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ACCESS HEALTH CT

Connecticut All Payers Claims Database

DRAFT DATA SUBMISSION GUIDE

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This draft: Version 1

Document History

Version	Date Edited	Author	Summary of changes
1.0		LG	First Draft
1.0	4/24	MP	Comments and revisions

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Definitions and Acronyms

Administrator: the entity granted statutory authority by the Connecticut General Assembly to implement and operate the APCD.

Connecticut resident: any insured individual whose address is within the State of Connecticut and all covered dependents, regardless of where the service was provided or the state where coverage was issued. For the purpose of this project, any student enrolled in a student plan at a Connecticut college or university is a Connecticut resident.

Data Dictionary: documentation that outlines each data element collected, the length, format and usage of each element along with any relationships between the datasets stated herein and/or additional datasets outside of this DSG.

Data Manager: the Administrator's designated contractor responsible for data intake, edits, quality assurance, warehousing and report production.

Data Submission Guide: the collection of documents that outline the health care data to be collected by element with format, requirements and any dependencies.

Health Care Data: the set of files that a Health Insurer is required to submit according to (statute cite and PP cite) consisting of Member Eligibility, Medical Claims, Pharmacy Claims, Pharmacy Claims and Providers.

Dental Claims File: a data file composed of service level dental information including but not limited to dental services rendered (Dcodes), member demographics and identifiers, provider information and identifiers, charge amount, paid amount, payment method and plan type. In general, the same information provided on any version of the ADA claim form or its direct data entry component or the HIPAA Transaction set equivalent (837D).

Medical Claims File: a data file composed of service level remittance information including, but not limited to, member demographics, provider information, charge and payment information, and clinical diagnosis/procedure codes from all paid claims and encounters that may have some denied lines of data. The major claims types expected are from Facilities using the UB04, professional claims reported on the 1500 and/or either of their HIPAA Transaction equivalents (837I and 837P). In addition, the data file can support the reporting of reimbursement billing models.

Member Eligibility File: a data file composed of demographic information for each Member who is eligible to receive medical, pharmacy, or dental coverage provided or administered by a Reporting Entity for one or more days of coverage during the reporting month.

Pharmacy Claims File: a data file composed of service level remittance information including, but not limited to, member demographics, provider information, charge and payment information and national drug codes from all paid claims for each prescription filled.

Provider File: "Provider Data File" means a data file composed of health care service entity attributes that define entity unique standard identifiers (NPI), taxonomy, specialties, affiliations and geographic settings as certified/credentialed by a health care claims payer and/or known contracted healthcare vendors.

HIPAA Transaction Set: the data set developed for the reporting of health information between various entities, typically between providers and payers. For the purposes of Access Health CT, the sets referenced are the Institutional, Professional, and Dental Claims data, Member Eligibility information, Benefit Enrollment Information, and the Payment Remittance.

Intake Edits: the logic built around the layout, format and content of the expected data sets. These edits account for and report on submission compliance, data element interdependencies, cross-file linking and quality assurance of valid value usage.

Reporting Entity: a health insurance carrier identified by the State of Connecticut to report health care data for the purpose of <FILL IN THE BLANK> and follows the same definition provided in Section 19a-724(a) (2) (B) of the 2012 Supplement to the General Statutes.

For internal draft only -- acronyms

ADA = American Dental Association

AHCT = Access Health CT

APCD = All-Payer Claims Database

ASCII = American Standard Code for Information Interchange

DSG = Data Submission Guide

HIPAA = Health Insurance Portability and Accountability Act

PP = Policies and Procedures to be issued by AHCT

Internal question – look at CT Insurance Dept. HB-56 Prompt Pay

I. Introduction

Statement of purpose: The Connecticut APCD was established for the purpose of collecting, assessing and reporting health care information relating to safety, quality, cost-effectiveness, access and efficiency for all levels of health care.

This document describes the data elements and formats for the required data files:

Member Eligibility

Medical Claims

Pharmacy Claims

Dental Claims

Provider Information

Questions about this guide should be submitted to Matt Salner at AccessHealth CT at matthew.salner@ct.gov.

II. Data Submission Requirements

A. General Information

1. Reporting Entities shall report paid claims and encounters at line level for all Connecticut residents receiving coverage or care.
2. Field definitions and other relevant data associated with these submissions are specified in the tables for each file.
3. The Reporting Entity is responsible for ensuring that both Provider and Member Identifiers are consistent across each file where appropriate.
4. Each submitted data file shall have control totals and transmission control data as defined in the Header and Trailer Record for each defined file.
5. Reporting Entities will submit files on a monthly basis to the APCD Data Manager, which will operate and maintain a secure file transfer portal for this project.
 - a. All claims data is to be submitted within one month after the close of the previous reporting month. EXAMPLE: Claims adjudicated by the payer in January are to be reported by the end of February in the January File.
 - b. All eligibility data is to be submitted monthly for any and all active eligibilities for the month as of the 15th of that month. The reporting of an inactive

member is allowed and can be accounted for in the data set, but there is no rolling-period methodology required.

c. All provider data is to be submitted monthly for any and all active provider contracts the payer has with a health care provider or health care vendors as of the 15th of the month. The reporting of inactive providers is allowed and can be accounted for in the data set, but there is no rolling-period methodology required.

6. Each Reporting Entity must submit documentation supporting their standard data extract files, including a data dictionary mapping internal system data elements to the data elements defined in this DSG. The documentation should include a detailed description of how the data extracts are created and how the requirements of this DSG and the rule are accomplished, including specifications on what data is being excluded and the parameters that define that excluded data.
7. The Reporting Entity shall include utilization and cost information for all services provided to members under any financial arrangement, including sub-capitated, bundled and global payment arrangements.

B. Exclusions

1. **The following types of policies are not required to submit files to the APCD:** hospital confinement indemnity coverage; disability income protection coverage; accident only coverage; long term care coverage; specified accident coverage; Medicare supplement coverage; specified disease coverage; TriCare Supplemental Coverage; travel health coverage; and single service ancillary coverage, with the exception of dental and prescription drug coverage.
2. **Minimum Number of Covered Lives:** Reporting Entities that, as of September 15 of any calendar year, have less than a total of 3,000 covered lives enrolled in plans that are offered or administered by the Reporting Entity are exempt from the data submission requirements. All Reporting Entities with less than a total of 3,000 covered lives on October 1 shall comply with the annual registration requirements as described in the posted Policies and Procedures.

III. Required Data Files

1. **Medical Claims Data**
 - a) Medical Claims files must include all services provided to the Member, including but not limited to medical, behavioral health, home care and durable medical equipment.

- b) Reporting Entities must provide information to identify the type of service and setting in which the service was provided given the standard claim type used for the setting
- c) Reporting Entities must submit data in the monthly file for any claim lines that some action has been taken on that claim (i.e., payment, adjustment or other modification). Claims denied for completeness, errors or other administrative reasons (sometimes known as “soft” denials) should not be submitted until the claim has been paid.
- d) Reporting Entities must provide a reference number that links the original claim to all subsequent actions associated with that claim.
- e) Reporting Entities are required to identify encounters corresponding to a capitation payment.

2. Pharmacy Claims Data

- a) Reporting Entities must provide data for all pharmacy paid claims for prescriptions that were actually dispensed to members and paid
- b) Medical plans (risk holders) that subcontract with other vendors for services such as mental health and substance abuse and prescription drug coverage and report those claims in separate submissions are responsible for ensuring that subscriber and member identifiers allow reliable attribution of claims across file types.

3. Member Eligibility Data

- a) Reporting Entities must provide a data set that contains information on every covered plan member who is a Connecticut resident 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.
- b) Eligibility files should provide one record per member per month as of the 15th of the month. Member is either the Subscriber or the Subscriber’s dependents and all instances where the Subscriber has dependents a link between them must be maintained
- c) If dual coverage exists, send coverage of eligible members where the insurance policy is defined as primary, secondary or tertiary.

4. Provider Data

- a) Reporting Entities must provide a data set that contains information on every provider with paid claims in the Medical Claims file during the targeted reporting period. Every Provider on a record in the Medical Claims file should have a corresponding record in the Provider file.
- b) Data about pharmacies is not required in the Provider file.
- c) In the event the same provider delivered and was reimbursed for services rendered from two different physical locations, than the provider data file shall

contain two separate records for that same provider reflecting each of those physical locations. One record shall be provided for each unique physical location for a provider.

5. Dental Claims Data

Stand alone dental carriers should provide contact information to the Connecticut APCD when these rules become effective. The Connecticut APCD will notify stand alone dental carriers of the process for submitting test files and regular updates. The process will include opportunities to discuss submission requirements prior to due dates.

B. File Submission Methods

The APCD Data Manager will provide credentials to Reporting Entities for access to a secure site for loading and transmitting data files.

C. Data Quality Requirements

- a) The data element descriptions include field definitions and information about completion and accuracy standards.
- b) Data validation and quality intake reviews are based on experience in other APCD states and adjusted for state-specific conditions and reporting goals. Over time, the APCD will modify these intake reviews to improve the quality of the data with tighter standards and intake criteria.
- c) The CT APCD seeks to populate the APCD with quality data. Each payer will need to work interactively with the CT APCD Data Manager to develop data extracts that achieve validation and quality specifications.
- d) Test data submissions and feedback from the Data Manager are intended to assist Reporting Entities in developing conforming data files. Reporting Entities should ensure that files submitted during the Historical, Year to date and Monthly processes incorporate the feedback provided during the testing process.

D. File Format

- 1. All files submitted to the APCD will be formatted as standard text files. Text files all comply with the following standards **{DRAFT}**
 - a) 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) Each field is defined as variable text length, variable number length, set text length or set number length and 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) Unless otherwise stipulated, numbers (ID numbers, account numbers, etc) do not contain spaces, hyphens or other punctuation marks.
- f) Text fields are never padded with leading or trailing spaces, unnecessary zeroes or tabs.
- g) Numeric fields are never padded with leading or trailing zeros or populated with 9-Fill to indicate null data..
- h) 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).

IV. Data Submission Schedule

A. Test Data

- 1. Reporting Entities shall submit test data files to the Data Manager within 150 calendar days after the release of this Guide.
- 2. Test files for subsequent revisions of this Guide will be due no less than 120 calendar days after the release of the revised Guide.

B. Historical and Year –to-Date Files

- 1. During the implementation phase of the APCD, Reporting Entities must provide three full calendar years of Claims Data for Connecticut Residents along with one Member Eligibility File for the three year period and one Provider File for the three year period.
- 2. Historical files will be due to the Data Manager within 90 calendar days of the Test Data due date.
- 3. The Administrator may also direct Reporting Entities to provide a Year-to-Date for purposes of establishing a complete data record within 45 days after the due date for the Historical files. The Administrator may adjust the deadline for initiating monthly data submission accordingly.
- 4. Reporting Entities that become subject to these regulations after the initial implementation phase are also required to submit three complete calendar years of historical data.

C. Monthly Submissions

On a monthly basis after submitting Historical Data (and, if required, Year to Date) files, Reporting Entities must submit monthly files due to the Data Manager by the last business day of the month after the month in which the claim was paid or adjudicated.

V. Implementation and Operations

A. Annual Registration

1. Each Reporting Entity must submit an annual registration form to the Administrator by September 15 of each calendar year, with the exception that the registration must be provided within 60 days of the posting date of the APCD Policies and Procedures.
2. The registration form shall indicate if the Reporting Entity is adjudicating claims for Members and, if applicable, the types of coverage, and its current enrollment.
3. The Administrator will provide a template and address for Reporting Entities to submit registration information.

B. Data Quality Reports

The Data Manager will provide secure access to each data submitter to view data quality reports describing each files level of compliance with established submission standards.

C. Amendments to the Data Submission Guide

1. From time to time, the Administrator may make revisions to the Data Submission Guide to clarify reporting requirements, improve data accuracy and meet analytic and reporting needs.
2. **Timeline:**
 - a) The Administrator will send a formal notice about any significant changes to Reporting Entities. Significant changes include adding new fields to the data layouts; major revisions to existing data elements; and requiring new files as part of the ongoing submission process.

The Administrator may provide ongoing clarifications through a regular communication strategy with Reporting Entities, including emails and webinars as well as an FAQ document. Examples of this category include the addition of additional values to improve compliance with existing standards.

D. Exemptions and Waivers

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Reporting Entities may request filing exemptions and waivers of specific data element reporting requirements. The Administrator will establish a process for submitting waiver and exemption requests.

Member Eligibility detail

Element	Data Element Name	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%
ME001	Submitter	Integer	ID Submitter	varchar[6]	CT APCD defined and maintained unique identifier	Name will be distributed by Data Manager.	All	100%
ME002	National Plan ID	Integer	ID Nat'l PlanID	int[10]	CMS National Plan Identification Number (PlanID)	Name will be distributed by Data Manager.	All	0%
ME003	Insurance Type Code/Product	Lookup Table – HIPAA code set	tkpInsuranceTypeCode	char[2]	Type / Product Identification Code	Report the code that defines the type of insurance under which this member's eligibility is maintained. EXAMPLE: HM = HMO	All	96%
ME004	Year	Date Period - Integer	Century Year	int[4]	Eligibility year reported in this submission.	year for which eligibility is reported in this submission in YYYY format. If reporting previous year's data, the year reported here will not match current year. Do not report a future year here.	All	100%
ME005	Month	Date Period - Numeric	Month	char[2]	Reporting Month of Eligibility	Month for which eligibility is reported in this submission expressed in numerical MM Format from 01 to 12. Leading zero is required for reporting January through September files.	All	100%
ME006	Insured Group or Policy Number	Text	ID Group	varchar[30]	Group / Policy Number	Report the number that defines the insured group or policy. Do not report the number that uniquely identifies the subscriber or member	All	99%
ME007	Coverage Level Code	Lookup Table - Text	tkpCoverageLevel	char[3]	Benefit Coverage Level Code	Report the code that defines the dependent coverage	All	99%
					Code	Description		
					CHD	Children Only		
					DEP	Dependents Only		
					ECH	Employee and Children		
					ELF	Employee and Life Partner		
					EMP	Employee Only		
					ESP	Employee and Spouse		
					FAM	Family		
					IND	Individual		
					SPC	Spouse and Children		
					SPO	Spouse Only		
					UNK	Unknown		
ME008	Subscriber SSN	Numeric	ID Tax	char[9]	Subscriber's Social Security Number	Report the Subscriber's SSN here; used to create Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here	All	85%
ME009	Plan Specific Contract Number	Text	ID Contract	varchar[30]	Contract Number	Report the Plan assigned contract number. Do not include values in this field that will distinguish one member of the family from another. This should be the contract or certificate number for the subscriber and all of the dependents.	All	95%
ME010	Member Suffix or Sequence Number	Text	ID Sequence	varchar[20]	Member's Contract Sequence Number	Report the unique number / identifier of the member within the contract	All	99%
ME011	Member SSN	Numeric	ID Tax	char[9]	Member's Social Security Number	Report the member's social security number here; used to create Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here	All	68%
ME012	Individual Relationship Code	Lookup Table – Numeric – HIPAA code set	tkpIndividualRelationshipCode	varchar[2]	Member to Subscriber Relationship Code	Report the value that defines the Member's relationship to the Subscriber. EXAMPLE: 20 = Self / Employee	All	98%
ME013	Member Gender	Lookup Table - Text	tkpGender	char[1]	Member's Gender	Report member gender as reported on enrollment form in alpha format. Used to create Unique Member ID. EXAMPLE: F = Female	All	100%
					Code	Description		
					F	Female		
					M	Male		
					U	Unknown		
ME014	Member Date of Birth	Full Date - Integer	Century Year Month Date	int[8]	Member's date of birth	Report the date the member was born in YYYYMMDD Format.	All	99%
ME015	Member City Name	Text	Address City Member	varchar[30]	City name of the Member	Report the city name of member.	All	99%
ME016	Member State	External Code Source 2 - Text	Address State External Code Source 2 - States	char[2]	State / Province of the Member	Report the state of the patient as defined by the US Postal Service. Report Province when Country Code does not = USA	All	99%
ME017	Member ZIP Code	External Code Source 2 - Text	Address Zip External Code Source 2 - Zip Codes	varchar[9]	Zip Code of the Member	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	99%
ME018	Medical Coverage	Lookup Table - Integer	tkpFlagIndicators	int[1]	Indicator - Medical Option	Report the value that defines the element. EXAMPLE: 1 = Yes there is Medical Coverage.	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
ME019	Prescription Drug Coverage	Lookup Table - Integer	tkpFlagIndicators	int[1]	Indicator - Pharmacy Option	Report the value that defines the element. EXAMPLE: 1 = Yes there is Prescription Coverage.	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
ME020	Dental Coverage	Lookup Table - Integer	tkpFlagIndicators	int[1]	Indicator - Dental Option	Report the value that defines the element. EXAMPLE: 1 = Yes there is Dental Coverage.	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
ME021	Race 1	Lookup Table - Text	tkpRace	char[2]	Member's self-disclosed Primary Race	Report the Member-identified primary race here. The code value "UNKNOWN" (Unknown/not specified), should be used ONLY when Member answers unknown, or refuses to answer. Do not report any value here if data has not been collected. Report only collected data. EXAMPLE: R9 = Other Race	All	3%
					Code	Description		
					R1	American Indian/Alaska Native		
					R2	Asian		
					R3	Black/African American		
					R4	Native Hawaiian or other Pacific Islander		
					R5	White		
					R9	Other Race		
					UN	Unknown/not specified		

Member Eligibility detail

Element	Data Element Name	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%
ME022	Race 2	Lookup Table - Text	tlkpRace	char[2]	Member's self-disclosed Secondary Race	Report the Member-identified primary race here. The code value "UNKNOW" (Unknown/not specified), should be used ONLY when Member answers unknown, or refuses to answer. Do not report any value here if data has not been collected. Report only collected data. EXAMPLE: R9 = Other Race	All	2%
					Code	Description		
					R1	American Indian/Alaska Native		
					R2	Asian		
					R3	Black/African American		
					R4	Native Hawaiian or other Pacific Islander		
					R5	White		
					R9	Other Race		
					UN	Unknown/not specified		
ME023	Other Race	Text	Free Text Field	varchar[15]	Member's Other Race	Report the member's self-disclosed race when ME021 or ME022 is entered as R9 Other Race; if not applicable, do not report any value here	Required when ME021 or ME022 = R9 (Other)	99%
ME024	Hispanic Indicator	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Hispanic Status	Report the value that defines the element. The code value "3" for unknown, should be used ONLY when member answers unknown, or refuses to answer. Do not report any value here if the data has not been collected. Report only collected data. EXAMPLE: 1 = Yes, Member has indicated Hispanic status.	All	3%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
ME025	Ethnicity 1	External Code Source 17 - Text	External Code Source 17 - Ethnicity	char[6]	Member's Primary Ethnicity	Report the Member-identified primary ethnicity from either the External Code Source or here, whichever provides the best detail as obtained from the Member / Subscriber. The value "UNKNOW" should be used ONLY when the Member answers unknown, or refuses to answer. Do not report any value here if data has not been collected. Report only collected data.	All	3%
ME026	Ethnicity 2	External Code Source 17 - Text	External Code Source 17 - Ethnicity	char[6]	Member's Secondary Ethnicity	Report the Member-identified primary ethnicity from either the External Code Source or here, whichever provides the best detail as obtained from the Member / Subscriber. The value "UNKNOW" should be used ONLY when the Member answers unknown, or refuses to answer. Do not report any value here if data has not been collected. Report only collected data.	All	2%
ME027	Other Ethnicity	Text	Free Text Field	varchar[20]	Member's Other Ethnicity	Report the member's self-disclosed ethnicity when ME025 or ME026 is entered as OTHER; if not applicable, do not report any value here	Required when ME025 or ME026 = OTHER	99%
ME028	Primary Insurance Indicator	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Primary Insurance Coverage	Report the value that defines the element. EXAMPLE: 1 = Yes, Insurance is Primary (Products, Plans or Benefits that only cover Copays, Coinsurance and Deductibles [Gap Coverage] will answer 2 = No here).	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
ME029	Coverage Type	Lookup Table - Text	tlkpCoverageType	char[3]	Type of Coverage Code	Report the code that defines the type of insurance policy by which the enrollee is covered. EXAMPLE: UND = Plan underwritten by the insurer	Required for for all fully insured commercial or self insured	98%
					Code	Description		
					ASW	Self-funded plans that are administered by a third-party administrator, where the employer has purchased stop-loss, or group excess, insurance coverage		
					ASO	Self-funded plans that are administered by a third-party administrator, where the employer has not purchased stop-loss, or group excess, insurance coverage		
					STN	Short-term, non-renewable health insurance		
					UND	Plans underwritten by the insurer		
					OTH	Any other plan. Insurers using this code shall obtain prior approval.		
ME033	Member language preference	External Code Source 7 - Integer	External Code Source 7 - Languages	int[3]	Member's self-disclosed verbal language preference	Report the code that defines the spoken language preference of the member. The code value 999 (Unknown/ Not Specified), should only be used when patient/client answers unknown or refuses to answer. Do not report any value here if the Carrier does not have the data. Report only collected data.	All	3%
ME034	Member language preference-Other	Text	Free Text Field	varchar[20]	Member's Other Language Preference	Report the other language the member / subscriber has identified. Do not report any value if no other language identified	Required when ME033= Other	99%
ME035	Medical Home Flag	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Medical Home indicator	Report the value that defines the element. EXAMPLE: 1 = Yes, Member has a medical home on record for this coverage period.	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
ME036	Medical Home Number	Text	ID Link to PV002	varchar[30]	Health Care Home ID	Report the submitter assigned medical home number. It is anticipated that this will be the same data submitter number used in reporting servicing provider. Do not report any data here if no applicable. The number of the member's healthcare home must also be in the Provider File in PV002, Provider ID.	Required when ME035 = 1	90%
ME037	Medical Home Tax ID Number	Numeric	ID Tax	char[9]	Health Care Home EIN	Report the Federal Tax Identification Number of the medical home here. If there is not medical home to report, do not report any value. Do not use hyphen or alpha prefix.	Required when ME035 = 1	90%
ME038	Medical Home National Provider ID -	External Code Source 3 - Integer	External Code Source 3 - National Provider ID	int[10]	National Provider Identification (NPI) of the Health Care Home Provider	Report the National Provider Identification (NPI) number for the entity or individual serving as the medical home. If there is no medical home to report, do not report any value.	Required when ME035 = 1	10%
ME039	Health Care Home Name	Text	Name Health Care Home	varchar[60]	Name of Health Care Home	Report the full name of the medical home. If the medical home is an individual, report in the format of Last name, first name and middle initial with no punctuation. If there is not medical home to report, do not report any value.	Required when ME035 = 1	90%
ME043	Member Street Address	Text	Address 1 Member	varchar[50]	Street address of the Member	Report the member's primary street address. Used to create Unique Member ID.	All	98%
ME044	Member Street Address 2	Text	Address 2 Member	varchar[50]	Secondary Street Address of the Member	Report the address of member which may include apartment number or suite, or other secondary information besides the street. Used to create Unique Member ID.	All	2%

Member Eligibility detail

Element	Data Element Name	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%
ME045	Purchased through Access Health CT Flag	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Access Health CT	Report the value that defines the element. EXAMPLE: 1 = Yes, policy for this eligibility was purchased through Access Health CT.	All Small or NonGroup	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
ME046	Member PCP ID	Text	ID Link to PV002	varchar[30]	Member's PCP ID	Report the identifier of the members PCP. The value in this field must have a corresponding Provider ID (PV002) in the Provider File. Report a value of 'UNKNOWN' when PCP is unknown or 'NA' if the eligibility does not require a PCP.	All	98%
ME051	Behavioral Health Benefit Flag	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Behavioral Health Option	Report the value that defines the element. EXAMPLE: 1 = Yes, Behavioral/Mental Health is a covered benefit.	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
ME053	Disease Management Enrollee Flag	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Chronic Illness Management indicator	Report the value that defines the element. EXAMPLE: 1 = Yes, Member's chronic illness is being managed by plan or vendor of plan.	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
ME055	Business Type Code	Lookup Table - Integer	tlkpBusinessType	int[1]	Business Type	Report the value that defines the submitter's line of business for this line of eligibility. EXAMPLE: 1 = Risk Holder of this line of eligibility	All	100%
					Value	Description		
					1	Risk Holder		
					2	TPA - Third Party Administrator		
					3	DBA - Delegated Business Administrator		
					4	PBM - Pharmacy Benefit Manger		
					5	DBM - Dental Benefit Manager		
					6	CSO - Computer Service Organization		
					7	Other		
					0	Unknown / Not Applicable		
ME057	Date of Death	Full Date - Integer	Century Year Month Date	int[8]	Member's Date of Death	Report the date the member expired in CCYYMMDD Format. If still alive or date of death is unknown, do not report any value here.	All	0%
ME058	Subscriber Street Address	Text	Address 1 Subscriber	varchar[50]	Street address of the Subscriber	Report the subscriber's primary street address here. Used to create Unique Member ID.	All	98%
ME061	Student Status	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Student Status	Report the value that defines the element. EXAMPLE: 1 = Yes, Member is a student under age 26 on a parent's plan	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
ME062	Marital Status	Lookup Table - Text	tlkpMaritalStatus	char[1]	Marital Status Code	Report the member's marital status here	All	100%
					Code	Description		
					C	Common Law Married		
					D	Divorced		
					M	Married		
					P	Domestic Partnership		
					S	Never Married		
					W	Widowed		
					X	Legally Separated		
					U	Unknown		
ME073	Fully Insured member	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Fully Insured identifier	Report the value that defines the element. EXAMPLE: 1 = Yes, Member is fully insured.	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
ME074	Interpreter	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Interpreter Need	Report the value that defines the element. EXAMPLE: 1 = Yes, Member requires an interpreter.	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
ME081	Medicare Code	Lookup Table - Integer	tlkpMedicareCode	int[1]	Medicare Plan Indicator Code	Report the value that defines if and what type of Medicare coverage that applies to this line of eligibility. EXAMPLE: 1 = Part A Only	All Medicare enrollees	100%
					Value	Description		
					1	Part A Only		
					2	Part B Only		
					3	Part A and B		
					4	Part C Only		
					5	Advantage		

Member Eligibility detail

Element	Data Element Name	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%
					6	Part D Only		
					9	Not Applicable		
					0	No Medicare Coverage		
ME082	Employer Name	Text	Name Employer	varchar[60]	Member's Employer Name	Report the name of the subscriber's / member's employer at time of enrollment.	All	90%
ME083	Employer EIN	Numeric	ID Tax	char[9]	Member's Employer EIN	Report the Federal Tax ID of the Employer here. Do not use hyphen or alpha prefix.	Required when ME082/Employer Name is populated	90%
ME101	Subscriber Last Name	Text	Name Last Subscriber	varchar[60]	Last name of Subscriber	Report the last name of the subscriber. Used to create Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE	All	100%
ME102	Subscriber First Name	Text	Name First Subscriber	varchar[25]	First name of Subscriber	Report the first name of the subscriber here. Used to create Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: Anne-Marie becomes ANNEMARIE	All	100%
ME103	Subscriber Middle Initial	Text	Name Middle Subscriber	char[1]	Middle initial of Subscriber	Report the Subscriber's middle initial here. Used to create Unique Member ID.	All	2%
ME104	Member Last Name	Text	Name Last Member	varchar[60]	Last name of Member	Report the last name of the member here. Used to create Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE	All	100%
ME105	Member First Name	Text	Name First Member	varchar[25]	First name of Member	Report the first name of the member here. Used to create Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: Anne-Marie becomes ANNEMARIE	All	100%
ME106	Member Middle Initial	Text	Name Middle Member	char[1]	Middle initial of Member	Report the middle initial of the member when available. Used to create Unique Member ID.	All	2%
ME107	Carrier Specific Unique Member ID	Text	ID Link to ME137, PC107 DC056	varchar[50]	Member's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation	All	100%
ME108	Subscriber City Name	Text	Address City Subscriber	varchar[30]	City name of the Subscriber	Report the city name of the Subscriber	All	98%
ME109	Subscriber State or Province	External Code Source 2	Address State External Code Source 2 - States	char[2]	State of the Subscriber	Report the state of the subscriber here. Used to create Unique Member ID.	All	99%
ME110	Subscriber ZIP Code	External Code Source 2	Address Zip External Code Source 2 - Zip Codes	varchar[9]	Zip Code of the Subscriber	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen. Used to create Unique Member ID.	All	99%
ME117	Carrier Specific Unique Subscriber ID	Text	ID Link to MC141, PC108 DC057	varchar[50]	Subscriber's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation	All	100%
ME118	Vision Benefit	Lookup Table - Integer	tkpFlagIndicators	int[1]	Indicator - Vision Option	Report the value that defines the element. EXAMPLE: 1 = Yes, Vision is a covered benefit.	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
ME120	Actuarial Value	Decimal - Numeric	Value	varchar[6]		Report the Actuarial Value for the Member's coverage for the time period indicated by Enrollment Start and End dates in 0.0000 Format.	Required for Risk Adjustment Covered Plans	100%
ME121	Metal Level	Lookup Table - Integer	tkpMetalLevel	int[1]	Standardized plan level in metal reference	Report the Metal Level benefits that the member is associated to in this line of eligibility. EXAMPLE: 1 = Bronze Level	Required for Risk Adjustment Covered Plans	100%
					Value	Description		
					1	Bronze		
					2	Silver		
					3	Gold		
					4	Platinum		
					0	Unknown / Not Applicable		
ME124	Group Size	Lookup Table		Char[2]	Insurance market group	Code indicating Group Size consistent with Connecticut Insurance Law and Regulation. Required only for plans sold in the commercial large, small and nongroup markets. The following plans/products are not requires to report this value: student plans, Medicare supplemental, Medicaid or publicly subsidized plans, stand alone behavioral health, dental and vision plans.	All commercial	100%
					A	Individual		
					B	2-50		
					C	51-100		
					D	100+		
ME899	Record Type	Text	ID File		0	Value = ME		

Pharmacy Detail

Element	Data Element Name	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%
PC001	Submitter	Integer	ID Submitter	varchar[6]	CT APCD defined and maintained unique identifier	Name will be distributed by Data Manager.	All	100%
PC002	National Plan ID	Integer	ID Nat'l PlanID	int[10]	CMS National Plan Identification Number (PlanID)	Name will be distributed by Data Manager.	All	0%
PC003	Insurance Type Code/Product	Lookup Table - HIPAA code set		char[2]	Type / Product Identification Code	Report the code that defines the type of insurance under which this patient's claim line was processed. EXAMPLE: HM = HMO	All	95%
PC004	Payer Claim Control Number	Text	ID Claim Number	varchar[35]	Payer Claim Control Identification	Report the Unique identifier within the payer's system that applies to the entire claim	All	100%
PC005	Line Counter	Integer	ID Count	varchar[4]	Incremental Line Counter	Report the line number for this service within the claim. Start with 1 and increment by 1 for each additional line. Do not start with 0, include alphas or special characters.	All	100%
PC005A	Version Number	Integer	Counter	varchar[4]	Claim Service Line Version Number	Report the version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line. No alpha or special characters.	All	100%
PC006	Insured Group or Policy Number	Text	ID Group	varchar[30]	Group / Policy Number	Report the number that defines the insured group or policy. Do not report the number that uniquely identifies the subscriber or member	All	98%
PC007	Subscriber SSN	Numeric	ID Tax	char[9]	Subscriber's Social Security Number	Report the Subscriber's SSN here; used to validate Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here	All	85%
PC008	Plan Specific Contract Number	Text	ID Contract	varchar[30]	Contract Number	Report the Plan assigned contract number. Do not include values in this field that will distinguish one member of the family from another. This should be the contract or certificate number for the subscriber and all of the dependents.	All	98%
PC009	Member Suffix or Sequence Number	Text	ID Sequence	varchar[20]	Member/Patient's Contract Sequence Number	Report the unique number / identifier of the member within the contract	All	98%
PC010	Member SSN	Numeric	ID Tax	char[9]	Member/Patient's Social Security Number	Report the patient's social security number here; used to validate Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here	All	98%
PC011	Individual Relationship Code	Lookup Table - HIPAA code set		char[2]	Patient to Subscriber Relationship Code	Report the value that defines the Patient's relationship to the Subscriber. EXAMPLE: 20 = Self / Employee	All	85%
PC012	Member Gender	Lookup Table - Text	tlkpGender	char[1]	Patient's Gender	Report patient gender as found on the claim in alpha format. Used to validate clinical services when applicable and Unique Member ID. EXAMPLE: F = Female	All	100%
					Code	Description		
					F	Female		
					M	Male		
					U	Unknown		
PC013	Member Date of Birth	Full Date - Integer	Century Year Month Date	int[8]	Member/Patient's date of birth	Report the date the member / patient was born in YYYYMMDD Format. Used to validate Unique Member ID.	All	99%
PC014	Member City Name of Residence	Text	Address City Member	varchar[50]	City name of the Member/Patient	Report the city name of the member / patient. Used to validate Unique Member ID	All	99%
PC015	Member State	External Code Source 2 - Text	External Code Source 2 - States	char[2]	State / Province of the Patient	Report the state of the patient as defined by the US Postal Service. Report Province when Country Code does not = USA	All	99%
PC016	Member ZIP Code	External Code Source 2 - Text	Address Zip External Code Source 2 - Zip Codes	varchar[9]	Zip code of the Member / Patient	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	99%
PC017	Date Service Approved (AP Date)	Full Date - Integer	Century Year Month Date	int[8]	Date Service Approved by Payer	Report the date that the payer approved this claim line for payment in CCYYMMDD Format. This element was designed to capture date other than the Paid date. If Approved Date and Paid Date are the same, then the date here should match Paid Date.	All	99%
PC018	Pharmacy Number	Text	ID Pharmacy	varchar[30]	Pharmacy Number	Report either the NCPDP or NABP number of the dispensing pharmacy	All	98%
PC019	Pharmacy Tax ID Number	Numeric	ID Tax	char[9]	Pharmacy Tax Identification Number	Report the Federal Tax ID of the Pharmacy here. Do not use hyphen or alpha prefix.	All	20%
PC020	Pharmacy Name	Text	Name Pharmacy	varchar[100]	Name of Pharmacy	Report the name of the pharmacy here	All	90%
PC021	National Provider ID - Pharmacy	External Code Source 3 - Integer	External Code Source 3 - National Provider ID	int[10]	National Provider Identification (NPI) of the Pharmacy	Report the Primary National Provider ID (NPI) here. This ID should be found on the Provider File in the NPI field (PV039)	All	98%
PC022	Pharmacy Location City	Text	Address City Provider	varchar[30]	City name of the Pharmacy	Report the city name of pharmacy - preferably pharmacy location	All	85%
PC023	Pharmacy Location State	External Code Source 2 - Text	Address State External Code Source 2 - States	char[2]	State of the Pharmacy	Report the state where the dispensing pharmacy is located.	All	90%

Pharmacy Detail

Element	Data Element Name	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%
PC024	Pharmacy ZIP Code	External Code Source 2 - Text	Address Zip External Code Source 2 - Zip Codes	varchar[9]	Zip code of the Pharmacy	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	90%
PC024d	Pharmacy Country Code	External Code Source 1 - Text	Address Country External Code Source 1 - Countries	char[3]	Country Code of the Pharmacy	Report the three-character country code as defined by ISO 3166-1, Alpha 3	All	90%
PC025	Claim Status	Lookup Table - HIPAA code set	tlkpClaimStatus	varchar[2]	Claim Line Status	Report the value that defines the payment status of this claim line	All	98%
PC026	Drug Code	External Code Source 12 - Text	External Code Source 12 - National Drug Codes	char[11]	National Drug Code (NDC)	Report the NDC Code as defined by the FDA in 11 digit format (5-4-2) without hyphenation	All	98%
PC027	Drug Name	External Code Source 12 - Text	External Code Source 12 - National Drug Names	varchar[80]	Name of the drug as supplied	Report the name of the drug that aligns to the National Drug Code. Do not report generic names with brand National Drug Codes	All	95%
PC028	New Prescription or Refill	Numeric	ID Count	char[2]	Prescription Status Indicator	Report the status of prescription by numeric value. EXAMPLE: 00 = new prescription; First Refill = 01, etc.	All	99%
PC029	Generic Drug Indicator	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Generic Drug Indicator	Report the value that defines the element. EXAMPLE: 1 = Yes, the drug reported is a generic.	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
PC030	Dispense as Written Code	Lookup Table - Integer	tlkpDispenseAsWritten	int[1]	Prescription Dispensing Activity Code	Report the value that defines how the drug was dispensed. EXAMPLE: 0 = Not dispensed as written	All	98%
					Value	Description		
					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		
					0	Not dispensed as written		
PC031	Compound Drug Indicator	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Compound Drug Indicator	Report the value that defines the element. EXAMPLE: 1 = Yes, drug is a compound.	All	optional
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
PC032	Date Prescription Filled	Full Date - Integer	Century Year Month Date	int[8]	Prescription filled date	Report the date the pharmacy filled AND dispensed prescription to the patient in YYYYMMDD Format.	All	99%
PC033	Quantity Dispensed	Quantity - Integer	Counter	±varchar[10]	Claim line units dispensed	Report the number of metric units of medication dispensed	All	optional
PC034	Days' Supply	Quantity - Integer	Days Prescription	±varchar[3]	Prescription Supply Days	Report the number of days the prescription will last if taken as prescribed	All	optional
PC035	Charge Amount	Integer	Currency	±varchar[10]	Amount of provider charges for the claim line	Report the amount the provider / dispensing facility billed the insurance carrier for this claim line service. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%

Pharmacy Detail

Element	Data Element Name	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%
PC036	Paid Amount	Integer	Currency	±varchar[10]	Amount paid by the carrier for the claim line	Report the amount paid for the claim line. Report 0 if line is paid as part of another procedure / claim line. Do not report any value if the line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%
PC037	Ingredient Cost/List Price	Integer	Currency	±varchar[10]	Amount defined as the List Price or Ingredient Cost	Report the amount that defines this pharmaceutical cost / price. Do not report any value if unknown. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%
PC038	Postage Amount Claimed	Integer	Currency	±varchar[10]	Amount of postage claimed on the claim line	Report the amount of postage claimed for this claim line. Report 0 if postage does not apply Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	optional
PC039	Dispensing Fee	Integer	Currency	±varchar[10]	Amount of dispensing fee for the claim line	Report the amount that defines the dispensing fee. Report 0 if fee does not apply. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%
PC040	Copay Amount	Integer	Currency	±varchar[10]	Amount of Copay member/patient is responsible to pay	Report the amount that the is the patient's responsibility. Report 0 if no Copay applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%
PC041	Coinsurance Amount	Integer	Currency	±varchar[10]	Amount of coinsurance member/patient is responsible to pay	Report the amount that the is the patient's responsibility. Report 0 if no Coinsurance applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%
PC042	Deductible Amount	Integer	Currency	±varchar[10]	Amount of deductible member/patient is responsible to pay on the claim line	Report the amount that the is the patient's responsibility. Report 0 if no Deductible applies to service. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%
PC044	Prescribing Physician First Name	Text	Name First Provider	varchar[25]	First name of Prescribing Physician	Report the first name of the prescribing physician here.	All	50%
PC045	Prescribing Physician Middle Name	Text	Name Middle Provider	varchar[25]	Middle initial of Prescribing Physician	Report the middle name of the prescribing physician here.	All	2%
PC046	Prescribing Physician Last Name	Text	Name Last Provider	varchar[60]	Last name of Prescribing Physician	Report the last name of the prescribing physician here.	All	50%
PC047	National Provider ID - Prescribing	External Code Source 3 - Integer	External Code Source 3 - National Provider ID	int[10]	National Provider Identification (NPI) of the Prescribing Provider	Report the Primary National Provider ID (NPI) of the Prescribing Provider in PC043. This ID should be found on the Provider File in the NPI Field (PV039). This field is looking to capture the NPI of an individual physician, not a group	All	80%
PC047a	Prescribing Physician Provider ID	External Code Source	External Code Source	varchar[30]	Prescriber Provider ID	Provider ID for the Prescribing Clinician	All	80%
PC047b	Prescribing Physician DEA	External Code Source	External Code Source	varchar[20]	Prescriber DEA	DEA Number for the Prescribing Clinician	All	optional
PC049	Prescribing Physician Plan Number	Text	ID Plan	varchar[30]	Carrier-assigned Provider Plan ID	Report the prescriber's plan number here. Do not report any value here if contracted with the carrier.	All	optional
PC050	Prescribing Physician License Number	Text	ID License	varchar[30]	Prescribing Physician License Number	Report the state license number for the provider identified in PV002. For a doctor this is the medical license for a non-doctor this is the practice license. Do not use zero-fill. If not available, or not applicable, such as for a group or corporate entity, do not report any value here.	All	optional
PC057	Mail Order pharmacy	Lookup Table Integer	tkpFlagIndicators	int[1]	Indicator - Mail Order Option	Report the value that defines the element. EXAMPLE: 1 = Yes, pharmacy is a mail order pharmacy	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
PC058	Script number	Text	ID Claim Number	varchar[20]	Prescription Number	Report the unique identifier of the prescription	All	100%
PC061	Member Street Address	Text	Address 1 Member	varchar[50]	Street address of the Member/Patient	Report the patient / member's address. Used to validate Unique Member ID.	All	90%
PC062	Billing Provider Tax ID Number	Numeric	ID Tax	char[9]	The Billing Provider's Federal Tax Identification Number (FTIN)	Report the Federal Tax ID of the Billing Provider here. Do not use hyphen or alpha prefix.	All	90%
PC063	Paid Date	Full Date - Integer	Century Year Month Date	int[8]	Paid date of the claim line	Report the date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment in CCYMMDD Format. This can be the same date as Processed Date. EXAMPLE: Claims paid in full, partial or zero paid	All	99%
PC064	Date Prescription Written	Full Date - Integer	Century Year Month Date	int[8]	Date prescription was prescribed	Report the date that was written on the prescription or called-in by the physician's office in CCYMMDD Format.	All	98%

Pharmacy Detail

Element	Data Element Name	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%
PC068	Allowed amount	Integer	Currency	±varchar[10]	Allowed Amount	Report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider contract and most often it is less than or equal to the fee charged by the pharmacy. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	Required when PC025 does not = 4, 22, or 23	99%
PC069	Member Self Pay Amount	Integer	Currency	±varchar[10]	Amount member/patient paid out of pocket on the claim line	Report the amount that the patient has paid beyond the copay structure. Report 0 if patient has not paid towards this claim line. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	20%
PC072	Carve Out Vendor CT APCD ID	Integer	ID Link to CT APCD ID	varchar[6]	CT APCD defined and maintained Org ID for linking across submitters	Report the CT APCD ID of the DBA here. This element contains the CT APCD assigned organization ID for the DBA. Contact the APCD for the appropriate value. If no DBA is affiliated with this claim line do not report any value here: i.e., do not repeat the CT APCD ID from PC001	All	98%
PC075	Drug Unit of Measure	Lookup Table - NCPDP reference		char[2]	Units of Measure	Report the code that defines the unit of measure for drug dispensed. EXAMPLE: EA = Each	All	80%
PC101	Subscriber Last Name	Text	Name Last Subscriber	varchar[60]	Last name of Subscriber	Report the last name of the subscriber. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE	All	98%
PC102	Subscriber First Name	Text	Name First Subscriber	varchar[25]	First name of Subscriber	Report the first name of the subscriber here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: Anne-Marie becomes ANNEMARIE	All	98%
PC103	Subscriber Middle Initial	Text	Name Middle Subscriber	char[1]	Middle initial of Subscriber	Report the Subscriber's middle initial here. Used to validate Unique Member ID.	All	2%
PC104	Member Last Name	Text	Name Last Member	varchar[60]	Last name of Member/Patient	Report the last name of the patient / member here. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE	All	98%
PC105	Member First Name	Text	Name First Member	varchar[25]	First name of Member/Patient	Report the first name of the patient / member here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: Anne-Marie becomes ANNEMARIE	All	98%
PC106	Member Middle Initial	Text	Name Middle Member	char[1]	Middle initial of the Member/Patient	Report the middle initial of the patient / member when available. Used to validate Unique Member ID.	All	2%
PC107	Carrier Specific Unique Member ID	Text	ID Link to ME107	varchar[50]	Member's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to validate Unique Member ID and link back to Member Eligibility (ME107)	All	100%
PC108	Carrier Specific Unique Subscriber ID	Text	ID Link to ME117	varchar[50]	Subscriber's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to validate Unique Member ID and link back to Member Eligibility (ME117)	All	100%
PC109	Member Street Address 2	Text	Address 2 Member	varchar[50]	Secondary Street Address of the Member/Patient	Report the address of member which may include apartment number or suite, or other secondary information besides the street. Used to validate Unique Member ID.	All	0%
PC110	Claim Line Type	Lookup Table - Text	tkpClaimLineType	char[1]	Claim Line Activity Type Code	Report the code that defines the claim line status in terms of adjudication. EXAMPLE: O = Original	All	98%
					Code	Description		
					O	Original		
					V	Void		
					R	Replacement		
					B	Back Out		
					A	Amendment		
PC111	Former Claim Number	Text	ID Claim Number	varchar[35]	Previous Claim Number	Report the Claim Control Number (PC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own PC004. Use of "Former Claim Number" to version claims can only be used if approved by the APCD. Contact the APCD for conditions of use.	All	0%
PC899	Record Type	Text	ID File	char[2]	File Type Identifier	Report PC here. This validates the type of file and the data contained within the file. This must match HD004	All	100%

Medical Claims Data Detail

Col	Element	Data Element Name	Type	Format / Length	Description	Element Submission Guideline	Condition	%
1	MC001	Submitter	Integer	varchar[6]	CT APCD defined and maintained unique identifier	Report the Unique Submitter ID as defined by CT APCD here. This must match the Submitter ID reported in HD002	All	100%
2	MC002	National Plan ID	Integer	int[10]	CMS National Plan Identification Number (PlanID)	Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans	All	0%
3	MC003	Insurance Type Code/Product	External Code Source	char[2]	Type / Product Identification Code	Report the code that defines the type of insurance under which this patient's claim line was processed. EXAMPLE: HM = HMO	All	92%
4	MC004	Payer Claim Control Number	Text	varchar[35]	Payer Claim Control Identification	Report the Unique identifier within the payer's system that applies to the entire claim	All	100%
5	MC005	Line Counter	Integer	varchar[4]	Incremental Line Counter	Report the line number for this service within the claim. Start with 1 and increment by 1 for each additional line. Do not start with 0, include alphas or special characters.	All	100%
6	MC005A	Version Number	Integer	varchar[4]	Claim Service Line Version Number	Report the version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line. No alpha or special characters.	All	100%
7	MC006	Insured Group or Policy Number	Text	varchar[30]	Group / Policy Number	Report the number that defines the insured group or policy. Do not report the number that uniquely identifies the subscriber or member	All	95%
8	MC007	Subscriber SSN	Numeric	char[9]	Subscriber's Social Security Number	Report the Subscriber's SSN here; used to validate Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here	All	79%
9	MC008	Plan Specific Contract Number	Text	varchar[30]	Contract Number	Report the Plan assigned contract number. Do not include values in this field that will distinguish one member of the family from another. This should be the contract or certificate number for the subscriber and all of the dependents.	All	98%
10	MC009	Member Suffix or Sequence Number	Text	varchar[20]	Member/Patient's Contract Sequence Number	Report the unique number / identifier of the member / patient within the contract	All	98%
11	MC010	Member SSN	Numeric	char[9]	Member/Patient's Social Security Number	Report the patient's social security number here; used to validate Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here	All	73%
12	MC011	Individual Relationship Code	External Code Source	char[2]	Patient to Subscriber Relationship Code	Report the value that defines the Patient's relationship to the Subscriber. EXAMPLE: 20 = Self / Employee	All	98%
13	MC012	Member Gender	Lookup Table - Text	char[1]	Patient's Gender	Report patient gender as found on the claim in alpha format. Used to validate clinical services when applicable and Unique Member ID. EXAMPLE: F = Female	All	98%
					Code	Description		
					F	Female		
					M	Male		
					U	Unknown		
14	MC013	Member Date of Birth	Full Date - Integer	int[8]	Member/Patient's date of birth	Report the date the member / patient was born in CCYYMMDD Format. Used to validate Unique Member ID.	All	98%
15	MC014	Member City Name	Text	varchar[30]	City name of the Member/Patient	Report the city name of the member / patient. Used to validate Unique Member ID	All	98%
16	MC015	Member State	External Code Source 2 - Text	char[2]	State / Province of the Patient	Report the state of the patient as defined by the US Postal Service. Report Province when Country Code does not = USA	All	98%
17	MC016	Member ZIP Code	External Code Source 2 - Text	varchar[9]	Zip Code of the Member / Patient	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	98%
18	MC017	Date Service Approved (AP Date)	Full Date - Integer	int[8]	Date Service Approved by Payer	Report the date that the payer approved this claim line for payment in CCYYMMDD Format. This element was designed to capture date other than the Paid date. If Approved Date and Paid Date are the same, then the date here should match Paid Date.	All	93%
19	MC018	Admission Date	Full Date - Integer	int[8]	Inpatient Admit Date	Report the date of admit to a facility in CCYYMMDD Format. Only applies to facility claims were Type of Bill = an inpatient setting.	Required when MC094 = 002 and MC039 is populated	98%

Medical Claims Data Detail

Col	Element	Data Element Name	Type	Format / Length	Description	Element Submission Guideline	Condition	%
20	MC019	Admission Hour	Numeric	char[4]	Admission Time	Report the Admit Time in HHMM Format. Only applies to facility claims were Type of Bill = an inpatient setting. Time is expressed in military time. If only the hour is known, code the minutes as 00. 4 AM would be reported as 0400; 4 PM would be reported as 1600.	Required when MC094 = 002 and MC039 is populated	5%
21	MC020	Admission Type	External Code Source 14 - Integer	int[1]	Admission Type Code	Report Admit Type as it applies to facility claims were Type of Bill = an inpatient setting. This code indicates the type of admission into an inpatient setting. Also known as Admission Priority.	Required when MC094 = 002 and MC039 is populated	98%
22	MC021	Admission Source	External Code Source 14 - Text	char[1]	Admission Source Code	Report the code that applies to facility claims were Type of Bill = an inpatient setting. This code indicates how the patient was referred into an inpatient setting at the facility.	Required when MC094 = 002 and MC039 is populated	98%
23	MC022	Discharge Hour	Numeric	char[4]	Discharge Time	Report the Discharge Time in HHMM Format. Only applies to facility claims were Type of Bill = an inpatient setting. Time is expressed in military time. If only the hour is known, code the minutes as 00. 4 AM would be reported as 0400; 4 PM would be reported as 1600.	Required when MC094 = 002 and MC069 is populated	5%
24	MC023	Discharge Status	External Code Source 14 - Numeric	char[2]	Inpatient Discharge Status Code	Report the appropriate Discharge Status Code of the patient as defined by External Code Source	Required when MC094 = 002 and MC069 is populated	98%
25	MC024	Service Provider Number	Text	varchar[30]	Service Provider Identification Number	Report the carrier / submitter assigned billing provider number. This number should be the identifier used for internal identification purposes, and does not routinely change. The value in this field must match a record in the provider file in PV002.	All	99%
26	MC025	Service Provider Tax ID Number	Numeric	char[9]	Service Provider's Tax ID number	Report the Federal Tax ID of the Service Provider here. Do not use hyphen or alpha prefix.	All	97%
27	MC026	National Provider ID - Service	External Code Source 3 - Integer	int[10]	National Provider Identification (NPI) of the Service Provider	Report the Primary National Provider ID (NPI) of the Servicing Provider in MC024. This ID should be found on the Provider File in the NPI Field (PV039)	All	98%
28	MC027	Service Provider Entity Type Qualifier	Lookup Table - integer	int[1]	Service Provider Entity Identifier Code	Report the value that defines the provider entity type. Only individuals should be identified with a 1. Facilities, professional groups and clinic sites should all be identified with a 2. EXAMPLE: 1 = Person	All	98%
					Value	Description		
					1	Person		
					2	Non-person entity		
29	MC028	Service Provider First Name	Text	varchar[25]	First name of Service Provider	Report the individual's first name here. If provider is a facility or organization , do not report any value here	Required when MC021 = 1	92%
30	MC029	Service Provider Middle Name	Text	varchar[25]	Middle initial of Service Provider	Report the individual's middle name here. If provider is a facility or organization , do not report any value here	Required when MC021 = 1	2%
31	MC030	Servicing Provider Last Name or Organization Name	Text	varchar[60]	Last name or Organization Name of Service Provider	Report the name of the organization or last name of the individual provider. MC027 determines if this is an Organization or Individual Name reported here.	All	94%
33	MC032	Service Provider Taxonomy	External Code Source 5 - Text	varchar[10]	Taxonomy Code	Report the standard code that defines this provider for this line of service. Taxonomy values allow for the reporting of nurses, assistants and laboratory technicians, where applicable, as well as Physicians, Medical Groups, Facilities, etc.	All	98%
34	MC033	Service Provider City Name	Text	varchar[30]	City Name of the Provider	Report the city name of provider - preferably practice location	All	98%
35	MC034	Service Provider State	External Code Source 2 - Text	char[2]	State of the Service Provider	Report the state of the service providers as defined by the US Postal Service	All	98%
36	MC035	Service Provider ZIP Code	External Code Source 2 - Text	varchar[9]	Zip Code of the Service Provider	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	98%

Medical Claims Data Detail

Col	Element	Data Element Name	Type	Format / Length	Description	Element Submission Guideline	Condition	%
37	MC036	Type of Bill - on Facility Claims	External Code Source 14 - Integer	int[2]	Type of Bill	Report the two-digit value that defines the Type of Bill on an institutional claim. Do not report leading zero	Required when MC094 = 002	98%
38	MC037	Site of Service - on NSF/CMS 1500 Claims	External Code Source 13 - Numeric	char[2]	Place of Service Code	Report the two-digit value that defines the Place of Service on professional claim	Required when MC094 = 001	100%
39	MC038	Claim Status	Lookup Table - Numeric	varchar[2]	Claim Line Status	Report the value that defines the payment status of this claim line	All	98%
40	MC039	Admitting Diagnosis	External Code Source 8 - Text	varchar[7]	Admitting Diagnosis Code	Report the diagnostic code assigned by provider that supported admission into the inpatient setting	Required when MC094 = 002 and MC036 = 11, 18, 21, 28, 41, 65, 66, 84, 86, or 89	98%
41	MC040	E-Code	External Code Source 8 - Text	varchar[7]	ICD Diagnostic External Injury Code	Report the external injury code for patient when appropriate to the claim	All	3%
42	MC041	Principal Diagnosis	External Code Source 8 - Text	varchar[7]	ICD Primary Diagnosis Code	Report the Primary ICD Diagnosis Code here	All	99%
43	MC042	Other Diagnosis - 1	External Code Source 8 - Text	varchar[7]	ICD Secondary Diagnosis Code	Report the Secondary ICD Diagnosis Code here	All	70%
44	MC043	Other Diagnosis - 2	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 2. If not applicable do not report any value here	All	24%
45	MC044	Other Diagnosis - 3	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 3. If not applicable do not report any value here	All	13%
46	MC045	Other Diagnosis - 4	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 4. If not applicable do not report any value here	All	7%
47	MC046	Other Diagnosis - 5	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 5. If not applicable do not report any value here	All	4%
48	MC047	Other Diagnosis - 6	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 6. If not applicable do not report any value here	All	3%
49	MC048	Other Diagnosis - 7	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 7. If not applicable do not report any value here	All	3%

Medical Claims Data Detail

Col	Element	Data Element Name	Type	Format / Length	Description	Element Submission Guideline	Condition	%
50	MC049	Other Diagnosis - 8	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 8. If not applicable do not report any value here	All	2%
51	MC050	Other Diagnosis - 9	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 9. If not applicable do not report any value here	All	1%
52	MC051	Other Diagnosis - 10	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 10. If not applicable do not report any value here.	All	1%
53	MC052	Other Diagnosis - 11	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 11. If not applicable do not report any value here.	All	1%
54	MC053	Other Diagnosis - 12	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 12. If not applicable do not report any value here.	All	1%
55	MC054	Revenue Code	External Code Source 14 - Numeric	char[4]	Revenue Code	Report the valid National Uniform Billing Committee Revenue Code here. Code using leading zeroes, left-justified, and four digits.	Required when MC094 = 002	98%
56	MC055	Procedure Code	Carrier Defined Table - OR - External Code Source 9 - Text	varchar[10]	HCPCS / CPT Code	Report a valid Procedure code for the claim line as defined by MC130	All	98%
57	MC056	Procedure Modifier - 1	External Code Source 9 - Text	char[2]	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055).	All	20%
58	MC057	Procedure Modifier - 2	External Code Source 9 - Text	char[2]	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055).	All	3%
59	MC058	ICD9-CM Procedure Code	External Codes Source 8 - Text	varchar[6]	ICD Primary Procedure Code	Report the primary ICD CM procedure code when appropriate. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	Required when MC094 = 002 and MC039 is populated	98%
60	MC059	Date of Service - From	Full Date - Integer	int[8]	Date of Service	Report the date of service for the claim line in CCYYMMDD Format.	All	98%
61	MC060	Date of Service - To	Full Date - Integer	int[8]	Date of Service	Report the end service date for the claim line in CCYYMMDD Format. For inpatient claims, the room and board line may or may not be equal to the discharge date. Procedures delivered during a visit should indicate which date they occurred.	All	98%
62	MC061	Quantity	Quantity - Integer	±varchar[15]	Claim line units of service	Report the count of services / units performed.	All	98%
63	MC062	Charge Amount	Integer	±varchar[10]	Amount of provider charges for the claim line	Report the charge amount for this claim line. 0 dollar charges allowed only when the procedure code indicates a Category II procedure code vs. a service code. When reporting Total Charges for facilities for the entire claim use 001 (the generally accepted Total Charge Revenue Code) in MC054 (Revenue Code). Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%

Medical Claims Data Detail

Col	Element	Data Element Name	Type	Format / Length	Description	Element Submission Guideline	Condition	%
64	MC063	Paid Amount	Integer	±varchar[10]	Amount paid by the carrier for the claim line	Report the amount paid for the claim line. Report 0 if line is paid as part of another procedure / claim line. Do not report any value if the line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%
66	MC065	Copay Amount	Integer	±varchar[10]	Amount of Copay member/patient is responsible to pay	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Copay applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%
67	MC066	Coinsurance Amount	Integer	±varchar[10]	Amount of coinsurance member/patient is responsible to pay	Report the amount that defines a calculated percentage amount for this claim line service that the patient is responsible to pay. Report 0 if no Coinsurance applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%
68	MC067	Deductible Amount	Integer	±varchar[10]	Amount of deductible member/patient is responsible to pay on the claim line	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Deductible applies to service. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%
69	MC068	Patient Control Number	Text	varchar[20]	Patient Control Number	Report the provider assigned Encounter / Visit number to identify patient treatment. Also known as the Patient Account Number	Required when MC094 = 001 or 002	98%
70	MC069	Discharge Date	Full Date - Integer	int[8]	Discharge Date	Report the date the member was discharged from the facility in CCYYMMDD Format. If patient is still in-house and claim represents interim billing for interim payment, report the interim through date.	Required when MC094 = 002 and MC039 is populated	98%
71	MC070	Service Provider Country Code	External Code Source 1 - Text	char[3]	Country name of the Service Provider	Report the three-character country code as defined by ISO 3166-1, Alpha 3	All	98%
72	MC071	DRG	External Code Source 15 - Text	varchar[7]	Diagnostic Related Group Code	Report the DRG number applied to this claim on every line to which its applicable. Insurers and health care claims processors shall code using the CMS methodology when available. When the CMS methodology for DRGs is not available, but the All Payer DRG system is used, the insurer shall format the DRG and the complexity level within the same element with the prefix of "A" and with a hyphen separating the AP DRG from the complexity level (e.g. AXXX-XX)	Required when MC094 = 002 and MC069 is populated	98%
73	MC072	DRG Version	External Code Source 15 - Text	char[2]	Diagnostic Related Group Version Number	Report the version of the grouper used	Required when MC071 is populated	20%
74	MC073	APC	External Code Source 15 - Text	char[4]	Ambulatory Payment Classification Number	Report the APC number applied to this claim line, with the leading zero(s) when applicable. Code using the CMS methodology.	Required when MC094 = 002 and MC039 is null	20%
75	MC074	APC Version	External Code Source 15 - Text	char[2]	Ambulatory Payment Classification Version	Report the version of the grouper used	Required when MC073 is populated	20%
76	MC075	Drug Code	External Code Source 12 - Text	char[11]	National Drug Code (NDC)	Report the NDC code used only when a medication is paid for as part of a medical claim or when a DME device has an NDC code. J codes should be submitted under procedure code (MC055), and have a procedure code type of 'HCPCS'. Drug Code as defined by the FDA in 11 digit format (5-4-2) without hyphenation	All	1%
77	MC076	Billing Provider Number	Text	varchar[30]	Billing Provider Number	Report the carrier / submitter assigned billing provider number. This number should be the identifier used for internal identification purposes, and does not routinely change. The value in this field must match a record in the provider file in PV002.	All	99%
78	MC077	National Provider ID - Billing	External Code Source 3 - Integer	int[10]	National Provider Identification (NPI) of the Billing Provider	Report the Primary National Provider ID (NPI) here. This ID should be found on the Provider File in the NPI field (PV039)	All	99%

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Col	Element	Data Element Name	Type	Format / Length	Description	Element Submission Guideline	Condition	%
79	MC078	Billing Provider Last Name or Organization Name	Text	varchar[60]	Last name or Organization Name of Billing Provider	Report the name of the organization or last name of the individual provider	All	99%
81	MC080	Payment Reason	Carrier Defined Table - OR External Code Source 16 - Text	varchar[10]	Payment Reason Code	Report the value that describes how the claim line was paid, either using a standard code set or a proprietary list pre-sent by submitter.	Required when MC038 = 01, 02, 03, 19, 20, or 21	100%
82	MC081	Capitated Encounter Flag	Lookup Table - Integer	int[1]	Indicator - Capitation Payment	Report the value that defines the element. EXAMPLE: 1 = Yes payment for this service is covered under a capitated arrangement.	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
83	MC082	Member Street Address	Text	varchar[50]	Street address of the Member/Patient	Report the patient / member's address. Used to validate Unique Member ID.	All	90%
84	MC083	Other ICD-CM Procedure Code - 1	External Codes Source 8 - Text	varchar[6]	ICD Secondary Procedure Code	Report the subsequent ICD CM procedure code when applicable. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	Required when MC094 = 002 and MC039 is populated	1%
85	MC084	Other ICD-CM Procedure Code - 2	External Codes Source 8 - Text	varchar[6]	ICD Other Procedure Code	Report the third ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Required when MC094 = 002 and MC039 is populated	1%
86	MC085	Other ICD-CM Procedure Code - 3	External Codes Source 8 - Text	varchar[6]	ICD Other Procedure Code	Report the fourth ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Required when MC094 = 002 and MC039 is populated	1%
87	MC086	Other ICD-CM Procedure Code - 4	External Codes Source 8 - Text	varchar[6]	ICD Other Procedure Code	Report the fifth ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Required when MC094 = 002 and MC039 is populated	1%
88	MC087	Other ICD-CM Procedure Code - 5	External Codes Source 8 - Text	varchar[6]	ICD Other Procedure Code	Report the sixth ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Required when MC094 = 002 and MC039 is populated	1%
89	MC088	Other ICD-CM Procedure Code - 6	External Codes Source 8 - Text	varchar[6]	ICD Other Procedure Code	Report the seventh ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Required when MC094 = 002 and MC039 is populated	1%
90	MC089	Paid Date	Full Date - Integer	int[8]	Paid date of the claim line	Report the date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment in CCYYMMDD Format. This can be the same date as Processed Date. EXAMPLE: Claims paid in full, partial or zero paid must have a date reported here	Required when MC038 = 01, 02, 03, 19, 20, or 21	98%
95	MC094	Type of Claim	Lookup Table - Text	int[1]	Type of Claim Indicator	Report the value that defines the type of claim submitted for payment. EXAMPLE: 001 = Professional Claim Line	All	100%
					Value	Description		
					1	Professional		
					2	Facility		
					3	Reimbursement Form		

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Col	Element	Data Element Name	Type	Format / Length	Description	Element Submission Guideline	Condition	%
99	MC098	Allowed amount	Integer	±varchar[10]	Allowed Amount	Report the maximum amount that a carrier will pay to a provider for a particular procedure or service. Report 0 when the claim line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC038 does not = 4, 22, or 23	99%
101	MC100	Carve Out Vendor CT APCD ID	Integer	varchar[6]	CT APCD defined and maintained Org ID for linking across submitters	Report the CT APCD ID of the Carve Out Vendor here. This element contains the CT APCD assigned organization ID for the Vendor. Contact the CT APCD for the appropriate value. If no Vendor is affiliated with this claim line do not report any value here: i.e., do not repeat the CT APCD ID from MC001	All	98%
102	MC101	Subscriber Last Name	Text	varchar[60]	Last name of Subscriber	Report the last name of the subscriber. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE	All	98%
103	MC102	Subscriber First Name	Text	varchar[25]	First name of Subscriber	Report the first name of the subscriber here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: Anne-Marie becomes ANNEMARIE	All	98%
104	MC103	Subscriber Middle Initial	Text	char[1]	Middle initial of Subscriber	Report the Subscriber's middle initial here. Used to validate Unique Member ID.	All	2%
105	MC104	Member Last Name	Text	varchar[60]	Last name of Member/Patient	Report the last name of the patient / member here. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE	All	98%
106	MC105	Member First Name	Text	varchar[25]	First name of Member/Patient	Report the first name of the patient / member here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: Anne-Marie becomes ANNEMARIE	All	98%
107	MC106	Member Middle Initial	Text	char[1]	Middle initial of Member/Patient	Report the middle initial of the patient / member when available. Used to validate Unique Member ID.	All	2%
108	MC107	ICD Indicator	Lookup Table - Integer	int[1]	International Classification of Diseases version	Report the value that defines whether the diagnoses on claim are ICD9 or ICD10. EXAMPLE: 9 = ICD9	Required when MC094 = 001 or 002 and MC039 thru MC053, MC142 thru MC153 is populated	100%
					Value	Description		
					9	ICD-9		
					0	ICD-10		
109	MC108	Procedure Modifier - 3	External Code Source 9 - Text	char[2]	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055).	All	0%
110	MC109	Procedure Modifier - 4	External Code Source 9 - Text	char[2]	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055).	All	0%
111	MC110	Claim Processed Date	Full Date - Integer	int[8]	Claim Processed Date	Report the date the claim was processed by the carrier / submitter in CCYYMMDD Format. This date can be equal to Paid or Denial Date, but cannot be after Paid or Denial Date.	All	98%

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Col	Element	Data Element Name	Type	Format / Length	Description	Element Submission Guideline	Condition	%
112	MC111	Diagnostic Pointer	Integer	varchar[4]	Diagnostic Pointer Number	Report the placement number of the diagnosis(es) a procedure is related to for a professional claim. Can report up to four diagnostic positions within the first nine diagnoses that can be reported. Do not separate multiple mappings with spaces, zeros or special characters. Do not zero fill. EXAMPLE: Procedure related to diagnoses 1, 4 and 5 = 145	Required when MC094 = 001	98%
113	MC112	Referring Provider ID	Text	varchar[30]	Referring Provider ID	Report the identifier of the provider that submitted the referral for the service or ordered the test that is on the claim (if applicable). The value in this field must have a corresponding Provider ID (PV002) on the provider file.	Required when MC118 = 1	98%
114	MC113	Payment Arrangement Type	Lookup Table - Numeric	char[2]	Payment Arrangement Type Value	Report the value that defines the contracted payment methodology for this claim line. EXAMPLE: 02 = Fee for Service	All	98%
					Value	Description		
					1	Capitation		
					2	Fee for Service		
					3	Percent of Charges		
					4	DRG		
					5	Pay for Performance		
					6	Global Payment		
					7	Other		
					8	Bundled Payment		
115	MC114	Excluded Expenses	Integer	±varchar[10]	Amount not covered at the claim line due to benefit/plan limitation	Report the amount that the patient has incurred towards covered but over-utilized services. Scenario: Physical Therapy units that are authorized for 15 visits at \$50 a visit but utilized 20. The amount reported here would be 25000 to state over-utilization by \$250.00. Report 0 if there are no Excluded Expenses. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	98%
120	MC119	PCP Indicator	Lookup Table - Integer	int[1]	Indicator - PCP Rendered Service	Report the value that defines the element. EXAMPLE: 1 = Yes service was performed by members PCP.	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
121	MC120	DRG Level	External Code Source 15 - Integer	int[1]	Diagnostic Related Group Code Severity Level	Report the level used for severity adjustment when applicable.	Required when MC071 is populated	80%
123	MC122	Global Payment Flag	Lookup Table - Integer	int[1]	Indicator - Global Payment	Report the value that defines the element. EXAMPLE: 1 = Yes the claim line was paid under a global payment arrangement.	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
124	MC123	Denied Flag	Lookup Table - Integer	int[1]	Denied Claim Line Indicator	Report the value that defines the element. EXAMPLE: 1 = Yes, Claim Line was denied.	Required when MC038 = 04	100%
					Value	Description		
					1	Yes		
					2	No		

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Col	Element	Data Element Name	Type	Format / Length	Description	Element Submission Guideline	Condition	%
					3	Unknown		
					4	Other		
					5	Not Applicable		
125	MC124	Denial Reason	Carrier Defined Table - OR External Code Source 16 - Text	varchar[15]	Denial Reason Code	Report the code that defines the reason for denial of the claim line. Carrier must submit denial reason codes in separate table to the APCD.	Required when MC123 = 1	98%
126	MC125	Attending Provider	Text	varchar[30]	Attending Provider ID	Report the ID that reflects the provider that provided general oversight of the patient's care. This individual may or may not be the Servicing or Rendering provider. This value needs to be found in field PV002 on the Provider File. This field may or may not be NPI based on the carrier's identifier system.	Required when MC094 = 002 and MC039 is populated	98%
127	MC126	Accident Indicator	Lookup Table - Integer	int[1]	Indicator - Accident Related	Report the value that defines the element. EXAMPLE: 1 = Yes, Claim Line is Accident related.	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
131	MC130	Procedure Code Type	Lookup Table - Integer	int[1]	Claim line Procedure Code Type Identifier	Report the value the defines the type of Procedure Code expected in MC055.	All	98%
					Value	Description		
					1	CPT or HCPCS Level 1 Code		
					2	HCPCS Level II Code		
					3	HCPCS Level III Code (State Medicare code).		
					4	American Dental Association (ADA) Procedure Code (Also referred to as CDT code.)		
					5	State defined Procedure Code		
					6	CPT Category II		
					7	Custom Code - Submitter must send in a lookup table of values for MC055		
132	MC131	InNetwork Indicator	Lookup Table - Integer	int[1]	Indicator - Network Rate Applied	Report the value that defines the element. EXAMPLE: 1 = Yes claim line was paid at an InNetwork rate.	All	100%
					Value	Description		
					1	Yes		
					2	No		
					3	Unknown		
					4	Other		
					5	Not Applicable		
134	MC133	Bill Frequency Code	External Code Source 14 - Text	char[1]	Bill Frequency	Report the valid frequency code of the claim to indicate version, credit/debit activity and/or setting of claim.	Required when MC094 = 001 or 002	100%
135	MC134	Plan Rendering Provider Identifier	Text	varchar[30]	Plan Rendering Number	Report the unique code which identifies for the carrier / submitter who or which individual provider cared for the patient for the claim line in question. This code must be able to link to the Provider File. Any value in this field must also show up as a value in field PV002 (Provider ID) on the Provider File.	All	100%
138	MC137	Carrier Specific Unique Member ID	Text	varchar[50]	Member's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to validate Unique Member ID and link back to Member Eligibility (ME107)	All	100%

Medical Claims Data Detail

Col	Element	Data Element Name	Type	Format / Length	Description	Element Submission Guideline	Condition	%
139	MC138	Claim Line Type	Lookup Table - Text	char[1]	Claim Line Activity Type Code	Report the code that defines the claim line status in terms of adjudication. EXAMPLE: O = Original	All	98%
					Code	Description		
					O	Original		
					V	Void		
					R	Replacement		
					B	Back Out		
					A	Amendment		
140	MC139	Former Claim Number	Text	varchar[35]	Previous Claim Number	Report the Claim Control Number (MC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own MC004. Use of "Former Claim Number" to version claims can only be used if approved by the APCD. Contact the APCD for conditions of use.	All	0%
141	MC140	Member Street Address 2	Text	varchar[50]	Secondary Street Address of the Member/Patient	Report the address of member which may include apartment number or suite, or other secondary information besides the street. Used to validate Unique Member ID.	All	1%
142	MC141	Carrier Specific Unique Subscriber ID	Text	varchar[50]	Subscriber's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to validate Unique Member ID and link back to Member Eligibility (ME117)	All	100%
143	MC142	Other Diagnosis - 13	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 13. If not applicable do not report any value here	All	1%
144	MC143	Other Diagnosis - 14	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 14. If not applicable do not report any value here	All	1%
145	MC144	Other Diagnosis - 15	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 15. If not applicable do not report any value here	All	1%
146	MC145	Other Diagnosis - 16	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 16. If not applicable do not report any value here	All	1%
147	MC146	Other Diagnosis - 17	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 17. If not applicable do not report any value here	All	1%
148	MC147	Other Diagnosis - 18	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 18. If not applicable do not report any value here	All	1%
149	MC148	Other Diagnosis - 19	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 19. If not applicable do not report any value here	All	1%
150	MC149	Other Diagnosis - 20	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 20. If not applicable do not report any value here	All	1%
151	MC150	Other Diagnosis - 21	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 21. If not applicable do not report any value here	All	1%

Medical Claims Data Detail

Col	Element	Data Element Name	Type	Format / Length	Description	Element Submission Guideline	Condition	%
152	MC151	Other Diagnosis - 22	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 22. If not applicable do not report any value here	All	1%
153	MC152	Other Diagnosis - 23	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 23. If not applicable do not report any value here	All	1%
154	MC153	Other Diagnosis - 24	External Code Source 8 - Text	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 24. If not applicable do not report any value here	All	1%
155	MC154	Present on Admission Code (POA) 01	External Code Source 15 - Text	char[1]	POA code for Principal Diagnosis	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC041 is populated	100%
156	MC155	Present on Admission Code (POA) 02	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 1	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC042 is populated	100%
157	MC156	Present on Admission Code (POA) 03	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 2	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC043 is populated	100%
158	MC157	Present on Admission Code (POA) 04	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 3	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC044 is populated	100%
159	MC158	Present on Admission Code (POA) 05	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 4	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC045 is populated	100%
160	MC159	Present on Admission Code (POA) 06	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 5	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC046 is populated	100%
161	MC160	Present on Admission Code (POA) 07	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 6	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC047 is populated	100%
162	MC161	Present on Admission Code (POA) 08	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 7	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC048 is populated	100%

Medical Claims Data Detail

Col	Element	Data Element Name	Type	Format / Length	Description	Element Submission Guideline	Condition	%
163	MC162	Present on Admission Code (POA) - 09	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 8	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC049 is populated	100%
164	MC163	Present on Admission Code (POA) - 10	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 9	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC050 is populated	100%
165	MC164	Present on Admission Code (POA) - 11	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 10	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC051 is populated	100%
166	MC165	Present on Admission Code (POA) - 12	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 11	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC052 is populated	100%
167	MC166	Present on Admission Code (POA) - 13	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 12	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC053 is populated	100%
168	MC167	Present on Admission Code (POA) - 14	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 13	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC142 is populated	100%
169	MC168	Present on Admission Code (POA) - 15	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 14	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC143 is populated	100%
170	MC169	Present on Admission Code (POA) - 16	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 15	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC144 is populated	100%
171	MC170	Present on Admission Code (POA) - 17	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 16	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC145 is populated	100%
172	MC171	Present on Admission Code (POA) - 18	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 17	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC146 is populated	100%
173	MC172	Present on Admission Code (POA) - 19	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 18	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC147 is populated	100%

Medical Claims Data Detail

Col	Element	Data Element Name	Type	Format / Length	Description	Element Submission Guideline	Condition	%
174	MC173	Present on Admission Code (POA) - 20	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 19	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC148 is populated	100%
175	MC174	Present on Admission Code (POA) - 21	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 20	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC149 is populated	100%
176	MC175	Present on Admission Code (POA) - 22	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 21	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC150 is populated	100%
177	MC176	Present on Admission Code (POA) - 23	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 22	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC151 is populated	100%
178	MC177	Present on Admission Code (POA) - 24	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 23	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC152 is populated	100%
179	MC178	Present on Admission Code (POA) - 25	External Code Source 15 - Text	char[1]	POA code for Other Diagnosis - 24	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC153 is populated	100%
242	MC241	APCD ID Code	Lookup Table - Integer	int[1]	Member Enrollment Type	Report the value that describes the member's / subscriber's enrollment into one of the predefined categories; aligns enrollment to appropriate editing and thresholds. EXAMPLE: 1 = FIG - Fully Insured Commercial Group Enrollee.	All	100%
					Value	Description		
					1	FIG - Fully-Insured Commercial Group Enrollee		
					2	SIG - Self-Insured Group Enrollee		
					3	State or Federal Employer Enrollee		
					5	Supplemental Policy Enrollee		
					0	Unknown / Not Applicable		
243	MC899	Record Type	Text	char[2]	File Type Identifier	Report MC here. This validates the type of file and the data contained within the file. This must match HD004	All	100%

DRAFT Provider File Data Elements

File	Col	Element	Data Element Name	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%
PV	1	PV001	Submitter	Integer	ID Submitter	varchar[6]	CT APCD defined and maintained unique identifier	Report the Unique Submitter ID as defined by CT APCD here. This must match the Submitter ID reported in HD002	All	100%
PV	2	PV002	Plan Provider ID	Text	ID Link to PV056, ME036, ME046, MC024, MC076, MC112, MC125, MC134, PC043, PC050, PC059, DC018	varchar[30]	Carrier Unique Provider Code	Report the submitter assigned unique number for every service provider (persons, facilities or other entities involved in claims transactions) that it has in its system(s). This field may or may not contain the provider NPI, but should not contain an individual's SSN	All	100%
PV	3	PV003	Tax ID	Numeric	ID Tax	char[9]	Federal Tax ID of non-individual Provider	Report the Federal Tax ID of the Provider here. Do not use hyphen or alpha prefix.	Required when PV034 = 2, 3, 4, 5, 6, 7, or 0	98%
PV	4	PV004	UPIN ID	Text	ID Medicare	char[6]	Unique Physician ID	Report the UPIN for the Provider identified in PV002. To report other Medicare Identifiers use PV036	Required when PV034 = 1	98%
PV	5	PV005	DEA ID	Text	ID DEA	char[9]	Provider DEA	Report the valid DEA ID of the individual, group or facility defined by PV002. If not available or applicable, do not report any value here.	Required when PV034 = 0, 1, 2, 3, 4, or 5	98%
PV	6	PV006	License ID	Text	ID License	varchar[25]	State practice license ID	Report the state license number for the provider identified in PV002. For a doctor this is the medical license for a non-doctor this is the practice license. Do not use zero-fill. If not available, or not applicable, such as for a group or corporate entity, do not report any value here.	All	98%
PV	8	PV008	Last Name	Text	Name Last Provider	varchar[50]	Last name of the Provider in PV002	Report the individual's last name here. Do not report any value here for facility or non-individual provider records. Report non-person entities in PV012 Facility Name	Required when PV034 = 1	98%
PV	9	PV009	First Name	Text	Name First Provider	varchar[50]	First name of the Provider in PV002	Report the individual's first name here. Do not report any value here for facility or non-individual provider records. Report non-person entities in PV012 Facility Name	Required when PV034 = 1	98%
PV	10	PV010	Middle Initial	Text	Name Middle Provider	char[1]	Middle initial of the Provider in PV002	Report the individual's middle initial here. Do not report any value here for facility or non-individual provider records. Report non-person entities in PV012 Facility Name	Required when PV034 = 1	1%
PV	12	PV012	Entity Name	Text	Name Provider Entity	varchar[100]	Group / Facility name	Report the Provider Entity Name when Punctuation may be included. This should only be populated for facilities or groups.	Required when PV034 = 2, 3, 4, 5, 6, 7, or 0	98%
PV	14	PV014	Gender Code	Lookup Table - Text	tlkpGender	char[1]	Gender of Provider identified in PV002	Report provider gender in alpha format as found on certification, contract and / or license.	Required when PV034 = 1	98%
							Code	Description		
							F	Female		
							M	Male		
							U	Unknown		
PV	16	PV016	Provider Street Address 1	Text	Address 1 Provider	varchar[50]	Street address of the Provider	Report the physical street address where provider sees plan members. If only mailing address is available, please send the mailing address in this field in addition to putting it in the mailing address field. If the provider sees members at two locations the provider should have a unique record for each to capture each site where the provider practices.	All	98%
PV	17	PV017	Provider Street Address 2	Text	Address 2 Provider	varchar[50]	Street Address 2 of the Provider	Report the physical street address where provider sees plan members. If only mailing address is available, please send the mailing address in this field in addition to putting it in the mailing address field. If the provider sees members at two locations the provider should have a unique record for each to capture each site where the provider practices.	All	2%

DRAFT Provider File Data Elements

File	Col	Element	Data Element Name	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%
PV	18	PV018	City Name	Text	Address City Provider	varchar[35]	City of the Provider	Report the city name where provider sees plan members. If only mailing address is available, please send the mailing address in this field in addition to putting it in the mailing address field. If the provider sees members at two locations the provider should have a unique record for each to capture each site where the provider practices.	All	98%
PV	19	PV019	State Code	External Code Source 2 - Text	Address State External Code Source 2 - States	char[2]	State of the Provider	Report the state of the site in which the provider sees plan members. When only a mailing address is available, populate with mailing state here as well as PV026. When a provider sees patients at two or more locations, the provider should have a unique record for each location to capture all possible practice sites.	All	98%
PV	20	PV020	Country Code	External Code Source 1 - Text	Address Country External Code Source 1 - Countries	char[3]	Country Code of the Provider	Report the three-character country code as defined by ISO 3166-1, Alpha 3	All	98%
PV	21	PV021	Zip Code	External Code Source 2 - Text	Address Zip External Code Source 2 - Zip Codes	varchar[9]	Zip code of the Provider	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	98%
PV	22	PV022	Taxonomy	External Code Source 5 - Text	External Code Source 5 - Taxonomy	char[10]	Taxonomy Code	Report the standard code that defines this provider for this line of service. Taxonomy values allow for the reporting of many types of clinicians, assistants and technicians, where applicable, as well as Physicians, Nurses, Groups, Facilities, etc.	Required when PV034 = 0, 1, 2, 3, 4, or 5	75%
PV	23	PV023	Mailing Street Address1 Name	Text	Address 1 Provider	varchar[50]	Street address of the Provider / Entity	Report the mailing address of the Provider / Entity in PV002	All	98%
PV	24	PV024	Mailing Street Address2 Name	Text	Address 2 Provider	varchar[50]	Secondary Street address of the Provider / Entity	Report the mailing address of the Provider / Entity in PV002	All	2%
PV	25	PV025	Mailing City Name	Text	Address City Provider	varchar[35]	City name of the Provider / Entity	Report the mailing city address of the Provider / Entity in PV002	All	98%
PV	26	PV026	Mailing State Code	External Code Source 2 - Text	Address State External Code Source 2 - States	char[2]	State name of the Provider / Entity	Report the mailing state address of the Provider / Entity in PV002	All	98%
PV	27	PV027	Mailing Country Code	External Code Source 1 - Text	Address Country External Code Source 1 - Countries	char[3]	Country name of the Provider / Entity	Report the three-character country code as defined by ISO 3166-1, Alpha 3	All	98%
PV	28	PV028	Mailing Zip Code	External Code Source 2 - Text	Address Zip External Code Source 2 - Zip Codes	varchar[9]	Zip code of the Provider	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	98%
PV	30	PV030	Primary Specialty Code	External Code Source 4 - Integer	External Code Source 4 - Specialties	char[2]	Specialty Code	Report the standard Primary Specialty code of the Provider here	Required when PV034 = 0, 1, 2, 3, 4, or 5	98%
PV	34	PV034	Provider ID Code	Lookup Table - Integer	tlkpEntityQualifierCode	int[1]	Provider Identification Code	Report the value that defines type of entity associated with PV002. The value reported here drives intake edits for quality purposes. EXAMPLE: 1 = Person; Physician, Clinician, Orthodontist, etc.	All	100%
							Value	Description		

DRAFT Provider File Data Elements

File	Col	Element	Data Element Name	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%
							1	Person ; physician, clinician, orthodontist, and any individual that is licensed/certified to perform health care services.		
							2	Facility ; hospital, health center, long term care, rehabilitation and any building that is licensed to transact health care services.		
							3	Professional Group ; collection of licensed/certified health care professionals that are practicing health care services under the same entity name and Federal Tax Identification Number.		
							4	Retail Site ; brick-and-mortar licensed/certified place of transaction that is not solely a health care entity, i.e., pharmacies, independent laboratories, vision services.		
							5	E-Site ; internet-based order/logistic system of health care services, typically in the form of durable medical equipment, pharmacy or vision services. Address assigned should be the address of the company delivering services or order fulfillment.		
							6	Financial Parent ; financial governing body that does not perform health care services itself but directs and finances health care service entities, usually through a Board of Directors.		
							7	Transportation ; any form of transport that conveys a patient to/from a healthcare provider		
							0	Other ; any type of entity not otherwise defined that performs health care services.		
PV	35	PV035	SSN Id	Numeric	ID Tax	char[9]	Provider's Social Security Number	Report the SSN of the individual provider in PV002. Do not zero-fill. Do not report any value here if not available or not applicable.	Required when PV034 = 1	98%
PV	36	PV036	Medicare ID	Text	ID Medicare	varchar[30]	Provider's Medicare Number, other than UPIN	Report the Medicare ID (OSCAR, Certification, Other, Unspecified, NSC or PIN) of the provider or entity in PV002. Do not report UPIN here, see PV004.	Required when PV034 = 0, 1, 2, 3, 4, or 5	90%
PV	39	PV039	National Provider ID	External Code Source 3 - Integer	External Code Source 3 - National Provider ID	int[10]	National Provider Identification (NPI) of the Provider	Report the NPI of the Provider / Clinician / Facility / Organization defined in this record	Required when PV034 = 0, 1, 2, 3, 4, or 5	98%
PV	40	PV040	National Provider ID 2	External Code Source 3 - Integer	External Code Source 3 - National Provider ID	int[10]	National Provider Identification (NPI) of the Provider	Report the Secondary or Other NPI of the Provider / Clinician / Facility / Organization defined in this record	Required when PV034 = 0, 1, 2, 3, 4, or 5	1%
PV	42	PV042	Secondary Specialty Code	Carrier Defined Table - Text	Carrier Defined Table - Specialty	varchar[10]	Specialty Code	Report the submitter's proprietary specialty code for the provider here. Known additional specialty code for a provider should be populated in elements PV043 and PV044. Value comes from a Carrier Defined Table only	Required when PV034 = 0, 1, 2, 3, 4, or 5	1%
PV	43	PV043	Other Specialty Code 3	Carrier Defined Table - OR - External Code Source 4 - Integer	External Code Source 4 - Specialties	varchar[10]	Specialty Code	See mapping notes for primary specialty code in PV030. Known additional specialty code for a provider should be populated in this field. Value can come from either a Carrier Defined Table or the External Code Source	Required when PV034 = 0, 1, 2, 3, 4, or 5	0%

DRAFT Provider File Data Elements

File	Col	Element	Data Element Name	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%
PV	44	PV044	Other Specialty Code 4	Carrier Defined Table - OR - External Code Source 4 - Integer	External Code Source 4 - Specialties	varchar[10]	Specialty Code	See mapping notes for primary specialty code in PV030. Known additional specialty code for a provider should be populated in this field. Value can come from either a Carrier Defined Table or the External Code Source	Required when PV034 = 0, 1, 2, 3, 4, or 5	0%
PV	47	PV047	Uses Electronic Health Records	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - EHR Utilization	Report the value that defines the element. EXAMPLE: 1 = Yes, provider uses Electronic Health Records	All	100%
							Value	Description		
							1	Yes		
							2	No		
							3	Unknown		
							4	Other		
							5	Not Applicable		
PV	52	PV052	Has multiple offices	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Multiple Office Provider	Report the value that defines the element. EXAMPLE: 1 = Yes, provider has multiple offices.	Required when PV034 = 1, 2, or 3	100%
							Value	Description		
							1	Yes		
							2	No		
							3	Unknown		
							4	Other		
							5	Not Applicable		
PV	54	PV054	Medical / Healthcare Home ID	Text	ID Link to PV002	varchar[15]	Medical Home Identification Number	Report the identifier of the patient-centered medical home the provider is linked-to here. The value in this field must have a corresponding Provider ID (PV002) in this or a previously submitted provider file.	Require when PV034 = 1, 2, or 3	0%
PV	55	PV055	PCP Flag	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Provider is a PCP	Report the value that defines the element. EXAMPLE: 1 = Yes, provider is a PCP.	Required when PV034 = 1	100%
							Value	Description		
							1	Yes		
							2	No		
							3	Unknown		
							4	Other		
							5	Not Applicable		
PV	56	PV056	Provider Affiliation	Text	ID Link to PV002	varchar[30]	Provider Affiliation Code	Report the Provider ID for any affiliation the provider has with another entity or parent company. If the provider is associated only with self, record the same value here as PV002.	All	99%
PV	57	PV057	Provider Telephone	Numeric	Telephone	varchar[10]	Telephone number associated with the provider identified in PV002	Report the telephone number of the provider associated with the identification in PV002. Do not separate components with hyphens, spaces or other special characters	All	10%
PV	64	PV064	PPO Indicator	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Provider PPO Contract	Report the value that defines the element. EXAMPLE: 1 = Yes, provider is a contracted network provider.	Required when PV034 = 0, 1, 2, 3, 4, or 5	100%
							Value	Description		
							1	Yes		
							2	No		

DRAFT Provider File Data Elements

File	Col	Element	Data Element Name	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%
							3	Unknown		
							4	Other		
							5	Not Applicable		
PV	71	PV899	Record Type	Text	ID File	char[2]	File Type Identifier	Report PV here. This validates the type of file and the data contained within the file. This must match HD004	All	100%