Data Submission Companion Guide

Connecticut All-Payer Claims Database (CT APCD)

Operated in Partnership with Access Health CT

DSG Version: 1.2
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Welcome

First things first: Welcome to the Connecticut All-Payer Claims Database (CT APCD).

The CT APCD was established for the purpose of collecting, assessing and reporting healthcare information relating to safety, quality, cost-effectiveness, access, and efficiency for all levels of healthcare. The APCD is overseen by Access Health CT (AHCT), which also operates the state's health insurance exchange.

Your organization will play a critical part in creating this important resource, providing the foundational data needed to enhance understanding of the use, cost, quality, and delivery of healthcare across Connecticut. We're glad you're part of this exciting initiative — and we're here to help.

We're Onpoint Health Data, Access Health CT's contracted vendor to perform data integration, enhancement, and reporting in support of the broad use and understanding of the APCD's data. We've been doing this work for more than 15 years, helping launch seven statewide APCDs from Maine to Minnesota. We're a nonprofit company committed to a singular mission: advancing informed decision making by providing independent and reliable health data services.

We'll work closely with you to help explain Connecticut's submission requirements and how to meet them as efficiently as possible. This *CT APCD Data Submission Companion Guide* is the place to start. On the following pages, we'll outline the process from start to finish, walking you through each step of working with Onpoint CDM (Claims Data Manager), our data integration solution for commercial, Medicaid, and Medicare files alike.

For new submitters, this is the place to familiarize yourself with the particulars of data submissions, including information on how data fields should be prepared, how to protect and transmit data for the CT APCD, and who to contact when questions arise. For submitters already familiar with Onpoint, these pages may provide a helpful refresher on coding specifications and program milestones. Whether new or veteran, welcome! We're glad you're part of the CT APCD.

Introductions

About Access Health CT

Access Health CT (AHCT), Connecticut's official health insurance marketplace, is a quasi-public agency created by the Connecticut legislature in 2011 to satisfy requirements of the federal Affordable Care Act. AHCT's mission is to increase the number of insured residents in Connecticut, promote health, lower costs, and eliminate health disparities. Connecticut residents and small business owners can compare and enroll in health care coverage and apply for tax credits for individuals through AHCT. AHCT (or the Marketplace) also coordinates eligibility and enrollment with state Medicaid and Children's Health Insurance Programs.

Learn more by visiting their website: www.accesshealthct.com

How to Reach Access Health CT

The state agency serving as the primary contact for the CT APCD is Access Health CT, the state's health insurance exchange. For questions about the APCD's statutory regulations and other issues under the State's purview, including submission compliance, please use the contact information below.

855-805-4325 (Eastern)

questions@accesshealthct.com

www.accesshealthct.com

Access Health CT
280 Trumbull Street, 15th Floor
Hartford, CT 06103

About Onpoint Health Data

Onpoint Health Data is Access Health CT's contracted vendor for the collection, cleansing, validation, and consolidation of all CT APCD submissions. We are a Maine-based independent, nonprofit organization formed in 1976 by key stakeholders from the state's healthcare community. We are a full-service health data organization with two primary divisions: Data Management Services and Analytic Services. Our Data Management Services team — data intake specialists, data architects, and systems and data analysts — collect and integrate data from payers, helping them meet our clients' quality thresholds. Onpoint's Analytics Services team — additional systems analysts, quality assurance staff, health services researchers, and senior consultants — put the data to use through customized analysis, reporting, data linkage, and Business Intelligence tools.

Learn more by visiting us online: www.onpointhealthdata.org

How to Reach Onpoint

Onpoint's data intake specialists are available to answer your questions regarding the mechanics of APCD collection, access to Onpoint's SFTP server, and technical issues regarding the population, intent, or contents of submitted fields. We can be reached using the information below.

207-623-2555, 8:00am – 4:30pm (Eastern)

ahct-support@onpointhealthdata.org

www.onpointcdm.org

Onpoint Health Data
Attn: CT APCD Intake Specialist
254 Commercial Street, Suite 257
Portland, ME 04101

Data Submission Requirements

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 CT APCD "Policies and Procedures" (Release Date: 12/05/2013; link) and official Data Submission Guide (Release Date: 12/05/2013; link). (Note that the submission of dental claims is not yet required for the CT APCD.)

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 the DSG. The documentation should include a detailed description of how the data extracts are created and how the requirements of the DSG and the rule are accomplished, including specifications on what data is being excluded and the parameters that define that excluded data. (Please note: This documentation is not being required of Reporting Entities at this time.)

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.

Mandatory re-registration is due each year prior to October 1 to ensure that the State's records are kept current. The registration form, which will be administered by Onpoint, shall indicate whether the Reporting Entity is processing claims for members and, if applicable, the types of coverage and current enrollment in each coverage type as of the October 1 of the registration year. Please see Access Health CT's formal "Policies and Procedures" for the CT APCD, adopted by the Board of Directors on December 5, 2013 (link).

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 time span 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; for 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, 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

a. 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

Onpoint leverages a managed file transfer application for secure file transfer and receipt. Data for the CT APCD must be transferred over an encrypted tunnel via secure file transfer protocol (SFTP). Onpoint's SFTP server is accessible from a wide range of SFTP client utilities and open-source solutions (e.g., WinSCP, FileZilla, etc.) as well as through a Hypertext Transfer Protocol Secure (HTTPS) online portal (https://sftp.onpointhealthdata.org).

SFTP submissions to Onpoint must be both encrypted using the OpenPGP standard and signed by the sender prior to transfer to ensure file integrity. Onpoint's SFTP server accepts files of any size and offers submitters an approach that can be fully scripted on their end to facilitate automation. To establish SFTP connectivity with us, please email our CT APCD support team at ahct-support@onpointhealthdata.org for an SFTP registration form.

After we have received and processed your SFTP registration information, we will send an email to your designated lead SFTP technical contact, including all necessary access information and (in separate emails) an assigned user name and a temporary password. Upon logging in for the first time, your contact will be prompted to change this temporary password to one of their choosing.

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). Milestones & Timeline

Table 1. Timeline for Key Milestones as Outlined in the CT APCD Policies and Procedures

Phase	Event	Previous Step	Days Since Previous Step
Administration	Individual submitter kick-off meetings	N/A	N/A
	Final data specifications for the *CT APCD Data Submission Guide* released (in Excel format) January 16, 2015	N/A	N/A
Initial Data Submissions Data Range: 1/1 2012 – 12/31/2012	Reporting entities submit **initial** files to Onpoint: The official CT APCD DSG states that these first files should include one full year of data for each file type (i.e., eligibility, medical claims, pharmacy claims, and provider data). However, we recommend starting with a single month of data for medical and pharmacy claims to avoid the need for resubmitting large files as we work together to validate your first data sets. Once this first month is approved for production, the remaining 11 months should be sent. The expectation for these "test files" is that the following steps will have been fully and successfully implemented by January 17, 2016: (a) SFTP connectivity and encryption testing are complete and (b) initial files, using production data, have passed all threshold requirements and data quality validations. **Please note:** While these submissions are referred to as "test files," they should contain production data intended to meet CT APCD data quality standards. Once quality validations are passed, these files will become part of the CT APCD.	Official notice of data collection start date	60 days
Historical Data Submissions Data Range: 1/1/2013 – 12/31/2015	Reporting entities submit **historical** files to Onpoint: 36 months of eligibility, medical claims, pharmacy claims, and provider data (calendar years 2013, 2014, and 2015).	Approval of initial data submissions	60 days
Year-to-Date Submissions Data Range: 1/1/2016 – Current	Reporting entities submit **year-to-date** files to Onpoint: Reporting entities submit current-year eligibility, medical claims, pharmacy claims, and provider data.	Historical data submissions	45 days
Regular Data Submissions (Monthly)	Insurers enter **production** mode with Onpoint: Monthly submission of eligibility, medical claims, pharmacy claims, and provider data .	Year-to-Date Submissions	30 days

Onpoint's testing protocol has been designed to bring reporting entities online as efficiently and accurately as possible. For the CT APCD, we will begin with one complete year — or one month of claims if a reporting entity prefers — of submitted data, evaluating several key components:

- The completeness of individual data elements
- The relationships between data elements
- The relationships between data types (eligibility and claims data)
- Utilization rates, per member per month (PMPM) measures, and longitudinal trends (if a year of data has been submitted)

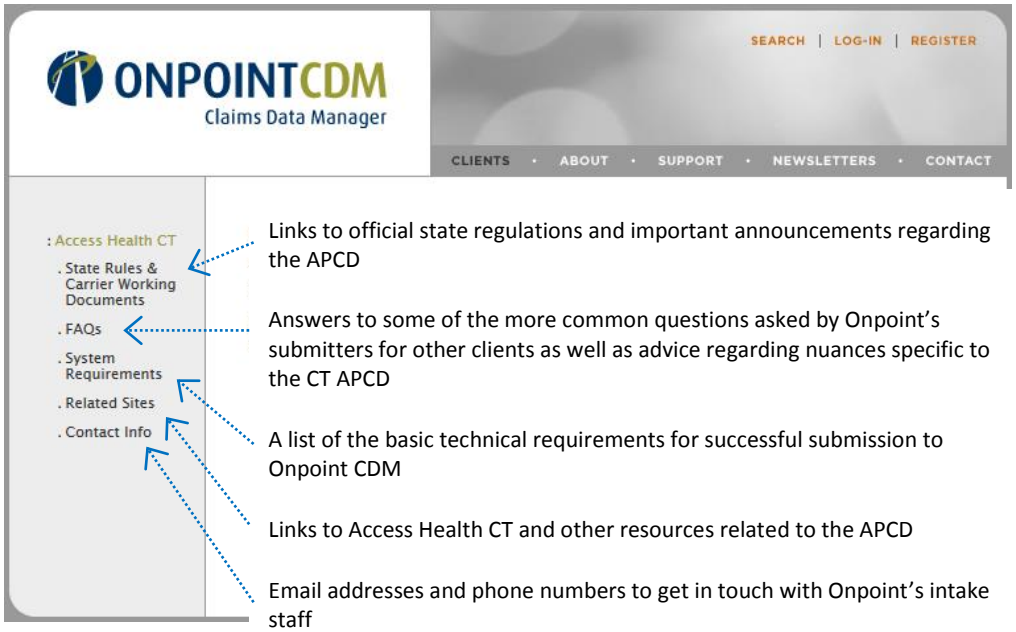
Getting Oriented at Onpoint CDM

Onpoint CDM begins with reporting entity registration and ends with processed, standardized data. In between, it spans a series of complicated steps that include mapping submitters' data, benchmarking data, vetting data against an extensive library of data quality validations, tuning acceptance thresholds, validating intake, verifying quality, mapping identifiers, compiling records, and consolidating the resulting data into an accurate resource for follow-on research and online reporting. Throughout the process, Onpoint CDM's online interface — www.onpointcdm.org — serves as a resource for data reporters and clients alike.

Options at the Public Level

Onpoint CDM's public zone offers quick access to publicly available reference materials, maintenance announcements, answers to frequently asked questions, and links to relevant state agencies and resources (see Figure 1). Onpoint CDM's section for the CT APCD can be found here.

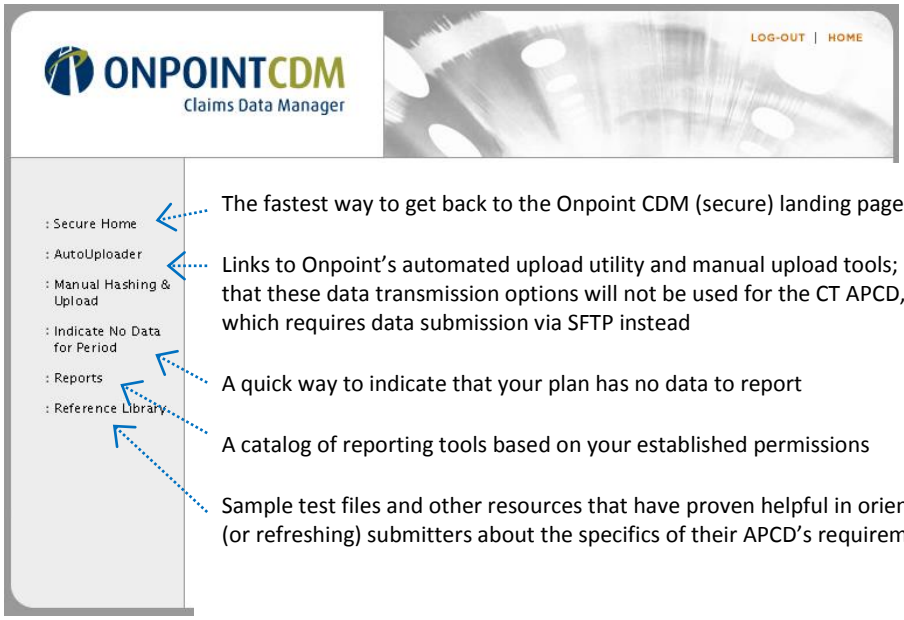
Figure 1. Onpoint CDM Options — Public Zone



Options at the Secure Level

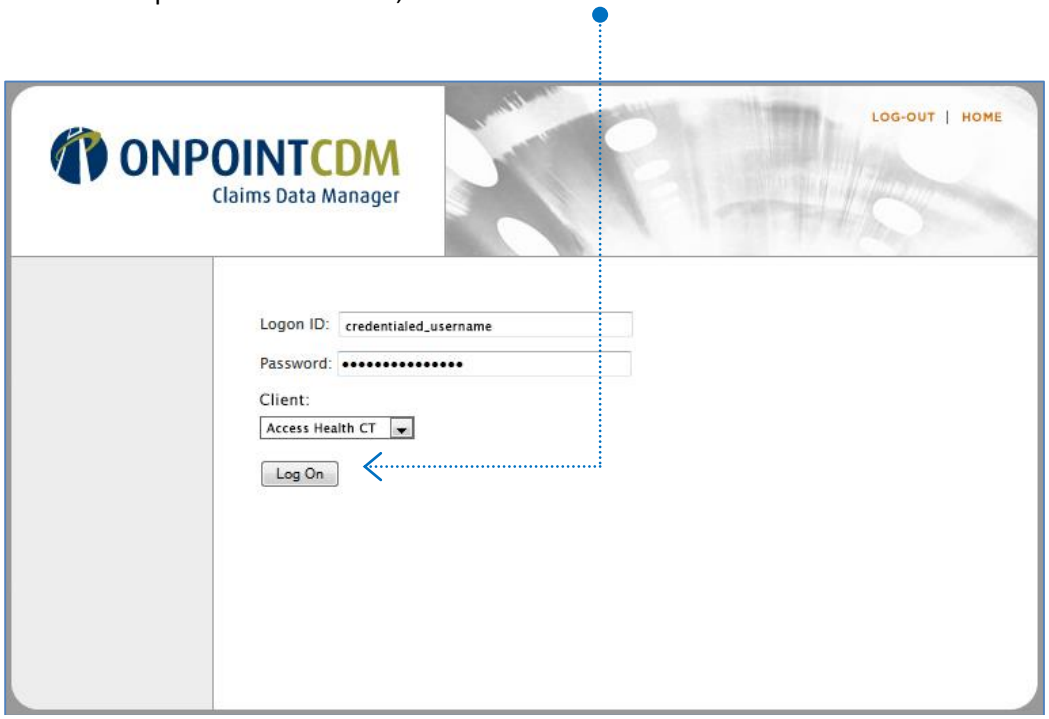
Once registered with Onpoint, credentialed users may access Onpoint CDM's secure portal, which facilitates submission monitoring and provides access to reports that help explain issues that we're seeing in your submitted data (see Figure 2). (Note that Onpoint's hashing and upload resources will not be utilized for the CT APCD, which requires submission via SFTP.)

Figure 2. Onpoint CDM Options — Secure Zone



Monitoring Your Submissions

Credentialed users can log in to Onpoint CDM anytime to monitor the status of their submissions, including up-to-date reporting on stage, status, reasons for file failure, and resubmission deadlines. Gaining access begins at the Onpoint CDM home page. Simply click the LOG-IN option from the page's upper-right corner. Next, enter your Onpoint-assigned Logon ID and Password, select ACCESS HEALTH CT from the drop-down list of states, and click the LOG ON button.



Supporting Submitters

Onpoint CDM's data quality validations can be a complex and rigorous test for reporting entities, which is why we will work hand in hand with your technical staff to understand and meet Connecticut's established data layouts, quality and completeness thresholds, and compliance processes. For further detail on compliance procedures for the CT APCD, please see the officially approved "Policies and Procedures" (Release Date: 12/05/2013; link).

Onpoint's data intake services distinguish us from other vendors in service to submitters. We don't simply fail a submission and abandon submitters to resolve issues on their own; we help you find the solutions that both you and AHCT need to obtain high-quality data. Our ultimate goal is to arrive at a solution that is efficient and programmable for reporting entities while not compromising the timeliness and quality of the CT APCD's data.

Onpoint CDM includes automated alerts and hands-on support — on the phone, by email, via webinar tools, etc. — to help resolve any issues as soon as they arise. We tackle these issues through two key tools: submission tracking and status updates.

Submission & Status Tracking

Throughout the entire data flow, Onpoint CDM monitors each submission from start to finish — and enables submitters to do the same. Onpoint CDM provides authorized data reporters with a series of tracking tools, including an updated log of each submission's status, frequency reports, and validation reports.

When your submission passes all phases — or at any failure prior to final review — Onpoint CDM will send you an email alert. Submissions that fail any threshold check trigger an auto-generated failure notice, which is created instantly at the time of failure and refers submitters to an online report documenting the failure. Submissions that fail a data quality check trigger a review by Onpoint's data intake team, who notify the submitter, identify the data problem, provide examples of the records failing the validation, and enumerate the necessary next steps. For more complex problems, intake staff also work with payers to suggest the probable cause and propose the likely fix. This process generally takes less than 48 hours following file processing. See Table 2 below for a summary of common stage and status categories.

All failure notices alert submitters to any required resubmission and include details regarding the data type, data period, and due date. Resubmission due dates are tracked by Onpoint CDM, which captures sufficient information to identify the submitter, the submission, the date due, the date received, the date entered, the submission stage, the submission status, and any additional comments, allowing our intake staff to track and report on compliance and resubmissions.

Table 2. Data Stage & Status Categories

Stage	Status	Description	Typical Follow-Up Action Required
PRELIM	**REJECTED**	File has been rejected in the preliminary stage since a preceding version has been extracted	Reason for resubmission required
PRELIM	**FAIL**	File has failed the preliminary stage for not meeting field requirements	Resubmission required
LOAD	**FAIL**	File has failed the load stage for not meeting the default threshold on particular fields	Resubmission or request for a waiver to the threshold required
DELETE	**DONE**	File has been replaced and deleted	None
DQ	**FAIL**	File has failed the data quality validations	Resubmission required
DQ	**HOLD**	File has some questionable data quality validations that are failing	Resubmission or explanation required
DQ	**REVIEW**	File has entered data quality review	Manual review by Onpoint's staff
DQ	**PASS**	File has passed the data quality validations	None
REPLACED	**FAIL**	Failed file has been replaced	None
REPLACED	**PASS**	Passed file has been replaced	None
TRANSMIT	**INHOUSE**	File has been received in house and is in the queue for processing	None

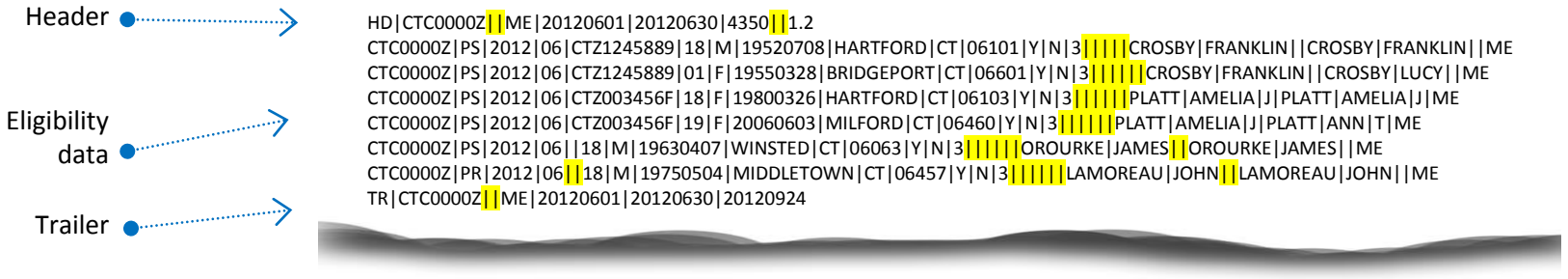
Requesting a Variance from AHCT's Standards

Throughout the course of capturing data for the CT APCD, it may be necessary to make exceptions to the Access Health CT's mandated data thresholds — most commonly when a reporting entity's system does not collect a required element or has special considerations based on the population that they serve. When these situations arise, Onpoint CDM enables AHCT to authorize submitter-specific overrides and variances. Approved variances have a built-in expiration date, requiring payers to reapply and justify any continuing exception on a regular basis. Credentialed CT APCD submitters wishing to apply for a variance may download an application form at Onpoint CDM's section for the CT APCD.

General File Specifications

Basic Rules

- **Header and trailer records.** Each submission regardless of type — eligibility, medical claims, pharmacy claims, and provider — must begin with a header record and end with a trailer record (example header and trailer records for a test eligibility submission of 4,350 records for June 2012 are included below).
- **Submitting multiple months of claims data at once.** You may submit multiple complete months of data with one pair of header and trailer records by indicating the earliest date in HD005 and TR005 and the latest date in HD006 and TR006. Note that each month of data will be evaluated for completeness in its own right and will pass or fail as if it were submitted as a single month of data. If a submitter provides a single file with six months of data for January through June and all months except May pass all checks, May will be rejected and the submitter will be asked to correct and resend only May data. No partially complete months are allowed. (**Note:** Since eligibility files must include all members active within the preceding 12 months, each month's submission should include one record per member for that reporting period. Additional records for a member would be warranted if their information (e.g., product code) changed during the reporting period.)
- **Indicating missing data.** When two or more pipes appear together, there is no data for the field. For example, in the Eligibility File example below (file type = ME), the lack of data between the pipes highlighted in yellow indicate fields that are unavailable for reporting.



- **No empty rows.** Please note that there should be no empty rows separating either the header or the trailer from the reported data.
- **No punctuation.** Punctuation should not be included in the reporting of any names, including the names of drugs. For example, a last name of O'Rourke should be reported as "OROURKE".
- **No decimal points.** Decimal points should not be included in the reporting of financial fields. For example, a dollar amount of $120.56 should be reported as "12056".
- **Date formats.** Dates, unless otherwise specified, should be reported using the 8-digit format of CCYYMMDD. For example, January 18, 1972, should be reported as "19720118".
- **Review the online FAQs.** Please refer to the FAQs section at Onpoint CDM's website — www.onpointcdm.org — for additional information and updates regarding the population of data fields.

Eligibility File

The Basics

Covered Parties All

Required Frequency Monthly

Specific Deadline Within 30 business days of the end of the preceding calendar month

File Layout & Specifications

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
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%	Administrative
HD-ME	HD002	Submitter Code	10/7/2013	Text	8	Header submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match across the following three fields: HD002, ME001, and TR002.	Mandatory	100.0%	Administrative
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 the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	Situational	0.0%	Administrative
HD-ME	HD004	Type of File	10/7/2013	Text	2	Header file type	This field must be coded ME to indicate the submission of eligibility data. The value reported here must match across the following three fields: HD004, ME899, and TR004.	Mandatory	100.0%	Administrative
HD-ME	HD005	Period Beginning Date	10/7/2013	Full Date - Integer	8	Header period start date	Report the date of the first 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-ME	HD006	Period Ending Date	10/7/2013	Full Date - Integer	8	Header period end date	Report the date of the last 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-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. If the number of records within the submission does not equal the number reported in this field, the submission will fail. The record count should not include the header and trailer records.	Mandatory	100.0%	Administrative
HD-ME	HD008	Comments	10/7/2013	Text	80	Header carrier comments	This field may be used by the submitter to document a file name, system source, or other administrative device to assist with their internal tracking of the submission.	Optional	0.0%	Administrative

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
HD-ME	HD009	APCD Version Number	10/7/2013	Decimal - Numeric	3	Header DSG version number	Report the DSG version number included on the cover page of this companion guide in x.x format, including the decimal point in the reported value. If the APCD Version Number reported in this field is not accurate, your submission will fail.	Mandatory	100.0%	Administrative
1	ME001	Submitter Code	4/1/2013	Text	8	Submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match across the following three fields: HD002, ME001, and TR002. Note that the first two characters of the submitter code are used to indicate the client 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	ME002	National Plan ID	4/1/2013	Text	10	CMS National Plan Identification Number (Plan ID)	Do not report any value here until the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	All	0.0%	

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
3	ME003	Insurance Type Code/Product	4/1/2013	Look-up Table - Text	2	Type / product identification code	Report the code that defines the type of insurance under which this member's eligibility is maintained. Valid codes include: 9.....Self-pay 11.....Other Non-Federal Programs (use of this value requires disclosure to Onpoint 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 .....Civilian Health and Medical Program of the Uniformed Services (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 Onpoint prior to submission) TV.....Title V VA .....Veterans Affairs Plan WC .....Workers' Compensation ZZ .....Mutually Defined (use of this value requires disclosure to Onpoint prior to submission)	All	96.0%	837/2000B/SBR/ /09
4	ME004	Year	4/1/2013	Date Period - Integer	4	Reporting year of eligibility	Use this field to report the 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%	Administrative
5	ME005	Month	4/1/2013	Text	2	Reporting month of eligibility	Use this field to report the month for which eligibility is reported in this submission expressed in numerical MM format from 01 to 12. The leading zero is required for reporting January through September files.	All	100.0%	Administrative

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
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 across file types: ME006, MC006, and PC006. 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%	271/2100C/REF/1L/02, 271/2100C/REF/IG/02, 271/2100C/REF/6P/02, 271/2100D/REF/1L/02, 271/2100D/REF/IG/02, 271/2100D/REF/6P/02
7	ME007	Coverage Level Code	4/1/2013	Look-up Table - Text	3	Benefit coverage level code	Use this field to report the benefit level of coverage. Valid codes include: 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%	271/2110C/EB/ /02, 271/2110D/EB/ /02
8	ME008	Subscriber SSN	4/1/2013	Text	9	Subscriber's Social Security Number	Report the subscriber's Social Security number. Do not code using hyphens. If not available, do not report any value here. If this field is not populated, ME009 must be populated. Notes: The value reported for this field should be reported consistently in the Subscriber Social Security Number field across file types: ME008, MC007, PC007. This field will not be passed into the analytic file.	All	85.0%	271/2100C/REF/SY/02
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. If this field is not populated, ME008 must be populated. Notes: The value reported for this field should be reported consistently in the Plan-Specific Contract Number across file types: ME009, MC008, and PC008.	All	95.0%	271/2100C/NM1/MI/09
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%	N/A
11	ME011	Member Social Security Number	4/1/2013	Text	9	Member Social Security number	Report the member's Social Security number. Do not code using hyphens. If not available, do not report any value here. If not available, report as null. Notes: The value reported for this field should be reported consistently in the Member Social Security Number field across file types: ME011, MC010, PC010. This field will not be passed into the analytic file.	All	68.0%	271/2100C/REF/SY/02, 271/2100D/REF/SY/02

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
12	ME012	Individual Relationship Code	10/30/2013	Look-up Table - Text	2	Member to subscriber relationship code	Report the value that defines the member's relationship to the subscriber. Please note that while there are two codes that allow for the reporting of "Self," correct coding practices require the use of "18". Valid codes include: 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 G8.....Other Relationship	All	98.0%	271/2100C/INS/Y/02, 271/2100D/INS/N/02
13	ME013	Member Gender	4/1/2013	Look-up Table - Text	1	Member's gender	Report the member's gender as reported on enrollment form in alpha format. Valid codes include: F .....Female M.....Male U.....Unknown Notes: The value reported for this field should be reported consistently in the Member Gender field across file types: ME013, MC012, and PC012.	All	100.0%	271/2100C/DMG/ /03, 271/2100D/DMG/ /03
14	ME014	Member Date of Birth	4/1/2013	Full Date - Integer	8	Member's date of birth	Use this field to report the date on which the member was born in YYYYMMDD format. Notes: The value reported for this field should be reported consistently in the Member Date of Birth field across file types: ME014, MC013, and PC013.	All	99.0%	271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02
15	ME015	Member City Name	4/1/2013	Text	30	City name of the member	Report the city name of the member.	All	99.0%	271/2100C/N4/ /01, 271/2100D/N4/ /01

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
16	ME016	Member State or Province	4/1/2013	External Code Source 2 - Text	2	State/province of the member	Use this field to report the member's state or province using the two-character abbreviation code defined by the U.S. Postal Service(for U.S. states) and Canada Post (for Canadian provinces).	All	99.0%	271/2100C/N4/ /02, 271/2100D/N4/ /02
17	ME017	Member ZIP Code	4/1/2013	External Code Source 2 - Text	9	ZIP code of the member	Use this field to report the ZIP/postal code associated with the member's residence. Notes: For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP/postal codes.	All	99.0%	271/2100C/N4/ /03, 271/2100D/N4/ /03
18	ME018	Medical Coverage Flag	4/1/2013	Look-up Table - Integer	1	Indicator - Medical option	Use this field to report whether or not the member's plan with your organization included coverage for medical services. Notes: Onpoint will be considering values of "3", "4", and "5" to be the same as a value of "2" (No). Only values of "1" and "2" are valid in this field. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative
19	ME019	Prescription Drug Coverage Flag	4/1/2013	Look-up Table - Integer	1	Indicator - Pharmacy option	Use this field to report whether or not the member's plan with your organization included coverage for prescription drugs. Notes: Onpoint will be considering values of "3", "4", and "5" to be the same as a value of "2" (No). Only values of "1" and "2" are valid in this field. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative
20	ME020	Dental Coverage Flag	4/1/2013	Look-up Table - Integer	1	Indicator - Dental option	Use this field to report whether or not the member's plan with your organization included coverage for dental services. Notes: Onpoint will be considering values of "3", "4", and "5" to be the same as a value of "2" (No). Only values of "1" and "2" are valid in this field. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
21	ME021	Race 1	4/1/2013	Look-up 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 the member answers "unknown" or refuses to answer. Report as null if data has not been collected. Valid codes include: 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%	N/A
22	ME022	Race 2	4/1/2013	Look-up 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 the member answers "unknown" or refuses to answer. Report as null if data has not been collected. Valid codes include: 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%	N/A
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%	N/A
24	ME024	Hispanic Indicator	4/1/2013	Look-up Table - Integer	1	Indicator - Hispanic status	Use this field to report whether or not the member identified as Hispanic. The code value "3" (Unknown), should be used only when the member answers "unknown" or refuses to answer. Report as null if data has not been collected. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	3.0%	N/A
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. Report as null if data has not been collected.	All	3.0%	N/A
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. Report as null if data has not been collected.	All	2.0%	N/A

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
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 reported as "OTHER"; if not applicable, do not report any value here.	Required when ME025 or ME026 = OTHER	99.0%	N/A
28	ME028	Primary Insurance Indicator	4/1/2013	Look-up Table - Integer	1	Indicator - Primary insurance coverage	Use this field to report whether or not this coverage is primary. Products, plans, or benefits that only cover copays, coinsurance, and deductibles (gap coverage) will answer "2" (No) here. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	N/A
29	ME029	Coverage Type	4/1/2013	Look-up Table - Text	3	Type of coverage code	Report the code that defines the type of insurance policy under which the enrollee is covered. Valid codes include: 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%	N/A

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
30	ME030	Group Size	7/2/2013	Look-up Table - Text	4	Group size code / market category code	Report the code to indicate group size consistent with Connecticut insurance law and regulations. Valid codes include: 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 10–25 employees GS4 .....Policies sold and issued directly to employers having 26–50 employees GS5 .....Policies sold and issued directly to employers having 1–50 employees GLG0 .....Policies sold and issued directly to employers having 51 or more employees GLG1 .....Policies sold and issued directly to employers having 51–99 employees GLG2 .....Policies sold and issued directly to employers having 100 or more employees GSA .....Policies sold and issued directly to small employers through a qualified association trust GLG3 .....Policies sold and issued directly to employers having 250–499 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	All	100.0%	N/A
31	ME031	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
32	ME032	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
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 the member answers "unknown" or refuses to answer. Report as null if data has not been collected.	All	3.0%	N/A
34	ME034	Member Language Preference - Other	4/1/2013	Text	20	Member's other language preference	Report the other language that the member has identified as preferred. Do not report any value if no other language was identified.	Required when ME033 = Other	99.0%	N/A

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
35	ME035	Medical Home Indicator	4/1/2013	Look-up Table - Integer	1	Medical home indicator	Use this field to report whether or not the member had a medical home on record for this coverage period. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative
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 number used when reporting the rendering provider. Do not report any data here if not applicable. The number of the member's healthcare home must also be reported in the Provider File using the Plan Provider ID field (PV002).	Required when ME035 = 1	90.0%	Administrative
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 no medical home to report, do not report any value. Do not use hyphen or alpha prefix.	Required when ME035 = 1	90.0%	Administrative
38	ME038	Medical Home National Provider ID	4/1/2013	External Code Source NPPES - Text	10	National Provider Identifier (NPI) of the Health Care Home Provider	Report the National Provider Identifier (NPI) 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%	Administrative
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 punctuations. If there is no medical home to report, do not report any value.	Required when ME035 = 1	90.0%	Administrative
40	ME040	Product ID Number	7/2/2013	Text	30	Product identification number	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 report using the following default value: "9999999999".	All	100.0%	Administrative
41	ME041	Enrollment Start Date	7/2/2013	Integer	8	Start date	Report the date on which the member was enrolled in YYYYMMDD format.	All	100.0%	Administrative
42	ME042	Enrollment End Date	7/2/2013	Integer	8	End date	Report the date on which the member was disenrolled in YYYYMMDD format. If the member was not disenrolled at the end of the current month, then report as null.	All	10.0%	Administrative
43	ME043	Member Street Address 1	4/1/2013	Text	50	Street address of the member	Use this field to report the first line of the member's street address.	All	98.0%	271/2100C/N3/ /01, 271/2100D/N3/ /01
44	ME044	Member Street Address 2	4/1/2013	Text	50	Secondary street address of the member	Use this field to report the second line of the member's street address, which may include apartment number, suite identifier, or other secondary information.	All	2.0%	271/2100C/N3/ /02, 271/2100D/N3/ /02

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
45	ME045	Purchased through Access Health CT Indicator	4/1/2013	Look-up Table - Integer	1	Indicator – Access Health CT	Use this field to report whether or not the policy for this eligibility record was purchased through Access Health CT. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	Required when ME126 = 1	100.0%	Administrative
46	ME046	Member PCP ID	4/1/2013	Text	30	Member's PCP ID	Report the identifier of the member's PCP. The value in this field must also be reported in the Provider File using the Plan Provider ID field (PV002). Report a value of "UNKNOWN" when PCP is unknown or "NA" if the eligibility does not require a PCP.	All	98.0%	834/2310/NM1/P3/SV/09
47	ME047	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
48	ME048	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
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 the member's annual deductible across all benefit types (medical, pharmacy, 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 the 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%	834/2100A/AMT/D2/02
50	ME050	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
51	ME051	Behavioral Health Benefit Indicator	4/1/2013	Look-up Table - Integer	1	Indicator - Behavioral health option	Use this field to report whether or not behavioral/mental health services were a covered benefit. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative
52	ME052	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
53	ME053	Disease Management Enrollee Indicator	4/1/2013	Look-up Table - Integer	1	Indicator - Chronic illness management	Use this field to report whether or not the member was enrolled in a disease management program. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative
54	ME054	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
55	ME055	Business Type Code	4/1/2013	Look-up Table - Integer	1	Business type	Report the value that defines the submitter's line of business for this line of eligibility. Valid codes include: 2.....Third-Party Administrator (TPA) 3.....Delegated Business Administrator (DBA) 4.....Pharmacy Benefit Manager (PBM) 5.....Dental Benefit Manager (DBM) 6.....Computer Service Organization (CSO) 7.....Other 0.....Unknown / Not Applicable	All	100.0%	Administrative
56	ME056	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
57	ME057	Date of Death	4/1/2013	Full Date - Integer	8	Member's date of death	Report the date on which the member expired in YYYYMMDD format. If still alive or date of death is unknown, report as null.	All	0.0%	Administrative
58	ME058	Subscriber Street Address	4/1/2013	Text	50	Street address of the subscriber	Use this field to report the subscriber's street address.	All	98.0%	271/2100C/N3/ /01
59	ME059	Disability Indicator	7/2/2013	Look-up Table - Integer	1	Indicator - Disability	Use this field to report whether or not disability applied to this record. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative
60	ME060	Employment Status	7/2/2013	Look-up Table - Text	1	Employment status code	Report the code that defines the employment status of the subscriber. Valid codes include: A.....Active I.....Involuntary Leave O .....Orphan P.....Pending R.....Retiree S .....Student Z.....Unemployed U .....Unknown	All	100.0%	Administrative
61	ME061	Student Status Flag	4/1/2013	Look-up Table - Integer	1	Indicator - Student status	Use this field to report whether or not the member was a student. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
62	ME062	Marital Status	4/1/2013	Look-up Table - Text	1	Marital status code	Report the member's marital status here. Valid codes include: C .....Common Law Married D.....Divorced M.....Married P .....Domestic Partnership S .....Never Married W.....Widowed X .....Legally Separated U.....Unknown	All	100.0%	834/2100A/DMG/ /04
63	ME063	Benefit Status	7/2/2013	Look-up Table - Text	1	Benefit status code	Report the code that defines the status of the benefits for the member. If member's benefits have been terminated, report as "U" (Unknown). Valid codes include: A.....Active C .....COBRA P .....Pending S .....Surviving Insured T .....TEFRA U.....Unknown	All	100.0%	834/2000/INS/ /05
64	ME064	Employee Type	7/2/2013	Look-up Table - Text	1	Employee type code	Report the code that defines the subscriber's type of employment. Valid codes include: H.....Hourly Q.....Seasonal S .....Salaried T .....Temporary U.....Unknown	Required when ME060 = A or P	100.0%	Administrative
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%	834/2000/DTP/286/D8/03
66	ME066	COBRA Status Indicator	7/2/2013	Integer	1	Indicator - COBRA usage	Use this field to report whether or not the member was covered using COBRA benefits. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative
67	ME067	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
68	ME068	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
69	ME069	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
70	ME070	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
71	ME071	Pool Indicator Code	7/2/2013	Look-up Table - Integer	1	Pool grouping code	Report the value that defines an employee attribute. Valid codes include: 1 .....State Employee - Active 2 .....State Employee - Retired 3 .....Federal Employee - Active 4 .....Federal Employee - Retired 5 .....Municipal Employee - Active 6 .....Municipal Employee - Retired	Required when ME134 = 3	100.0%	Administrative
72	ME072	Family Size	7/2/2013	Integer	2	Family size as contracted	Report the number of individuals covered under the policy/contract identified in the subscriber's Plan-Specific Contract Number field (ME009).	Required when ME126 = 1	100.0%	Administrative
73	ME073	Fully Insured Member Indicator	4/1/2013	Look-up Table - Integer	1	Fully insured identifier	Use this field to report whether or not the member was fully insured. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative
74	ME074	Interpreter Indicator	4/1/2013	Look-up Table - Integer	1	Indicator - Interpreter need	Use this field to report whether or not the member requires the assistance of an interpreter. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative
75	ME075	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
76	ME076	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
77	ME077	Member's North American Industry Classification System (NAICS) Code	7/2/2013	External Code Source NAICS - Text	6	Member's standard NAICS code	Report the North American Industry Classification System (NAICS) code that describes the industry of the subscriber and/or member.	All	25.0%	Administrative
78	ME078	Employer ZIP Code	7/2/2013	Text	9	ZIP code of the employer	Use this field to report the ZIP/postal code associated with the subscriber's employer. Notes: For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP/postal codes.	Required when ME060 = A or P	98.0%	834/2100D/N4/ /03
79	ME079	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
80	ME080	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
81	ME081	Medicare Code	7/2/2013	Integer	1	Medicare plan code	Report the value that defines if and what type of Medicare coverage applied to this line of eligibility. Valid codes include: 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 the time of enrollment.	Required when ME060 = A or P	98.0%	834/2100D/NM1/36/03
83	ME083	Employer EIN	4/1/2013	Text	9	Member's employer EIN	Report the federal tax ID number of the employer here. Do not use a hyphen or alpha prefix.	Required when ME060 = A or P	98.0%	834/2100D/NM1/24/09
84	ME101	Subscriber Last Name	4/1/2013	Text	60	Last name of subscriber	Report the last name of the subscriber. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: O'Brien should be reported as "OBRIEN"; Carlton-Smythe should be reported as "CARLTONSMYTHE".	All	100.0%	271/2100C/NM1/ /03
85	ME102	Subscriber First Name	4/1/2013	Text	25	First name of subscriber	Report the first name of the subscriber. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: Anne-Marie should be reported as "ANNEMARIE".	All	100.0%	271/2100C/NM1/ /04
86	ME103	Subscriber Middle Initial	4/1/2013	Text	1	Middle initial of subscriber	Report the subscriber's middle initial here.	All	2.0%	271/2100C/NM1/ / 05
87	ME104	Member Last Name	4/1/2013	Text	60	Last name of member	Report the last name of the member. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: O'Brien should be reported as "OBRIEN"; Carlton-Smythe should be reported as "CARLTONSMYTHE".	All	100.0%	271/2100C/NM1/ /03, 271/2100D/NM1/ /03
88	ME105	Member First Name	4/1/2013	Text	25	First name of member	Report the first name of the member. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: Anne-Marie should be reported as "ANNEMARIE".	All	100.0%	271/2100C/NM1/ /04, 271/2100D/NM1/ /04
89	ME106	Member Middle Initial	4/1/2013	Text	1	Middle initial of member	Report the middle initial of the member when available.	All	2.0%	271/2100C/NM1/ /05, 271/2100D/NM1/ /05
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%	Administrative
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%	271/2100C/N4/ /01
92	ME109	Subscriber State or Province	4/1/2013	External Code Source 2 - Text	2	State/province of the subscriber	Use this field to report the subscriber's state or province using the two-character abbreviation code defined by the U.S. Postal Service(for U.S. states) and Canada Post (for Canadian provinces).	All	99.0%	271/2100C/N4/ /02, 271/2100D/N4/ /02

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
93	ME110	Subscriber ZIP Code	4/1/2013	External Code Source 2 - Text	9	ZIP code of the subscriber	Use this field to report the ZIP/postal code associated with the subscriber's residence. Notes: For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP/postal codes.	All	99.0%	271/2100C/N4/ /03, 271/2100D/N4/ /03
94	ME111	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
95	ME112	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
96	ME113	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
97	ME114	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
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 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 the 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%	Administrative
99	ME116	Vision Deductible Flag	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 the 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%	Administrative
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%	Administrative
101	ME118	Vision Benefit Indicator	4/1/2013	Look-up Table - Integer	1	Indicator - Vision option	Use this field to report whether or not the member's plan included vision coverage. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative
102	ME119	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
103	ME120	Actuarial Value	4/1/2013	Text	6	Actuarial value	Report the actuarial value for the member's coverage for the time period indicated by enrollment start and end dates in 0.0000 format. For this field, please report the decimal.	Required when ME126 = 1	100.0%	Administrative

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
104	ME121	Metal Level	4/1/2013	Look-up Table - Integer	1	Standardized plan level in metal reference	Report the metal level benefits that the member is associated with in this line of eligibility. Valid codes include: 1 .....Bronze 2 .....Silver 3 .....Gold 4 .....Platinum 5 .....Catastrophic 0 .....Unknown / Not Applicable	Required when ME126 = 1	100.0%	Administrative
105	ME122	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
106	ME123	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
107	ME124	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
108	ME125	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
109	ME126	Risk-Adjustment Covered Plan (RACP)	7/2/2013	Integer	1	Subscriber/member enrolled in a risk-adjustment plan	Use this field to report whether or not the subscriber was enrolled with a non-grandfathered individual or small group plan 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. Valid codes include: 1 .....Yes 2 .....No	All	100.0%	Administrative
110	ME127	Billable Member Flag	7/2/2013	Integer	1	Indicator - Billable member	Use this field to report whether or not the member was billable. Valid codes include: 1 .....Yes 2 .....No	Required when ME126 = 1	100.0%	
111	ME128	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
112	ME129	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
113	ME130	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
114	ME131	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
115	ME132	Total Monthly Premium	7/2/2013	Decimal,2	10	Combined contribution of employer and subscriber	Report the total monthly premium at the subscriber level. Report “0” if no premium is charged. Do not code the 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%	

ELIGIBILITY FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
116	ME133	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
117	ME134	APCD ID Code	7/2/2013	Look-up 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 validations and thresholds. Valid codes include: 1 .....Fully -Insured Commercial Group Enrollee (FIG) 2 .....Self-Insured Group Enrollee (SIG) 3 .....State or Federal Employer Enrollee 4 .....Individual - Non-Group Enrollee 5 .....Supplemental Policy Enrollee 6 .....Integrated Care Organization (ICO) 0 .....Unknown / Not Applicable	All	100.0%	Administrative
118	ME899	Record Type	4/1/2013	Text	2	File type identifier	This field must be coded ME to indicate the submission of eligibility data. The value reported here must match across the following three fields: HD004, ME899, and TR004.	All	100.0%	Administrative
TR-ME	TR001	Record Type	10/7/2013	Text	2	Trailer record identifier	Report TR here. Indicates the beginning of the trailer elements of the file.	Mandatory	100.0%	Administrative
TR-ME	TR002	Submitter Code	10/7/2013	Text	8	Trailer submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match across the following three fields: HD002, ME001, and TR002.	Mandatory	100.0%	Administrative
TR-ME	TR003	National Plan ID	10/7/2013	Text	10	Trailer CMS National Plan Identification Number (Plan ID)	Report as null until the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	Situational	0.0%	Administrative
TR-ME	TR004	Type of File	10/7/2013	Text	2	Trailer file type	This field must be coded ME to indicate the submission of eligibility data. The value reported here must match across the following three fields: HD004, ME899, and TR004.	Mandatory	100.0%	Administrative
TR-ME	TR005	Period Beginning Date	10/7/2013	Full Date - Integer	8	Trailer period start date	Report the date of the first 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 HD005.	Mandatory	100.0%	Administrative
TR-ME	TR006	Period Ending Date	10/7/2013	Full Date - Integer	8	Trailer period end date	Report the date of the last 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 HD006.	Mandatory	100.0%	Administrative
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%	Administrative

Medical Claims

The Basics

Covered Parties All

Required Frequency Monthly

Specific Deadline Within 30 business days of the end of the preceding calendar month

Important Notes

- Medical claims submissions must include all claims adjudicated during the reported time period.
- All lines of partially denied claims are to be reported. Only fully denied claims are to be excluded.
- One record must be submitted for each service adjudicated during the period reported in the header and trailer records. As noted in the Q&As released to CT APCD submitters, a consistent date must be used as the basis for claims submission to ensure that all records are reported each month. The Date Service Approved field (MC017) should be used for this purpose. All dates reported in this field should fall within the period beginning/ending dates reported in the header and trailer (HD005/TR005 and HD006/TR006).
- Submissions must cover full months of data; partial months must not be reported.
- Please note: The element ID provided in the layout table's second column (e.g., HD001 for "Record Type") is reserved for administrative purposes only. These IDs, which can change as file layouts change, should not be incorporated into the field names used for your submissions.

File Layout & Specifications

MEDICAL CLAIMS FILE										
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 Code	10/7/2013	Text	8	Header submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match across the following three fields: HD002, MC001, and TR002.	Mandatory	100.0%	Administrative
HD-MC	HD003	National Plan ID	10/7/2013	Text	10	Header CMS National Plan Identification Number (Plan ID)	Report as null until the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	Situational	0.0%	Administrative
HD-MC	HD004	Type of File	10/7/2013	Text	2	Header file type	This field must be coded MC to indicate the submission of medical claims data. The value reported here must match across the following three fields: HD004, MC899, and TR004.	Mandatory	100.0%	Administrative

MEDICAL CLAIMS FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
HD-MC	HD005	Period Beginning Date	10/7/2013	Full Date - Integer	8	Header period start date	Report the date of the first 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 end date	Report the date of the last 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. If the number of records within the submission does not equal the number reported in this field, the submission will fail. The record count should not include the header and trailer records.	Mandatory	100.0%	Administrative
HD-MC	HD008	Comments	10/7/2013	Text	80	Header carrier comments	This field may be used by the submitter to document a file name, system source, or other administrative device to assist with their internal tracking of the submission.	Optional	0.0%	Administrative
HD-MC	HD009	APCD Version Number	10/7/2013	Decimal - Numeric	3	Header DSG version number	Report the DSG version number included on the cover page of this companion guide in x.x format, including the decimal point in the reported value. If the APCD Version Number reported in this field is not accurate, your submission will fail.	Mandatory	100.0%	Administrative
1	MC001	Submitter Code	4/1/2013	Text	8	Submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match across the following three fields: HD002, MC001, and TR002. Note that the first two characters of the submitter code are used to indicate the client 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)	Report as null until the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	All	0.0%	835/1000A/REF/NF/02, 835/1000A/N1/XV/04

MEDICAL CLAIMS FILE										
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	Look-up Table - Text	2	Type / product identification code	Report the code that defines the type of insurance under which this member's claim line was processed. Valid codes include: 9 .....Self-pay 11 .....Other Non-Federal Programs (use of this value requires disclosure to Onpoint 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.....Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (now TRICARE) DS .....Disability HM .....Health Maintenance Organization LM .....Liability Medical MA.....Medicare Part A (use to report Medicare Fee for Service only) MB.....Medicare Part B (use to report Medicare Fee for Service only) MC.....Medicaid OF.....Other Federal Program (use of this value requires disclosure to Onpoint prior to submission) TV .....Title V VA.....Veterans Affairs Plan WC.....Workers' Compensation ZZ .....Mutually Defined (use of this value requires disclosure to Onpoint prior to submission)	All	100.0%	837/2000B/SBR/ /09
4	MC004	Payer Claim Control Number	4/1/2013	Text	35	Payer claim control identifier	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" (not "0") and increment by 1 for each additional line. Do not 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. Do not include alphas or special characters.	All	100.0%	Administrative

MEDICAL CLAIMS FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
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 across file types: ME006, MC006, and PC006. 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
8	MC007	Subscriber SSN	4/1/2013	Text	9	Subscriber's Social Security number	Report the subscriber's Social Security number. Do not code using hyphens. If not available, report as null. If this field is not populated, MC008 must be populated. Notes: The value reported for this field should be reported consistently in the Subscriber Social Security Number field across file types: ME008, MC007, PC007. This field will not be passed into the 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. If this field is not populated, MC007 must be populated. Notes: The value reported for this field should be reported consistently in the Plan-Specific Contract Number across file types: ME009, MC008, and PC008.	All	98.0%	835/2100/NM1/MI/09
10	MC009	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	98.0%	N/A
11	MC010	Member SSN	4/1/2013	Text	9	Member's Social Security number	Report the member's Social Security number. Do not code using hyphens. If not available, report as null. If not available, report as null. Notes: The value reported for this field should be reported consistently in the Member Social Security Number field across file types: ME011, MC010, PC010. This field will not be passed into the analytic file.	All	75.0%	835/2100/NM1/34/09

MEDICAL CLAIMS FILE										
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	Look-up Table - Text	2	Member to subscriber relationship code	Report the value that defines the member's relationship to the subscriber. Please note that while there are two codes that allow for the reporting of "Self," correct coding practices require the use of "18". Valid codes include: 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	Look-up Table - Text	1	Member's gender	Report the member's gender as reported on enrollment form in alpha format. Valid codes include: F .....Female M.....Male U.....Unknown Notes: The value reported for this field should be reported consistently in the Member Gender field across file types: ME013, MC012, and PC012.	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's date of birth	Use this field to report the date on which the member was born in YYYYMMDD format. Notes: The value reported for this field should be reported consistently in the Member Date of Birth field across file types: ME014, MC013, and PC013.	All	99.0%	837/2010BA/DMG/D8/02 837/2010CA/DMG/D8/02
15	MC014	Member City Name	4/1/2013	Text	30	City of the member	Report the city name of the member.	All	99.0%	837/2010BA/N4/ /01 837/2010CA/N4/ /01

MEDICAL CLAIMS FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
16	MC015	Member State or Province	4/1/2013	External Code Source 2 - Text	2	State/province of the member	Use this field to report the member's state or province using the two-character abbreviation code defined by the U.S. Postal Service(for U.S. states) and Canada Post (for Canadian provinces).	All	99.9%	837/2010BA/N4/ /02 837/2010CA/N4/ /02
17	MC016	Member ZIP Code	4/1/2013	External Code Source 2 - Text	9	ZIP code of the member	Use this field to report the ZIP/postal code associated with the member's residence. Notes: For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP/postal codes.	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 a date other than the Paid Date (MC089). If Date Service Approved 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 admission date	Report the date of admit to a facility in YYYYMMDD format. Only applies to facility claims where the reported Type of Bill (MC036) indicates 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 where the reported Type of Bill (MC036) indicates an inpatient setting. Time is expressed in military time. If only the hour is known, code the minutes as "00". 4 A.M. would be reported as "0400"; 4 P.M. 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 where the reported Type of Bill (MC036) indicates 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 where the reported Type of Bill (MC036) indicates 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 where the reported Type of Bill (MC036) indicates an inpatient setting. Time is expressed in military time. If only the hour is known, code the minutes as "00". 4 A.M. would be reported as "0400"; 4 P.M. 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

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Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
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 also be reported in the Provider File using the Plan Provider ID field (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
27	MC026	National Provider Identifier – Rendering	4/1/2013	External Code Source NPPES - Text	10	National Provider Identifier (NPI) of the rendering provider	Report the primary National Provider Identifier (NPI) of the Servicing Provider reported in MC024. This NPI should also be reported using the National Provider Identifier field (PV039) in the provider file.	All	99.0%	Institutional 837/2010AA/NMI/XX/09 Professional 837/2420A/NMI/XX/09, 837/2310B/NM1/XX/09
28	MC027	Rendering Provider Entity Type Qualifier	4/1/2013	Look-up Table - integer	1	Rendering 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. Valid codes include: 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	Rendering Provider First Name	4/1/2013	Text	25	First name of the rendering provider	Report the individual's first name here. If provider is a facility or organization, report as null.	Required when MC027 = 1	92.0%	Professional 837/2420A/NM1/82/04, 837/2310B/NM1/82/04
30	MC029	Rendering Provider Middle Name	4/1/2013	Text	25	Middle name of the rendering provider	Report the individual's middle name here. If provider is a facility or organization, report as null.	Required when MC027 = 1	2.0%	Professional 837/2420A/NM1/82/05, 837/2310B/NM1/82/05
31	MC030	Rendering Provider Last Name or Organization Name	4/1/2013	Text	60	Last name or organization name of the rendering provider	Report the name of the organization or the 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 / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
33	MC032	Rendering Provider Taxonomy	4/1/2013	External Code Source - WPC - Text	10	Taxonomy code of the rendering provider	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

MEDICAL CLAIMS FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
34	MC033	Rendering Provider City Name	4/1/2013	Text	30	City name of the rendering 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	Rendering Provider State	4/1/2013	External Code Source - USPS - Text	2	State of the rendering provider	Report the state of the service provider as defined by the U.S. Postal Service	All	98.0%	Institutional 837/2010AA/N4/ /02 Professional 837/2420C/N4//02, 837/2310C/N4/ /02
36	MC035	Rendering Provider ZIP Code	4/1/2013	External Code Source - USPS - Text	9	ZIP code of the rendering provider	Use this field to report the ZIP/postal code associated with the rendering provider's location. Notes: For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP/postal codes.	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
39	MC038	Claim Status	10/7/2013	Look-up Table - integer	2	Claim line status	Report the value that defines the payment status of this claim line. Valid codes include: 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 cause of injury code	Report the external cause of injury code for patient when appropriate to the claim. 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

MEDICAL CLAIMS FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
42	MC041	Principal Diagnosis	4/1/2013	External Code Source - ICD - Text	7	ICD principal diagnosis code	Use this field to report the ICD diagnosis for the principal diagnosis. 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	Use this field to report the ICD diagnosis code for the first secondary diagnosis. 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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the second secondary diagnosis. If not applicable, report as null. 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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the third secondary diagnosis. If not applicable, report as null. 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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the fourth secondary diagnosis. If not applicable, report as null. 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
47	MC046	Other Diagnosis - 5	4/1/2013	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the fifth secondary diagnosis. If not applicable, report as null. 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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the sixth secondary diagnosis. If not applicable, report as null. 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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the seventh secondary diagnosis. If not applicable, report as null. 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

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Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
50	MC049	Other Diagnosis - 8	4/1/2013	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the eighth secondary diagnosis. If not applicable, report as null. 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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the ninth secondary diagnosis. If not applicable, report as null. 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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the tenth secondary diagnosis. If not applicable, report as null. 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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the eleventh secondary diagnosis. If not applicable, report as null. 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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the twelfth secondary diagnosis. If not applicable, report as null. 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
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 If using carrier-defined codes, submitter must provide reference table of values.	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

MEDICAL CLAIMS FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
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 the 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 (from)	Report the first 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 (to)	Report the last 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. May be reported as a negative.	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 the 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”. May be reported as a negative.	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 the 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”. May be reported as a negative.	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 the 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”. May be reported as a negative.	All	99.0%	N/A
66	MC065	Copay Amount	4/1/2013	Decimal,2	10	Amount of copay that the member is responsible to pay	Report the amount that defines a preset, fixed amount for this claim line service that the member is responsible to pay. Report “0” if no Copay applies. Do not code the 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”. May be reported as a negative.	All	100.0%	835/2110/CAS/PR/3-03
67	MC066	Coinsurance Amount	4/1/2013	Decimal,2	10	Amount of coinsurance that the member is responsible to pay	Report the amount that defines a calculated percentage amount for this claim line service that the member is responsible to pay. Report “0” if no Coinsurance applies. Do not code the 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”. May be reported as a negative.	All	100.0%	835/2110/CAS/PR/2-03

MEDICAL CLAIMS FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
68	MC067	Deductible Amount	4/1/2013	Decimal,2	10	Amount of deductible that the member is responsible to pay on the claim line	Report the amount that defines a preset, fixed amount for this claim line service that the member is responsible to pay. Report "0" if no Deductible applies to service. Do not code the 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". May be reported as a negative.	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. This field is 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 on which the member was discharged from the facility in YYYYMMDD format. If member 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	Rendering Provider Country Code	12/1/2010	External Code Source - ANSI - Text	3	Country name of the rendering 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	Diagnosis Related Group (DRG) 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	DRG 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 (APC) 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	APC version number	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 also be reported in the Provider File using the Plan Provider ID field (PV002).	All	99.0%	837/2010BB/REF/G2/02

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Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
78	MC077	National Provider ID - Billing	4/1/2013	External Code Source - NPPES - Text	10	National Provider Identifier (NPI) of the billing provider	Report the primary National Provider Identifier (NPI) here. This NPI should also be reported using the National Provider Identifier field (PV039) in the provider file.	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. Individuals' names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes.	All	99.0%	837/2010AA/NM1/ /03
80	MC079	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
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. If using carrier-defined codes, submitter must provide reference table of values.	Required when MC038 = 01, 02, 03, 19, 20, or 21	99.5%	835/2110/CAS
82	MC081	Capitated Encounter Indicator	4/1/2013	Look-up Table - Integer	1	Indicator - Capitation payment	Use this field to report whether or not the service was covered under a capitated arrangement. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative
83	MC082	Member Street Address 1	4/1/2013	Text	50	Street address of the member	Use this field to report the first line of the member's street address. Note that additional street address information can be reported using the Member Street Address 2 field (MC140).	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 the 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 the 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

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Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
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 the 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 the 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 the 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 the 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/06-2 837/2300/HI/BBQ/06-2
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 remittance 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. Note: Claims paid in full, partial, or zero paid must have a date reported here.	All	100.0%	835/Header Financial Information/BPR/ /16
91	MC090	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
92	MC091	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
93	MC092	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
94	MC093	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A

MEDICAL CLAIMS FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
95	MC094	Type of Claim	10/7/2013	Look-up Table - Text	3	Type of claim code	Report the value that defines the type of claim submitted for payment. Valid codes include: 001 .....Professional 002 .....Facility 003 .....Reimbursement Form	All	100.0%	Administrative
96	MC095	COB/TPL Amount	7/2/2013	Decimal,2	10	Amount due from a secondary carrier	Report the amount for which another payer is liable after the submitting payer has processed this claim line. Report "0" if there is no coordination of benefits (COB) / third-party liability (TPL) amount. Do not code the 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". May be reported as a negative.	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 toward this claim line; otherwise, report as null. Do not code the 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". May be reported as a negative.	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 toward this claim line. Only Report "0" if Medicare paid 0 toward this claim line; otherwise do not report any value here. Do not code the 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". May be reported as a negative.	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 is less than or equal to the fee charged by the provider. Report "0" when the claim line is denied. Do not code the 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". May be reported as a negative.	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 was not reimbursable due to eligibility limitations or unmet provider requirements. Report "0" when the claim line was paid or fell into other categories. Do not code the 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". May be reported as a negative.	All	100.0%	835/2110/CAS
101	MC100	Carve-Out Vendor CT APCD ID	4/1/2013	Text	8	Onpoint-defined and maintained code for linking across submitters	Report the Onpoint-assigned submitter code of the carve-out/parent vendor. This field identifies either the payer on behalf of whom the carve-out vendor is reporting (i.e., the parent) or the carve-out vendor contracted to report this claim. Contact the CT APCD for the appropriate value. If no vendor is affiliated with this claim line, report the code from MC001.	All	98.0%	Administrative

MEDICAL CLAIMS FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
102	MC101	Subscriber Last Name	10/15/2010	Text	60	Last name of subscriber	Report the last name of the subscriber. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: O'Brien should be reported as "OBRIEN"; Carlton-Smythe should be reported as "CARLTONSMYTHE".	All	100.0%	837/2010BA/NM1/ /03
103	MC102	Subscriber First Name	10/15/2010	Text	25	First name of subscriber	Report the first name of the subscriber. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: Anne-Marie should be reported as "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.	All	2.0%	837/2010BA/NM1/ /05
105	MC104	Member Last Name	4/1/2013	Text	60	Last name of member	Report the last name of the member. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: O'Brien should be reported as "OBRIEN"; Carlton-Smythe should be reported as "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	Report the first name of the member. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: Anne-Marie should be reported as "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	Report the middle initial of the member when available.	All	2.0%	837/2010CA/NM1/ /05, 837/2010BA/NM1/ /05
108	MC107	ICD Indicator	4/1/2013	Look-up Table - Integer	1	International Classification of Diseases (ICD) version	Use this field to report whether the diagnoses on the claim were coded using ICD-9 or ICD-10 codes Valid codes include: 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(-ses) to which a reported procedure is related 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 also be reported in the Provider File using the Plan Provider ID field (PV002).	Required when MC118 = 1	98.0%	Institutional 837/2310F/REF/G2/02

MEDICAL CLAIMS FILE										
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	Look-up Table - Integer	1	Payment arrangement type value	Report the value that defines the contracted payment methodology for this claim line. Valid codes include: 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 member 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 the 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	Look-up Table - Integer	1	Indicator - Medicare payment applied	Use this field to report whether or not Medicare paid for part or all of the services. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative
117	MC116	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	all	0.0%	N/A
118	MC117	Authorization Needed Indicator	7/2/2013	Look-up Table - Integer	1	Indicator - Authorization needed	Use this field to report whether or not the service required a pre-authorization. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative
119	MC118	Referral Indicator	7/2/2013	Look-up Table - Integer	1	Indicator - Referral needed	Use this field to report whether or not the service was preceded by a referral. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative

MEDICAL CLAIMS FILE										
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	Look-up Table - Integer	1	Indicator - PCP rendered service	Use this field to report whether or not the service was performed by the member's PCP. Valid codes include: 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	Diagnosis Related Group (DRG) code severity level	Report the level used for severity adjustment when applicable.	Required when MC071 is populated	80.0%	Administrative
122	MC121	Member Total Out-of-Pocket Amount	7/2/2013	Decimal,2	10	Total amount member must pay for this claim line	Report the total amount that the 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 the 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". This should total copay, coinsurance, and deductible amounts.	All	100.0%	Administrative
123	MC122	Global Payment Indicator	4/1/2013	Look-up Table - Integer	1	Indicator - Global payment	Use this field to report whether or not the claim line was paid under a global payment arrangement. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative
124	MC123	Denied Indicator	4/1/2013	Look-up Table - Integer	1	Denied claim line indicator	Use this field to report whether or not the claim line was denied. Valid codes include: 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 Look-up 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. If using carrier-defined codes, submitter must provide reference table of values.	Required when MC123 = 1	99.9%	835/2110/CAS
126	MC125	Attending Provider ID	4/1/2013	Text	30	Attending provider ID	Report the ID that reflects the provider that provided general oversight of the member's care. This individual may or may not be the Servicing or Rendering provider. This value must also be reported in the Provider File using the Plan Provider ID field (PV002). 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 FILE										
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	Look-up Table - Integer	1	Indicator - Accident related	Use this field to report whether or not the claim line was accident related. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative
128	MC127	Family Planning Indicator	7/2/2013	Look-up Table - Integer	1	Indicator - Family planning related	Use this field to report whether or not this claim was for services related to family planning. Valid codes include: 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	Look-up Table - Integer	1	Indicator - Employment related	Use this field to report whether or not the rendered service was for an employment-related claim. Valid codes include: 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	Look-up Table - Integer	1	Indicator - EPSDT	Use this field to report whether or not the service was related to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits and the type of EPSDT service. Valid codes include: 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	Look-up Table - Integer	1	Claim line procedure code type identifier	Use this field to report the type of reported Procedure Code (MC055). Valid codes include: 1 .....CPT, HCPCS Level 1, or HIPPS 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 or CPT Category III code 7 .....Custom Code - Submitter must provide a look-up table of values for MC055	Required when MC055 is populated	100.0%	Administrative

MEDICAL CLAIMS FILE										
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	Look-up Table - Integer	1	Indicator – In-network rate applied	Use this field to report whether or not the claim line was paid at an in-network rate. Valid codes include: 1 .....Yes 2 .....No 3 .....Unknown 4 .....Other 5 .....Not Applicable	All	100.0%	Administrative
133	MC132	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
134	MC133	Bill Frequency Code	4/1/2013	External Code Source - NUBC - Text	1	Bill frequency code	Report the valid frequency code of the claim to indicate version, credit/debit activity, and/or setting of claim. This should match the third digit in the Type of Bill reported in MC036. Default value for professional claims is "1".	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 that identifies for the carrier/submitter who or which individual provider cared for the member for the claim line in question. This code must be able to link to the Provider File. Any value in this field must also be reported in the Provider File using the Plan Provider ID field (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
136	MC135	Provider Location	10/7/2013	Text	30	Location of provider	Report the unique code that identifies the location/site. Any value in this field must also be reported in the Provider File using the Plan Provider ID field (PV002).	All	90.0%	Administrative
137	MC136	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
138	MC137	Carrier-Specific Unique Member ID	4/1/2013	Text	50	Member's unique ID	Report the identifier that the carrier/submitter uses internally to uniquely identify the member.	All	100.0%	Administrative
139	MC138	Claim Line Type	4/1/2013	Look-up Table - Text	1	Claim line activity type code	Report the code that defines the claim line status in terms of adjudication. Valid codes include: 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 Payer 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 PC004. Use of the Former Claim Number field to version claims can only be used if approved by AHCT.	All	0.0%	Administrative
141	MC140	Member Street Address 2	4/1/2013	Text	50	Secondary street address of the member	Use this field to report the second line of the member's street address, which may include apartment number, suite identifier, or other secondary information.	All	2.0%	837/2010BA/N3/ /02 837/2010CA/N3/ /02

MEDICAL CLAIMS FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
142	MC141	Carrier-Specific Unique Subscriber ID	4/1/2013	Text	50	Subscriber's unique ID	Report the identifier that the carrier/submitter uses internally to uniquely identify the subscriber.	All	100.0%	Administrative
143	MC142	Other Diagnosis - 13	4/1/2013	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the thirteenth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	MC094=002	0.0%	Institutional 837/2300/HI/BF/13-2, 837/2300/HI/ABF/13-2
144	MC143	Other Diagnosis - 14	4/1/2013	External Code Source - ICD - Text	7	ICD secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the fourteenth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the fifteenth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the sixteenth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the seventeenth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the eighteenth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the nineteenth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the twentieth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the twenty-first secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the twenty-second secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the twenty-third secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	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 secondary diagnosis code (additional)	Use this field to report the ICD diagnosis code for the twenty-fourth secondary diagnosis. If not applicable, report as null. Do not include the decimal point when coding this field.	MC094=002	0.0%	Institutional 837/2300/HI/BF/24-2, 837/2300/HI/ABF/24-2

MEDICAL CLAIMS FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
155	MC154	Present on Admission (POA) Code - 01	4/1/2013	External Code Source - CMS - Text	1	POA code for Principal Diagnosis	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 02	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 1	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 03	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 2	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 04	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 3	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 05	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 4	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC045 is populated	90.0%	Institutional 837/2300/HI/BF/04-9 837/2300/HI/ABF/04-9
160	MC159	Present on Admission (POA) Code - 06	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 5	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC046 is populated	90.0%	Institutional 837/2300/HI/BF/05-9 837/2300/HI/ABF/05-9

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Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
161	MC160	Present on Admission (POA) Code - 07	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 6	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 08	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 7	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 09	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 8	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 10	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 9	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 11	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 10	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 12	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 11	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC052 is populated	90.0%	Institutional 837/2300/HI/BF/11-9 837/2300/HI/ABF/11-9

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Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
167	MC166	Present on Admission (POA) Code - 13	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 12	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 14	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 13	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 15	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 14	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 16	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 15	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 17	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 16	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 18	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 17	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC146 is populated	90.0%	Institutional 837/2300/HI/BF/17-9 837/2300/HI/ABF/17-9

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Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
173	MC172	Present on Admission (POA) Code - 19	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 18	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 20	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 19	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 21	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 20	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 22	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 21	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 23	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 22	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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 (POA) Code - 24	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 23	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	Required when MC094 = 002, MC039 and MC152 is populated	90.0%	Institutional 837/2300/HI/BF/23-9 837/2300/HI/ABF/23-9

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Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
179	MC178	Present on Admission (POA) Code - 25	4/1/2013	External Code Source - CMS - Text	1	POA code for Other Diagnosis - 24	Report the appropriate value from the look-up table to describe whether or not the corresponding diagnosis was present upon admission. If the related diagnosis code is exempt from POA reporting, please code as "1" (Exempt from POA Reporting); do not code as null. Note: Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	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, report as null.	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, report as null.	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, report as null.	Required when MC094 = 002	10.0%	Institutional 837/2300/HI/BG/03-02
183	MC182	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
184	MC183	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
185	MC184	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
186	MC185	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
187	MC186	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
188	MC187	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
189	MC188	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
190	MC189	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
191	MC190	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
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 the 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

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Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
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
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 the 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 the 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	MC197	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
199	MC198	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
200	MC199	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
201	MC200	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
202	MC201	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
203	MC202	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
204	MC203	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
205	MC204	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
206	MC205	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
207	MC206	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
208	MC207	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
209	MC208	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A

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Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
210	MC209	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
211	MC210	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
212	MC211	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
213	MC212	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
214	MC213	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
215	MC214	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
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	MC221	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
223	MC222	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
224	MC223	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
225	MC224	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
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

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Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
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
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	MC231	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
233	MC232	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
234	MC233	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
235	MC234	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
236	MC235	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
237	MC236	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
238	MC237	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
239	MC238	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
240	MC239	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A
241	MC240	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%	N/A

MEDICAL CLAIMS FILE										
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold	Reference
242	MC241	APCD ID Code	4/1/2013	Look-up 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 validations and thresholds. Valid codes include: 1 .....Fully- Insured Commercial Group Enrollee (FIG) 2 .....Self-Insured Group Enrollee (SIG) 3 .....State or Federal Employer Enrollee 4 .....Individual - Non-Group Enrollee 5 .....Supplemental Policy Enrollee 6 .....Integrated Care Organization (ICO) 0 .....Unknown / Not Applicable	All	100.0%	Administrative
243	MC899	Record Type	4/1/2013	Text	2	File type identifier	This field must be coded MC to indicate the submission of medical claims data. The value reported here must match across the following three fields: HD004, MC899, and TR004.	All	100.0%	Administrative
TR-MC	TR001	Record Type	10/7/2013	Text	2	Trailer record identifier	Report TR here. Indicates the beginning of the trailer elements of the file.	Mandatory	100.0%	Administrative
TR-MC	TR002	Submitter Code	10/7/2013	Text	8	Trailer submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match across the following three fields: HD002, MC001, and TR002.	Mandatory	100.0%	Administrative
TR-MC	TR003	National Plan ID	10/7/2013	Text	10	Trailer CMS National Plan Identification Number (Plan ID)	Do not report any value here until the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	Situational	0.0%	Administrative
TR-MC	TR004	Type of File	10/7/2013	Text	2	Trailer file type	This field must be coded MC to indicate the submission of medical claims data. The value reported here must match across the following three fields: HD004, MC899, and TR004.	Mandatory	100.0%	Administrative
TR-MC	TR005	Period Beginning Date	10/7/2013	Full Date - Integer	8	Trailer period start date	Report the date of the first 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 HD005.	Mandatory	100.0%	Administrative
TR-MC	TR006	Period Ending Date	10/7/2013	Full Date - Integer	8	Trailer period end date	Report the date of the last 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 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

Pharmacy Claims

The Basics

Covered Parties All

Required Frequency Monthly

Specific Deadline Within 30 business days of the end of the preceding calendar month

Important Notes

- All lines of partially denied claims are to be reported. Only fully denied claims are to be excluded.
- One record must be submitted for each service adjudicated during the period reported in the header and trailer records. As noted in the Q&As released to CT APCD submitters, a consistent date must be used as the basis for claims submission to ensure that all records are reported each month. The Date Service Approved field (PC017) should be used for this purpose. All dates reported in this field should fall within the period beginning/ending dates reported in the header and trailer (HD005/TR005 and HD006/TR006).
- Submissions must cover full months of data; partial months must not be reported.
- Please note: The element ID provided in the layout table's second column (e.g., HD001 for "Record Type") is reserved for administrative purposes only. These IDs, which can change as file layouts change, should not be incorporated into the field names used for your submissions.

File Layout & Specifications

PHARMACY CLAIMS FILE

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 Code	10/7/2013	Text	8	Header submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match across the following three fields: HD002, PC001, and TR002.	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 the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	Situational	0.0%
HD-PC	HD004	Type of File	10/7/2013	Text	2	Header file type	This field must be coded PC to indicate the submission of pharmacy claims data. The value reported here must match across the following three fields: HD004, PC899, and TR004.	Mandatory	100.0%
HD-PC	HD005	Period Beginning Date	10/7/2013	Full Date - Integer	8	Header period start date	Report the date of the first 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 end date	Report the date of the last 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%

PHARMACY CLAIMS FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
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. If the number of records within the submission does not equal the number reported in this field, the submission will fail. The record count should not include the header and trailer records.	Mandatory	100.0%
HD-PC	HD008	Comments	10/7/2013	Text	80	Header carrier comments	This field may be used by the submitter to document a file name, system source, or other administrative device to assist with their internal tracking of the submission.	Optional	0.0%
HD-PC	HD009	APCD Version Number	10/7/2013	Decimal - Numeric	3	Header DSG version number	Report the DSG version number included on the cover page of this companion guide in x.x format, including the decimal point in the reported value. If the APCD Version Number reported in this field is not accurate, your submission will fail.	Mandatory	100.0%
1	PC001	Submitter Code	4/1/2013	Text	8	Submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match across the following three fields: HD002, PC001, and TR002. Note that the first two characters of the submitter code are used to indicate the client 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 the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	All	0.0%

PHARMACY CLAIMS FILE									
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	Look-up Table - Text	2	Type / product identification code	Report the code that defines the type of insurance under which this member's claim line was processed. Valid codes include: 9..... Self-pay 11..... Other Non-Federal Programs (use of this value requires disclosure to Onpoint 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 ..... Civilian Health and Medical Program of the Uniformed Services (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 Onpoint prior to submission) TV ..... Title V VA ..... Veterans Affairs Plan WC..... Workers' Compensation ZZ..... Mutually Defined (use of this value requires disclosure to Onpoint 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" (not "0") and increment by 1 for each additional line. Do not 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. Do not include alphas or special characters.	All	100.0%
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 across file types: ME006, MC006, and PC006. 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%

PHARMACY CLAIMS FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
8	PC007	Subscriber SSN	4/1/2013	Text	9	Subscriber's Social Security number	Report the subscriber's Social Security number. Do not code using hyphens. If not available, do not report any value here. If this field is not populated, PC008 must be populated. Notes: The value reported for this field should be reported consistently in the Subscriber Social Security Number field across file types: ME008, MC007, PC007. This field will not be passed into the 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. If this field is not populated, PC007 must be populated. Notes: The value reported for this field should be reported consistently in the Plan-Specific Contract Number across file types: ME009, MC008, and PC008.	All	98.0%
10	PC009	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	98.0%
11	PC010	Member SSN	4/1/2013	Text	9	Member's Social Security number	Report the member's Social Security number. Do not code using hyphens. If not available, do not report any value here. If not available, report as null. Notes: The value reported for this field should be reported consistently in the Member Social Security Number field across file types: ME011, MC010, PC010. This field will not be passed into the analytic file.	All	75.0%
12	PC011	Individual Relationship Code	10/30/2013	Look-up Table - Text	2	Member to subscriber relationship code	Report the value that defines the member's relationship to the subscriber. Please note that while there are two codes that allow for the reporting of "Self," correct coding practices require the use of "18". Valid codes include: 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	All	98.0%

PHARMACY CLAIMS FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
							76..... Dependent G8 ..... Other Relationship		
13	PC012	Member Gender	4/1/2013	Look-up Table - Text	1	Member's gender	Report the member's gender as reported on enrollment form in alpha format. Valid codes include: F..... Female M ..... Male U ..... Unknown Notes: The value reported for this field should be reported consistently in the Member Gender field across file types: ME013, MC012, and PC012.	All	100.0%
14	PC013	Member Date of Birth	4/1/2013	Full Date - Integer	8	Member's date of birth	Use this field to report the date on which the member was born in YYYYMMDD format. Notes: The value reported for this field should be reported consistently in the Member Date of Birth field across file types: ME014, MC013, and PC013.	All	99.0%
15	PC014	Member City Name of Residence	4/1/2013	Text	50	City of the member	Report the city name of the member.	All	99.0%
16	PC015	Member State or Province	4/1/2013	External Code Source - USPS - Text	2	State/province of the member	Use this field to report the member's state or province using the two-character abbreviation code defined by the U.S. Postal Service(for U.S. states) and Canada Post (for Canadian provinces).	All	99.9%
17	PC016	Member ZIP Code	4/1/2013	External Code Source - USPS - Text	9	ZIP code of the member	Use this field to report the ZIP/postal code associated with the member's residence. Notes: For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP/postal codes.	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 a date other than the Paid Date (PC063). If Date Service Approved 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 ID number	Report the federal tax ID number of the pharmacy. Do not use hyphens or alpha prefix.	All	20.0%
21	PC020	Pharmacy Name	4/1/2013	Text	100	Name of pharmacy	Report the name of the pharmacy.	All	90.0%
22	PC021	National Provider ID - Pharmacy	4/1/2013	External Code Source - NPPES - text	10	National Provider Identifier (NPI) of the pharmacy	Report the pharmacy's primary National Provider Identifier (NPI). This NPI should also be reported using the National Provider Identifier field (PV039) in the provider file.	All	99.0%
23	PC022	Pharmacy Location City	4/1/2013	Text	30	City name of the pharmacy	Report the city name of the dispensing 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%

PHARMACY CLAIMS FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
25	PC024	Pharmacy ZIP Code	4/1/2013	External Code Source - USPS - Text	9	ZIP code of the pharmacy	Use this field to report the ZIP/postal code associated with the pharmacy's location. Notes: For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP/postal codes.	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	Look-up Table - integer	2	Claim line status	Report the value that defines the payment status of this claim line. Valid codes include: 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 as defined by the FDA in 11-digit format (5-4-2) without hyphenation.	All	98.0%
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 NDC.	All	95.0%
30	PC028	New Prescription or Refill	4/1/2013	Text	2	Prescription status indicator	Use this field to report whether this is a new prescription or refill. Valid codes include: 00..... New prescription 01–99..... Number of refill(s)	All	99.0%
31	PC029	Generic Drug Indicator	4/1/2013	Look-up Table - Integer	1	Generic drug indicator	Use this field to report whether or not the dispensed drug was a generic drug. Valid codes include: 1..... Yes 2..... No 3..... Unknown 4..... Other 5..... Not Applicable	All	100.0%

PHARMACY CLAIMS FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
32	PC030	Dispense as Written Code	4/1/2013	Look-up Table - Integer	1	Prescription dispensing activity code	Report the value that defines how the drug was dispensed. Valid codes include: 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	Look-up Table - Integer	1	Compound drug indicator	Use this field to indicate whether or not the dispensed drug was a compound drug. Valid codes include: 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 on which the pharmacy filled and dispensed the prescription to the member in YYYYMMDD format.	All	99.0%
35	PC033	Quantity Dispensed	4/1/2013	Decimal, 2	10	Claim line units dispensed	Report the count of services / units dispensed. May be reported as a negative.	All	75.0%
36	PC034	Days' Supply	4/1/2013	Integer	3	Prescription supply days	Report the number of days that 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 that the provider / dispensing facility billed the insurance carrier for this claim line service. Do not code the 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%
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 the 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 the 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 the 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 the 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 is responsible to pay	Report the amount that is the member's responsibility. Report "0" if no copay applies. Do not code the 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%

PHARMACY CLAIMS FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
43	PC041	Coinsurance Amount	4/1/2013	Decimal, 2	10	Amount of coinsurance member is responsible to pay	Report the amount that defines a calculated percentage amount for this claim line service that the member is responsible to pay. Report "0" if no coinsurance applies. Do not code the 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 is responsible to pay on the claim line	Report the amount that defines a preset, fixed amount for this claim line service that the member is responsible to pay. Report "0" if no deductible applies to service. Do not code the 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 also be reported in the Provider File using the Plan Provider ID field (PV002).	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.	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.	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.	All	50.0%
49	PC047	Prescribing Physician DEA	7/2/2013	Text	9	Prescriber DEA number	Report the primary DEA number for the prescribing physician.	All	80.0%
50	PC048	National Provider ID - Prescribing	7/2/2013	External Code Source - NPPES - Text	10	National Provider Identifier (NPI) of the prescribing physician	Report the primary National Provider Identifier (NPI) of the prescribing physician identified in PC043–PC047. This NPI should also be reported using the National Provider Identifier field (PV039) in the provider file when the provider is contracted with the carrier.	All	99.0%
51	PC049	Prescribing Physician Plan Number	7/2/2013	Text	30	Carrier-assigned provider plan ID	Report the prescribing physician's plan number here. Do not report any value here if contracted with the carrier. This identifier must match an identifier reported 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 the Plan Provider ID field (PV002) in the Provider File. For a doctor, this is the medical license number; for a non-doctor, this is the practice license number. Do not use zero-fill. If not available or not applicable, such as for a group or corporate entity, report as null.	All	50.0%
53	PC051	Prescribing Physician Street Address 1	7/2/2013	Text	50	Street address of the prescribing physician	Use this field to report the first line of the prescribing physician's street address.	All	10.0%
54	PC052	Prescribing Physician Street Address 2	7/2/2013	Text	50	Secondary street address of the prescribing physician	Use this field to report the second line of the prescribing physician's street address, which may include office number, suite identifier, P.O. Box, or other secondary information.	All	10.0%
55	PC053	Prescribing Physician City	7/2/2013	Text	30	City of the prescribing physician	Use this field to 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	Use this field to report the prescribing physician's state.	All	10.0%

PHARMACY CLAIMS FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
57	PC055	Prescribing Physician ZIP Code	7/2/2013	External Code Source - USPS - Text	9	ZIP code of the prescribing physician	Use this field to report the ZIP/postal code associated with the prescribing physician's location. Notes: For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP/postal codes.	All	10.0%
58	PC056	Filler / Placeholder	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 Indicator	4/1/2013	Look-up Table - Integer	1	Indicator – Mail-order option	Use this field to report whether or not the pharmacy was a mail-order pharmacy. Valid codes include: 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 / Placeholder	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	Look-up Table - Integer	1	Indicator - Drug source	Report the value that defines the availability of the pharmaceutical. Valid codes include: 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 1	4/1/2013	Text	50	Street address of the member	Use this field to report the first line of the member's street address. Note that additional street address information can be reported using the Member Street Address 2 field (PC109).	All	90.0%
64	PC062	Billing Provider Tax ID Number	4/1/2013	Text	9	Billing provider's federal tax ID number (FTIN)	Report the federal tax ID number of the billing provider. Do not use hyphens 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 remittance 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. Note: Claims paid in full, partial, or zero paid must have a date reported here.	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 prescribing 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 for which another payer is liable after the submitting payer has processed this claim line. Report "0" if there is no coordination of benefits (COB) / third-party liability (TPL) amount. Do not code the 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, which indicates that the submitting payer is "secondary" to the prior payer. Only report "0" if the prior payer paid 0 toward this claim line; otherwise do not report any value here. Do not code the 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%

PHARMACY CLAIMS FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
69	PC067	Medicare Paid Amount	7/2/2013	Decimal, 2	10	Any amount Medicare paid towards claim line	Report the amount that Medicare paid toward this claim line. Only Report "0" if Medicare paid 0 toward this claim line; otherwise do not report any value here. Do not code the 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 is less than or equal to the fee charged by the pharmacy. Report "0" when the claim line is denied. Do not code the 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 paid out of pocket on the claim line	Report the amount that the member has paid beyond the copay structure. Report "0" if the member has not paid toward this claim line. Do not code the 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	Look-up Table - Integer	1	Indicator - Rebate	Use this field to report whether or not the prescribed drug was eligible for rebate. Valid codes include: 1..... Yes 2..... No 3..... Unknown 4..... Other 5..... Not Applicable	All	100.0%
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 the 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	Onpoint-defined and maintained code for linking across submitters	Report the Onpoint-assigned submitter code of the carve-out/parent vendor. This field identifies either the payer on behalf of whom the carve-out vendor is reporting (i.e., the parent) or the carve-out vendor contracted to report this claim. Contact the CT APCD for the appropriate value. If no vendor is affiliated with this claim line, report the code from MC001.	All	98.0%
75	PC073	Formulary Indicator	7/2/2013	Look-up Table - Integer	1	Indicator - Formulary inclusion	Use this field to report whether or not the prescribed drug was on the carrier's formulary list. Valid codes include: 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. Note: Valid codes are maintained by the National Council for Prescription Drug Programs (NCPDP) and are available in the NCPDP standards set.	All	99.9%

PHARMACY CLAIMS FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
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 the drug dispensed. The only valid codes for this field are: EA ..... Each GM..... Grams ML..... Milliliter OT ..... Other Note: With the exception of the supplementary code of "OT" (Other), valid codes are maintained by the National Council for Prescription Drug Programs (NCPDP) and are available in the NCPDP's Billing Unit Standards set.	All	80.0%
78	PC101	Subscriber Last Name	4/1/2013	Text	60	Last name of subscriber	Report the last name of the subscriber. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: O'Brien should be reported as "OBRIEN"; Carlton-Smythe should be reported as "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. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: Anne-Marie should be reported as "ANNEMARIE".	All	100.0%
80	PC103	Subscriber Middle Initial	4/1/2013	Text	1	Middle initial of subscriber	Report the subscriber's middle initial.	All	2.0%
81	PC104	Member Last Name	4/1/2013	Text	60	Last name of member	Report the last name of the member. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: O'Brien should be reported as "OBRIEN"; Carlton-Smythe should be reported as "CARLTONSMYTHE".	All	100.0%
82	PC105	Member First Name	4/1/2013	Text	25	First name of member	Report the first name of the member. Names should be reported in upper case and should be concatenated to exclude all punctuation, including hyphens, spaces, and apostrophes. EXAMPLE: Anne-Marie should be reported as "ANNEMARIE".	All	100.0%
83	PC106	Member Middle Initial	4/1/2013	Text	1	Middle initial of member	Report the middle initial of the member when available.	All	2.0%
84	PC107	Carrier-Specific Unique Member ID	4/1/2013	Text	50	Member's unique ID	Report the identifier that the carrier/submitter uses internally to uniquely identify the member.	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.	All	100.0%
86	PC109	Member Street Address 2	4/1/2013	Text	50	Secondary street address of the member	Use this field to report the second line of the member's street address, which may include apartment number, suite identifier, or other secondary information.	All	2.0%
87	PC110	Claim Line Type	4/1/2013	Look-up Table - Text	1	Claim line activity type code	Report the code that defines the claim line status in terms of adjudication. Valid codes include: O ..... Original V ..... Void R ..... Replacement B ..... Back-Out A ..... Amendment	All	98.0%

PHARMACY CLAIMS FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
88	PC111	Former Claim Number	4/1/2013	Text	35	Previous claim number	Report the Payer 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 the Former Claim Number field to version claims can only be used if approved by AHCT.	All	0.0%
89	PC112	Medicare Indicator	7/2/2013	Look-up Table - Integer	1	Indicator - Medicare payment applied	Use this field to report whether or not Medicare paid for part or all of the services. Valid codes include: 1..... Yes 2..... No 3..... Unknown 4..... Other 5..... Not Applicable	All	100.0%
90	PC113	Pregnancy Indicator	7/2/2013	Look-up Table - Integer	1	Indicator - Pregnancy	Use this field to report whether or not the member was pregnant. Valid codes include: 1..... Yes 2..... No 3..... Unknown 4..... Other 5..... Not Applicable	All	100.0%
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	Look-up Table - Integer	1	International Classification of Diseases (ICD) version	Use this field to report whether the diagnoses on the claim were coded using ICD-9 or ICD-10 codes. Valid codes include: 9..... ICD-9 0..... ICD-10	Required when PC114 is populated	100.0%
93	PC116	Denied Flag	7/2/2013	Look-up Table - Integer	1	Indicator - Denied claim line	Use this field to report whether or not the claim line was denied. Valid codes include: 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 Look-up Table - Text	30	Denial reason code	Report the code that defines the reason for denial of the claim line. If using carrier-specific codes, submitter must provide reference table.	Required when PC116 = 1	100.0%

PHARMACY CLAIMS FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
95	PC118	Payment Arrangement Type	7/2/2013	Look-up Table - Integer	1	Payment arrangement type value	Use this field to report the value that defines the contracted payment methodology for this claim line. Valid codes include: 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 / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%
97	PC120	APCD ID Code	4/1/2013	Look-up Table - Integer	1	Member enrollment type	Use this field to report the value that describes the member's/subscriber's enrollment into one of the predefined categories; aligns enrollment to appropriate validations and thresholds. Valid codes include: 1..... Fully -Insured Commercial Group Enrollee (FIG) 2..... Self-Insured Group Enrollee (SIG) 3..... State or Federal Employer Enrollee 4..... Individual - Non-Group Enrollee 5..... Supplemental Policy Enrollee 6..... Integrated Care Organization (ICO) 0..... Unknown / Not Applicable	All	100.0%
98	PC899	Record Type	4/1/2013	Text	2	File type Identifier	This field must be coded PC to indicate the submission of pharmacy claims data. The value reported here must match across the following three fields: HD004, PC899, and TR004.	All	100.0%
TR-PC	TR001	Record Type	10/7/2013	Text	2	Trailer record identifier	Report TR here. Indicates the beginning of the trailer elements of the file.	Mandatory	100.0%
TR-PC	TR002	Submitter Code	10/7/2013	Text	8	Trailer submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match across the following three fields: HD002, PC001, and TR002.	Mandatory	100.0%
TR-PC	TR003	National Plan ID	10/7/2013	Text	10	Trailer CMS National Plan Identification Number (Plan ID)	Do not report any value here until the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	Situational	0.0%
TR-PC	TR004	Type of File	10/7/2013	Text	2	Trailer file type	This field must be coded PC to indicate the submission of pharmacy claims data. The value reported here must match across the following three fields: HD004, PC899, and TR004.	Mandatory	100.0%
TR-PC	TR005	Period Beginning Date	10/7/2013	Full Date - Integer	8	Trailer period start date	Report the date of the first 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 HD005.	Mandatory	100.0%
TR-PC	TR006	Period Ending Date	10/7/2013	Full Date - Integer	8	Trailer period end date	Report the date of the last 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 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%

Provider File

The Basics

Covered Parties All

Required Frequency Monthly

Specific Deadline Within 30 business days of the end of the preceding calendar month

Important Notes

- One record must be submitted for each variation in a provider's information during the period reported in the header and trailer records.
- Submissions must include information for all providers who rendered services reported in your claims data for the quarter.
- The provider file should include all Connecticut-based providers, providers outside of Connecticut who have been reported in the claims files and PCPs reported in the eligibility file.
- Please note: The element ID provided in the layout table's second column (e.g., HD001 for "Record Type") is reserved for administrative purposes only. These IDs, which can change as file layouts change, should not be incorporated into the field names used for your submissions.

File Layout & Specifications

PROVIDER FILE									
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 Code	10/7/2013	Text	8	Header submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match across the following three fields: HD002, PV001, and TR002.	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 the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	Situational	0.0%
HD-PV	HD004	Type of File	10/7/2013	Text	2	Header file type	This field must be coded PV to indicate the submission of provider data. The value reported here must match across the following three fields: HD004, PV899, and TR004.	Mandatory	100.0%
HD-PV	HD005	Period Beginning Date	10/7/2013	Full Date - Integer	8	Header period start date	Use this field to report the date of the first 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	Full Date - Integer	8	Header period end date	Use this field to report the date of the last 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%

PROVIDER FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
HD-PV	HD007	Record Count	10/7/2013	Integer	10	Header record count	Use this field to report the total number of records submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters. If the number of records within the submission does not equal the number reported in this field, the submission will fail. The record count should not include the header and trailer records.	Mandatory	100.0%
HD-PV	HD008	Comments	10/7/2013	Text	80	Header carrier comments	This field may be used by the submitter to document a file name, system source, or other administrative device to assist with their internal tracking of the submission.	Optional	0.0%
HD-PV	HD009	APCD Version Number	10/7/2013	Decimal - Numeric	3	Header DSG version number	Use this field to report the DSG version number included on the cover page of this companion guide in x.x format, including the decimal point in the reported value. If the APCD Version Number reported in this field is not accurate, your submission will fail.	Mandatory	100.0%
1	PV001	Submitter Code	4/1/2013	Text	8	Submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match across the following three fields: HD002, PV001, and TR002. Note that the first two characters of the submitter code are used to indicate the client 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	Unique carrier provider code	Use this field to 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 links to PV056, ME036, ME046 MC024, MC076, MC112, MC125, MC134, MC135, and PC043.	All	100.0%
3	PV003	Tax ID	4/1/2013	Text	9	Federal tax ID of non-individual providers	Use this field to 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	4/1/2013	Text	6	Unique physician identification number	Use this field to report the Unique Physician Identification Number (UPIN) for the provider identified in PV002. To report other Medicare identifiers, use PV036.	Required when PV034 = 1	0.0%
5	PV005	DEA Number	4/1/2013	Text	9	Provider DEA registration number	Use this field to report the valid U.S. Drug Enforcement Agency (DEA) registration number assigned to the individual, group, or facility identified in 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	Use this field to 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 identified in PV002	Use this field to report the individual provider's last name. Do not report any value here for facility or non-individual provider records. Report non-person entities in the Entity Name field (PV012).	Required when PV034 = 1	98.0%

PROVIDER FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
9	PV009	First Name	4/1/2013	Text	50	First name of the provider identified in PV002	Use this field to report the individual provider's first name. Do not report any value here for facility or non-individual provider records. Report non-person entities in the Entity Name field (PV012).	Required when PV034 = 1	98.0%
10	PV010	Middle Initial	4/1/2013	Text	1	Middle initial of the provider identified in PV002	Report the individual's middle initial. Do not report any value here for facility or non-individual provider records. Report non-person entities the Entity Name field (PV012).	Required when PV034 = 1	1.0%
11	PV011	Filler / Placeholder	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	Use this field to report the provider's entity name. This should only be populated for facilities or groups. Punctuation may be included.	Required when PV034 = 2, 3, 4, 5, 6, 7, or 0	98.0%
14	PV014	Gender Code	4/1/2013	Look-up Table - Text	1	Gender of provider identified in PV002	Use this field to report provider gender in alpha format as found on certification, contract and / or license. Valid codes include: F ..... Female M..... Male U..... Unknown	Required when PV034 = 1	98.0%
15	PV015	Provider Date of Birth	7/2/2013	Integer	8	Birth date of the provider	Use this field to 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 1 of the provider	Use this field to report the first line of the physical street address where provider sees plan members. If only a mailing address is available, please send the mailing address in this field in addition to reporting it in the Mailing Street Address 1 field (PV023). 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	Use this field to report the second line (if needed) of the physical street address where provider sees plan members. If only a mailing address is available, please report the mailing address in this field in addition to reporting it in the Mailing Street Address 2 field (PV024). 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%
18	PV018	City Name	4/1/2013	Text	35	City of the provider	Use this field to report the city name of the site at which the provider sees plan members. If only a mailing address is available, please report the city name in this field in addition to reporting it in the Mailing City Name field (PV025). 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	Use this field to report the state of the site at which the provider sees plan members. If only a mailing address is available, please report the mailing state here in addition to reporting it in the Mailing State Code field (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	Use this field to report the three-character country code as defined by ISO 3166-1 alpha_3, of the site at which the provider sees plan members. If only a mailing address is available, please report the mailing country here in addition to reporting it in the Mailing Country Code field (PV027). 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%
21	PV021	ZIP Code	4/1/2013	External Code Source - USPS - Text	9	ZIP code of the provider	Use this field to report the ZIP/postal code associated with the provider's location. Notes: For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP/postal codes.	All	98.0%

PROVIDER FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
22	PV022	Taxonomy	4/1/2013	External Code Source WPC - Text	10	Taxonomy code	Use this field to 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 Address 1	4/1/2013	Text	50	Street address of the provider/entity	Use this field to report the mailing address of the provider/entity identified in PV002.	All	98.0%
24	PV024	Mailing Street Address 2	4/1/2013	Text	50	Secondary street address of the provider/entity	Use this field to report the mailing address of the provider/entity identified in PV002.	All	2.0%
25	PV025	Mailing City Name	4/1/2013	Text	35	City name of the provider/entity	Use this field to report the city of the mailing address of the provider/entity identified 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	Use this field to report the state of the mailing address of the provider/entity identified 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	Use this field to 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/entity	Use this field to report the ZIP/postal code associated with the provider's mailing address. Notes: For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code) when possible. Do not code dashes or spaces within ZIP/postal codes.	All	98.0%
30	PV030	Primary Specialty Code	4/1/2013	External Code Source 4 -Text	2	Specialty code	Use this field to report the standard primary specialty code of the provider.	Required when PV034 = 0, 1, 2, 3, 4, or 5	98.0%
34	PV034	Provider ID Code	4/1/2013	Look-up Table - Integer	1	Provider identification code	Report the value that defines type of entity associated with PV002. The value reported here drives intake validations for quality purposes. Valid codes include: 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%

PROVIDER FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
35	PV035	SSN	4/1/2013	Text	9	Provider's Social Security number (SSN)	Report the SSN of the individual provider identified 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 identified in PV002. Do not report UPIN here; instead, please report the UPIN in 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 Identifier	4/1/2013	External Code Source NPPES - Text	10	National Provider Identifier (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 Identifier 2	4/1/2013	External Code Source NPPES - Text	10	Second National Provider Identifier (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 / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%
42	PV042	Secondary Specialty Code	4/1/2013	Carrier Defined Table - Text	10	Secondary 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. Submitters to provide a reference table for these values.	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	Other 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. If using carrier-defined codes, submitter must provide reference table of values.	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	Other 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. If using carrier-defined codes, submitter must provide reference table of values.	Required when PV034 = 0, 1, 2, 3, 4, or 5	0.0%
44	PV045	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%
45	PV046	Filler / Placeholder	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	Look-up Table - Integer	1	Indicator – Electronic Health Record (HER) utilization	Use this field to report whether or not the provider uses electronic health records. Valid codes include: 1 ..... Yes 2 ..... No 3 ..... Unknown 4 ..... Other 5 ..... Not Applicable	All	100.0%
48	PV048	Filler / Placeholder	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 FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
49	PV049	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%
50	PV050	Filler / Placeholder	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	PV051	Filler / Placeholder	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	Look-up Table - Integer	1	Indicator - Multiple office provider	Use this field to report whether or not the provider uses multiple office locations. Valid codes include: 1 ..... Yes 2 ..... No 3 ..... Unknown 4 ..... Other 5 ..... Not Applicable	Required when PV034 = 1, 2, or 3	100.0%
53	PV053	Filler / Placeholder	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%
55	PV055	PCP Flag	4/1/2013	Look-up Table - Integer	1	Indicator - Provider is a PCP	Use this field to report whether or not the provider is a PCP. Valid codes include: 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 Indicator	7/2/2013	Integer	1	Indicator - Delegated record	Use this field to report whether or not this record pertains to a delegated provider. Valid codes include: 1 ..... Yes 2 ..... No 3 ..... Unknown 4 ..... Other 5 ..... Not Applicable	All	100.0%
59	PV059	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%
60	PV060	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%
61	PV061	Filler / Placeholder	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	PV062	Filler / Placeholder	7/2/2013	Filler	0	Filler	Access Health CT reserves this field for future use. Do not populate with any data.	All	0.0%
63	PV063	Filler / Placeholder	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 FILE									
Col. #	Element	Data Element Name	Date Modified	Format	Length	Description	Element Submission Guideline Comments	Condition (Denominator)	Recommended Threshold
64	PV064	PPO Indicator	4/1/2013	Look-up Table - Integer	1	Indicator - Provider PPO contract	Use this field to report whether or not the provider was participating as part of a Preferred Provider Organization (PPO). Valid codes include: 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	This field must be coded PV to indicate the submission of provider data. The value reported here must match across the following three fields: HD004, PV899, and TR004.	All	100.0%
TR-PV	TR001	Record Type	10/7/2013	Text	2	Trailer record identifier	Report TR here. Indicates the beginning of the trailer elements of the file.	Mandatory	100.0%
TR-PV	TR002	Submitter Code	10/7/2013	Text	8	Trailer submitter code assigned by Onpoint	Use this field to report your Onpoint-assigned submitter code. The value reported here must match across the following three fields: HD002, PV001, and TR002.	Mandatory	100.0%
TR-PV	TR003	National Plan ID	10/7/2013	Text	10	Trailer CMS National Plan Identification Number (Plan ID)	Do not report any value here until the National Plan ID is fully implemented. This is a unique identifier as outlined by the U.S. Centers for Medicare and Medicaid Services (CMS) for plans and sub-plans.	Situational	0.0%
TR-PV	TR004	Type of File	10/7/2013	Text	2	Trailer file type	This field must be coded PV to indicate the submission of provider data. The value reported here must match across the following three fields: HD004, PV899, and TR004.	Mandatory	100.0%
TR-PV	TR005	Period Beginning Date	10/7/2013	Full Date - Integer	8	Trailer period start date	Report the date of the first 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 HD005.	Mandatory	100.0%
TR-PV	TR006	Period Ending Date	10/7/2013	Full Date - Integer	8	Trailer period end date	Report the date of the last 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 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%

Definitions & Acronyms

Definitions

- **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 (Release Date: 12/05/2013; link).
- **Data Dictionary:** Documentation that outlines each data element collected, the length, format, and usage of each element along with any relationships between the data sets stated in the DSG and/or additional data sets outside of the DSG.
- **Data Manager:** The Administrator's designated contractor responsible for data intake, validation, 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, Dental 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 Validations:** The logic built around the layout, format, and content of the expected data sets. These validations 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 (Release Date: 12/05/2013; link)

- HIPAA: Health Insurance Portability and Accountability Act of 1996
- PP: Policies and Procedures issued by AHCT (Release Date: 12/05/2013; link)
- RA: Risk-Adjustment

Reaching Onpoint

Onpoint's staff are committed to helping Access Health CT's reporting entities every step of the way — from helping to explain state requirements to answering general questions to trouble-shooting specific challenges. In order to process questions as promptly as possible, please be prepared to provide detailed information to help us understand your specific questions and issues. We offer several ways to find support:

207-623-2555, 8:00am – 4:30pm (Eastern)

ahct-support@onpointhealthdata.org

www.onpointcdm.org

Onpoint Health Data
Attn: CT APCD Intake Specialist
254 Commercial Street, Suite 257
Portland, ME 04101

One last note: Please remember to refer to Access Health CT's website as the authoritative source for CT APCD regulations, announcements, calendars, reports, publications, and links of interest. The Access Health CT portal at www.onpointcdm.org offers easy access to many of these documents, but focuses primarily on reporting entity support, including registration and technical information related to file preparation and data submission.

Reliable data. Informed decisions. Strategic advantage.

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www.OnpointHealthData.org