |

| | | | | | | |
|-------|--------|-----------------------------------|---------|-----|---|----------------------|
| | | | | | follows. | |
| 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 (future use) | O |
| PC044 | N/A | Prescribing Physician First Name | varchar | 25 | Physician first name. | R - if PC047 = DEA # |
| PC045 | N/A | Prescribing Physician Middle Name | varchar | 25 | Physician middle name or initial. | R - if PC047 = DEA # |
| PC046 | 427-DR | Prescribing Physician Last Name | varchar | 60 | Physician last name. | R |
| 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 | Subscriber Last Name | R |
| PC102 | 312-CC | Subscriber First Name | varchar | 128 | Subscriber First Name | R |

| | | | | | | |
|--------|--------|-----------------------------------|---------|-----|--|---|
| PC103 | N/A | Subscriber Middle Initial | char | 1 | Subscriber Middle Initial | O |
| PC104 | 311-CB | Member Last Name | varchar | 128 | Member Last Name | R |
| PC105 | 310-CA | Member First Name | varchar | 128 | Member First Name | R |
| PC106 | N/A | Member Middle Initial | char | 1 | Member Middle Initial | 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. | O |
| 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 Must match MP001. | R |
| PC047b | 421-DZ | Prescribing Physician DEA | varchar | 20 | DEA number for prescribing physician | O |
| PC899 | N/A | Record Type | char | 2 | PC | R |
| PC905 | | Drug Unit of Measure | varchar | 3 | Report the code that defines the unit of measure for the drug dispensed in PC033 See Lookup Table B-1.K for valid values. | 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.

A-4.1 PROVIDER FILE

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|-------------------|---------|--------|--|----------|
| MP001 | N/A | Provider ID | varchar | 30 | Unique identified for the provider as assigned by the reporting entity Must match MC024, MC076, PC018, or 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 I – IPA P - Practitioner | R |

| | | | | | | |
|-------|-----|---|---------|----|--|---|
| MP004 | N/A | Provider First Name | varchar | 25 | Individual first name. Leave blank if provider is a facility or organization. | R |
| MP005 | N/A | Provider Middle Name or Initial | varchar | 25 | Provider Middle Name or Initial | 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 | Suffix to individual name. Leave blank 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 |
| 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 – city where provider delivers health care services | R |
| MP011 | N/A | Provider Office State | char | 2 | Physical address – state where provider delivers health care services. As defined by the US Postal Service. | R |
| MP012 | N/A | Provider Office ZIP | varchar | 11 | Physical address – ZIP where provider delivers health care services. May include non-US codes; do not include dash. Plus 4 optional but | R |

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| | | | | | | |
|-------|-----|-------------------------------|---------|----|---|----|
| | | | | | desired. | |
| MP013 | N/A | Provider DEA Number | varchar | 12 | Provider DEA Number | TH |
| MP014 | N/A | Provider NPI | varchar | 20 | Provider NPI | TH |
| MP015 | N/A | Provider State License Number | varchar | 20 | Prefix with two-character state of licensure with no punctuation. Example UTLL12345 | TH |
| 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) |
| CH Children's Health Insurance Program (CHIP) |
| 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 Fee For Service (FFS) |
| MD Medicare Part D |
| MP Medicare Primary |
| MO Medicaid Accountable Care Organization (ACO) |
| QM Qualified Medicare Beneficiary |
| SP Medicare Supplemental (Medi-gap) plan |
| TV Title V |
| 99 Other |

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B-1.B COVERAGE LEVEL CODE

| |
|---|
| 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 |
| ESP Employee and Spouse |
| FAM Family |
| IND Individual |
| SPC Spouse and Children |
| SPO Spouse Only |

B-1.C 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.D RACE CODES

| |
|--|
| R1 American Indian/Alaska Native |
| R2 Asian |
| R3 Black/African American |
| R4 Native Hawaiian or other Pacific Islander |
| R5 White |
| R9 Other Race |
| UNKNOWN Unknown/Not Specified |

B-1.E ETHNICITY CODES

| |
|---|
| 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 |
| 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 |

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| |
|------------------------------|
| 2118-8 Middle Eastern |
| PORTUG Portuguese |
| RUSSIA Russian |
| EASTEU Eastern European |
| 2047-9 Vietnamese |
| OTHER Other Ethnicity |
| UNKNOW Unknown/Not Specified |

B-1.F 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 |

B-1.G TYPE OF BILL

| 1st Digit - Type of Facility | 2nd Digit - Bill Classification (varies based on 1st Digit) | 3rd Digit - Frequency |
|--|--|---|
| 1 Hospital 2 Skilled Nursing 3 Home Health 4 Christian Science Hospital 5 Christian Science Extended Care 6 Intermediate Care | 1 Inpatient (Including Medicare Part A) 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 | 1 admit through discharge 2 interim - first claim 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 |
| 7 Clinic | 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 | |
| 8 Special Facility | 1 Hospice (Non-Hospital Based) 2 Hospice (Hospital-Based) 3 Ambulatory Surgery Center 4 Free Standing Birthing Center 9 Other | |

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B-1.H 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.I 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.J DISPENSE AS WRITTEN CODES

| |
|--|
| 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 |

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B-1.K DRUG UNIT OF MEASURE

| |
|------------------------|
| EA Each |
| F2 International Units |
| GM Grams |
| ML Milliliters |
| MG Milligrams |
| MEQ Milliequivalent |
| MM Millimeter |
| UG Microgram |
| UU Unit |
| OT Other |