ACCESS HEALTH CT

Connecticut All Payers Claims Database

DATA SUBMISSION GUIDE

December 5, 2013

Version 1.2 (with clarifications)

Contents

Definitions and Acronyms

Administrator: an individual appointed by the Chief Executive Officer of the Exchange to direct the activities of the APCD.

Member: Please refer to the Connecticut Health Insurance Exchange Policies and Procedures: All-Payer Claims Database document for the formal definition of member.

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

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

Health Care Data: the set of files that a Reporting Entity is required to submit according to Public Act 13-247 consisting of Member Eligibility, Medical Claims, Pharmacy Claims, Pharmacy Claims, and Providers.

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

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

Reporting Entity: has the same meaning as provided in Section 144 (a)(2) of Public Act 13-247.

Risk Adjustment: a series of algorithms performed on member data to ascertain relative illness burden.

Acronyms:

ADA = American Dental Association

AHCT = Access Health CT

APCD = All-Payer Claims Database

ASCII = American Standard Code for Information Interchange

DSG = Data Submission Guide

HIPAA = Health Insurance Portability and Accountability Act

PP = Policies and Procedures to be issued by AHCT

RA = Risk Adjustment

I. Introduction

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

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

Member Eligibility

Medical Claims

Pharmacy Claims

Dental Claims

Provider Information

Questions about this guide should be submitted to Access Health CT at Ctapcd.Analytics@ct.gov and ahct-support@onpointhealthdata.org.

II. Data Submission Requirements

General Information

1. Reporting Entities shall submit complete and accurate Eligibility Data Files, Medical Claims Data Files, Pharmacy Claims Data Files, Dental Claims Data Files, and Provider Files to the Exchange for all of their Members in accordance with the Policies and Procedures and this Submission Guide**.**
2. Each Reporting Entity shall also submit all Medical Claims Data Files, Dental Claims Data Files, Pharmacy Claims Data Files, and associated Provider Files for any claims processed by any sub-contractor on the Reporting Entity's behalf.
3. Field definitions and other relevant data associated with these submissions are specified in the tables for each file.
4. The Reporting Entity is responsible for ensuring that both Provider and Member Identifiers are consistent across each file where appropriate.
5. Each submitted data file shall have control totals and transmission control data as defined in the Header and Trailer Record for each defined file.
6. Reporting Entities will submit files on a monthly basis to the APCD Data Manager, which will operate and maintain a secure file transfer portal for this project.

a. All claims data is to be submitted within one month after the close of the previous reporting month. EXAMPLE: Claims adjudicated by the payer in January are to be reported by the end of February in the January File.

b. All eligibility data is to be submitted monthly for any and all active eligible members in the prior 12 months of the reporting period. This rolling period methodology requires the submission of both claimants and non-claimants.

c. All provider data is to be submitted monthly for any and all providers who had a claim within the reporting period. The reporting of inactive providers is allowed and can be accounted for in the data set, but there is no rolling-period methodology required.

7. Each Reporting Entity must submit documentation for key strategic variables and processes, as requested by the Administrator, supporting their standard data extract files, including a data dictionary mapping internal system data elements to the data elements defined in this DSG. The documentation should include a detailed description of how the data extracts are created and how the requirements of this DSG and the rule are accomplished, including specifications on what data is being excluded and the parameters that define that excluded data.

8. The Reporting Entity shall include utilization and cost information for all services provided to members under any financial arrangement, including sub-capitated, bundled and global payment arrangements.

III. Required Data Files

A. General Requirements

1. **Medical Claims Data**
   a) Medical Claims files must include all services provided to the Member, including but not limited to medical, behavioral health, home care and durable medical equipment.
   b) Reporting Entities must provide information to identify the type of service and setting in which the service was provided given the standard claim type used for the setting
   c) Reporting Entities must submit data in the monthly file for any claim lines that some action has been taken on that claim (i.e., payment, adjustment or other modification). Claims denied for completeness, errors or other administrative reasons (sometimes known as “soft” denials) should not be submitted until the claim has been paid.
   d) Reporting Entities must provide a reference number that links the original claim to all subsequent actions associated with that claim.

e) Reporting Entities are required to identify encounters corresponding to a capitation payment.

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

3. **Member Eligibility Data**
   a) Reporting Entities must provide a data set that contains information on every covered plan member whether or not the member utilized services during the reporting period. The file must include member identifiers, subscriber name and identifier, member relationship to subscriber, residence, age, race, ethnicity and language, and other required fields to allow retrieval of related information from pharmacy and medical claims data sets.
   b) Reporting Entities should provide enrollment data in rolling 12-month periods each month. Member eligibility should be submitted using enrollment spans in an effort to capture any changes in eligibility attributes, attributed provider, benefit information, or enrollment/disenrollment. Member eligibility should contain one record per member per product for the given timespan that product was in effect. As a result, overlaps in enrollment start and enrollment end dates are permissible.
   c) Member is either the Subscriber or the Subscriber's dependents and all instances where the Subscriber has dependents a link between them must be maintained
   d) If dual coverage exists, send coverage of eligible members where the insurance policy is defined as primary, secondary or tertiary.

4. **Provider Data**
   a) Reporting Entities must provide a data set that contains information on every provider with a paid claim in the Medical Claims file during the targeted reporting period. Every provider on a record in the Medical Claims file should have a corresponding record in the Provider file.
   b) Data about pharmacies is not required in the Provider file.
   c) In the event the same provider delivered and was reimbursed for services rendered from two different physical locations, than the provider data file shall contain two separate records for that same provider reflecting each of those physical locations. One record shall be provided for each unique physical location for a provider.

5. **Dental Claims Data**

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

B. File Submission Methods

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

C. Data Quality Requirements

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

D. File Format

1. All files submitted to the APCD will be formatted as standard text files. Text files will comply with the following standards:

    a) One line item per row; No single line item of data may contain carriage return or line feed characters.
    b) All rows delimited by the carriage return + line feed character combination.
    c) Each field is defined as variable text length, variable number length, set text length or set number length and delimited using the pipe character (ASCII=124). It is imperative that no pipes ('|') appear in the data itself. If your data contains pipes, either remove them or discuss using an alternate delimiter character.
    d) Text fields are never demarcated or enclosed in single or double quotes. Any quotes detected are regarded as a part of the actual data.
    e) Unless otherwise stipulated, numbers (ID numbers, account numbers, etc) do not contain spaces, hyphens or other punctuation marks.

f) Text fields are never padded with leading or trailing spaces, unnecessary zeroes or tabs.
g) Numeric fields are never padded with leading or trailing zeros or populated with 9-Fill to indicate null data.
h) If a field is not available, or is not applicable, leave it blank. 'Blank' means do not supply any value at all between pipes (including quotes or other characters).

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
HD-ME	HD001	Record Type	10/7/2013	Text	2	Header Record Identifier	Report HD here. Indicates the beginning of the Header Elements of the file.	Mandatory	100.0%
HD-ME	HD002	Submitter	10/7/2013	Text	8	Header Submitter/ Carrier ID defined by AHCT	Report unique Submitter ID here. AHCT will provide this unique identifier to the carrier. TR002 must match the Submitter ID reported here. This ID is linked to other elements in the file for quality control.	Mandatory	100.0%
HD-ME	HD003	National Plan ID	10/7/2013	Text	10	Header CMS National Plan Identification Number (Plan ID)	Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	Situational	0.0%
HD-ME	HD004	Type of File	10/7/2013	Text	2	Defines the file type and data expected.	This field must be coded ME to indicate submission of eligibility data. This must match the File Type reported inTR004.	Mandatory	100.0%
HD-ME	HD005	Period Beginning Date	10/7/2013	Full Date - Integer	8	Header Period Start Date	Report the Year, Month and Day of the reported submission period in YYYYMMDD format. This date is the first day of the month for the reporting period and must be repeated in TR005.	Mandatory	100.0%
HD-ME	HD006	Period Ending Date	10/7/2013	Full Date - Integer	8	Header Period Ending Date	Report the Year, Month and Day of the reported submission period in YYYYMMDD format. This date is the last day of the month for the reporting period and must be repeated in TR006.	Mandatory	100.0%
HD-ME	HD007	Record Count	10/7/2013	Integer	10	Header Record Count	Report the total number of records submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters.	Mandatory	100.0%
HD-ME	HD008	Comments	10/7/2013	Text	80	Header Carrier Comments	May be used to document the submission by assigning a filename, system source, compile identifier, etc.	Optional	0.0%
HD-ME	HD009	APCD Version Number	10/7/2013	Decimal - Numeric	3	Submission Guide Version	Report the version number as presented on the APCD Medical Claim File Submission Guide in 0.0Format. Sets the intake control for editing elements. Version must be accurate else file will drop. EXAMPLE: 3.0 = Newest Version Code Description 1.2 Current Version: required for reporting periods as of October 2013	Mandatory	100.0%
1	ME001	Submitter	4/1/2013	Text	8	CT APCD defined and maintained unique identifier	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the reporting state and the third character designates the type of submitter. For Connecticut's APCD collection, valid prefixes include: CTC ..... Commercial carrier CTG ..... Governmental agency CTT ..... Third-party administrator Notes: A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	All	100.0%
2	ME002	National Plan ID	4/1/2013	Text	10	CMS National Plan Identification Number (Plan ID)	Name will be distributed by Data Manager.	All	0.0%

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
3	ME003	Insurance Type Code/Product	4/1/2013	Lookup Table - Text	2	Type / Product Identification Code	Report the code that defines the type of insurance under which this member's eligibility is maintained. EXAMPLE: HM = HMO Code Description 9 Self-pay 11 Other Non-Federal Programs * (use of this value requires disclosure to Data Manager prior to submission) 12 Preferred Provider Organization (PPO) * 13 Point of Service (POS) * 14 Exclusive Provider Organization (EPO) * 15 Indemnity Insurance * 16 Health Maintenance Organization (HMO) Medicare Risk (Use to report Medicare Part C/Medicare Advantage Plans)* 17 Dental Maintenance Organization (DMO) * 96 Husky Health A 97 Husky Health B 98 Husky Health C 99 Husky Health D AM Automobile Medical * CH Champus (now TRICARE) * DS Disability * HM Health Maintenance Organization * LM Liability Medical * MA Medicare Part A * (Medicare Fee for Service only) MB Medicare Part B * (Medicare Fee for Service only) MC Medicaid * MD Medicare Part D OF Other Federal Program * (use of this value requires disclosure to Data Manager prior to submission) TV Title V * VA Veterans Affairs Plan * WC Workers' Compensation * ZZ Mutually Defined * (use of this value requires disclosure to Data Manager prior to submission)	All	96.0%
4	ME004	Year	4/1/2013	Date Period - Integer	4	Eligibility year reported in this submission.	Year for which eligibility is reported in this submission in YYYY format. If reporting previous year's data, the year reported here will not match current year. Do not report a future year here.	All	100.0%
5	ME005	Month	4/1/2013	Text	2	Reporting Month of Eligibility	Month for which eligibility is reported in this submission expressed in numerical MM Format from 01 to 12. Leading zero is required for reporting January through September files.	All	100.0%

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
6	ME006	Insured Group or Policy Number	4/1/2013	Text	30	Group / Policy Number	Use this field to report the group or policy number. Notes: The value reported for this field should be reported consistently in the "Insured Group or Policy Number" field in both the medical claims (MC006) and pharmacy claims (PC006) data. This is not the number that uniquely identifies the subscriber. If a policy is sold to an individual as a non-group policy, report with a value of "IND". This principle pertains to all claim types: commercial, Medicaid, and Medicare.	All	99.0%
7	ME007	Coverage Level Code	4/1/2013	Lookup Table - Text	3	Benefit Coverage Level Code	Use this field to report the benefit level of coverage. Code Description CHD Children Only DEP Dependents Only ECH Employee and Children ELF Employee and Life Partner EMP Employee Only ESP Employee and Spouse FAM Family IND Individual SPC Spouse and Children SPO Spouse Only UNK Unknown	All	99.0%
8	ME008	Subscriber SSN	4/1/2013	Text	9	Subscriber's Social Security Number	Report the subscriber's social security number here; used to create Unique Member ID; Do not use hyphen. If not available do not report any value here. Notes: The value reported for this field should be reported consistently in the "Subscriber Social Security Number" field in both the medical claims (MC007) and pharmacy claims (PC007) data. This field will not be passed into analytic file.	All	85.0%
9	ME009	Plan Specific Contract Number	4/1/2013	Text	30	Contract Number	Report the Plan assigned contract number. Do not include values in this field that will distinguish one member of the family from another. This should be the contract or certificate number for the subscriber and all of the dependents. Notes: The value reported for this field should be reported consistently in the "Plan-Specific Contract Number" field in both the medical claims (MC008) and pharmacy claims (PC008) data.	All	95.0%
10	ME010	Member Suffix or Sequence Number	4/1/2013	Text	20	Member's Contract Sequence Number	Report the unique number / identifier of the member within the contract	All	99.0%
11	ME011	Member SSN	4/1/2013	Text	9	Member's Social Security Number	Report the member's social security number here; used to create Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here. Notes: The value reported for this field should be consistently reported in the "Member Social Security Number" field in both the medical claims (MC010) and pharmacy claims (PC010) data.	All	68.0%

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
12	ME012	Individual Relationship Code	10/30/2013	Lookup Table - Text	2	Member to Subscriber Relationship Code	Report the value that defines the Member's relationship to the Subscriber. EXAMPLE: 1 = Spouse Code Description 1 Spouse 4 Grandfather or Grandmother 5 Grandson or Granddaughter 7 Nephew or Niece 10 Foster Child 12 Other Adult 15 Ward 17 Stepson or Stepdaughter 18 Self 19 Child 20 Employee 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 34 Other Adult 36 Emancipated Minor 39 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Child Where Insured Has No Financial Responsibility 53 Life Partner 76 Dependent	All	98.0%
13	ME013	Member Gender	4/1/2013	Lookup Table - Text	1	Member's Gender	Report member gender as reported on enrollment form in alpha format. Used to create Unique Member ID. EXAMPLE: F = Female Code Description F Female M Male U Unknown Notes: The value reported for this field should be consistently reported in the "Member Gender" field in both the medical claims (MC012) and pharmacy claims (PC012) data.	All	100.0%
14	ME014	Member Date of Birth	4/1/2013	Full Date - Integer	8	Member's date of birth	Report the date the member was born in YYYYMMDD Format. Notes: The value reported for this field should be consistently reported in the "Member Date of Birth" field in both the medical claims (MC013) and pharmacy claims (PC013) data.	All	99.0%
15	ME015	Member City Name	4/1/2013	Text	30	City name of the Member	Report the city name of member.	All	99.0%

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
16	ME016	Member State	4/1/2013	External Code Source 2 - Text	2	State / Province of the Member	Report the state of the patient as defined by the US Postal Service. Report Province when Country Code does not = USA	All	99.0%
17	ME017	Member ZIP Code	4/1/2013	External Code Source 2 - Text	9	Zip Code of the Member	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	99.0%
18	ME018	Medical Coverage	4/1/2013	Lookup Table - Integer	1	Indicator - Medical Option	Report the value that defines the element. EXAMPLE: 1 = Yes there is Medical Coverage. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
19	ME019	Prescription Drug Coverage	4/1/2013	Lookup Table - Integer	1	Indicator - Pharmacy Option	Report the value that defines the element. EXAMPLE: 1 = Yes there is Prescription Coverage. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
20	ME020	Dental Coverage	4/1/2013	Lookup Table - Integer	1	Indicator - Dental Option	Report the value that defines the element. EXAMPLE: 1 = Yes there is Dental Coverage. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
21	ME021	Race 1	4/1/2013	Lookup Table - Text	2	Member's self-disclosed Primary Race	Report the Member-identified primary 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. EXAMPLE: R9 = Other 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	All	3.0%

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
22	ME022	Race 2	4/1/2013	Lookup Table - Text	2	Member's self-disclosed Secondary Race	Report the Member-identified secondary 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. EXAMPLE: R9 = Other 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	All	2.0%
23	ME023	Other Race	4/1/2013	Text	15	Member's Other Race	Report the member's self-disclosed race when ME021 or ME022 is entered as R9 Other Race; if not applicable, do not report any value here	Required when ME021 or ME022 = R9 (Other)	99.0%
24	ME024	Hispanic Indicator	4/1/2013	Lookup Table - Integer	1	Indicator - Hispanic Status	Report the value that defines the element. The code value "3" for unknown, should be used ONLY when member answers unknown, or refuses to answer. Do not report any value here if the data has not been collected. Report only collected data. EXAMPLE: 1 = Yes, Member has indicated Hispanic status. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	3.0%
25	ME025	Ethnicity 1	4/1/2013	External Code Source CDC - Text	6	Member's Primary Ethnicity	Report the Member-identified primary ethnicity from either the External Code Source or here, whichever provides the best detail as obtained from the Member / Subscriber. The value "UNKNOW" should be used ONLY when the Member answers unknown, or refuses to answer. Do not report any value here if data has not been collected. Report only collected data.	All	3.0%
26	ME026	Ethnicity 2	4/1/2013	External Code Source CDC - Text	6	Member's Secondary Ethnicity	Report the Member-identified secondary ethnicity from either the External Code Source or here, whichever provides the best detail as obtained from the Member / Subscriber. The value "UNKNOW" should be used ONLY when the Member answers unknown, or refuses to answer. Do not report any value here if data has not been collected. Report only collected data.	All	2.0%
27	ME027	Other Ethnicity	4/1/2013	Text	20	Member's Other Ethnicity	Report the member's self-disclosed ethnicity when ME025 or ME026 is entered as OTHER; if not applicable, do not report any value here	Required when ME025 or ME026 = OTHER	99.0%

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
28	ME028	Primary Insurance Indicator	4/1/2013	Lookup Table - Integer	1	Indicator - Primary Insurance Coverage	Report the value that defines the element. EXAMPLE: 1 = Yes, Insurance is Primary (Products, Plans or Benefits that only cover Copays, Coinsurance and Deductibles [Gap Coverage] will answer 2 = No here). Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
29	ME029	Coverage Type	4/1/2013	Lookup Table - Text	3	Type of Coverage Code	Report the code that defines the type of insurance policy by which the enrollee is covered. EXAMPLE: UND = Plan underwritten by the insurer Code Description ASW Self-funded plans that are administered by a third-party administrator, where the employer has purchased stop-loss, or group excess, insurance coverage ASO Self-funded plans that are administered by a third-party administrator, where the employer has not purchased stop-loss, or group excess, insurance coverage STN Short-term, non-renewable health insurance UND Plans underwritten by the insurer OTH Any other plan. Insurers using this code shall obtain prior approval.	Required when ME134 = 1 or 2	98.0%

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
30	ME030	Group Size	7/2/2013	Lookup Table - Text	4	Group Size Code/Market Category Code	Code indicating Group Size consistent with Connecticut Insurance Law and Regulation. Code Description IND Policies sold and issued directly to individuals (i.e., a non-group policy) FCH Policies sold and issued directly to individuals on a franchise basis GCV Policies sold and issued directly to individuals as group conversion Policies GS1 Policies sold and issued directly to employers having exactly one employee GS2 Policies sold and issued directly to employers having between two and nine employees GS3 Policies sold and issued directly to employers having between 10 and 25 employees GS4 Policies sold and issued directly to employers having between 26 and 50 employees GLG1 Policies sold and issued directly to employers having between 51 and 99 employees GLG2 Policies sold and issued directly to employers having between 100 and 249 employees GLG3 Policies sold and issued directly to employers having between 250 and 499 employees GLG4 Policies sold and issued directly to employers having 500 or more employees GSA Policies sold and issued directly to small employers through a qualified association trust OTH Policies sold to other types of entities. Insurers using this market code shall obtain prior approval.	All	100.0%
31-32	ME031 - ME032	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
33	ME033	Member language preference	4/1/2013	External Code Source Census - Integer	3	Member's self-disclosed verbal language preference	Report the code that defines the spoken language preference of the member. The code value 999 (Unknown/ Not Specified), should only be used when patient/client answers unknown or refuses to answer. Do not report any value here if the Carrier does not have the data. Report only collected data.	All	3.0%
34	ME034	Member language preference -Other	4/1/2013	Text	20	Member's Other Language Preference	Report the other language the member / subscriber has identified. Do not report any value If no other language identified	Required when ME033= Other	99.0%
35	ME035	Medical Home Flag	4/1/2013	Lookup Table - Integer	1	Medical Home indicator	Report the value that defines the element. EXAMPLE: 1 = Yes, Member has a medical home on record for this coverage period. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
36	ME036	Medical Home Number	4/1/2013	Text	30	Health Care Home ID	Report the submitter assigned medical home number. It is anticipated that this will be the same data submitter number used in reporting servicing provider. Do not report any data here if no applicable. The number of the member's healthcare home must also be in the Provider File in PV002, Provider ID.	Required when ME035 = 1	90.0%
37	ME037	Medical Home Tax ID Number	4/1/2013	Text	9	Health Care Home EIN	Report the Federal Tax Identification Number of the medical home here. If there is not medical home to report, do not report any value. Do not use hyphen or alpha prefix.	Required when ME035 = 1	90.0%
38	ME038	Medical Home National Provider ID –	4/1/2013	External Code Source NPPES - Text	10	National Provider Identification (NPI) of the Health Care Home Provider	Report the National Provider Identification (NPI) number for the entity or individual serving as the medical home. If there is no medical home to report, do not report any value.	Required when ME035 = 1	10.0%
39	ME039	Health Care Home Name	4/1/2013	Text	60	Name of Health Care Home	Report the full name of the medical home. If the medical home is an individual, report in the format of Last name, first name and middle initial with no punctuation. If there is not medical home to report, do not report any value.	Required when ME035 = 1	90.0%
40	ME040	Product ID Number	7/2/2013	Text	30	Product Identification	Report the submitter-assigned identifier for the product. This element is used to understand Product and Eligibility attributes of the member / subscriber as applied to this record. Note: if no product IDs are assigned, please assign the following default value: "9999999999."	All	100.0%
41	ME041	Enrollment Start Date	7/2/2013	Integer	8	Start Date	Report the date the member was enrolled in YYYYMMDD Format.	All	100.0%
42	ME042	Enrollment End Date	7/2/2013	Integer	8	End Date	Report the date the member was disenrolled in YYYYMMDD Format. If the member was not disenrolled at the end of the current month, then do not fill with any value.	All	10.0%
43	ME043	Member Street Address	4/1/2013	Text	50	Street address of the Member	Report the member's primary street address. Used to create Unique Member ID.	All	98.0%
44	ME044	Member Street Address 2	4/1/2013	Text	50	Secondary Street Address of the Member	Report the address of member which may include apartment number or suite, or other secondary information besides the street. Used to create Unique Member ID.	All	2.0%
45	ME045	Purchased through Access Health CT Flag	4/1/2013	Lookup Table - Integer	1	Indicator – Access Health CT	Report the value that defines the element. EXAMPLE: 1 = Yes, policy for this eligibility was purchased through Access Health CT. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	Required when ME126 = 1	100.0%
46	ME046	Member PCP ID	4/1/2013	Text	30	Member's PCP ID	Report the identifier of the members PCP. The value in this field must have a corresponding Provider ID (PV002) in the Provider File. Report a value of 'UNKNOWN' when PCP is unknown or 'NA' if the eligibility does not require a PCP.	All	98.0%
47-48	ME047 - ME048	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
49	ME049	Member Deductible	7/2/2013	Decimal,2	10	Annual maximum out-of-pocket Member Deductible across all benefit types	Report the maximum amount of Subscriber's / Member's annual deductible across all benefit types (Medical, Rx, Vision, Behavioral Health, etc.) before certain services are covered. Report only In-Network Deductible here if plan has an In-Network vs. Out-of-Network deductible methodology. Report 0 when there is no deductible applied to all benefits for this eligibility. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	100.0%
50	ME050	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
51	ME051	Behavioral Health Benefit Flag	4/1/2013	Lookup Table - Integer	1	Indicator - Behavioral Health Option	Report the value that defines the element. EXAMPLE: 1 = Yes, Behavioral/Mental Health is a covered benefit. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
52	ME052	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
53	ME053	Disease Management Enrollee Flag	4/1/2013	Lookup Table - Integer	1	Chronic Illness Management indicator	Report the value that defines the element. EXAMPLE: 1 = Yes, Member's chronic illness is being managed by plan or vendor of plan. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
54	ME054	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
55	ME055	Business Type Code	4/1/2013	Lookup Table - Integer	1	Business Type	Report the value that defines the submitter's line of business for this line of eligibility. EXAMPLE: 1 = Risk Holder of this line of eligibility Code Description 1 Risk Holder 2 TPA - Third Party Administrator 3 DBA - Delegated Business Administrator 4 PBM - Pharmacy Benefit Manger 5 DBM - Dental Benefit Manager 6 CSO - Computer Service Organization 7 Other 0 Unknown / Not Applicable	All	100.0%
56	ME056	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
57	ME057	Date of Death	4/1/2013	Full Date - Integer	8	Member's Date of Death	Report the date the member expired in YYYYMMDD Format. If still alive or date of death is unknown, do not report any value here.	All	0.0%

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
58	ME058	Subscriber Street Address	4/1/2013	Text	50	Street address of the Subscriber	Report the subscriber's primary street address here. Used to create Unique Member ID.	All	98.0%
59	ME059	Disability Indicator	7/2/2013	Lookup Table - Integer	1	Indicator - Disability	Report the value that defines the element. EXAMPLE: 1 = Yes, Member is on disability Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
60	ME060	Employment Status	7/2/2013	Lookup Table - Text	1	Employment Status Code	Report the code that defines the employment status of the subscriber / member Code Description A Active I Involuntary Leave O Orphan P Pending R Retiree S Student Z Unemployed U Unknown	All	100.0%
61	ME061	Student Status	4/1/2013	Lookup Table - Integer	1	Indicator - Student Status	Report the value that defines the element. EXAMPLE: 1 = Yes, Member is a student under age 26 on a parent's plan Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
62	ME062	Marital Status	4/1/2013	Lookup Table - Text	1	Marital Status Code	Report the member's marital status here Code Description C Common Law Married D Divorced M Married P Domestic Partnership S Never Married W Widowed X Legally Separated U Unknown	All	100.0%

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
63	ME063	Benefit Status	7/2/2013	Lookup Table - Text	1	Benefit Status Code	Report the code that defines the status of the benefits for the subscriber / member. If member's benefits have been terminated, report as U (Unknown) Code Description A Active C COBRA P Pending S Surviving Insured T TEFRA U Unknown	All	100.0%
64	ME064	Employee Type	7/2/2013	Lookup Table - Text	1	Employee Type Code	Report the code that defines the subscriber's employment Code Description H Hourly Q Seasonal S Salaried T Temporary U Unknown	Required when ME060 = A or P	100.0%
65	ME065	Date of Retirement	7/2/2013	Integer	8	Employee's Date of Retirement	Report the date of the subscriber's retirement in YYYYMMDD Format.	Required when ME060 = R	95.0%
66	ME066	COBRA Status	7/2/2013	Integer	1	Indicator - COBRA Usage	Report the value that defines the elements. EXAMPLE: 1 = Yes, Member is covered using COBRA Benefits Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
67-70	ME067 - ME070	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
71	ME071	Pool Indicator	7/2/2013	Lookup Table - Integer	1	Indicator - Pool Grouping	Report the value that defines an employer attribute. Code Description 1 State Employee - Active 2 State Employee - Retired 3 Federal Employee - Active 4 Federal Employee - Retired 5 Municipal Employee - Active 6 Municipal Employee - Retired	When ME134 = 3	100.0%
72	ME072	Family Size	7/2/2013	Integer	2	Family Size as Contracted	Report the number of individuals covered under the policy / contract identifier (ME009) of the Subscriber.	Required when ME126 = 1	100.0%

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
73	ME073	Fully Insured member	4/1/2013	Lookup Table - Integer	1	Fully Insured identifier	Report the value that defines the element. EXAMPLE: 1 = Yes, Member is fully insured. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
74	ME074	Interpreter	4/1/2013	Lookup Table - Integer	1	Indicator - Interpreter Need	Report the value that defines the element. EXAMPLE: 1 = Yes, Member requires an interpreter. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
75-76	ME075-ME076	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
77	ME077	Member's North American Industry Code (NAICS)	7/2/2013	External Code Source NAICS - Text	6	Member's Standard NAICS Code	Report the standard code that describes the industry of the subscriber and/or member.	All	25.0%
78	ME078	Employer Zip Code	7/2/2013	Text	9	Zip Code of the Employer	Report the 5 or 9 digit zip code of the Employer of the Subscriber / Member.	Required when ME060 = A or P	98.0%
78-80	ME079 - ME080	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
81	ME081	Medicare Code	7/2/2013	Integer	1	Indicator - Medicare Plan	Report the value that defines if and what type of Medicare coverage that applies to this line of eligibility. EXAMPLE: 1 = Member has Part A Only Code Description 1 Part A Only 2 Part B Only 3 Part A and B 4 Part C Only 5 Part C & D 6 Part D Only 9 Not Applicable 0 No Medicare Coverage	Required when ME003 = 16, MA, MB or MD	100.0%
82	ME082	Employer Name	4/1/2013	Text	60	Member's Employer Name	Report the name of the subscriber's / member's employer at time of enrollment.	Required when ME060 = A or P	98.0%
83	ME083	Employer EIN	4/1/2013	Text	9	Member's Employer EIN	Report the Federal Tax ID of the Employer here. Do not use hyphen or alpha prefix.	Required when ME060 = A or P	98.0%

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
84	ME101	Subscriber Last Name	4/1/2013	Text	60	Last name of Subscriber	Report the last name of the subscriber. Used to create Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE	All	100.0%
85	ME102	Subscriber First Name	4/1/2013	Text	25	First name of Subscriber	Report the first name of the subscriber here. Used to create Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: Anne-Marie becomes ANNEMARIE	All	100.0%
86	ME103	Subscriber Middle Initial	4/1/2013	Text	1	Middle initial of Subscriber	Report the Subscriber's middle initial here. Used to create Unique Member ID.	All	2.0%
87	ME104	Member Last Name	4/1/2013	Text	60	Last name of Member	Report the last name of the patient / member here. Used to create Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE	All	100.0%
88	ME105	Member First Name	4/1/2013	Text	25	First name of Member	Report the first name of the member here. Used to create Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: Anne-Marie becomes ANNEMARIE	All	100.0%
89	ME106	Member Middle Initial	4/1/2013	Text	1	Middle initial of Member	Report the middle initial of the member when available. Used to create Unique Member ID.	All	2.0%
90	ME107	Carrier Specific Unique Member ID	4/1/2013	Text	50	Member's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation	All	100.0%
91	ME108	Subscriber City Name	4/1/2013	Text	30	City name of the Subscriber	Report the city name of the Subscriber	All	98.0%
92	ME109	Subscriber State or Province	4/1/2013	External Code Source 2 - Text	2	State of the Subscriber	Report the state of the subscriber here. Used to create Unique Member ID.	All	99.0%
93	ME110	Subscriber ZIP Code	4/1/2013	External Code Source 2 - Text	9	Zip Code of the Subscriber	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen. Used to create Unique Member ID.	All	99.0%
94-97	ME111 - 114	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
98	ME115	Dental Deductible	7/2/2013	Decimal,2	10	Maximum out-of-pocket amount of member's deductible applied to Dental Benefits	Report the maximum amount of the Subscriber's / Member's deductible that is applied to dental services before dental services are covered. Report 0 when there is no deductible for this benefit. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	Required when ME020 = 1	98.0%

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
99	ME116	Vision Deductible	7/2/2013	Decimal,2	10	Maximum out-of-pocket amount of member's deductible applied to Vision Benefits	Report the maximum amount of the Subscriber's / Member's deductible that is applied to vision services before vision services are covered. Report 0 when there is no deductible for this benefit. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	Required when ME118 = 1	98.0%
100	ME117	Carrier Specific Unique Subscriber ID	4/1/2013	Text	50	Subscriber's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation	All	100.0%
101	ME118	Vision Benefit	4/1/2013	Lookup Table - Integer	1	Indicator - Vision Option	Report the value that defines the element. EXAMPLE: 1 = Yes, Vision is a covered benefit. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
102	ME119	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
103	ME120	Actuarial Value	4/1/2013	Text	6		Report the Actuarial Value for the Member's coverage for the time period indicated by Enrollment Start and End dates in 0.0000 Format.	Required when ME126 = 1	100.0%
104	ME121	Metal Level	4/1/2013	Lookup Table - Integer	1	Standardized plan level in metal reference	Report the Metal Level benefits that the member is associated to in this line of eligibility. . EXAMPLE: 1 = Bronze Level Code Description 1 Bronze 2 Silver 3 Gold 4 Platinum 5 Catastrophic 0 Unknown / Not Applicable	Required when ME126 = 1	100.0%
105-108	ME122 - ME125	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
109	ME126	Risk Adjustment Covered Plan (RACP)	7/2/2013	Integer	1	Subscriber / Member enrolled in a Risk Adjustment Plan	Non-grandfathered individual and small group plans underwritten and filed in the State of Connecticut. Large group plans, self-insured plans, and plans underwritten and filed in states other than Connecticut are not subject to risk adjustment algorithms. Report the status as of the 15th of the month. EXAMPLE: 1 = Yes, member was enrolled in a RACP as of the 15th of the month. Code Description 1 Yes 2 No	All	100.0%

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
110	ME127	Billable Member	7/2/2013	Integer	1	Indicator - Billable Member	Report the value that defines the element. EXAMPLE: 1 = Yes, member is defined as a Billable Member. Code Description 1 Yes 2 No	Required when ME126 = 1	100.0%
111-114	ME128 - ME131	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
115	ME132	Total Monthly Premium	7/2/2013	Decimal,2	10	Combined contribution of Employer + Subscriber	Report the total monthly premium at the Subscriber level. Report 0 if no premium is charged. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	Required when ME126 = 1	100.0%
116	ME133	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
117	ME134	APCD ID Code	7/2/2013	Lookup Table - Integer	1	Member Enrollment Type	Report the value that describes the subscriber's / member's enrollment into one of the predefined categories; aligns enrollment to appropriate editing and thresholds. EXAMPLE: 1 = FIG = Fully Insured Commercial Group Code Description 1 FIG - Fully -Insured Commercial Group Enrollee 2 SIG - Self-Insured Group Enrollee 3 State or Federal Employer Enrollee 4 Individual - Non-Group Enrollee 5 Supplemental Policy Enrollee 6 ICO - Integrated Care Organization 0 Unknown / Not Applicable	All	100.0%
118	ME899	Record Type	4/1/2013	Text	2	Tile Type Identifier	Report ME here. This validates the type of file and the data contained within the file. This must match HD004.	All	100.0%
TR-ME	TR001	Record Type	10/7/2013	Text	2	Trailer Record Identifier	Report TR here. Indicates the end of the data file.	Mandatory	100.0%
TR-ME	TR002	Submitter	10/7/2013	Text	8	Trailer Submitter /Carrier ID defined by AHCT	Report unique Submitter ID here. AHCT will provide this unique identifier to the carrier. This must match the Submitter ID reported inHD002.	Mandatory	100.0%
TR-ME	TR003	National Plan ID	10/7/2013	Text	10	CMS National Plan Identification Number (Plan ID)	Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	Situational	0.0%
TR-ME	TR004	Type of File	10/7/2013	Text	2	Validates the file type defined inHD004.	Report ME here. This must match the File Type reported in HD004.	Mandatory	100.0%
TR-ME	TR005	Period Beginning Date	10/7/2013	Full Date - Integer	8	Trailer Period Start Date	Report the Year, Month and Day of the reported submission period in YYYYMMDD format. This date is the first day of the month for the reporting period and must match the date reported in HD005.	Mandatory	100.0%
TR-ME	TR006	Period Ending Date	10/7/2013	Full Date - Integer	8	Trailer Period Ending Date	Report the Year, Month and Day of the reported submission period in YYYYMMDD format. This date is the last day of the month for the reporting period and must match the date reported in HD006.	Mandatory	100.0%
TR-ME	TR007	Date Processed	10/7/2013	Full Date - Integer	8	Trailer Processed Date	Report the full date that the submission was compiled by the submitter in YYYYMMDD Format.	Mandatory	100.0%

Member Eligibility Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold

*These remain consistent across all file types (ME, MC, PC, DC).

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
HD-MC	HD001	Record Type	10/7/2013	Text	2	Header Record Identifier	Report HD here. Indicates the beginning of the Header Elements of the file.	Mandatory	100.0%	Administrative
HD-MC	HD002	Submitter	10/7/2013	Text	8	Header Submitter/ Carrier ID defined by AHCT	Report unique Submitter ID here. AHCT will provide this unique identifier to the carrier. TR002 must match the Submitter ID reported here. This ID is linked to other elements in the file for quality control.	Mandatory	100.0%	Administrative
HD-MC	HD003	National Plan ID	10/7/2013	Text	10	Header CMS National Plan Identification Number (Plan ID)	Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	Situational	0.0%	Administrative
HD-MC	HD004	Type of File	10/7/2013	Text	2	Defines the file type and data expected.	Report **MC** here. Indicates that the data within this file is expected to be MEDICAL CLAIM-based. This must match the File Type reported inTR004.	Mandatory	100.0%	Administrative
HD-MC	HD005	Period Beginning Date	10/7/2013	Full Date - Integer	8	Header Period Start Date	Report the Year, Month and Day of the reported submission period in YYYYMMDD format. This date is the first day of the month for the reporting period and must be repeated in TR005.	Mandatory	100.0%	Administrative
HD-MC	HD006	Period Ending Date	10/7/2013	Full Date - Integer	8	Header Period Ending Date	Report the Year, Month and Day of the reported submission period in YYYYMMDD format. This date is the last day of the month for the reporting period and must be repeated in TR006.	Mandatory	100.0%	Administrative
HD-MC	HD007	Record Count	10/7/2013	Integer	10	Header Record Count	Report the total number of records submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters.	Mandatory	100.0%	Administrative
HD-MC	HD008	Comments	10/7/2013	Text	80	Header Carrier Comments	May be used to document the submission by assigning a filename, system source, compile identifier, etc.	Optional	0.0%	Administrative
HD-MC	HD009	APCD Version Number	10/7/2013	Decimal - Numeric	3	Submission Guide Version	Report the version number as presented on the APCD Medical Claim File Submission Guide in 0.0Format. Sets the intake control for editing elements. Version must be accurate else file will drop. EXAMPLE: 3.0 = Newest Version Code Description 1.2 Current Version; required for reporting periods as of October 2013	Mandatory	100.0%	Administrative
1	MC001	Submitter	4/1/2013	Text	8	CT APCD defined and maintained unique identifier	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the reporting state and the third character designates the type of submitter. For Connecticut's APCD collection, valid prefixes include: CTC ..... Commercial carrier CTG ..... Governmental agency CTT ..... Third-party administrator Notes: A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	All	100.0%	Administrative
2	MC002	National Plan ID	4/1/2013	Text	10	CMS National Plan Identification Number (Plan ID)	Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans	All	0.0%	835/1000A/REF/NF/02, 835/1000A/N1/XV/04

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
3	MC003	Insurance Type Code/Product	7/2/2013	Lookup Table - Text	2	Type / Product Identification Code	Report the code that defines the type of insurance under which this patient's claim line was processed. EXAMPLE: HM = HMO Code Description 9 Self-pay 11 Other Non-Federal Programs * (use of this value requires disclosure to Data Manager prior to submission) 12 Preferred Provider Organization (PPO) * 13 Point of Service (POS) * 14 Exclusive Provider Organization (EPO) * 15 Indemnity Insurance * 16 Health Maintenance Organization (HMO) Medicare Risk * (Use to report Medicare Part C/Medicare Advantage Plans) 17 Dental Maintenance Organization (DMO) * 96 Husky Health A 97 Husky Health B 98 Husky Health C 99 Husky Health D AM Automobile Medical * CH Champus (now TRICARE) * DS Disability * HM Health Maintenance Organization * LM Liability Medical * MA Medicare Part A * Used to report Medicare Fee for Service only MB Medicare Part B * Used to report Medicare Fee for Service only MC Medicaid * OF Other Federal Program * (use of this value requires disclosure to Data Manager prior to submission) TV Title V * VA Veterans Affairs Plan * WC Workers' Compensation * ZZ Mutually Defined * (use of this value requires disclosure to Data Manager prior to submission)	All	100.0%	837/2000B/SBR/ /09
4	MC004	Payer Claim Control Number	4/1/2013	Text	35	Payer Claim Control Identification	Report the Unique identifier within the payer's system that applies to the entire claim	All	100.0%	835/2100/CLP/ /07
5	MC005	Line Counter	4/1/2013	Integer	4	Incremental Line Counter	Report the line number for this service within the claim. Start with 1 and increment by 1 for each additional line. Do not start with 0, include alphas or special characters.	All	100.0%	837/2400/LX/ /01
6	MC005A	Version Number	4/1/2013	Integer	4	Claim Service Line Version Number	Report the version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line. No alpha or special characters.	All	100.0%	Administrative
7	MC006	Insured Group or Policy Number	4/1/2013	Text	30	Group / Policy Number	Use this field to report the group or policy number. Notes: The value reported for this field should be reported consistently in the "Insured Group or Policy Number" field in both the medical eligibility (ME006) and pharmacy claims (PC006) data. This is not the number that uniquely identifies the subscriber. If a policy is sold to an individual as a non-group policy, report with a value of "IND". This principle pertains to all claim types: commercial, Medicaid, and Medicare.	All	98.0%	837/2000B/SBR/ /03

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
8	MC007	Subscriber SSN	4/1/2013	Text	9	Subscriber's Social Security Number	Report the subscriber's social security number here; used to create Unique Member ID; Do not use hyphen. If not available do not report any value here. Notes: The value reported for this field should be reported consistently in the "Subscriber Social Security Number" field in both the eligibility (ME008) and pharmacy claims (PC007) data. This field will not be passed into analytic file.	All	75.0%	835/2100/NM1/34/09
9	MC008	Plan Specific Contract Number	4/1/2013	Text	30	Contract Number	Report the Plan assigned contract number. Do not include values in this field that will distinguish one member of the family from another. This should be the contract or certificate number for the subscriber and all of the dependents. Notes: The value reported for this field should be reported consistently in the "Plan-Specific Contract Number" field in both the eligibility (ME009) and pharmacy claims (PC008) data.	All	98.0%	835/2100/NM1/MI/09
10	MC009	Member Suffix or Sequence Number	4/1/2013	Text	20	Member/Patient's Contract Sequence Number	Report the unique number / identifier of the member / patient within the contract	All	98.0%	N/A
11	MC010	Member SSN	4/1/2013	Text	9	Member/Patient's Social Security Number	Report the member's social security number here; used to create Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here. Notes: The value reported for this field should be consistently reported in the "Member Social Security Number" field in both the eligibility (MC011) and pharmacy claims (PC010) data.	All	75.0%	835/2100/NM1/34/09

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
12	MC011	Individual Relationship Code	10/30/2013	Lookup Table - Text	2	Patient to Subscriber Relationship Code	Report the value that defines the Patient's relationship to the Subscriber. EXAMPLE: 1 = Spouse Code Description 1 Spouse 4 Grandfather or Grandmother 5 Grandson or Granddaughter 7 Nephew or Niece 10 Foster Child 12 Other Adult 15 Ward 17 Stepson or Stepdaughter 18 Self 19 Child 20 Self / Employee 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 34 Other Adult 36 Emancipated Minor 39 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Child Where Insured Has No Financial Responsibility 53 Life Partner 76 Dependent G8 Other relationship	All	98.0%	837/2000B/SBR/ /02 837/2000C/PAT/ /01
13	MC012	Member Gender	4/1/2013	Lookup Table - Text	1	Patient's Gender	Report member gender as reported on enrollment form in alpha format. Used to create Unique Member ID. EXAMPLE: F = Female Code Description F Female M Male U Unknown Notes: The value reported for this field should be consistently reported in the "Member Gender" field in both the eligibility(ME013) and pharmacy claims (PC012) data.	All	100.0%	837/2010BA/DMG/ /03, 837/2010CA/DMG/ /03
14	MC013	Member Date of Birth	4/1/2013	Full Date - Integer	8	Member/Patient's date of birth	Report the date the member / patient was born in YYYYMMDD Format. Used to validate Unique Member ID.	All	99.0%	837/2010BA/DMG/D8/02 837/2010CA/DMG/D8/02
15	MC014	Member City Name	4/1/2013	Text	30	City name of the Member/Patient	Report the city name of the member / patient. Used to validate Unique Member ID	All	99.0%	837/2010BA/N4/ /01 837/2010CA/N4/ /01
16	MC015	Member State	4/1/2013	External Code Source 2 - Text	2	State / Province of the Patient	Report the state of the patient as defined by the US Postal Service. Report Province when Country Code does not = USA	All	99.9%	837/2010BA/N4/ /02 837/2010CA/N4/ /02

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
17	MC016	Member ZIP Code	4/1/2013	External Code Source 2 - Text	9	Zip Code of the Member / Patient	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	99.9%	837/2010BA/N4/ /03 837/2010CA/N4/ /03
18	MC017	Date Service Approved (AP Date)	4/1/2013	Full Date - Integer	8	Date Service Approved by Payer	Report the date that the payer approved this claim line for payment in YYYYMMDD Format. This element was designed to capture date other than the Paid date. If Approved Date and Paid Date are the same, then the date here should match Paid Date.	All	100.0%	835/Header Financial Information/BPR/ /16
19	MC018	Admission Date	4/1/2013	Full Date - Integer	8	Inpatient Admit Date	Report the date of admit to a facility in YYYYMMDD Format. Only applies to facility claims where Type of Bill = an inpatient setting.	Required when MC094 = 002 and MC036 starts with 11, 18, 21, 28, 41, 65, 66, or 86	98.0%	Institutional 837/2300/DTP/435/DT/03
20	MC019	Admission Hour	4/1/2013	Text	4	Admission Time	Report the Admit Time in HHMM Format. Only applies to facility claims were Type of Bill = an inpatient setting. Time is expressed in military time. If only the hour is known, code the minutes as 00. 4 AM would be reported as 0400; 4 PM would be reported as 1600.	Required when MC094 = 002 and MC036 starts with 11, 18, 21, 28, 41	5.0%	Institutional 837/2300/DTP/435/03
21	MC020	Admission Type	4/1/2013	External Code Source - NUBC - Integer	1	Admission Type Code	Report Admit Type as it applies to facility claims were Type of Bill = an inpatient setting. This code indicates the type of admission into an inpatient setting. Also known as Admission Priority.	Required when MC094 = 002 and MC036 starts with 11, 18, 21, 28, 41, 65, 66, or 86	98.0%	Institutional 837/2300/CL1/ /01
22	MC021	Admission Source	4/1/2013	External Code Source - NUBC - Text	1	Admission Source Code	Report the code that applies to facility claims were Type of Bill = an inpatient setting. This code indicates how the patient was referred into an inpatient setting at the facility.	Required when MC094 = 002 and MC036 starts with 11, 18, 21, 28, 41, 65, 66, or 86	98.0%	Institutional 837/2300/CL1/ /02
23	MC022	Discharge Hour	4/1/2013	Text	4	Discharge Time	Report the Discharge Time in HHMM Format. Only applies to facility claims were Type of Bill = an inpatient setting. Time is expressed in military time. If only the hour is known, code the minutes as 00. 4 AM would be reported as 0400; 4 PM would be reported as 1600.	Required when MC094 = 002,MC069 is populated and MC036 starts with 11, 18, 21, 28, 41, 65, 66, or 86	5.0%	Institutional 837/2300/CL1/ /02
24	MC023	Discharge Status	4/1/2013	External Code Source - NUBC - Text	2	Inpatient Discharge Status Code	Report the appropriate Discharge Status Code of the patient as defined by External Code Source	Required when MC094 = 002 and MC036 starts with11, 18, 21, 28, 41, 65, 66, or 86	98.0%	Institutional 837/2300/CL1/ /03
25	MC024	Service Provider Number	4/1/2013	Text	30	Service Provider Identification Number	Report the carrier / submitter assigned service provider number. This number should be the identifier used for internal identification purposes, and does not routinely change. The value in this field must match a record in the provider file in PV002.	All	99.0%	835/2100/REF/1A/02, 835/2100/REF/1B/02, 835/2100/REF/1C/02, 835/2100/REF/1D/02, 835/2100/REF/G2/02, 835/2100/NM1/BD/09, 835/2100/NM1/PC/09, 835/2100/NM1/MC/09, 835/2100/NM1/BS/09
26	MC025	Service Provider Tax ID Number	4/1/2013	Text	9	Service Provider's Tax ID number	Report the Federal Tax ID of the Service Provider identified in MC024 here. Do not use hyphen or alpha prefix.	All	97.0%	835/2100/NM1/FI/09

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
27	MC026	National Provider ID - Service	4/1/2013	External Code Source NPPES - Text	10	National Provider Identification (NPI) of the Service Provider	Report the Primary National Provider ID (NPI) of the Servicing Provider in MC024. This ID should be found on the Provider File in the NPI Field (PV039)	All	99.0%	Institutional 837/2010AA/NMI/XX/09 Professional 837/2420A/NMI/XX/09, 837/2310B/NM1/XX/09
28	MC027	Service Provider Entity Type Qualifier	4/1/2013	Lookup Table - integer	1	Service Provider Entity Identifier Code	Report the value that defines the provider entity type. Only individuals should be identified with a 1. Facilities, professional groups and clinic sites should all be identified with a 2. EXAMPLE: 1 = Person Code Description 1 Person 2 Non-person entity	All	98.0%	Institutional 837/2010AA/NM1/85/02 Professional 837/2420A/NM1/82/02, 837/2310B/NM1/82/02
29	MC028	Service Provider First Name	4/1/2013	Text	25	First name of Service Provider	Report the individual's first name here. If provider is a facility or organization , do not report any value here	Required when MC027 = 1	92.0%	Professional 837/2420A/NM1/82/04, 837/2310B/NM1/82/04
30	MC029	Service Provider Middle Name	4/1/2013	Text	25	Middle name of Service Provider	Report the individual's middle name here. If provider is a facility or organization , do not report any value here	Required when MC027 = 1	2.0%	Professional 837/2420A/NM1/82/05, 837/2310B/NM1/82/05
31	MC030	Servicing Provider Last Name or Organization Name	4/1/2013	Text	60	Last name or Organization Name of Service Provider	Report the name of the organization or last name of the individual provider. MC027 determines if this is an Organization or Individual Name reported here.	All	94.0%	Institutional 837/2010AA/NM1/85/2/03 Professional 837/2420A/NM1/82/03, 837/2310B/NM1/82/03
32	MC031	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%	
33	MC032	Service Provider Taxonomy	4/1/2013	External Code Source - WPC - Text	10	Taxonomy Code	Report the standard code that defines this provider for this line of service. Taxonomy values allow for the reporting of nurses, assistants and laboratory technicians, where applicable, as well as Physicians, Medical Groups, Facilities, etc.	All	98.0%	Institutional 837/2000A/PRV/PXC/03 Professional 837/2310B/PRV/PXC/03
34	MC033	Service Provider City Name	4/1/2013	Text	30	City Name of the Provider	Report the city name of provider - preferably practice location	All	98.0%	Institutional 837/2010AA/N4/ /01 Professional 837/2420C/N4//01, 837/2310C/N4/ /01
35	MC034	Service Provider State	4/1/2013	External Code Source - USPS - Text	2	State of the Service Provider	Report the state of the service providers as defined by the US Postal Service	All	98.0%	Institutional 837/2010AA/N4/ /02 Professional 837/2420C/N4//02, 837/2310C/N4/ /02
36	MC035	Service Provider ZIP Code	4/1/2013	External Code Source - USPS - Text	9	Zip Code of the Service Provider	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	98.0%	Institutional 837/2010AA/N4/ /03 Professional 837/2420C/N4//03, 837/2310C/N4/ /03
37	MC036	Type of Bill - on Facility Claims	4/1/2013	External Code Source - NUBC-Text	3	Type of Bill	Report the three-digit value that defines the Type of Bill on an institutional claim.	Required when MC094 = 002	98.0%	Institutional 837/2300/CLM/ /05-1 and 837/2300/CLM/ /05-3
38	MC037	Site of Service - on NSF/CMS 1500 Claims	4/1/2013	External Code Source - CMS - Text	2	Place of Service Code	Report the two-digit value that defines the Place of Service on professional claim	Required when MC094 = 001	100.0%	Professional 837/2300/CLM/ /05-1

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
39	MC038	Claim Status	10/7/2013	Lookup Table - integer	2	Claim Line Status	Report the value that defines the payment status of this claim line Code Description 1 Processed as primary 2 Processed as secondary 3 Processed as tertiary 4 Denied 19 Processed as primary, forwarded to additional payer(s) 20 Processed as secondary, forwarded to additional payer(s) 21 Processed as tertiary, forwarded to additional payer(s) 22 Reversal of previous payment 23 Not our claim, forwarded to additional payer(s) 25 Predetermination Pricing Only - no payment	All	98.0%	835/2100/CLP/ /02
40	MC039	Admitting Diagnosis	4/1/2013	External Code Source - ICD - Text	7	Admitting Diagnosis Code	Report the diagnostic code assigned by provider that supported admission into the inpatient setting Notes: Do not include the decimal point when coding this field.	Required when MC094 = 002 and MC036 starts with 11, 18, 21, 28, 41, 65, 66, or 86	98.0%	Institutional 837/2300/HI/BJ/01-2, 837/2300/HI/ABJ/01-2
41	MC040	E-Code	4/1/2013	External Code Source - ICD - Text	7	ICD Diagnostic External Injury Code	Report the external injury code for patient when appropriate to the claim Notes: Do not include the decimal point when coding this field.	MC094=002	3.0%	Institutional 837/2300/HI/BN/01-2, 837/2300/HI/ABN/01-2
42	MC041	Principal Diagnosis	4/1/2013	External Code Source - ICD - Text	7	ICD Primary Diagnosis Code	Report the Primary ICD Diagnosis Code here Notes: Do not include the decimal point when coding this field.	All	99.0%	837/2300/HI/BK/01-2, 837/2300/HI/ABK/01-2
43	MC042	Other Diagnosis - 1	4/1/2013	External Code Source - ICD - Text	7	ICD Secondary Diagnosis Code	Report the Secondary ICD Diagnosis Code here Notes: Do not include the decimal point when coding this field.	All	70.0%	Institutional 837/2300/HI/BF/01-2, 837/2300/HI/ABF/01-2 Professional 837/2300/HI/BF/02-2, 837/2300/HI/ABF/02-2
44	MC043	Other Diagnosis - 2	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 2. If not applicable do not report any value here Notes: Do not include the decimal point when coding this field.	All	24.0%	Institutional 837/2300/HI/BF/02-2, 837/2300/HI/ABF/02-2 Professional 837/2300/HI/BF/03-2, 837/2300/HI/ABF/03-2
45	MC044	Other Diagnosis - 3	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 3. If not applicable do not report any value here Notes: Do not include the decimal point when coding this field.	All	13.0%	Institutional 837/2300/HI/BF/03-2, 837/2300/HI/ABF/03-2 Professional 837/2300/HI/BF/04-2, 837/2300/HI/ABF/04-2
46	MC045	Other Diagnosis - 4	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 4. If not applicable do not report any value here Notes: Do not include the decimal point when coding this field.	All	7.0%	Institutional 837/2300/HI/BF/04-2, 837/2300/HI/ABF/04-2 Professional 837/2300/HI/BF/05-2, 837/2300/HI/ABF/05-2

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
47	MC046	Other Diagnosis - 5	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 5. If not applicable do not report any value here Notes: Do not include the decimal point when coding this field.	All	4.0%	Institutional 837/2300/HI/BF/05-2, 837/2300/HI/ABF/05-2 Professional 837/2300/HI/BF/06-2, 837/2300/HI/ABF/06-2
48	MC047	Other Diagnosis - 6	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 6. If not applicable do not report any value here Notes: Do not include the decimal point when coding this field.	All	3.0%	Institutional 837/2300/HI/BF/06-2, 837/2300/HI/ABF/06-2 Professional 837/2300/HI/BF/07-2, 837/2300/HI/ABF/07-2
49	MC048	Other Diagnosis - 7	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 7. If not applicable do not report any value here Notes: Do not include the decimal point when coding this field.	All	3.0%	Institutional 837/2300/HI/BF/07-2, 837/2300/HI/ABF/07-2 Professional 837/2300/HI/BF/08-2, 837/2300/HI/ABF/08-2
50	MC049	Other Diagnosis - 8	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 8. If not applicable do not report any value here Notes: Do not include the decimal point when coding this field.	All	2.0%	Institutional 837/2300/HI/BF/08-2, 837/2300/HI/ABF/08-2 Professional 837/2300/HI/BF/09-2, 837/2300/HI/ABF/09-2
51	MC050	Other Diagnosis - 9	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 9. If not applicable do not report any value here Notes: Do not include the decimal point when coding this field.	All	1.0%	Institutional 837/2300/HI/BF/09-2, 837/2300/HI/ABF/09-2 Professional 837/2300/HI/BF/10-2, 837/2300/HI/ABF/10-2
52	MC051	Other Diagnosis - 10	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 10. If not applicable do not report any value here. Notes: Do not include the decimal point when coding this field.	All	1.0%	Institutional 837/2300/HI/BF/10-2, 837/2300/HI/ABF/10-2 Professional 837/2300/HI/BF/11-2, 837/2300/HI/ABF/11-2
53	MC052	Other Diagnosis - 11	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 11. If not applicable do not report any value here. Notes: Do not include the decimal point when coding this field.	All	1.0%	Institutional 837/2300/HI/BF/11-2, 837/2300/HI/ABF/11-2 Professional 837/2300/HI/BF/12-2, 837/2300/HI/ABF/12-2
54	MC053	Other Diagnosis - 12	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 12. If not applicable do not report any value here. Notes: Do not include the decimal point when coding this field.	MC094=002	1.0%	Institutional 837/2300/HI/BF/12-2, 837/2300/HI/ABF/12-2
55	MC054	Revenue Code	4/1/2013	External Code Source - NUBC - Text	4	Revenue Code	Report the valid National Uniform Billing Committee Revenue Code here. Code using leading zeroes, left-justified, and four digits.	Required when MC094 = 002	98.0%	835/2110/SVC/NU/01-2 835/2110/SVC/ /04

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
56	MC055	Procedure Code	4/1/2013	External Code Source - AMA - OR - Carrier Defined Table - Text	10	HCPCS / CPT Code	Report a valid Procedure code for the claim line as defined by MC130	All	98.0%	835/2110/SVC/HC/01-2, 835/2110/SVC/HP/01-2
57	MC056	Procedure Modifier - 1	4/1/2013	External Code Source - AMA - Text	2	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055).	Required when MC055 is populated	20.0%	835/2110/SVC/HC/01-3
58	MC057	Procedure Modifier - 2	4/1/2013	External Code Source - AMA - Text	2	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055).	Required when MC055 is populated	3.0%	835/2110/SVC/HC/01-4
59	MC058	ICD Primary Procedure Code	4/1/2013	External Code Source - ICD - Text	7	ICD Primary Procedure Code	Report the primary ICD CM/PCS procedure code when appropriate. Repeat this code on all lines of the facility claim. Do not code decimal point.	Required when MC094 = 002 and MC036 starts with 11, 13, 18, 41. Optional for other facility claims.	50.0%	Institutional 837/2300/HI/BR/01-2 837/2300/HI/BBR/01-2
60	MC059	Date of Service - From	4/1/2013	Full Date - Integer	8	Date of Service	Report the date of service for the claim line in YYYYMMDD Format.	All	98.0%	835/2110/DTM/472/02, 835/2110/DTM/150/02
61	MC060	Date of Service - To	4/1/2013	Full Date - Integer	8	Date of Service	Report the end service date for the claim line in YYYYMMDD Format. For inpatient claims, the room and board line may or may not be equal to the discharge date. Procedures delivered during a visit should indicate which date they occurred.	All	98.0%	835/2110/DTM/472/02, 835/2110/DTM/151/02
62	MC061	Quantity	4/1/2013	Decimal,2	15	Claim line units of service	Report the count of services / units performed.	All	98.0%	835/2110/SVC/ /05
63	MC062	Charge Amount	4/1/2013	Decimal,2	10	Amount of provider charges for the claim line	Report the charge amount for this claim line. 0 dollar charges allowed only when the procedure code indicates a Category II procedure code vs. a service code. When reporting Total Charges for facilities for the entire claim use 001 (the generally accepted Total Charge Revenue Code) in MC054 (Revenue Code). Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99.0%	835/2110/SVC/ /02
64	MC063	Paid Amount	4/1/2013	Decimal,2	10	Amount paid by the carrier for the claim line	Report the amount paid for the claim line. Report 0 if line is paid as part of another procedure / claim line. Report 0 if the line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99.0%	835/2110/SVC/ /03
65	MC064	Prepaid Amount	7/2/2013	Decimal,2	10	Amount carrier has prepaid towards the claim line	Report the prepaid amount for the claim line. Report the Fee for Service equivalent amount for Capitated Services. Report 0 if there is no Prepaid Amount. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99.0%	N/A
66	MC065	Copay Amount	4/1/2013	Decimal,2	10	Amount of Copay member/patient is responsible to pay	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Copay applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	100.0%	835/2110/CAS/PR/3-03

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
67	MC066	Coinsurance Amount	4/1/2013	Decimal,2	10	Amount of coinsurance member/patient is responsible to pay	Report the amount that defines a calculated percentage amount for this claim line service that the patient is responsible to pay. Report 0 if no Coinsurance applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	100.0%	835/2110/CAS/PR/2-03
68	MC067	Deductible Amount	4/1/2013	Decimal,2	10	Amount of deductible member/patient is responsible to pay on the claim line	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Deductible applies to service. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	100.0%	835/2110/CAS/PR/1-03
69	MC068	Patient Control Number	4/1/2013	Text	20	Patient Control Number	Report the provider assigned Encounter / Visit number to identify patient treatment. Also known as the Patient Account Number	Required when MC094 = 001 or 002	98.0%	837/2300/REF/EA/02
70	MC069	Discharge Date	4/1/2013	Full Date - Integer	8	Discharge Date	Report the date the member was discharged from the facility in YYYYMMDD Format. If patient is still in-house and claim represents interim billing for interim payment, report the interim through date.	Required when MC094 = 002	98.0%	Institutional 837/2300/DTP/RD8/04 Professional 837/2300/DTP/D8/03,
71	MC070	Service Provider Country Code	12/1/2010	External Code Source - ANSI - Text	3	Country name of the Service Provider	Report the three-character country code as defined by ISO 3166-1, Alpha 3. Example: United States is reported as USA	All	98.0%	N/A
72	MC071	DRG	4/1/2013	External Code Source CMS - Text	7	Diagnostic Related Group Code	Report the DRG number applied to this claim on every line to which its applicable. Insurers and health care claims processors shall code using the CMS methodology when available. When the CMS methodology for DRGs is not available, but the All Payer DRG system is used, the insurer shall format the DRG and the complexity level within the same element with the prefix of "A" and with a hyphen separating the AP DRG from the complexity level (e.g. AXXX-XX)	Required when MC094 = 002 and MC069 is populated and MC036 starts with 11,12, 18,41	98.0%	837/2300/HI/DR/01-2
73	MC072	DRG Version	4/1/2013	External Code Source CMS - Text	2	Diagnostic Related Group Version Number	Report the version of the grouper used	Required when MC071 is populated	20.0%	Administrative
74	MC073	APC	4/1/2013	External Code Source CMS - Text	4	Ambulatory Payment Classification Number	Report the APC number applied to this claim line, with the leading zero(s) when applicable. Code using the CMS methodology.	Required when MC094 = 002 and MC036 starts with 13 or 14	20.0%	835/2110/REF/APC/02
75	MC074	APC Version	4/1/2013	External Code Source CMS - Text	2	Ambulatory Payment Classification Version	Report the version of the grouper used	Required when MC073 is populated	20.0%	Administrative
76	MC075	Drug Code	4/1/2013	External Code Source FDA - Text	11	National Drug Code (NDC)	Report the NDC code used only when a medication is paid for as part of a medical claim or when a DME device has an NDC code. J codes should be submitted under procedure code (MC055), and have a procedure code type of 'HCPCS'. Drug Code as defined by the FDA in 11 digit format (5-4-2) without hyphenation	All	1.0%	837/2410/LIN/N4/03
77	MC076	Billing Provider Number	4/1/2013	Text	30	Billing Provider Number	Report the carrier / submitter assigned billing provider number. This number should be the identifier used for internal identification purposes, and does not routinely change. The value in this field must match a record in the provider file in PV002.	All	99.0%	837/2010BB/REF/G2/02
78	MC077	National Provider ID - Billing	4/1/2013	External Code Source - NPPES - Text	10	National Provider Identification (NPI) of the Billing Provider	Report the Primary National Provider ID (NPI) here. This ID should be found on the Provider File in the NPI field (PV039)	All	99.0%	837/2010AA/NM1/XX/09
79	MC078	Billing Provider Last Name or Organization Name	4/1/2013	Text	60	Last name or Organization Name of Billing Provider	Report the name of the organization or last name of the individual provider	All	99.0%	837/2010AA/NM1/ /03

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
80	MC079	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%	
81	MC080	Payment Reason	4/1/2013	External Code Source - HIPPA - OR - Carrier Defined Table - Text	10	Payment Reason Code	Report the value that describes how the claim line was paid, either using a standard code set or a proprietary list pre-sent by submitter.	Required when MC038 = 01, 02, 03, 19, 20, or 21	99.5%	835/2110/CAS
82	MC081	Capitated Encounter Flag	4/1/2013	Lookup Table - Integer	1	Indicator - Capitation Payment	Report the value that defines the element. EXAMPLE: 1 = Yes payment for this service is covered under a capitated arrangement. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%	Administrative
83	MC082	Member Street Address	4/1/2013	Text	50	Street address of the Member/Patient	Report the patient / member's address. Used to validate Unique Member ID.	All	90.0%	837/2010BA/N3/ /01 837/2010CA/N3/ /01
84	MC083	Other ICD Procedure Code - 1	4/1/2013	External Code Source - ICD - Text	7	ICD Secondary Procedure Code	Report the subsequent ICD CM procedure code when applicable. Repeat this code on all lines of the facility claim. Do not code decimal point.	Required when MC094 = 002 and MC036 starts with 11, 13, 18, 41. Optional for other facility claims.	1.0%	Institutional 837/2300/HI/BQ/01-2 837/2300/HI/BBQ/01-2
85	MC084	Other ICD Procedure Code - 2	4/1/2013	External Code Source - ICD - Text	7	ICD Other Procedure Code	Report the third ICD procedure code when applicable. Repeat this code on all lines of the facility claim. Do not code decimal point.	Required when MC094 = 002 and MC036 starts with 11, 13, 18, 41. Optional for other facility claims.	1.0%	Institutional 837/2300/HI/BQ/02-2 837/2300/HI/BBQ/02-2
86	MC085	Other ICD Procedure Code - 3	4/1/2013	External Code Source - ICD - Text	7	ICD Other Procedure Code	Report the fourth ICD procedure code when applicable. Repeat this code on all lines of the facility claim. Do not code decimal point.	Required when MC094 = 002 and MC036 starts with 11, 13, 18, 41. Optional for other facility claims.	1.0%	Institutional 837/2300/HI/BQ/03-2 837/2300/HI/BBQ/03-2
87	MC086	Other ICD Procedure Code - 4	4/1/2013	External Code Source - ICD - Text	7	ICD Other Procedure Code	Report the fifth ICD procedure code when applicable. Repeat this code on all lines of the facility claim. Do not code decimal point.	Required when MC094 = 002 and MC036 starts with 11, 13, 18, 41. Optional for other facility claims.	1.0%	Institutional 837/2300/HI/BQ/04-2 837/2300/HI/BBQ/04-2
88	MC087	Other ICD Procedure Code - 5	4/1/2013	External Code Source - ICD - Text	7	ICD Other Procedure Code	Report the sixth ICD procedure code when applicable. Repeat this code on all lines of the facility claim. Do not code decimal point.	Required when MC094 = 002 and MC036 starts with 11, 13, 18, 41. Optional for other facility claims.	1.0%	Institutional 837/2300/HI/BQ/05-2 837/2300/HI/BBQ/05-2
89	MC088	Other ICD Procedure Code - 6	4/1/2013	External Code Source - ICD - Text	7	ICD Other Procedure Code	Report the seventh ICD procedure code when applicable. Repeat this code on all lines of the facility claim. Do not code decimal point.	Required when MC094 = 002 and MC036 starts with 11, 13, 18, 41.	1.0%	Institutional 837/2300/HI/BQ/06-2 837/2300/HI/BBQ/06-2

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
90	MC089	Paid Date	4/1/2013	Integer	8	Paid date of the claim line	Report the date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment in YYYYMMDD Format. This can be the same date as Processed Date. EXAMPLE: Claims paid in full, partial or zero paid must have a date reported here	All	100.0%	835/Header Financial Information/BPR/ /16
91-94	MC090 - MC093	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%	
95	MC094	Type of Claim	10/7/2013	Lookup Table - Text	3	Type of Claim Indicator	Report the value that defines the type of claim submitted for payment. EXAMPLE: 001 = Professional Claim Line Code Description 001 Professional	All	100.0%	Administrative
96	MC095	COB / TPL Amount	7/2/2013	Decimal,2	10	Amount due from a secondary carrier	Report the amount that another payer is liable for after submitting payer has processed this claim line. Report 0 if there is no COB / TPL amount. Do not code decimal or round-up / down to whole dollars, code zero cents (00) when	Required when MC038 = 19, 20 or 21	98.0%	835/2110/CAS
97	MC096	Other Insurance Paid Amount	7/2/2013	Decimal,2	10	Amount already paid by primary carrier	Report the amount that a prior payer has paid for this claim line. Indicates the submitting Payer is 'secondary' to the prior payer. Only report 0 if the Prior Payer paid 0 towards this claim line, else do not report any value here. Do not code decimal or round-up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC038 = 2, 3, 20 or 21	98.0%	835/2110/CAS
98	MC097	Medicare Paid Amount	7/2/2013	Decimal,2	10	Any amount Medicare Paid towards claim line	Report the amount that Medicare paid towards this claim line. Only report 0 if Medicare paid 0 towards this claim line, else do not report any value here. Do not code decimal or round-up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC115 = 1	100.0%	835/2110/CAS
99	MC098	Allowed amount	4/1/2013	Decimal,2	10	Allowed Amount	Report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider contract and most often it is less than or equal to the fee charged by the provider. Report 0 when the claim line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99.0%	835/2110/CAS
100	MC099	Non-Covered Amount	7/2/2013	Decimal,2	10	Amount of claim line charge not covered	Report the amount that was charged on a claim line that is not reimbursable due to eligibility limitations or unmet provider requirements. Report 0 when the claim line is paid or fall into other categories. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	100.0%	835/2110/CAS
101	MC100	Carve Out Vendor CT APCD ID	4/1/2013	Text	8	CT APCD defined and maintained Org ID for linking across submitters	Report the CT APCD ID of the Carve Out Vendor here. This element contains the CT APCD assigned organization ID for the Vendor. This field is also used to report the payer for whom the carve-out vendor is reporting on behalf of. Contact the CT APCD for the appropriate value. If no Vendor is affiliated with this claim line report the CT APCD ID from MC001.	All	98.0%	Administrative
102	MC101	Subscriber Last Name	10/15/2010	Text	60	Last name of Subscriber	Report the last name of the subscriber. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE.	All	100.0%	837/2010BA/NM1/ /03

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
103	MC102	Subscriber First Name	10/15/2010	Text	25	First name of Subscriber	Report the first name of the subscriber here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: Anne-Marie becomes ANNEMARIE.	All	100.0%	837/2010BA/NM1/ /04
104	MC103	Subscriber Middle Initial	10/15/2010	Text	1	Middle initial of Subscriber	Report the Subscriber's middle initial here. Used to validate Unique Member ID.	All	2.0%	837/2010BA/NM1/ /05
105	MC104	Member Last Name	4/1/2013	Text	60	Last name of Member/Patient	Report the last name of the patient / member here. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE.	All	100.0%	837/2010CA/NM1/ /03, 837/2010BA/NM1/ /03
106	MC105	Member First Name	4/1/2013	Text	25	First name of Member/Patient	Report the first name of the patient / member here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: Anne-Marie becomes ANNEMARIE.	All	100.0%	837/2010CA/NM1/ /04, 837/2010BA/NM1/ /04
107	MC106	Member Middle Initial	4/1/2013	Text	1	Middle initial of Member/Patient	Report the middle initial of the patient / member when available. Used to validate Unique Member ID.	All	2.0%	837/2010CA/NM1/ /05, 837/2010BA/NM1/ /05
108	MC107	ICD Indicator	4/1/2013	Lookup Table - Integer	1	International Classification of Diseases version	Report the value that defines whether the diagnoses on claim are ICD9 or ICD10. EXAMPLE: 9 = ICD9 Code Description 9 ICD-9 0 ICD-10	Required when MC094 = 001 or 002 and MC041 is populated	100.0%	N/A
109	MC108	Procedure Modifier - 3	4/1/2013	External Code Source - AMA - Text	2	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055).	Required when MC055 is populated	0.0%	835/2110/SVC/HC/01-5
110	MC109	Procedure Modifier - 4	4/1/2013	External Code Source - AMA - Text	2	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055).	Required when MC055 is populated	0.0%	835/2110/SVC/HC/01-6
111	MC110	Claim Processed Date	4/1/2013	Full Date - Integer	8	Claim Processed Date	Report the date the claim was processed by the carrier / submitter in YYYYMMDD Format. This date can be equal to Paid or Denial Date, but cannot be after Paid or Denial Date.	All	98.0%	Administrative
112	MC111	Diagnostic Pointer	4/1/2013	Integer	4	Diagnostic Pointer Number	Report the placement number of the diagnosis(es) a procedure is related to for a professional claim. Can report up to four diagnostic positions within the first nine diagnoses that can be reported. Do not separate multiple mappings with spaces, zeros or special characters. Do not zero fill. EXAMPLE: Procedure related to diagnoses 1, 4 and 5 = 145	Required when MC094 = 001	98.0%	Professional 837/2400/SV1//07
113	MC112	Referring Provider ID	4/1/2013	Text	30	Referring Provider ID	Report the identifier of the provider that submitted the referral for the service or ordered the test that is on the claim (if applicable). The value in this field must have a corresponding Provider ID (PV002) on the provider file.	Required when MC118 = 1	98.0%	Institutional 837/2310F/REF/G2/02

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
114	MC113	Payment Arrangement Type	4/1/2013	Lookup Table - Integer	1	Payment Arrangement Type Value	Report the value that defines the contracted payment methodology for this claim line. EXAMPLE: 02 = Fee for Service Code Description 1 Capitation 2 Fee for Service 3 Percent of Charges 4 DRG 5 Pay for Performance 6 Global Payment 7 Other 8 Bundled Payment	All	98.0%	Administrative
115	MC114	Excluded Expenses	4/1/2013	Decimal,2	10	Amount not covered at the claim line due to benefit/plan limitation	Report the amount that the patient has incurred towards covered but over-utilized services. Scenario: Physical Therapy units that are authorized for 15 visits at $50 a visit but utilized 20. The amount reported here would be 25000 to state over-utilization by $250.00. Report 0 if there are no Excluded Expenses. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	98.0%	Administrative
116	MC115	Medicare Indicator	7/2/2013	Lookup Table - Integer	1	Indicator - Medicare Payment Applied	Report the value that defines the element. EXAMPLE: 1 = Yes, Medicare paid for part or all of services Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%	Administrative
117	MC116	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	all	0.0%	
118	MC117	Authorization Needed	7/2/2013	Lookup Table - Integer	1	Indicator - Authorization Needed	Report the value that defines the element. EXAMPLE: 1 = Yes service required a pre-authorization Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%	Administrative
119	MC118	Referral Indicator	7/2/2013	Lookup Table - Integer	1	Indicator - Referral Needed	Report the value that defines the element. EXAMPLE: 1 = Yes service was preceded by a referral Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%	Administrative

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
120	MC119	PCP Indicator	4/1/2013	Lookup Table - Integer	1	Indicator - PCP Rendered Service	Report the value that defines the element. EXAMPLE: 1 = Yes service was performed by members PCP. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%	Administrative
121	MC120	DRG Level	4/1/2013	External Code Source - CMS - Integer	1	Diagnostic Related Group Code Severity Level	Report the level used for severity adjustment when applicable.	Required when MC071 is populated	80.0%	Administrative
122	MC121	Patient Total Out of Pocket Amount	7/2/2013	Decimal,2	10	Total amount patent / member must pay for this claim line	Report the total amount patient / member is responsible to pay to the provider as part of their costs for services. Report 0 if there are no Out of Pocket expenses. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	100.0%	Administrative
123	MC122	Global Payment Flag	4/1/2013	Lookup Table - Integer	1	Indicator - Global Payment	Report the value that defines the element. EXAMPLE: 1 = Yes the claim line was paid under a global payment arrangement. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%	Administrative
124	MC123	Denied Flag	4/1/2013	Lookup Table - Integer	1	Denied Claim Line Indicator	Report the value that defines the element. EXAMPLE: 1 = Yes, Claim Line was denied. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%	Administrative
125	MC124	Denial Reason	4/1/2013	External Code Source - HIPAA - OR- Carrier Lookup Table - Text	15	Denial Reason Code	Report the code that defines the reason for denial of the claim line. Carrier must submit denial reason codes in separate table to the APCD.	Required when MC123 = 1	99.9%	835/2110/CAS
126	MC125	Attending Provider	4/1/2013	Text	30	Attending Provider ID	Report the ID that reflects the provider that provided general oversight of the patient's care. This individual may or may not be the Servicing or Rendering provider. This value needs to be found in field PV002 on the Provider File. This field may or may not be NPI based on the carrier's identifier system.	Required when MC094 = 002 and MC039 is populated	98.0%	Institutional 837/2310A/REF/G2/02

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
127	MC126	Accident Indicator	4/1/2013	Lookup Table - Integer	1	Indicator - Accident Related	Report the value that defines the element. EXAMPLE: 1 = Yes, Claim Line is Accident related. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%	Administrative
128	MC127	Family Planning Indicator	7/2/2013	Lookup Table - Integer	1	Indicator - Family planning related	Report the value that defines if Family Planning services were provided . EXAMPLE: 1 = Family planning services provided Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	Required when MC094 = 001	100.0%	Administrative
129	MC128	Employment Related Indicator	7/2/2013	Lookup Table - Integer	1	Indicator - Employment Related	Report the value that defines the element. EXAMPLE: 1 = Yes, Claim Line is related to employment ~~accident~~ Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	Required when MC094 = 001	100.0%	Administrative
130	MC129	EPSDT Indicator	7/2/2013	Lookup Table - Integer	1	Indicator - EPSDT	Report the value that defines if the service was related to EPSDT and the type of EPSDT service. EXAMPLE: 1 = EPSDT Screening Code Description 1 EPSDT Screening 2 EPSDT Treatment 3 EPSDT Referral 0 Unknown / Not Applicable	Required when MC094 = 001	100.0%	Administrative
131	MC130	Procedure Code Type	4/1/2013	Lookup Table - Integer	1	Claim line Procedure Code Type Identifier	Report the value the defines the type of Procedure Code expected in MC055. Code Description 1 CPT or HCPCS Level 1 Code 2 HCPCS Level II Code 3 HCPCS Level III Code (State Medicare code). 4 American Dental Association (ADA) Procedure Code (Also referred to as CDT code.) 5 State defined Procedure Code 6 CPT Category II 7 Custom Code - Submitter must send in a lookup table of values for MC055	Required when MC055 is populated	100.0%	Administrative

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
132	MC131	In Network Indicator	4/1/2013	Lookup Table - Integer	1	Indicator - Network Rate Applied	Report the value that defines the element. EXAMPLE: 1 = Yes claim line was paid at an In Network rate. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%	Administrative
133	MC132	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%	
134	MC133	Bill Frequency Code	4/1/2013	External Code Source - NUBC - Text	1	Bill Frequency	Report the valid frequency code of the claim to indicate version, credit/debit activity and/or setting of claim.	Required when MC094 = 001 or 002	100.0%	837/2300/CLM/ /05-3
135	MC134	Plan Rendering Provider Identifier	4/1/2013	Text	30	Plan Rendering Number	Report the unique code which identifies for the carrier / submitter who or which individual provider cared for the patient for the claim line in question. This code must be able to link to the Provider File. Any value in this field must also show up as a value in field PV002 (Provider ID) on the Provider File.	All	99.0%	835/2100/REF/1A/02, 835/2100/REF/1B/02, 835/2100/REF/1C/02, 835/2100/REF/1D/02, 835/2100/REF/G2/02, 835/2100/NM1/BD/09, 835/2100/NM1/PC/09, 835/2100/NM1/MC/09, 835/2100/NM1/BS/09
136	MC135	Provider Location	10/7/2013	Text	30	Location of Provider	Report the unique code which identifies the location / site	All	90.0%	Administrative
137	MC136	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%	
138	MC137	Carrier Specific Unique Member ID	4/1/2013	Text	50	Member's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to validate Unique Member ID and link back to Member Eligibility (ME107)	All	100.0%	Administrative
139	MC138	Claim Line Type	4/1/2013	Lookup Table - Text	1	Claim Line Activity Type Code	Report the code that defines the claim line status in terms of adjudication. EXAMPLE: O = Original Code Description O Original V Void R Replacement B Back Out A Amendment	All	98.0%	Administrative
140	MC139	Former Claim Number	4/1/2013	Text	35	Previous Claim Number	Report the Claim Control Number (MC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own MC004. Use of “Former Claim Number” to version claims can only be used if approved by the APCD. Contact the APCD for conditions of use.	All	0.0%	Administrative
141	MC140	Member Street Address 2	4/1/2013	Text	50	Secondary Street Address of the Member/Patient	Report the address of member which may include apartment number or suite, or other secondary information besides the street. Used to validate Unique Member ID.	All	2.0%	837/2010BA/N3/ /02 837/2010CA/N3/ /02
142	MC141	Carrier Specific Unique Subscriber ID	4/1/2013	Text	50	Subscriber's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to validate Unique Member ID and link back to Member Eligibility (ME117)	All	100.0%	Administrative
143	MC142	Other Diagnosis - 13	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 13. If not applicable do not report any value here. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	MC094=002	0.0%	Institutional 837/2300/HI/BF/13-2, 837/2300/HI/ABF/13-2

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
144	MC143	Other Diagnosis - 14	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 14. If not applicable do not report any value here. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	MC094=002	0.0%	Institutional 837/2300/HI/BF/14-2, 837/2300/HI/ABF/14-2
145	MC144	Other Diagnosis - 15	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 15. If not applicable do not report any value here. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	MC094=002	0.0%	Institutional 837/2300/HI/BF/15-2, 837/2300/HI/ABF/15-2
146	MC145	Other Diagnosis - 16	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 16. If not applicable do not report any value here. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	MC094=002	0.0%	Institutional 837/2300/HI/BF/16-2, 837/2300/HI/ABF/16-2
147	MC146	Other Diagnosis - 17	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 17. If not applicable do not report any value here. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	MC094=002	0.0%	Institutional 837/2300/HI/BF/17-2, 837/2300/HI/ABF/17-2
148	MC147	Other Diagnosis - 18	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 18. If not applicable do not report any value here. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	MC094=002	0.0%	Institutional 837/2300/HI/BF/18-2, 837/2300/HI/ABF/18-2
149	MC148	Other Diagnosis - 19	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 19. If not applicable do not report any value here. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	MC094=002	0.0%	Institutional 837/2300/HI/BF/19-2, 837/2300/HI/ABF/19-2
150	MC149	Other Diagnosis - 20	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 20. If not applicable do not report any value here. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	MC094=002	0.0%	Institutional 837/2300/HI/BF/20-2, 837/2300/HI/ABF/20-2
151	MC150	Other Diagnosis - 21	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 21. If not applicable do not report any value here. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	MC094=002	0.0%	Institutional 837/2300/HI/BF/21-2, 837/2300/HI/ABF/21-2
152	MC151	Other Diagnosis - 22	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 22. If not applicable do not report any value here. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	MC094=002	0.0%	Institutional 837/2300/HI/BF/22-2, 837/2300/HI/ABF/22-2
153	MC152	Other Diagnosis - 23	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 23. If not applicable do not report any value here. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	MC094=002	0.0%	Institutional 837/2300/HI/BF/23-2, 837/2300/HI/ABF/23-2
154	MC153	Other Diagnosis - 24	4/1/2013	External Code Source - ICD - Text	7	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 24. If not applicable do not report any value here. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	MC094=002	0.0%	Institutional 837/2300/HI/BF/24-2, 837/2300/HI/ABF/24-2
155	MC154	Present on Admission Code (POA) - 01	4/1/2013	External Code Source - CMS - Text	1	POA code for Principal Diagnosis	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC041 is populated	95.0%	Institutional 837/2300/HI/BK/01-9 837/2300/HI/ABK/01-9
156	MC155	Present on Admission Code (POA) - 02	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 1	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC042 is populated	90.0%	Institutional 837/2300/HI/BF/01-9 837/2300/HI/ABF/01-9
157	MC156	Present on Admission Code (POA) - 03	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 2	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC043 is populated	90.0%	Institutional 837/2300/HI/BF/02-9 837/2300/HI/ABF/02-9
158	MC157	Present on Admission Code (POA) - 04	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 3	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC044 is populated	90.0%	Institutional 837/2300/HI/BF/03-9 837/2300/HI/ABF/03-9
159	MC158	Present on Admission Code (POA) - 05	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 4	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC045 is populated	90.0%	Institutional 837/2300/HI/BF/04-9 837/2300/HI/ABF/04-9

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
160	MC159	Present on Admission Code (POA) - 06	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 5	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC046 is populated	90.0%	Institutional 837/2300/HI/BF/05-9 837/2300/HI/ABF/05-9
161	MC160	Present on Admission Code (POA) - 07	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 6	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC047 is populated	90.0%	Institutional 837/2300/HI/BF/06-9 837/2300/HI/ABF/06-9
162	MC161	Present on Admission Code (POA) - 08	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 7	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC048 is populated	90.0%	Institutional 837/2300/HI/BF/07-9 837/2300/HI/ABF/07-9
163	MC162	Present on Admission Code (POA) - 09	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 8	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC049 is populated	90.0%	Institutional 837/2300/HI/BF/08-9 837/2300/HI/ABF/08-9
164	MC163	Present on Admission Code (POA) - 10	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 9	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC050 is populated	90.0%	Institutional 837/2300/HI/BF/09-9 837/2300/HI/ABF/09-9
165	MC164	Present on Admission Code (POA) - 11	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 10	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC051 is populated	90.0%	Institutional 837/2300/HI/BF/10-9 837/2300/HI/ABF/10-9
166	MC165	Present on Admission Code (POA) - 12	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 11	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC052 is populated	90.0%	Institutional 837/2300/HI/BF/11-9 837/2300/HI/ABF/11-9
167	MC166	Present on Admission Code (POA) - 13	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 12	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC053 is populated	90.0%	Institutional 837/2300/HI/BF/12-9 837/2300/HI/ABF/12-9
168	MC167	Present on Admission Code (POA) - 14	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 13	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC142 is populated	90.0%	Institutional 837/2300/HI/BF/13-9 837/2300/HI/ABF/13-9
169	MC168	Present on Admission Code (POA) - 15	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 14	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC143 is populated	90.0%	Institutional 837/2300/HI/BF/14-9 837/2300/HI/ABF/14-9
170	MC169	Present on Admission Code (POA) - 16	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 15	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC144 is populated	90.0%	Institutional 837/2300/HI/BF/15-9 837/2300/HI/ABF/15-9
171	MC170	Present on Admission Code (POA) - 17	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 16	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC145 is populated	90.0%	Institutional 837/2300/HI/BF/16-9 837/2300/HI/ABF/16-9
172	MC171	Present on Admission Code (POA) - 18	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 17	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC146 is populated	90.0%	Institutional 837/2300/HI/BF/17-9 837/2300/HI/ABF/17-9

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
173	MC172	Present on Admission Code (POA) - 19	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 18	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC147 is populated	90.0%	Institutional 837/2300/HI/BF/18-9 837/2300/HI/ABF/18-9
174	MC173	Present on Admission Code (POA) - 20	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 19	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC148 is populated	90.0%	Institutional 837/2300/HI/BF/19-9 837/2300/HI/ABF/19-9
175	MC174	Present on Admission Code (POA) - 21	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 20	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC149 is populated	90.0%	Institutional 837/2300/HI/BF/20-9 837/2300/HI/ABF/20-9
176	MC175	Present on Admission Code (POA) - 22	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 21	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC150 is populated	90.0%	Institutional 837/2300/HI/BF/21-9 837/2300/HI/ABF/21-9
177	MC176	Present on Admission Code (POA) - 23	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 22	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC151 is populated	90.0%	Institutional 837/2300/HI/BF/22-9 837/2300/HI/ABF/22-9
178	MC177	Present on Admission Code (POA) - 24	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 23	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC152 is populated	90.0%	Institutional 837/2300/HI/BF/23-9 837/2300/HI/ABF/23-9
179	MC178	Present on Admission Code (POA) - 25	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 24	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC153 is populated	90.0%	Institutional 837/2300/HI/BF/24-9 837/2300/HI/ABF/24-9
180	MC179	Condition Code - 1	7/2/2013	External Code Source - NUBC - Text	2	Condition Code 1	Report the appropriate value that defines a condition for the claim or the patient. If not applicable do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BG/01-02
181	MC180	Condition Code - 2	7/2/2013	External Code Source - NUBC - Text	2	Condition Code 2	Report the appropriate value that defines a condition for the claim or the patient. If not applicable do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BG/02-02
182	MC181	Condition Code - 3	7/2/2013	External Code Source - NUBC - Text	2	Condition Code 3	Report the appropriate value that defines a condition for the claim or the patient. If not applicable do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BG/03-02
183-191	MC182 - MC190	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%	
192	MC191	Value Code - 1	7/2/2013	External Code Source - NUBC - Text	2	Value Code 1	Report the appropriate value that defines a value category for the claim or the patient. If not applicable do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BE/01-2
193	MC192	Value Amount - 1	7/2/2013	Decimal,2	10	Amount that corresponds to Value Code - 1	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC191 is populated	100.0%	Institutional 837/2300/HI/BE/01-5
194	MC193	Value Code - 2	7/2/2013	External Code Source - NUBC - Text	2	Value Code 2	Report the appropriate value that defines a value category for the claim or the patient. If not applicable do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BE/02-2

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
195	MC194	Value Amount - 2	7/2/2013	Decimal,2	10	Amount that corresponds to Value Code - 2	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC193 is populated	100.0%	Institutional 837/2300/HI/BE/02-5
196	MC195	Value Code - 3	7/2/2013	External Code Source - NUBC - Text	2	Value Code 3	Report the appropriate value that defines a value category for the claim or the patient. If not applicable do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BE/03-2
197	MC196	Value Amount - 3	7/2/2013	Decimal,2	10	Amount that corresponds to Value Code - 3	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC195 is populated	100.0%	Institutional 837/2300/HI/BE/03-5
198-215	MC197 - MC214	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%	
216	MC215	Occurrence Code - 1	7/2/2013	External Code Source - NUBC - Text	2	Occurrence Code 1	Report the appropriate value that defines an occurrence category for the claim or the patient. If not applicable do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BH/01-2
217	MC216	Occurrence Date - 1	7/2/2013	Integer	8	Date that corresponds to Occurrence Code - 1	Report the appropriate date that corresponds to the occurrence code in YYYYMMDD Format.	Required when MC215 is populated	99.9%	Institutional 837/2300/HI/BH/RD8/01-4
218	MC217	Occurrence Code - 2	7/2/2013	External Code Source - NUBC - Text	2	Occurrence Code 2	Report the appropriate value that defines an occurrence category for the claim or the patient. If not applicable do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BH/02-2
219	MC218	Occurrence Date - 2	7/2/2013	Integer	8	Date that corresponds to Occurrence Code - 2	Report the appropriate date that corresponds to the occurrence code in YYYYMMDD Format.	Required when MC217 is populated	99.9%	Institutional 837/2300/HI/BH/RD8/02-4
220	MC219	Occurrence Code - 3	7/2/2013	External Code Source - NUBC - Text	2	Occurrence Code 3	Report the appropriate value that defines an occurrence category for the claim or the patient. If not applicable do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BH/03-2
221	MC220	Occurrence Date - 3	7/2/2013	Integer	8	Date that corresponds to Occurrence Code - 3	Report the appropriate date that corresponds to the occurrence code in YYYYMMDD Format.	Required when MC219 is populated	99.9%	Institutional 837/2300/HI/BH/RD8/03-4
222-225	MC221 - MC224	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%	
226	MC225	Occurrence Span Code - 1	7/2/2013	External Code Source - NUBC - Text	2	Occurrence Span Code 1	Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BI/01-2
227	MC226	Occurrence Span Start Date - 1	7/2/2013	Integer	8	Start Date that corresponds to Occurrence Span Code - 1	Report the appropriate start date that corresponds to the occurrence code in YYYYMMDD Format.	Required when MC225 is populated	99.9%	Institutional 837/2300/HI/BH/RD8/01-4
228	MC227	Occurrence Span End Date - 1	7/2/2013	Integer	8	End Date that corresponds to Occurrence Span Code - 1	Report the appropriate end date that corresponds to the occurrence code in YYYYMMDD Format.	Required when MC226 is populated	99.9%	Institutional 837/2300/HI/BH/RD8/01-4
229	MC228	Occurrence Span Code - 2	7/2/2013	External Code Source - NUBC - Text	2	Occurrence Span Code 2	Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BI/02-2
230	MC229	Occurrence Span Start Date - 2	7/2/2013	Integer	8	Start Date that corresponds to Occurrence Span Code - 2	Report the appropriate start date that corresponds to the occurrence code in YYYYMMDD Format.	Required when MC228 is populated	99.9%	Institutional 837/2300/HI/BH/RD8/02-4

Medical Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
231	MC230	Occurrence Span End Date - 2	7/2/2013	Integer	8	End Date that corresponds to Occurrence Span Code - 2	Report the appropriate end date that corresponds to the occurrence code in YYYYMMDD Format.	Required when MC229 is populated	99.9%	Institutional 837/2300/HI/BH/RD8/02-4
232-241	MC231 - MC240	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%	
242	MC241	APCD ID Code	4/1/2013	Lookup Table - Integer	1	Member Enrollment Type	Report the value that describes the member's / subscriber's enrollment into one of the predefined categories; aligns enrollment to appropriate editing and thresholds. EXAMPLE: 1 = FIG - Fully Insured Commercial Group Enrollee. Code Description 1 FIG - Fully- Insured Commercial Group Enrollee 2 SIG - Self-Insured Group Enrollee 3 State or Federal Employer Enrollee 4 Individual - Non-Group Enrollee 5 Supplemental Policy Enrollee 6 ICO - Integrated Care Organization 0 Unknown / Not Applicable	All	100.0%	Administrative
243	MC899	Record Type	4/1/2013	Text	2	File Type Identifier	Report MC here. This validates the type of file and the data contained within the file. This must match HD004	All	100.0%	Administrative
TR-MC	TR001	Record Type	10/7/2013	Text	2	Trailer Record Identifier	Report TR here. Indicates the end of the data file.	Mandatory	100.0%	Administrative
TR-MC	TR002	Submitter	10/7/2013	Text	8	Trailer Submitter /Carrier ID defined by AHCT	Report unique Submitter ID here. AHCT will provide this unique identifier to the carrier. This must match the Submitter ID reported inHD002.	Mandatory	100.0%	Administrative
TR-MC	TR003	National Plan ID	10/7/2013	Text	10	CMS National Plan Identification Number (Plan ID)	Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	Situational	0.0%	Administrative
TR-MC	TR004	Type of File	10/7/2013	Text	2	Validates the file type defined inHD004.	Report MC here. This must match the File Type reported in HD004.	Mandatory	100.0%	Administrative
TR-MC	TR005	Period Beginning Date	10/7/2013	Full Date - Integer	8	Trailer Period Start Date	Report the Year, Month and Day of the reported submission period in YYYYMMDD format. This date is the first day of the month for the reporting period and must match the date reported in HD005.	Mandatory	100.0%	Administrative
TR-MC	TR006	Period Ending Date	10/7/2013	Full Date - Integer	8	Trailer Period Ending Date	Report the Year, Month and Day of the reported submission period in YYYYMMDD format. This date is the last day of the month for the reporting period and must match the date reported in HD006.	Mandatory	100.0%	Administrative
TR-MC	TR007	Date Processed	10/7/2013	Full Date - Integer	8	Trailer Processed Date	Report the full date that the submission was compiled by the submitter in YYYYMMDD Format.	Mandatory	100.0%	Administrative

*These remain consistent across all file types (ME, MC, PC, DC).

Pharmacy Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
HD-PC	HD001	Record Type	10/7/2013	Text	2	Header Record Identifier	Report HD here. Indicates the beginning of the Header Elements of the file.	Mandatory	100.0%
HD-PC	HD002	Submitter	10/7/2013	Text	8	Header Submitter/ Carrier ID defined by AHCT	Report unique Submitter ID here. AHCT will provide this unique identifier to the carrier. TR002 must match the Submitter ID reported here. This ID is linked to other elements in the file for quality control.	Mandatory	100.0%
HD-PC	HD003	National Plan ID	10/7/2013	Text	10	Header CMS National Plan Identification Number (Plan ID)	Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	Situational	0.0%
HD-PC	HD004	Type of File	10/7/2013	Text	2	Defines the file type and data expected.	Report **PC** here. Indicates that the data within this file is expected to be PHARMACY CLAIM-based. This must match the File Type reported inTR004.	Mandatory	100.0%
HD-PC	HD005	Period Beginning Date	10/7/2013	Full Date - Integer	8	Header Period Start Date	Report the Year, Month and Day of the reported submission period in YYYYMMDD format. This date is the first day of the month for the reporting period and must be repeated in TR005.	Mandatory	100.0%
HD-PC	HD006	Period Ending Date	10/7/2013	Full Date - Integer	8	Header Period Ending Date	Report the Year, Month and Day of the reported submission period in YYYYMMDD format. This date is the last day of the month for the reporting period and must be repeated in TR006.	Mandatory	100.0%
HD-PC	HD007	Record Count	10/7/2013	Integer	10	Header Record Count	Report the total number of records submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters.	Mandatory	100.0%
HD-PC	HD008	Comments	10/7/2013	Text	80	Header Carrier Comments	May be used to document the submission by assigning a filename, system source, compile identifier, etc.	Optional	0.0%
HD-PC	HD009	APCD Version Number	10/7/2013	Decimal - Numeric	3	Submission Guide Version	Report the version number as presented on the APCD Medical Claim File Submission Guide in 0.0Format. Sets the intake control for editing elements. Version must be accurate else file will drop. EXAMPLE: 3.0 = Newest Version Code Description 1.2 Current Version; required for reporting periods as of October 2013	Mandatory	100.0%
1	PC001	Submitter	4/1/2013	Text	8	CT APCD defined and maintained unique identifier	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the reporting state and the third character designates the type of submitter. For Connecticut's APCD collection, valid prefixes include: CTC ..... Commercial carrier CTG ..... Governmental agency CTT ..... Third-party administrator Notes: A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	All	100.0%
2	PC002	National Plan ID	4/1/2013	Text	10	CMS National Plan Identification Number (Plan ID)	Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by the Center for Medicare and Medicaid Services (CMS) for Plans and Sub-plans.	All	0.0%

Pharmacy Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
3	PC003	Insurance Type Code / Product	4/1/2013	Lookup Table - Text	2	Type / Product Identification Code	Report the code that defines the type of insurance under which this patient's claim line was processed. EXAMPLE: HM = HMO * Descriptions with an asterisk are aligned with the HIPPA 835 Claim Filing Indicator Code List Code Description 9 Self-pay 11 Other Non-Federal Programs * (use of this value requires disclosure to Data Manager prior to submission) 12 Preferred Provider Organization (PPO) * 13 Point of Service (POS) * 14 Exclusive Provider Organization (EPO) * 15 Indemnity Insurance * 16 Health Maintenance Organization (HMO) Medicare Risk *(Use to report Medicare Part C/Medicare Advantage Plans) 17 Dental Maintenance Organization (DMO) * 96 Husky Health A 97 Husky Health B 98 Husky Health C 99 Husky Health D AM Automobile Medical * CH Champus (now TRICARE) * DS Disability * HM Health Maintenance Organization * LM Liability Medical * MA Medicare Part A * (Medicare Fee for Service only) MB Medicare Part B * (Medicare Fee for Service only) MC Medicaid * MD Medicare Part D OF Other Federal Program * (use of this value requires disclosure to Data Manager prior to submission) TV Title V * VA Veterans Affairs Plan * WC Workers' Compensation * ZZ Mutually Defined * (use of this value requires disclosure to Data Manager prior to submission)	All	100.0%
4	PC004	Payer Claim Control Number	4/1/2013	Text	35	Payer Claim Control Identification	Report the Unique identifier within the payer's system that applies to the entire claim	All	100.0%
5	PC005	Line Counter	4/1/2013	Text	4	Incremental Line Counter	Report the line number for this service within the claim. Start with 1 and increment by 1 for each additional line. Do not start with 0, include alphas or special characters.	All	100.0%
6	PC005A	Version Number	4/1/2013	Text	4	Claim Service Line Version Number	Report the version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line. No alpha or special characters.	All	100.0%

Pharmacy Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
7	PC006	Insured Group or Policy Number	4/1/2013	Text	30	Group / Policy Number	Use this field to report the group or policy number. Notes: The value reported for this field should be reported consistently in the "Insured Group or Policy Number" field in both the medical eligibility (ME006) and medical claims (MC006) data. This is not the number that uniquely identifies the subscriber. If a policy is sold to an individual as a non-group policy, report with a value of "IND". This principle pertains to all claim types: commercial, Medicaid, and Medicare.	All	98.0%
8	PC007	Subscriber SSN	4/1/2013	Text	9	Subscriber's Social Security Number	Report the subscriber's social security number here; used to create Unique Member ID; Do not use hyphen. If not available do not report any value here. Notes: The value reported for this field should be reported consistently in the "Subscriber Social Security Number" field in both the eligibility (ME008) and medical claims (MC007) data. This field will not be passed into analytic file.	All	75.0%
9	PC008	Plan Specific Contract Number	4/1/2013	Text	30	Contract Number	Report the Plan assigned contract number. Do not include values in this field that will distinguish one member of the family from another. This should be the contract or certificate number for the subscriber and all of the dependents. Notes: The value reported for this field should be reported consistently in the "Plan-Specific Contract Number" field in both the eligibility (ME009) and medical claims (MC008) data.	All	98.0%
10	PC009	Member Suffix or Sequence Number	4/1/2013	Text	20	Member/Patient's Contract Sequence Number	Report the unique number / identifier of the member within the contract	All	98.0%
11	PC010	Member SSN	4/1/2013	Text	9	Member/Patient's Social Security Number	Report the member's social security number here; used to create Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here. Notes: The value reported for this field should be consistently reported in the "Member Social Security Number" field in both the eligibility (MC011) and medical claims (MC010) data.	All	75.0%

Pharmacy Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
12	PC011	Individual Relationship Code	10/30/2013	Lookup Table - Text	2	Patient to Subscriber Relationship Code	Report the value that defines the Patient's relationship to the Subscriber. EXAMPLE: 1 = Spouse Code Description 1 Spouse 4 Grandfather or Grandmother 5 Grandson or Granddaughter 7 Nephew or Niece 10 Foster Child 12 Other Adult 15 Ward 17 Stepson or Stepdaughter 18 Self 19 Child 20 Self / Employee 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 34 Other Adult 36 Emancipated Minor 39 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Child Where Insured Has No Financial Responsibility 53 Life Partner 76 Dependent	All	98.0%
13	PC012	Member Gender	4/1/2013	Lookup Table - Text	1	Patient's Gender	Report member gender as reported on enrollment form in alpha format. Used to create Unique Member ID. EXAMPLE: F = Female Code Description F Female M Male U Unknown Notes: The value reported for this field should be consistently reported in the "Member Gender" field in both the eligibility(ME013) and medical claims (MC012) data	All	100.0%
14	PC013	Member Date of Birth	4/1/2013	Full Date - Integer	8	Member/Patient's date of birth	Report the date the member / patient was born in YYYYMMDD Format. Used to validate Unique Member ID.	All	99.0%
15	PC014	Member City Name of Residence	4/1/2013	Text	50	City name of the Member/Patient	Report the city name of the member / patient. Used to validate Unique Member ID	All	99.0%

Pharmacy Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
16	PC015	Member State	4/1/2013	External Code Source - USPS - Text	2	State / Province of the Patient	Report the state of the patient as defined by the US Postal Service. Report Province when Country Code does not = USA	All	99.9%
17	PC016	Member ZIP Code	4/1/2013	External Code Source - USPS - Text	9	Zip code of the Member / Patient	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	99.9%
18	PC017	Date Service Approved (AP Date)	4/1/2013	Full Date - Integer	8	Date Service Approved by Payer	Report the date that the payer approved this claim line for payment in YYYYMMDD Format. This element was designed to capture date other than the Paid date. If Approved Date and Paid Date are the same, then the date here should match Paid Date.	All	100.0%
19	PC018	Pharmacy Number	4/1/2013	Text	30	Pharmacy Number	Report either the NCPDP or NABP number of the dispensing pharmacy	All	98.0%
20	PC019	Pharmacy Tax ID Number	4/1/2013	Text	9	Pharmacy Tax Identification Number	Report the Federal Tax ID of the Pharmacy here. Do not use hyphen or alpha prefix.	All	20.0%
21	PC020	Pharmacy Name	4/1/2013	Text	100	Name of Pharmacy	Report the name of the pharmacy here	All	90.0%
22	PC021	National Provider ID - Pharmacy	4/1/2013	External Code Source - NPPES - text	10	National Provider Identification (NPI) of the Pharmacy	Report the Primary National Provider ID (NPI) here. This ID should be found on the Provider File in the NPI field (PV039)	All	99.0%
23	PC022	Pharmacy Location City	4/1/2013	Text	30	City name of the Pharmacy	Report the city name of pharmacy - preferably pharmacy location	All	85.0%
24	PC023	Pharmacy Location State	4/1/2013	External Code Source - USPS - Text	2	State of the Pharmacy	Report the state where the dispensing pharmacy is located.	All	90.0%
25	PC024	Pharmacy ZIP Code	4/1/2013	External Code Source - USPS - Text	9	Zip code of the Pharmacy	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	90.0%
26	PC024A	Pharmacy Country Code	4/1/2013	External Code Source - ANSI - Text	3	Country Code of the Pharmacy	Report the three-character country code as defined by ISO 3166-1, Alpha 3	All	90.0%
27	PC025	Claim Status	10/7/2013	Lookup Table - integer	2	Claim Line Status	Report the value that defines the payment status of this claim line Code Description 1 Processed as primary 2 Processed as secondary 3 Processed as tertiary 4 Denied 19 Processed as primary, forwarded to additional payer(s) 20 Processed as secondary, forwarded to additional payer(s) 21 Processed as tertiary, forwarded to additional payer(s) 22 Reversal of previous payment 23 Not our claim, forwarded to additional payer(s) 25 Predetermination Pricing Only - no payment	All	98.0%
28	PC026	Drug Code	4/1/2013	External Code Source - FDA - Text	11	National Drug Code (NDC)	Report the NDC Code as defined by the FDA in 11 digit format (5-4-2) without hyphenation	All	98.0%

Pharmacy Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
29	PC027	Drug Name	4/1/2013	External Code Source - FDA - Text	80	Name of the drug as supplied	Report the name of the drug that aligns to the National Drug Code. Do not report generic names with brand National Drug Codes	All	95.0%
30	PC028	New Prescription or Refill	4/1/2013	Text	2	Prescription Status Indicator	Report the status of prescription by numeric value. EXAMPLE: 00 = new prescription; First Refill = 01, etc.	All	99.0%
31	PC029	Generic Drug Indicator	4/1/2013	Lookup Table - Integer	1	Generic Drug Indicator	Report the value that defines the element. EXAMPLE: 1 = Yes, the drug reported is a generic. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
32	PC030	Dispense as Written Code	4/1/2013	Lookup Table - Integer	1	Prescription Dispensing Activity Code	Report the value that defines how the drug was dispensed. EXAMPLE: 0 = Not dispensed as written Code Description 1 Physician dispense as written 2 Member dispense as written 3 Pharmacy dispense as written 4 No generic available 5 Brand dispensed as generic 6 Override 7 Substitution not allowed, brand drug mandated by law 8 Substitution allowed, generic drug not available in marketplace 9 Other 0 Not dispensed as written	All	98.0%
33	PC031	Compound Drug Indicator	4/1/2013	Lookup Table - Integer	1	Compound Drug Indicator	Report the value that defines the element. EXAMPLE: 1 = Yes, drug is a compound. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	0.0%
34	PC032	Date Prescription Filled	4/1/2013	Full Date - Integer	8	Prescription filled date	Report the date the pharmacy filled AND dispensed prescription to the patient in YYYYMMDD Format.	All	99.0%
35	PC033	Quantity Dispensed	4/1/2013	Decimal, 2	10	Claim line units dispensed	Report the number of metric units of medication dispensed	All	75.0%
36	PC034	Days' Supply	4/1/2013	Integer	3	Prescription Supply Days	Report the number of days the prescription will last if taken as prescribed	All	10.0%
37	PC035	Charge Amount	4/1/2013	Decimal, 2	10	Amount of provider charges for the claim line	Report the amount the provider / dispensing facility billed the insurance carrier for this claim line service. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99.0%

Pharmacy Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
38	PC036	Paid Amount	4/1/2013	Decimal, 2	10	Amount paid by the carrier for the claim line	Report the amount paid for the claim line. Report 0 if line is paid as part of another procedure / claim line. Report as 0 if the line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99.0%
39	PC037	Ingredient Cost/List Price	4/1/2013	Decimal, 2	10	Amount defined as the List Price or Ingredient Cost	Report the amount that defines this pharmaceutical cost / price. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99.0%
40	PC038	Postage Amount Claimed	4/1/2013	Decimal, 2	10	Amount of postage claimed on the claim line	Report the amount of postage claimed for this claim line. Report 0 if postage does not apply Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	100.0%
41	PC039	Dispensing Fee	4/1/2013	Decimal, 2	10	Amount of dispensing fee for the claim line	Report the amount that defines the dispensing fee. Report 0 if fee does not apply. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99.0%
42	PC040	Copay Amount	4/1/2013	Decimal, 2	10	Amount of Copay member/patient is responsible to pay	Report the amount that the is the patient's responsibility. Report 0 if no Copay applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	100.0%
43	PC041	Coinsurance Amount	4/1/2013	Decimal, 2	10	Amount of coinsurance member/patient is responsible to pay	Report the amount that defines a calculated percentage amount for this claim line service that the patient is responsible to pay. Report 0 if no Coinsurance applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	100.0%
44	PC042	Deductible Amount	4/1/2013	Decimal, 2	10	Amount of deductible member/patient is responsible to pay on the claim line	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Deductible applies to service. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	100.0%
45	PC043	Prescribing Provider ID	7/2/2013	Text	30	Prescribing Provider Identification	Report the identification of the prescribing provider here. The information in this element must have a matching Provider ID (PV002) in the Provider File.	All	99.0%
46	PC044	Prescribing Physician First Name	4/1/2013	Text	25	First name of Prescribing Physician	Report the first name of the prescribing physician here.	All	50.0%
47	PC045	Prescribing Physician Middle Name	4/1/2013	Text	25	Middle name of Prescribing Physician	Report the middle name of the prescribing physician here.	All	2.0%
48	PC046	Prescribing Physician Last Name	4/1/2013	Text	60	Last name of Prescribing Physician	Report the last name of the prescribing physician here.	All	50.0%
49	PC047	Prescribing Physician DEA	7/2/2013	Text	9	Prescriber DEA	Report the Primary DEA identifier for the prescribing physician	All	80.0%
50	PC048	National Provider ID - Prescribing	7/2/2013	External Code Source - NPPES - Text	10	National Provider Identification (NPI) of the Prescriber	Report the Primary National Provider ID (NPI) of the Prescribing Provider in PC046. This ID should be found on the Provider File in the NPI field (PV039) when the Provider is contracted with the carrier.	All	99.0%

Pharmacy Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
51	PC049	Prescribing Physician Plan Number	7/2/2013	Text	30	Carrier-assigned Provider Plan ID	Report the prescriber's plan number here. Do not report any value here if contracted with the carrier. This identifier must match an existing identifier in the Provider File	All	100.0%
52	PC050	Prescribing Physician License Number	7/2/2013	Text	30	Prescribing Physician License Number	Report the state license number for the provider identified in PV002. For a doctor this is the medical license for a non-doctor this is the practice license. Do not use zero-fill. If not available, or not applicable, such as for a group or corporate entity, do not report any value here.	All	50.0%
53	PC051	Prescribing Physician Street Address	7/2/2013	Text	50	Street address of the Prescribing Physician	Report the street address of the prescribing physician	All	10.0%
54	PC052	Prescribing Physician Street Address 2	7/2/2013	Text	50	Secondary street address of the Prescribing Physician	Report the street address of the prescribing physician that may contain the office number, suite number, or PO Box	All	10.0%
55	PC053	Prescribing Physician City	7/2/2013	Text	30	City name of the Prescribing Physician	Report the Prescribing Physician's City	All	10.0%
56	PC054	Prescribing Physician State	7/2/2013	External Code Source - USPS - Text	2	State of the Prescribing Physician	Report the Prescribing Physician's State	All	10.0%
57	PC055	Prescribing Physician Zip Code	7/2/2013	External Code Source - USPS - Text	9	Zip code of the Prescribing Physician	Report the Prescribing Physician's Zip code	All	10.0%
58	PC056	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
59	PC057	Mail Order pharmacy	4/1/2013	Lookup Table - Integer	1	Indicator - Mail Order Option	Report the value that defines the element. EXAMPLE: 1 = Yes, pharmacy is a mail order pharmacy Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
60	PC058	Script number	4/1/2013	Text	20	Prescription Number	Report the unique identifier of the prescription	All	99.9%
61	PC059	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
62	PC060	Single / Multiple Source Indicator	7/2/2013	Lookup Table - Integer	1	Indicator - Drug Source	Report the value that defines the availability of the pharmaceutical. EXAMPLE: 3 = Single-source brand Code Description 1 Multi-source brand 2 Multi-source brand with generic equivalent 3 Single source brand 4 Single source brand with generic equivalent 5 Unknown	All	100.0%
63	PC061	Member Street Address	4/1/2013	Text	50	Street address of the Member/Patient	Report the patient / member's address. Used to validate Unique Member ID.	All	90.0%

Pharmacy Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
64	PC062	Billing Provider Tax ID Number	4/1/2013	Text	9	The Billing Provider's Federal Tax Identification Number (FTIN)	Report the Federal Tax ID of the Billing Provider here. Do not use hyphen or alpha prefix.	All	90.0%
65	PC063	Paid Date	4/1/2013	Integer	8	Paid date of the claim line	Report the date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment in YYYYMMDD Format. This can be the same date as Processed Date. EXAMPLE: Claims paid in full, partial or zero paid	Required when PC025 = 01, 02, 03, 19, 20, or 21	100.0%
66	PC064	Date Prescription Written	4/1/2013	Full Date - Integer	8	Date prescription was prescribed	Report the date that was written on the prescription or called-in by the physician's office in YYYYMMDD Format.	All	98.0%
67	PC065	COB / TPL Amount	7/2/2013	Decimal, 2	10	Amount due from a secondary carrier	Report the amount that another payer is liable for after submitting payer has processed this claim line. Report 0 if there is no COB / TPL amount. Do not code decimal or round-up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	Required when PC025 = 19, 20 or 21	98.0%
68	PC066	Other Insurance Paid Amount	7/2/2013	Decimal, 2	10	Amount already paid by primary carrier	Report the amount that a prior payer has paid for this claim line. Indicates the submitting Payer is 'secondary' to the prior payer. Only report 0 if the Prior Payer paid 0 towards this claim line, else do not report any value here. Do not code decimal or round-up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	Required when PC025 = 2, 3, 20 or 21	98.0%
69	PC067	Medicare Paid Amount	7/2/2013	Decimal, 2	10	Any amount Medicare Paid towards claim line	Report the amount that Medicare paid towards this claim line. Only report 0 if Medicare paid 0 towards this claim line, else do not report any value here. Do not code decimal or round-up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	Required when PC112 = 1	100.0%
70	PC068	Allowed amount	4/1/2013	Decimal, 2	10	Allowed Amount	Report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider contract and most often it is less than or equal to the fee charged by the pharmacy. Report 0 when the claim line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	99.0%
71	PC069	Member Self Pay Amount	4/1/2013	Decimal, 2	10	Amount member/patient paid out of pocket on the claim line	Report the amount that the patient has paid beyond the copay structure. Report 0 if patient has not paid towards this claim line. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	20.0%
72	PC070	Rebate Indicator	7/2/2013	Lookup Table - Integer	1	Indicator - Rebate	Report the value that defines the element. EXAMPLE: 1 = Yes, drug is eligible for rebate Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%

Pharmacy Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
73	PC071	State Sales Tax	7/2/2013	Decimal, 2	10	Amount of applicable sales tax on the claim line	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 or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	0.0%
74	PC072	Carve Out Vendor CT APCD ID	4/1/2013	Text	8	CT APCD defined and maintained Org ID for linking across submitters	Report the CT APCD ID of the Carve Out Vendor/DBA here. This element contains the CT APCD assigned organization ID for the Vendor. This field is also used to report the payer for whom the carve-out vendor is reporting on behalf of. Contact the CT APCD for the appropriate value. If no Vendor is affiliated with this claim line do not report any value here: i.e., do not repeat the CT APCD ID from MC001 report the CT APCD ID from PC001.	All	98.0%
75	PC073	Formulary Code	7/2/2013	Lookup Table - Integer	1	Indicator - Formulary Inclusion	Report the value that defines the element. EXAMPLE: 1 = Yes, the drug is on the carrier's formulary list Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
76	PC074	Route of Administration	7/2/2013	External Codes Source - NCPDP - Text	2	Route of Administration	Report the pharmaceutical Route of Administration that defines the method of drug administration. EXAMPLE: 11 = Oral	All	99.9%
77	PC075	Drug Unit of Measure	4/1/2013	External Codes Source - NCPDP - Text	2	Units of Measure	Report the code that defines the unit of measure for drug dispensed. EXAMPLE: EA = Each	All	80.0%
78	PC101	Subscriber Last Name	4/1/2013	Text	60	Last name of Subscriber	Report the last name of the subscriber. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE	All	100.0%
79	PC102	Subscriber First Name	4/1/2013	Text	25	First name of Subscriber	Report the first name of the subscriber here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: Anne-Marie becomes ANNEMARIE	All	100.0%
80	PC103	Subscriber Middle Initial	4/1/2013	Text	1	Middle initial of Subscriber	Report the Subscriber's middle initial here. Used to validate Unique Member ID.	All	2.0%
81	PC104	Member Last Name	4/1/2013	Text	60	Last name of Member/Patient	Report the last name of the patient / member here. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE	All	100.0%

Pharmacy Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
82	PC105	Member First Name	4/1/2013	Text	25	First name of Member/Patient	Report the first name of the patient / member here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. EXAMPLE: Anne-Marie becomes ANNEMARIE	All	100.0%
83	PC106	Member Middle Initial	4/1/2013	Text	1	Middle initial of the Member/Patient	Report the middle initial of the patient / member when available. Used to validate Unique Member ID.	All	2.0%
84	PC107	Carrier Specific Unique Member ID	4/1/2013	Text	50	Member's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to validate Unique Member ID and link back to Member Eligibility (ME107)	All	100.0%
85	PC108	Carrier Specific Unique Subscriber ID	4/1/2013	Text	50	Subscriber's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to validate Unique Member ID and link back to Member Eligibility (ME117)	All	100.0%
86	PC109	Member Street Address 2	4/1/2013	Text	50	Secondary Street Address of the Member/Patient	Report the address of member which may include apartment number or suite, or other secondary information besides the street. Used to validate Unique Member ID.	All	2.0%
87	PC110	Claim Line Type	4/1/2013	Lookup Table - Text	1	Claim Line Activity Type Code	Report the code that defines the claim line status in terms of adjudication. EXAMPLE: O = Original Code Description O Original V Void R Replacement B Back Out A Amendment	All	98.0%
88	PC111	Former Claim Number	4/1/2013	Text	35	Previous Claim Number	Report the Claim Control Number (PC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own PC004. Use of "Former Claim Number" to version claims can only be used if approved by the APCD. Contact the APCD for conditions of use.	All	0.0%
89	PC112	Medicare Indicator	7/2/2013	Lookup Table - Integer	1	Indicator - Medicare Payment Applied	Report the value that defines the element. EXAMPLE: 1 = Yes, Medicare paid for part or all of services Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
90	PC113	Pregnancy Indicator	7/2/2013	Lookup Table - Integer	1	Indicator - Pregnancy	Report the value that defines the element. EXAMPLE: 1 = Yes, the patient is pregnant. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%

Pharmacy Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
91	PC114	Diagnosis Code	7/2/2013	External Codes Source - ICD - Text	7	ICD Diagnosis Code	Report the ICD Diagnosis Code when applicable	All	1.0%
92	PC115	ICD Indicator	7/2/2013	Lookup Table - Integer	1	International Classification of Diseases version	Report the value that defines whether the diagnoses on claim are ICD9 or ICD10. EXAMPLE: 9 = ICD9 Code Description 9 ICD-9 0 ICD-10	Required when PC114 is populated	100.0%
93	PC116	Denied Flag	7/2/2013	Lookup Table - Integer	1	Indicator - Denied Claim Line	Report the value that defines the element. EXAMPLE: 1 = Yes, Claim Line is denied Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
94	PC117	Denial Reason	7/2/2013	External Code Source - HIPAA -OR- Carrier Lookup Table - Text	30	Denial Reason Code	Report the Denial Reasons and/or Code that defines the reason for denial of the claim line. Carrier must submit denial reason codes in a separate table to Access Health CT.	Required when PC116 = 1	100.0%
95	PC118	Payment Arrangement Type	7/2/2013	Lookup Table - Integer	1	Payment Arrangement Type Value	Report the value that defines the contracted payment methodology for this claim line. EXAMPLE: 2 = Fee for Service Code Description 1 Capitation 2 Fee for Service 3 Percent of Charges 4 DRG 5 Pay for Performance 6 Global Payment 7 Other 8 Bundled Payment	All	98.0%
96	PC119	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%

Pharmacy Claims Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
97	PC120	APCD ID Code	4/1/2013	Lookup Table - Integer	1	Member Enrollment Type	Report the value that describes the member's / subscriber's enrollment into one of the predefined categories; aligns enrollment to appropriate editing and thresholds. EXAMPLE: 1 = FIG - Fully Insured Commercial Group Enrollee. Code Description 1 FIG - Fully -Insured Commercial Group Enrollee 2 SIG - Self-Insured Group Enrollee 3 State or Federal Employer Enrollee 4 Individual - Non-Group Enrollee 5 Supplemental Policy Enrollee 6 ICO - Integrated Care Organization 0 Unknown / Not Applicable	All	100.0%
98	PC899	Record Type	4/1/2013	Text	2	File Type Identifier	Report PC here. This validates the type of file and the data contained within the file. This must match HD004	All	100.0%
TR-PC	TR001	Record Type	10/7/2013	Text	2	Trailer Record Identifier	Report TR here. Indicates the end of the data file.	Mandatory	100.0%
TR-PC	TR002	Submitter	10/7/2013	Text	8	Trailer Submitter /Carrier ID defined by AHCT	Report unique Submitter ID here. AHCT will provide this unique identifier to the carrier. This must match the Submitter ID reported inHD002.	Mandatory	100.0%
TR-PC	TR003	National Plan ID	10/7/2013	Text	10	CMS National Plan Identification Number (Plan ID)	Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	Situational	0.0%
TR-PC	TR004	Type of File	10/7/2013	Text	2	Validates the file type defined inHD004.	Report PC here. This must match the File Type reported in HD004.	Mandatory	100.0%
TR-PC	TR005	Period Beginning Date	10/7/2013	Full Date - Integer	8	Trailer Period Start Date	Report the Year, Month and Day of the reported submission period in YYYYMMDD format. This date is the first day of the month for the reporting period and must match the date reported in HD005.	Mandatory	100.0%
TR-PC	TR006	Period Ending Date	10/7/2013	Full Date - Integer	8	Trailer Period Ending Date	Report the Year, Month and Day of the reported submission period in YYYYMMDD format. This date is the last day of the month for the reporting period and must match the date reported in HD006.	Mandatory	100.0%
TR-PC	TR007	Date Processed	10/7/2013	Full Date - Integer	8	Trailer Processed Date	Report the full date that the submission was compiled by the submitter in YYYYMMDD Format.	Mandatory	100.0%

*These remain consistent across all file types (ME, MC, PC, DC).

Dental Claims Data Contents Guide
12/5/2013

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
HD-DC	HD001	Record Type	10/7/2013	Text	char[2]	Header Record Identifier	Report HD here. Indicates the beginning of the Header Elements of the file.	Mandatory	100%	n/a
HD-DC	HD002	Submitter	10/7/2013	Integer	varchar[6]	Header Submitter / Carrier ID defined by AHCT	Report unique Submitter ID here. AHCT will provide this unique identifier to the carrier. TR002 must match the Submitter ID reported here. This ID is linked to other elements in the file for quality control.	Mandatory	100%	n/a
HD-DC	HD003	National Plan ID	10/7/2013	Integer	int[10]	Header CMS National Plan Identification Number (PlanID)	Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	Situational	0%	n/a
HD-DC	HD004	Type of File	10/7/2013	Text	char[2]	Defines the file type and data expected.	Report **DC** here. Indicates that the data within this file is expected to be MEDICAL CLAIM-based. This must match the File Type reported in TR004.	Mandatory	100%	n/a
HD-DC	HD005	Period Beginning Date	10/7/2013	Full Date - Integer	int[8]	Header Period Start Date	Report the Year and Month of the reported submission period in YYYYMMDD format. This date period must be repeated in HD006, TR005 and TR006. This same date must be selected in the upload application for successful transfer.	Mandatory	100%	n/a
HD-DC	HD006	Period Ending Date	10/7/2013	Full Date - Integer	int[8]	Header Period Ending Date	Report the Year and Month of the reporting submission period in YYYYMMDD format. This date period must match the date period reported in HD005 and be repeated in TR005 and TR006.	Mandatory	100%	n/a
HD-DC	HD007	Record Count	10/7/2013	Integer	varchar[10]	Header Record Count	Report the total number of records submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters.	Mandatory	100%	n/a
HD-DC	HD008	Comments	10/7/2013	Text	varchar[80]	Header Carrier Comments	May be used to document the submission by assigning a filename, system source, compile identifier, etc.	Optional	0%	n/a
HD-DC	HD009	APCD Version Number	10/7/2013	Decimal - Numeric	char[3]	Submission Guide Version	Report the version number as presented on the APCD Medical Claim File Submission Guide in 0.0 Format. Sets the intake control for editing elements. Version must be accurate else file will drop. EXAMPLE: 3.0 = Newest Version	Mandatory	100%	n/a
						Code	**Description**			
						1.2	Current Version; required for reporting periods as of October 2013			
1	DC001	Submitter	7/2/2013	Integer	varchar[6]	CT APCD defined and maintained unique identifier	Report the Unique Submitter ID as defined by CT APCD here. This must match the Submitter ID reported in HD002	All	100%	Loop 1000A Segment NM109

Dental Claims Data Contents Guide
12/5/2013

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
2	DC002	National Plan ID	7/2/2013	Text	int[10]	CMS National Plan Identification Number (PlanID)	Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	All	0%	n/a
3	DC003	Insurance Type Code / Product	7/2/2013	Lookup Table - Text	char[2]	Type / Product Identification Code	Report the code that defines the type of insurance under which this patient's claim line was processed. **EXAMPLE:** 17 = Dental Maintenance Organization	All	100%	n/a
						Code	***Description***			
						9	Self-pay			
						11	Other Non-Federal Programs * (use of this value requires disclosure to Data Manager prior to submission)			
						12	Preferred Provider Organization (PPO) *			
						13	Point of Service (POS) *			
						14	Exclusive Provider Organization (EPO) *			
						15	Indemnity Insurance *			
						16	Health Maintenance Organization (HMO) Medicare Risk *			
						17	Dental Maintenance Organization (DMO) *			
						96	Husky Health A			
						97	Husky Health B			
						98	Husky Health C			
						99	Husky Health D			
						AM	Automobile Medical *			
						CH	Champus (now TRICARE) *			
						CI	Commercial Insurance			
						DS	Disability *			
						HM	Health Maintenance Organization *			
						LM	Liability Medical *			
						MA	Medicare Part A *			
						MB	Medicare Part B *			
						MC	Medicaid *			
						OF	Other Federal Program * (use of this value requires disclosure to Data Manager prior to submission)			
						TV	Title V *			
						VA	Veterans Affairs Plan *			
						WC	Workers' Compensation *			
						ZZ	Mutually Defined * (use of this value requires disclosure to Data Manager prior to submission)			
4	DC004	Payer Claim Control Number	7/2/2013	Text	varchar[35]	Payer Claim Control Identification	Report the Unique identifier within the payer's system that applies to the entire claim.	All	100%	Loop 2300 Segment CLM01
5	DC005	Line Counter	7/2/2013	Integer	varchar[4]	Incremental Line Counter	Report the line number for this service within the claim. Start with 1 and increment by 1 for each additional line. Do not start with 0, include alphas or special characters.	All	100%	Loop 2400 Segment LX01
6	DC005A	Version Number	7/2/2013	Integer	varchar[4]	Claim Service Line Version Number	Report the version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line. No alpha or special characters.	All	100%	n/a
7	DC006	Insured Group or Policy Number	7/2/2013	Text	varchar[30]	Group / Policy Number	Report the number that defines the insured group or policy. Do not report the number that uniquely identifies the subscriber or member.	All	98%	n/a

Dental Claims Data Contents Guide
12/5/2013

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
8	DC007	Subscriber SSN	7/2/2013	Numeric	char[9]	Subscriber's Social Security Number	Report the Subscriber's SSN here; used to validate Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here.	All	75%	Loop 2010BA Segment REF02 where REF01 - SY
9	DC008	Plan Specific Contract Number	7/2/2013	Text	varchar[30]	Contract Number	Report the Plan assigned contract number. Do not include values in this element that will distinguish one member of the family from another. This should be the contract or certificate number for the subscriber and all of the dependents.	All	98%	Loop 2300 Segment CN104
10	DC009	Member Suffix or Sequence Number	7/2/2013	Text	varchar[20]	Member/Patient's Contract Sequence Number	Report the unique number / identifier of the member / patient within the contract	All	98%	n/a
11	DC010	Member SSN	7/2/2013	Numeric	char[9]	Member/Patient's Social Security Number	Report the patient's social security number here; used to validate Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here	All	75%	Loop 2010BA Segment REF02 where REF01 = SY when Segment SBR02 = 18 - ELSE - Loop 2010CA Segment REF02 where REF01 = SY
12	DC011	Individual Relationship Code	10/30/2013	Lookup Table - Text	varchar[2]	Patient to Subscriber Relationship Code	Report the value that defines the Patient's relationship to the Subscriber. **EXAMPLE:** 1 = Spouse	All	98%	When present Loop 2000B SBR02 = 18 - ELSE - Loop 2000C Segment PAT01
						Code	***Description***			
						1	Spouse			
						4	Grandfather or Grandmother			
						5	Grandson or Granddaughter			
						7	Nephew or Niece			
						10	Foster Child			
						12	Other Adult			
						15	Ward			
						17	Stepson or Stepdaughter			
						19	Child			
						20	Self / Employee			
						21	Unknown			
						22	Handicapped Dependent			
						23	Sponsored Dependent			
						24	Dependent of a Minor Dependent			
						29	Significant Other			
						32	Mother			
						33	Father			
						34	Other Adult			
						36	Emancipated Minor			
						39	Organ Donor			
						40	Cadaver Donor			
						41	Injured Plaintiff			
						43	Child Where Insured Has No Financial Responsibility			
						53	Life Partner			
						76	Dependent			
13	DC012	Member Gender	7/2/2013	Lookup Table - Text	char[1]	Patient's Gender	Report patient gender as found on the claim in alpha format. Used to validate clinical services when applicable and Unique Member ID. **EXAMPLE:** F = Female	All	100%	Loop 2010BA Segment DMG03 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment DMG03
						Code	***Description***			

Dental Claims Data Contents Guide
12/5/2013

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
						F	Female			
						M	Male			
						O	Other			
						U	Unknown			
14	DC013	Member Date of Birth	7/2/2013	Full Date - Integer	int[8]	Member/Patient's date of birth	Report the date the member / patient was born in YYYYMMDD Format. Used to validate Unique Member ID.	All	99%	Loop 2010BA Segment DMG02 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment DMG02
15	DC014	Member City Name	7/2/2013	Text	varchar[50]	City name of the Member/Patient	Report the city name of the member / patient. Used to validate Unique Member ID	All	99%	Loop 2010BA Segment N401 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment N401
16	DC015	Member State	7/2/2013	External Code Source - USPS	char[2]	State / Province of the Patient	Report the state of the patient as defined by the US Postal Service. Report Province when Country Code does not = USA	All	100%	Loop 2010BA Segment N402 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment N402
17	DC016	Member ZIP Code	7/2/2013	External Code Source - USPS	varchar[9]	Zip Code of the Member / Patient	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	100%	Loop 2010BA Segment N403 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment N403
18	DC017	Date Service Approved (AP Date)	7/2/2013	Full Date - Integer	int[8]	Date Service Approved by Payer	Report the date that the payer approved this claim line for payment in YYYYMMDD Format. This element was designed to capture date other than the Paid date. If Approved Date and Paid Date are the same, then the date here should match Paid Date.	All	100%	n/a
19	DC018	Service Provider Number	7/2/2013	Text	varchar[30]	Service Provider Identification Number	Report the carrier / submitter assigned service provider number. This number should be the identifier used for internal identification purposes, and does not routinely change. The value in this element must match a record in the provider file in PV002.	All	100%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment REF02 where REF01 = G2
20	DC019	Service Provider Tax ID Number	7/2/2013	Numeric	char[9]	Service Provider's Tax ID number	Report the Federal Tax ID of the Service Provider here. Do not use hyphen or alpha prefix.	All	99%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment REF02 where REF01 = EI or SY
21	DC020	National Provider ID - Service	7/2/2013	External Code Source - NPPES	int[10]	National Provider Identification (NPI) of the Service Provider	Report the Primary National Provider ID (NPI) here. This ID should be found on the Provider File in the NPI element (PV039)	All	99%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM109
22	DC021	Service Provider Entity Type Qualifier	7/2/2013	Lookup Table - integer	int[1]	Service Provider Entity Identifier Code	Report the value that defines the provider entity type. Only individuals should be identified with a 1. Facilities, professional groups and clinic sites should all be identified with a 2. **EXAMPLE:** 1 = Person	All	98%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM102 - sets this value = 2 always
						Value	***Description***			
						1	Person			
						2	Non-person entity			
23	DC022	Service Provider First Name	7/2/2013	Text	varchar[25]	First name of Service Provider	Report the individual's first name here. If provider is a facility or organization , do not report any value here	All	98%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM104 when present
24	DC023	Service Provider Middle Name	7/2/2013	Text	varchar[25]	Middle initial of Service Provider	Report the individual's middle name here. If provider is a facility or organization , do not report any value here	All	2%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM105 when present

Dental Claims Data Contents Guide
12/5/2013

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
25	DC024	Service Provider Last Name or Organization Name	7/2/2013	Text	varchar[60]	Last name or Organization Name of Service Provider	Report the name of the organization or last name of the individual provider. DC021 determines if this is an Organization or Individual Name reported here.	All	98%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM103
26	DC025	Carve Out Vendor CT APCD ID	7/2/2013	Integer	varchar[6]	CT APCD defined and maintained Org ID for linking across submitters	Report the CT APCD ID of the Carve Out Vendor here. This element contains the CT APCD assigned organization ID for the Vendor. Contact the CT APCD for the appropriate value. If no Vendor is affiliated with this claim line do not report any value here: i.e., do not repeat the CT APCD ID from MC001	All	98%	n/a
27	DC026	Service Provider Taxonomy	7/2/2013	External Code Source - WPC	varchar[10]	Taxonomy Code	Report the standard code that defines this provider for this line of service. Taxonomy values allow for the reporting of hygienists, assistants and laboratory technicians, where applicable, as well as Dentists, Orthodontists, etc.	All	98%	Assuming Service Provider = Billing Provider: Loop 2000A Segment PRV03
28	DC027	Service Provider City Name	7/2/2013	Text	varchar[30]	City name of the Provider	Report the Providers practice city location	All	98%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment N401
29	DC028	Service Provider State	7/2/2013	External Code Source - USPS	char[2]	State of the Service Provider	Report the state of the service providers as defined by the US Postal Service	All	98%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment N402
30	DC029	Service Provider ZIP Code	7/2/2013	External Code Source - USPS	varchar[9]	Zip Code of the Service Provider	Report the 5 or 9 digit Zip Code as defined by the US Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	98%	Assuming Service Provider = Billing Provider: Loop 2010AA Segment N403
31	DC030	Facility Type - Professional	7/2/2013	External Code Source - CMS	char[2]	Place of Service Code	Report the code the defines the location code where services were performed by the provider referenced on the claim	All	80%	Loop 2300 CLM05-01 where CLM05-02 = B
32	DC031	Claim Status	10/7/2013	Lookup Table - integer	varchar[2]	Claim Line Status	Report the value that defines the payment status of this claim line	All	98%	n/a

Value	*Description*
1	Processed as primary
2	Processed as secondary
3	Processed as tertiary
4	Denied
19	Processed as primary, forwarded to additional payer(s)
20	Processed as secondary, forwarded to additional payer(s)
21	Processed as tertiary, forwarded to additional payer(s)
22	Reversal of previous payment
23	Not our claim, forwarded to additional payer(s)
25	Predetermination Pricing Only - no payment

33	DC032	CDT Code	7/2/2013	External Code Source - ADA	char[5]	HCPCS / CDT Code	Report the Common Dental Terminology code here	All	99%	As Sent by Provider - Loop 2400 Segment SV301-02 -OR- As Adjudicated - Loop 2430 Segment SVD03-02
34	DC033	Procedure Modifier - 1	7/2/2013	External Code Source - AMA	char[2]	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (DC032).	All	0%	As Sent by Provider - Loop 2400 Segment SV301-03 - OR- As Adjudicated - Loop 2430 Segment SVD03-03
35	DC034	Procedure Modifier - 2	7/2/2013	External Code Source - AMA	char[2]	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (DC032).	All	0%	As Sent by Provider - Loop 2400 Segment SV301-04 - OR- As Adjudicated - Loop 2430 Segment SVC03-04

Dental Claims Data Contents Guide
12/5/2013

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
36	DC035	Date of Service - From	7/2/2013	Full Date - Integer	int[8]	Date of Service	Report the date of service for this claim line in YYYYMMDD Format.	All	99%	Loop 2300 Segment DTP03 when DTP02 = D8 where DTP01 = 472; Else first eight digits of Loop 2300 Segment DTP03 when DTP02 = RD8 where DTP01 = 472 - OR - Loop 2400 Segment DTP03 when DTP02 = D8 where DTP01 = 472
37	DC036	Date of Service - To	7/2/2013	Full Date - Integer	int[8]	Date of Service	Report the end service date for the claim line in YYYYMMDD Format; it can equal DC035 when a single date of service is being reported.	All	0%	Loop 2300 Segment DTP03 when DTP02 = D8 where DTP01 = 472; Else last eight digits of Loop 2300 Segment DTP03 when DTP02 = RD8 where DTP01 = 472 - OR - Loop 2400 Segment DTP03 when DTP02 = D8 where DTP01 = 472
38	DC037	Charge Amount	7/2/2013	Integer	±varchar[10]	Amount of provider charges for the claim line	Report the amount the provider billed the insurance carrier for this claim line service. Report 0 for services rendered in conjunction with other services on the claim. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%	Loop 2400 Segment SV302
39	DC038	Paid Amount	7/2/2013	Integer	±varchar[10]	Amount paid by the carrier for the claim line	Report the amount paid for the claim line. Report 0 if line is paid as part of another procedure / claim line. Do not report any value if the line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%	Loop 2430 Segment SVD02
40	DC039	Copay Amount	7/2/2013	Integer	±varchar[10]	Amount of Copay member/patient is responsible to pay	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Copay applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	100%	Loop 2430 Segment CAS03, 06, 09, 12, 15 or 18 where CAS01 = PR and CAS02 = 3
41	DC040	Coinsurance Amount	7/2/2013	Integer	±varchar[10]	Amount of coinsurance member/patient is responsible to pay	Report the amount that defines a calculated percentage amount for this claim line service that the patient is responsible to pay. Report 0 if no Coinsurance applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	100%	Loop 2430 Segment CAS03, 06, 09, 12, 15 or 18 where CAS01 = PR and CAS02 = 2
42	DC041	Deductible Amount	7/2/2013	Integer	±varchar[10]	Amount of deductible member/patient is responsible to pay on the claim line	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Deductible applies to service. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	100%	Loop 2430 Segment CAS03, 06, 09, 12, 15 or 18 where CAS01 = PR and CAS02 = 1
43	DC042	Filler	7/2/2013	Filler	char[0]	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0%	n/a
44	DC043	Member Street Address	7/2/2013	Text	varchar[50]	Street address of the Member/Patient	Report the patient / member's address. Used to validate Unique Member ID.	All	90%	Loop 2010BA Segment N301 when Loop 2000B SBR02 = 18 - ELSE - Loop 2010CA Segment N301

Dental Claims Data Contents Guide
12/5/2013

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
45	DC044	Billing Provider Tax ID Number	7/2/2013	Numeric	char[9]	The Billing Provider's Federal Tax Identification Number (FTIN)	Report the Federal Tax ID of the Billing Provider here. Do not use hyphen or alpha prefix.	All	90%	Loop 2010AA Segment REF02 when REF01 = EI
46	DC045	Paid Date	7/2/2013	Integer	int[8]	Paid date of the claim line	Report the date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment in YYYYMMDD Format. This can be the same date as Processed Date. EXAMPLE: Claims paid in full, partial or zero paid.	Required when DC031 = 01, 02, 03, 19, 20, or 21	100%	Loop 2430 Segment DTP03
47	DC046	Allowed Amount	7/2/2013	Integer	±varchar[10]	Allowed Amount	Report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider contract and most often it is less than or equal to the fee charged by the provider. Report 0 when the claim line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when DC031 does not = 4, 22, or 23	99%	n/a
48	DC047	Tooth Number/Letter	7/2/2013	External Code Source - ADA	varchar[2]	Tooth Number or Letter Identification	Report the tooth identifier(s) when DC032 is within the given range. Report one tooth per line when DC032 = D2000 thru D2999	Required when DC032 = D2000 thru D2999	100%	Loop 2400 Segment TOO02
49	DC048	Dental Quadrant	7/2/2013	External Code Source - ADA	char[10]	Dental Quadrant	Report the standard quadrant identifier from the External Code Source here. Provides further detail on procedure(s).	Required when DC032 indicates procedures of 3 or more consecutive teeth	100%	Loop 2400 Segment SV304-01, and/or SV304-02 and/or SV304-03 and/or SV304-04 and/or SVC304-05
50	DC049	Tooth Surface	7/2/2013	External Code Source - ADA	varchar[5]	Tooth Service Identification	Report the tooth surface(s) that this service relates to per tooth. Provides further detail on procedure.	Required when DC047 is populated	100%	Loop 2400 Segment TOO03-01 and/or TOO03-02 and/or TOO03-03 and/or TOO03-04 and/or TOO03-05
51	DC050	Subscriber Last Name	7/2/2013	Text	varchar[60]	Last name of Subscriber	Report the last name of the subscriber. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. **EXAMPLE:** O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE	All	100%	Loop 2010BA Segment NM103
52	DC051	Subscriber First Name	7/2/2013	Text	varchar[25]	First name of Subscriber	Report the first name of the subscriber here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. **EXAMPLE:** Anne-Marie becomes ANNEMARIE	All	100%	Loop 2010BA Segment NM104
53	DC052	Subscriber Middle Initial	7/2/2013	Text	char[1]	Middle initial of Subscriber	Report the Subscriber's middle initial here. Used to validate Unique Member ID.	All	2%	Loop 2010BA Segment NM105
54	DC053	Member Last Name	7/2/2013	Text	varchar[60]	Last name of Member/Patient	Report the last name of the patient / member here. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. **EXAMPLE**: O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE	All	100%	Loop 2010BA Segment NM103 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment NM103
55	DC054	Member First Name	7/2/2013	Text	varchar[25]	First name of Member/Patient	Report the first name of the patient / member here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. **EXAMPLE:** Anne-Marie becomes ANNEMARIE	All	100%	Loop 2010BA Segment NM104 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment NM104

Dental Claims Data Contents Guide
12/5/2013

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
56	DC055	Member Middle Initial	7/2/2013	Text	char[1]	Middle initial of the Member/Patient	Report the middle initial of the patient / member when available. Used to validate Unique Member ID.	All	2%	Loop 2010BA Segment NM105 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment NM105
57	DC056	Carrier Specific Unique Member ID	7/2/2013	Text	varchar[50]	Member's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to validate Unique Member ID and link back to Member Eligibility (ME107)	All	100%	Loop 2010BA Segment NM109 when Loop 2000B SBR02 = 18 - ELSE - Loop 2010CA Segment NM109
58	DC057	Carrier Specific Unique Subscriber ID	7/2/2013	Text	varchar[50]	Subscriber's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to validate Unique Member ID and link back to Member Eligibility (ME117)	All	100%	Loop 2010BA Segment NM109
59	DC058	Member Street Address 2	7/2/2013	Text	varchar[50]	Secondary Street Address of the Member/Patient	Report the address of member which may include apartment number or suite, or other secondary information besides the street. Used to validate Unique Member ID.	All	2%	Loop 2010BA Segment N302 when Loop 2000B SBR02 = 18 - ELSE - Loop 2010CA Segment N302
60	DC059	Claim Line Type	7/2/2013	Lookup Table - Text	char[1]	Claim Line Activity Type Code	Report the code that defines the claim line status in terms of adjudication. **EXAMPLE:** O = Original	All	98%	n/a
						Code	***Description***			
						O	Original			
						V	Void			
						R	Replacement			
						B	Back Out			
						A	Amendment			
61	DC060	Former Claim Number	7/2/2013	Text	varchar[35]	Previous Claim Number	Report the Claim Control Number (DC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own DC004. Use of "Former Claim Number" to version claims can **only** be used if approved by the APCD. Contact the APCD for conditions of use.	All	0%	n/a
62	DC061	Diagnosis Code	7/2/2013	External Code Source - ICD	varchar[7]	ICD Diagnosis Code	Report the ICD Diagnosis Code when applicable	Required when DC032 is within the ranges of D7000-D7999 or D9220 or D9221	75%	Loop 2300 Segment HI01-02
63	DC062	ICD Indicator	7/2/2013	Lookup Table - Integer	int[1]	International Classification of Diseases version	Report the value that defines whether the diagnoses on claim are ICD9 or ICD10. **EXAMPLE:** 9 = ICD9	Required when DC061 is populated	100%	Set value here based upon value in Loop 2300 Segment HI01-01 starting with the letter A
						Value	***Description***			
						9	ICD-9			
						0	ICD-10			
64	DC063	Denied Flag	7/2/2013	Lookup Table - Integer	int[1]	Denied Claim Line Indicator	Report the value that defines the element. **EXAMPLE:** 1 = Yes, Claim Line was denied.	Required when DC031 = 04	100%	Loop 2430 CAS identification will set APCD value to 1 or 2 - THIS REQUIRES PAYER BY PAYER MAPPING
						Value	***Description***			
						1	Yes			
						2	No			
						3	Unknown			
						4	Other			
						5	Not Applicable			

Dental Claims Data Contents Guide
12/5/2013

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
65	DC064	Denial Reason	7/2/2013	External Code Source - HIPAA **-OR-** Carrier Lookup Table	varchar[20]	Denial Reason Code	Report the code that defines the reason for denial of the claim line. Carrier must submit denial reason codes in separate table to the APCD.	Required when DC063 = 1	100%	Loop 2430 CAS/Carrier Defined Table identification will set APCD value to 1 or 2 - THIS REQUIRES PAYER BY PAYER MAPPING
66	DC065	Payment Arrangement Type	7/2/2013	Lookup Table - Numeric	char[2]	Payment Arrangement Type Value	Report the value that defines the contracted payment methodology for this claim line. **EXAMPLE:** 02 = Fee for Service	All	98%	n/a
						Value	***Description***			
						1	Capitation			
						2	Fee for Service			
						3	Percent of Charges			
						4	DRG			
						5	Pay for Performance			
						6	Global Payment			
						7	Other			
						8	Bundled Payment			
67	DC066	Filler	7/2/2013	Filler	char[0]	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0%	n/a
68	DC067	APCD ID Code	7/2/2013	Lookup Table - Integer	int[1]	Member Enrollment Type	Report the value that describes the member's / subscriber's enrollment into one of the predefined categories; aligns enrollment to appropriate editing and thresholds. **EXAMPLE:** 1 = FIG - Fully Insured Commercial Group Enrollee.	All	100%	n/a
						Value	***Description***			
						1	FIG - Fully-Insured Commercial Group Enrollee			
						2	SIG - Self-Insured Group Enrollee			
						3	State or Federal Employer Enrollee			
						4	Individual - Non-Group Enrollee			
						5	Supplemental Policy Enrollee			
						6	ICO - Integrated Care Organization			
						0	Unknown / Not Applicable			
69	DC068	Bill Frequency Code	7/2/2013	External Code Source - NUBC	char[1]	Bill Frequency	Report the valid frequency code of the claim to indicate version, credit/debit activity and/or setting of claim.	All	100%	Loop 2300 Segment CLM05-03
70	DC899	Record Type	7/2/2013	Text	char[2]	File Type Identifier	Report **DC** here. This validates the type of file and the data contained within the file. This must match HD004	All	100%	n/a
TR-DC	TR001	Record Type	10/7/2013	Text	char[2]	Trailer Record Identifier	Report TR here. Indicates the end of the data file.	Mandatory	100%	n/a
TR-DC	TR002	Submitter	10/7/2013	Integer	varchar[6]	Trailer Submitter / Carrier ID defined by AHCT	Report unique Submitter ID here. AHCT will provide this unique identifier to the carrier. This must match the Submitter ID reported in HD002.	Mandatory	100%	n/a
TR-DC	TR003	National Plan ID	10/7/2013	Integer	int[10]	CMS National Plan Identification Number (PlanID)	Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	Situational	0%	n/a

Dental Claims Data Contents Guide
12/5/2013

Col	Elmt	Data Element Name	Date Modified	Type	Format / Length	Description	Element Submission Guideline	Condition	%	PACDR 837I Map
TR-DC	TR004	Type of File	10/7/2013	Text	char[2]	Validates the file type defined in HD004.	Report **DC** here. This must match the File Type reported in HD004.	Mandatory	100%	n/a
TR-DC	TR005	Period Beginning Date	10/7/2013	Full Date - Integer	int[8]	Trailer Period Start Date	Report the Year and Month of the reported submission period in YYYYMMDD format. This date period must match the date period reported in HD005 and HD006.	Mandatory	100%	n/a
TR-DC	TR006	Period Ending Date	10/7/2013	Full Date - Integer	int[8]	Trailer Period Ending Date	Report the Year and Month of the reporting submission period in YYYYMMDD format. This date period must match the date period reported in TR005 and HD005 and HD006.	Mandatory	100%	n/a
TR-DC	TR007	Date Processed	10/7/2013	Full Date - Integer	int[8]	Trailer Processed Date	Report the full date that the submission was compiled by the submitter in YYYYMMDD Format.	Mandatory	100%	n/a

Provider Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
HD-PV	HD001	Record Type	10/7/2013	Text	2	Header Record Identifier	Report HD here. Indicates the beginning of the Header Elements of the file.	Mandatory	100.0%
HD-PV	HD002	Submitter	10/7/2013	Text	8	Header Submitter/ Carrier ID defined by AHCT	Report unique Submitter ID here. AHCT will provide this unique identifier to the carrier. TR002 must match the Submitter ID reported here. This ID is linked to other elements in the file for quality control.	Mandatory	100.0%
HD-PV	HD003	National Plan ID	10/7/2013	Text	10	Header CMS National Plan Identification Number (Plan ID)	Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	Situational	0.0%
HD-PV	HD004	Type of File	10/7/2013	Text	2	Defines the file type and data expected.	This field must be coded PV to indicate submission of provider data. This must match the File Type reported inTR004.	Mandatory	100.0%
HD-PV	HD005	Period Beginning Date	10/7/2013	Integer	8	Header Period Start Date	Report the Year, Month and Day of the reported submission period in YYYYMMDD format. This date is the first day of the month for the reporting period and must be repeated in TR005.	Mandatory	100.0%
HD-PV	HD006	Period Ending Date	10/7/2013	Integer	8	Header Period Ending Date	Report the Year, Month and Day of the reported submission period in YYYYMMDD format. This date is the last day of the month for the reporting period and must be repeated in TR006.	Mandatory	100.0%
HD-PV	HD007	Record Count	10/7/2013	Integer	10	Header Record Count	Report the total number of records submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters.	Mandatory	100.0%
HD-PV	HD008	Comments	10/7/2013	Text	80	Header Carrier Comments	May be used to document the submission by assigning a filename, system source, compile identifier, etc.	Optional	0.0%
HD-PV	HD009	APCD Version Number	10/7/2013	Decimal - Numeric	5	Submission Guide Version	Report the version number as presented on the APCD Medical Claim File Submission Guide in 0.0Format. Sets the intake control for editing elements. Version must be accurate else file will drop. EXAMPLE: 3.0 = Newest Version Code Description 1.2 Current Version; required for reporting periods as of October 2013	Mandatory	100.0%
1	PV001	Submitter	4/1/2013	Text	8	CT APCD defined and maintained unique identifier	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the reporting state and the third character designates the type of submitter. For Connecticut's APCD collection, valid prefixes include: CTC ..... Commercial carrier CTG ..... Governmental agency CTT ..... Third-party administrator Notes: A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	All	100.0%
2	PV002	Plan Provider ID	4/1/2013	Text	30	Carrier Unique Provider Code	Report the submitter assigned unique number for every service provider (persons, facilities or other entities involved in claims transactions) that it has in its system(s). This field may or may not contain the provider NPI, but should not contain an individual's SSN. NOTE: ID Link to PV056, ME036, ME046 MC024, MC076, MC112, MC125, MC134, PC043, PC050, PC059, DC018	All	100.0%

Provider Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
3	PV003	Tax ID	4/1/2013	Text	9	Federal Tax ID of non-individual Provider	Report the Federal Tax ID of the Provider here. Do not use hyphen or alpha prefix.	Required when PV034 = 2, 3, 4, 5, 6, 7, or 0	98.0%
4	PV004	UPIN ID	4/1/2013	Text	6	Unique Physician ID	Report the UPIN for the Provider identified in PV002. To report other Medicare Identifiers use PV036	Required when PV034 = 1	0.0%
5	PV005	DEA ID	4/1/2013	Text	9	Provider DEA	Report the valid DEA ID of the individual, group or facility defined by PV002. If not available or applicable, do not report any value here.	Required when PV034 = 0, 1, 2, 3, 4, or 5	50.0%
6	PV006	License ID	4/1/2013	Text	25	State practice license ID	Report the state license number for the provider identified in PV002. For a doctor this is the medical license for a non-doctor this is the practice license. Do not use zero-fill. If not available, or not applicable, such as for a group or corporate entity, do not report any value here.	All	98.0%
8	PV008	Last Name	4/1/2013	Text	50	Last name of the Provider in PV002	Report the individual's last name here. Do not report any value here for facility or non-individual provider records. Report non-person entities in PV012 Facility Name	Required when PV034 = 1	98.0%
9	PV009	First Name	4/1/2013	Text	50	First name of the Provider in PV002	Report the individual's first name here. Do not report any value here for facility or non-individual provider records. Report non-person entities in PV012 Facility Name	Required when PV034 = 1	98.0%
10	PV010	Middle Initial	4/1/2013	Text	1	Middle initial of the Provider in PV002	Report the individual's middle initial here. Do not report any value here for facility or non-individual provider records. Report non-person entities in PV012 Facility Name	Required when PV034 = 1	1.0%
11	PV011	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
12	PV012	Entity Name	4/1/2013	Text	100	Group / Facility name	Report the Provider Entity Name when Punctuation may be included. This should only be populated for facilities or groups.	Required when PV034 = 2, 3, 4, 5, 6, 7, or 0	98.0%
14	PV014	Gender Code	4/1/2013	Lookup Table - Text	1	Gender of Provider identified in PV002	Report provider gender in alpha format as found on certification, contract and / or license. F ..... Female M..... Male U ..... Unknowr	Required when PV034 = 1	98.0%
15	PV015	Provider Date of Birth	7/2/2013	Integer	8	Birth date of the provider	Report the individual's date of birth in CCYYMMDD Format. Data reported here is used to create unique providers with similar attributes. Do not report any values here for non-individuals	Required when PV034 = 1	50.0%
16	PV016	Provider Street Address 1	4/1/2013	Text	50	Street address of the Provider	Report the physical street address where provider sees plan members. If only mailing address is available, please send the mailing address in this field in addition to putting it in the mailing address field. If the provider sees members at two locations the provider should have a unique record for each to capture each site where the provider practices.	All	98.0%
17	PV017	Provider Street Address 2	4/1/2013	Text	50	Street Address 2 of the Provider	Report the physical street address where provider sees plan members. If only mailing address is available, please send the mailing address in this field in addition to putting it in the mailing address field. If the provider sees members at two locations the provider should have a unique record for each to capture each site where the provider practices.	All	2.0%

Provider Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
18	PV018	City Name	4/1/2013	Text	35	City of the Provider	Report the city name where provider sees plan members. If only mailing address is available, please send the mailing address in this field in addition to putting it in the mailing address field. If the provider sees members at two locations the provider should have a unique record for each to capture each site where the provider practices.	All	98.0%
19	PV019	State Code	4/1/2013	External Code Source - USPS - Text	2	State of the Provider	Report the state of the site in which the provider sees plan members. When only a mailing address is available, populate with mailing state here as well as PV026. When a provider sees patients at two or more locations, the provider should have a unique record for each location to capture all possible practice sites.	All	98.0%
20	PV020	Country Code	4/1/2013	External Code Source - ANSI - Text	3	Country Code of the Provider	Report the three-character country code as defined by ISO 3166-1, Alpha 3	All	98.0%
21	PV021	Zip Code	4/1/2013	External Code Source - USPS - Text	9	Zip code of the Provider	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	98.0%
22	PV022	Taxonomy	4/1/2013	External Code Source WPC - Text	10	Taxonomy Code	Report the standard code that defines this provider for this line of service. Taxonomy values allow for the reporting of many types of clinicians, assistants and technicians, where applicable, as well as Physicians, Nurses, Groups, Facilities, etc.	Required when PV034 = 0, 1, 2, 3, 4, or 5	75.0%
23	PV023	Mailing Street Address1 Name	4/1/2013	Text	50	Street address of the Provider / Entity	Report the mailing address of the Provider / Entity in PV002	All	98.0%
24	PV024	Mailing Street Address2 Name	4/1/2013	Text	50	Secondary Street address of the Provider / Entity	Report the mailing address of the Provider / Entity in PV002	All	2.0%
25	PV025	Mailing City Name	4/1/2013	Text	35	City name of the Provider / Entity	Report the mailing city address of the Provider / Entity in PV002	All	98.0%
26	PV026	Mailing State Code	4/1/2013	External Code Source USPS - Text	2	State name of the Provider / Entity	Report the mailing state address of the Provider / Entity in PV002	All	98.0%
27	PV027	Mailing Country Code	4/1/2013	External Code Source USPS - Text	3	Country name of the Provider / Entity	Report the three-character country code as defined by ISO 3166-1, Alpha 3	All	98.0%
28	PV028	Mailing Zip Code	4/1/2013	External Code Source USPS - Text	9	Zip code of the Provider	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	98.0%
30	PV030	Primary Specialty Code	4/1/2013	External Code Source 4 -Text	2	Specialty Code	Report the standard Primary Specialty code of the Provider here	Required when PV034 = 0, 1, 2, 3, 4, or 5	98.0%

Provider Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
34	PV034	Provider ID Code	4/1/2013	Lookup Table - Integer	1	Provider Identification Code	Report the value that defines type of entity associated with PV002. The value reported here drives intake edits for quality purposes. EXAMPLE: 1 = Person; Physician, Clinician, Orthodontist, etc. Code Description 1 Person; physician, clinician, orthodontist, and any individual that is licensed/certified to perform health care services. 2 Facility; hospital, health center, long term care, rehabilitation and any building that is licensed to transact health care services. 3 Professional Group; collection of licensed/certified health care professionals that are practicing health care services under the same entity name and Federal Tax Identification Number. 4 Retail Site; brick-and-mortar licensed/certified place of transaction that is not solely a health care entity, i.e., pharmacies, independent laboratories, vision services. 5 E-Site; internet-based order/logistic system of health care services, typically in the form of durable medical equipment, pharmacy or vision services. Address assigned should be the address of the company delivering services or order fulfillment. 6 Financial Parent; financial governing body that does not perform health care services itself but directs and finances health care service entities, usually through a Board of Directors. 7 Transportation; any form of transport that conveys a patient to/from a healthcare provider 0 Other; any type of entity not otherwise defined that performs health care services.	All	100.0%
35	PV035	SSN Id	4/1/2013	Text	9	Provider's Social Security Number	Report the SSN of the individual provider in PV002. Do not zero-fill. Do not report any value here if not available or not applicable.	Required when PV034 = 1	98.0%
36	PV036	Medicare ID	4/1/2013	Text	30	Provider's Medicare Number, other than UPIN	Report the Medicare ID (OSCAR, Certification, Other, Unspecified, NSC or PIN) of the provider or entity in PV002. Do not report UPIN here, see PV004.	Required when PV034 = 0, 1, 2, 3, 4, or 5	50.0%
37	PV037	Start Date	7/2/2013	Integer	8	Provider Start Date	Report the date the provider becomes eligible / contracted to perform services as In-Network under any plan offering for plan members in CCYYMMDD Format.	Required when PV064 = 1	100.0%
38	PV038	End Date	7/2/2013	Integer	8	Provider End Date	Report the date the provider is no longer eligible / contracted to perform services as In-Network for all plan offerings for plan members in CCYYMMDD Format. Annually contracted providers can report the contract end date here as a future date.	Required when PV064 = 1	10.0%
39	PV039	National Provider ID	4/1/2013	External Code Source NPPES - Text	10	National Provider Identification (NPI) of the Provider	Report the NPI of the Provider / Clinician / Facility / Organization defined in this record	Required when PV034 = 0, 1, 2, 3, 4, or 5	98.0%
40	PV040	National Provider ID 2	4/1/2013	External Code Source NPPES - Text	10	National Provider Identification (NPI) of the Provider	Report the Secondary or Other NPI of the Provider / Clinician / Facility / Organization defined in this record	Required when PV034 = 0, 1, 2, 3, 4, or 5	0.0%
41	PV041	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%

Provider Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
42	PV042	Secondary Specialty Code	4/1/2013	Carrier Defined Table - Text	10	Specialty Code	Report the submitter's proprietary specialty code for the provider here. Known additional specialty code for a provider should be populated in elements PV043 and PV044. Value comes from a Carrier Defined Table only	Required when PV034 = 0, 1, 2, 3, 4, or 5	1.0%
43	PV043	Other Specialty Code 3	4/1/2013	Carrier Defined Table - OR - External Code Source 4 - Text	10	Specialty Code	See mapping notes for primary specialty code in PV030. Known additional specialty code for a provider should be populated in this field. Value can come from either a Carrier Defined Table or the External Code Source	Required when PV034 = 0, 1, 2, 3, 4, or 5	0.0%
44	PV044	Other Specialty Code 4	4/1/2013	Carrier Defined Table - OR - External Code Source 4 - Text	10	Specialty Code	See mapping notes for primary specialty code in PV030. Known additional specialty code for a provider should be populated in this field. Value can come from either a Carrier Defined Table or the External Code Source	Required when PV034 = 0, 1, 2, 3, 4, or 5	0.0%
44-45	PV045 - PV046	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
47	PV047	Uses Electronic Health Records	4/1/2013	Lookup Table - Integer	1	Indicator - EHR Utilization	Report the value that defines the element. EXAMPLE: 1 = Yes, provider uses Electronic Health Records Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
48-51	PV048 - PV051	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
52	PV052	Has multiple offices	4/1/2013	Lookup Table - Integer	1	Indicator - Multiple Office Provider	Report the value that defines the element. EXAMPLE: 1 = Yes, provider has multiple offices. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	Required when PV034 = 1, 2, or 3	100.0%
53	PV053	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
54	PV054	Medical / Healthcare Home ID	4/1/2013	Text	30	Medical Home Identification Number	Report the identifier of the patient-centered medical home the provider is linked-to here. The value in this field must have a corresponding Provider ID (PV002) in this or a previously submitted provider file.	Require when PV034 = 1, 2, or 3	0.0%

Provider Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
55	PV055	PCP Flag	4/1/2013	Lookup Table - Integer	1	Indicator - Provider is a PCP	Report the value that defines the element. EXAMPLE: 1 = Yes, provider is a PCP. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	Required when PV034 = 1	100.0%
56	PV056	Provider Affiliation	4/1/2013	Text	30	Provider Affiliation Code	Report the Provider ID for any affiliation the provider has with another entity or parent company. If the provider is associated only with self, record the same value here as PV002.	All	99.0%
57	PV057	Provider Telephone	4/1/2013	Numeric	10	Telephone number associated with the provider identified in PV002	Report the telephone number of the provider associated with the identification in PV002. Do not separate components with hyphens, spaces or other special characters	All	10.0%
58	PV058	Delegated Provider Record Flag	7/2/2013	Integer	1	Indicator - Delegated Record	Report the value that defines the element. EXAMPLE: 1 = Yes, provider record was sourced from a delegated provider resource system. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	All	100.0%
59-63	PV059 - PV063	Filler	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data	All	0.0%
64	PV064	PPO Indicator	4/1/2013	Lookup Table - Integer	1	Indicator - Provider PPO Contract	Report the value that defines the element. EXAMPLE: 1 = Yes, provider is a contracted network provider. Code Description 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	Required when PV034 = 0, 1, 2, 3, 4, or 5	100.0%
71	PV899	Record Type	4/1/2013	Text	2	File Type Identifier	Report PV here. This validates the type of file and the data contained within the file. This must match HD004	All	100.0%
TR-PV	TR001	Record Type	10/7/2013	Text	2	Trailer Record Identifier	Report TR here. Indicates the end of the data file.	Mandatory	100.0%
TR-PV	TR002	Submitter	10/7/2013	Text	8	Trailer Submitter /Carrier ID defined by AHCT	Report unique Submitter ID here. AHCT will provide this unique identifier to the carrier. This must match the Submitter ID reported inHD002.	Mandatory	100.0%
TR-PV	TR003	National Plan ID	10/7/2013	Text	10	CMS National Plan Identification Number (Plan ID)	Do not report any value here until National Plan ID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	Situational	0.0%
TR-PV	TR004	Type of File	10/7/2013	Text	2	Validates the file type defined inHD004.	Report PV here. This must match the File Type reported in HD004.	Mandatory	100.0%

Provider Data Contents Guide
12/5/2013

Col	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
TR-PV	TR005	Period Beginning Date	10/7/2013	Integer	8	Trailer Period Start Date	Report the Year, Month and Day of the reported submission period in YYYYMMDD format. This date is the first day of the month for the reporting period and must match the date reported in HD005.	Mandatory	100.0%
TR-PV	TR006	Period Ending Date	10/7/2013	Integer	8	Trailer Period Ending Date	Report the Year, Month and Day of the reported submission period in YYYYMMDD format. This date is the last day of the month for the reporting period and must match the date reported in HD006.	Mandatory	100.0%
TR-PV	TR007	Date Processed	10/7/2013	Full Date - Integer	8	Trailer Processed Date	Report the full date that the submission was compiled by the submitter in YYYYMMDD Format.	Mandatory	100.0%

Appendix – External Code Sources

1. Countries

American National Standards Institute

http://www.iso.org/iso/home/standards/country_codes.htm

MC070	PC024A	PV020	PV027

2. States, Zip Codes and Other Areas of the US

U.S. Postal Service

https://www.usps.com/send/official-abbreviations.htm

MC015	MC016	MC034	MC035	ME016	ME017	ME078	ME109	ME110
PC015	PC016	PC023	PC024	PC054	PC055	DC015	DC016	DC028
DC029	PV019	PV021	PV026	PV028				

3. National Provider Identifiers

National Plan & Provider Enumeration System

https://nppes.cms.hhs.gov/NPPES/

MC026	MC077	ME038	PC021	PC048	DC020	PV039	PV040

4. Health Care Provider Taxonomy

Washington Publishing Company

http://www.wpc-edi.com/reference/