ONPOINT Health Data

Data Submission Guide

Minnesota Health Care Claims Reporting System Carrier Communication Package

VERSION: 3.0

UPDATED: May 2015

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1. WELCOME

Welcome to the Minnesota all-payer claims database (APCD), known also as the Minnesota Health Care Claims Reporting System (MHCCRS). This important resource was established for the purpose of collecting, assessing and reporting de-identified healthcare information relating to safety, quality, cost-effectiveness, access, and efficiency for all levels of healthcare. The APCD is overseen by the Minnesota Department of Health (MDH) and serves as a critical component of the State's long-standing healthcare reform efforts.

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

We're Onpoint Health Data, MDH's contracted vendor to perform data collection, validation, integration, and enhancement in support of the MDH's analytic initiatives. We've been doing this type of work for more than 15 years, helping launch statewide and regional APCDs across the country to support improved understanding of healthcare delivery and reform initiatives. 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 MHCCRS submission requirements and how to meet them as efficiently as possible. This *MHCCRS Carrier Communication Package* 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 MN 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 MN APCD.

2. INTRODUCTIONS & CONTACT INFORMATION

About the Minnesota Department of Health

Minnesota's public health system is known as one of the best in the nation. It is built upon a strong partnership between the Minnesota Department of Health (MDH), local public health agencies, tribal governments and a range of other organizations. The department's mission is to protect, maintain and improve the health of all Minnesotans. In 2008, Minnesota enacted landmark health reform legislation that took a comprehensive approach to public health investment, market transparency, care redesign and payment reform and consumer engagement.

Learn more by visiting their website: www.health.state.mn.us

How to Reach the Minnesota Department of Health

The state agency serving as the primary contact for the MN APCD is the Minnesota Department of Health. 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.

health.apcd@state.mn.us

www.health.state.mn.us

About Onpoint Health Data

Onpoint Health Data is the Minnesota Department of Health's' contracted vendor for the collection, cleansing, validation, and consolidation of all submissions to the Minnesota Health Care Claims Reporting System (MHCCRS). We are a Maine-based independent, nonprofit organization formed in 1976 by key stakeholders from the 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 systems, 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)

mn-support@onpointhealthdata.org

www.onpointhealthdata.org
www.onpointcdm.org

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

3. GENERAL SUBMISSION REQUIREMENTS

Who Must Register & Supply Data to the MN APCD?

All health plan companies and third party administrators (TPAs), including pharmacy benefit managers (PBMs), covering Minnesota residents, as defined within Minnesota Administrative Rules, Chapter 4653, and related statutes, must register annually with Onpoint Health Data. Registration is due by April 1 of each year. (Note that if you already submit data to Onpoint for another client, you still need to register for MHCCRS submissions. To keep things simple, though, we'll extend your authorizations appropriately, enabling you to use your existing Onpoint CDM login and password for all submissions to Onpoint.)

While all health plan companies and TPAs must register, only some must submit enrollment and healthcare claims data. A brief summary of the determining guidelines follows (for full rules and requirements, please see Minnesota Administrative Rules, Chapter 4653).

Health Plan Companies & TPAs That Must Submit Data

During its annual registration, a health plan company or TPA must determine if they paid a total of at least $3 million in medical (institutional and professional) and pharmacy claims (or at least $300,000 if a PBM) for Minnesota residents during the previous calendar year. If a health plan company or TPA meets this threshold, they are considered a data submitter under the rule and must begin submitting detailed enrollment and healthcare claims data to Onpoint CDM as specified within the rule. Once a health plan company or TPA is considered a data submitter, they must continue to submit the required data until they meet the discontinuance criteria, as described below.

Discontinuance of Data Submission

A data submitter may discontinue submitting enrollment and healthcare claims data to Onpoint CDM only after it sees a significant and sustained drop in its level of paid claims. Specifically, a data submitter must have paid less than $1 million in healthcare claims for covered individuals (or less than $100,000 for PBMs) for each of the two previous consecutive calendar years before they are able to discontinue their data submission. Three months' written notice to the Commissioner of Health is required. Such notice should be sent to:

Minnesota Department of Health, Health Economics Program
Attn: Encounter Data Collection
85 East Seventh Place, Suite 220
St. Paul, MN 55101

Health Plan Companies & TPAs That are Not Required to Submit Data

Health plan companies or TPAs that both were not considered a data submitter during the previous year's registration *and* do not currently meet the annual $3 million threshold (or $300,000 for PBMs), as described above, do not have to submit enrollment and healthcare claims data.

Note that when calculating total claims payments for the above determination of status as a data submitter, Medicare Supplement data should be excluded. Consequently, health plan companies and

TPAs that exclusively provide or administer Medicare Supplement Insurance coverage will not have any claims or enrollment files to submit at this time. (See the "January 2010 Update" in this document for more details.)

However, regardless of the proportion of claims that come from Medicare Supplement Insurance coverage, all health plan companies and TPAs, as defined within Minnesota Administrative Rules, Chapter 4653, must continue to register annually.

Information included on the standard registration form includes:

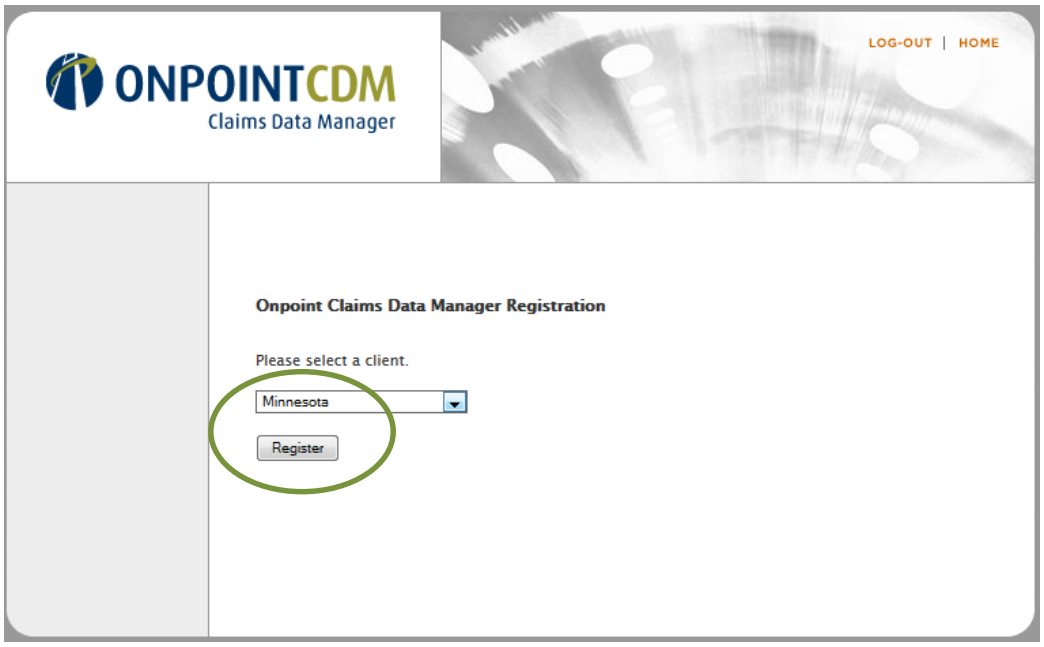
- Company address(es)
- Number of covered lives
- Adjustment-reporting methodology
- Contacts for questions regarding eligibility, medical claims, pharmacy claims, and compliance
- Enumeration of required APCD elements that your system does not record

To get started, please visit www.onpointcdm.org, and click the "Register" link in the home page's upper menu (see Figure 1).

Figure 1. Onpoint CDM's Public Home Page

Next, simply select “Minnesota” from the list of clients and click the “Register” button (Figure 2), which will direct you to the online registration form.

Figure 2. Onpoint CDM’s Registration Launch Page



After registration, each of your organization’s identified contacts will receive an email with their assigned login and password. Each contact will receive a copy of all Onpoint CDM emails. Contacts who wish to receive email regarding only a subset of topics (e.g., compliance, newsletters, etc.) must send an email specifying their preferences to mn-support@onpointhealthdata.org to restrict their email distribution.

Please remember that mandatory re-registration is due each year prior to April 1 to ensure that the State’s records are kept current. If you have any questions, please contact the MDH or Onpoint’s intake specialists for further details or clarification regarding registration requirements.

What is the Submission Schedule?

While MHCCRS regulations allow for semi-annual reporting, **the MDH requests that all submitters work as hard as possible to follow a monthly reporting schedule** to enable more timely use of the data. The preferred monthly reporting schedule is provided in Table 1:

Table 1. Monthly Reporting Schedule (30 Days After Close of Preceding Calendar Month)

Calendar Month	Submission by . . .
January	February 28 (February 29 on leap years)
February	March 31
March	April 30
April	May 31
May	June 30
June	July 31
July	August 31
August	September 30
September	October 31
October	November 30
November	December 31
December	January 31 of the next calendar year

For MHCCRS submitters that are unable to report on a month-to-month basis, the optional quarterly and mandatory semi-annual schedules follow in tables 2 and 3.

Table 2. Quarterly Reporting Schedule (30 Days After Close of Preceding Calendar Quarter)

Calendar Quarter	Submission by . . .
Q1: January 1 – March 31	April 30
Q2: April 1 – June 30	July 31
Q3: July 1 – September 30	October 31
Q4: October 1 – December 31	January 31 of the next calendar year

Table 3. Semi-Annual Reporting Schedule (90 Days After Close of Six-Month Period)

Enrollment & Paid Claims Dates	Submission by . . .
October 1 (of the preceding year) – March 31 (of the current year)	June 30
April 1 – September 30 (both current year)	December 31

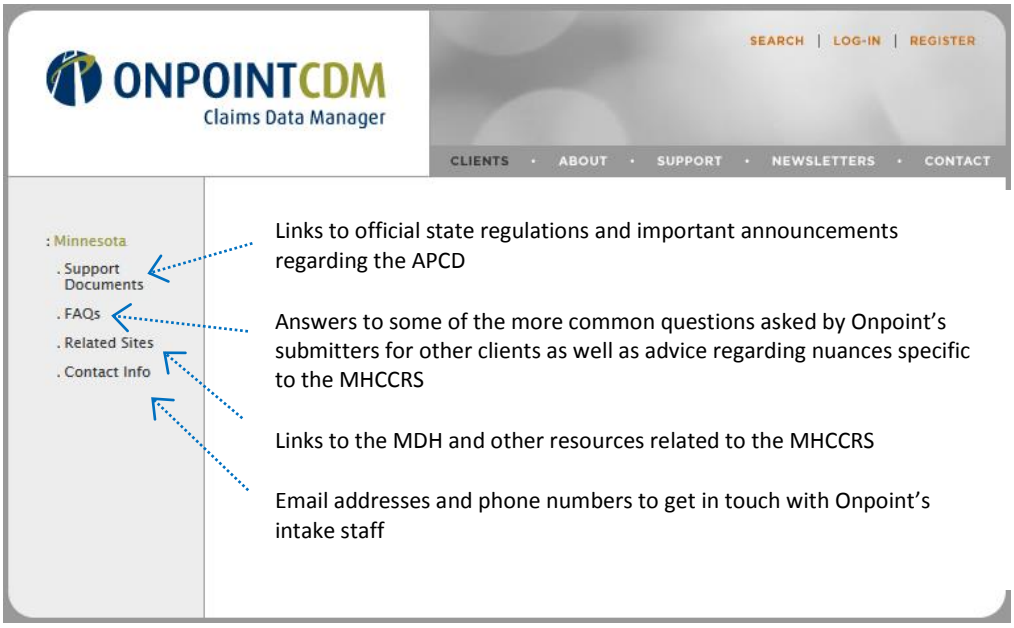
4. GETTING ORIENTED AT ONPOINT CDM

Data collection and validation for Minnesota claims submissions will be performed by Onpoint's suite of data integration and processing services, Onpoint CDM (Claims Data Manager). 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 3). Onpoint CDM's section for the MN APCD can be found here.

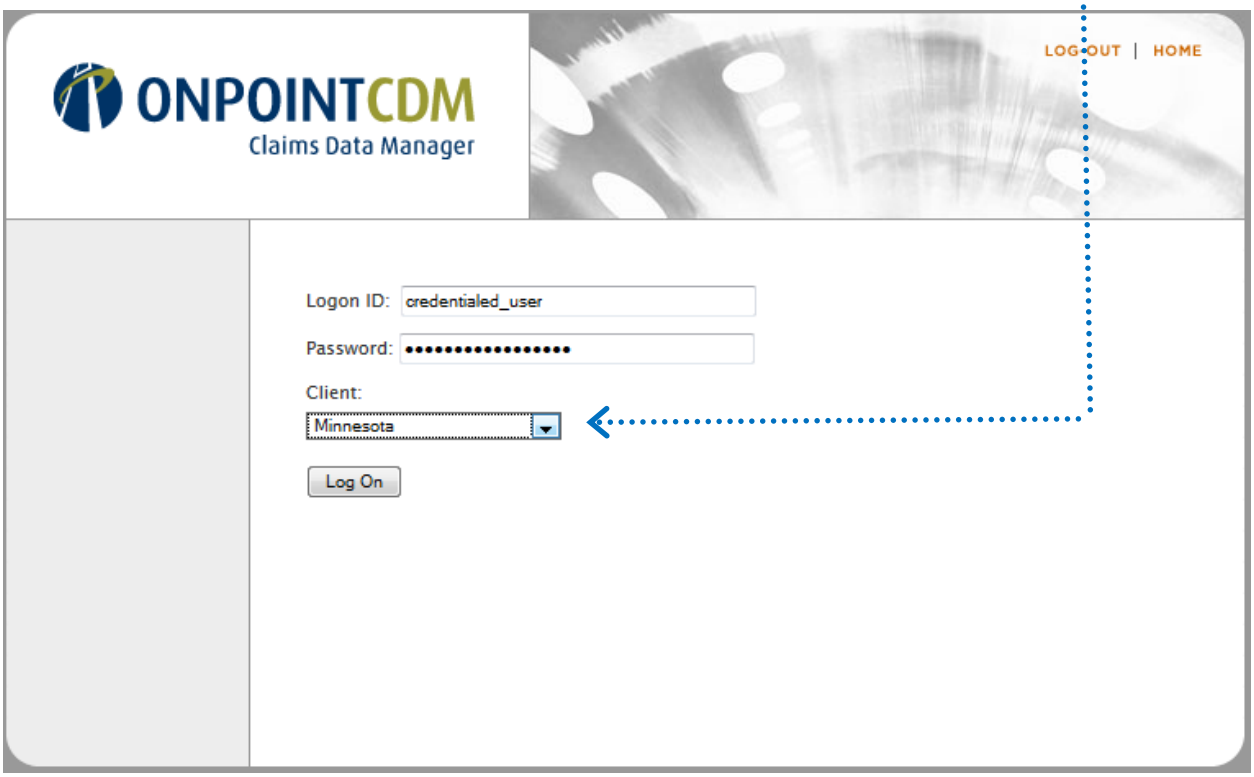
Figure 3. Onpoint CDM Options — Public Zone



Options at the Secure Level

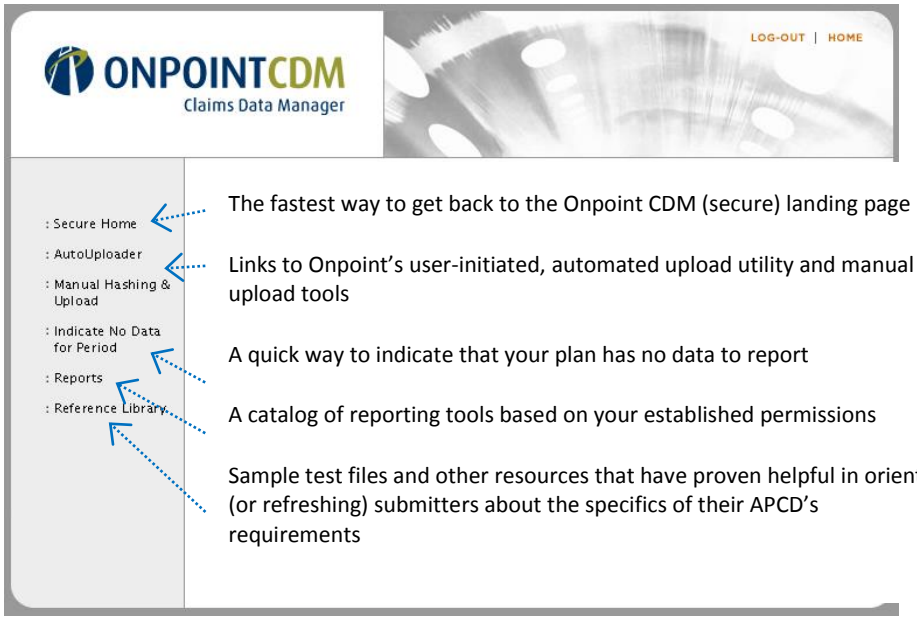
Credentialed users can log in to Onpoint CDM anytime to monitor the status of their submissions, including up-to-date reporting on stage, status, reasons for file failure, and resubmission deadlines. Gaining access begins at the Onpoint CDM home page. Simply click the LOG-IN option from the page's upper-right corner. Next, enter your Onpoint-assigned Logon ID and Password, select MINNESOTA from the drop-down list of clients, and click the LOG ON button (Figure 4).

Figure 4. Onpoint CDM Options — Logging in to the Secure Zone



Within Onpoint CDM's secure portal, the left-hand menu provides a range of options to help you monitor submissions and access reports that help explain issues that we're seeing in your submitted data (see Figure 5).

Figure 5. Onpoint CDM Options — Secure Zone



Supporting Submitters

Onpoint's data intake staff will work hand in hand with your technical staff to understand and meet the Minnesota's established data layouts, quality and completeness thresholds, and data quality validation process. We don't simply fail a submission and abandon submitters to resolve issues on their own; instead, we will help you find the solutions that both you and the MDH need to obtain high-quality data. Our ultimate goal is to arrive at a solution that is efficient and programmable for participating plans while not compromising the timeliness and high quality of the MHCCRS and its important follow-on analytics.

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 check, and enumerate the necessary next steps. For more complex problems, intake staff also work with plans to suggest the probable cause and identify possible fixes. This process generally takes less than 48 hours following file processing. See Table 4 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 any needed resubmissions.

Table 4. 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

Understanding the Data Quality Review Process

Testing is required by all health plan companies and third party administrators (TPAs), including pharmacy benefit managers (PBMs) who fall under the Minnesota data submission rule. Test submissions are flagged by the data reporter using the drop-down menu on the upload page of Onpoint CDM's web application. These submissions then run through the full battery of data evaluation processes and quality checks to assess the integrity, quality, and completeness of the submitted data.

Threshold Levels

Threshold levels for individual data elements are validated against those defined in the Minnesota rule. Submissions failing to meet one or more of the thresholds will be rejected automatically and will initiate

an automatic email from the system. A detailed copy of the threshold report, also referred to as a frequency report, is available on the web for review by authorized individuals for the data reporter that is testing.

There are four types of threshold checks:

- **Minimum Completeness Threshold Requirement** — Onpoint CDM evaluates submitted records to make sure they meet the minimum requirements for completeness. The numerator is all records with a *valid* entry that is not null. The denominator specifications appear in the tables below.
- **Zero Percent, Voluntary** — There are a number of fields that the state is requesting, but not requiring. The voluntary fields are:

MC005A	Version Number
PC027	Drug Name
PC029	Generic Drug Indicator
PC044	Prescribing Physician First Name
PC045	Prescribing Physician Middle Name

- **Zero Percent, Required** — There are several pairs of fields where the frequency of occurrence of a field is dependent upon the mix of claims. For those pairs, a threshold of 0 percent is given for the individual fields, but in combination the total percent completeness for the two fields must be at least 100 percent. The paired fields are:

MC024	Service Provider Number	&	MC026	National Service Provider ID (NPI)
MC076	Billing Provider Number	&	MC077	National Billing Provider ID (NPI)
PC018	Pharmacy Number	&	PC021	National Pharmacy ID Number (NPI)
PC047	Prescribing Physician DEA/Legacy Number	&	PC048	National Provider Identification Number (NPI)

- **Percent of Records with Value of** 9999999999 — A value of all 9s is to be used to indicate an unknown amount in a financial field. A maximum of 1 percent of all records may have a value of 9999999999 in the following fields:

MC062	Charge Amount
MC063	Paid Amount
MC063C	Managed Care Withhold
MC064	Prepaid Amount
MC065	Copay/Coinsurance Amount
MC067	Deductible Amount

PC035	Gross Amount Due
PC036	Total Amount Paid
PC036A	Other Amount Paid
PC036B	Other Payer Amount Recognized
PC037	Ingredient Cost / List Price
PC039	Dispensing Fee Paid
PC040	Copay/Coinsurance Amount
PC042	Deductible Amount
PC043	Patient Pay Amount

Quality Checks

Onpoint's testing protocol has been designed to bring payers online as efficiently and accurately as possible. For MN APCD submitters, we typically begin with one complete month of payer data (i.e., January 2009), evaluating three key components:

- The completeness of individual data elements
- The relationships between data elements
- The relationships between data types (eligibility and claims data)

Once that single month of data has been approved, submitters will continue the historical load, reporting the rest of their first six historical months of each data type (i.e., February 2009 – June 2009). This larger volume of data will be evaluated on the same three components; this time, however, we also will examine utilization rates, per member per month (PMPM) measures, and longitudinal trends. PMPM statistics will be generated on this larger data set, including member months by product type, total number of claims, total payments, total number of high-cost claims, total member payments by month, and the number of unique members. Following this step, payers will be asked to supply the remainder of their historical data (i.e., July 2009 – current).

Requesting a Variance from Minnesota's Standards

Throughout the course of capturing data for the MN APCD, it may be necessary to make exceptions to the Minnesota's mandated data thresholds — most commonly when a data submitter'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 MDH to authorize submitter-specific overrides and variances.

Submitters wishing to request a variance must apply using a form established by the Commissioner of the Department of Health. The process and requirements are identified in the State's rule, and forms are available in Onpoint CDM's Minnesota section.

5. USING ONPOINT CDM TO SEND & RECEIVE DATA

Element De-Identification & Transformation

Onpoint's data collection system ensures that reported member information, whether live or de-identified, remains secure — both at rest and in motion — through the use of a federally recommended hashing algorithm. This hashing is not performed by Onpoint; instead, it is performed locally by submitters. Using Onpoint's system, all direct member identifiers, as identified in Minnesota regulations, are hashed upon preparation for submission, remain solely within the health plan's platform, and are neither transmitted nor received by Onpoint.

For the MHCCRS, Table 5 identifies the fields that are either transformed or de-identified through non-reversible hashing prior to transmission to Onpoint.

Table 5. Fields Transformed or Hashed Prior to Submission

Common Name	Field Number(s)
Claim Submitter's Identifier	MC004A
Plan-Specific Contract Number	ME009, MC008, PC008
Member Date of Birth *	ME014, MC013, PC013
Subscriber Last Name	ME101, MC101, PC101
Subscriber First Name	ME102, MC102, PC102
Subscriber Middle Initial	ME103, MC103, PC103
Member Last Name	ME104, MC104, PC104
Member First Name	ME105, MC105, PC105
Member Middle Initial	ME106, MC106, PC106

* The encryption application supplied by Onpoint will use date of birth to calculate age, add age to the record, and encrypt date of birth before the submitter uploads the data. The actual date of birth will not be in the Minnesota data warehouse.

All data submitted to Onpoint CDM are processed first by our hashing and upload applications, which safeguard electronic protected health information (ePHI) both at rest (within applications at the point of capture) and in motion (during transmission from payers to Onpoint using HTTPS and SSL protocols). These applications also provide preliminary validation of the data being submitted, zip the file for more efficient transmission, and rename the file according to normalizing conventions.

Onpoint CDM also features success verification and viewable logs to provide reassurance to carriers and clients alike. Our software additionally validates the contents of submissions at a very high level, providing a preliminary safeguard against critical flaws.

Files that fail any of the following checks are rejected prior to completing the hashing process:

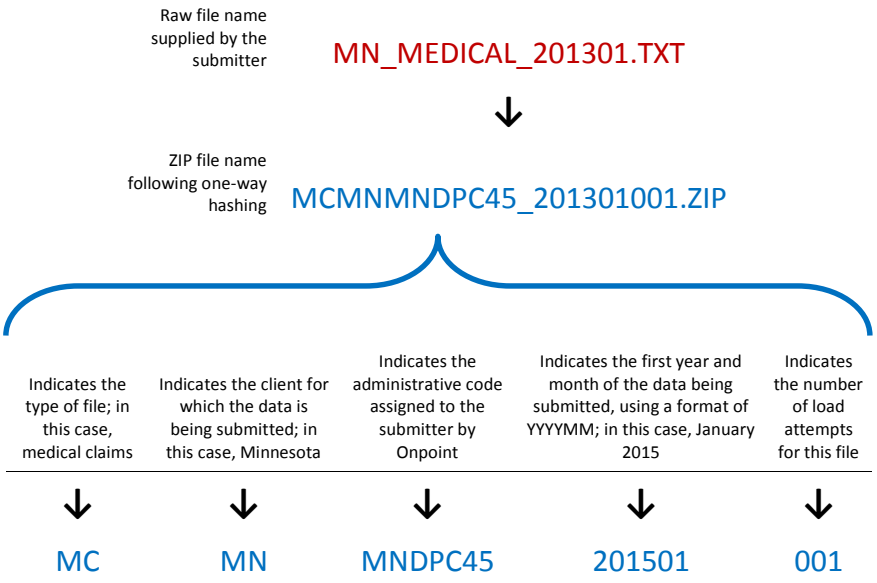
1. The file contains one header record and one trailer record, both of which are formatted correctly
2. The correct number of fields appears in each record
3. The number of data records matches the count in the header record

4. The data type is valid
5. The length and format of submitted Social Security numbers are valid
6. Each file's last record element (i.e., **899 — Record Type) is populated correctly (i.e., ME for eligibility, MC for medical claims, PC for pharmacy claims, and PV for provider); this field is required even on opt-out eligibility records
7. For eligibility data, the year and month of eligibility are within the period beginning and period ending values cited in the header record
8. For claims data, the date approved for payment is within the period beginning and period ending values cited in the header record

For MN APCD submissions, the hashing application performs a critical, additional function as noted with Table 5 (above): Immediately prior to hashing this field, Onpoint's hashing application calculates a member's age in months based on the Member Date of Birth field (ME014, MC013, PC013). The Member Date of Birth field is then hashed and both the hashed value and the value-added Age in Months element are submitted to the APCD — the hashed value to allow for quality assurance review, the de-identified Age in Months to enable analytic use of the APCD.

After hashing, a ZIP file is created in accordance with Onpoint CDM's required naming conventions. If the user renames the ZIP file before submission, the submission will be rejected. An example of Onpoint CDM's hashing name convention is included below in Figure 6:

Figure 6. Naming Convention for Zipped, Hashed Files



Providing hashing software that is run by all submitters ensures that all identifiers are hashed consistently and without exception. Since this hashing is done at the carrier's site, the carrier can verify easily that all PHI processed by the hashing software have been removed and replaced with an unrecognizable, hashed 128-character field.

The time from receipt of the data by Onpoint CDM to notification of success or failure (due to quality checks) depends on a number of variables, including system load, file size, data type. In general, submitters should expect an email regarding their submission within 24 hours of receipt.

Step 1: Verifying the Presence of Java Runtime Environment (JRE)

All of Onpoint CDM's hashing and upload utilities employ a Java Web Start application that assists in the execution of the SHA-512 hashing algorithm necessary to de-identify any PHI on incoming submissions. Before you can use any of our submission tools, you will need to verify that your system has Oracle's Java Runtime Environment (JRE) properly installed.

Perhaps the easiest way to do this is to install the AutoUploader (see below) and try to submit a test file. If you have JRE installed, the application will first prepare the Java environment on your computer and then install. Two notes about this process:

1. If you have Java installed, but are questioning whether it is JRE, Oracle notes that Java Runtime Environment goes by many names, including Java Runtime, Runtime, Java Virtual Machine, Virtual Machine, Java VM, Java plug-in, Java add-on, and Java download.
2. It may appear that the installer is done, but nothing happens; do not be alarmed. This step sometimes takes a few minutes. If this happens, check your computer's task bar to see if a Web Start button has appeared and if a Java warning message is there. Clicking YES at this point will allow you to proceed with hashing, but you will receive the same prompt each time you run the

hashing software. Clicking NO will not install the hashing software. By clicking ALWAYS, you will be able to proceed with hashing and will not be prompted again.

If you are prompted to choose an application to launch the hashing application, you most likely do not have JRE installed. In that case, please visit Oracle's website to download the latest version here: http://java.com/en/download/index.jsp.

Step 2: Choosing Your Upload Option

Onpoint offers carriers two options for securely submitting their data — AutoUploader and a web-based utility that requires manual operation. Both options utilize our one-way hashing algorithms to eliminate the possibility of ePHI re-identification or recovery.

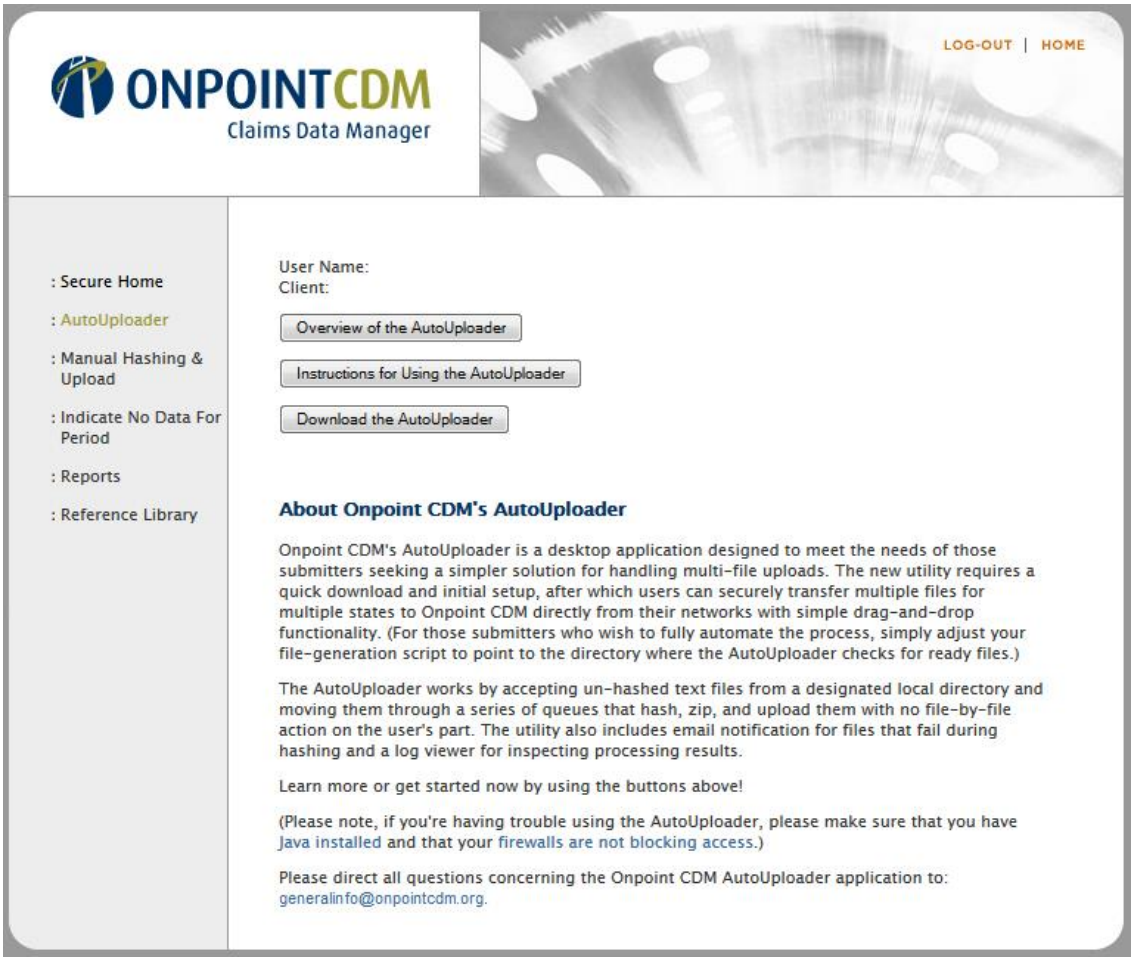
The tool most preferred by our submitters is Onpoint CDM's AutoUploader. The AutoUploader works by accepting unencrypted text files from a designated local directory and moving them through a series of queues that hash, zip, and upload them. Key features include:

- **Easy installation.** The utility, which is compatible with Windows, Linux, and UNIX, is distributed as an executable file that runs as a self-contained console/desktop application.
- **Robust scope.** Any number of files for any number of clients may be queued as long as the data requires hashing prior to submission.
- **Customizable configuration.** The AutoUploader allows each user to tailor their alerts for efficient usage.
- **Durable sessions.** Since the utility runs entirely on the user's network, there is no login and no session expiration to disrupt uploads midstream.
- **Viewable logs.** The application provides a log viewer, allowing users to see key details and track the status of their submissions.
- **Secure uploads.** Users' original files are never seen by Onpoint; only hashed contents are viewable after being uploaded to Onpoint CDM.

Upload Option 1: AutoUploader

To get started with AutoUploader, log in to Onpoint CDM and select the AutoUploader link from the page's left menu (see Figure 7). Also be sure to download the latest instructions using the on-page link.

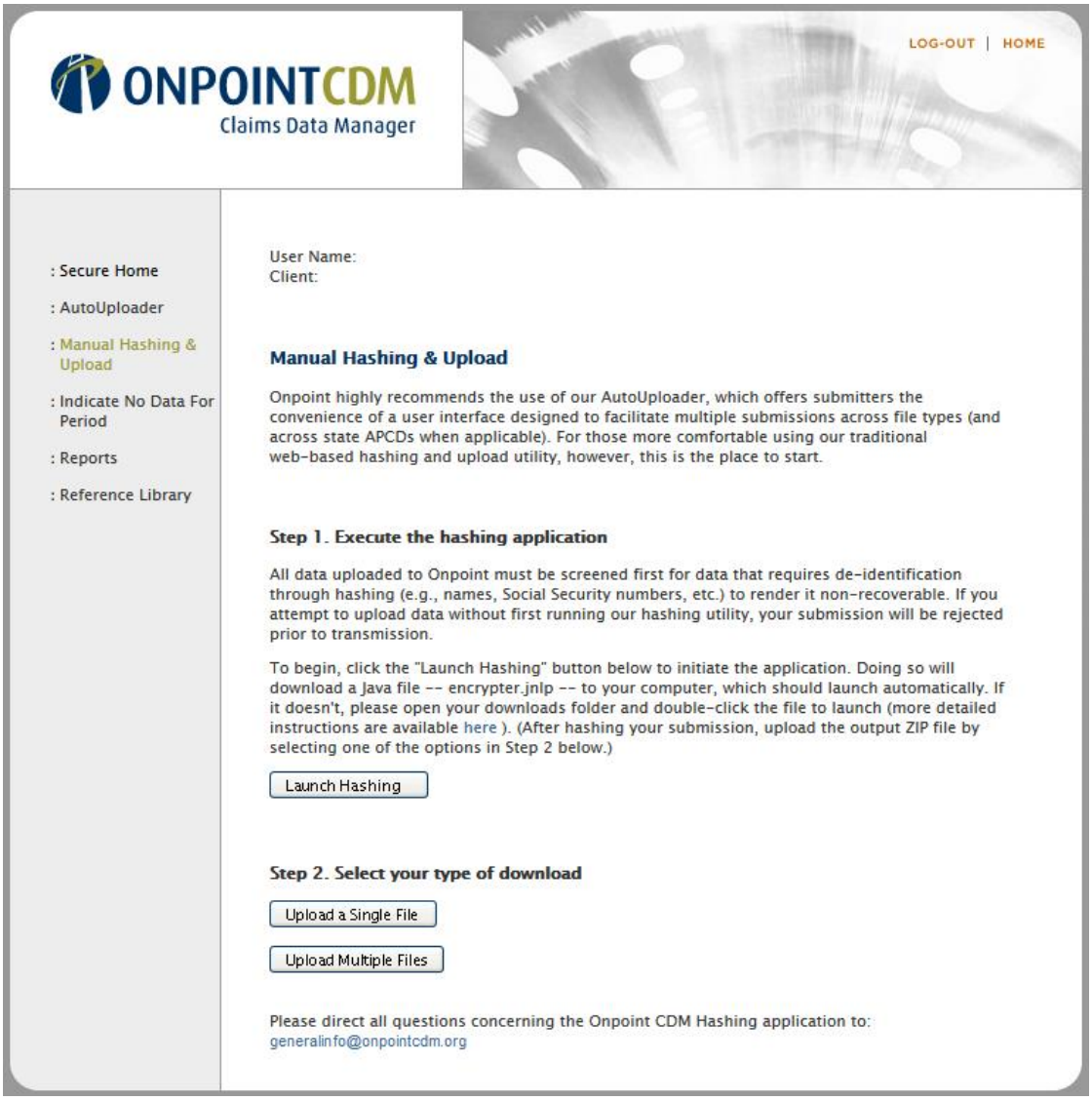
Figure 7. Onpoint CDM (Secure) — AutoUploader Page



Upload Option 2: Manual Hashing & Uploading

Onpoint highly recommends the use of our AutoUploader, but for those more comfortable using our manual web-based hashing and upload utility, this is the place to start. Start by selecting the Manual Hashing & Upload option from the screen's left menu (see Figure 8).

Figure 8. Onpoint CDM (Secure) — Manual Hashing & Upload Page

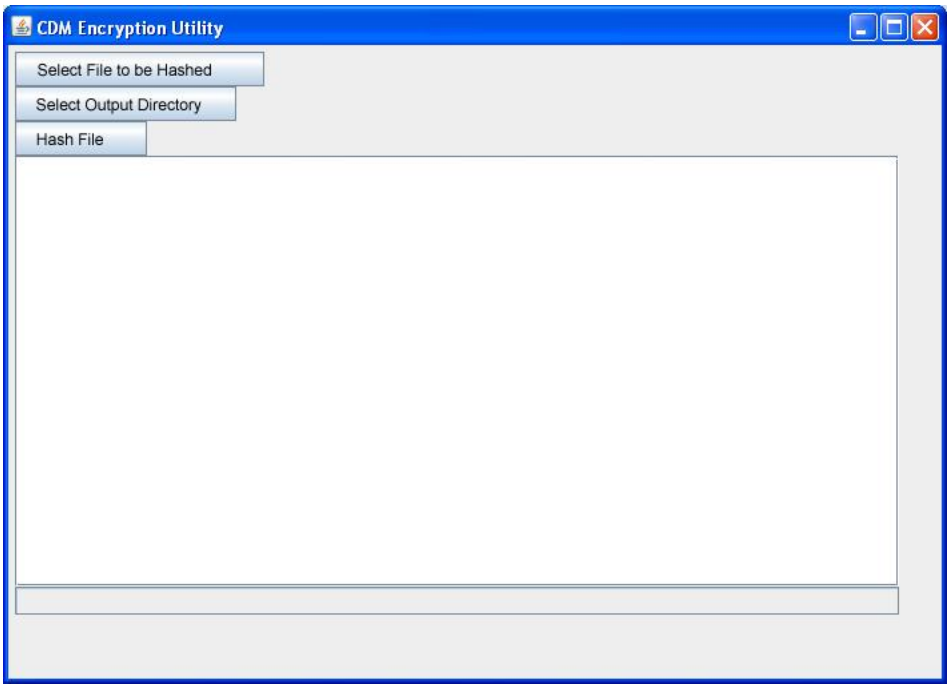


Upload Option 2 (Part 1): Manually Hash Your Data

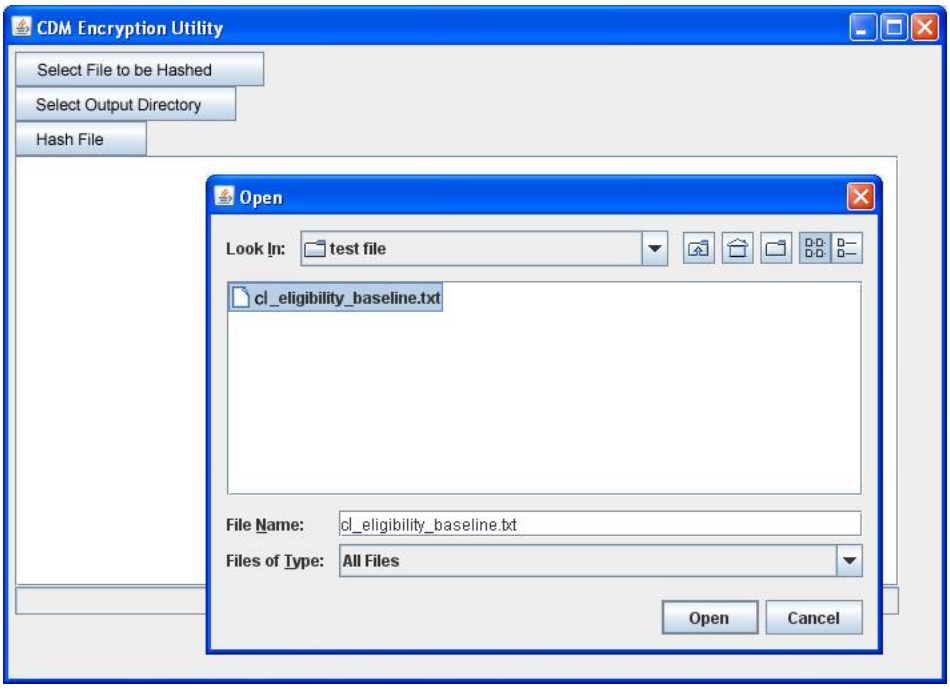
1. All data uploaded to Onpoint must undergo screening and hashing to prevent PHI from being transmitted to the APCD. To begin, click the LAUNCH HASHING button under the page's Step 1 narrative.

2. Doing so will download a file — ENCRYPTER.JNLP — to your computer, which is designed to launch automatically. (If it does not launch due to local settings, please open your downloads folder and double-click the file to launch.)

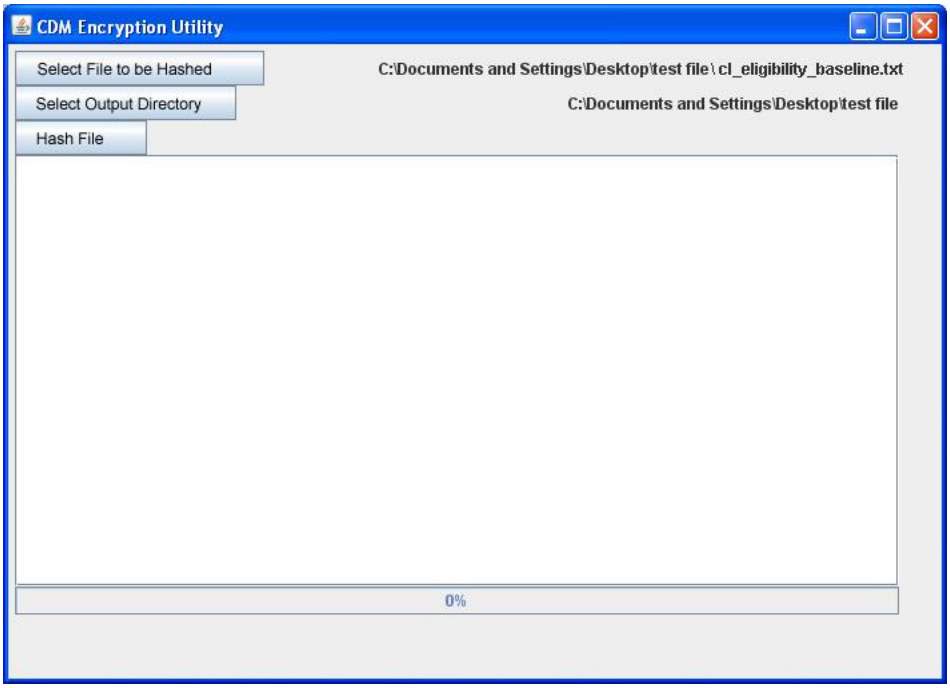
3. In the hashing application, you will be required to select a target file to be screened and hashed. To do so, click the SELECT FILE TO BE HASHED button. (Note that the manual upload utility allows the selection of only a single file at a time; for expedited and batch processing, please use the AutoUploader.)



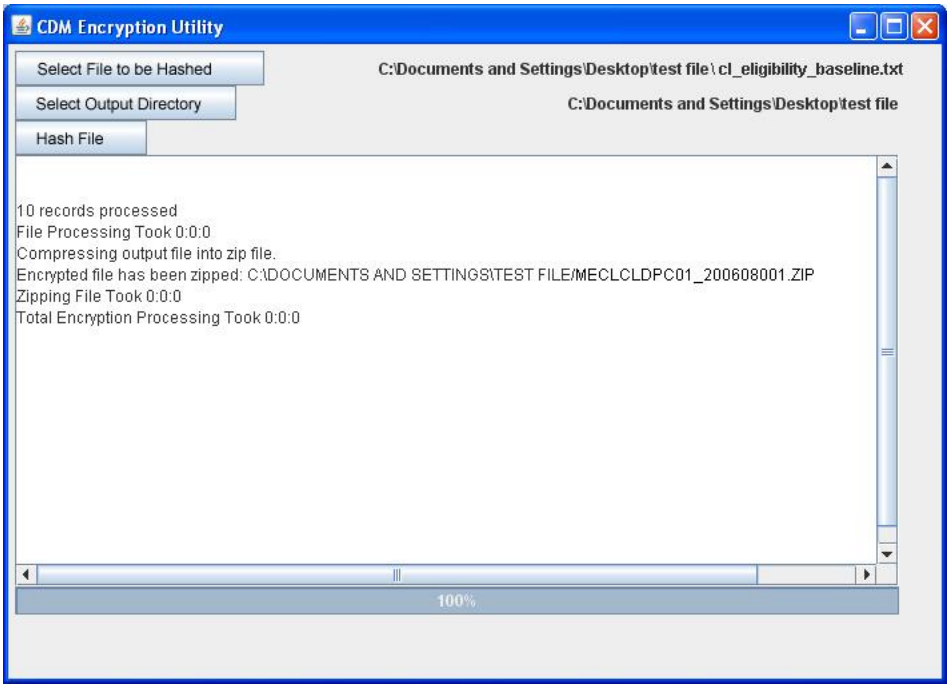
4. In the pop-up dialog box, locate the file within your local system, then click OPEN. You can verify the selected file by checking the path name to the right of the button.

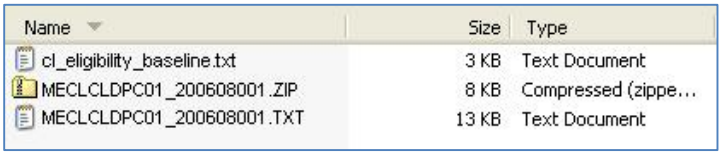


5. Next, identify the desired location for the output file by clicking the SELECT OUTPUT DIRECTORY and designating the desired location on your local system. This selection also can be verified by checking the path to the right of the button.



6. After verifying both the target file and the output location, click the HASH FILE button. The application will process the file, display its progress, and output two files: (1) a compressed ZIP file that contains your hashed data for submission and (2) a non-zipped copy of the TXT file for rapid verification of successful hashing.

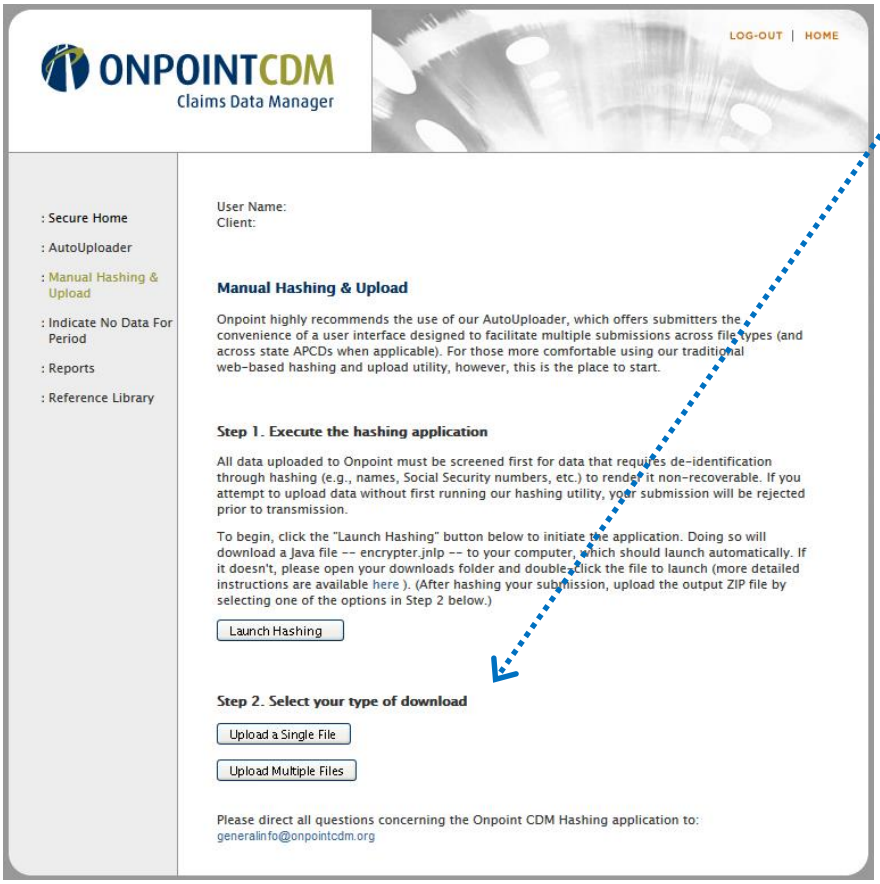




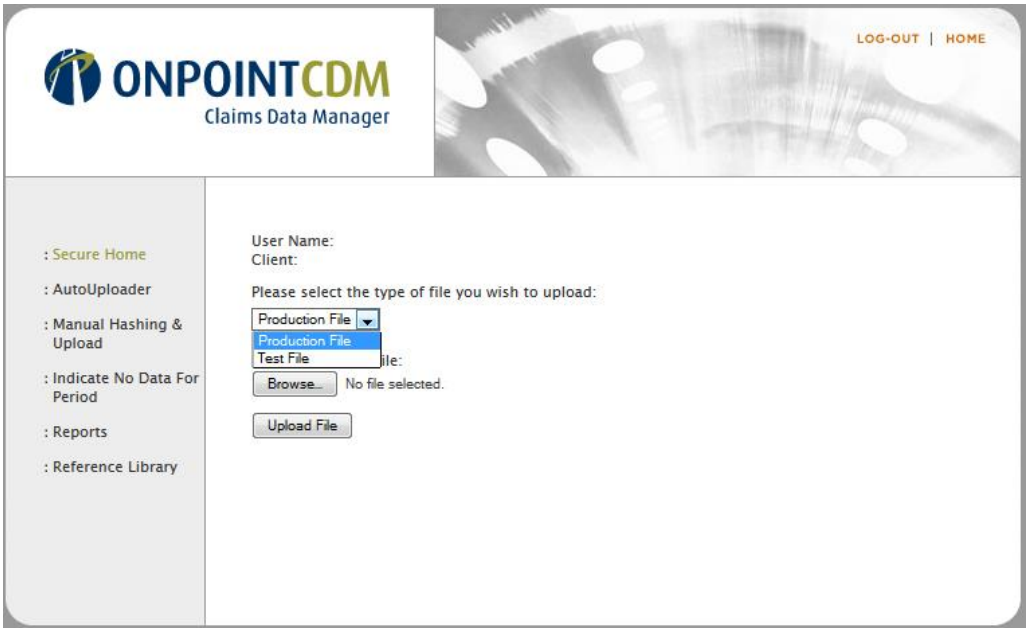
7. After this step, return to your web browser to begin the upload process.

Upload Option 2 (Part 2): Manually Uploading Your File

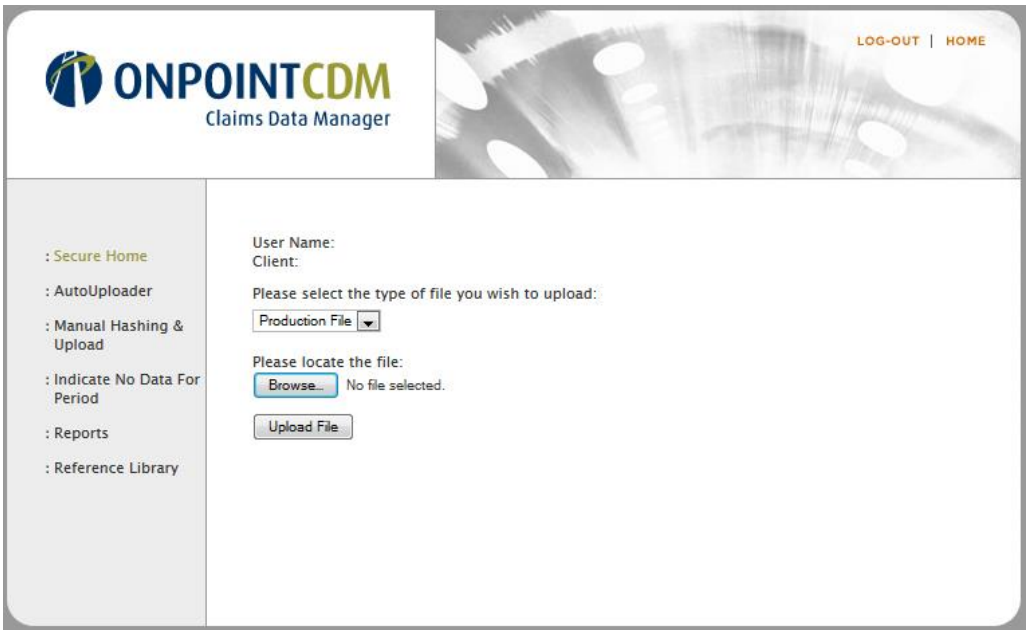
1. The next step of the manual process requires you to designate whether you plan to upload a single file or multiple files instead. Do so by clicking the appropriate button under Step 2. (The following directions will discuss uploading a single file; skip to the next section if uploading multiple files.)

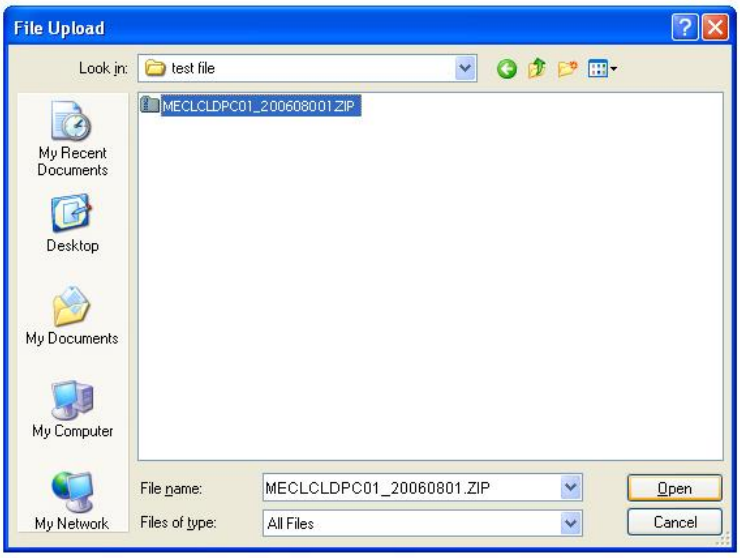


2. After clicking the UPLOAD A SINGLE FILE button, designate the type of file — production or test — that you plan to upload. (Since most payers have entered production with Onpoint's system, the default selection is a production file. If in the testing phase, simply use the drop-down option to change the file type.)

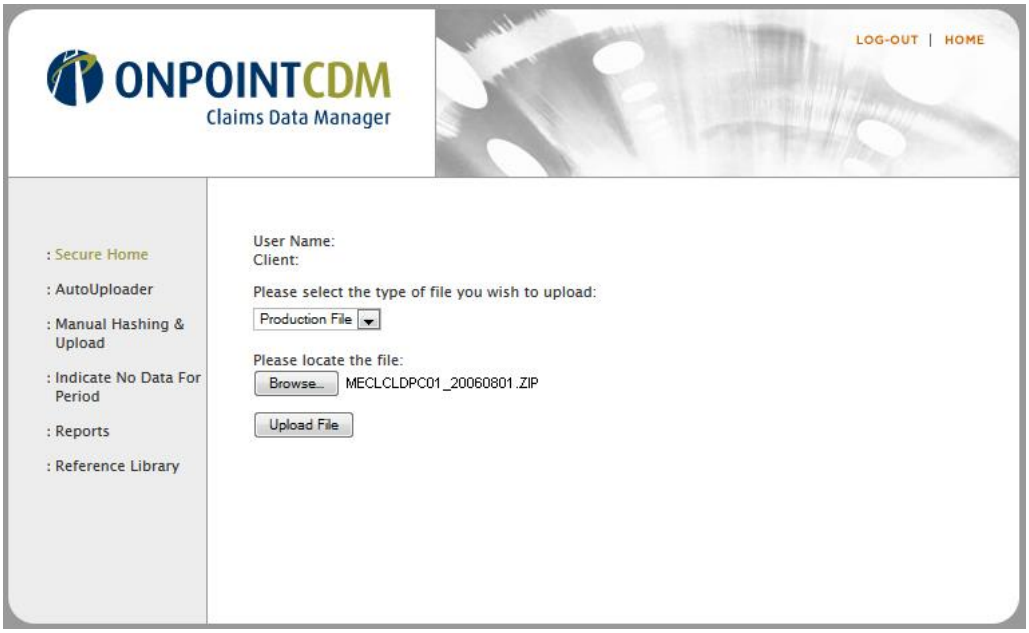


3. Next, click the BROWSE button to locate the file within your local system that you plan to upload. Do so by using the FILE UPLOAD pop-up dialog box and clicking OPEN.

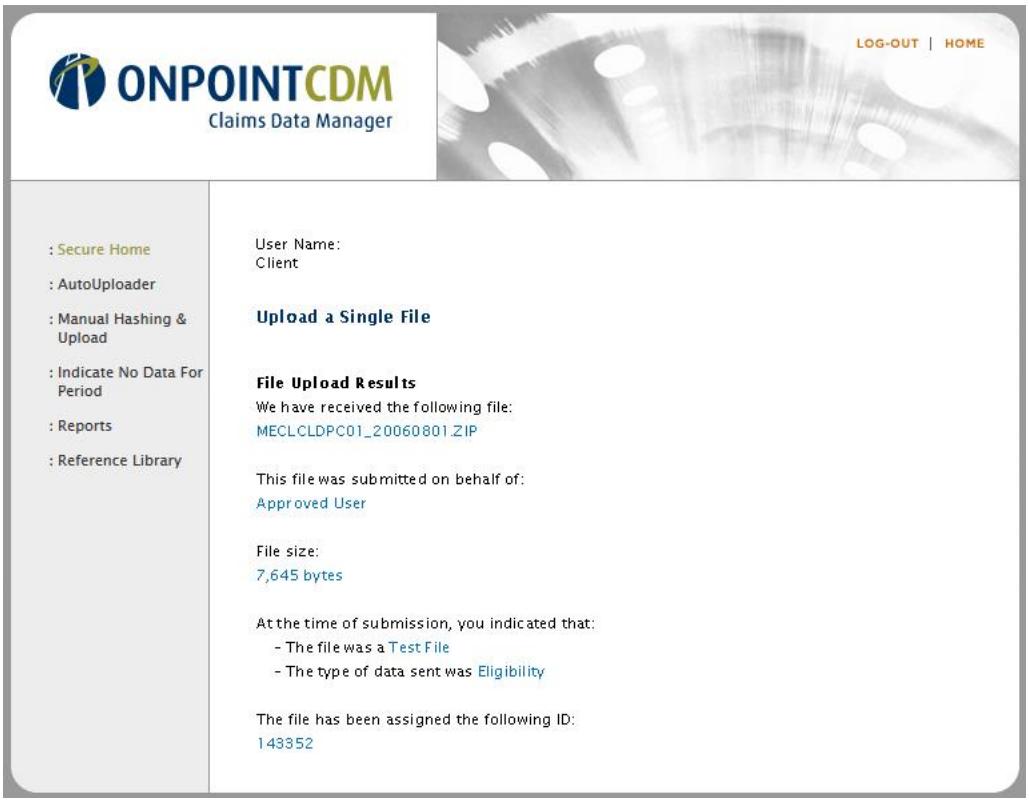




4. After verifying the correct file selection by examining the displayed file name to the right of the BROWSE button, click the UPLOAD FILE button to begin transmission to Onpoint.



5. Once your file has been submitted to Onpoint CDM, a response file will notify you of the upload results, providing documentation that can be used to track your submission.

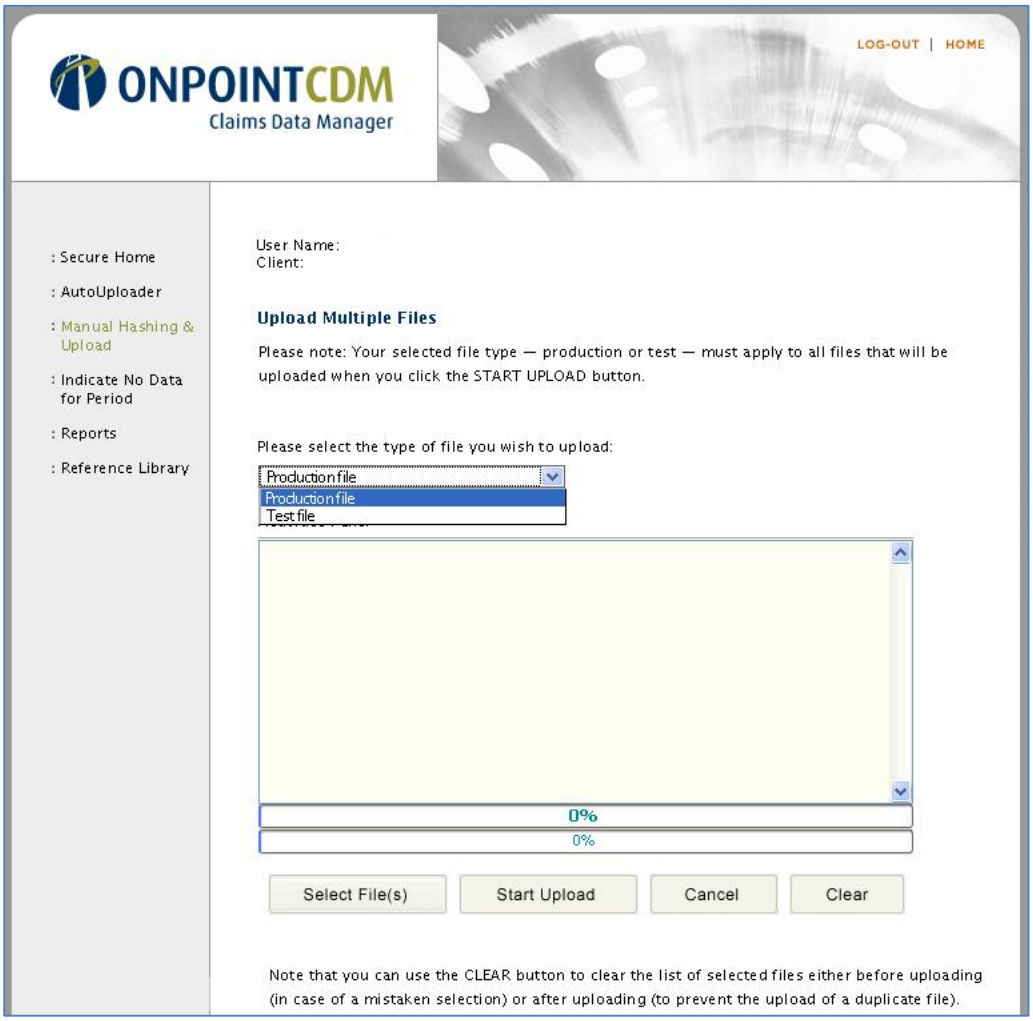


Uploading Multiple Files

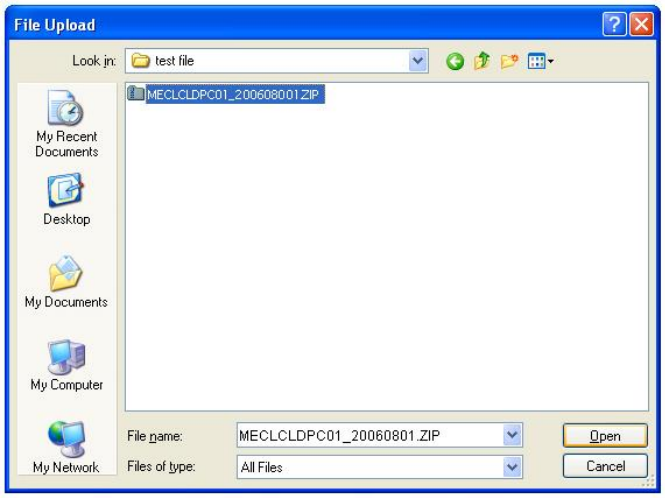
1. Manually uploading multiple files follows a similar path. After manually hashing your data, click instead on the UPLOAD MULTIPLE FILES button.

2. Depending on your browser's cache file and session storage, Java may need to reload. If so, you will see the animated Java icon with a progress bar (below).

3. Once the Java applet has loaded, use the drop-down menu to identify whether your files are production or test files. (Note that all files submitted during a manual upload must be of the same type.) You may use the multiple file uploader to submit files for more than one state at the same time, and you may select as many files as you wish to upload at one time.



4. Click on the SELECT FILES(S) button at the bottom of the screen and browse to find the hashed files to be uploaded. Verify your file selection by checking the session's Activity Panel in the center of the screen.



5. After selecting the files that you wish to upload, click the START UPLOAD button. Note that you can use the CLEAR button to clear the list of selected files either before uploading (in case of a mistaken selection) or after uploading (to prevent the upload of a duplicate file).

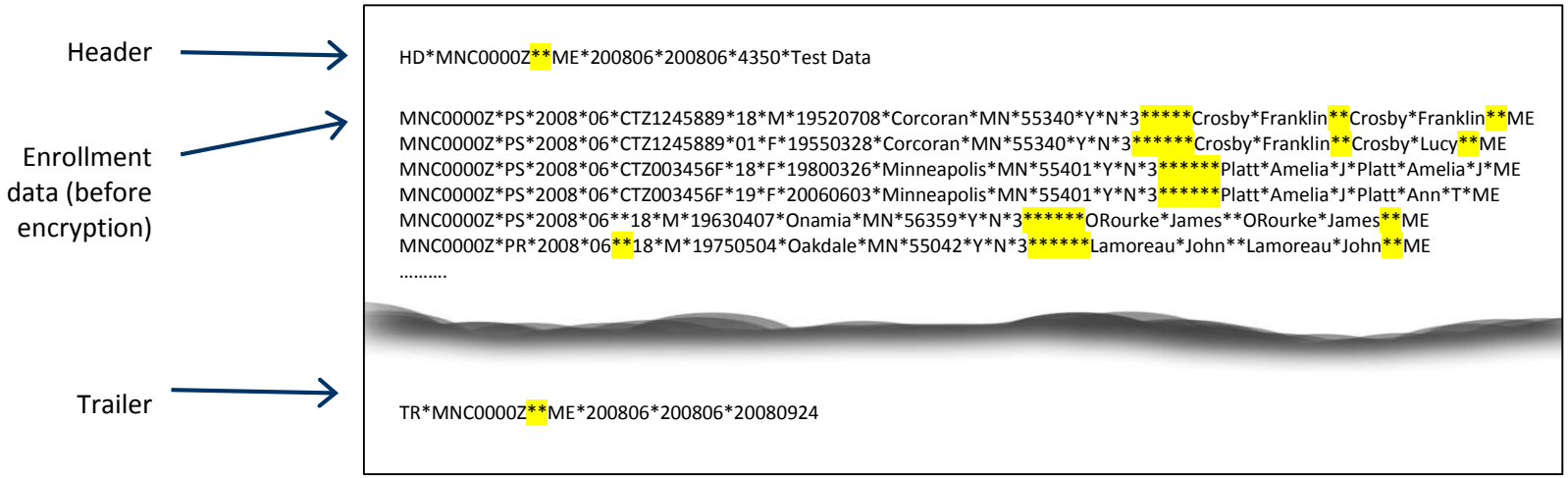
6. While your files are uploading, the upper progress bar shows the percentage complete for the file currently being uploaded. The lower progress bar shows the percentage of files that have completed the upload process. You can click CANCEL if you wish to stop the upload. When all of your files have finished uploading, your screen will show a status message for each one.

7. Additionally, when your files have finished uploading, a window or tab will open with a report on all of the files that you have uploaded today.

6. 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 at once.** You may submit multiple complete months of data with one pair of header and trailer records by indicating the earliest year and month in HD005 and TR005 and the latest year and month 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.
- **Indicating missing data.** When two or more asterisks appear together, there is no data for the field. For example, in the eligibility file example below (fictional data only), the lack of data between the asterisks highlighted in yellow indicate fields that are unavailable for reporting.



- **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.

7. ELIGIBILITY FILE

The Basics

Required Frequency

- Monthly, quarterly, or semi-annually (for more details, see the "What is the Submission Schedule?" section)

Important Notes

- One record must be submitted for each member who had coverage during the period reported in the header and trailer records.
- Submissions must cover full months of data; partial months must not be reported.

Columns Included in the Eligibility File

Col. #	ID	Name	Hashed?	Type	Max. Length	Description	X12 Reference Standard	Thresh. %	Denom.
Indicates the element's required position within the submission file	Indicates the element's reference number	Indicates the element's name	Indicates whether or not the element's true value has been rendered permanently non-recoverable by one-way hashing prior to submission to Onpoint	Indicates whether the type of data for the element is a date, decimal, integer, or text	Indicates the maximum length allowed for this element	Provides a general description of the data element, including valid codes for elements whose acceptable codes vary from industry standards and for elements that lack a national standard altogether. Values appended with superscript text in blue (e.g., + 01/01/2012) note the effective date of newly valid values; those with strikethrough text (i.e., ~~strikethrough~~) are no longer valid and have their expiration dates appended in red superscript text (e.g., x 12/31/2011).	Indicates the element's X12 reference standard	Indicates the percent of submitted records for which this element must have a valid code	Indicates the type of records to be used to calculate the threshold percent for submission.

Eligibility									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	X12 Ref. Standard	Thresh. %	Denom.
1	HD001	Record Type	N	Text	2	RECTYPE — This field must be coded HD to indicate the start of the Header record.	Administrative element	100%	All
2	HD002	Payer	N	Text	8	PAYER — This field must contain the payer or submitter code assigned by Onpoint CDM.	Administrative element	100%	All
3	HD003	Placeholder	N	Text	30	PLACEHOLDER — This field must be coded as null; it is reserved for header consistency across all states using Onpoint CDM.	Administrative element	0%	All
4	HD004	Type of File	N	Text	2	FILETYPE — This field must be coded ME to indicate submission of eligibility/enrollment data.	Administrative element	100%	All
5	HD005	Period Beginning Date	N	Integer	6	BEGPERIOD — Use this field to report the earliest enrollment year/month included in the submission in CCYYMM format. Submissions with records containing an enrollment period (ME004, ME005) before this date will fail.	Administrative element	100%	All
6	HD006	Period Ending Date	N	Integer	6	ENDPERIOD — Use this field to report the latest enrollment year/month included in the submission in CCYYMM format. Submissions with records containing an enrollment period (ME004, ME005) after this date will fail.	Administrative element	100%	All
7	HD007	Record Count	N	Integer	10	RECCNT — Use this field to report the total number of records in the submission, excluding the header and trailer records. If the number of records within the submission does not equal the number reported in this field, the submission will fail.	Administrative element	100%	All
8	HD008	Comments	N	Text	80	CMNTS — Use this field to supply any submitter comments.	Administrative element	0%	All
1	ME001	Payer	N	Text	8	PAYER — This field must contain the Onpoint CDM-assigned submitter code for the data submitter. The first two characters of the submitter code indicate Minnesota and the third character designates the type of submitter: MNC .....Commercial carrier MNG.....Governmental agency MNT .....Third-party administrator MNU.....Unlicensed entity A single data submitter may have multiple submitter codes because the data submitter is 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 6 characters. A suffix will be used to distinguish the location and/or system variations.	Administrative element	100%	All
2	ME003	Insurance Type / Product Code	N	Text	6	PRODUCT — Use this field to report the insurance type or product code that indicates the individual's type of insurance coverage. All codes must be 2 characters except for MC and XX, which also must include a valid subcode. Valid codes and subcodes:	271/2110C/EB/ /04, 271/2110D/EB/ /04	99.9%	All

Eligibility									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	X12 Ref. Standard	Thresh. %	Denom.
						12 .....Medicare Secondary – Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 .....Medicare Secondary – End-Stage Renal Disease Beneficiary in the 12 month Coordination Period with an Employer's Group Health Plan 14 .....Medicare Secondary – No-fault Insurance Including Auto is Primary 15 .....Medicare Secondary – Worker's Compensation 16 .....Medicare Secondary – Public Health Service or Other Federal Agency 41 .....Medicare Secondary – Black Lung 42 .....Medicare Secondary – Veterans' Administration 43 .....Medicare Secondary – Disabled Beneficiary Under Age 65 with Large Group Health 47 .....Medicare Secondary – Other Liability Insurance is Primary CP .....Medicare Conditionally Primary D.....Disability DB.....Disability Benefits EP .....Exclusive Provider Organization HM .....Health Maintenance Organization (HMO) HN .....Health Maintenance Organization (HMO) Medicare Risk / Medicare Part C HS.....Special Low-Income Medicare Beneficiary IN.....Indemnity MA.....Medicare Part A MB.....Medicare Part B MC.....Medical Assistance; this code must also include one of the following subcodes: FFSM..... Fee-for-service Medical Assistance PMAP..... Prepaid Medical Assistance Program MDHO..... MN Disability Health Options MSHO ..... MN Senior Health Options SNBC..... Special Needs Basic Care MISC ..... Other managed care program within Medical Assistance MD .....Medicare Part D MH .....Medigap Part A MI.....Medigap Part B MP.....Medicare Primary			

Eligibility									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	X12 Ref. Standard	Thresh. %	Denom.
						PR .....Preferred Provider Organization (PPO) PS .....Point of Service (POS) QM .....Qualified Medicare Beneficiary SP .....Supplemental Policy XX .....Non-Medical-Assistance Public Program; this code must also include one of the following subcodes: CDEP ..... Chemical Dependency GAMC ..... General Assistance Medical Care HIVA..... HIV/AIDS MCHA ..... Minnesota Comprehensive Health Association MNCR ..... MinnesotaCare MISC ..... Other non-Medical Assistance public program			
3	ME004	Year	N	Integer	4	YEAR — Use this field to report the year during which the member was eligible for services. This field generally is used in conjunction with the Month field (ME005) to determine a specific period of eligibility.	Administrative element	99.9%	All
4	ME005	Month	N	Integer	2	MONTH — Use this field to report the month during which the member was eligible for services. This field generally is used in conjunction with the Year field (ME004) to determine a specific period of eligibility.	Administrative element	99.9%	All
5	ME009	Plan-Specific Contract Number	Y	Text	128	CONTRACT — Use this field to report the data submitter-assigned contract number for the subscriber. This field is encrypted using the same algorithm across all data submitters and is not available in the analytical data warehouse. When this field is populated, it forms the core of the unique member identification code. Set as null if unavailable.	271/2100C/NM1/MI/09	99.9%	All
6	ME012	Individual Relationship Code	N	Text	2	REL — Use this field to report the member's relationship to the subscriber or the insured. Valid codes: 01 .....Spouse 18 .....Self 19 .....Child 20 .....Employee + 01/01/2012 21 .....Unknown ~~34 .....Other Adult~~ x 12/31/2011 39 .....Organ donor + 01/01/2012 40 .....Cadaver donor + 01/01/2012 53 .....Life partner + 01/01/2012 G8.....Other relationship + 01/01/2012	271/2100C/INS/Y/02, 271/2100D/INS/N/02	99.9%	All

Eligibility									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	X12 Ref. Standard	Thresh. %	Denom.
7	ME013	Member Gender	N	Text	1	SEX — Use this field to report the member's gender. Valid codes: M.....Male F .....Female U.....Unknown	271/2100C/DMG/ /03, 271/2100D/DMG/ /03	99.9%	All
8	ME014	Member Date of Birth	Y Trans-formed	Date	8	DOB — Use this field to report the member's date of birth with a format of CCYYMMDD. During the encryption process, this field is used to calculate age as of the first day of the membership month. The field is then encrypted. This data element will not be transmitted in unencrypted form.	271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02	99.5%	All
9	ME015	Member City Name	N	Text	30	PATCITY — Use this field to report the name of the member's city of residence.	271/2100C/N4/ /01, 271/2100D/N4/ /01	90%	All
10	ME016	Member State or Province	N	Text	2	PATST — Use this field to report the member's state or province using the two-character abbreviation code defined by the U.S. Postal Service.	271/2100C/N4/ /02, 271/2100D/N4/ /02	90%	All
11	ME017	Member ZIP Code	N	Text	5	PATZIP — Use this field to report the ZIP code associated with the member's residence.	271/2100C/N4/ /03, 271/2100D/N4/ /03	99.5%	All
12	ME018	Medical Coverage Flag	N	Text	1	MEDICAL — Use this field to indicate that the reported member is covered for medical expenses. This is an administrative field required by Onpoint CDM. Valid codes: Y .....Yes N.....No	Administrative element	99.9%	All
13	ME019	Prescription Drug Coverage Flag	N	Text	1	RX — Use this field to indicate that the reported member is covered for prescription drug expenses. This is an administrative field required by Onpoint CDM. Valid codes: Y .....Yes N.....No	Administrative element	99.9%	All
14	ME032	Health Care Home Assigned Flag	N	Text	1	HCHDES — Use this field to flag whether the member reported has an approved medical home for this coverage period. Valid codes: 1 .....Yes 2 .....No 3 .....Unknown	Administrative element reserved for assignment	0%	All
15	ME033	Health Care Home Number	N	Text	30	HCHNUM — Use this field to report the data submitter-assigned medical home number. It is anticipated that this will be the same data submitter number used when reporting the servicing provider. This field will be used to create a master provider index for Minnesota providers encompassing medical service providers, prescribing physicians, and medical homes.	Administrative element reserved for assignment	0%	All
16	ME034	Health Care Home Tax ID Number	N	Text	10	HCHTAXID — Use this field to report the federal tax payer's identification number for the medical home. This field will be used to create a master provider index for Minnesota providers encompassing medical service providers, prescribing physicians, and medical homes	Administrative element reserved for assignment	0%	All

Eligibility									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	X12 Ref. Standard	Thresh. %	Denom.
17	ME035	Health Care Home National Provider ID	N	Text	20	HCHNPI — Use this field to report the National Provider Identifier (NPI) for the entity or individual serving as the medical home. This field will be used to create a master provider index for Minnesota providers encompassing medical service providers, prescribing physicians, and medical homes.	Administrative element reserved for assignment	0%	All
18	ME036	Health Care Home Name	N	Text	60	HCHNAME — Use this field to report the full name of the provider (i.e., facility, organization or individual). If the medical home is an individual, report in the format of last name, first name, and middle initial with no punctuation.	Administrative element reserved for assignment	0%	All
19	ME101	Subscriber Last Name	Y	Text	128	SUBSLNAME — Use this field to report the subscriber's last name. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	271/2100C/NM1/ /03	100%	All
20	ME102	Subscriber First Name	Y	Text	128	SUBSFNAME — Use this field to report the subscriber's first name. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	271/2100C/NM1/ /04	90%	All
21	ME103	Subscriber Middle Initial	Y	Text	1	SUBSMI — This field contains the subscriber's middle initial. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	271/2100C/NM1/ /05	0%	All
22	ME104	Member Last Name	Y	Text	128	MEMSLNAME — This field contains the member's last name. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	271/2100C/NM1/ /03, 271/2100D/NM1/ /03	100%	All
23	ME105	Member First Name	Y	Text	128	MEMSFNAME — This field contains the member's first name. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	271/2100C/NM1/ /04, 271/2100D/NM1/ /04	90%	All
24	ME106	Member Middle Initial	Y	Text	1	MEMSMI — This field contains the member's middle initial. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	271/2100C/NM1/ /05, 271/2100D/NM1/ /05	0%	All
25	ME899	Record Type	N	Text	2	RECTYPE — This field must be coded ME to indicate the submission of member eligibility/enrollment records.	Administrative element	100%	All
1	TR001	Record Type	N	Text	2	RECTYPE — This field must be coded TR to indicate the start of the Trailer record.	Administrative element	100%	All
2	TR002	Payer	N	Text	8	PAYER — This field must contain the payer or submitter code assigned by Onpoint CDM.	Administrative element	100%	All
3	TR003	Placeholder	N	Text	30	This field must be coded as null; it is reserved for header consistency across all states using Onpoint CDM.	Administrative element	0%	All
4	TR004	Type of File	N	Text	2	FILETYPE — This field must be coded ME to indicate submission of eligibility/enrollment data.	Administrative element	100%	All
5	TR005	Period Beginning Date	N	Integer	6	BEGPERIOD — Use this field to report the earliest enrollment year/month included in the submission in CCYYMM format. Submissions with records containing an enrollment period (ME004, ME005) before this date will fail.	Administrative element	100%	All

Eligibility									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	X12 Ref. Standard	Thresh. %	Denom.
6	TR006	Period Ending Date	N	Integer	6	ENDPERIOD — Use this field to report the latest enrollment year/month included in the submission in CCYYMM format. Submissions with records containing an enrollment period (ME004, ME005) after this date will fail.	Administrative element	100%	All
7	TR007	Date Processed	N	Date	8	PROCDATE — Use this field to report the date on which the file was created in CCYYMMDD format.	Administrative element	0%	All

8. MEDICAL CLAIMS

The Basics

Required Frequency

- Monthly, quarterly, or semi-annually (for more details, see the "What is the Submission Schedule?" section)

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.
- Submissions must cover full months of data; partial months must not be reported.

Columns Included in the Medical Claims File

Col. #	ID	Name	Hashed?	Type	Max. Length	Description	X12 Reference Standard	Thresh. %	Denom.
Indicates the element's required position within the submission file	Indicates the element's reference number	Indicates the element's name	Indicates whether or not the element's true value has been rendered permanently non-recoverable by one-way hashing prior to submission to Onpoint	Indicates whether the type of data for the element is a date, decimal, integer, or text	Indicates the maximum length allowed for this element	codes for elements whose acceptable codes vary from industry standards and for elements that lack a national standard altogether. Values appended with superscript text in blue (e.g., + 01/01/2012) note the effective date of newly valid values; those with strikethrough text (i.e., ~~strikethrough~~) are no longer valid and have their expiration dates appended in red superscript text (e.g., x 12/31/2011).	Indicates the element's relevant reference standard across national coding systems	Indicates the percent of submitted records for which this element must have a valid code	Indicates the type of records to be used to calculate the threshold percent for submission.

Medical Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	HIPAA 5010 Ref. Standard	Thresh. %	Denom.
1	HD001	Record Type	N	Text	2	RECTYPE — This field must be coded HD to indicate the start of the Header record.	Administrative element	100%	All
2	HD002	Payer	N	Text	8	PAYER — This field must contain the payer or submitter code assigned by Onpoint CDM.	Administrative element	100%	All
3	HD003	Placeholder	N	Text	30	PLACEHOLDER — This field must be coded as null; it is reserved for header consistency across all states using Onpoint CDM.	Administrative element	0%	All
4	HD004	Type of File	N	Text	2	FILETYPE — This field must be coded MC to indicate submission of professional and institutional claims data.	Administrative element	100%	All
5	HD005	Period Beginning Date	N	Integer	6	BEGPERIOD — Use this field to report the earliest payment year/month included in the submission in CCYYMM format. Submissions with records containing a Check Issue or EFT Effective Date value (MC017) before this date will fail.	Administrative element	100%	All
6	HD006	Period Ending Date	N	Integer	6	ENDPERIOD — Use this field to report the latest payment year/month included in the submission in CCYYMM format. Submissions with records containing a Check Issue or EFT Effective Date value (MC017) after this date will fail.	Administrative element	100%	All
7	HD007	Record Count	N	Integer	10	RECCNT — Use this field to report the total number of records in the submission, excluding the header and trailer records. If the number of records within the submission does not equal the number reported in this field, the submission will fail.	Administrative element	100%	All
8	HD008	Comments	N	Text	80	CMNTS — Use this field to supply any submitter comments.	Administrative element	0%	All
1	MC001	Payer	N	Text	8	PAYER — This field must contain the Onpoint CDM-assigned submitter code for the data submitter. The first two characters of the submitter code indicate Minnesota and the third character designates the type of submitter: MNC .....Commercial carrier MNG.....Governmental agency MNT .....Third-party administrator MNU.....Unlicensed entity A single data submitter may have multiple submitter codes because the data submitter is 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 6 characters. A suffix will be used to distinguish the location and/or system variations.	Administrative element	100%	All
2	MC003	Insurance Type / Product Code	N	Text	6	PRODUCT — Use this field to report the insurance type or product code that indicates the individual's type of insurance coverage. All codes must be 2 characters except for MC and XX, which also must include a valid subcode. Note that for data harmonization purposes, this claims field deliberately uses values from the eligibility files (i.e., HIPAA 271). Valid codes and subcodes: 12 .....Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 .....Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month Coordination Period with an Employer's Group Health Plan 14 .....Medicare Secondary, No-fault Insurance Including Auto is Primary	Administrative element	99.9%	All

Medical Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	HIPAA 5010 Ref. Standard	Thresh. %	Denom.
						15 .....Medicare Secondary Worker's Compensation 16 .....Medicare Secondary Public Health Service or Other Federal Agency 41 .....Medicare Secondary Black Lung 42 .....Medicare Secondary Veteran's Administration 43 .....Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health 47 .....Medicare Secondary, Other Liability Insurance is Primary CP .....Medicare Conditionally Primary D.....Disability DB.....Disability Benefits EP .....Exclusive Provider Organization HM .....Health Maintenance Organization (HMO) HN .....Health Maintenance Organization (HMO) Medicare Risk/Medicare Part C HS.....Special Low Income Medicare Beneficiary IN.....Indemnity MA.....Medicare Part A MB.....Medicare Part B MC.....Medical Assistance; this code must also include one of the following subcodes: FFSM..... Fee-for-service Medical Assistance PMAP ..... Prepaid Medical Assistance Program MDHO..... MN Disability Health Options MSHO ..... MN Senior Health Options SNBC..... Special Needs Basic Care MISC ..... Other managed care program within Medical Assistance MD .....Medicare Part D MH .....Medigap Part A MI.....Medigap Part B MP.....Medicare Primary PR .....Preferred Provider Organization (PPO) PS .....Point of Service (POS) QM .....Qualified Medicare Beneficiary SP .....Supplemental Policy XX .....Non-Medical-Assistance Public Program; this code must also include one of the following subcodes: CDEP ..... Chemical Dependency GAMC ..... General Assistance Medical Care HIVA..... HIV/AIDS MCHA ..... Minnesota Comprehensive Health Association			

Medical Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	HIPAA 5010 Ref. Standard	Thresh. %	Denom.
						MNCR ..... MinnesotaCare MISC ..... Other non-Medical Assistance public program			
3	MC004	Payer Claim Control Number	N	Text	35	CLAIM — Use this field to report the claim number used by the data submitter to internally track the claim. In general, the claim number is associated with all service lines of the claim. It must apply to the entire claim and be unique within the data submitter's system.	835/2100/CLP/ /07	99.9%	All
4	MC004A	Claim Submitter's Identifier	Y	Text	38	CLSUBTID — Use this field to report the claim number used by the healthcare provider (i.e., the doctor, hospital, etc.) to track a claim from creation through payment.	837/2300/CLM/ /01	50%	All
5	MC005	Line Counter	N	Integer	4	LINE — Use this field to report the line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim. If the data submitter's processing system assigns an internal line counter for the adjudication process, that number may be submitted in place of the line number submitted by the provider.	837/2400/LX/ /01	99.5%	All
6	MC005A	Version Number	N	Integer	4	VERSION — Use this field to report the version number of the claim service line. The Version Number begins with 0 and is incremented by 1 for each subsequent version of that service line. This field is used in algorithms to determine the final payment for the service. This is a voluntary field.	Administrative element	0%	All
7	MC008	Plan-Specific Contract Number	Y	Text	128	CPMTRACT — Use this field to report the data submitter-assigned contract number for the subscriber. This field is encrypted using the same algorithm across all data submitters and is not available in the analytical data warehouse. When this field is populated, it forms the core of the unique member identification code. Set as null if unavailable.	835/2100/NM1/MI/09	99.9%	All
8	MC011	Individual Relationship Code	N	Text	2	REL — Use this field to report the member's relationship to the subscriber or the insured. Valid codes: 01 .....Spouse ~~04 .....Grandfather or Grandmother~~ x 12/31/2011 ~~05 .....Grandson or Granddaughter~~ x 12/31/2011 ~~07 .....Nephew or Niece~~ x 12/31/2011 ~~10 .....Foster Child~~ x 12/31/2011 ~~15 .....Ward~~ x 12/31/2011 ~~17 .....Stepson or Stepdaughter~~ x 12/31/2011 18 .....Self 19 .....Child 20 .....Employee 21 .....Unknown ~~22 .....Handicapped Dependent~~ x 12/31/2011 ~~23 .....Sponsored Dependent~~ x 12/31/2011 ~~24 .....Dependent of a Minor Dependent~~ x 12/31/2011 ~~29 .....Significant Other~~ x 12/31/2011 ~~32 .....Mother~~ x 12/31/2011 ~~33 .....Father~~ x 12/31/2011 ~~34 .....Other Adult~~ x 12/31/2011	837/2000B/SBR/ /02, 837/2000C/PAT/ /01	99.9%	All

Medical Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	HIPAA 5010 Ref. Standard	Thresh. %	Denom.
						~~36 .....Emancipated Minor~~ x 12/31/2011 39 .....Organ Donor 40 .....Cadaver Donor ~~41 .....Injured Plaintiff~~ x 12/31/2011 ~~43 .....Child Where Insured Has No Financial Responsibility~~ x 12/31/2011 53 .....Life Partner G8.....Other relationship + 01/01/2012			
9	MC012	Member Gender	N	Text	1	SEX — Use this field to report the member's gender. Valid codes: M.....Male F .....Female U.....Unknown	837/2010BA/DMG/ /03, 837/2010CA/DMG/ /03	100%	All
10	MC013	Member Date of Birth	Y Trans-formed	Date	8	DOB — Use this field to report the member's date of birth with a format of CCYYMMDD. During the encryption process, this field is used to calculate age as of the Date of Service (From) field (MC059). The field is then encrypted. This data element will not be transmitted in unencrypted form.	837/2010BA/DMG/D8/02, 837/2010CA/DMG/D8/02	99.5%	All
11	MC014	Member City Name	N	Text	30	PATCITY — Use this field to report the name of the member's city of residence.	837/2010BA/N4/ /01, 837/2010CA/N4/ /01	90%	All
12	MC015	Member State or Province	N	Text	2	PATST — Use this field to report the member's state or province using the two-character abbreviation code defined by the U.S. Postal Service.	837/2010BA/N4/ /02, 837/2010CA/N4/ /02	90%	All
13	MC016	Member ZIP Code	N	Text	5	PATZIP — Use this field to report the ZIP code associated with the member's residence.	837/2010BA/N4/ /03, 837/2010CA/N4/ /03	90%	All
14	MC017	Check Issue or EFT Effective Date	N	Date	8	PDATE — Use this field to report the date on which the record was approved for payment. This is generally referred to as the paid date and reported with a CCYYMMDD format. When BPR04 is "NON" for nonpayment, include remittance date.	835/Header Financial Information/BPR/ /16	100%	All
15	MC018	Admission Date	N	Date	8	ADMDAT — Use this field to report the date of the inpatient admission with a CCYYMMDD format.	Professional 837/2300/DTP/435/D8/03, Institutional 837/2300/DTP/435/DT/03	90%	Institutional Inpatient
16	MC020	Admission Type	N	Integer	1	ADMTYPE — Use this field to report the type of admission for the inpatient hospital claim. Valid codes: 1 .....Emergency 2 .....Urgent 3 .....Elective 4 .....Newborn 5 .....Trauma Center 9 .....Information not Available	Institutional 837/2300/CL1/ /01	60%	Institutional Inpatient

Medical Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	HIPAA 5010 Ref. Standard	Thresh. %	Denom.
17	MC021	Admission Source	N	Text	1	ADMSR — Use this field to report the source of admission. This field is required for inpatient hospital claims. Valid codes: **For newborns (Admission Type = 4)** 5 .....Born inside this hospital 6 .....Born outside this hospital **Admissions other than newborn** 1 .....Non-healthcare facility point of origin 2 .....Clinic or physician's office 4 .....Transfer from a hospital 5 .....Transfer from a skilled nursing facility, intermediate care facility, or assisted-living facility 6 .....Transfer from another health care facility ~~7 .....Emergency room~~ x 07/01/2010 8 .....Court/Law enforcement 9 .....Information not available ~~B .....Transfer from another home health agency~~ x 07/01/2010 ~~C .....Readmission into same home health agency~~ x 07/01/2010 D.....Transfer from one distinct unit of the hospital to another distinct unit of the same hospital, resulting in a separate claim to the payer E .....Transfer from ambulatory surgery center F .....Transfer from a hospice facility and is under a hospice plan or enrolled in a hospice program	Institutional 837/2300/CL1/ /02	60%	Institutional Inpatient
18	MC023	Discharge Status	N	Integer	2	PTDIS — Use this field to report the status for the patient discharged from the hospital. Valid codes: 01 .....Discharged to home or self care 02 .....Discharged/transferred to another short-term general hospital for inpatient care 03 .....Discharged/transferred to a skilled nursing facility (SNF) ~~04 .....Discharged/transferred to an intermediate care facility (ICF)~~ x 09/30/2009 04 .....Discharged/transferred to a facility that provides custodial or supportive care + 10/01/2009 05 .....Discharged/transferred to a designated cancer center or children's hospital 06 .....Discharged/transferred to home under care of an organized home health service organization 07 .....Left against medical advice or discontinued care 09 .....Admitted as an inpatient to this hospital 20 .....Expired 21 .....Discharged/transferred to court / law enforcement + 10/01/2009 30 .....Still patient or expected to return for outpatient services	Institutional 837/2300/CL1/ /03	90%	Institutional Inpatient

Medical Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	HIPAA 5010 Ref. Standard	Thresh. %	Denom.
						40 .....Expired at home 41 .....Expired in a medical facility 42 .....Expired, place unknown 43 .....Discharged/transferred to a federal healthcare facility 50 .....Hospice – Home 51 .....Hospice – Medical facility 61 .....Discharged/transferred to a hospital-based Medicare-approved swing bed 62 .....Discharged/transferred to an inpatient rehabilitation facility, including distinct parts of a hospital 63 .....Discharge/transferred to a Medicare-certified long-term care hospital 64 .....Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 .....Discharged/transferred to psychiatric hospital or psychiatric distinct part-unit of a hospital 66 .....Discharged/transferred to a critical-access hospital 70 .....Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list			
19	MC024	Service Provider Number	N	Text	30	PRV — Use this field to report the data submitter-assigned or legacy rendering/attending provider number. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers. This field is required if the National Service Provider ID field (MC026) is not filled. When populating this field, the Service Provider Number must be supplemented for Minnesota's collection by one of the following prefixes: U.....UMPI M.....MHCP L.....Legacy/pre-NPI O.....Other	Professional 837/2310B/REF/G2/02, 837/2420A/REF/G2/02 Institutional 837/2010BB/REF/G2/02	0%	All
20	MC025	Service Provider Tax ID Number	N	Text	10	PRVTAXID — Use this field to report the federal taxpayer identification number for the rendering/attending provider. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	835/2100/NM1/FI/09	90%	All
21	MC026	National Service Provider ID	N	Text	20	NPRV — Use this field to report the National Provider Identification (NPI) number for the entity or individual directly providing the service. This field will be used to create a master provider index for Minnesota medical service and prescribing providers. This field is required if the Service Provider Number field (MC024) is not filled.	Professional 837/2420A/NMI/XX/09, 837/2310B/NM1/XX/09 Institutional 837/2010AA/NMI/XX/09	0%	All
22	MC027	Service Provider Entity Type Qualifier	N	Text	1	PRVTYPE — Use this field to report whether the service provider was an individual or a non-person entity. Valid codes: 1 .....Person 2 .....Non-Person Entity	Professional 837/2420A/NM1/82/02, 837/2310B/NM1/82/02 Institutional 837/2010AA/NM1/85/02	90%	All

Medical Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	HIPAA 5010 Ref. Standard	Thresh. %	Denom.
23	MC028	Service Provider First Name	N	Text	25	PRVFNAME — Use this field to report the service provider's first name. Set to null if provider is a facility or an organization. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	Professional 837/2420A/NM1/82/04, 837/2310B/NM1/82/04	40%	All
24	MC029	Service Provider Middle Name	N	Text	25	PRVMNAME — Use this field to report the service provider's middle name or initial. Set to null if provider is a facility or an organization. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	Professional 837/2420A/NM1/82/05, 837/2310B/NM1/82/05	0%	All
25	MC030	Service Provider Last Name or Organization Name	N	Text	100	PRVLNAME — Use this field to report the last name of the service provider or the full name if the provider is a facility or an organization. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	Professional 837/2420A/NM1/82/03, 837/2310B/NM1/82/03 Institutional 837/2010AA/NM1/85/2/03	99.5%	All
26	MC031	Service Provider Suffix	N	Text	10	PRVSUFFIX — Use this field to report any generational identifiers associated with an individual clinician's name (e.g., JR, SR, III). Do not code punctuation and do not code the clinician's credentials (e.g., MD, LCSW) in this field. Set to null if the provider is a facility or an organization. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	Professional 837/2420A/NM1/82/07, 837/2310B/NM1/82/07	0%	All
27	MC033	Service Provider City Name	N	Text	30	PRVCITY — Use this field to report the city name of the service provider's address, preferably the practice location. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	Professional 837/2420C/N4/ /01, 837/2310C/N4/ /01 Institutional 837/2010AA/N4/ /01	90%	All
28	MC034	Service Provider State or Province	N	Text	2	PRVST — Use this field to report the service provider's state or province using the two-character abbreviation code defined by the U.S. Postal Service. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	Professional 837/2420C/N4//02, 837/2310C/N4/ /02 Institutional 837/2010AA/N4/ /02	90%	All
29	MC035	Service Provider ZIP Code	N	Text	15	PRVZIP — Use this field to report the ZIP code associated with the servicing provider's address, preferably the practice location. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	Professional 837/2420C/N4//03, 837/2310C/N4/ /03 Institutional 837/2010AA/N4/ /03	90%	All
30	MC036	Type of Bill - Institutional	N	Text	3	BILLTYPE — Use this field to report the code for the type of bill per the National Uniform Billing Committee's official UB-04 specifications manual. This field is required for institutional claims and must be set to null for professional claims. Note that submitted codes should not include any leading zeroes. Valid codes: **First Two Digits** 11x.....Hospital inpatient (including Medicare Part A) 12x.....Hospital inpatient (Medicare Part B only) 13x.....Hospital outpatient 14x.....Hospital – Laboratory services provided to non-patients 18x.....Hospital – swing beds	Institutional 837/2300/CLM/ /05-1	99%	Institutional

Medical Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	HIPAA 5010 Ref. Standard	Thresh. %	Denom.
						21x.....Skilled nursing – Inpatient (including Medicare Part A) 22x.....Skilled nursing – Inpatient (Medicare Part B only) 23x.....Skilled nursing – Outpatient 28x.....Skilled nursing – Swing beds 32x.....Home health – Inpatient (plan of treatment under Part B only) 33x.....Home health – Outpatient (plan of treatment under Part A, including DME under Part A) 34x.....Home health – Other (for medical and surgical services not under a plan of treatment) 41x.....Religious non-medical healthcare institutions – Hospital inpatient 43x.....Religious non-medical healthcare institutions – Outpatient services 65x.....Intermediate care – Level I 66x.....Intermediate care – Level II 71x.....Clinic – Rural health 72x.....Clinic – Hospital-based or independent renal dialysis center 73x.....Clinic – Freestanding 74x.....Clinic – Outpatient rehabilitation facility (ORF) 75x.....Clinic – Comprehensive outpatient rehabilitation facility (CORF) 76x.....Clinic – Community mental health center 77x.....Clinic – Federally Qualified Health Center (FQHC) + 04/01/2010 78x.....Licensed freestanding emergency medical facility+ 07/01/2012 79x.....Clinic – Other 81x.....Hospice (non-hospital based) 82x.....Hospice (hospital based) 83x.....Ambulatory surgery center 84x.....Freestanding birthing center 85x.....Critical access hospital 86x.....Residential facility 89x.....Special facility – Other **Third Digit (Frequency)** 0 .....Nonpayment/Zero 1 .....Admit through discharge claim 2 .....Interim – First claim 3 .....Interim – Continuing claim 4 .....Interim – Last claim 5 .....Late charge(s) only 7 .....Replacement of prior claim 8 .....Void/Cancel of prior claim 9 .....Final claim for a home health PPS episode A .....Admission/Election notice			

Medical Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	HIPAA 5010 Ref. Standard	Thresh. %	Denom.
						B .....Hospice / CMS Coordinated Care demonstration / Religious non-medical healthcare institution / Centers of Excellence demonstration / Provider Partnerships demonstration C .....Hospice change of provider notice D.....Hospice / CMS Coordinated Care demonstration / Religious non-medical healthcare institution / Centers of Excellence demonstration / Provider Partnerships demonstration – Void/Cancel E .....Hospice change of ownership F .....Beneficiary-initiated adjustment claim G.....CWF- initiated adjustment claim H.....CMS-initiated adjustment claim I .....Intermediary adjustment claim (other than QIO or provider) J .....Initiated adjustment claim – Other K .....OIG-initiated adjustment claim M.....MSP-initiated adjustment claim O.....Nonpayment/Zero claims P .....QIO adjustment claim Q.....Claim submitted for reconsideration outside of timely limits X .....Void/Cancel a prior abbreviated encounter submission Y .....Replacement of prior abbreviated encounter submission Z .....New abbreviated encounter submission			
31	MC037	Place of Service - on NSF/CMS 1500 Claims	N	Text	2	SVCSITE — Use this field to report the place where the service was performed. This field is required for professional claims and must be set to null for institutional claims. Valid codes: 01 .....Pharmacy 03 .....School 04 .....Homeless shelter 05 .....Indian Health Service freestanding facility 06 .....Indian Health Service provider-based facility 07 .....Tribal 638 freestanding facility 08 .....Tribal 638 provider-based facility 09 .....Prison-correctional facility 11 .....Office 12 .....Home 13 .....Assisted living facility 14 .....Group home 15 .....Mobile unit 16 .....Temporary lodging 20 .....Urgent care facility 21 .....Inpatient hospital 22 .....Outpatient hospital	Professional 837/2300/CLM/ /05-1	99%	Professional

Medical Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	HIPAA 5010 Ref. Standard	Thresh. %	Denom.
						23 .....Emergency room – Hospital 24 .....Ambulatory surgery center 25 .....Birthing center 26 .....Military treatment facility 31 .....Skilled nursing facility 32 .....Nursing facility 33 .....Custodial care facility 34 .....Hospice 35 .....Boarding home 41 .....Ambulance – Land 42 .....Ambulance – Air or water 49 .....Independent clinic 50 .....Federally qualified center 51 .....Inpatient psychiatric facility 52 .....Psychiatric facility partial hospitalization 53 .....Community mental health center 54 .....Intermediate care facility-mentally retarded 55 .....Residential substance abuse treatment facility 56 .....Psychiatric residential treatment center 57 .....Non-residential substance abuse treatment facility 60 .....Mass immunization center 61 .....Comprehensive inpatient rehab facility 62 .....Comprehensive outpatient rehab facility 65 .....End-stage renal disease treatment facility 71 .....State or local public health clinic 72 .....Rural health clinic 81 .....Independent laboratory 99 .....Other unlisted facility			
32	MC039	Admitting Diagnosis	N	Text	7	ADMDX — Use this field to report the ICD diagnosis code indicating the reason for the inpatient admission. The decimal point is not coded.	Institutional 837/2300/HI/BJ/01-2, 837/2300/HI/ABJ/01-2	60%	Institutional Inpatient
33	MC040	External Cause of Injury (ECI) Code	N	Text	7	ECODE — Use this field to report an injury, poisoning, or adverse effect using an ICD ECI code. The decimal point is not coded. Additional ECI codes may be reported in other diagnosis fields MC041–MC053.	Institutional 837/2300/HI/BN/01-2, 837/2300/HI/ABN/01-2	5%	Institutional

Medical Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	HIPAA 5010 Ref. Standard	Thresh. %	Denom.
34	MC041	Principal Diagnosis | ICD Version Indicator	N	Text	9	Use this field to report both the ICD diagnosis for the Principal Diagnosis and the ICD Version Indicator separated by the pipe character. For example, ICD diagnosis code V30.00 (i.e., single liveborn, born in hospital, delivered without mention of cesarean section) would be reported in the asterisk-delimited file as *V3000|9*. Note that the ICD Version Indicator should declare the version of ICD reported on this service line. The only valid codes for this field are: 9 .....ICD-9 0 .....ICD-10 **Notes:** Do not include the decimal point when coding the diagnosis field. The ICD Version Indicator should be consistent for the entire claim and for all ICD diagnosis and procedure codes.	Principal Diagnosis: 837/2300/HI/BK/01-2, 837/2300/HI/ABK/01-2	Principal Diagnosis: 90% ICD Version Indicator: 100%	All
35	MC042	Other Diagnosis - 1	N	Text	7	DX2 — Use this field to report the ICD diagnosis code for the first secondary diagnosis. The decimal point is not coded.	Professional 837/2300/HI/BF/02-2, 837/2300/HI/ABF/02-2 Institutional 837/2300/HI/BF/01-2, 837/2300/HI/ABF/01-2	50%	All
36	MC043	Other Diagnosis - 2	N	Text	7	DX3 — Use this field to report the ICD diagnosis code for the second secondary diagnosis. The decimal point is not coded.	Professional 837/2300/HI/BF/03-2, 837/2300/HI/ABF/03-2 Institutional 837/2300/HI/BF/02-2, 837/2300/HI/ABF/02-2	20%	All
37	MC044	Other Diagnosis - 3	N	Text	7	DX4 — Use this field to report the ICD diagnosis code for the third secondary diagnosis. The decimal point is not coded.	Professional 837/2300/HI/BF/04-2, 837/2300/HI/ABF/04-2 Institutional 837/2300/HI/BF/03-2, 837/2300/HI/ABF/03-2	5%	All
38	MC045	Other Diagnosis - 4	N	Text	7	DX5 — Use this field to report the ICD diagnosis code for the fourth secondary diagnosis. The decimal point is not coded.	Professional 837/2300/HI/BF/05-2, 837/2300/HI/ABF/05-2 Institutional 837/2300/HI/BF/04-2, 837/2300/HI/ABF/04-2	0%	All
39	MC046	Other Diagnosis - 5	N	Text	7	DX6 — Use this field to report the ICD diagnosis code for the fifth secondary diagnosis. The decimal point is not coded.	Professional 837/2300/HI/BF/06-2, 837/2300/HI/ABF/06-2 Institutional 837/2300/HI/BF/05-2, 837/2300/HI/ABF/05-2	0%	All

Medical Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	HIPAA 5010 Ref. Standard	Thresh. %	Denom.
40	MC047	Other Diagnosis - 6	N	Text	7	DX7 — Use this field to report the ICD diagnosis code for the sixth secondary diagnosis. The decimal point is not coded.	Professional 837/2300/HI/BF/07-2, 837/2300/HI/ABF/07-2 Institutional 837/2300/HI/BF/06-2, 837/2300/HI/ABF/06-2	0%	All
41	MC048	Other Diagnosis - 7	N	Text	7	DX8 — Use this field to report the ICD diagnosis code for the seventh secondary diagnosis. The decimal point is not coded.	Professional 837/2300/HI/BF/08-2, 837/2300/HI/ABF/08-2 Institutional 837/2300/HI/BF/07-2, 837/2300/HI/ABF/07-2	0%	All
42	MC049	Other Diagnosis - 8	N	Text	7	DX9 — Use this field to report the ICD diagnosis code for the eighth secondary diagnosis. The decimal point is not coded.	Professional 837/2300/HI/BF/09-2, 837/2300/HI/ABF/09-2 Institutional 837/2300/HI/BF/08-2, 837/2300/HI/ABF/08-2	0%	All
43	MC050	Other Diagnosis - 9	N	Text	7	DX10 — This field contains the ICD diagnosis code for the ninth secondary diagnosis. The decimal point is not coded.	Professional 837/2300/HI/BF/10-2, 837/2300/HI/ABF/10-2 Institutional 837/2300/HI/BF/09-2, 837/2300/HI/ABF/09-2	0%	All
44	MC051	Other Diagnosis - 10	N	Text	7	DX11 — Use this field to report the ICD diagnosis code for the tenth secondary diagnosis. The decimal point is not coded.	Professional 837/2300/HI/BF/11-2, 837/2300/HI/ABF/11-2 Institutional 837/2300/HI/BF/10-2, 837/2300/HI/ABF/10-2	0%	All
45	MC052	Other Diagnosis - 11	N	Text	7	DX12 — Use this field to report the ICD diagnosis code for the eleventh secondary diagnosis. The decimal point is not coded.	Professional 837/2300/HI/BF/12-2, 837/2300/HI/ABF/12-2 Institutional 837/2300/HI/BF/11-2, 837/2300/HI/ABF/11-2	0%	All
46	MC053	Other Diagnosis - 12	N	Text	7	DX13 — Use this field to report the ICD diagnosis code for the twelfth secondary diagnosis. The decimal point is not coded.	Institutional 837/2300/HI/BF/12-2, 837/2300/HI/ABF/12-2	0%	All
47	MC054	Revenue Code	N	Text	4	REV — Use this field to report the revenue code for institutional claims using National Uniform Billing codes. It is one of three fields used to report the type of service. Code using leading zeroes, left justification, and four digits.	835/2110/SVC/NU/01-2, 835/2110/SVC/ /04	99.9%	Institutional
48	MC055	Procedure Code	N	Text	5	CPT — Use this field to report the HCPCS or CPT code for the procedure performed. It is one of three fields used to report the service. Health Care Common Procedural Coding System (HCPCS), including CPT codes of the American Medical Association, are accepted.	835/2110/SVC/HC/01-2, 835/2110/SVC/HP/01-2	80%	All

Medical Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	HIPAA 5010 Ref. Standard	Thresh. %	Denom.
49	MC056	Procedure Modifier - 1	N	Text	2	MOD1 — Use this field to report a modifier indicating that a service or procedure has been altered by some specific circumstance but has not changed in its definition or code. Modifiers may be used to indicate that a service or procedure has both a professional and a technical component, that only part of a service was performed, that a bilateral procedure was performed, or that a service or procedure was provided more than once. A procedure modifier is required when a modifier clarifies or improves the reporting accuracy of the associated procedure code.	835/2110/SVC/HC/01-3	10%	All
50	MC057A	Procedure Modifier - 2	N	Text	2	MOD2 — Use this field to report a modifier indicating that a service or procedure has been altered by some specific circumstance but has not changed in its definition or code. Modifiers may be used to indicate that a service or procedure has both a professional and a technical component, that only part of a service was performed, that a bilateral procedure was performed, or that a service or procedure was provided more than once. A procedure modifier is required when a modifier clarifies or improves the reporting accuracy of the associated procedure code.	835/2110/SVC/HC/01-4	2%	All
51	MC057B	Procedure Modifier - 3	N	Text	2	MOD3 — Use this field to report a modifier indicating that a service or procedure has been altered by some specific circumstance but has not changed in its definition or code. Modifiers may be used to indicate that a service or procedure has both a professional and a technical component, that only part of a service was performed, that a bilateral procedure was performed, or that a service or procedure was provided more than once. A procedure modifier is required when a modifier clarifies or improves the reporting accuracy of the associated procedure code.	835/2110/SVC/HC/01-5	0%	All
52	MC057C	Procedure Modifier - 4	N	Text	2	MOD4 — Use this field to report a modifier indicating that a service or procedure has been altered by some specific circumstance but has not changed in its definition or code. Modifiers may be used to indicate that a service or procedure has both a professional and a technical component, that only part of a service was performed, that a bilateral procedure was performed, or that a service or procedure was provided more than once. A procedure modifier is required when a modifier clarifies or improves the reporting accuracy of the associated procedure code.	835/2110/SVC/HC/01-6	0%	All
53	MC058	Principal ICD-CM Procedure Code	N	Text	7	OP — Use this field to report the principal inpatient ICD procedure code. The decimal point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary. Use fields MC058A–E to report other ICD-CM procedure codes.	Institutional 837/2300/HI/BR/01-2, 837/2300/HI/BBR/01-2	55%	Institutional Inpatient
54	MC058A	Other ICD-CM Procedure Code - 1	N	Text	7	OP1 — Use this field to report the second ICD procedure code. The decimal point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Institutional 837/2300/HI/BQ/01-2, 837/2300/HI/BBQ/01-2	30%	Institutional Inpatient
55	MC058B	Other ICD-CM Procedure Code - 2	N	Text	7	OP2 — Use this field to report the third ICD procedure code. The decimal point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Institutional 837/2300/HI/BQ/02-2, 837/2300/HI/BBQ/02-2	15%	Institutional Inpatient
56	MC058C	Other ICD-CM Procedure Code - 3	N	Text	7	OP3 — Use this field to report the fourth ICD procedure code. The decimal point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Institutional 837/2300/HI/BQ/03-2, 837/2300/HI/BBQ/03-2	10%	Institutional Inpatient

Medical Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	HIPAA 5010 Ref. Standard	Thresh. %	Denom.
57	MC058D	Other ICD-CM Procedure Code - 4	N	Text	7	OP4 — Use this field to report the fifth ICD procedure code. The decimal point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Institutional 837/2300/HI/BQ/04-2, 837/2300/HI/BBQ/04-2	5%	Institutional Inpatient
58	MC058E	Other ICD-CM Procedure Code - 5	N	Text	7	OP5 — Use this field to report the sixth ICD procedure code. The decimal point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Institutional 837/2300/HI/BQ/05-2, 837/2300/HI/BBQ/05-2	0%	Institutional Inpatient
59	MC059	Date of Service (From)	N	Date	8	FDATE — Use this field to report the first date of service for this service line in a CCYYMMDD format.	835/2110/DTM/150/02, 835/2110/DTM/472/02	99.5%	All
60	MC060	Date of Service (Through)	N	Date	8	LDATE — Use this field to report the last date of service for this service line in a CCYYMMDD format. Future dates are acceptable.	835/2110/DTM/151/02, 835/2110/DTM/472/02	99.5%	All
61	MC061	Quantity	N	Integer	5	QTY — Use this field to report a count of services performed. This field may be negative.	835/2110/SVC/ /05	99.5%	All
62	MC062	Charge Amount	N	Decimal	10	CHG — Use this field to report the total charges for the service as reported by the provider. This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. A reported value of 0 is acceptable. Code “data not available” as a series of ten 9s (i.e., 9999999999). Only 1% of submissions may contain 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.	835/2110/SVC/ /02	99%	All
63	MC063	Paid Amount	N	Decimal	10	TPAY — Use this field to the total dollar amount paid to the provider, including all health plan payments and excluding all member payments and withholds from providers. This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. A reported value of 0 is acceptable. Code “data not available” as a series of ten 9s (i.e., 9999999999). Only 1% of submissions may contain 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.	835/2110/SVC/ /03	99%	All
64	MC063A	Header / Line Payment Indicator	N	Text	1	HDPAYID — Use this field to report whether the payment is reported on the header or line level. Code H for Header or L for Line. If H, populate each line after the first line with “H” and a paid amount of 0. If L, populate each line as necessary.	Pricing data	100%	All
65	MC063C	Managed Care Withhold	N	Decimal	10	MNGCRWITH — Use this field to report an amount withheld from payment to a provider by a managed care organization, which may be paid at a later date. A reported value of 0 is acceptable. Code “data not available” as a series of ten 9s (i.e., 9999999999). Only 1% of submissions may contain 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.	835/2110/CAS/CO/104	99%	All
66	MC064	Prepaid Amount	N	Decimal	10	PREPAID — Use this field to report capitated services, the fee for service equivalent amount. A reported value of 0 is acceptable. Code “data not available” as a series of ten 9s (i.e., 9999999999). Only 1% of submissions may contain 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.	Pricing data	99%	All

Medical Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	HIPAA 5010 Ref. Standard	Thresh. %	Denom.
67	MC065	Copay / Coinsurance Amount	N	Decimal	10	COPAY/COINS — Use this field to report the sum of two amounts: the copay (i.e., the preset, fixed dollar amount payable by a member, often on a per visit/service basis) and the coinsurance (i.e., the dollar amount that a member must pay toward the cost of a covered service, which is often a percentage of total cost).This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. A reported value of 0 is acceptable. Code “data not available” as a series of ten 9s (i.e., 9999999999). Only 1% of submissions may contain 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.	Sum of: 835/2110/CAS/PR/3, 835/2110/CAS/PR/2	99%	All
68	MC067	Deductible Amount	N	Decimal	10	DED — Use this field to report the dollar amount that a member must pay before health plan benefits will begin to reimburse for services. It is usually an annual amount of all healthcare costs that are not covered by the member's insurance plan. This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value A reported value of 0 is acceptable. Code “data not available” as a series of ten 9s (i.e., 9999999999). Only 1% of submissions may contain 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.	835/2110/CAS/PR/1	99%	All
69	MC076	Billing Provider Number	N	Text	30	PRVBILL — Use this field to report the data submitter-assigned billing provider number. This should be the identifier used by the data submitter for internal reasons and does not routinely change. This field is required if the National Billing Provider ID field (MC077) is not filled. When populating this field, the Billing Provider Number must be supplemented for Minnesota’s collection by one of the following prefixes: U.....UMPI M.....MHCP L.....Legacy/pre-NPI O.....Other	837/2010BB/REF/G2/02	0%	All
70	MC077	National Billing Provider ID	N	Text	10	NPRVBILL — Use this field to report the National Provider Identifier (NPI) for the billing provider. This field is required if the Billing Provider Number field (MC076) is not filled.	837/2010AA/NM1/XX/09	0%	All
71	MC078	Billing Provider Last Name or Organization Name	N	Text	60	PRVLNAMEBILL — Use this field to report the full name of the billing organization or the last name of the individual billing provider.	837/2010AA/NM1/ /03	99.5%	All
72	MC079	Diagnosis Code Pointer - 1	N	Text	2	DXPT1 — Use this field to report a pointer to the claim diagnosis code in the order of importance to this service. Use this pointer for the first diagnosis code pointer (primary diagnosis for this service line).	Professional 837/2400/SV1//07-1	90%	Professional
73	MC080	Diagnosis Code Pointer - 2	N	Text	2	DXPT2 — Use this field to report a pointer to the claim diagnosis code in the order of importance to this service. Use this pointer for the second diagnosis code pointer if applicable.	Professional 837/2400/SV1//07-2	10%	Professional
74	MC081	Diagnosis Code Pointer - 3	N	Text	2	DXPT3 — Use this field to report a pointer to the claim diagnosis code in the order of importance to this service. Use this pointer for the third diagnosis code pointer if applicable.	Professional 837/2400/SV1//07-3	0%	Professional
75	MC082	Diagnosis Code Pointer - 4	N	Text	2	DXPT4 — Use this field to report a pointer to the claim diagnosis code in the order of importance to this service. Use this pointer for the fourth diagnosis code pointer if applicable.	Professional 837/2400/SV1//07-4	0%	Professional

Medical Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	HIPAA 5010 Ref. Standard	Thresh. %	Denom.
76	MC101	Subscriber Last Name	Y	Text	128	SUBSLNAME — Use this field to report the subscriber's last name. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	837/2010BA/NM1/ /03	100%	All
77	MC102	Subscriber First Name	Y	Text	128	SUBSFNAME — Use this field to report the subscriber's first name. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	837/2010BA/NM1/ /04	90%	All
78	MC103	Subscriber Middle Initial	Y	Text	1	SUBSMI — Use this field to report the subscriber's middle initial. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	837/2010BA/NM1/ /05	0%	All
79	MC104	Member Last Name	Y	Text	128	MEMSLNAME — Use this field to report the member's last name. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	837/2010BA/NM1/ /03, 837/2010CA/NM1/ /03	100%	All
80	MC105	Member First Name	Y	Text	128	MEMSFNAME — Use this field to report the member's first name. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	837/2010BA/NM1/ /04, 837/2010CA/NM1/ /04,	90%	All
81	MC106	Member Middle Initial	Y	Text	1	MEMSMI — Use this field to report the member's middle initial. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	837/2010BA/NM1/ /05, 837/2010CA/NM1/ /05	0%	All
82	MC899	Record Type	N	Text	2	RECTYPE — This field must be coded MC to indicate the submission of medical claims (i.e., professional and institutional claims) records.	Administrative element	100%	All
1	TR001	Record Type	N	Text	2	RECTYPE — This field must be coded TR to indicate the start of the Trailer record.	Administrative element	100%	All
2	TR002	Payer	N	Text	8	PAYER — This field must contain the payer or submitter code assigned by Onpoint CDM.	Administrative element	100%	All
3	TR003	Placeholder	N	Text	30	PLACEHOLDER — This field must be coded as null; it is reserved for header consistency across all states using Onpoint CDM.	Administrative element	0%	All
4	TR004	Type of File	N	Text	2	FILETYPE — This field must be coded MC to indicate submission of professional and institutional claims data.	Administrative element	100%	All
5	TR005	Period Beginning Date	N	Integer	6	BEGPERIOD — Use this field to report the earliest payment year/month included in the submission in CCYYMM format. Submissions with records containing a Check Issue or EFT Effective Date value (MC017) before this date will fail.	Administrative element	100%	All
6	TR006	Period Ending Date	N	Integer	6	ENDPERIOD — Use this field to report the latest payment year/month included in the submission in CCYYMM format. Submissions with records containing a Check Issue or EFT Effective Date value (MC017) after this date will fail.	Administrative element	100%	All
7	TR007	Date Processed	N	Date	8	PROCDATE — Use this field to report the date on which the file was created in CCYYMMDD format.	Administrative element	0%	All

9. PHARMACY CLAIMS

The Basics

Required Frequency

- Monthly, quarterly, or semi-annually (for more details, see the "What is the Submission Schedule?" section)

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.
- Submissions must cover full months of data; partial months must not be reported.

Columns Included in the Pharmacy Claims File

Col. #	ID	Name	Hashed?	Type	Max. Length	Description	NCPDP Reference	Thresh. %	Denom.
↓ Indicates the element's required position within the submission file	↓ Indicates the element's reference number	↓ Indicates the element's name	↓ Indicates whether or not the element's true value has been rendered permanently non-recoverable by one-way hashing prior to submission to Onpoint	↓ Indicates whether the type of data for the element is a date, decimal, integer, or text	↓ Indicates the maximum length allowed for this element	↓ Provides a general description of the data element, including valid codes vary from industry standards and for elements that lack a national standard altogether. Values appended with superscript text in blue (e.g., +01/01/2012) note the effective date of newly valid values; those with strikethrough text (i.e., ~~strikethrough~~) are no longer valid and have their expiration dates appended in red superscript text (e.g., x12/31/2011).	↓ Indicates the element's NCPDP reference standard	↓ Indicates the percent of submitted records for which this element must have a valid code	↓ Indicates the type of records to be used to calculate the threshold percent for submission.

Pharmacy Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	NCPDP Reference	Thresh. %	Denom.
1	HD001	Record Type	N	Text	2	RECTYPE — This field must be coded HD to indicate the start of the Header record.	Administrative element	100%	All
2	HD002	Payer	N	Text	8	PAYER — This field must contain the payer or submitter code assigned by Onpoint CDM.	Administrative element	100%	All
3	HD003	Placeholder	N	Text	30	PLACEHOLDER — This field must be coded as null; it is reserved for header consistency across all states using Onpoint CDM.	Administrative element	0%	All
4	HD004	Type of File	N	Text	2	FILETYPE — This field must be coded PC to indicate submission of pharmacy claims data.	Administrative element	100%	All
5	HD005	Period Beginning Date	N	Integer	6	BEGPERIOD — Use this field to report the earliest date service approved year/month included in the submission in CCYYMM format. Submissions with records containing a Date Service Approved (AP Date) value (PC017) before this date will fail.	Administrative element	100%	All
6	HD006	Period Ending Date	N	Integer	6	ENDPERIOD — Use this field to report the latest date service approved year/month included in the submission in CCYYMM format. Submissions with records containing a Date Service Approved (AP Date) value (PC017) after this date will fail.	Administrative element	100%	All
7	HD007	Record Count	N	Integer	10	RECCNT — Use this field to report the total number of records in the submission, excluding the header and trailer records. If the number of records within the submission does not equal the number reported in this field, the submission will fail.	Administrative element	100%	All
8	HD008	Comments	N	Text	80	CMNTS — Use this field to supply any submitter comments.	Administrative element	0%	All
1	PC001	Payer	N	Text	8	PAYER — This field must contain the Onpoint CDM-assigned submitter code for the data submitter. The first two characters of the submitter code indicate Minnesota and the third character designates the type of submitter: MNC .....Commercial carrier MNG.....Governmental agency MNT .....Third-party administrator MNU.....Unlicensed entity A single data submitter may have multiple submitter codes because the data submitter is 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 6 characters. A suffix will be used to distinguish the location and/or system variations.	Administrative element	100%	All
2	PC003	Insurance Type / Product Code	N	Text	6	PRODUCT —Use this field to report the insurance type or product code that indicates the individual's type of insurance coverage. All codes must be 2 characters except for MC and XX, which also must include a valid subcode. Valid codes and subcodes: EP .....Exclusive Provider Organization HM .....Health Maintenance Organization (HMO)	Administrative element	0%	All

Pharmacy Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	NCPDP Reference	Thresh. %	Denom.
						HN .....Health Maintenance Organization (HMO) Medicare Risk HS .....Special Low Income Medicare Beneficiary IN.....Indemnity MC.....Medical Assistance; this code must also include one of the following subcodes: FFSM..... Fee-for-service Medical Assistance PMAP..... Prepaid Medical Assistance Program MDHO..... MN Disability Health Options MSHO ..... MN Senior Health Options SNBC..... Special Needs Basic Care MISC ..... Other managed care program within Medical Assistance MD .....Medicare Part D PR .....Preferred Provider Organization (PPO) PS .....Point of Service (POS) QM .....Qualified Medicare Beneficiary XX .....Non-Medical-Assistance Public Program; this code must also include one of the following subcodes: CDEP..... Chemical Dependency GAMC ..... General Assistance Medical Care HIVA..... HIV/AIDS MCHA ..... Minnesota Comprehensive Health Association MNCR ..... MinnesotaCare MISC ..... Other non-Medical Assistance public program			
3	PC004	Payer Claim Control Number	N	Text	35	CLAIM — Use this field to report the claim number used by the data submitter to internally track the claim. In general the claim number is associated with all service lines of the bill. It must apply to the entire claim and be unique within the data submitter's system.	Administrative element	99.9%	All
4	PC005	Line Counter	N	Integer	4	LINE — Use this field to report the line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim. If the data submitter's processing system assigns an internal line counter for the adjudication process, that number may be submitted in place of the line number submitted by the provider.	Administrative element	99.5%	All
5	PC008	Plan-Specific Contract Number	Y	Text	128	CONTRACT — Use this field to report the data submitter-assigned contract number for the subscriber. This field is encrypted using the same algorithm across all data submitters and is not available in the analytical data warehouse. When this field is populated, it forms the core of the unique member identification code. Set as null if unavailable.	302-C2	99.9%	All

Pharmacy Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	NCPDP Reference	Thresh. %	Denom.
6	PC011	Individual Relationship Code	N	Integer	2	REL — Use this field to report the member's relationship to the subscriber or the insured. Valid codes: 01 .....Covered Individual is Policy holder 02 .....Spouse 03 .....Child 04 .....Other	306-C6	100%	All
7	PC012	Member Gender	N	Integer	1	SEX — Use this field to report the gender of the member. Valid codes: 1 .....Male 2 .....Female 3 .....Unknown	305-C5	100%	All
8	PC013	Member Date of Birth	Y Trans-formed	Date	8	DOB — Use this field to report the member's date of birth with a format of CCYYMMDD. During the encryption process, this field is used to calculate age as of the date the prescription was filled. The field is then encrypted. This data element will not be transmitted in unencrypted form.	304-C4	99.5%	All
9	PC014	Member City Name of Residence	N	Text	30	PATCITY — Use this field to report the name of the member's city of residence.	323-CN	90%	All
10	PC015	Member State or Province	N	Text	2	PATST — Use this field to report the member's state or province using the two-character abbreviation code defined by the U.S. Postal Service.	324-CO	90%	All
11	PC016	Member ZIP Code	N	Text	5	PATZIP — Use this field to report the ZIP code associated with the member's residence.	325-CP	90%	All
12	PC017	Date Service Approved (AP Date)	N	Date	8	PDATE — Use this field to report the date on which the record was approved for payment. This is generally referred to as the paid date and reported with a CCYYMMDD format.	Pricing data	100%	All
13	PC018	Pharmacy Number	N	Text	30	PHARM — Use this field to report the payer-assigned pharmacy number. This field is required if the National Pharmacy ID Number field (PC021) is not filled.	201-B1	0%	All
14	PC020	Pharmacy Name	N	Text	30	PHARMNM — Use this field to report the name of the pharmacy.	833-5P	99.5%	All
15	PC021	National Pharmacy ID Number	N	Text	20	NPHARM — The field contains the National Provider Identification (NPI) number and pertains to the entity or individual directly providing the service. This field is required if the Pharmacy Number field (PC018) is not filled.	201-B1	0%	All
16	PC025	Claim Status	N	Text	2	STATUS — Use this field to supply the status of the claim as reported by the data submitter. This field will be used in the algorithms to determine the final payment for this service. Valid codes: 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)	Administrative element	99.5%	All

Pharmacy Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	NCPDP Reference	Thresh. %	Denom.
						21 .....Processed as tertiary, forwarded to additional payer(s) 22 .....Reversal of previous payment 25 .....Predetermination pricing only – no payment			
17	PC026	Drug Code	N	Text	11	NDC — This field is used to report the National Drug Code assigned by the U.S. Food and Drug Administration (FDA). Each drug product listed under Section 510 of the Federal Food, Drug, and Cosmetic Act is assigned a unique 10-digit, three-segment number. This number, known as the National Drug Code (NDC), identifies the labeler/vendor, product, and trade package size. The first segment, the labeler/vendor code, is assigned by the FDA. A labeler is any firm that manufactures, repacks, or distributes a drug product. The second segment, the product code, identifies a specific strength, dosage form, and formulation for a particular firm. The third segment, the package code, identifies package sizes. Both the product and package codes are assigned by the firm. The NDC will be in one of the following configurations: 4-4-2, 5-3-2, or 5-4-1.	407-D7	99.5%	All
18	PC027	Drug Name	N	Text	80	DRUGNM — Use this field to report the text name of drug as supplied by the data submitter. This is a voluntary field.	516-FG	0%	All
19	PC028	New Prescription or Refill	N	Integer	2	NEWPR — This field can be used to determine if this is a new prescription. It contains the prescription number. 00 .....New prescription 01–99 .....Refill prescription	403-D3	99.5%	All
20	PC029	Generic Drug Indicator	N	Text	1	GENRX — This field indicates whether the drug is a branded drug or a generic drug. This is a voluntary field. Valid codes: N.....No, branded drug Y .....Yes, generic drug	425-DP	0%	All
21	PC030	Dispense as Written Code	N	Integer	1	DAW — Use this field to report the instructions given to the pharmacist for filling the prescription. For example, a prescription for a brand name drug that also has a generic equivalent may not have the generic equivalent substituted. In this case, the code is 1 (i.e., the physician requires the script to be filled as written). Valid codes: 0 .....Not dispensed as written 1 .....Physician dispense as written 2 .....Member dispense as written 3 .....Pharmacy dispense as written 4 .....No generic available 5 .....Brand dispensed as generic 6 .....Override 7 .....Substitution not allowed — brand drug mandated by law 8 .....Substitution allowed — generic drug not available in marketplace 9 .....Other	408-D8	95%	All

Pharmacy Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	NCPDP Reference	Thresh. %	Denom.
22	PC031	Compound Drug Indicator	N	Text	1	COMPOUND — Use this field to indicate whether or not the drug is a compound drug. Valid codes: 0 .....Not specified 1 .....Not compound 2 .....Compound	406-D6	95%	All
23	PC032	Date Prescription Filled	N	Text	8	FDATE — Use this field to report the date on which the prescription was filled in a CCYYMMDD format.	401-D1	99.5%	All
24	PC033	Quantity Dispensed	N	Integer	5	QTY — Use this field to report the total unit dosage in metric units. This field may be negative.	404-D4	85%	All
25	PC034	Days' Supply	N	Integer	3	DAYS — Use this field to report the actual days' supply for the prescription based on the metric quantity dispensed. This field may contain a negative value.	405-D5	95%	All
26	PC035	Gross Amount Due	N	Decimal	10	CHG — Use this field to report the total charges for the service as reported by the provider. This is a money field containing dollars and cents with an implied decimal point and may contain a negative value. A reported value of 0 is acceptable. Code "data not available" as a series of ten 9s (i.e., 9999999999). Only 1% of submissions may contain 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.	430-DU	95%	All
27	PC036	Total Amount Paid	N	Decimal	10	TPAY — Use this field to report the total dollar amount paid to the provider, including all health plan payments and excluding withhold amounts and all member payments. This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. A reported value of 0 is acceptable. Code "data not available" as a series of ten 9s (i.e., 9999999999). Only 1% of submissions may contain 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.	509-F9	99%	All
28	PC036A	Other Amount Paid	N	Decimal	10	OTHPAY — Use this field to report the amount paid for additional costs claimed in "Other Amount Claimed Submitted (480-H9)." This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. A reported value of 0 is acceptable. Code "data not available" as a series of ten 9s (i.e., 9999999999). Only 1% of submissions may contain 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.	565-J4	99%	All
29	PC036B	Other Payer Amount Recognized	N	Decimal	10	OTHAMTREC — Use this field to report the total dollar amount of any payment from another source, including coupons. This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. A reported value of 0 is acceptable. Code "data not available" as a series of ten 9s (i.e., 9999999999). Only 1% of submissions may contain 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.	565-J5	99%	All
30	PC037	Ingredient Cost / List Price	N	Decimal	10	INGRED — Use this field to report the cost of the drug that was dispensed as reported by the data submitter. This is a money field containing dollars and cents with an implied decimal point. A reported value of 0 is acceptable. Code "data not available" as a series of ten 9s (i.e., 9999999999). Only 1% of submissions may	506-F6	99%	All

Pharmacy Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	NCPDP Reference	Thresh. %	Denom.
						contain 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.			
31	PC039	Dispensing Fee Paid	N	Decimal	10	DISPFEE — Use this field to report the amount charged for dispensing. This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. A reported value of 0 is acceptable. Code “data not available” as a series of ten 9s (i.e., 9999999999). Only 1% of submissions may contain 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.	507-F7	99%	All
32	PC040	Copay/Co-insurance Amount	N	Decimal	10	COPAY/COINS — Use this field to report the sum of two amounts: the copay (i.e., the preset, fixed dollar amount payable by a member, often on a per visit/service basis) and the coinsurance (i.e., the dollar amount that a member must pay toward the cost of a covered service, which is often a percentage of total cost).This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. A reported value of 0 is acceptable. Code “data not available” as a series of ten 9s (i.e., 9999999999). Only 1% of submissions may contain 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.	518-FI	99%	All
33	PC042	Deductible Amount	N	Decimal	10	DED — Use this field to report the dollar amount that a member must pay before health plan benefits will begin to reimburse for services. This is usually an annual amount of all healthcare costs that are not covered by the member's insurance plan. This is a money field containing dollars and cents with an implied decimal point. A reported value of 0 is acceptable. Code “data not available” as a series of ten 9s (i.e., 9999999999). Only 1% of submissions may contain 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.	Pricing data	99%	All
34	PC043	Patient Pay Amount	N	Decimal	10	PTPAY — Use this field to report the total amount to be paid by the patient. This is a money field containing dollars and cents with an implied decimal point. A reported value of 0 is acceptable. Code “data not available” as a series of ten 9s (i.e., 9999999999). Only 1% of submissions may contain 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.	505-F5	99%	All
35	PC044	Prescribing Physician First Name	N	Text	25	PHYSFNAME — Use this field to report the first name of the prescribing physician. This will be used to create a master provider index for Minnesota providers encompassing medical service providers, prescribing providers, and medical homes. Since there is currently no HIPAA equivalent field for prescribing physician first name, this is a voluntary field.	Administrative element	0%	All
36	PC045	Prescribing Physician Middle Name	N	Text	25	PHYSMNAME — Use this field to report the middle name or initial of the prescribing physician. This will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers. Since there is currently no HIPAA equivalent field for prescribing physician middle initial, this is a voluntary field.	Administrative element	0%	All

Pharmacy Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	NCPDP Reference	Thresh. %	Denom.
37	PC046	Prescribing Physician Last Name	N	Text	60	PHYSLNAME — Use this field to report the last name of the prescribing physician. This will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	427-DR	99%	All
38	PC047	Prescribing Physician DEA / Legacy Number	N	Text	10	PHYSNUM — Use this field to report either the DEA number; the data submitter's legacy, pre-NPI number; or the Minnesota Health Care Program ID for the prescribing physician. This will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers. This field is required if the Prescribing Physician National Provider Identification Number field (PC048) is not filled. When populating this field, the Prescribing Physician DEA / Legacy Number must be supplemented for Minnesota's collection by one of the following prefixes: D.....DEA ID number L.....Legacy ID number M.....MHCP O.....Other Please note: In accordance with Minnesota Statutes, any claims originating on or after May 23, 2008, cannot use DEA as the prescribing physician identifier within element PC047. For these claims, the prescribing physician should be identified by submission of the NPI within element PC048.	411-DB	0%	All
39	PC048	Prescribing Physician National Provider Identification Number	N	Text	20	PHYSNPI — Use this field to report the National Provider Identifier (NPI) for the prescribing physician. This will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers. This field is required if the Prescribing Physician DEA / Legacy Number field (PC047) is not filled.	411-DB	0%	All
40	PC101	Subscriber Last Name	Y	Text	128	SUBSLNAME — Use this field to report the subscriber's last name. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	313-CD	100%	All
41	PC102	Subscriber First Name	Y	Text	128	SUBSFNAME — Use this field to report the subscriber's first name. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	312-CC	90%	All
42	PC103	Subscriber Middle Initial	Y	Text	1	SUBSMI — Use this field to report the subscriber's middle initial. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	Administrative element	0%	All
43	PC104	Member Last Name	Y	Text	128	MEMSLNAME — Use this field to report the member's last name. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	311-CB	100%	All
44	PC105	Member First Name	Y	Text	128	MEMSFNAME — Use this field to report the member's first name. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	310-CA	90%	All

Pharmacy Claims									
Col. #	ID	Name	Hashed?	Type	Max. Length	Description	NCPDP Reference	Thresh. %	Denom.
45	PC106	Member Middle Initial	Y	Text	1	MEMSMI — Use this field to report the member's middle initial. This field is used to create a unique de-identified member ID and is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	Administrative element	0%	All
46	PC899	Record Type	N	Text	2	RECTYPE — This field must be coded PC to indicate the submission of pharmacy claims records.	Administrative element	100%	All
1	TR001	Record Type	N	Text	2	RECTYPE — This field must be coded TR to indicate the start of the Trailer record.	Administrative element	100%	All
2	TR002	Payer	N	Text	8	PAYER — This field must contain the payer or submitter code assigned by Onpoint CDM.	Administrative element	100%	All
3	TR003	Placeholder	N	Text	30	PLACEHOLDER — This field must be coded as null; it is reserved for header consistency across all states using Onpoint CDM.	Administrative element	0%	All
4	TR004	Type of File	N	Text	2	FILETYPE — This field must be coded PC to indicate submission of pharmacy claims data.	Administrative element	100%	All
5	TR005	Period Beginning Date	N	Integer	6	BEGPERIOD — Use this field to report the earliest date service approved year/month included in the submission in CCYYMM format. Submissions with records containing a Date Service Approved (AP Date) value (PC017) before this date will fail.	Administrative element	100%	All
6	TR006	Period Ending Date	N	Integer	6	ENDPERIOD — Use this field to report the latest date service approved year/month included in the submission in CCYYMM format. Submissions with records containing a Date Service Approved (AP Date) value (PC017) after this date will fail.	Administrative element	100%	All
7	TR007	Date Processed	N	Date	8	PROCDATE — Use this field to report the date on which the file was created in CCYYMMDD format.	Administrative element	0%	All

10. A CLOSER LOOK AT SELECT DATA ELEMENTS

Voluntary Data Elements

Medical Claims (Institutional & Professional)

ELEMENT #	COMMON NAME
Institutional & Professional Claims	
MC005A	Version Number
Pharmacy Claims	
PC027	Drug Name
PC029	Generic Drug Indicator
PC044	Prescribing Physician First Name
PC045	Prescribing Physician Middle Name

Provider Data Elements

Service Provider, Rendering Provider, Attending Provider (Medical Claims)

ELEMENT #	COMMON NAME
Name	
MC028	Service Provider First Name
MC029	Service Provider Middle Name
MC030	Service Provider Last Name or Organization Name
MC031	Service Provider Suffix
Location (preferably practice location)	
MC033	Service Provider City Name
MC034	Service Provider State or Province
MC035	Service Provider ZIP Code
Identifiers	
MC024*	Service Provider Number
MC025	Service Provider Tax ID Number
MC026*	National Service Provider ID (NPI)
Other	
MC027	Service Provider Entity Type Qualifier

* Note that every record must have at least one entry in MC024 or in MC026 to indicate the servicing provider. MC024 is primarily available for pre-NPI claims and for claims submitted by atypical providers. The UMPI and MCPH codes will be reported in MC024.

Billing Provider

ELEMENT #	COMMON NAME
Name	
MC078	Billing Provider Last Name or Organization Name
Identifiers	
MC076	Billing Provider Number
MC077	National Billing Provider ID (NPI)

* Note that every record must have at least one entry in MC076 or in MC077 to indicate the servicing provider. MC076 is primarily available for pre-NPI claims and for claims submitted by atypical providers. The UMPI and MCPH codes will be reported in MC076.

Pharmacy Data

Pharmacy

ELEMENT #	COMMON NAME
Name	
PC020	Pharmacy Name
Identifiers	
PC018	Pharmacy Number
PC021	National Pharmacy ID Number (NPI)

* Note that every record must have at least one entry in PC018 or in PC026 to indicate the pharmacy. PC018 is primarily available for pre-NPI claims.

Prescribing Physician

ELEMENT #	COMMON NAME
Name	
PC044	Prescribing Physician First Name (Voluntary)
PC045	Prescribing Physician Middle Name (Voluntary)
PC046	Prescribing Physician Last Name
Identifiers	
PC047	Prescribing Physician DEA/Legacy Number
PC048	Prescribing Physician National Provider Identification Number

* Note that every record must have at least one entry in PC047 or in PC048 to indicate the prescribing provider. Please note: In accordance with Minnesota Statutes, any claims originating on or after May 23, 2008, cannot use DEA as the prescribing physician identifier within element PC047. For these claims, the prescribing physician should be identified by submission of the NPI within element PC048.

Financial Data Elements

Medical Claims (Institutional & Professional)

Note that all records with a value of 9999999999 — data not available — will not factor into the calculation of the threshold. The entire field must be populated with a series of ten 9s (i.e., 999999999).

ELEMENT #	COMMON NAME	THRESHOLD
Charges		
MC062	Charge Amount	1% threshold for 9999999999
Payments		
MC063	Paid Amount	1% threshold for 9999999999
MC064	Prepaid Amount	1% threshold for 9999999999
MC065	Copay/Coinsurance Amount	1% threshold for 9999999999
MC067	Deductible Amount	1% threshold for 9999999999
Other		
MC063C	Managed Care Withhold	1% threshold for 9999999999

Pharmacy Claims

Note that all records with a value of 9999999999 — data not available — will not factor into the calculation of the threshold. The entire field must be populated with a series of ten 9s (i.e., 999999999).

ELEMENT #	COMMON NAME	THRESHOLD
Charges		
PC035	Gross Amount Due	1% threshold for 9999999999
Payments		
PC036	Total Amount Paid	1% threshold for 9999999999
PC036A	Other Amount Paid	1% threshold for 9999999999
PC039	Dispensing Fee Paid	1% threshold for 9999999999
PC040	Copay/Coinsurance Amount	1% threshold for 9999999999
PC042	Deductible Amount	1% threshold for 9999999999
PC043	Patient Pay Amount	1% threshold for 9999999999
Other		
PC036B	Other Payer Amount Recognized	1% threshold for 9999999999
PC037	Ingredient Cost/List Price	1% threshold for 9999999999

11. ANNOUNCEMENTS & ADDITIONAL INFORMATION

January 2010 Update: Medicare Supplement Insurance

The Minnesota Department of Health currently does not require submission of Medicare Supplement Insurance enrollment or claims records by health plan companies or third-party administrators (TPAs). All other claims and enrollment files associated with health plan coverage for covered individuals must continue to be submitted by all data submitters. Data submitters should remove any enrollment or claims records for Medicare Supplement policies from their data streams prior to submission to Onpoint CDM.

Health plan companies and third-party administrators that provide or administer Medicare Supplement Insurance coverage should not include claims paid towards this coverage type when determining whether they meet or exceed the threshold for consideration as a data submitter. For example, if, over the past calendar year, your company paid $2 million in claims from Medicare Supplement coverage and $1 million in claims from non-Medicare Supplement coverage, your company would not be considered a data submitter at this time. For health plan companies and third-party administrators that exclusively provide or administer Medicare Supplement Insurance coverage, this means that you will not have any claims or enrollment files to submit at this time.

However, regardless of the proportion of claims that come from Medicare Supplement Insurance coverage, all health plan companies and third-party administrators, as defined within Minnesota Rules, Chapter 4653, must continue to register annually.

November 2014 Update — Transition to ICD-10

As you know, the ICD-10 transition deadline is fast approaching. In order to accommodate data submissions that include the new ICD-10 codes, beginning with October 2015 paid claims, Onpoint Health Data, in partnership with the Minnesota Department of Health (MDH), would like to update you on the following solutions for claims submissions to the Minnesota Health Care Claims Reporting System (MHCCRS).

Beginning November 2015 (for paid claims beginning October 1, 2015), the data element MC041 (Principal Diagnosis) will be used to report *both* the Principal Diagnosis and the ICD Version Indicator separated by a pipe (please see the example, highlighted in yellow, below). The ICD Version Indicator applies to all ICD diagnosis and procedure codes reported in the record. A 100% threshold will be required for this element.

Element #	MC041
Valid Values	9 = ICD-9 0 = ICD-10
Threshold	100%
Denominator	All

Column	ID	Name	Type	Max. Length	Description	X12 Mapping
48	MC041	Principal Diagnosis | ICD Version Indicator	Text	9	Use this field to report both the ICD diagnosis for the Principal Diagnosis and the ICD Version Indicator separated by the pipe character.* For example, ICD-9 diagnosis code V30.00 (i.e., single liveborn, born in hospital, delivered without mention of cesarean section) would be reported in the asterisk-delimited file as *V3000|9*. Note that the ICD Version Indicator should declare the version of ICD reported on this service line. The only valid codes for this field are: 9 .....ICD-9 0 .....ICD-10 **Notes:** Do not include the decimal point when coding the diagnosis field. The ICD Version Indicator should be consistent for the entire claim and for all ICD diagnosis and procedure codes.	837/2300/HI/BK/01-2, 837/2300/HI/ABK/01-2

* Note: The pipe character can be created in a variety of ways, most commonly by typing the backslash key while depressing the SHIFT key or by entering the Unicode value *U+007C*. For additional character mappings, please see: http://en.wikipedia.org/wiki/Vertical_bar#In_common_character_maps

Beginning summer 2015, a phased approach to the above solution will be available to data submitters. Beginning July 1, 2015, submission of the ICD Version Indicator will be optional until the hard deadline of September 1, 2015. This will afford data submitters the ability to test the process before the mandatory implementation deadline. Please keep in mind that these deadlines are submission dates, not service dates, so a file with March 2015 dates of service uploaded on September 2, 2015, for example, will still need to be submitted in the updated format.

Other preparations are also under way to prepare for the collection of ICD-10 codes. The length of the ICD diagnosis and procedure codes have been increased to 7. Data validations will be revised to accommodate the collection of both ICD-9 and ICD-10 codes, including revisions to the validations for MC040 (E-Code) which will no longer be classified as E-Codes under ICD-10.

We greatly appreciate your partnership in this initiative and look forward to receiving your input. If you have any questions, please do not hesitate to reach out to the Minnesota Department of Health at health.apcd@state.mn.us.

12. CHANGE LOG

Following is a list of key changes from the previous version (Version 2.1, July 2012). These changes should be reviewed carefully to evaluate whether or not any action is needed on the submitter's part.

Length Updates

Note: Red shading in the last column indicates elements whose lengths have been expanded; blue shading indicates those that have been contracted; please review your code and make any necessary updates prior to importing these fields.

Table	ID	Common Name	Length		Notes
			Previous	Updated	
Medical Claims	MC039	Admitting Diagnosis	5	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC040	External Cause of Injury (ECI) Code	5	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC041	Principal Diagnosis | ICD Version Indicator	5	9	Expanded to accommodate intake of the ICD version indicator
Medical Claims	MC042	Other Diagnosis - 1	5	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC043	Other Diagnosis - 2	5	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC044	Other Diagnosis - 3	5	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC045	Other Diagnosis - 4	5	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC046	Other Diagnosis - 5	5	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC047	Other Diagnosis - 6	5	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC048	Other Diagnosis - 7	5	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC049	Other Diagnosis - 8	5	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC050	Other Diagnosis - 9	5	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC051	Other Diagnosis - 10	5	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC052	Other Diagnosis - 11	5	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC053	Other Diagnosis - 12	5	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC058	Principal ICD-CM Procedure Code	4	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC058A	Other ICD-CM Procedure Code - 1	4	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC058B	Other ICD-CM Procedure Code - 2	4	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC058C	Other ICD-CM Procedure Code - 3	4	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC058D	Other ICD-CM Procedure Code - 4	4	7	Expanded to accommodate ICD-10 coding
Medical Claims	MC058E	Other ICD-CM Procedure Code - 5	4	7	Expanded to accommodate ICD-10 coding

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254 Commercial Street
Suite 257
Portland, ME 04101

207 623-2555

www.OnpointHealthData.org