WEST VIRGINIA SECRETARY OF STATE

MAC WARNER

ADMINISTRATIVE LAW DIVISION

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7/29/2022 2:21:06 PM

Office of West Virginia
Secretary Of State

NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE AND FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: Secretary of the WV DHHR and WV Insurance Commissioner TITLE-SERIES: 114A-03

RULE TYPE: Legislative Amendment to Existing Rule: No Repeal of existing rule: No

RULE NAME: 114A-03 All-Payer Claims Database - Submission Manual

PRIMARY CONTACT

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CITE STATUTORY AUTHORITY: 33-4A-8

EXPLANATION OF THE STATUTORY AUTHORITY FOR THE LEGISLATIVE RULE, INCLUDING A DETAILED SUMMARY OF THE EFFECT OF EACH PROVISION OF THE LEGISLATIVE RULE WITH CITATION TO THE SPECIFIC STATUTORY PROVISION WHICH EMPOWERS THE AGENCY TO ENACT SUCH RULE PROVISION:

IS THIS FILING SOLELY FOR THE SUNSET PROVISION REQUIREMENTS IN W. VA. CODE §29A-3-19(e)? No

IF YES, DO YOU CERTIFY THAT THE ONLY CHANGES TO THE RULE ARE THE FILING DATE, EFFECTIVE DATE AND AN EXTENSION OF THE SUNSET DATE? No

DATE eFiled FOR NOTICE OF HEARING OR PUBLIC COMMENT PERIOD: 6/28/2022

DATE OF PUBLIC HEARING(S) OR PUBLIC COMMENT PERIOD ENDED: 7/28/2022

COMMENTS RECEIVED: Yes

(IF YES, PLEASE UPLOAD IN THE COMMENTS RECEIVED FIELD COMMENTS RECEIVED AND RESPONSES TO COMMENTS)

PUBLIC HEARING: No

(IF YES, PLEASE UPLOAD IN THE PUBLIC HEARING FIELD PERSONS WHO APPEARED AT THE HEARING(S) AND TRANSCRIPTS)

RELEVANT FEDERAL STATUTES OR REGULATIONS: No

WHAT OTHER NOTICE, INCLUDING ADVERTISING, DID YOU GIVE OF THE HEARING?

n/a

SUMMARY OF THE CONTENT OF THE LEGISLATIVE RULE, AND A DETAILED DESCRIPTION OF THE RULE'S PURPOSE AND ALL PROPOSED CHANGES TO THE RULE:

This rules sets forth the required data format, data elements, code tables, edit specifications, thresholds required for a submission to be deemed complete, methods for submitting data, submission schedules, and other information associated with the data submitters submission and reporting duties for the All-Payer Claims Database.

STATEMENT OF CIRCUMSTANCES WHICH REQUIRE THE RULE:

This is a new rule pursuant to the passage of W. Va. Code R. 114A-01.

SUMMARIZE IN A CLEAR AND CONCISE MANNER THE OVERALL ECONOMIC IMPACT OF THE PROPOSED LEGISLATIVE RULE:

A. ECONOMIC IMPACT ON REVENUES OF STATE GOVERNMENT:

n/a

B. ECONOMIC IMPACT ON SPECIAL REVENUE ACCOUNTS:

n/a

C. ECONOMIC IMPACT OF THE LEGISLATIVE RULE ON THE STATE OR ITS RESIDENTS:

n/a

D. FISCAL NOTE DETAIL:

Effect of Proposal	Fiscal Year		
	2022 Increase/Decrease (use "-")	2023 Increase/Decrease (use "-")	Fiscal Year (Upon Full Implementation)
1. Estimated Total Cost			0
Personal Services			0
Current Expenses			0
Repairs and Alterations			0
Assets			0
Other			0
2. Estimated Total Revenues			0

E. EXPLANATION OF ABOVE ESTIMATES (INCLUDING LONG-RANGE EFFECT):

n/a

BY CHOOSING 'YES', I ATTEST THAT THE PREVIOUS STATEMENT IS TRUE AND CORRECT.

Yes

April L Robertson -- By my signature, I certify that I am the person authorized to file legislative rules, in accordance with West Virginia Code §29A-3-11 and §39A-3-2.

TITLE 114A
LEGISLATIVE RULE
DEPARTMENT OF HEALTH AND HUMAN RESOURCES and OFFICES OF THE INSURANCE COMMISSIONER

SERIES 3
ALL-PAYER CLAIMS DATABASE – SUBMISSION MANUAL

§114A-3-1. General.

1.1. Scope. -- This rule sets forth the required data file format, data elements, code tables, edit specifications, thresholds required for a submission to be deemed complete, methods for submitting data, submission schedules, and other information associated with the data submitters' submission and reporting duties for the All-Payer Claims Database.

1.2. Authority. -- W. Va. Code §33-4A-8.

1.3. Filing Date. --

1.4. Effective Date. --

1.5. Sunset Provision. -- This rule will terminate and have no further force or effect on August 1, 2028.

§114A-3-2. Incorporated by Reference.

2.1. The Department of Health and Human Resources and the Offices of the Insurance Commissioner hereby adopt and incorporate by reference the submission manual as outlined in the *Data Submission Manual with Technical Specifications for the All-Payer Claims Database* as follows:

Data Submission Manual with Technical Specifications for the All-Payer Claims Database

Developed for the Department of Health and Human Resources

By West Virginia University, Office of Health Affairs

With assistance from

Freedman HealthCare

June 17, 2022

Data Submission Manual and Technical Specifications for the All-Payer Claims Database

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Overview of the West Virginia APCD

The West Virginia All-Payer Claims Database (WV APCD) is a program created by W. Va. Code §33-4A-1 *et seq.* authorizing the Secretary of the Department of Health and Human Resources (DHHR) to collect, retain, use, and disclose information concerning the claims and administrative expenses of those health care payers as defined in W. Va. Code R. §114A-1-1 *et seq.* The WV APCD was created to serve as a unique resource to support public health improvement, evaluate the performance of state programs, review health care utilization, expenditures and performance in the state, support academic research, and enhance the ability of consumers to make informed and cost-effective decisions.

The WV APCD includes health care claims data from both public and private health plans[1], including private insurance carriers, Medicare, and Medicaid. Claims data refers to administrative records created when health care providers request payment (bill) for services delivered to patients. Claims used for billing purposes contain coded information for diagnoses and procedures, but are different from "medical records," e.g., claims do not contain physician notes. Claims data are used by the DHHR to support evidence-based policy decisions and other uses specified by the APCD statute and rule.

This Data Submission Manual describes the required data file format, data elements, code tables, edit specifications, thresholds required for a submission to be deemed complete, methods for submitting data, submission schedules, and other information associated with the data submitters' submission and reporting duties. Insurance carriers in West Virginia are required to use the APCD-CDL™ standardized data format as described in this document. APCD-CDL™ specifications were developed and are maintained by the APCD Council, the National Association of Health Data Organizations (NAHDO), and the University of New Hampshire. Where a standard does not currently exist or is not feasible for use in West Virginia, a standard will be established by the Secretary. The APCD-CDL™ is available to the non-profit community for the purpose of harmonizing claims data collection efforts across states. This reduces administrative costs for insurance carriers and allows cross-state comparisons through use of the same format.

Appendices A-H of this document list all data elements required in each file type submitted for the WV APCD. Data submissions include identifiable data elements found on every health insurance claim form. Under the APCD statute, DHHR is prohibited from the release of identifiable information; however, the submission of this type of information from insurance carriers is critical for DHHR's internal use in the development of the APCD data resources.

DHHR functions as a covered entity under the HIPAA Privacy Rule and is required to have appropriate privacy and security safeguards for handling protected health information. The protections in place for the WV APCD data collection are compliant with the HIPAA Privacy Rule and consistent with what is also in place for the protection of identifiable Medicaid and Medicare data.

[1] Health insurance claims are defined by W. Va. Code §33-4A-1(d) with exclusions noted in §33-4A-1(d)(1)-(2). Further claims may be excluded under federal law. *See gen.* 29 U.S.C. § 1144, 42 C.F.R. § 422.402.

WV APCD Data Technical Submission Requirements

File Content Summary

- Individual data elements, data types, field lengths, field description/code assignments, and sources of industry standards can be found in the file layout in Appendices A-H of this document.

- The member eligibility file, medical claims file, pharmacy claims file, dental claims file, and provider file shall be submitted as separate standard flat files with variable field lengths, and comma delimited. The preference is for .CSV, but other formats may be accommodated.

- The reporting period is calendar year quarter and data should be submitted within 30 days from the last day of each quarter. The Secretary may grant an extension under extenuating circumstances.

- Changes to the Submission Manual will be made no more frequently than once a year, pending Legislative review.

- Information for all West Virginia resident members should be included. "Member" is defined as individuals, employees, and dependents for which there is an obligation to adjudicate, pay or disburse claims payments. The term includes covered lives. For employer-sponsored coverage, members include certificate holders and their dependents.

- Data should include no quotation marks, the first row limited to field names, numbers are numerals only, no punctuation or leading zeroes, no spaces or tabs in text fields, and fields with no data should be left blank. Variations from this format can cause data processing delays and errors and additional resources to be expended in order to bring non-compliant submissions into the APCD. Therefore, exceptions to these requirements should only be granted in exceptional circumstances where compliance by the data submitter is not a practical option. Any exceptions should only be granted for the shortest time possible.

- Data submitters should use pipe or comma delimiters, no quotation marks, limit the first row to field names, include numbers are numerals only, use no punctuation or leading zeroes, have no spaces or tabs in text fields and, fields with no data should be left blank. Dates should be formatted as YYMMDD. Integers should be whole numbers (positive, negative and 0) fixed precision and scale. Characters should be fixed length, with character limits, and Varchar should be used for variable length characters text.

- Data suppliers should use version numbers to differentiate any re-submissions of the same file, for example using the letter V followed by two digits starting with V01 for the original submission. This is important if a file needs to be resubmitted to resolve an issue such as validation.

- Files submitted should use a naming convention developed to facilitate file management without requiring access to the contents. The naming convention is as follows - FILETYPE_STARTDATE_ENDDATE_VERSION#.

- The submission of the medical, pharmacy, and dental claims are based upon the adjudication data in each reporting period.

- Data should contain adjudicated paid claims and encounters for all Members for all covered services provided in all care settings, including but not limited to inpatient, outpatient, professional, therapies, home health, rehabilitative and skilled nursing facility care, durable medical equipment, medical transportation, and medical devices.

- Any claims paid, modified, or adjusted partially or in whole during the reporting period should be included in the submitted files. If a procedure is denied within a claim that was partially paid, please report all claim lines, including the denied lines.

- Documentation for submitted data must be provided and include the following:
  - A data dictionary that includes data element names & definitions
  - A list of any data elements excluded and the reason(s) for exclusion
  - A description of the methodology used for any calculated values including calculating the average number of covered lives for the current 12-month period/year.
  - Information describing how claims may be linked to all subsequent actions associated with that claim. Data submitters should assign a unique claim control number to the initial and all subsequent versions of the same claim.

- Submitted data files should have control totals and transmission control data as defined in the Header and Trailer Record for each submitted file.

Submission Files

Header and Trailer Records

Each member eligibility, medical claims, pharmacy claims, dental claims, and provider file submission must contain a header record and a trailer record. The header record is the first record of each separate file submission, and the trailer record is the last.

Member Eligibility File (ME)

A member eligibility file is a data file composed of demographic information for each individual member eligible for medical, pharmacy, and dental benefits for one or more days of coverage at any time during the quarterly reporting period.

Information on every covered plan member should be included regardless of whether the member utilized services during the reporting period. One record per member, per month, per plan is required. For example, if a member is covered as both a subscriber and a dependent on two different policies during the same month, two records must be submitted. If a member has two contract numbers for two different coverage types, then two member eligibility records must be submitted.

Medical Claims File (MC)

A medical claims file is a data file composed of service level remittance information, including, but not limited to, member demographics, provider information, charge/payment/allowed information, clinical diagnosis codes, and procedure codes from all non-denied adjudicated claims for each billed service.

- Data suppliers must report medical service paid claims and encounters data for all applicable/covered members.

Pharmacy Claims File (PC)

A pharmacy claims file is a data file composed of service-level remittance information including, but not limited to, member demographics, provider information, charge/payment/allowed information, and national drug codes from all non-denied adjudicated prescription drug claims.

- Data suppliers must provide data for all pharmacy claims for prescriptions that were dispensed and paid for the reporting period.

- If pharmacy benefits are administered by a Pharmacy Benefit Manager (PBM) separate from medical claims, this should be clearly indicated and a method or unique member identifier for joining the medical and pharmacy claims must be provided.

- If subcontracts are in place with a pharmacy benefits manager or other organization that manages claims for members, data suppliers should ensure that the member information on the subcontractor's files are consistent with the member information on eligibility, medical claims, and prescription drugs files.

- Coordination of Benefits: If a health plan contracts with a PBM or other another entity processing claims for West Virginia resident members, the health plan is responsible for ensuring submission of complete and accurate files for all rendered services.

Dental Claims File (DC)

A dental claims file is a data file composed of service level remittance information including, but not limited to, member demographics, provider information, charge/payment/allowed information,clinical diagnosis codes, and procedure codes.

- Data suppliers must report dental service paid claims and encounters data for all applicable members.

Provider File (PV)

A provider file is a data file composed of information including, but not limited to, provider IDs, provider names, National Provider Identifiers (NPI), specialty codes, and practice location(s) for all providers as indicated by the payer on the eligibility file and on the claim.

- Provider data should include all providers for whom claims were adjudicated during the quarterly reporting period.

- The provider file should include provider ID, name, National Provider Identifier (NPI), taxonomy/specialty codes, and practice locations/addresses. Data should contain information to facilitate identification of providers rendering services from more than one physical location. Third Party Administrators (including PBMs) must include information for providers rendering services.

Consistent Inter-file Identifier

The member file, claims files, and provider file are intended to be used as parts of a multi-relational database. Therefore, it is critical to provide a consistent person identifier across all files for members, providers, and plans.

- A health care claims processor and any contracted entity acting on behalf of a carrier shall ensure that member and subscriber identifiers for the same individuals are unique and consistent

across medical claims, pharmacy claims, dental claims, and member eligibility file.

Financial Amounts

Financial amount data elements assume the following:

- The sum of all claim lines for a given data element will equal the total charge, paid, prepaid, co-pay, coinsurance, or deductible amounts for the entire claim (variables may differ among the medical, pharmacy and dental claims files).

- The paid amount provided for each non-charge financial amount data element is mutually exclusive.

Data Quality

- If data is not submitted in the correct format, it will not be ingested into the system. If that happens, data submitters will be notified of file rejections, as well as the procedures and timelines for correcting or resubmitting files that do not meet quality standards.

File Transfer Procedures

- Secure File Transport Protocol (SFTP) should be used for all file submissions. Unique login credentials will be provided to each data submitter to facilitate secure file transmission to the WV APCD.

- Data are due within 30 days of the end of each quarter.

Appendix A1 - Heading				
CDL Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLHD001	Record Type	char	2	HD.
CDLHD002	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.
CDLHD003	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLHD004	Data Submitter Name	varchar	75	Name of data submitter.
CDLHD005	File Type	char	2	ME = Member Eligibility; MC = Medical Claims; PC = Pharmacy Claims; DC = Dental Claims; PV = Provider File.
CDLHD006	Period Beginning Date	date	6	CCYYMM. Beginning of period covered for Eligibility. Beginning of paid/adjudicated period for Claims.
CDLHD007	Period Ending Date	date	6	CCYYMM. End of period covered for Eligibility. End of paid/adjudicated period for Claims.
CDLHD008	Test File Flag	char	1	T=File submitted is a test file; P= File submitted is a production file.

CDLHD009	Comments	varchar	50	Comments.

Appendix A2 - Trailer

CDL Data Element #	Data Element Name	Type	Max Length	Description/Valid Values
CDLTR001	Record Type	char	2	TR.
CDLTR002	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned tothe plan by the APCD registration system (may be multi-tiered to supportdifferent platforms). This may or may not be the same code as the payer.
CDLTR003	Payer Code	varchar	8	APCD-assigned identifier of insurer/underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLTR004	Data Submitter Name	varchar	75	Name of data submitter.
CDLTR005	File Type	char	2	ME = Member Eligibility; MC = Medical Claims; PC = Pharmacy Claims; DC = Dental Claims; PV = Provider File.
CDLTR006	Extraction Date	date	8	YYMMDD; Date file was created.

CDLTR007	Control Total of Paid Amount	int	12	Medical (MC) Pharmacy (PC) and Dental (DC) Claims files only. Provide total paid dollars submitted in the file. Control total for each file (MC063,PC036, DC038). Eligibility and provider file blank. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).
CDLTR008	Record Count	int	10	Total number of records submitted in the file, excluding header and trailerrecords.

Appendix B - Eligibility

CDL Data Element #	Data Element Name	Type	Max Length	Description/Codes/Sources	ASC X12 271 References
CDLME001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCDregistration system (may be multi-tiered to support different platforms). This may or may notbe the same code used in the Payer Code field.	N/A
CDLME002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administratorin the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).	N/A
CDLME003	Intentionally left blank				

CDLME004	Member Insurance/ Product Category code	char	2	See Appendix G-1: Insurance/Product Category for codes. Use the most granular choice available.	271/2110D/EB/ /04
CDLME005	Start Year of Submission	int	4	The year for which eligibility is reported in thissubmission file. CCYY.	N/A
CDLME006	Start Month ofSubmission	char	2	The month for which eligibility is reported in thissubmission file expressed numerical from 01 to 12.	N/A
CDLME007	Insured Group or Policy Number	varchar	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. ME006 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, leave blank. If a policy is sold to an individual as a non-group policy, then report with a value of "IND".	271/2100C/ REF/1L/02, 271/2100C/REF/ IG/02, 271/2100C/ REF/6P/02, 271/2100D/ REF/1L/02, 271/2100D/REF/ IG/02, 271/2100D/ REF/6P/02
CDLME008	Coverage Level Code	char	3	Benefit coverage level selected: CHD = Children Only; DEP = Dependents Only; ECH =Subscriber and Children/dependents; EMP = Subscriber only; ESP = Subscriber and Spouse/Life Partner; FAM = Family; SPC = Spouse/Life Partner and Children/ dependents; SPO = Spouse/Life Partner Only.	271/2110C/EB/ /02, 271/2110D/EB/ /02
CDLMC009	Medicaid AID category	char	4	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the states Medicaid agency. If not applicable, leave blank.	N/A
CDLME010	Subscriber Social Security Number	char	9	Subscriber's Social Security Number - do not include dashes. Required if collected. Leave blank if not collected.	271/2100C/REF/ SY/02

CDLME011	Plan Specific Contract Number	varchar	80	Plan assigned contract number. Leave blank if Plan Specific Contract Number is the subscriber's Social Security Number. If this is a Medicaid claim, provide Medicaid ID.	271/2100C/NM1/ MI/09
CDLME012	Subscriber Last Name	varchar	60	The subscriber's last name.	271/2100C/NM103
CDLME013	Subscriber First Name	varchar	35	The subscriber's first name.	271/2100C/NM104
CDLME014	Subscriber Middle Initial	char	1	The subscriber's middle initial.	271/2100C/NM105
CDLME015	Sequence Number	varchar	20	Unique number of the member within the contract. When the member is the subscriber use subscriber sequence number.	N/A
CDLME016	Member Social Security Number	char	9	Member's Social Security Number - do not include dashes. Required if collected. Leave blank if not collected.	271/2100C/NM1/ MI/09
CDLME017	Individual Relationship Code	char	2	Member's relationship to insured. Individual Relationship Code is maintained by ANSI ASC X12. See Appendix H: External Code Source, Accredited Standards Committee.	271/2100C/INS/Y/02, 271/2100D/ INS/N/02 If subscriber is patient, then use 2010BA, otherwise, use 2010CA for all related references for "member" (2010CA is patient; 2010BA is

					subscriber)
CDLME018	Member Gender	char	1	Gender of the member. M = Male; F = Female; U = UNKNOWN.	271/2100C/DMG/ /03, 271/2100D/ DMG/ /03
CDLME019	Member Date of Birth	date	8	Date of birth of the member. YYMMDD.	271/2100C/DMG/ D8/02, 271/2100D/ DMG/D8/02
CDLME020	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.	271/2100D/NM103
CDLME021	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name.	271/2100D/NM104
CDLME022	Member Middle Initial	char	1	The member's middle initial. If the member is the subscriber, report the subscriber's middle initial.	271/2100D/NM105
CDLME023	Member Street Address	varchar	55	Street address of member's residence.	271/2100C/N3/ /01, 02 271/2100D/N3/ /01, 02
CDLME024	Member City Name	varchar	30	City location of member's residence.	271/2100C/N4/ /01, 271/2100D/N4/ /01

CDLME025	Member State or Province	char	2	State or province of member's residence. State or Province codes are maintained by the US Postal Service and Canada Post. See Appendix H: External Code Sources, United States Postal Service.	271/2100C/N4/ /02, 271/2100D/N4/ /02
CDLME026	Member ZIP Code	varchar	9	United States Postal Service Report the 5 or 9 digit Zip Code of the member's residence. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.	271/2100C/N4/ /03, 271/2100D/N4/ /03
CDLME027	Member FIPs County Code	char	5	Report the FIPS county code based on the members residential address. The FIPS county code is a five-digit Federal Information Processing Standard (FIPS) code (FIPS 6-4) which uniquely identifies counties and county equivalents in the United States, certain U.S. possessions, and certain freely associated states. Leave blank if member lives outside US. See Appendix H: External Code Source, United States Postal Service.	N/A
CDLME028	Member Country Code	char	2	Country of member. Code US for United States. See Appendix H: External Code Source, United States Postal Service.	N/A
CDLME029	Race 1	varchar	2	Report the Member-identified race here. The code value "UN" (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. See Appendix G-2: Race 1/Race 2 for codes.	N/A
CDLME030	Intentionally left blank				

CDLME031	Intentionally left blank				
CDLME032	Hispanic Indicator	char	1	Report the value that defines the element. The code value "U" for unknown, should be used ONLYwhen member answers unknown, or refuses to answer. Do not report any value here if the data has not been collected. Report only collected data. Y = Member is Hispanic/Latino/Spanish; N = Member is not Hispanic/Latino/Spanish; U = Unknown/not specified.	N/A
CDLME033	Intentionally left blank				
CDLME034	Intentionally left blank				
CDLME035	Intentionally left blank				
CDLME036	Medical Coverage Under This Plan	char	1	Is medical coverage part of this member's plan(Note: medical coverage may be bundled withother types of coverage)? Medical coverage includes any type of coverage besides prescription drug. Y = Yes; N = No.	N/A
CDLME037	Pharmacy Coverage Under This Plan	char	1	Is pharmacy coverage part of this member's plan (Note: pharmacy coverage may include prescription drugs, supplies and DME; and may be bundled with other types of coverage)? Y = Yes; N = No.	N/A

CDLME038	Dental Coverage Under This Plan	char	1	Is dental coverage part of this member's plan (Note: dental coverage may be bundled with other types of coverage)? Y = Yes; N = No.	N/A
CDLME039	Behavioral Health Coverage Under this Plan	char	1	Use this field to indicate whether behavioral health coverage is part of this member's plan (Note: behavioral health coverage may be bundled with other types of coverage). Valid codes include: Y = Yes; N = No.	N/A
CDLME040	Primary Insurance Indicator	char	1	Use this field to report whether or not the policy for this eligibility record is the primary insurance for the member. Y = Yes, primary insurance; N = No, this is not the member's primary insurance.	N/A
CDLME041	Coverage Type	char	3	This field identifies which entity holds the risk: ASW = Self-funded plans administered by a TPA, where the employer has purchased stop-loss, or group excess insurance coverage; ASO = Self- funded plans administered by a TPA, where the employer has not purchased stop-loss, or group excess insurance coverage; STN = Short-term, non-readable health insurance (e.g., COBRA); UND = Plans underwritten by the insurer (fully insured group and individual policies); MEW = Associations/Trusts and Multiple Employer Welfare Arrangements; OTH = Any other plan (for example- student health plan). Insurers using this code shall obtain prior approval.	N/A

CDLME042	Plan State	char	2	State in which the plan is sold/issued. State or Province codes are maintained by the US Postal Service and Canada Post. See Appendix H: External Code Sources, United States Postal Service.	N/A
CDLME043	Market Category Code	varchar	4	Code for identifying market category. See Appendix G-3: Market Category Codes which defines the market category by size and or association to which the policy is directly sold and issued. Report subscribers (not employees).	N/A
CDLME044	Special Coverage	varchar	6	Reserved for specific state coverage. 0 = Not applicable; XXXXXX = Specific state coverage.	N/A
CDLME045	Group Name	varchar	60	Name of the group which is covering the member (the name established in the payers system and not the full legal name). If the member is part of a group of one, or non-group, then use IND.	N/A
CDLME046	Payer assigned Member PCP ID	Varchar	35	Unique code identified for the Primary Care Provider (PCP) as assigned by the reporting entity. Payer assigned provider ID for the provider that is the members PCP. This should be the identifier used by the payer for internal identification purposes, and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File. If not applicable, leave blank.	N/A
CDLME047	NPI of Member's PCP	char	10	NPI of the member's Primary Care Provider. If not applicable, leave blank.	N/A
CDLME048	PCP Assignment	char	1	1 = PCP in CDLME046 was selected by the member; 2 = PCP in CDLME046 was attributed by the health plan; 3 = PCP is not selected and no services rendered; 4 = PCP is not-	N/A

				assigned/ unknown.	
CDLME049	Member PCP Effective Date	date	8	Primary Care Provider Effective Date with member if CDLME048=1 or 2 (PCP Assignment). Report the date in YYMMDD format. If not applicable, leave blank.	N/A
CDLME050	Plan Effective Date	date	8	YYMMDD. Effective date of coverage; Date eligibility started for this member under this plan type. The purpose of this data element is to maintain an eligibility span for each member.	N/A
CDLME051	Plan Term Date	date	8	YYMMDD. Last continuous day of coverage (date eligibility ended) for this member under this plan. The purpose of this data element is to maintain an eligibility span for each member. For open contracts, leave blank.	N/A
CDLME052	HIOS Plan indicator	varchar	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Is the member enrolled in a Health Insurance Oversight System plan? 1=Yes; 2=No; 3=Unknown/not applicable.	N/A
CDLME053	HIOS Plan ID	varchar	16	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Health Insurance Oversight System ID. Required for qualified health plans (QHPs) as defined in the Patient Protection and Affordable Care Act (ACA). If CDLME051 is NOT=1 or 2, leave blank. The HIOS Plan ID (Standard Component) includes a five-digit issuer ID, two character state ID, three digit product number, four digit standard component number and two digit variant component ID. This field may not be available for all market segments. If not applicable, leave blank.	N/A

CDLME054	Metal Tier	char	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Health benefit plan metal tier for qualified health plans (QHPs) and catastrophic plans as defined in the Patient Protection and Affordable Care Act, Public Law 111-148, Section 1302: Essential Health Benefits Requirements: 0=Not a QHP or catastrophic plan; 1=Catastrophic; 2=Bronze; 3=Silver; 4=Gold; 5 =Platinum. If not applicable, leave blank.	N/A
CDLME055	Medical Home Indicator	char	1	Use this field to report whether or not the member had a medical home on record for this coverage period. If not stored in payer system, use code '3'. Valid codes include: 1=Yes; 2=No; 3=Unknown/not applicable.	N/A
CDLME056	Payer assigned ID for Medical Home	varchar	30	Unique code identified for the Medical Home (as assigned by the reporting entity). Payer assigned ID for the Medical Home is for the Medical Home to which the member belongs. Payer assigned ID for the Medical Home is the identifier used by the payer for internal identification purposes, and does not routinely change. Must correspond to a Payer Assigned Provider ID (CDLPV004) in the Provider File. If not applicable, leave blank.	N/A
CDLME057	Enrolled Through a Public Health Insurance Exchange	char	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Use this field to report whether or not the policy for this eligibility record was enrolled through a Public Health Insurance Exchange. Valid codes include: 1=Yes; 2=No; 3=Unknown/ not applicable.	N/A
CDLME058	Employer Tax ID	varchar	15	Subscriber's employer EIN or SSN. If coverage not purchased through or enrolled by an employer, leave blank. If not received leave blank.	N/A

CDLME059	Employment Status	char	1	Report the code that defines the employment status of the member/subscriber: A=Active; I=Involuntary Leave; P=Pending; R=Retiree; Z=Unemployed; U=Unknown.	N/A
CDLME060	Employer Zip Code	varchar	9	Report the 5 or 9 digit Zip Code of the employer (as reported in CDLME058) as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. If coverage not purchased through or enrolled by an employer, leave blank. See Appendix H: External Code Source, United States Postal Service.	N/A
CDLME061	Carrier Specific Unique Member ID	varchar	50	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.	N/A
CDLME062	Carrier Specific Unique Subscriber ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLME063	NAIC ID	char	5	Report the NAIC Code associated with the entity that maintains this product. Leave blank if entity does not have a NAIC Code. See Appendix H: External Code Source; NAIC codes are maintained by the National Association of Insurance Commissioners.	N/A
CDLME064	High Deductible Plan Indicator	char	1	High deductible plan as defined by the IRS at start of plan year. Valid codes include: Y=Yes; N=No. If not applicable, leave blank.	N/A
				For fully-insured premiums, report the average monthly fee paid by a subscriber and/or employer for health insurance coverage for a given number of members (e.g. individual, individual plus one, family), prior to any medical loss ratio	

CDLME065	Total Monthly Premium Amount	int	12	rebate payments, but inclusive of any fees paid to a third party (e.g., exchange fees, reinsurance). Report the total monthly premium at the Subscriber level only. Do not report on member lines. Report 0 if no premium is charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A
CDLME066	Actuarial Value	dec	6,4	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Report value as calculated in the most recent version of the HHS Actuarial Value Calculator. Include decimal point with reported value. Format to be used is 0.0000. For example, an AV of 88.27689% should be reported as 0.8828. Required as of January 1, 2014, for small group and non-group (individual) plans sold inside or outside the Exchange. If not applicable, leave blank. See Appendix H: External Code Source, Centers for Medicaid and Medicare Services.	N/A
CDLME067	Grandfathered Plan Indicator	char	1	Indicates if a plan qualifies as a "Grandfathered" or "Transitional Plan" under the Affordable Care Act (ACA). Please see definition for "grandfathered" and "transitional" in HHS rules 45-CFR-147.140: https://www.federalregister.gov/select-citation/2013/06/03/45-CFR-147. The values of the indicator are as follows: 1= Grandfathered; 2 = Non-Grandfathered; 3 =Transitional; 4 = Not Applicable.	N/A
				For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Indicates cost-sharing reduction under the Affordable Care Act (ACA). This is a person- level indicator in which enrollees who qualify for cost-sharing reduction are assigned cost- sharing indicator values of 1-8. Non-Cost-Sharing recipients are assigned a cost-sharing indicator value of zero. Valid codes	

CDLME068	Cost-Sharing Reduction Indicator	char	1	include: 1 = Enrollees in 94% Actuarial Value (AV) Silver Plan Variation; 2 = Enrollees in 87% AV Silver Plan Variation; 3 = Enrollees in 73% AV Silver Plan Variation; 4 = Enrollees in Zero Cost Sharing Plan Variation of Platinum Level QHP (Qualified Health Plan); 5 = Enrollee in Zero Cost Sharing Plan Variation of Gold Level QHP; 6 = Enrollee in Zero Cost Sharing Plan Variation of Silver Level QHP; 7 = Enrollee in Zero Cost Sharing Plan Variation of Bronze Level QHP; 8 = Enrollee in Limited Cost Sharing Plan Variation; 0 = Non-CSR recipient, and enrollees with unknown CSR.	N/A
CDLME069	Administrative Service Fees	int	12	Administrative Service Fees (ASFs): Average monthly fee paid by an employer to cover its self- insured health plan administration, excluding any stop-loss premiums, and divided by the number of members under administration. Administrator services for these fees may vary, including: plan design and network access, claims adjudication and administration, and/or population health management. Primary reporting goal will be to monitor self-insured coverage costs over time, using ASFs as one component of a "premium- equivalent." Report 0 if no fee is charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Required when CDLME041 =ASW or ASO.	N/A
CDLME070	Tiered Network	char	1	Tiered Network: Plans that segment their provider networks into tiers, with tiers typically based on differences in the quality and/or the cost of care provided. Tiers are not considered separate networks, but rather sub-segments of a payer's HMO or PPO network. A tiered network is different than a plan only splitting benefits by in- network vs. out-of-network; a tiered network will have varying degrees of payments of in-network providers. Report the code that defines the tier network of the member/subscriber' plan: 0 = Limited Network; 1 = Single	N/A

				Tier-Not tiered; 2 = Two Tier; 3 = Three Tier; 4 = Four Tier; 5 = Other.	
CDLME071	Un-assigned			Reserved for future use. Elements will only be added with review from states and payers.	N/A
CDLME072	Record Type	char	2	Value = ME.	N/A

Appendix C - Medical

CDL Data Element #	Data Element Name	Type	Max Length	Description/Codes/Sources	PACDR References
CDLMC001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to supportdifferent platforms). This may or may not be the same code as the Payer Code (CDLMC002).	N/A
CDLMC002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assignedto the plan by the APCD registration system (may be multi-tiered to support different platforms).	N/A
CDLMC003	Intentionally left blank				
CDLMC004	Member Insurance/ Product Category Code	char	2	See Appendix G-1: Insurance Type/Product Category for codes. Use the most granular choiceavailable.	2320 SBR09

CDLMC005	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system. Payer Claim Control Number (PCCN) must be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (CDLMC007) will be used to determine which rows will carry forward into the final claim. It is also imperative that a reversal uses the same PCCN as the original paid claim.	2330B REF02 where REF01 = F8
CDLMC006	Line Counter	int	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.	2400 LX01
CDLMC007	Version Number	int	4	The version number of this claim service line. The version number begins with 0, and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, Cross Reference Claims ID (CDLMC008) is to be utilized.	N/A
CDLMC008	Cross Reference Claims ID	varchar	35	The original Payer Claim Control Number (CDLMC005). Used when a Payer Claim Control Number is assigned to an adjusted claim and a Version Number (CDLMC007) is not used.	N/A
CDLMC009	Insured Group or Policy Number	varchar	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. CDLME007 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, leave blank. If a policy is sold to an individual as a non-group policy, then report with a value of "IND".	2000B SBR03 (I); 2320 SBR03 (P)

CDLMC010	Medicaid AID category	char	4	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the states Medicaid agency. If not applicable, leave blank.	N/A
CDLMC011	Subscriber Social Security Number	char	9	Subscriber's Social Security Number - do not include dashes. Required if collected. If not collected, leave blank.	2010BA REF02
CDLMC012	Plan Specific Contract Number	varchar	128	Plan assigned contract number. Leave blank if Plan Specific Contract Number is the subscriber's Social Security Number. If this is a Medicaid claim, provide Medicaid ID.	2010BA NM109
CDLMC013	Subscriber Last Name	varchar	60	The subscriber's last name.	2010BA/NM1//03
CDLMC014	Subscriber First Name	varchar	35	The subscriber's first name.	2010BA/NM1//03

CDLMC015	Sequence Number	varchar	20	Unique number of the member within the contract. When the member is the subscriber use subscriber sequence number.	N/A
CDLMC016	Member Social Security Number	char	9	Member's Social Security Number - do not include dashes; Required if collected. Leave blank if not collected.	2010CA REF109 or 2010BA REF109
CDLMC017	Individual Relationship Code	char	2	Member's relationship to insured. Individual Relationship codes are maintained by ANSI ASC X12. See Appendix H: External Code Source, see Accredited Standards Committee.	2000C PAT01 or 2000B SBR02
CDLMC018	Member Gender	char	1	Gender of Member M = Male; F = Female; U = Unknown.	2010CA DMG03 or 2010BA DMG03
CDLMC019	Member Date of Birth	date	8	YYMMDD; Date of birth of member.	2010CA DMG02 or 2010BA DMG02

CDLMC020	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.	2010CA NM103
CDLMC021	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name.	2010CA NM104
CDLMC022	Member ZIP Code	varchar	9	Report the 5- or 9-digit Zip Code of the member's residence When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources, US Postal Service.	2010CA N403 or 2010BA N403
CDLMC023	Patient Control Number	varchar	20	Patient's unique (alphanumeric) number assigned by the provider to facilitate retrieval of the individual's account of services.	2300 CLM 01
CDLMC024	Paid Date	date	8	YYMMDD. 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 YYMMDD Format. If paid/adjudicated date is not available use Processed Date. Claims paid in full, partial, or zero paid, must have a date reported here.	2330B DTP03 where DTP01 = 57

CDLMC025	Admission Date	date	8	YYMMDD. Required for all inpatient claims, this is the date of admission. For professional claims leave blank.	2300 DTP03 where DTP01 = 435 (I)
CDLMC026	Admission Hour	char	4	HHMM. (Military time) The hour during which the patient was admitted for inpatient care. For professional claims leave blank.	2300 DTP03 where DTP01 = 435 and DTP02 = DT (I)
CDLMC027	Admission Type	char	1	Required for all inpatient claims. Valid codes are: 1 = Emergency; 2 = Urgent; 3 = Elective; 4 = born; 5 = Trauma Center; 9 = Information not available. For professional claims, leave blank. Admission Type codes are maintained by NUBC. See Appendix H: External Code Source, National Uniform Billing Committee.	2300 CL101 (I)
CDLMC028	Point of Origin	char	1	A code indicating the point of patient origin for this admission or visit. Required for all institutional claims. Admission Type codes are maintained by NUBC. See Appendix H: External Code Source, National Uniform Billing Committee.	2300 CL102 (I)
CDLMC029	Discharge Date	date	8	YYMMDD. Date patient discharged. Required for all inpatient claims.	2300 DTP 03

CDLMC030	Discharge Hour	char	4	HHMM (Military time). The hour during which the patient was discharged from inpatient care. For professional claims, leave blank.	2300 DTP02 where DTP01=096 and DTP02=TM (I)
CDLMC031	Discharge Status	char	2	Required for all institutional claims. Discharge Status codes are maintained by NUBC. For professional claims, leave blank. See Appendix H: External Code Source, National Uniform Billing Committee.	2300 CL103 (I)
CDLMC032	Type of Bill – Institutional	char	3	Required for institutional claims. Not to be used for professional claims. As defined by the National Uniform Billing Committee. Do not include the leading zero. Type of Bill codes are maintained by NUBC. See Appendix H: External Code Source, National Uniform Billing Committee.	2300 CLM 05-2 & CLM05-3 (I)
CDLMC033	Place of Service – Professional	char	2	Required for professional claims. Not to be used for institutional claims. Place of Service codes are maintained by CMS. See Appendix H: External Code Source, Center for Medicaid and Medicare Services.	2300 CLM05-01 (P)
CDLMC034	Admitting Diagnosis	varchar	7	The ICD code describing the patient's diagnosis at the time of admission. Required on all inpatient admission claims and encounters. Codes found in ICD-9-CM or ICD -10-CM. Do not code decimal point. See Appendix H: External Code Source, World Health Organization.	2300 HI01-2 (I)

CDLMC035	First External Cause Code	varchar	7	The ICD diagnosis codes pertaining to environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. As submitted by provider in the first external cause field- if not submitted by the provider or captured by the carrier leave blank. Codes found in ICD-9-CM or ICD -10-CM. Do not code decimal point. See Appendix H: External Code Source, World Health Organization.	2300 HI01-2 where HI01-1 = BN (ICD-9) or = ABN (ICD- 10)
CDLMC036	ICD-9/ICD-10 Flag	char	1	The purpose of this field is to identify which code set is being utilized. 9 = This claim contains ICD-9- CM codes. 0= This claim contains ICD-10-CM codes.	N/A
CDLMC037	Principal Diagnosis	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. Cannot include codes V00-Y99. See Appendix H: External Code Source.	2300 HI01-2 where HI01-1 = BK (ICD-9) or = ABK (ICD- 10)
CDLMC038	Other Diagnosis – 1	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI01-2 where HI01-1 = BF (ICD-9) or = ABF (ICD- 10)
CDLMC039	Other Diagnosis – 2	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI02-2 where HI02-1 = BF (ICD-9) or = ABF (ICD- 10)

CDLMC040	Other Diagnosis – 3	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI03-2 where HI03-1 = BF (ICD-9) or = ABF (ICD- 10)
CDLMC041	Other Diagnosis – 4	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI04-2 where HI04-1 = BF (ICD-9) or = ABF (ICD- 10)
CDLMC042	Other Diagnosis – 5	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI05-2 where HI05-1 = BF (ICD-9) or = ABF (ICD- 10)
CDLMC043	Other Diagnosis – 6	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI06-2 where HI06-1 = BF (ICD-9) or = ABF (ICD- 10)
CDLMC044	Other Diagnosis – 7	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI07-2 where HI07-1 = BF (ICD-9) or = ABF (ICD- 10)

CDLMC045	Other Diagnosis – 8	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI08-2 where HI08-1 = BF (ICD-9) or = ABF (ICD- 10)
CDLMC046	Other Diagnosis – 9	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI09-2 where HI09-1 = BF (ICD-9) or = ABF (ICD- 10)
CDLMC047	Other Diagnosis – 10	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI10-02 where HI10- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC048	Other Diagnosis – 11	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI11-02 where HI11- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC049	Other Diagnosis – 12	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI12-02 where HI12- 01 = BF (ICD-9) or = ABF (ICD-10)

CDLMC050	Other Diagnosis - 13	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI13-02 where HI13- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC051	Other Diagnosis - 14	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI14-02 where HI14- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC052	Other Diagnosis - 15	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI15-02 where HI15- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC053	Other Diagnosis - 16	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI16-02 where HI16- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC054	Other Diagnosis - 17	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI17-02 where HI17- 01 = BF (ICD-9) or = ABF (ICD-10)

CDLMC055	Other Diagnosis - 18	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI18-02 where HI18- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC056	Other Diagnosis - 19	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI19-02 where HI19- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC057	Other Diagnosis - 20	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI20-02 where HI20- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC058	Other Diagnosis - 21	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI21-02 where HI21- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC059	Other Diagnosis - 22	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI22-02 where HI22- 01 = BF (ICD-9) or = ABF (ICD-10)

CDLMC060	Other Diagnosis - 23	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI23-02 where HI23-01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC061	Other Diagnosis - 24	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI24-02 where HI24-01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC062	Present on Admission Code -01	char	1	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. Required on for inpatient claims. See Appendix H: External Code Source, World Health Organization.	2300 HI01-09 where 2300 HI01-2 where HI01-1 = BK (ICD-9) or = ABK (ICD-10) and HI01-01 is populated
CDLMC063	Present on Admission Code -02	char	1	POA Code for Other Diagnosis – 1. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI01-09 where HI01-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC064	Present on Admission Code -03	char	1	POA Code for Other Diagnosis – 1. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI02-09 where HI02-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated

CDLMC065	Present on Admission Code -04	char	1	POA Code for Other Diagnosis – 1. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI03-09 where HI03-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC066	Present on Admission Code -05	char	1	POA Code for Other Diagnosis – 1. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI04-09 where HI04-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC067	Present on Admission Code -06	char	1	POA Code for Other Diagnosis – 1. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI05-09 where HI05-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC068	Present on Admission Code -07	char	1	POA Code for Other Diagnosis – 1. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI06-09 where HI06-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC069	Present on Admission Code -08	char	1	POA Code for Other Diagnosis – 1. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI07-09 where HI07-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated

CDLMC070	Present on Admission Code -09	char	1	POA Code for Other Diagnosis – 1. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI08-09 where HI08- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC071	Present on Admission Code -10	char	1	POA Code for Other Diagnosis – 1. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI09-09 where HI09- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC072	Present on Admission Code -11	char	1	POA Code for Other Diagnosis – 1. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI10-09 where HI10- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC073	Present on Admission Code -12	char	1	POA Code for Other Diagnosis – 1. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI11-09 where HI11- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC074	Present on Admission Code -13	char	1	POA Code for Other Diagnosis – 1. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI12-09 where HI12- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated

CDLMC075	Present on Admission Code - 14	char	1	POA Code for Other Diagnosis – 1. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI13-09 where HI13-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC076	Present on Admission Code - 15	char	1	POA Code for Other Diagnosis – 1. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI14-09 where HI14-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC077 thru CDLMC86	Intentionally left blank				
CDLMC087	Revenue Code	char	4	Codes that identify specific accommodations, ancillary service or unique billing calculations or arrangements. NUBC Code using leading zeroes, left justified, and four digits. To be filled for all institutional claims. Revenue codes are maintainedby NUBC. See Appendix H: External Code Source, National Uniform Billing Committee.	2400 SV201 (I)
CDLMC088	Procedure Code	varchar	5	Healthcare Common Procedural Coding System (HCPCS). This includes the CPT codes maintained by the American Medical Association. This field should not include modifiers. Modifiers are submitted in different fields. See Appendix H: External Code Source, American Medical Association.	2400 SV202-02 where SV202-01 = HC (I); 2400 SV101-02 where SV101- 01=HC (P)

CDLMC089	Procedure Modifier – 1	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association.	2400 SV202-03; 2400 SV101-03 where SV101- 01=HC (P)
CDLMC090	Procedure Modifier – 2	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association.	2400 SV2 02-4
CDLMC091	Procedure Modifier – 3	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association.	2400 SV2 02-5
CDLMC092	Procedure Modifier – 4	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association.	2400 SV2 02-6

CDLMC093	ICD-9 CM/10-PCS Principal Procedure Code	char	7	Primary procedure code for this line of service. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI01-2 where 2300 HI01-01 = BR (ICD-9-CM) or BBR (ICD10PCS)
CDLMC094	ICD-9 CM/10-CM-PCS Other Procedure Code – 1	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI01-2 where HI01-1 = BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC095	ICD-9 CM/10-CM-PCS Other Procedure Code – 2	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. If not submitted by theprovider or captured by the carrier leave blank. SeeAppendix H: External Code Source, World Health Organization.	2300 HI02-2 where HI02-1 = BQ (ICD-9) or = BBQ (ICD-10)
CDLMC096	ICD-9 CM/10-CM-PCS Other Procedure Code – 3	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. If not submitted by theprovider or captured by the carrier leave blank. SeeAppendix H: External Code Source, World Health Organization.	2300 HI03-2 where HI03-1 = BQ (ICD-9) or = BBQ (ICD-10)

CDLMC097	ICD-9 CM/10-CM-PCS Other Procedure Code – 4	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. If not submitted by theprovider or captured by the carrier leave blank. SeeAppendix H: External Code Source, World Health Organization.	2300 HI04-2 where HI04-1 = BQ (ICD-9) or = BBQ (ICD-10)
CDLMC098	ICD-9 CM/10-CM-PCS Other Procedure Code – 5	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. If not submitted by theprovider or captured by the carrier leave blank. SeeAppendix H: External Code Source, World Health Organization.	2300 HI05-2 where HI05-1 = BQ (ICD-9) or = BBQ (ICD-10)
CDLMC099	ICD-9 CM/10-CM-PCS Other Procedure Code – 6	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. If not submitted by theprovider or captured by the carrier leave blank. SeeAppendix H: External Code Source, World Health Organization.	2300 HI06-2 where HI06-1 = BQ (ICD-9) or = BBQ (ICD-10)
CDLMC100	ICD-9 CM/10-CM-PCS Other Procedure Code – 7	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI07-2 where HI07-1 = BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC101	ICD-9 CM/10-CM-PCS Other Procedure Code – 8	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI08-2 where HI08-1 = BQ (ICD-9) or = BBQ (ICD- 10)

CDLMC102	ICD-9 CM/10-CM- PCS Other Procedure Code –9	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI09-2 where HI09-1 = BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC103	ICD-9 CM/10-CM- PCS Other Procedure Code – 10	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI10-2 where HI10-1 = BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC104	ICD-9 CM/10-CM- PCS Other Procedure Code – 11	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI11-2 where HI11-1 = BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC105	ICD-9 CM/10-CM- PCS Other Procedure Code – 12	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI12-2 where HI12-1 = BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC106	ICD-9 CM/10-CM- PCS Other Procedure Code – 13	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI13-2 where HI13-1 = BQ (ICD-9) or = BBQ (ICD- 10)

CDLMC107	ICD-9 CM/10-CM- PCS Other Procedure Code – 14	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI14-2 where HI14-1 = BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC108	ICD-9 CM/10-CM- PCS Other Procedure Code – 15	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI15-2 where HI15-1 = BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC109 thru CDLMC118	Intentionally left blank				
CDLMC119	Date of Service – From	date	8	YYMMDD. First date of service for this service line. Filled for all claim types. (This date should be within the coverage period on the Eligibility file i.e., between the Plan Effective Date and the Plan TermDate on the Eligibility file all inclusive).	2300 DTP 03 where DTP 02 = RD8 (I); 2400 DTP03 where DTP01 = 472 or 2300 DTP03 where DTP01 = 434 (P)
CDLMC120	Date of Service – Thru	date	8	YYMMDD Last date of service for this service line.Filled for all claim types.	2300 DTP 03 where DTP 02 = RD8 (I); 2400 DTP03 where DTP01 = 472 or 2300 DTP03 where DTP01 = 434 (P)

CDLMC121	Service Units/ Quantity	dec	12,2	Count of service units performed. Count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay.	2400 SV205 where SV204 =(I); 2400 SV104 (P)
CDLMC122	Unit of Measure	varchar	2	Type of units reported in CDLMC121.Example codes: DA=Days; MJ= Minutes; UN=Units. If CDLMC121 is blank (not reported), leave CDLMC122blank.	N/A
CDLMC123	Charge Amount	int	12	The amount charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 convertedto 100025).	2400 SV203 (I); 2400 SV102 (P)
CDLMC124	Withhold Amount	int	12	A claim-based payment that is included in total medical expense. Report the amount paid to the provider for this claim line if the provider qualified / met performance guarantees. Do not code decimalpoint or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A
CDLMC125	Plan Paid Amount	int	12	This is the amount paid by the plan to cover the services, to the provider or member. This excludes the patient liability. For capitated claims, set to zero. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2430 SVD02

CDLMC126	Co-Pay Amount	int	12	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. If only collected on the header record, report the co-pay amount on the first claim line. Report 0 if there is no co-pay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2320 and/or 2430 CASxx where the CARC code is 3
CDLMC127	Coinsurance Amount	int	12	The dollar amount for which the member is responsible attributed to the coinsurance amount. This is the dollar amount, not the percentage from which the dollar amount was calculated. If only collected on the header record, report the coinsurance amount on the first claim line. Report 0 if there is no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2320 and/or 2430 CASxx where the CARC code is 2
CDLMC128	Deductible Amount	int	12	Report the amount of the deductible applied to the claim. If only collected on the header record, report the deductible amount on the first claim line. Report 0 if there is no deductible amount applied to the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2320 and/or 2430 CASxx where the CARC code is 1.
CDLMC129	Other Insurance Paid Amount	int	12	Amount already paid by another carrier. Report the amount that a prior payer has paid for this claim line. Indicates the submitting payer is not the primary payer. Only Report "0" if the prior payer paid 0 toward this claim line; if there is no prior payer, leave blank. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). May be reported as a negative.	N/A

CDLMC130	COB/TPL Amount	int	12	Amount due from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2320 AMT02
CDLMC131	Allowed Amount	int	12	When payment arrangement type in CDLMC132 is equal to 01 for capitated services, report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. If there is not an allowed amount, leave blank. When payment arrangement type in CDLMC132 is equal to 02 for fee for service, report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. If there is not an allowed amount, leave blank. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2300 HCP02
CDLMC132	Payment Arrangement Type Flag	char	2	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 03=Percent of Charges; 04=DRG; 05=Pay For Performance; 06=Global Payment; 07=Other; 08=Bundled Payment.	N/A

CDLMC133	Drug Code	char	11	Report the NDC code only when a medication is paid for as part of a medical claim. Do not include dashes. NDC codes are maintained by the Federal Drug Administration. If not submitted by the provider or applicable leave blank. See Appendix H: External Code Source, United States Food and Drug Administration.	2410 LIN03 where LIN02 = N4 (I)
CDLMC134	Rendering Provider ID	varchar	35	Unique code identified for the provider as assigned by the reporting entity. Payer assigned provider ID for the provider that provided the services on the claims. This should be the identifier used by the payer for internal identification purposes, and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	2310D REF02 where REF01 = G2 (I) or 2310A REF02 where REF01 =G2 (I); 2420A REF02 where REF01 =G2 (P) or 2310B REF02 where REF01 = G2 (P)
CDLMC135	Rendering Provider NPI	char	10	Rendering Provider NPI is the NPI of the entity or individual directly providing the service, as enumerated in the Center for Medicaid and Medicare Services NPPES.	2310D NM109 (I) or 2310A NM109 (I); 2420A NM109 (P) or 2310B NM109 (P)
CDLMC136	Rendering Provider Entity Type Qualifier	char	1	Use this field to indicate whether the rendering provider is a person or "non-person entity. HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "Person." Valid codes are: 1 = Person; 2 = Non-Person Entity.	2310D NM102 (I) or 2310A NM102 (I); 2420A NM102 (P) or 2310B NM102 (P)

CDLMC137	In Plan Network Indicator	char	1	A yes/no indicator that specifies if the provider (not the benefit) is within the health plan network. Valid codes are: N=No; Y=Yes.	N/A
CDLMC138	Rendering Provider First Name	varchar	35	Individual first name. If CDLMC136=2, leave blank.	2310D NM104 (I) or 2310A NM104 (I); 2420A NM104 (P) or 2310B NM104 (P)
CDLMC139	Rendering Provider Middle Name	varchar	25	Individual middle name or initial. If CDLMC136=2, leave blank.	2310D NM105 (I) or 2310A NM105 (I); 2420A NM105 (P) or 2310B NM105 (P) or 2010AA NM105 (P)
CDLMC140	Rendering Provider Last Name or Organization Name	varchar	60	Full name of provider organization ("non-person entity") or last name of individual ("person") provider. CDLMC136 determines if the Rendering Provider is a "person" or a "non-person entity".	2310D NM103 (I) or 2310A NM103 (I); 2420A NM103 (P) or 2310B NM103 (P) or 2010AA NM103 (P)
CDLMC141	Rendering Provider Suffix	varchar	10	Suffix of Rendering Provider. Leave blank if provider is a facility or organization. The rendering provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III). Do not use credentials such as MD or PhD.	2310D NM107 (I) or 2310A NM107 (I); 2420A NM107 (P) or 2310B NM107 (P) or 2010AA NM107 (P)

CDLMC142	Rendering Provider Specialty	varchar	10	Standard code that identifies the provider specialty for this line of service. Report the HIPAA-compliant healthcare provider national taxonomy code. Provider taxonomy codes are maintained by the National Uniform Claims Committee (NUCC). See Appendix H: External Code Source, National Uniform Claims Committee.	2310A PRV03 (I); 2420A PRV03 (P) or 2310B PRV03 (P) or 2000AA PRV03 (P)
CDLMC143	Rendering Provider City Name	varchar	30	City name of provider or service facility location.	2310E N401 (I); 2420C N401 (P) or 2310C N401 (P)
CDLMC144	Rendering Provider State or Province	char	2	State or Province codes are maintained by the US Postal Service and Canada Post. See Appendix H: External Code Sources, United States Postal Service.	2310E N402 (I); 2420C N402 (P) or 2310C N402 (P)
CDLMC145	Rendering Provider ZIP Code	varchar	9	Report the 5 or 9 digit Zip Code of the Rendering Provider as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. See Appendix H: External Code Sources, United States Postal Service.	2310E N403 (I); 2420C N403 (P) or 2310C N403 (P)
CDLMC146	Rendering Provider Group Practice NPI	varchar	60	NPI of group practice to which a rendering provider is affiliated if different from CDLMC135.	N/A

CDLMC147	Billing Provider ID	varchar	30	Unique code assigned to the provider by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes, and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	2010AA REF02 where REF01 = G2 and/or LU
CDLMC148	Billing Provider NPI	char	10	NPI for billing provider as enumerated in the Center for Medicaid and Medicare Services NPPES.	2010AA NM109 where 2010AA NM108 = XX
CDLMC149	Billing Provider Last Name or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.	2010AA NM103
CDLMC150	Billing Provider Tax ID	varchar	10	Tax ID of the billing provider. Do not code punctuation.	
CDLMC151	Referring Provider ID	varchar	30	Payer assigned provider ID for the referring provider. The Referring Provider is the provider who directed the patient for care to the provider that rendered the services being submitted on the claim form. The Referring Provider Number is the identifier used by the payer for internal identification purposes, and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File. Leave blank if not applicable.	

CDLMC152	Referring Provider NPI	char	10	NPI of the referring provider. The referring provider is the entity or individual that submitted the referral of the service or procedure. The Referring Provider is the individual who directed the patient for care to the provider that rendered the services being submitted on the claim form. Leave blank if not applicable.	2310A NM109 (I);
CDLMC153	Attending Provider ID	varchar	30	Payer assigned provider ID for the attending provider. On the institutional claim, the Attending Provider is the individual that has primary responsibility for the patient's medical care and treatment reported in the claim. The Attending Provider Number is the identifier used by the payer for internal identification purposes, and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File. Leave blank if not applicable.	
CDLMC154	Attending Provider NPI	char	10	NPI of the attending provider. The Attending Provider on an 837I claim represents the individual that has primary responsibility for the patient's medical care and treatment reported in the claim. The Attending and Rendering provider can be the same individual. Leave blank if not applicable.	
CDLMC155	Carrier Associated with Claim	varchar	8	For each claim, use the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved- out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. Leave blank if not applicable. See Appendix H: External Code Source, National Association of Insurance Commissioners.	N/A

CDLMC156	Type of Claim	char	1	Indicates the type of claim that was submitted. Valid codes are: 1=Professional; 2=Institutional/ Facility; 3=Reimbursement Form (Member).	N/A
CDLMC157	Claim Status	char	3	Claim status codes maintained by ANSI ASC X12 is the code identifying type of claim. See Appendix H: External Code Source, Accredited Standards Committee.	2320 SBR01
CDLMC158	Denied Claim Line Indicator	char	1	Use this field to indicate whether the payer denied this specific line on this specific claim. Valid codes are: 1=Yes (denied); 2= No (not denied).	N/A
CDLMC159	Claim adjustment reason code	varchar	3	Report the claim adjustment reason code for the denial. If CDLMC158=1, report the code that defines the reason for denial of the claim line. Otherwise, leave blank. Reason codes are maintained by ANSI ASC X12. See Appendix H: External Code Source, Accredited Standards Committee.	N/A
CDLMC160	Claim Line Type	char	1	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment.	N/A
CDLMC161	Carrier Specific Unique Member ID	varchar	50	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.	N/A

CDLMC162	Carrier Specific Unique Subscriber ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLMC163	Un-assigned			Reserved for future use. Elements will only be added with review from states and payers.	N/A
CDLMC164	Record Type	char	2	Value = MC.	N/A

Appendix D - Pharmacy

CDL Data Element #	Type	Max Length	Description/Codes/Sources	NCPDP Reporting Guide Reference # Uniform Healthcare Payer Data Standard Imp. Guide
CDLPC001	varchar	8	APCD-assigned identifier of payer submittingdata file. Code assigned to the plan by the APCD registration system (may be multi- tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLPC002).	N/A
CDLPC002	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-fundedcoverage. Code assigned to the plan by theAPCD registration system (may be multi- tiered to support different platforms).	879-N2
CDLPC003	Intentionally left blank			
CDLPC004	char	2	See Appendix G-1: Insurance Type/ProductCategory for codes. Use the most granular choice available.	A90

CDLPC005	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be uniquewithin the payer's system. Payer Claim Control Number (PCCN) must be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (CDLPC007)will be used to determine which rows will carry forward into the final claim. It is also imperative that a reversal uses the same PCCN as the original paid claim.	993-A7 Carrier Plan SpecificContract Number or Subscriber/Member Social Security Number
CDLPC006	Line Counter	int	4	Line number for this service. The line counterbegins with 1 and is incremented by 1 for each additional service line of a claim.	A91
CDLPC007	Version Number	int	4	The version number of this claim service line. The version number begins with 0, andis incremented by 1 for each subsequent version of the claim. If version numbers are not used, Cross Reference Claims ID (CDLPC008) is to be utilized.	102-A2 (version/release number of the claim)
CDLPC008	Cross Reference Claims ID	varchar	35	The original Payer Claim Control Number (CDLPC005). Used when a Payer ClaimControl Number is assigned to an adjustedclaim and a Version Number (CDLPC007) isnot used.	N/A
CDLPC009	Insured Group or Policy Number	varchar	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. CDLPC009 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, leave blank. If a policy is	246

				sold to an individual as a non-group policy, then report with a value of "IND".	
CDLPC010	Medicaid AID category	char	4	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank.	
CDLPC011	Subscriber Social Security Number	char	9	Subscriber's Social Security Number - do not include dashes. Required if collected. Leave blank if not collected.	A89
CDLPC012	Plan Specific Contract Number	varchar	9	Plan assigned subscriber's contract number (NCPDP refers to this as the Cardholder ID). Leave blank if Plan Specific Contract Number is the subscriber's Social Security Number. If this is a Medicaid claim, provide Medicaid ID.	302-C2
CDLPC013	Subscriber Last Name	varchar	60	The subscriber's last name.	716
CDLPC014	Subscriber First Name	varchar	35	The subscriber's first name.	717
CDLPC015	Sequence Number	varchar	20	Unique number of the member within the contract (NCPDP refers to this as Person Code). When the member is the subscriber, use subscriber sequence number.	303-C3

CDLPC016	Member Social Security Number	char	9	Member's Social Security Number - do not include dashes. Required if collected. Leave blank if not collected.	332-CY
CDLPC017	Individual Relationship Code	char	1	Member's relationship to insured. Individual Relationship codes maintained by ANSI ASC X12. See Appendix H: External Code Source.	306-C6
CDLPC018	Member Gender	char	1	1 = Male; 2 = Female; 0 = Unspecified.	305-C5
CDLPC019	Member Date of Birth	varchar	8	YYMMDD; Date of birth of member.	304-C4
CDLPC020	Member Last Name	varchar	60	Member last name.	716
CDLPC021	Member First Name	varchar	35	Member first name.	717
CDLPC022	Member ZIP Code	varchar	9	Report the 5- or 9-digit Zip Code of the member's residence When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service.	730-TC
CDLPC023	Date Prescription Filled	date	8	YYMMDD. Date the prescription was filled.	401-D1

CDLPC024	Paid Date	date	8	YYMMDD. 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 YYMMDD Format. If paid/adjudicated date is not available use Processed Date. Claims paid in full, partial, or zero paid, must have a date reported here.	216 (check date) or 578 (adjudication date)
CDLPC025	Drug Code	char	11	NDC Code for the drug on the claim. Do not include dashes. NDC codes are maintained by the Federal Drug Administration. See Appendix H: External Code Source, United States Federal Drug Administration.	407-D7
CDLPC026	Prescription or Refill	char	2	Provide '00' for prescriptions; for refills, provide the refill number. 00 = prescription; 01–99 = Refill.	254
CDLPC027	Generic Drug Indicator	char	2	Indicates whether the drug itself is generic, not how the payer pays it. Valid codes are: 01 = Branded drug; 02 = Generic drug.	425-DP
CDLPC028	Dispensed as Written Code	char	1	"Use this field to indicate how the drug was dispensed: 0 = No Product Selection Indicated (may also have missing values) 1 = Substitution Not Allowed by Prescriber 2 = Substitution Allowed - Patient Requested That Brand Product Be Dispensed 3 = Substitution Allowed - Pharmacist Selected Product Dispensed	408-D8

				4 = Substitution Allowed - Generic Drug Not in Stock 5 = Substitution Allowed - Brand Drug 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."	
CDLPC029	Compound Drug Indicator	char	1	Use this field to indicate whether the drug is a compound drug or non-compound drug. Valid codes are: N = Non-compound drug; Y = Compound drug; U = Unknown.	406-D6
CDLPC030	Compound Drug Name or Compound Drug Ingredient List	char	80	If CDLPC029 = Y, then provide the name of the compound drug. If no compound drug name is identified, include the names of the compound drug ingredients. Use spaces between multiple drugs.	
CDLPC031	Formulary Indicator	char	1	Use this field to report if the prescribed drug was on the carrier's formulary list. Valid codes include: 1=Yes; 2= No; 3= Unknown; 4= Other; 5= Not applicable.	
CDLPC032	Quantity Dispensed	dec	10,2	Number of metric units of medication dispensed.	442-E7

CDLPC033	Days' Supply	int	3	Estimated number of days the prescription will last.	405-D5
CDLPC034	Drug Unit of Measure	varchar	3	Report the code that defines the unit of measure for the drug dispensed in PC033. Valid codes are: EA= Each; F2= International Units; GM= Grams; ML=Milliliters; MG= Milligrams; MEQ= Milliequivalent; MM= Millimeter; UG= Microgram; UU= Unit; OT=Other.	
CDLPC035	Prescription Number	varchar	20	Report the unique prescription identifier.	254 (fill number calculated)
CDLPC036	Charge Amount	int	10	NCPDP refers to this as Gross Amount Due. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	430-DU
CDLPC037	Plan Paid Amount	int	10	Includes all health plan payments and excludes all member payments. NCPDP refers to this as Net Amount Due. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	281
CDLPC038	Allowed Amount	int	12	When payment arrangement type in CDLPC049 is equal to 01 for capitated services, report the maximum amount that would have been paid under fee for service for a prescription. If there is not an allowed amount, such as state supplied vaccine, report 0. When payment arrangement type in CDLPC049 is equal to 02 for fee for service, report the maximum amount contractually allowed. If there is not an allowed amount, report 0. Do not code decimal point or provide any punctuation (e.g.	N/A

				$1,000.25 converted to 100025).	
CDLPC039	Sales Tax Amount	int	12	Report the amount of state sales tax applied to this claim line. Report 0 if state sales tax does not apply. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Do not round up / down to whole dollars, code zero cents (00) when applicable.	558-AW
CDLPC040	Ingredient Cost/List Price	int	10	Cost of the drug dispensed. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	506-F6
CDLPC041	Postage Amount Claimed	int	10	Postage amount associated with the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A
CDLPC042	Dispensing Fee	int	10	Dispensing fee associated with the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	507-F7
CDLPC043	Co-Pay Amount	int	10	Actual co-payment dollar amount paid for which the individual is responsible. (e.g., If the fixed amount is $25 but the cost to the member is $4 report, 400.) Report 0 if there is no co-pay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	518-FI

CDLPC044	Coinsurance Amount	int	10	The dollar amount of coinsurance for this claim line for which an individual is responsible, not the percentage. Report 0 if no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	572-4U
CDLPC045	Deductible Amount	int	10	The dollar amount for this claim line applied to the deductible. Report 0 if there is no deductible amount applied to the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	517-FH
CDLPC046	COB/TPL Amount	int	12	Amount due from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/ TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A
CDLPC047	Other Insurance Paid Amount	int	10	Amount already paid by another carrier. Report the amount that a prior payer has paid for this claim line. Indicates the submitting payer is not the primary payer. Only Report "0" if the prior payer paid 0 toward this claim line; if there is no prior payer, leave blank. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). May be reported as a negative.	565-J4

CDLPC048	Member Self-Pay Amount	int	12	Report the amount that the member has paid beyond the other patient obligations (e.g., gap on Medicare Part D, or difference between generic and brand) that are not otherwise listed in the file in CDLPC043, CDLPC044, CDLPC045. Report "0" if the member has not paid toward this claim line. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Do not round up / down to whole dollars, code zero cents (00) when applicable.	505-F5
CDLPC049	Payment Arrangement Type Flag	char	2	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 03=Percent of Charges; 07=Other.	N/A
CDLPC050	Prescribing Physician ID	varchar	30	Payer assigned provider ID for the prescribing physician. This should be the identifier used by the payer for internal identification purposes, and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	N/A
CDLPC051	Prescribing Physician NPI	char	10	NPI number for prescribing physician.	411-DB
CDLPC052	Prescribing Physician First Name	varchar	25	Prescribing Physician's first name or initial.	A92

CDLPC053	Prescribing Physician Last Name	varchar	60	Prescribing Physician's last name.	716
CDLPC054	Pharmacy NCPDP Number	varchar	7	Unique 7-digit number assigned by the National Council for Prescription Drug Program (NCPDP).	N/A
CDLPC055	Pharmacy ID	varchar	30	Payer assigned pharmacy ID. This should be the identifier used by the payer for internal identification purposes, and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	201-B1
CDLPC056	Pharmacy Tax ID Number	varchar	10	Dispensing pharmacy federal taxpayer's identification number coded with no punctuation (carriers that contract with outside PBMs may not have this data).	N/A
CDLPC057	Pharmacy NPI	char	10	NPI of the entity or individual (pharmacy) directly providing the service.	201-B1
CDLPC058	Pharmacy Location Street Address	varchar	55	Street address of pharmacy that dispensed the prescription, including street number, name. Include suite number if applicable. Relates to CDLPC059-CDLPC062.	728-SU

CDLPC059	Pharmacy Location State	char	2	State or Province where dispensing pharmacy or Province codes are maintained by the US Postal Service and Canada Post. See Appendix H: External Code Sources, United States Postal Service and Canada Post.	729-TA
CDLPC060	Pharmacy ZIP Code	varchar	9	Report the 5- or 9-digit Zip Code of the Pharmacy as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. See Appendix H: External Code Sources, United States Postal Service and Canada Post.	730-TC
CDLPC061	Pharmacy Country Name	char	2	Country where dispensing pharmacy located. Code US for United States. See Appendix H: External Code Sources, United States Postal Service and Canada Post.	A93-1T
CDLPC062	Mail-Order Pharmacy Indicator	char	1	Use this field to report if the pharmacy was a mail-order pharmacy. Valid codes include: 1=Yes mail order pharmacy; 2=No-not a mail order pharmacy; 3=Unknown ; 4=Other; 5=Not applicable.	N/A
CDLPC063	Carrier Associated with Claim	varchar	8	For each claim, use the NAIC code of the carrier when a PBM processes claims on behalf of the carrier. Optional if all pharmacy claims processed by a PBM under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance	N/A

				Commissioners. See Appendix H: External Code Source, National Association of Insurance Commissioners.	
CDLPC064	In Plan Network Indicator	char	1	Use this field to specify if services from the requested provider were provided within the health plan network. Valid values are: N=No; Y=Yes.	N/A
CDLPC065	Record Status Code	char	1	Claim status codes maintained by NCPDP is the code identifying type of claim. See Appendix H: External Code Source, NCPDP.	399
CDLPC066	Claim Line Type	char	1	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment.	N/A
CDLPC067	Reject Code	varchar	3	Report the reason code for the denial. Report the code that defines the reason for denial of the claim line. Otherwise, leave blank. Reason codes are maintained by NCPDP. See Appendix H: External Code Source, NCPDP.	511-FB
CDLPC068	Carrier Specific Unique Member ID	varchar	50	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.	N/A

CDLPC069	Carrier Specific Unique Subscriber ID	char	50	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.	N/A
CDLPC070	Prescriber Specialty	varchar	10	Report the NUUC healthcare Exploratory code. See Appendix H, National Uniform Claim Committee	296
CDLPC071	Pharmacy City	varchar	30	City or town where dispensing pharmacy located.	N/A

Appendix E - Dental

CDL Data Element #	Data Element Name	Type	Max Length	Description/Codes/Sources	PACDR References
CDLDC001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tieredto support different platforms). This may or may not be the same code as the Payer Code (CDLDC002).	
CDLDC002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-fundedcoverage. Code assigned to the plan by the APCD registration system (may be multi-tieredto support different platforms).	
CDLDC003	Intentionally left blank				
CDLDC004	Member Insurance/ Product Category code	char	2	See Appendix G-1: Insurance Type/ProductCategory for codes. Use the most granular choice available.	2320 SBR09
CDLDC005	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system. Payer Claim Control Number (PCCN) must be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (CDLDC007) will be used to determine which rows will carry forward into the final claim. It is also imperative that a reversal uses the same PCCN as the original paid claim.	2330B REF02 where REF01 = F8

CDLDC006	Line Counter	int	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.	2400 LX01
CDLDC007	Version Number	int	4	The version number of this claim service line. The version number begins with 0, and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, use Cross Reference Claims ID (CDLDC008).	N/A
CDLDC008	Cross Reference Claims ID	varchar	35	The original Payer Claim Control Number (CDLDC005) Used when a Payer Claim Control Number is assigned to an adjusted claim and a Version Number (CDLDC007) is not used.	N/A
CDLDC009	Insured Group or Policy Number	varchar	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. CDLDC009 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, leave blank. If a policy is sold to an individual as a non-group policy, then report with a value of "IND".	2000B SBR03 (I); 2320 SBR03 (P)
CDLDC010	Medicaid AID category	char	2	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank.	N/A
CDLDC011	Subscriber Social Security Number	char	9	Subscriber's Social Security Number - do not include dashes. Required if collected. If not collected, leave blank.	2010BA REF02

CDLDC012	Plan Specific Contract Number	varchar	128	Plan assigned contract number. Leave blank if Plan Specific Contract Number is the subscriber's Social Security Number. If this is a Medicaid claim, provide the Medicaid ID.	2010BA NM109
CDLDC013	Subscriber Last Name	varchar	60	The subscriber's last name.	2010BA/NM1//03
CDLDC014	Subscriber First Name	varchar	35	The subscriber's first name.	2010BA/NM1//03
CDLDC015	Sequence Number	varchar	20	Unique number of the member within the contract. When the member is the subscriber, use subscriber sequence number.	N/A
CDLDC016	Member Social Security Number	char	9	Member's Social Security Number - do not include dashes. Required if collected. Leave blank if not collected.	2010CA REF109 or 2010BA REF109
CDLDC017	Individual Relationship Code	char	2	Member's relationship to insured. Individual Relationship codes maintained by ANSI ASC X12. See Appendix H: External Code Source, Accredited Standards Committee.	2000C PAT01 or 2000B SBR02
CDLDC018	Member Gender	char	1	Gender of Member M = Male; F = Female; U = Unknown.	2010CA DMG03 or 2010BA DMG03
CDLDC019	Member Date of Birth	date	8	YYMMDD. Date of birth of member.	2010CA DMG02 or 2010BA DMG02

CDLDC020	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.	2010CA NM103
CDLDC021	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name.	2010CA NM104
CDLDC022	Member ZIP Code	varchar	9	Report the 5- or 9-digit Zip Code of the member's residence When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources, US Postal Service.	2010CA N403 or 2010BA N403
CDLDC023	Paid Date	date	8	YYMMDD. 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 YYMMDD format. If paid/adjudicated date is not available use Processed Date. Claims paid in full, partial, or zero paid must have a date reported.	2330B DTP03 where DTP01 = 57
CDLDC024	Place of Service -- Professional	char	2	Required for professional claims. Not to be used for institutional claims. Place of Service codes are maintained by CMS. See Appendix H: External Code Source, Center for Medicaid and Medicare Services.	2300 CLM05-01 (P)
CDLDC025	Intentionally left blank				
CDLDC026	CDT Code	varchar	5	Common Dental Terminology code for the dental procedure on the claim. CDT codes aremaintained by American Dental Association. See Appendix H: External Code Source, American Dental Association.	2400 SVD03-02

CDLDC027	Procedure Modifier – 1	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CDT codes and modifiers are maintained by the American Dental Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source.	2400 SVD03-03
CDLDC028	Procedure Modifier – 2	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CDT codes and modifiers are maintained by the American Dental Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Dental Association.	2400 SVD03-04
CDLDC029	Procedure Modifier – 3	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CDT codes and modifiers are maintained by the American Dental Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Dental Association.	2400 SVD03-05
CDLDC030	Procedure Modifier – 4	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CDT codes and modifiers are maintained by the American Dental Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Dental Association.	2400 SVD03-06
CDLCD031 thru CDLDC058	Intentionally left blank				

CDLDC059	Date of Service – From	date	8	YYMMDD. First date of service for this serviceline. Filled for all claim types. (This date should be within the coverage period on the Eligibility file i.e., between the Plan Effective Date and the Plan Term Date on the Eligibility file allinclusive).	2400 DTP03 where DTP01 = 472 or 2300 DTP03 where DTP01 =434
CDLDC060	Date of Service – Thru	date	8	YYMMDD Last date of service for this service line. Filled for all claim types.	2400 DTP03 where DTP01 = 472 or 2300 DTP03 where DTP01 = 434
CDLDC061	Charge Amount	int	12	The amount charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2400 SV203 (I); 2400 SV102 (P)
CDLDC062	Withhold Amount	int	12	A claim-based payment that is included in total medical expense. Report the amount paid to the provider for this claim line if the provider qualified / met performance guarantees. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A
CDLDC063	Plan Paid Amount	int	12	This is the amount paid by the plan to cover the services, to the provider or member. This excludes the patient liability. For capitated claims, set to zero. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2430 SVD02

CDLDC064	Co-pay Amount	int	12	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. If only collected on the header record, report the co-pay amount on the first claim line. Report 0 if there is no co-pay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2320 and/or 2430 CASxx where the CARC code is 3
CDLDC065	Coinsurance Amount	int	12	The dollar amount for which the member is responsible attributed to the coinsurance amount. This is the dollar amount, not the percentage from which the dollar amount was calculated. If only collected on the header record, report the coinsurance amount on the first claim line. Report 0 if there is no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2320 and/or 2430 CASxx where the CARC code is 2
CDLDC066	Deductible Amount	int	12	Report the amount of the deductible applied to the claim. If only collected on the header record, report the deductible amount on the first claim line. Report 0 if there is no deductible amount applied to the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2320 and/or 2430 CASxx where the CARC code is 1.

CDLDC067	Allowed Amount	Int	12	When payment arrangement type in CDLDC068is equal to 01 for capitated services, report the maximum amount that would have been paid under fee for service for a particular procedure or service. If there is not an allowed amount leave blank. When payment arrangement type in CDLDC068 is equal to 02 for fee for service, report the maximum amount contractually allowed, and that a carrier will pay for a particular procedure or service. If there is not anallowed amount, report 0. Do not code decimalpoint or provide any punctuation (e.g. $1,000.25converted to 100025).	2300 HCP02
CDLDC068	Payment Arrangement Type Flag	char	2	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service;03=Percent of Charges; 07=Other.	N/A
CDLDC069	Rendering Provider ID	varchar	30	Unique code identified for the provider as assigned by the reporting entity. Payer assignedprovider ID for the provider that provided the services on the claims. This should be the identifier used by the payer for internal identification purposes, and does not routinelychange. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	2420A REF02 where REF01 =G2 (P) or 2310B REF02 where REF01 = G2(P)
CDLDC070	Rendering Provider NPI	char	10	Rendering Provider NPI is the NPI of the entity or individual directly providing the service, as enumerated in the Center for Medicaid and Medicare Services NPPES.	2420A NM109 (P) or 2310B NM109 (P)

CDLDC071	Rendering Provider Entity Type Qualifier	char	1	Use this field to indicate whether the rendering provider is a person or "non-person entity. HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "Person." Valid codes are: 1=Person; 2=Non- Person Entity.	2420A NM102 (P) or 2310B NM102 (P)
CDLDC072	Rendering Provider First Name	varchar	25	Individual first name. If CDLDC071=2, leave blank.	2420A NM104 (P) or 2310B NM104 (P)
CDLDC073	Rendering Provider Middle Name	varchar	25	Individual middle name or initial. If CDLDC071=2, leave blank.	2420A NM105 (P) or 2310B NM105 (P) or 2010AA NM105 (P)
CDLDC074	Rendering Provider Last Name or Organization Name	varchar	60	Full name of provider organization ("non- person entity") or last name of individual ("person") provider. CDLDC071 determines if the rendering provider is a "person" or a "non- person entity".	2420A NM103 (P) or 2310B NM103 (P) or 2010AA NM103 (P)
CDLDC075	Rendering Provider Suffix	varchar	10	Suffix to individual name. Set to null if provider is a facility or organization. The service provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III).	2420A NM107 (P) or 2310B NM107 (P) or 2010AA NM107 (P)

CDLDC076	Rendering Provider Specialty	varchar	10	Standard code that identifies the provider specialty for this line of service. Report the HIPAA-compliant healthcare provider national taxonomy code. Provider taxonomy codes are maintained by the National Uniform Claims Committee (NUCC). See Appendix H: External Code Source, National Uniform Claims Committee.	2420A PRV03 (P) or 2310B PRV03 (P) or 2000AA PRV03 (P)
CDLDC077	Rendering Provider City Name	varchar	30	City name of provider or practice location.	2420C N401 (P) or 2310C N401 (P)
CDLDC078	Rendering Provider State or Province	char	2	State of provider or practice location. State or Province codes are maintained by the US Postal Service and Canada Post. See Appendix H: External Code Sources, United States Postal Service.	2420C N402 (P) or 2310C N402 (P)
CDLDC079	Rendering Provider ZIP Code	varchar	9	Report the 5- or 9-digit Zip Code of the Rendering Provider as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. See Appendix H: External Code Sources, United States Postal Service.	2420C N403 (P) or 2310C N403 (P)
CDLDC080	Practitioner Group Practice NPI	varchar	60	NPI of group practice to which a practitioner is affiliated if different from CDLDC070.	N/A

CDLDC081	Billing Provider ID	varchar	30	Unique code identified for the provider as assigned by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes, and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	2010AA REF02 where REF01 = G2 and/or LU
CDLDC082	Billing Provider NPI	char	10	NPI for billing provider as enumerated in the Center for Medicaid and Medicare Services NPPES.	2010AA NM109 where 2010AA NM108 = XX
CDLDC083	Billing Provider Last Name or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.	2010AA NM103
CDLDC084	Billing Provider Tax ID	varchar	10	Tax ID of the billing provider. Do not code punctuation.	N/A

CDLDC085	Carrier Associated with Claim	varchar	8	For each claim, use the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved- out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. Leave blank if not applicable. See Appendix H: External Code Source, National Association of Insurance Commissioners.	N/A
CDLDC086	Claim Status	char	2	Claim status codes maintained by ANSI ASC X12 is the code identifying type of claim. See Appendix H: External Code Source, Accredited Standards Committee.	2320 SBR01
CDLDC087	Claim Line Type	char	1	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment.	N/A
CDLDC088	Carrier Specific Unique Member ID	varchar	50	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.	N/A

CDLDC089	Carrier Specific Unique Subscriber ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLDC090	Un-assigned			Reserved for future use. Elements will only be added with review from states and payers.	N/A
CDLDC091	Record Type	char	2	Value = DC.	N/A

Appendix F - Provider

CDL Data Element #	Data Element Name	Type	Max Length	Description/Codes/Sources	ASC X12 271 References
CDLPV001	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLPV002).	
CDLPV002	Payer Code	varchar	8	APCD-assigned identifier of insurer/underwriter in the case of premiums-based coverage, or of theadministrator in the case of self-funded coverage. Code assigned to the plan by the APCD registrationsystem (may be multi-tiered to support different platforms).	
CDLPV003	Intentionally left blank				
CDLPV004	Payer Assigned Provider ID	varchar	30	Unique code identified for the provider as assigned by the reporting entity. For every provider includedin the Eligibility, Medical, Pharmacy and Dental claims the payer assigned provider IDs shall be included.	
CDLPV005	Provider Tax ID	varchar	10	Tax ID of the provider. Do not code punctuation.	

CDLPV006	Entity Type Qualifier	char	2	Use this field to indicate whether the rendering provider is a person or "non-person entity. HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "Person." Valid codes are: 1=Person; 2=Non-Person Entity.	
CDLPV007	Provider NPI	char	10	NPI for provider as enumerated in the Center for Medicaid and Medicare Services NPPES.	
CDLPV008	Provider DEA Number	varchar	12	Provider Drug Enforcement Agency number. For all prescribing providers (CDLPC050) that have a DEA number.	
CDLPV009	Provider State License Number	varchar	15	Prefix with two-character state of licensure with no punctuation. Example: COLL12345. Do not leave a blank space in between state and license number.	
CDLPV010	Provider First Name	varchar	35	Individual first name. Leave blank if provider is a facility or organization.	
CDLPV011	Provider Middle Name or Initial	varchar	1	Individual middle name or initial. Leave blank if provider is a facility or organization.	
CDLPV012	Provider Last Name or Organization Name	varchar	60	Full name of provider organization or last name of individual provider.	
CDLPV013	Provider Suffix	varchar	10	Suffix to individual name. Leave blank if provider is a facility or organization. The provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III) Do not use credentials such as MD or PhD.	

CDLPV014	Provider Street Address	varchar	55	Physical address – address where the provider delivers healthcare services (street number and street name). Include suite number if applicable. Multiple addresses will require multiple provider records.	
CDLPV015	Provider Office City	varchar	30	The city of the physical address where the provider delivers healthcare services. Multiple addresses will require multiple provider records.	
CDLPV016	Provider Office State	char	2	The state of the physical address where the provider delivers healthcare services. Use postal service standard 2 letter abbreviations. Multiple addresses will require multiple provider records. See Appendix H: External Code Source, United States Postal Service.	
CDLPV017	Provider Office Zip	varchar	9	The zip code of the physical address where provider delivers healthcare services. As defined by the US Postal Service. Do not include dash. Multiple addresses will require multiple provider records. See Appendix H: External Code Source, United States Postal Service.	
CDLPV018	Provider County Name	char	2	County of provider. See Appendix H: External Code Source, United States Postal Service.	
CDLPV019	Provider Country Name	char	2	Country of provider's practice location. Code US for United States. See Appendix H: External Code Source, United States Postal Service.	
CDLPV020	Provider Phone	char	10	Phone number of provider.	
CDLPV021	Provider	varchar	10	Report the NUCC healthcare provider taxonomy code. See Appendix H: External Code Source, National Uniform Claim Committee.	

	Specialty				
CDLPV022	Atypical Provider Taxonomy Code	varchar	10	Non-medical or atypical providers not defined as covered entities by CMS. Non-medical providers who supply non-healthcare services, such as non-emergency transportation, will continue to submit claims and other transactions using their current provider ID and taxonomy. Use Code set for Atypical Provider Taxonomy Codes (maintained by NUCC). Leave blank if not applicable. See Appendix H: External Code Source, National Uniform Claim Committee.	
CDLPV023	Provider Medicare Provider ID	varchar	30	Provider ID as assigned by Medicare. Leave blank if unavailable.	
CDLPV024	Provider Medicaid Provider ID	varchar	30	Provider ID as assigned by Medicaid. Leave blank if unavailable.	
CDLPV025	Provider Specialty-2	varchar	10	Report additional NUCC healthcare provider taxonomy code for second specialty. In addition to the taxonomy code listed in CDLPV021. Leave blank if unavailable. See Appendix H: External Code Source, National Uniform Claim Committee.	
CDLPV026	Provider Specialty-3	varchar	10	Report third NUCC healthcare provider taxonomy code. Leave blank if unavailable. See Appendix H: External Code Source, National Uniform Claim Committee.	
CDLPV027	Provider Specialty-4	varchar	10	Report fourth NUCC healthcare provider taxonomy code. Leave blank if unavailable. See Appendix H: External Code Source, National Uniform Claim Committee.	

CDLPV028	Provider Specialty-5	varchar	10	Report fifth NUCC healthcare provider taxonomy code. Leave blank if unavailable. See Appendix H: External Code Source, National Uniform Claim Committee.	
CDLPV029	Un-assigned			Reserved for future use. Elements will only be added with review from states and payers.	
CDLPV030	Record Type	char	2	Value = PV.	

Appendix G1 - Insurance Product Codes

Code	Description
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group HealthPlan
14	Medicare Secondary, No-Fault Insurance including Insurance in which Auto Is Primary
15	Medicare Secondary Workers' Compensation
16	Medicare Secondary Public Health Service (PHS) or Other Federal Agency
17	Dental
18	Vision
19	Prescription Drugs (Commercial Coverage)
41	Medicare Secondary Black Lung
42	Medicare Secondary Veterans' Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47	Medicare Secondary, Other Liability Is Primary
AP	Auto Insurance Policy
C1	Other Commercial (Not Specified Elsewhere)

CO	Consolidated Omnibus Reconciliation Act (COBRA)
CP	Medicare Conditionally Primary
D	Disability
DB	Disability Benefits
E	Medicare – Point of Service (POS)
EP	Exclusive Provider Organization
FH	Federal Employees Health Benefits Program (HMO)
FP	Federal Employees Health Benefits Program (PPO)
FF	Family or Friends
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) Medicare Advantage/Risk
HS	Special Low Income Medicare Beneficiary
IN	Indemnity
IP	Individual Policy
LC	Long Term Care
LD	Long Term Policy
LI	Life Insurance

LT	Litigation
MA	Medicare Part A (not to be used for commercial plans)
MB	Medicare Part B (not to be used for commercial plans)

Appendix G2 - Place of Service Codes

Code	Description
1	Pharmacy
2	Telehealth
3	School
4	Homeless shelter
5	Indian Health Service Free-standing Facility
6	Indian Health Service Provider-based Facility
7	Tribal 638 Free-standing Facility
8	Tribal 638 Provider-based Facility
9	Prison/Correctional Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment-Worksite
19	Off Campus-Outpatient Hospital
20	Urgent care Facility
21	Inpatient Hospital
22	On Campus-Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgery Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility

33	Custodial Care Facility

Place of Service Codes for Professional Claims
SOURCE: Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244-1850

Appendix G3 - Type of Facility Codes

	Type of Facility First Digit
1	Hospital
2	Skilled Nursing
3	Home Health
4	Christian Science Hospital
4	Other (for hospital referenced diagnostic services or home health not under a plan of treatment)
5	Comprehensive Outpatient Rehabilitation Facilities (CORFs)
4	Free Standing Birthing Center
4	interim - last claim
5	Christian Science Extended Care
5	Nursing Facility Level I
6	Community Mental Health Center
9	Other
5	late charge only
6	Intermediate Care
6	Nursing Facility Level II
9	Other
7	Replacement of prior claim
7	Clinic
7	Intermediate Care - Level III Nursing Facility
8	Void/cancel of a prior claim
8	Special Facility

8	Swing Beds
9	Final claim for a home

Appendix G4 – Discharge Status Codes

Code	Description
1	Discharged to home or self-care
2	Discharged/transferred to another short-term general hospital for inpatient care
3	Discharged/transferred to skilled nursing facility (SNF)
4	Discharged/transferred to nursing facility (NF)
5	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution
6	Discharged/transferred to home under care of organized home health service organization
7	Left against medical advice or discontinued care
8	Discharged/transferred to home under care of a Home IV provider
9	Admitted as an inpatient to this hospital
10	Expired
21	Discharged/Transferred To Court/Law Enforcement
30	Still patient or expected to return for outpatient services
40	Expired at home
41	Expired in a medical facility
42	Expired, place unknown
43	Discharged/ transferred to a Federal Hospital
50	Hospice – home
51	Hospice – medical facility
61	Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital
63	Discharged/transferred to a long-term care hospital

64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a critical access hospital (cah)
69	Discharged/transferred to a designated disaster alternative care site (effective 10/1/13)
70	Discharged/transferred to another type of health care institution not defined elsewhere in this code list
81	Discharged to home or self care with a planned acute care hospital inpatient readmission (effective 10/1/13)
82	Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission (effective 10/1/13)
83	Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (effective 10/1/13)
84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (effective 10/1/13)
85	Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
86	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care with a planned acute care hospital inpatient readmission (effective 10/1/13)
87	Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission (effective 10/1/13)
88	Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission (effective 10/1/13)

89	Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission (effective 10/1/13)
90	Discharged/transferred to an inpatient rehabilitation facility (irf) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
91	Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
92	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (effective 10/1/13)
93	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
94	Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
95	Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission (effective 10/1/13)
op	default '01' = home
p	default '00' = unknown

National Uniform Billing Committee (NUBC)
NUBC Codes
SOURCE: National Uniform Billing Committee Official Data Specifications Manual
National Uniform Billing Committee American Hospital Association
155 N Wacker Drive Chicago, IL 60606
www.nubc.org

Appendix G5 – Insurance Type Codes

MC	Medicaid
MD	Medicare Part D
MH	Medigap Part A
MI	Medigap Part B
MO	Medicare Advantage PPO
MP	Medicare Primary (not to be used for commercial plans)
MT	Medicaid CHIP
OT	Other
PE	Property Insurance – Personal
PL	Personal
PP	Personal Payment (Cash – No Insurance)
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
RP	Property Insurance – Real
SP	Supplemental Policy

S1	Medicare Special Needs Plan – Chronic Condition
S2	Medicare Special Needs Plan - Institutionalized
S3	Medicare Special Needs Plan – Dual Eligible
TF	Tax Equity Fiscal Responsibility Act (TEFRA)
TR	Tricare
U	Multiple Options Health Plan
VA	Veterans Administration Plan
WC	Workers' Compensation
WU	Wrap Up Policy
11	Other Non-Federal Programs
DM	Dental Maintenance Organization
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	Champus
CI	Commercial Insurance Company
LB	Liability
LM	Liability Medical

OF	Other Federal Program
TV	Title V
SL	Standalone limited (for example, vision only, hearing only)
Z	Mutually Defined (Use code ZZ when Type of Insurance is Unknown)

Appendix G6 – Race	
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
These codes are a limited subset from http://www.cdc.gov/nchs/data/dvs/Race_Ethnicity_CodeSet.pdf	

Appendix G7 – Market Category	
Code	Description
IND	Individuals (non-group)
FCH	Individuals on a franchise basis
GCV	Individuals as group conversion Policies
GS1	Employers having exactly 1 employee
GS2	Employers having 2 thru 9 employees
GS3	Employers having 10 thru 25 employees
GS4	Employers having 26 thru 50 employees
GLG1	Employers having 51 thru 100 employees
GLG2	Employers having 101 thru 250 employees
GLG3	Employers having 251 thru 500 employees
GLG4	Employers having more than 500 employees
GSA	Small employers through a qualified association trust
OTH	Other types of entities. Insurers using this market code shall obtain prior approval.

Appendix H – Coding Sources

American Dental Association

Current Dental Terminology (CDT) Codes
SOURCE: Current Dental Terminology
(CDT) ManualAVAILABLE FROM:
American
Dental
Association211
East Chicago
Avenue
Chicago, IL
60611-2678
ABSTRACT: The CDT contains the American Dental Association's codes for dental procedures and nomenclature and is the nationally accepted set of numeric codes and descriptive terms for reporting dental treatments.

American Medical Association

Current Procedural Terminology (CPT) Codes
SOURCE: Physicians' Current Procedural Terminology (CPT)
ManualAVAILABLE FROM:
American
Medical
Association515
North State
Street Chicago,
IL 60654
ABSTRACT: A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

Accredited Standards Committee (ASC)

ASC X12 Directories
SOURCE: PACDR Implementation Guides, ASC X12 005010
StandardAVAILABLE FROM:
Data Interchange Standards Association,
Inc. (DISA)7600 Leesburg Pike Ste 430
Falls
Church, VA
22043
http://store
.x12.org/st
ore
Washington Publishing Company http://www.wpc-edi.com/reference/
ABSTRACT: The PACDR Implementation Guides contain the descriptions of data elements used to construct X12 segments. The PACDR Guides also contain code lists associated with these data elements.

Canada Post
Canadian Provinces Cities and ZIP Code
SOURCE : Canada Post AVAILABLE FROM :
http://www.canadapost.ca/

Centers for Disease Control and Prevention
HL7/CDC Race and Ethnicity Code Set SOURCE: Race and Ethnicity Code Set AVAILABLE FROM :
Centers for Disease Control and Prevention 1600 Clifton Road
Atlanta, GA 30329-4027 http://www.cdc.gov/nchs/data/dvs/Race_Ethnicity_CodeSet.pdf
ABSTRACT: The race and ethnicity code set is to be used for coding the race and ethnicity of the member.

Centers for Medicare and Medicaid Services
Health Care Common Procedural Coding System SOURCE: Health Care Common Procedural Coding System AVAILABLE FROM :
Centers for Medicare and Medicaid Services 7500 Security Boulevard
Baltimore, MD 21244-1850 www.cms.gov/HCPCSReleaseCodeSets/
ABSTRACT: HCPCS is the Centers for Medicare and Medicaid Services (CMS) coding scheme to group procedures performed for payment to

providers.

Centers for Medicare and Medicaid Services
HHS Actuarial Value Calculator
SOURCE: Center for Consumer Information & Insurance Oversight AVAILABLE FROM :
Centers for Medicare and Medicaid Services 7500 Security Boulevard
Baltimore, MD 21244-1850 https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html
ABSTRACT: CCIIO publishes an AV calculator on an annual basis.

Centers for Medicare and Medicaid Services
Health Insurance Prospective Payment System (HIPPS) SOURCE: Center for Medicare & Medicaid Services AVAILABLE FROM:
Center for Medicare and Medicaid Services 7500 Security Boulevard
Baltimore, MD 21244
http://www.cms.gov/Medicare/Medicare-fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html
ABSTRACT: Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Case-mix groups are developed based on research into utilization patterns among various provider types. For the payment systems that use HIPPS codes, clinical assessment data is the basic input used to determine which case-mix group applies to a particular patient. A standard patient assessment instrument is interpreted by case-mix grouping software algorithms, which assign the case mix group. For payment purposes, at least one HIPPS code is defined to represent each case-mix group. These HIPPS codes are reported on claims to insurers.

Centers for Medicare and Medicaid Services
National Provider Identifier
SOURCE: National Plan and Provider Enumeration System AVAILABLE FROM:
Centers for Medicare and Medicaid Services 7500 Security Boulevard
Baltimore, MD 21244-1850 https://nppes.cms.hhs.gov/NPPES/Welcome.do
ABSTRACT: The Centers for Medicare and Medicaid Services developed the National Provider Identifier as the standard, unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

Centers for Medicare and Medicaid Services
Place of Service Codes for Professional Claims SOURCE: Place of Service Codes for Professional Claims AVAILABLE FROM :
Centers for Medicare and Medicaid Services 7500 Security Boulevard
Baltimore, MD 21244-1850 www.cms.gov/physicianfeesched/downloads/Website_POS_database.pdf

ABSTRACT: The place of service code identifies the location where the healthcare service was rendered.

ISO 3166 Maintenance Agency
Country Codes
SOURCE: ISO 3166 Maintenance Agency AVAILABLE FROM:
ISO 3166 Maintenance Agency
c/o International Organization for Standardization Chemin de Blandonnet 8
CP 401
1214 Verni, Geneva Switzerland
Telephone: +41 22 749 01 11
e-mail: customerservice@iso.org
www.iso.org/iso/country_codes

National Association of Insurance Commissioners
NAIC Codes
SOURCE: National Association of Insurance Commissioners AVAILABLE FROM:
NAIC Central Office
1100 Walnut Street Suite 1500 Kansas City, MO 64106 816.842.3600
http://www.naic.org/prod_serv/LOC-ZU-15-01.pdf https://eapps.naic.org/cis/companySearch.do
ABSTRACT: NAIC maintains an identification code for each payer that is a 5 digit unique number assigned to an insurance entity by the NAIC. NAIC has developed a tool to look up the code and find the company, or look up the company to find the code:

National Council for Prescription Drug Programs (NCPDP)
National Association of Boards of Pharmacy Number
SOURCE: National Association of Boards of Pharmacy Database and Listings AVAILABLE FROM:
www.ncpdp.org
National Council for Prescription Drug Programs 9240 East Raintree Drive
Scottsdale, AZ 85260-7518
ABSTRACT: A unique number assigned in the U.S. and its territories to individual clinic, hospital, chain, and independent pharmacy locations that conduct business at retail by billing third-party drug benefit payers. The National Council for Prescription Drug Programs (NCPDP) maintains this database under contract from the National Association of Boards of Pharmacy. The National Association of Boards of Pharmacy Number is a seven-digit numeric number with the following format SSNNNNC, where SS=NCPDP assigned state code number, NNNN=NCPDP assigned pharmacy location number, and C=check digit calculated by algorithm from previous six digits.

National Council for Prescription Drug Programs (NCPDP)
Uniform Healthcare Payer Data
SOURCE: NCPDP Uniform Healthcare Payer Data Standard Implementation Guide AVAILABLE FROM:
National Council for Prescription Drug Programs 9240 East Raintree Drive
Scottsdale, AZ 85260 www.ncpdp.org
ABSTRACT: The Implementation Guide is intended to meet an industry need to supply detailed drug or utilization claim information from adjudicated claims that processors/payers or their clients report to States or their Agents.

National Uniform Billing Committee (NUBC)
NUBC Codes
SOURCE: National Uniform Billing Committee Official Data Specifications Manual AVAILABLE FROM:
National Uniform Billing Committee American Hospital Association
155 N Wacker Drive Chicago, IL 60606
www.nubc.org

National Uniform Claim Committee (NUCC)
Healthcare Provider Taxonomy Code Set SOURCE: Washington Publishing Company AVAILABLE FROM:
National Uniform Claim Committee nuccinfo@nucc.org
www.nucc.org
http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40

United States Food and Drug Administration (FDA)
National Drug Codes
SOURCE: National Drug Data File AVAILABLE FROM:
U.S. Food and Drug Administration Center for Drug Evaluation and Research
Division of Data Management and Services 10903 Hampshire Avenue
Silver Spring, MD 20993
www.fda.gov or http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm
ABSTRACT: The National Drug Code is a coding convention established by the Food and Drug Administration to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.

United States Census Bureau
2010 FIPS Codes for Counties and County Equivalent Entities SOURCE : United States Census Bureau, Geography
https://www.census.gov/geo/reference/codes/cou.html

United States Postal Service (USPS)
States and Outlying Areas of the U.S. ZIP Code SOURCE : United States Postal Service AVAILABLE FROM :
U.S. Postal Service
National Information Data Center
P.O. Box 9408
Gaithersburg, MD 20898-9408 https://www.usps.com
ABSTRACT: Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two right-most digits identify a local delivery area. In the 9-digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery area. The two leftmost digits identify a sector which may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes.

World Health Organization (WHO)
International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure and Diagnosis SOURCE: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) AVAILABLE FROM:
WHO Publications Center AUS 49 Sheridan Avenue
Albany, NY 12210 http://www.cdc.gov/nchs/icd/icd9cm.htm
ABSTRACT: The International Classification of Diseases, 9th Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and procedures.

World Health Organization (WHO)
International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS)
SOURCE: International Classification of Diseases, 10th Revision, (ICD-10-CM/PCS) AVAILABLE FROM:
WHO Publications Center AUS 49 Sheridan Avenue
Albany, NY 12210 www.cdc.gov/nchs/icd/icd10cm.htm#9update
ABSTRACT: The International Classification of Diseases, 10th Revision, is used to report medical diagnosis in all U.S. health care settings after October 1, 2015.