UTAH APCD

Utah All-Payer Claims Database DATA SUBMISSION GUIDE

REVISION HISTORY

Date	Version	Description	Author
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Sept 2014	2.1	Incorporated changes approved by HDC	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.

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 Heath 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.

All files 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
- EntityAbbreviation – 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

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

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

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

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.	R - if ME106 = A ME106 = B O - Others

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 5 – Catastrophic 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	R - if ME106 = A ME106 = B O - Others

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 *DSG 2.0 Additional Elements* 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

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 YYMM as the version number.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC006	837/2000B/SBR/ /03	Insured Group or Policy Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber.	R
MC007	835/2100/NM1/34/ 09	Subscriber Social Security Number	varchar	9	Subscriber's Social Security Number; 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/02~~1~~1-2	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/03~~1~~1-2	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/01-2	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/01-2	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/01-3	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/01-4	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/01-2	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	Do not code decimal point or provide any punctuation. 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/01-2	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/01-2	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/01-2	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	Do not code decimal point or provide any punctuation. 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

					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

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
UNKNOW 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

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	

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

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