

The Commonwealth of Massachusetts

Center for Health Information and Analysis

**The Massachusetts**

**All-Payer Claims Database**

**Medical Claim File**

**Submission Guide**

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**Revision History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Version** | **Description** | **Author** |
| **12/1/2012** | **3.0** | **Administrative Bulletin 12-01; issued 11/8/2012** | **M. Prettenhofer** |
| **1/25/2013** | **3.1** | * **Removed ‘Non-Massachusetts Resident’ section** * **Increased length of ICD-CM Procedure Code fields to varchar(7)** * **MC241 (APCD Id Code): Added option 6) ICO – Integrated Care Organization** * **MC113 Payment Arrangement: Added option for MassHealth** | **H. Hines** |
| **5/31/13** | **3.1** | * **Updated HD009 to reflect reporting period change** | **H. Hines** |
| **5/31/13** | **3.1** | * **Updated Condition on MC062 Charge Amount, MC107 ICD Indicator** * **Updated element submission guideline for Delegated Benefit Adminstrator OrganizationID (MC100)** * **Updated code source on Procedure Code (MC055)** | **K. Hines** |

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Introduction

Access to timely, accurate, and relevant data is essential to improving quality, mitigating costs, and promoting transparency and efficiency in the health care delivery system. A valuable source of data can be found in health care claims but it is currently collected by a variety of government entities in various formats and levels of completeness. Using its broad authority to collect health care data ("without limitation") under M.G.L. c. 118G, § 6 and 6A, the Center for Health Information and Analysis (CHIA) has adopted regulations to create a comprehensive all payer claims database (APCD) with medical, pharmacy, and dental claims as well as provider, product, and member eligibility information derived from fully-insured, self-insured, Medicare, Medicaid and Supplemental Policy data. CHIA is a clearinghouse for comprehensive quality and cost information to ensure consumers, employers, insurers, and government have the data necessary to make prudent health care purchasing decisions.

To facilitate communication and collaboration, CHIA maintains a dedicated MA APCD website ([www.mass.gov/chia/apcd](http://www.mass.gov/chia/apcd)) with resources that currently include the submission and release regulations, Administrative Bulletins, the technical submission guide with examples, and support documentation. These resources will be periodically updated with materials and the CHIA staff will continue to work with all affected submitters to ensure full compliance with the regulation.

While CHIA is committed to establishing and maintaining an APCD that promotes transparency, improves health care quality, and mitigates health care costs, we welcome your ongoing suggestions for revising reporting requirements that facilitate our shared goal of administrative simplification. If you have any questions regarding the regulations or technical specifications we encourage you to utilize the online resources and reach out to our staff for any further questions.

Thank you for your partnership with CHIA on the all payer claims database.

114.5 CMR 21.00 – Health Care Claims

114.5 CMR 21.00 governs the reporting requirements for Health Care Payers to submit data and information to CHIA in accordance with M.G.L. c. 118G, § 6. The regulation establishes the data submission requirements for health care payers to submit information concerning the costs and utilization of health care in Massachusetts. CHIA will collect data essential for the continued monitoring of health care cost trends, minimize the duplication of data submissions by payers to state entities, and promote administrative simplification among state entities in Massachusetts.

Health care data and information submitted by Health Care Payers to CHIA is not a public record. No public disclosure of any health plan information or data shall be made unless specifically authorized under 114.5 CMR 21.00 or 114.5 CMR 22.00.

Acronyms Frequently Used

APCD – All-Payer Claims Database

CHIA – Center for Health Information and Analysis

CSO – Computer Services Organization

DBA – Delegated Benefit Administrator

DBM – Dental Benefit Manager

DOI – Division of Insurance

GIC – Group Insurance Commission

ID – Identification; Identifier

MA APCD – Massachusetts’ All-Payer Claims Database

PBM – Pharmacy Benefit Manager

QA – Quality Assurance

RA – Risk Adjustment; Risk Adjuster

TME / RP – Total Medical Expense / Relative Pricing

TPA – Third Party Administrator

The File Types:

DC – Dental Claims

MC – Medical Claims

ME – Member Eligibility

PC – Pharmacy Claims

PR – Product File

PV – Provider File

BP – Benefit Plan Control Total File

The APCD Monthly Medical Claims File

As part of the MA APCD, submitters are required to submit a Medical Claims File. CHIA, in an effort to decrease any programming burden, has maintained the file layout previously used. There are minor changes to this layout so that it will connect appropriately across other required filings for the MA APCD and a few added elements to aid with line of business identification for better-directed editing of the data.

Below we have provided details on business rules, data definitions and the potential uses of this data.

| **Specification Question** | **Clarification** | **Rationale** |
| --- | --- | --- |
| Frequency of submission | Medical claim files are to be submitted monthly | CHIA requires this frequency to maintain a current dataset for analysis. |
| What is the format of the file | Each submission must be a variable field length asterisk delimited file | An asterisk cannot be used within an element in lieu of another character. Example: if the file includes “Smith\*Jones” in the Last Name, the system will read an incorrect number of elements and drop the file. |
| What each row in the file represents | Each row represents a claim line. If there are multiple services performed and billed on a claim, each of those services will be uniquely identified and reported on a line. | It is necessary to obtain line item data to better understand how services are perceived and adjudicated by different carriers. |
| Won’t reporting claim lines create redundancy? | Yes, certain data elements of claim level data will be repeated in every row in order to report unique line item processing. The repeated claim level data will be de-duplicated at CHIA. | Claim-line level data is required to capture accurate details of claims and encounters. |
| Are denied claims to be reported? | No. Wholly denied claims should not be reported at this time. However, if a single procedure is denied within a paid claim that denied line should be reported. | Denied line items of an adjudicated claim aid with cost analysis. |
| Should claims that are paid under a ‘global payment’, or ‘capitated payment’ thus zero paid, be reported in this file. | Yes. Any medical claim that is considered ‘paid’ by the carrier should appear in this filing. Paid amount should be reported as 0 and the corresponding Allowed, Contractual, Deductible Amounts should be calculated accordingly. | The reporting of Zero Paid Medical Claims is required to accurately capture encounters and to further understand contractual arrangements. |
| Should previously paid but now Voided claims be reported? | Yes. Claims that were paid and reported in one period and voided by either the Provider or the Carrier in a subsequent period should be reported in the subsequent file. See MC139 below. | The reporting of Voided Claims maintains logic integrity related to medical costs and utilization. |
| What types of claims are to be included? | The Medical Claims file is used to report both institutional and professional claims. The unique elements that apply to each are included; however only those elements that apply to the claim type should be submitted. Example: Diagnostic Pointer is a Professional Claim element and would not be a required element on an Institutional Claim record. See MC094 below for claim type ID. | CHIA has adopted the most widely used specification at this time. It is important to note that adhering to claim rules for each specific type will provide cleaner analysis. |
| The word ‘Member’ is used in the specification. Are ‘Member’ and ‘Patient’ used synonymously? | Yes. Member and Patient are to be used in the same manner in this specification | Member is used in the claim specification to strengthen the reporting bond between Member Eligibility and the claims attached to a Member. |
| If claims are processed by a third-party administrator, who is responsible for submitting the data and how should the data be submitted? | In instances where more than one entity administers a health plan, the health care carrier **and** third-party administrators are responsible for submitting data according to the specifications and format defined in the Submission Guides. The Center expects each party to report the Organization ID of the other party in the Delegated Benefit Organization ID (MC100) field to assist in linkage between the health care carrier and the third party administrator. | CHIA’s objective is to create a **comprehensive** All-Payer database which must include data from all health care carriers and all their third-party administrators (TPAs, PBMs, DBAs, CSOs, etc.). |

Types of Data collected in the Medical Claim File

Non-Massachusetts Resident

Under Administrative Bulletin 13-02, the Center is reinstating the requirement that payers submitting claims and encounter data on behalf of an employer group submit claims and encounter data for employees who reside outside of Massachusetts.

CHIA requires data submission for employees that are based in Massachusetts whether the employer is based in MA or the employer has a site in Massachusetts that employs individuals.  This requirement is for all payers that are licensed by the MA Division of Insurance, are involved in the MA Health Connector’s Risk Adjustment Program, or are required by contract with the Group Insurance Commission to submit paid claims and encounter data for all Massachusetts residents, and all members of a Massachusetts employer group including those who reside outside of Massachusetts.

Submitter-assigned Identifiers

CHIA requires various Submitter-assigned identifiers for matching-logic to the other files, Product and Member Eligibility. Some examples of these elements include MC003, MC006, MC137 and MC141. These elements will be used by CHIA to aid with the matching algorithm to those other files. This matching allows for data aggregation and required reporting.

Claims Data

CHIA requires the line-level detail of all Medical Claims for analysis. The line-level data aids with understanding utilization within products across submitters. The specific medical data reported in the majority of the MC file correspond to elements found on the UB04, HCFA 1500 and the HIPAA 837I and 837P data sets or a Carrier specific direct data entry system.

Subscriber and Member (Patient) submitter unique identifiers are being requested to aid with the matching algorithm, see MC137 and MC141.

**Elements MC024-MC035 - Servicing provider data:**

The set of elements MC024-MC035 are all related to the servicing provider **entity**. CHIA collects entity level rendering provider information here, and at the lowest level achievable by the submitter.

If the submitter only knows the billing entity, and the billing entity is not a ***service rendering*** provider, then the billing provider data (MC076-MC078) is ***not*** appropriate. In this case the submitter would need a variance request for the service provider elements.

If the carrier only has the data for a main ***service rendering*** site but not the specific satellite information where services are rendered, then the main service site ***is*** acceptable for the service provider elements.

For example – XYZ Orthopedic Group is acceptable, if XYZ Orthopedic Group Westside is not available. However, XYZ Orthopedic Group Westside is preferable, and ultimately the goal.

A physician’s office is also appropriate here, but not the physician. The physician or other person providing the service is expected in MC134.

**Elements MC134 Plan Rendering Provider and MC135 Provider Location:**

These elements should describe precisely who performed the services on the patient and where the service was rendered. If the carrier does not know who actually performed the service or the specific site where the service was actually performed, the carrier will need a variance request for one or both of these elements. It is not appropriate to include facility or billing information here in MC134.

**MC134 – Plan Rendering Provider:** The intent of this element is to capture the details of the individual that performed the service on the patient or for the patient (lab technician, supply delivery, etc.).

**MC135 – Provider Location:** The intent of this element is to capture the details of the site where the Plan Rendering Provider delivered those services (Office, Hospital, etc.) For Home Services this location ID should be the Suppliers ID.

Adjudication Data

CHIA requires adjudication-centric data on the MC file for analysis of Member Eligibility to Product. The elements typically used in an adjudication process are MC017 through MC023, MC036 through MC038, MC063 through MC069, MC071 through MC075, MC080, MC081, MC089, MC092 through MC099, MC113 through MC119, MC122 through MC124, MC128, and MC138 and are variations of paper remittances or the HIPAA 835 4010.

CHIA has made a conscious decision to collect numerous identifiers that may be associated with a provider. The provider identifiers will be used to help link providers across carriers in the event that the primary linking data elements are not a complete match. The existence of these extra identifying elements in claims are part of our quality assurance process, and will be analyzed in conjunction with the provider file. We expect this will improve the quality of our matching algorithms within and across carriers.

**Denied Claims:** Payers will not be required to submit wholly denied claims at this time. CHIA will issue an Administrative Bulletin notifying Submitters when the requirement to submit denied claims will become effective, the detailed process required to identify and report, and the due dates of denied claim reporting.

The Provider ID

Element MC024 (Service Provider ID), MC134 (Plan Rendering Provider) and MC135 (Provider Location) are critical elements in the MA APCD process as it links the Provider identified on the Medical Claims file with the corresponding Provider ID (PV002) in the Provider File. The definition of the PV002 element is:

*The Provider ID is a unique number for every service provider (persons, facilities or other entities involved in claims transactions) that a carrier/submitter has in its system. This element may or may not be the provider NPI and this element is used to uniquely identify a provider and that provider’s affiliation when applicable, as well as the provider's practice location within this provider file.*

The following are the elements that are required to link to PV002:

**Medical Claim Links: MC024** – Service Provider Number; **MC076** – Billing Provider Number; **MC112** – Referring Provider ID; **MC125** – Attending Provider; **MC134** – Plan Rendering Provider Identifier; **MC135** – Provider Location

The goal of PV002, Provider ID, is to help identify provider data elements associated with provider data that was submitted in the claim line detail, and to identify the details of the Provider Affiliation.

New Data Elements

Under Administrative Simplification, CHIA has worked with Division of Insurance, The Connector, Group Insurance Commission and our own internal departments to identify new elements to be added to the MA APCD Dataset to satisfy that goal. Below is a list of those elements, the submitter type expected to report them, the reason and the data expected within the element.

**MC091 – Coinsurance Days;** *all submitters, conditionally required on inpatient facility claims*

This new element on the MC File is used to determine a type of covered benefit days as defined by Medicare. Submitters that use a similar methodology are encouraged to report the appropriate number of days that correspond with the Medicare definition.

**MC107 – ICD Indicator;** *all submitters, required to invoke the correct ICD version edits*

This new element is required and becomes invoked when any Diagnosis Element is populated. It is required to insure that clinical editing and categorization occurs correctly and is assumed to report ICD9 until ICD10 implementation. The values present on the MA APCD table align to those used by the Center for Medicare and Medicaid Services to provide continuity across submitters.

**MC121 – Patient Total Out of Pocket Expense;** *all submitters, required for all claim lines*

This new element on the MC File is required to measure patient / member out of pocket expenses in correlation to the benefits assigned on the eligibility file. Submitters should report 0 when there is no out of pocket expense for a claim line.

**MC133 – Bill Frequency Code;** *all submitters, required on all facility and professional claims*

This new element on the MC file is required to identify aspects of claim line activity for versioning lines to the highest value. The allowable values are those that are generally accepted.

**MC142 thru MC153 – Other Diagnoses 13 thru 24;** *all submitters, conditionally required*

This new set of elements was added to supplement the current diagnosis reporting of Primary through 12. The additional diagnoses aid with comprehensive grouping and reporting of data, and provide additional detail to clinical analyses.

**MC154 thru MC178 – Present on Admission Codes 01 thru 25;** *all submitters, conditionally required*

This new set of elements was added to allow the MA APCD to group inpatient facility claims in more recent versions of the clinical grouper. Clinical grouping at CHIA allows for standardized DRG and APC assignment and reduces the burden on submitters that do not utilize DRG or APC for their clinical / payment systems.

**MC179 thru MC190 – Condition Codes 01 thru 12;** *all submitters, conditionally required*

This new set of elements was added so that submitters could provide greater detail on facility claims that related to specific conditions of the claim / provider / patient and have an impact on the claim processing and payment.

**MC191 thru MC214 – Value Code and Value Amount 01 thru 12;** *all submitters, conditionally required*

This new set of elements was added so that submitters could provide a greater detail on facility claims that related to specific amounts of the claim / provider / patient and have an impact on the claim processing and payment.

**MC215 thru 224 – Occurrence Code and Date 01 thru 05;** *all submitters, conditionally required*

This new set of elements was added so that submitters could provide a greater detail on facility claims that related to specific occurrences of the claim / provider / patient and have an impact on the claim processing and payment.

**MC225 thru MC239 – Occurrence Span Code and Dates 01 thru 05;** *all submitters, conditionally required*

This new set of elements was added so that submitters could provide a greater detail on facility claims that related to specific occurrence span dates of the claim / provider / patient and have an impact on the claim processing and payment.

**MC240 – GIC ID;** *all GIC Contracted Carriers, to aid with GIC reporting requirements*

This new element is to report the GIC assigned identifier from the member. The presence of this identifier is dependent upon the value reported in MC241. Non-GIC reporters SHOULD NOT report a value here as this will invoke other data elements that may not be applicable to a line of business.

**MC241 – APCD ID Code;** *all APCD submitters, to aid with data requirements and edits*

The new element utilizes a new MA APCD pre-defined lookup table with the values for identifying a line of eligibility being categorized as a Fully Insured Group Enrollee, Self-Insured Group Enrollee, GIC Group Enrollee, MassHealth MCO Enrollee, Supplement Policy Enrollee, Integrated Care Organization or Unknown. The value selected here will invoke various edits that apply to that enrollee category in tandem with the CHIA assigned OrgID. Please note selecting an incorrect category will invoke edits on elements not typically populated by submitter type and may create a Failed File for not meeting base thresholds. Additionally, OrgIDs that submit Unknown 100% of the time but have been identified as one of the other values will inadvertently Fail their file.

CHIA is committed to working with all submitters and their technical teams to ensure compliance with applicable laws and regulations.  CHIA will continue to provide support through technical assistance calls and resources available on the CHIA website, [www.mass.gov/chia](http://www.mass.gov/chia)

File Guideline and Layout

Legend

1. File: Identifies the file per element as well as the Header and Trailer Records that repeat on all MA APCD File Types. Headers and Trailers are Mandatory as a whole, with just a few elements allowing situational reporting.
2. Col: Identifies the column the data resides in when reported
3. Elmt: This is the number of the element in regards to the file type
4. Data Element Name: Provides identification of basic data required
5. Date Modified: Identifies the last date that an element was adjusted.
6. Type: Defines the data as Decimal, Integer, Numeric or Text. Additional information provided for identification, e.g., Date Period – Integer
7. Type Description: Used to group like-items together for quick identification
8. Format / Length: Defines both the reporting length and element min/max requirements. See below:
   1. char[n] – this is a fixed length element of [n] characters, cannot report below or above [n]. This can be any type of data, but is governed by the type listed for the element, Text vs. Numeric.
   2. varchar[n] – this is a variable length field of max [n] characters, cannot report above [n]. This can be any type of data, but is governed by the type listed for the element, Text vs. Numeric.
   3. int[n] – this is a fixed type and length element of [n] for numeric reporting only. This cannot be anything but numeric with no decimal points or leading zeros.

The plus/minus symbol (**±**) in front on any of the Formats above indicate that a negative can be submitted in the element under specific conditions. **Example:** When the Claim Line Type (MC138) = V (void) or B (backout) then certain claim values can be negative.

1. Description: Short description that defines the data expected in the element
2. Element Submission Guideline: Provides detailed information regarding the data required as well as constraints, exceptions and examples.
3. Condition: Provides the condition for reporting the given data
4. %: Provides the base percentage that the MA APCD is expecting in volume of data in regards to condition requirements.
5. Cat: Provides the category or tiering of elements and reporting margins where applicable. ‘A’ level fields must meet their APCD threshold percentage in order for a file to pass. The other categories (B, C, Z) are also monitored but will not cause a file to fail. Header and Trailer Mandatory element errors will cause a file to drop. Where elements have a conditional requirement, the percentages are applied to the number of records that meet the condition.

HM = Mandatory Header element; HS = Situational Header element; HO = Optional Header element; A0 = Data is required to be valid per Conditions and must meet threshold percent with 0% variation; A1= Data is required to be valid per Conditions and must meet threshold percent with no more than 1% variation; A2 = Data is required to be valid per Conditions and must meet threshold percent with no more than 2% variation; B and C = Data is requested and errors are reported, but will not cause a file to fail; Z = Data is not required; TM = Mandatory Trailer element; TS = Situational Trailer element; TO = Optional Trailer element.

Elements that are highlighted indicate that a MA APCD lookup table is present and contains valid values expected in the element. In very few cases, there is a combination of a MA APCD lookup table and an External Code Source or Carrier Defined Table, these maintain the highlight.

It is important to note that Type, Format/Length, Condition, Threshold and Category are considered as a suite of requirements that the intake edits are built around to insure compliance, continuity and quality. This insures that the data can be standardized at other levels for greater understanding of healthcare utilization.

| **File** | **Col** | **Elmt** | **Data Element Name** | **Date Modified** | **Type** | **Type Description** | **Format / Length** | **Description** | **Element Submission Guideline** | **Condition** | **%** | **Cat** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| HD-MC | 1 | HD001 | Record Type | 11/8/12 | Text | ID Record | char[2] | Header Record Identifier | Report **HD** here. Indicates the beginning of the Header Elements of the file. | Mandatory | 100% | HM |
| HD-MC | 2 | HD002 | Submitter | 11/8/12 | Integer | ID OrgID | varchar[6] | Header Submitter / Carrier ID defined by CHIA | Report CHIA defined, unique Submitter ID here. TR002 must match the Submitter ID reported here. This ID is linked to other elements in the file for quality control. | Mandatory | 100% | HM |
| HD-MC | 3 | HD003 | National Plan ID | 11/8/12 | Integer | ID Nat'l PlanID | int[10] | Header CMS National Plan Identification Number (PlanID) | Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans. | Situational | 0% | HS |
| HD-MC | 4 | HD004 | Type of File | 11/8/12 | Text | ID File | char[2] | Defines the file type and data expected. | Report **MC** here. Indicates that the data within this file is expected to be MEDICAL CLAIM-based. This must match the File Type reported in TR004. | Mandatory | 100% | HM |
| HD-MC | 5 | HD005 | Period Beginning Date | 11/8/12 | Date Period - Integer | Century Year Month - CCYYMM | int[6] | Header Period Start Date | Report the Year and Month of the reported submission period in CCYYMM format. This date period must be repeated in HD006, TR005 and TR006. This same date must be selected in the upload application for successful transfer. | Mandatory | 100% | HM |
| HD-MC | 6 | HD006 | Period Ending Date | 11/8/12 | Date Period - Integer | Century Year Month - CCYYMM | int[6] | Header Period Ending Date | Report the Year and Month of the reporting submission period in CCYYMM format. This date period must match the date period reported in HD005 and be repeated in TR005 and TR006. | Mandatory | 100% | HM |
| HD-MC | 7 | HD007 | Record Count | 11/8/12 | Integer | Counter | varchar[10] | Header Record Count | Report the total number of records submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters. | Mandatory | 100% | HM |
| HD-MC | 8 | HD008 | Comments | 11/8/12 | Text | Free Text Field | varchar[80] | Header Carrier Comments | May be used to document the submission by assigning a filename, system source, compile identifier, etc. | Optional | 0% | HO |
| HD-MC | 9 | HD009 | APCD Version Number | 11/8/12 | Decimal - Numeric | ID Version | char[3] | Submission Guide Version | Report the version number as presented on the APCD Medical Claim File Submission Guide in 0.0 Format. Sets the intake control for editing elements. Version must be accurate else file will drop. **EXAMPLE:** 3.0 = Newest Version | Mandatory | 100% | HM |
|  |  |  |  |  |  |  |  | ***Code*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 2.1 | Prior Version; valid only for reporting periods prior to October 2013 |  |  |  |
|  |  |  |  |  |  |  |  | 3.0 | Current Version; required for reporting periods as of October 2013 |  |  |  |
| MC | 1 | MC001 | Submitter | 11/8/12 | Integer | ID Submitter | varchar[6] | CHIA defined and maintained unique identifier | Report the Unique Submitter ID as defined by CHIA here. This must match the Submitter ID reported in HD002. | All | 100% | A0 |
| MC | 2 | MC002 | National Plan ID | 11/8/12 | Integer | ID Nat'l PlanID | int[10] | CMS National Plan Identification Number (PlanID) | Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans. | All | 0% | Z |
| MC | 3 | MC003 | Insurance Type Code/Product | 11/8/12 | Lookup Table - Text | tlkpClaimInsuranceType | char[2] | Type / Product Identification Code | Report the code that defines the type of insurance under which this patient's claim line was processed. **EXAMPLE:** HM = HMO | All | 92% | C |
|  |  |  |  |  |  |  |  | ***Code*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 09 | Self-pay |  |  |  |
|  |  |  |  |  |  |  |  | 10 | Central Certification |  |  |  |
|  |  |  |  |  |  |  |  | 11 | Other Non-Federal Programs |  |  |  |
|  |  |  |  |  |  |  |  | 12 | Preferred Provider Organization (PPO) |  |  |  |
|  |  |  |  |  |  |  |  | 13 | Point of Service (POS) |  |  |  |
|  |  |  |  |  |  |  |  | 14 | Exclusive Provider Organization (EPO) |  |  |  |
|  |  |  |  |  |  |  |  | 15 | Indemnity Insurance |  |  |  |
|  |  |  |  |  |  |  |  | 16 | Health Maintenance Organization (HMO) Medicare Risk |  |  |  |
|  |  |  |  |  |  |  |  | 17 | Dental Maintenance Organization (DMO) |  |  |  |
|  |  |  |  |  |  |  |  | AM | Automobile Medical |  |  |  |
|  |  |  |  |  |  |  |  | BL | Blue Cross / Blue Shield |  |  |  |
|  |  |  |  |  |  |  |  | CC | Commonwealth Care |  |  |  |
|  |  |  |  |  |  |  |  | CE | Commonwealth Choice |  |  |  |
|  |  |  |  |  |  |  |  | CH | Champus |  |  |  |
|  |  |  |  |  |  |  |  | CI | Commercial Insurance Co. |  |  |  |
|  |  |  |  |  |  |  |  | DS | Disability |  |  |  |
|  |  |  |  |  |  |  |  | HM | Health Maintenance Organization |  |  |  |
|  |  |  |  |  |  |  |  | LI | Liability |  |  |  |
|  |  |  |  |  |  |  |  | LM | Liability Medical |  |  |  |
|  |  |  |  |  |  |  |  | MA | Medicare Part A |  |  |  |
|  |  |  |  |  |  |  |  | MB | Medicare Part B |  |  |  |
|  |  |  |  |  |  |  |  | MC | Medicaid |  |  |  |
|  |  |  |  |  |  |  |  | OF | Other Federal Program |  |  |  |
|  |  |  |  |  |  |  |  | TF | HSN Trust Fund |  |  |  |
|  |  |  |  |  |  |  |  | TV | Title V |  |  |  |
|  |  |  |  |  |  |  |  | VA | Veterans Administration Plan |  |  |  |
|  |  |  |  |  |  |  |  | WC | Workers' Compensation |  |  |  |
|  |  |  |  |  |  |  |  | ZZ | Other |  |  |  |
| MC | 4 | MC004 | Payer Claim Control Number | 6/24/10 | Text | ID Claim Number | varchar[35] | Payer Claim Control Identification | Report the Unique identifier within the payer's system that applies to the entire claim. | All | 100% | A0 |
| MC | 5 | MC005 | Line Counter | 11/8/12 | Integer | ID Count | varchar[4] | Incremental Line Counter | Report the line number for this service within the claim. Start with 1 and increment by 1 for each additional line. Do not start with 0, include alphas or special characters. | All | 100% | A0 |
| MC | 6 | MC005A | Version Number | 6/24/10 | Integer | Counter | varchar[4] | Claim Service Line Version Number | Report the version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line. No alpha or special characters. | All | 100% | A0 |
| MC | 7 | MC006 | Insured Group or Policy Number | 6/24/10 | Text | ID Group | varchar[30] | Group / Policy Number | Report the number that defines the insured group or policy. Do not report the number that uniquely identifies the subscriber or member. | All | 95% | C |
| MC | 8 | MC007 | Subscriber SSN | 11/8/12 | Numeric | ID Tax | char[9] | Subscriber's Social Security Number | Report the Subscriber's SSN here; used to validate Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here | All | 79% | B |
| MC | 9 | MC008 | Plan Specific Contract Number | 6/24/10 | Text | ID Contract | varchar[30] | Contract Number | Report the Plan assigned contract number. Do not include values in this field that will distinguish one member of the family from another. This should be the contract or certificate number for the subscriber and all of the dependents. | All | 98% | C |
| MC | 10 | MC009 | Member Suffix or Sequence Number | 6/24/10 | Text | ID Sequence | varchar[20] | Member/Patient's Contract Sequence Number | Report the unique number / identifier of the member / patient within the contract. | All | 98% | B |
| MC | 11 | MC010 | Member SSN | 11/8/12 | Numeric | ID Tax | char[9] | Member/Patient's Social Security Number | Report the patient's social security number here; used to validate Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here. | All | 73% | B |
| MC | 12 | MC011 | Individual Relationship Code | 6/24/10 | Lookup Table - Text | tlkpIndividualRelathionshipCode | char[2] | Patient to Subscriber Relationship Code | Report the value that defines the Patient's relationship to the Subscriber. **EXAMPLE:** 20 = Self / Employee | All | 98% | B |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 01 | Spouse |  |  |  |
|  |  |  |  |  |  |  |  | 04 | Grandfather or Grandmother |  |  |  |
|  |  |  |  |  |  |  |  | 05 | Grandson or Granddaughter |  |  |  |
|  |  |  |  |  |  |  |  | 07 | Nephew or Niece |  |  |  |
|  |  |  |  |  |  |  |  | 10 | Foster Child |  |  |  |
|  |  |  |  |  |  |  |  | 15 | Ward |  |  |  |
|  |  |  |  |  |  |  |  | 17 | Stepson or Stepdaughter |  |  |  |
|  |  |  |  |  |  |  |  | 19 | Child |  |  |  |
|  |  |  |  |  |  |  |  | 20 | Self/Employee |  |  |  |
|  |  |  |  |  |  |  |  | 21 | Unknown |  |  |  |
|  |  |  |  |  |  |  |  | 22 | Handicapped Dependent |  |  |  |
|  |  |  |  |  |  |  |  | 23 | Sponsored Dependent |  |  |  |
|  |  |  |  |  |  |  |  | 24 | Dependent of a Minor Dependent |  |  |  |
|  |  |  |  |  |  |  |  | 29 | Significant Other |  |  |  |
|  |  |  |  |  |  |  |  | 32 | Mother |  |  |  |
|  |  |  |  |  |  |  |  | 33 | Father |  |  |  |
|  |  |  |  |  |  |  |  | 36 | Emancipated Minor |  |  |  |
|  |  |  |  |  |  |  |  | 39 | Organ Donor |  |  |  |
|  |  |  |  |  |  |  |  | 40 | Cadaver Donor |  |  |  |
|  |  |  |  |  |  |  |  | 41 | Injured Plaintiff |  |  |  |
|  |  |  |  |  |  |  |  | 43 | Child Where Insured Has No Financial Responsibility |  |  |  |
|  |  |  |  |  |  |  |  | 53 | Life Partner |  |  |  |
|  |  |  |  |  |  |  |  | 76 | Dependent |  |  |  |
| MC | 13 | MC012 | Member Gender | 6/24/10 | Lookup Table - Text | tlkpGender | char[1] | Patient's Gender | Report patient gender as found on the claim in alpha format. Used to validate clinical services when applicable and Unique Member ID.  **EXAMPLE:**  F = Female | All | 98% | B |
|  |  |  |  |  |  |  |  | ***Code*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | F | Female |  |  |  |
|  |  |  |  |  |  |  |  | M | Male |  |  |  |
|  |  |  |  |  |  |  |  | O | Other |  |  |  |
|  |  |  |  |  |  |  |  | U | Unknown |  |  |  |
| MC | 14 | MC013 | Member Date of Birth | 6/24/10 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Member/Patient's date of birth | Report the date the member / patient was born in CCYYMMDD Format. Used to validate Unique Member ID. | All | 98% | B |
| MC | 15 | MC014 | Member City Name | 6/24/10 | Text | Address City Member | varchar[30] | City name of the Member/Patient | Report the city name of the member / patient. Used to validate Unique Member ID. | All | 98% | B |
| MC | 16 | MC015 | Member State | 11/8/12 | External Code Source 2 - Text | Address State External Code Source 2 - States | char[2] | State / Province of the Patient | Report the state of the patient as defined by the US Postal Service. Report Province when Country Code does not = USA. | All | 98% | B |
| MC | 17 | MC016 | Member ZIP Code | 11/8/12 | External Code Source 2 - Text | Address Zip External Code Source 2 - Zip Codes | varchar[9] | Zip Code of the Member / Patient | Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen. | All | 98% | B |
| MC | 18 | MC017 | Date Service Approved (AP Date) | 6/24/10 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Date Service Approved by Payer | Report the date that the payer approved this claim line for payment in CCYYMMDD Format. This element was designed to capture date other than the Paid date. If Approved Date and Paid Date are the same, then the date here should match Paid Date. | All | 93% | C |
| MC | 19 | MC018 | Admission Date | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Inpatient Admit Date | Report the date of admit to a facility in CCYYMMDD Format. Only applies to facility claims were Type of Bill = an inpatient setting. | Required when MC094 = 002 and MC039 is populated | 98% | A1 |
| MC | 20 | MC019 | Admission Hour | 11/8/12 | Numeric | Time Period Hour Minutes | char[4] | Admission Time | Report the Admit Time in HHMM Format. Only applies to facility claims where Type of Bill = an inpatient setting. Time is expressed in military time. If only the hour is known, code the minutes as 00. 4 AM would be reported as 0400; 4 PM would be reported as 1600. | Required when MC094 = 002 and MC039 is populated | 5% | C |
| MC | 21 | MC020 | Admission Type | 11/8/12 | External Code Source 14 - Integer | External Code Source 14 - Admission Type | int[1] | Admission Type Code | Report Admit Type as it applies to facility claims where Type of Bill = an inpatient setting. This code indicates the type of admission into an inpatient setting. Also known as Admission Priority. | Required when MC094 = 002 and MC039 is populated | 98% | A1 |
| MC | 22 | MC021 | Admission Source | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Admission Source | char[1] | Admission Source Code | Report the code that applies to facility claims where Type of Bill = an inpatient setting. This code indicates how the patient was referred into an inpatient setting at the facility. | Required when MC094 = 002 and MC039 is populated | 98% | A1 |
| MC | 23 | MC022 | Discharge Hour | 11/8/12 | Numeric | Time Period Hour Minutes | char[4] | Discharge Time | Report the Discharge Time in HHMM Format. Only applies to facility claims where Type of Bill = an inpatient setting. Time is expressed in military time. If only the hour is known, code the minutes as 00. 4 AM would be reported as 0400; 4 PM would be reported as 1600. | Required when MC094 = 002 and MC069 is populated | 5% | C |
| MC | 24 | MC023 | Discharge Status | 11/8/12 | External Code Source 14 - Numeric | External Code Source 14 - Discharge Status | char[2] | Inpatient Discharge Status Code | Report the appropriate Discharge Status Code of the patient as defined by External Code Source | Required when MC094 = 002 and MC069 is populated | 98% | A1 |
| MC | 25 | MC024 | Service Provider Number | 6/24/10 | Text | ID Link to PV002 | varchar[30] | Service Provider Identification Number | Report the carrier / submitter assigned service provider number. This number should be the identifier used for internal identification purposes, and does not routinely change. The value in this field must match a record in the provider file in PV002. | All | 99% | A1 |
| MC | 26 | MC025 | Service Provider Tax ID Number | 11/8/12 | Numeric | ID Tax | char[9] | Service Provider's Tax ID number | Report the Federal Tax ID of the Service Provider here. Do not use hyphen or alpha prefix. | All | 97% | C |
| MC | 27 | MC026 | National Provider ID - Service | 11/8/12 | External Code Source 3 - Integer | External Code Source 3 - National Provider ID | int[10] | National Provider Identification (NPI) of the Service Provider | Report the Primary National Provider ID (NPI) of the Service Provider in MC024. This ID should be found on the Provider File in the NPI Field (PV039) | All | 98% | C |
| MC | 28 | MC027 | Service Provider Entity Type Qualifier | 11/8/12 | Lookup Table - integer | tlkpServProvEntityTypeQualifier | int[1] | Service Provider Entity Identifier Code | Report the value that defines the Service Provider entity type. Only individuals should be identified with a 1. Facilities, professional groups and clinic sites should all be identified with a 2. **EXAMPLE:** 1 = Person | All | 98% | A0 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | Person |  |  |  |
|  |  |  |  |  |  |  |  | 2 | Non-person entity |  |  |  |
| MC | 29 | MC028 | Service Provider First Name | 11/8/12 | Text | Name First Provider | varchar[25] | First name of Service Provider | Report the individual's first name here. If provider is a facility or organization , do not report any value here | All | 92% | C |
| MC | 30 | MC029 | Service Provider Middle Initial | 11/8/12 | Text | Name Middle Provider | varchar[25] | Middle initial of Service Provider | Report the individual's middle initial here. If provider is a facility or organization , do not report any value here | All | 2% | C |
| MC | 31 | MC030 | Servicing Provider Last Name or Organization Name | 6/24/10 | Text | Name Last / Org Provider | varchar[60] | Last name or Organization Name of Service Provider | Report the name of the organization or last name of the individual provider. MC027 determines if this is an Organization or Individual Name reported here. | All | 94% | A2 |
| MC | 32 | MC031 | Service Provider Suffix | 10/15/10 | Lookup Table - Integer | tlkpLastNameSuffix | int[1] | Provider Name Suffix | Report the individuals name-suffix when applicable here. Used to capture the generation of the individual clinician (e.g., Jr. Sr., III). Do not report degree acronyms here. **EXAMPLE:**  0 = Unknown / Not Applicable | All | 2% | Z |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | I. |  |  |  |
|  |  |  |  |  |  |  |  | 2 | II. |  |  |  |
|  |  |  |  |  |  |  |  | 3 | III. |  |  |  |
|  |  |  |  |  |  |  |  | 4 | Jr. |  |  |  |
|  |  |  |  |  |  |  |  | 5 | Sr. |  |  |  |
|  |  |  |  |  |  |  |  | 0 | Unknown / Not Applicable |  |  |  |
| MC | 33 | MC032 | Service Provider Taxonomy | 11/8/12 | External Code Source 5 - Text | External Code Source 5 - Taxonomy | varchar[10] | Taxonomy Code | Report the standard code that defines this provider for this line of service. Taxonomy values allow for the reporting of nurses, assistants and laboratory technicians, where applicable, as well as Physicians, Medical Groups, Facilities, etc. | All | 98% | A2 |
| MC | 34 | MC033 | Service Provider City Name | 6/24/10 | Text | Address City Provider | varchar[30] | City Name of the Provider | Report the city name of provider - preferably practice location. Do not report any value if not available. | All | 98% | B |
| MC | 35 | MC034 | Service Provider State | 11/8/12 | External Code Source 2 - Text | Address State External Code Source 2 - States | char[2] | State of the Service Provider | Report the state of the service providers as defined by the US Postal Service. Do not report any value if not available. | All | 98% | B |
| MC | 36 | MC035 | Service Provider ZIP Code | 11/8/12 | External Code Source 2 - Text | Address Zip External Code Source 2 - Zip Codes | varchar[9] | Zip Code of the Service Provider | Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen. | All | 98% | B |
| MC | 37 | MC036 | Type of Bill - on Facility Claims | 11/8/12 | External Code Source 14 - Integer | External Code Source 14 - Type of Bill | int[2] | Type of Bill | Report the two-digit value that defines the Type of Bill on an institutional claim. Do not report leading zero | Required when MC094 = 002 | 98% | A0 |
| MC | 38 | MC037 | Site of Service - on NSF/CMS 1500 Claims | 11/8/12 | External Code Source 13 - Numeric | External Code Source 13 - Place of Service | char[2] | Place of Service Code | Report the two-digit value that defines the Place of Service on professional claim | Required when MC094 = 001 | 100% | A0 |
| MC | 39 | MC038 | Claim Status | 11/8/12 | Lookup Table - Numeric | tlkpClaimStatus | varchar[2] | Claim Line Status | Report the value that defines the payment status of this claim line | All | 98% | A0 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | Processed as primary |  |  |  |
|  |  |  |  |  |  |  |  | 2 | Processed as secondary |  |  |  |
|  |  |  |  |  |  |  |  | 3 | Processed as tertiary |  |  |  |
|  |  |  |  |  |  |  |  | 4 | Denied |  |  |  |
|  |  |  |  |  |  |  |  | 19 | Processed as primary, forwarded to additional payer(s) |  |  |  |
|  |  |  |  |  |  |  |  | 20 | Processed as secondary, forwarded to additional payer(s) |  |  |  |
|  |  |  |  |  |  |  |  | 21 | Processed as tertiary, forwarded to additional payer(s) |  |  |  |
|  |  |  |  |  |  |  |  | 22 | Reversal of previous payment |  |  |  |
|  |  |  |  |  |  |  |  | 23 | Not our claim, forwarded to additional payer(s) |  |  |  |
|  |  |  |  |  |  |  |  | 25 | Predetermination Pricing Only - no payment |  |  |  |
| MC | 40 | MC039 | Admitting Diagnosis | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | Admitting Diagnosis Code | Report the diagnostic code assigned by provider that supported admission into the inpatient setting. | Required when MC094 = 002 and MC036 = 11, 18, 21, 28, 41, 65, 66, 84, 86, or 89 | 98% | A1 |
| MC | 41 | MC040 | E-Code | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Diagnostic External Injury Code | Report the external injury code for patient when appropriate to the claim. | All | 3% | C |
| MC | 42 | MC041 | Principal Diagnosis | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Primary Diagnosis Code | Report the Primary ICD Diagnosis Code here. | All | 99% | A0 |
| MC | 43 | MC042 | Other Diagnosis - 1 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Secondary Diagnosis Code | Report the Secondary ICD Diagnosis Code here. If not applicable do not report any value here. | All | 70% | B |
| MC | 44 | MC043 | Other Diagnosis - 2 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 2. If not applicable do not report any value here. | All | 24% | B |
| MC | 45 | MC044 | Other Diagnosis - 3 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 3. If not applicable do not report any value here. | All | 13% | C |
| MC | 46 | MC045 | Other Diagnosis - 4 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 4. If not applicable do not report any value here. | All | 7% | C |
| MC | 47 | MC046 | Other Diagnosis - 5 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 5. If not applicable do not report any value here. | All | 4% | C |
| MC | 48 | MC047 | Other Diagnosis - 6 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 6. If not applicable do not report any value here. | All | 3% | C |
| MC | 49 | MC048 | Other Diagnosis - 7 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 7. If not applicable do not report any value here. | All | 3% | C |
| MC | 50 | MC049 | Other Diagnosis - 8 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 8. If not applicable do not report any value here. | All | 2% | C |
| MC | 51 | MC050 | Other Diagnosis - 9 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 9. If not applicable do not report any value here. | All | 1% | C |
| MC | 52 | MC051 | Other Diagnosis - 10 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 10. If not applicable do not report any value here. | All | 1% | C |
| MC | 53 | MC052 | Other Diagnosis - 11 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 11. If not applicable do not report any value here. | All | 1% | C |
| MC | 54 | MC053 | Other Diagnosis - 12 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 12. If not applicable do not report any value here. | All | 1% | C |
| MC | 55 | MC054 | Revenue Code | 11/8/12 | External Code Source 14 - Numeric | External Code Source 14 - Revenue Code | char[4] | Revenue Code | Report the valid National Uniform Billing Committee Revenue Code here. Code using leading zeroes, left-justified, and four digits. | Required when MC094 = 002 | 98% | A0 |
| MC | 56 | MC055 | Procedure Code | 11/8/12 | External Code Source 9 - Text | External Code Source 9 - CPTs & HCPCS | varchar[10] | HCPCS / CPT Code | Report a valid Procedure code for the claim line as defined by MC130. | All | 98% | A1 |
| MC | 57 | MC056 | Procedure Modifier - 1 | 11/8/12 | External Code Source 9 - Text | External Code Source 9 - Modifiers | char[2] | HCPCS / CPT Code Modifier | Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055). | All | 20% | B |
| MC | 58 | MC057 | Procedure Modifier - 2 | 11/8/12 | External Code Source 9 - Text | External Code Source 9 - Modifiers | char[2] | HCPCS / CPT Code Modifier | Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055). | All | 3% | B |
| MC | 59 | MC058 | ICD-CM Primary Procedure Code | 11/8/12 | External Codes Source 8 - Text | External Code Source 8 - ICDCM Procedure Codes | varchar[7] | ICD Primary Procedure Code | Report the primary ICD CM procedure code when appropriate. Repeat this code on all lines of the inpatient claim. Do not code decimal point. | Required when MC094 = 002 and MC039 is populated | 98% | A2 |
| MC | 60 | MC059 | Date of Service - From | 6/24/10 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Date of Service | Report the date of service for the claim line in CCYYMMDD Format. | All | 98% | A0 |
| MC | 61 | MC060 | Date of Service - To | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Date of Service | Report the end service date for the claim line in CCYYMMDD Format. For inpatient claims, the room and board line may or may not be equal to the discharge date. Procedures delivered during a visit should indicate which date they occurred. | All | 98% | A0 |
| MC | 62 | MC061 | Quantity | 11/8/12 | Quantity - Integer | Counter | **±**varchar[15] | Claim line units of service | Report the count of services / units performed. | All | 98% | A1 |
| MC | 63 | MC062 | Charge Amount | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount of provider charges for the claim line | Report the charge amount for this claim line. 0 dollar charges allowed only when the procedure code indicates a Category II procedure code vs. a service code. When reporting Total Charges for facilities for the entire claim use 001 (the generally accepted Total Charge Revenue Code) in MC054 (Revenue Code). Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070 | All  MC062 must be greater than zero when MC0130 is not 6. | 99% | A0 |
| MC | 64 | MC063 | Paid Amount | 10/3/10 | Integer | Currency | **±**varchar[10] | Amount paid by the carrier for the claim line | Report the amount paid for the claim line. Report 0 if line is paid as part of another procedure / claim line. Do not report any value if the line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070 | All | 99% | A0 |
| MC | 65 | MC064 | Prepaid Amount | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount carrier has prepaid towards the claim line | Report the prepaid amount for this claim line. Report the Fee for Service equivalent amount for Capitated services. Report 0 when there is no Prepaid amount. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070 | All | 100% | A2 |
| MC | 66 | MC065 | Copay Amount | 6/24/10 | Integer | Currency | **±**varchar[10] | Amount of Copay member/patient is responsible to pay | Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Copay applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070 | All | 99% | A1 |
| MC | 67 | MC066 | Coinsurance Amount | 6/24/10 | Integer | Currency | **±**varchar[10] | Amount of coinsurance member/patient is responsible to pay | Report the amount that defines a calculated percentage amount for this claim line service that the patient is responsible to pay. Report 0 if no Coinsurance applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:**  150.00 is reported as 15000; 150.70 is reported as 15070 | All | 99% | A1 |
| MC | 68 | MC067 | Deductible Amount | 6/24/10 | Integer | Currency | **±**varchar[10] | Amount of deductible member/patient is responsible to pay on the claim line | Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Deductible applies to service. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:**  150.00 is reported as 15000; 150.70 is reported as 15070 | All | 99% | A1 |
| MC | 69 | MC068 | Patient Control Number | 11/8/12 | Text | ID Claim Number | varchar[20] | Patient Control Number | Report the provider assigned Encounter / Visit number to identify patient treatment. Also known as the Patient Account Number. | Required when MC094 = 002 | 98% | A2 |
| MC | 70 | MC069 | Discharge Date | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Discharge Date | Report the date the member was discharged from the facility in CCYYMMDD Format. If patient is still in-house and claim represents interim billing for interim payment, report the interim through date. | Required when MC094 = 002 and MC039 is populated | 98% | A2 |
| MC | 71 | MC070 | Service Provider Country Code | 12/1/10 | External Code Source 1 - Text | Address Country External Code Source 1 - Countries | char[3] | Country name of the Service Provider | Report the three-character country code as defined by ISO 3166-1, Alpha 3 | All | 98% | C |
| MC | 72 | MC071 | DRG | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - DRG | varchar[7] | Diagnostic Related Group Code | Report the DRG number applied to this claim on every line to which it’s applicable. Insurers and health care claims processors shall code using the CMS methodology when available. When the CMS methodology for DRGs is not available, but the All Payer DRG system is used, the insurer shall format the DRG and the complexity level within the same element with the prefix of "A" and with a hyphen separating the AP DRG from the complexity level (e.g. AXXX-XX) | Required when MC094 = 002 and MC069 is populated | 98% | B |
| MC | 73 | MC072 | DRG Version | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - DRG | char[2] | Diagnostic Related Group Version Number | Report the version of the grouper used. | Required when MC071 is populated | 20% | B |
| MC | 74 | MC073 | APC | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - DRG | char[4] | Ambulatory Payment Classification Number | Report the APC number applied to this claim line, with the leading zero(s) when applicable. Code using the CMS methodology. | Required when MC094 = 002 and MC039 is null | 20% | C |
| MC | 75 | MC074 | APC Version | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - DRG | char[2] | Ambulatory Payment Classification Version | Report the version of the grouper used. | Required when MC073 is populated | 20% | C |
| MC | 76 | MC075 | Drug Code | 6/24/10 | External Code Source 12 - Text | External Code Source 12 - National Drug Codes | char[11] | National Drug Code (NDC) | Report the NDC code used only when a medication is paid for as part of a medical claim or when a DME device has an NDC code. J codes should be submitted under procedure code (MC055), and have a procedure code type of 'HCPCS'. Drug Code as defined by the FDA in 11 digit format (5-4-2) without hyphenation. | All | 1% | B |
| MC | 77 | MC076 | Billing Provider Number | 6/24/10 | Text | ID Link to PV002 | varchar[30] | Billing Provider Number | Report the carrier / submitter assigned billing provider number. This number should be the identifier used for internal identification purposes, and does not routinely change. The value in this field must match a record in the provider file in PV002. | All | 99% | B |
| MC | 78 | MC077 | National Provider ID - Billing | 11/8/12 | External Code Source 3 - Integer | External Code Source 3 - National Provider ID | int[10] | National Provider Identification (NPI) of the Billing Provider | Report the Primary National Provider ID (NPI) here. This ID should be found on the Provider File in the NPI field (PV039). | All | 99% | B |
| MC | 79 | MC078 | Billing Provider Last Name or Organization Name | 6/24/10 | Text | Name Last / Org Provider | varchar[60] | Last name or Organization Name of Billing Provider | Report the name of the organization or last name of the individual provider. | All | 99% | B |
| MC | 80 | MC079 | Product ID Number | 11/8/12 | Text | ID Link to PR001 | varchar[30] | Product Identification | Report the submitter-assigned identifier as it appears in PR001 in the Product File. This element is used to understand Product and Eligibility attributes of the member / subscriber as applied to this record. | All | 100% | A0 |
| MC | 81 | MC080 | Payment Reason | 11/8/12 | Carrier Defined Table **- OR -** External Code Source 16 - Text | External Code Source 16 - Claim Adjustment Reasons**- OR –**  Carrier Defined Table | varchar[10] | Payment Reason Code | Report the value that describes how the claim line was paid, either using a standard code set or a proprietary list pre-sent by submitter. | Required when MC038 = 1, 2, 3, 19, 20, or 21 | 100% | A0 |
| MC | 82 | MC081 | Capitated Encounter Flag | 11/8/12 | Lookup Table - Integer | tlkpFlagIndicators | int[1] | Indicator - Capitation Payment | Report the value that defines the element. **EXAMPLE:** 1 = Yes payment for this service is covered under a capitated arrangement. | All | 100% | A0 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | Yes |  |  |  |
|  |  |  |  |  |  |  |  | 2 | No |  |  |  |
|  |  |  |  |  |  |  |  | 3 | Unknown |  |  |  |
|  |  |  |  |  |  |  |  | 4 | Other |  |  |  |
|  |  |  |  |  |  |  |  | 5 | Not Applicable |  |  |  |
| MC | 83 | MC082 | Member Street Address | 11/8/12 | Text | Address 1 Member | varchar[50] | Street address of the Member/Patient | Report the patient / member's address. Used to validate Unique Member ID. | All | 90% | B |
| MC | 84 | MC083 | Other ICD-CM Procedure Code - 1 | 4/5/13 | External Codes Source 8 - Text | External Code Source 8 - ICDCM Procedure Codes | varchar[7] | ICD Secondary Procedure Code | Report the subsequent ICD CM procedure code when applicable. Repeat this code on all lines of the inpatient claim. Do not code decimal point. | Required when MC094 = 002 and MC039 is populated | 1% | C |
| MC | 85 | MC084 | Other ICD-CM Procedure Code - 2 | 4/5/13 | External Codes Source 8 - Text | External Code Source 8 - ICDCM Procedure Codes | varchar[7] | ICD Other Procedure Code | Report the third ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary. | Required when MC094 = 002 and MC039 is populated | 1% | C |
| MC | 86 | MC085 | Other ICD-CM Procedure Code - 3 | 4/5/13 | External Codes Source 8 - Text | External Code Source 8 - ICDCM Procedure Codes | varchar[7] | ICD Other Procedure Code | Report the fourth ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary. | Required when MC094 = 002 and MC039 is populated | 1% | C |
| MC | 87 | MC086 | Other ICD-CM Procedure Code - 4 | 4/5/13 | External Codes Source 8 - Text | External Code Source 8 - ICDCM Procedure Codes | varchar[7] | ICD Other Procedure Code | Report the fifth ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary. | Required when MC094 = 002 and MC039 is populated | 1% | C |
| MC | 88 | MC087 | Other ICD-CM Procedure Code - 5 | 4/5/13 | External Codes Source 8 - Text | External Code Source 8 - ICDCM Procedure Codes | varchar[7] | ICD Other Procedure Code | Report the sixth ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary. | Required when MC094 = 002 and MC039 is populated | 1% | C |
| MC | 89 | MC088 | Other ICD-CM Procedure Code - 6 | 4/5/13 | External Codes Source 8 - Text | External Code Source 8 - ICDCM Procedure Codes | varchar[7] | ICD Other Procedure Code | Report the seventh ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary. | Required when MC094 = 002 and MC039 is populated | 1% | C |
| MC | 90 | MC089 | Paid Date | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Paid date of the claim line | Report the date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment in CCYYMMDD Format. This can be the same date as Processed Date. **EXAMPLE:** Claims paid in full, partial or zero paid must have a date reported here. | Required when MC038 = 1, 2, 3, 19, 20, or 21 | 98% | A0 |
| MC | 91 | MC090 | LOINC Code | 11/8/12 | External Code Source 11 - Text | External Code Source 11 - LOINC | varchar[7] | Logical Observation Identifiers, Names and Codes (LOINC) | Report the LOINC here, a standardized test code (lab work) when applicable and available. Do not report any value if not applicable. | All | 0% | B |
| MC | 92 | MC091 | Coinsurance Days | 11/8/12 | Quantity - Integer | Days Partially Covered | **±**varchar[4] | Covered Coinsurance Days | Report the number of partially covered days the patient incurred during this admission. Report 0 if all days were covered and/or Noncovered days. | Required when MC094 = 002 and MC039 is populated | 98% | B |
| MC | 93 | MC092 | Covered Days | 11/8/12 | Quantity - Integer | Days Covered | **±**varchar[4] | Covered Inpatient Days | Report the number of covered days the patient incurred during this admission. Report 0 if days were Noncovered or partially covered under Coinsurance Days. | Required when MC094 = 002 and MC039 is populated | 98% | B |
| MC | 94 | MC093 | Non Covered Days | 11/8/12 | Quantity - Integer | Days Noncovered | **±**varchar[4] | Noncovered Inpatient Days | Report the number of Noncovered days the patient incurred during this admission. Report 0 if all days were covered. | Required when MC094 = 002 and MC039 is populated | 87% | B |
| MC | 95 | MC094 | Type of Claim | 11/8/12 | Lookup Table - Text | tlkpTypeOfClaim | char[3] | Type of Claim Indicator | Report the value that defines the type of claim submitted for payment. **EXAMPLE:** 001 = Professional Claim Line | All | 100% | A0 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 001 | Professional |  |  |  |
|  |  |  |  |  |  |  |  | 002 | Facility |  |  |  |
|  |  |  |  |  |  |  |  | 003 | Reimbursement Form |  |  |  |
| MC | 96 | MC095 | Coordination of Benefits/TPL Liability Amount | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount due from a Secondary Carrier when known | Report the amount that another carrier / insurer is liable for after submitting payer has processed this claim line. Report 0 if there is no COB / TPL amount. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable.  **EXAMPLE:**  150.00 is reported as 15000; 150.70 is reported as 15070 | Required when MC038 = 19, 20 or 21 | 98% | A2 |
| MC | 97 | MC096 | Other Insurance Paid Amount | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount paid by a Primary Carrier | Report the amount that a prior payer has paid for this claim line. Indicates the submitting Payer is 'secondary' to the prior payer. Only report 0 if the Prior Payer paid 0 towards this claim line, else do not report any value here. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:**  150.00 is reported as 15000; 150.70 is reported as 15070 | Required when MC038 = 2, 3, 20, or 21 | 98% | A2 |
| MC | 98 | MC097 | Medicare Paid Amount | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount Medicare paid on claim | Report the amount Medicare paid towards this claim line. Only report 0 here if Medicare paid 0. If Medicare did not pay towards this claim line do not report any value here. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable.  **EXAMPLE:**  150.00 is reported as 15000; 150.70 is reported as 15070 | Required when MC115 = 1 | 98% | A2 |
| MC | 99 | MC098 | Allowed amount | 11/8/12 | Integer | Currency | **±**varchar[10] | Allowed Amount | Report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider contract and most often it is less than or equal to the fee charged by the provider. Report 0 when the claim line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable.  **EXAMPLE:**  150.00 is reported as 15000; 150.70 is reported as 15070 | Required when MC038 does not = 4, 22, or 23 | 99% | A2 |
| MC | 100 | MC099 | Non-Covered Amount | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount of claim line charge not covered | Report the amount that was charged on a claim that is not reimbursable due to eligibility limitations or provider requirements. Report 0 if all charges are covered or fall into other categories. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable.  **EXAMPLE:**  150.00 is reported as 15000; 150.70 is reported as 15070 | All | 98% | A2 |
| MC | 101 | MC100 | Delegated Benefit Administrator Organization ID | 11/8/12 | Integer | ID Link to OrgID | varchar[6] | CHIA defined and maintained Org ID for linking across submitters | Risk holders report the OrgID of the DBA here. DBAs report the OrgID of the insurance carrier here. This element contains the CHIA assigned organization ID for the DBA. Contact the APCD for the appropriate value. If no DBA is affiliated with this claim line do not report any value here: i.e., do not repeat the OrgID from MC001 | All | 98% | A2 |
| MC | 102 | MC101 | Subscriber Last Name | 10/15/10 | Text | Name Last Subscriber | varchar[60] | Last name of Subscriber | Report the last name of the subscriber. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. **EXAMPLE:** O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE | All | 98% | B |
| MC | 103 | MC102 | Subscriber First Name | 10/15/10 | Text | Name First Subscriber | varchar[25] | First name of Subscriber | Report the first name of the subscriber here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. **EXAMPLE:** Anne-Marie becomes ANNEMARIE | All | 98% | B |
| MC | 104 | MC103 | Subscriber Middle Initial | 10/15/10 | Text | Name Middle Subscriber | char[1] | Middle initial of Subscriber | Report the Subscriber's middle initial here. Used to validate Unique Member ID. | All | 2% | C |
| MC | 105 | MC104 | Member Last Name | 6/24/10 | Text | Name Last Member | varchar[60] | Last name of Member/Patient | Report the last name of the patient / member here. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces.  **EXAMPLE:** O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE | All | 98% | B |
| MC | 106 | MC105 | Member First Name | 6/24/10 | Text | Name First Member | varchar[25] | First name of Member/Patient | Report the first name of the patient / member here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces.  **EXAMPLE:** Anne-Marie becomes ANNEMARIE | All | 98% | B |
| MC | 107 | MC106 | Member Middle Initial | 6/24/10 | Text | Name Middle Member | char[1] | Middle initial of Member/Patient | Report the middle initial of the patient / member when available. Used to validate Unique Member ID. | All | 2% | C |
| MC | 108 | MC107 | ICD Indicator | 11/8/12 | Lookup Table - Integer | tlkpICDIndicator | int[1] | International Classification of Diseases version | Report the value that defines whether the diagnoses on claim are ICD9 or ICD10. **EXAMPLE:**  9 = ICD9 | Required when MC094 = 001 or 002 and any of the following MC039 thru MC053, MC058, MC083 thru MC088, MC142 thru MC153 is populated | 100% | B |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 9 | ICD-9 |  |  |  |
|  |  |  |  |  |  |  |  | 0 | ICD-10 |  |  |  |
| MC | 109 | MC108 | Procedure Modifier - 3 | 11/8/12 | External Code Source 9 - Text | External Code Source 9 - Modifiers | char[2] | HCPCS / CPT Code Modifier | Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055). | All | 0% | C |
| MC | 110 | MC109 | Procedure Modifier - 4 | 11/8/12 | External Code Source 9 - Text | External Code Source 9 - Modifiers | char[2] | HCPCS / CPT Code Modifier | Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055). | All | 0% | C |
| MC | 111 | MC110 | Claim Processed Date | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Claim Processed Date | Report the date the claim was processed by the carrier / submitter in CCYYMMDD Format. This date can be equal to Paid Date, but cannot be after Paid Date. | All | 98% | A2 |
| MC | 112 | MC111 | Diagnostic Pointer | 11/8/12 | Integer | ID Diagnosis | varchar[4] | Diagnostic Pointer Number | Report the placement number of the diagnosis(es) a procedure is related to for a professional claim. Can report up to four diagnostic positions within the first nine diagnoses that can be reported. Do not separate multiple mappings with spaces, zeros or special characters. Do not zero fill. **EXAMPLE:**  Procedure related to diagnoses 1, 4 and 5 = 145 | Required when MC094 = 001 | 98% | B |
| MC | 113 | MC112 | Referring Provider ID | 11/8/12 | Text | ID Link to PV002 | varchar[30] | Referring Provider ID | Report the identifier of the provider that submitted the referral for the service or ordered the test that is on the claim (if applicable). The value in this field must have a corresponding Provider ID (PV002) on the provider file. | Required when MC118 = 1 | 98% | A2 |
| MC | 114 | MC113 | Payment Arrangement Type | 11/8/12 | Lookup Table - Numeric | tlkpPaymentArrangementType | char[2] | Payment Arrangement Type Value | Report the value that defines the contracted payment methodology for this claim line. **EXAMPLE:** 02 = Fee for Service | All | 98% | A0 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 01 | Capitation |  |  |  |
|  |  |  |  |  |  |  |  | 02 | Fee for Service |  |  |  |
|  |  |  |  |  |  |  |  | 03 | Percent of Charges |  |  |  |
|  |  |  |  |  |  |  |  | 04 | DRG |  |  |  |
|  |  |  |  |  |  |  |  | 05 | Pay for Performance |  |  |  |
|  |  |  |  |  |  |  |  | 06 | Global Payment |  |  |  |
|  |  |  |  |  |  |  |  | 07 | Other |  |  |  |
|  |  |  |  |  |  |  |  | 08 | Bundled Payment |  |  |  |
|  |  |  |  |  |  |  |  | 09 | Payment Amount Per Episode (PAPE) (MassHealth) | ( 09 **Valid for HD002 = MassHealth orgid ONLY )** |  |  |
| MC | 115 | MC114 | Excluded Expenses | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount not covered at the claim line due to benefit/plan limitation | Report the amount that the patient has incurred towards covered but over-utilized services. Scenario: Physical Therapy units that are authorized for 15 visits at $50 a visit but utilized 20. The amount reported here would be 25000 to state over-utilization by $250.00. Report 0 if there are no Excluded Expenses. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:**  150.00 is reported as 15000; 150.70 is reported as 15070 | All | 98% | A2 |
| MC | 116 | MC115 | Medicare Indicator | 11/8/12 | Lookup Table - Integer | tlkpFlagIndicators | int[1] | Indicator - Medicare Payment Applied | Report the value that defines the element. **EXAMPLE:** 1 = Yes, Medicare paid for part or all of services. | All | 100% | A0 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | Yes |  |  |  |
|  |  |  |  |  |  |  |  | 2 | No |  |  |  |
|  |  |  |  |  |  |  |  | 3 | Unknown |  |  |  |
|  |  |  |  |  |  |  |  | 4 | Other |  |  |  |
|  |  |  |  |  |  |  |  | 5 | Not Applicable |  |  |  |
| MC | 117 | MC116 | Withhold Amount | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount to be paid to the provider upon guarantee of performance | Report the amount paid to the provider for this claim line if the provider qualified / met performance guarantees. Report 0 if the provider has the agreement but did not satisfy the measure, else do not report any value here. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070 | All | 98% | A2 |
| MC | 118 | MC117 | Authorization Needed | 11/8/12 | Lookup Table - Integer | tlkpFlagIndicators | int[1] | Indicator - Authorization Needed | Report the value that defines the element. **EXAMPLE:** 1 = Yes service required a pre-authorization. | All | 100% | A2 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | Yes |  |  |  |
|  |  |  |  |  |  |  |  | 2 | No |  |  |  |
|  |  |  |  |  |  |  |  | 3 | Unknown |  |  |  |
|  |  |  |  |  |  |  |  | 4 | Other |  |  |  |
|  |  |  |  |  |  |  |  | 5 | Not Applicable |  |  |  |
| MC | 119 | MC118 | Referral Indicator | 11/8/12 | Lookup Table - Integer | tlkpFlagIndicators | int[1] | Indicator - Referral Needed | Report the value that defines the element. **EXAMPLE:** 1 = Yes service was preceded by a referral. | All | 100% | A0 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | Yes |  |  |  |
|  |  |  |  |  |  |  |  | 2 | No |  |  |  |
|  |  |  |  |  |  |  |  | 3 | Unknown |  |  |  |
|  |  |  |  |  |  |  |  | 4 | Other |  |  |  |
|  |  |  |  |  |  |  |  | 5 | Not Applicable |  |  |  |
| MC | 120 | MC119 | PCP Indicator | 11/8/12 | Lookup Table - Integer | tlkpFlagIndicators | int[1] | Indicator - PCP Rendered Service | Report the value that defines the element. **EXAMPLE:** 1 = Yes service was performed by members PCP. | All | 100% | A2 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | Yes |  |  |  |
|  |  |  |  |  |  |  |  | 2 | No |  |  |  |
|  |  |  |  |  |  |  |  | 3 | Unknown |  |  |  |
|  |  |  |  |  |  |  |  | 4 | Other |  |  |  |
|  |  |  |  |  |  |  |  | 5 | Not Applicable |  |  |  |
| MC | 121 | MC120 | DRG Level | 11/8/12 | External Code Source 15 - Integer | External Code Source 15 - DRG | int[1] | Diagnostic Related Group Code Severity Level | Report the level used for severity adjustment when applicable. | Required when MC071 is populated | 80% | B |
| MC | 122 | MC121 | Patient Total Out of Pocket Amount | 11/8/12 | Integer | Currency | **±**varchar[10] | Total amount patient/member must pay | Report the total amount patient / member is responsible to pay to the provider as part of their costs for services. Report 0 if there are no Out of Pocket expenses. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070 | All | 100% | A2 |
| MC | 123 | MC122 | Global Payment Flag | 11/8/12 | Lookup Table - Integer | tlkpFlagIndicators | int[1] | Indicator - Global Payment | Report the value that defines the element. **EXAMPLE:** 1 = Yes the claim line was paid under a global payment arrangement. | All | 100% | A0 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | Yes |  |  |  |
|  |  |  |  |  |  |  |  | 2 | No |  |  |  |
|  |  |  |  |  |  |  |  | 3 | Unknown |  |  |  |
|  |  |  |  |  |  |  |  | 4 | Other |  |  |  |
|  |  |  |  |  |  |  |  | 5 | Not Applicable |  |  |  |
| MC | 124 | MC123 | Denied Flag | 11/8/12 | Lookup Table - Integer | tlkpFlagIndicators | int[1] | Denied Claim Line Indicator | Report the value that defines the element. **EXAMPLE:** 1 = Yes, Claim Line was denied. | Required when MC038 = 4 | 100% | A0 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | Yes |  |  |  |
|  |  |  |  |  |  |  |  | 2 | No |  |  |  |
|  |  |  |  |  |  |  |  | 3 | Unknown |  |  |  |
|  |  |  |  |  |  |  |  | 4 | Other |  |  |  |
|  |  |  |  |  |  |  |  | 5 | Not Applicable |  |  |  |
| MC | 125 | MC124 | Denial Reason | 11/8/12 | Carrier Defined Table **- OR -** External Code Source 16 - Text | External Code Source 16 - Denial Reason  OR  Carrier-Defined lookup | varchar[15] | Denial Reason Code | Report the code that defines the reason for denial of the claim line. Carrier must submit denial reason codes in separate table to the APCD. | Required when MC123 = 1 | 98% | A2 |
| MC | 126 | MC125 | Attending Provider | 11/8/12 | Text | ID Link to PV002 | varchar[30] | Attending Provider ID | Report the ID that reflects the provider that provided general oversight of the patient's care. This individual may or may not be the Servicing or Rendering provider. This value needs to be found in field PV002 on the Provider File. This field may or may not be NPI based on the carrier’s identifier system. | Required when MC094 = 002 and MC039 is populated | 98% | A1 |
| MC | 127 | MC126 | Accident Indicator | 11/8/12 | Lookup Table - Integer | tlkpFlagIndicators | int[1] | Indicator - Accident Related | Report the value that defines the element. **EXAMPLE:** 1 = Yes, Claim Line is Accident related. | All | 100% | A2 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | Yes |  |  |  |
|  |  |  |  |  |  |  |  | 2 | No |  |  |  |
|  |  |  |  |  |  |  |  | 3 | Unknown |  |  |  |
|  |  |  |  |  |  |  |  | 4 | Other |  |  |  |
|  |  |  |  |  |  |  |  | 5 | Not Applicable |  |  |  |
| MC | 128 | MC127 | Family Planning Indicator | 11/8/12 | Lookup Table - Integer | tlkpFamilyPlanning | int[1] | Service is related to Family Planning | Report the value that defines if family planning services were provided.  **EXAMPLE:**  0 = Unknown / Not Applicable | All | 98% | A2 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | Family planning services provided |  |  |  |
|  |  |  |  |  |  |  |  | 2 | Abortion services provided |  |  |  |
|  |  |  |  |  |  |  |  | 3 | Sterilization services provided |  |  |  |
|  |  |  |  |  |  |  |  | 4 | No family planning services provided |  |  |  |
|  |  |  |  |  |  |  |  | 0 | Unknown / Not Applicable / Not Avail |  |  |  |
| MC | 129 | MC128 | Employment Related Indicator | 11/8/12 | Lookup Table - Integer | tlkpFlagIndicators | int[1] | Indicator - Accident Related | Report the value that defines the element. **EXAMPLE:** 1 = Yes, Claim Line was related to employment accident. | All | 100% | A2 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | Yes |  |  |  |
|  |  |  |  |  |  |  |  | 2 | No |  |  |  |
|  |  |  |  |  |  |  |  | 3 | Unknown |  |  |  |
|  |  |  |  |  |  |  |  | 4 | Other |  |  |  |
|  |  |  |  |  |  |  |  | 5 | Not Applicable |  |  |  |
| MC | 130 | MC129 | EPSDT Indicator | 11/8/12 | Lookup Table - Integer | tlkpEPSDTIndicator | int[1] | Service related to Early Periodic Screening, Diagnosis and Treatment (EPSDT) | Report the value that defines if service was related to EPSDT and the type of EPSDT service, such as 'screening', 'treatment' or ‘referral’.  **EXAMPLE:**  0 = Unknown / Not Applicable | All | 98% | B |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | EPSDT Screen |  |  |  |
|  |  |  |  |  |  |  |  | 2 | EPSDT Treatment |  |  |  |
|  |  |  |  |  |  |  |  | 3 | EPSDT Referral |  |  |  |
|  |  |  |  |  |  |  |  | 0 | Unknown / Not Applicable / Not Available |  |  |  |
| MC | 131 | MC130 | Procedure Code Type | 11/8/12 | Lookup Table - Integer | tlkpProcedureCodeType | int[1] | Claim line Procedure Code Type Identifier | Report the value that defines the type of Procedure Code expected in MC055. | All | 98% | A1 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | CPT or HCPCS Level 1 Code |  |  |  |
|  |  |  |  |  |  |  |  | 2 | HCPCS Level II Code |  |  |  |
|  |  |  |  |  |  |  |  | 3 | HCPCS Level III Code (State Medicare code). |  |  |  |
|  |  |  |  |  |  |  |  | 4 | American Dental Association (ADA) Procedure Code (Also referred to as CDT code.) |  |  |  |
|  |  |  |  |  |  |  |  | 5 | State defined Procedure Code |  |  |  |
|  |  |  |  |  |  |  |  | 6 | CPT Category II |  |  |  |
| MC | 132 | MC131 | InNetwork Indicator | 11/8/12 | Lookup Table - Integer | tlkpFlagIndicators | int[1] | Indicator - Network Rate Applied | Report the value that defines the element. **EXAMPLE:** 1 = Yes claim line was paid at an InNetwork rate. | All | 100% | A2 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | Yes |  |  |  |
|  |  |  |  |  |  |  |  | 2 | No |  |  |  |
|  |  |  |  |  |  |  |  | 3 | Unknown |  |  |  |
|  |  |  |  |  |  |  |  | 4 | Other |  |  |  |
|  |  |  |  |  |  |  |  | 5 | Not Applicable |  |  |  |
| MC | 133 | MC132 | Service Class | 6/24/10 | Carrier Defined Table - Text | Carrier Defined Table - MCO Service Class | char[2] | Service Class Code | Report the code that defines the service class for Medicaid PCC members receiving behavioral health services (values based on MassHealth encounter table). | Required when Submitter is identified as a MassHealth / MCO Submitter | 10% | C |
| MC | 134 | MC133 | Bill Frequency Code | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Type of Bill | char[1] | Bill Frequency | Report the valid frequency code of the claim to indicate version, credit/debit activity and/or settling of claim. | Required when MC094 = 001 or 002 | 100% | A2 |
| MC | 135 | MC134 | Plan Rendering Provider Identifier | 11/8/12 | Text | ID Link to PV002 | varchar[30] | Plan Rendering Number | Report the unique code which identifies for the carrier / submitter who or which individual provider cared for the patient for the claim line in question. This code must be able to link to the Provider File. Any value in this field must also show up as a value in field PV002 (Provider ID) on the Provider File. | All | 100% | A0 |
| MC | 136 | MC135 | Provider Location | 11/8/12 | Text | ID Link to PV002 | varchar[30] | Location of Provider | Report the unique code which identifies the location / site of the service provided by the plan rendering provider identified in MC134. The code should link to a provider record in field PV002 (Provider ID) and indicate that the service was performed at a specific location; e.g.: Dr. Jones Pediatrics, 123 Main St, Boston, MA, or Pediatric Associates, or Mass General Hospital, etc. Only the code is needed in this field, and the link to the Provider ID in the field PV002 (Provider ID) will allow the physical address and other identifying information about the service location to be captured. Type of location is an incorrect value. | All | 98% | A2 |
| MC | 137 | MC136 | Discharge Diagnosis | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Discharge Diagnosis Code | Report the ICD diagnosis code as applied to the patient upon discharge. This may or may not be the same as the primary diagnosis or admitting diagnosis. | Required when MC069 is populated | 80% | B |
| MC | 138 | MC137 | Carrier Specific Unique Member ID | 11/8/12 | Text | ID Link to ME107 | varchar[50] | Member's Unique ID | Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to validate Unique Member ID and link back to Member Eligibility (ME107). | All | 100% | A0 |
| MC | 139 | MC138 | Claim Line Type | 11/8/12 | Lookup Table - Text | tlkpClaimLineType | char[1] | Claim Line Activity Type Code | Report the code that defines the claim line status in terms of adjudication. **EXAMPLE:** O = Original | All | 98% | A2 |
|  |  |  |  |  |  |  |  | ***Code*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | O | Original |  |  |  |
|  |  |  |  |  |  |  |  | V | Void |  |  |  |
|  |  |  |  |  |  |  |  | R | Replacement |  |  |  |
|  |  |  |  |  |  |  |  | B | Back Out |  |  |  |
|  |  |  |  |  |  |  |  | A | Amendment |  |  |  |
| MC | 140 | MC139 | Former Claim Number | 12/1/10 | Text | ID Claim Number | varchar[35] | Previous Claim Number | Report the Claim Control Number (MC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own MC004. Use of “Former Claim Number” to version claims can **only** be used if approved by the APCD. Contact the APCD for conditions of use. | All | 0% | B |
| MC | 141 | MC140 | Member Street Address 2 | 11/8/12 | Text | Address 2 Member | varchar[50] | Secondary Street Address of the Member/Patient | Report the address of member which may include apartment number or suite, or other secondary information besides the street. Used to validate Unique Member ID. | All | 1% | B |
| MC | 142 | MC141 | Carrier Specific Unique Subscriber ID | 11/8/12 | Text | ID Link to ME117 | varchar[50] | Subscriber's Unique ID | Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to validate Unique Member ID and link back to Member Eligibility (ME117). | All | 100% | A0 |
| MC | 143 | MC142 | Other Diagnosis - 13 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 13. If not applicable do not report any value here. | All | 1% | C |
| MC | 144 | MC143 | Other Diagnosis - 14 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 14. If not applicable do not report any value here. | All | 1% | C |
| MC | 145 | MC144 | Other Diagnosis - 15 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 15. If not applicable do not report any value here. | All | 1% | C |
| MC | 146 | MC145 | Other Diagnosis - 16 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 16. If not applicable do not report any value here. | All | 1% | C |
| MC | 147 | MC146 | Other Diagnosis - 17 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 17. If not applicable do not report any value here. | All | 1% | C |
| MC | 148 | MC147 | Other Diagnosis - 18 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 18. If not applicable do not report any value here. | All | 1% | C |
| MC | 149 | MC148 | Other Diagnosis - 19 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 19. If not applicable do not report any value here. | All | 1% | C |
| MC | 150 | MC149 | Other Diagnosis - 20 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 20. If not applicable do not report any value here. | All | 1% | C |
| MC | 151 | MC150 | Other Diagnosis - 21 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 21. If not applicable do not report any value here. | All | 1% | C |
| MC | 152 | MC151 | Other Diagnosis - 22 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 22. If not applicable do not report any value here. | All | 1% | C |
| MC | 153 | MC152 | Other Diagnosis - 23 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 23. If not applicable do not report any value here. | All | 1% | C |
| MC | 154 | MC153 | Other Diagnosis - 24 | 11/8/12 | External Code Source 8 - Text | External Codes Source 8 - International Classification of Diseases | varchar[7] | ICD Other Diagnosis Code | Other ICD Diagnosis Code - 24. If not applicable do not report any value here. | All | 1% | C |
| MC | 155 | MC154 | Present on Admission Code (POA) - 01 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Principal Diagnosis | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC041 is populated | 100% | A2 |
| MC | 156 | MC155 | Present on Admission Code (POA) - 02 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 1 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC042 is populated | 100% | A2 |
| MC | 157 | MC156 | Present on Admission Code (POA) - 03 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 2 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC043 is populated | 100% | A2 |
| MC | 158 | MC157 | Present on Admission Code (POA) - 04 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 3 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC044 is populated | 100% | A2 |
| MC | 159 | MC158 | Present on Admission Code (POA) - 05 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 4 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC045 is populated | 100% | A2 |
| MC | 160 | MC159 | Present on Admission Code (POA) - 06 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 5 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC046 is populated | 100% | A2 |
| MC | 161 | MC160 | Present on Admission Code (POA) - 07 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 6 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC047 is populated | 100% | A2 |
| MC | 162 | MC161 | Present on Admission Code (POA) - 08 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 7 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC048 is populated | 100% | A2 |
| MC | 163 | MC162 | Present on Admission Code (POA) - 09 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 8 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC049 is populated | 100% | A2 |
| MC | 164 | MC163 | Present on Admission Code (POA) - 10 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 9 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC050 is populated | 100% | A2 |
| MC | 165 | MC164 | Present on Admission Code (POA) - 11 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 10 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC051 is populated | 100% | A2 |
| MC | 166 | MC165 | Present on Admission Code (POA) - 12 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 11 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC052 is populated | 100% | A2 |
| MC | 167 | MC166 | Present on Admission Code (POA) - 13 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 12 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC053 is populated | 100% | A2 |
| MC | 168 | MC167 | Present on Admission Code (POA) - 14 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 13 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC142 is populated | 100% | A2 |
| MC | 169 | MC168 | Present on Admission Code (POA) - 15 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 14 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC143 is populated | 100% | A2 |
| MC | 170 | MC169 | Present on Admission Code (POA) - 16 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 15 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC144 is populated | 100% | A2 |
| MC | 171 | MC170 | Present on Admission Code (POA) - 17 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 16 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC145 is populated | 100% | A2 |
| MC | 172 | MC171 | Present on Admission Code (POA) - 18 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 17 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC146 is populated | 100% | A2 |
| MC | 173 | MC172 | Present on Admission Code (POA) - 19 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 18 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC147 is populated | 100% | A2 |
| MC | 174 | MC173 | Present on Admission Code (POA) - 20 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 19 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC148 is populated | 100% | A2 |
| MC | 175 | MC174 | Present on Admission Code (POA) - 21 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 20 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC149 is populated | 100% | A2 |
| MC | 176 | MC175 | Present on Admission Code (POA) - 22 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 21 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC150 is populated | 100% | A2 |
| MC | 177 | MC176 | Present on Admission Code (POA) - 23 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 22 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC151 is populated | 100% | A2 |
| MC | 178 | MC177 | Present on Admission Code (POA) - 24 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 23 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC152 is populated | 100% | A2 |
| MC | 179 | MC178 | Present on Admission Code (POA) - 25 | 11/8/12 | External Code Source 15 - Text | External Code Source 15 - Present on Admission | char[1] | POA code for Other Diagnosis - 24 | Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt. | Required when MC094 = 002, MC039 and MC153 is populated | 100% | A2 |
| MC | 180 | MC179 | Condition Code - 1 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Condition Codes | char[2] | Condition Code | Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 181 | MC180 | Condition Code - 2 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Condition Codes | char[2] | Condition Code | Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 182 | MC181 | Condition Code - 3 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Condition Codes | char[2] | Condition Code | Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 183 | MC182 | Condition Code - 4 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Condition Codes | char[2] | Condition Code | Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 184 | MC183 | Condition Code - 5 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Condition Codes | char[2] | Condition Code | Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 185 | MC184 | Condition Code - 6 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Condition Codes | char[2] | Condition Code | Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 186 | MC185 | Condition Code - 7 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Condition Codes | char[2] | Condition Code | Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 187 | MC186 | Condition Code - 8 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Condition Codes | char[2] | Condition Code | Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here | All | 1% | B |
| MC | 188 | MC187 | Condition Code - 9 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Condition Codes | char[2] | Condition Code | Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 189 | MC188 | Condition Code - 10 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Condition Codes | char[2] | Condition Code | Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 190 | MC189 | Condition Code - 11 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Condition Codes | char[2] | Condition Code | Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here.. | All | 1% | B |
| MC | 191 | MC190 | Condition Code - 12 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Condition Codes | char[2] | Condition Code | Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 192 | MC191 | Value Code - 1 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Value Codes | char[2] | Value Code | Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here. | All | 1% | B |
| MC | 193 | MC192 | Value Amount - 1 | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount that corresponds to Value Code - 1 | Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:**  150.00 is reported as 15000; 150.70 is reported as 15070 | Required when MC191 is populated | 100% | B |
| MC | 194 | MC193 | Value Code - 2 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Value Codes | char[2] | Value Code | Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here. | All | 1% | B |
| MC | 195 | MC194 | Value Amount - 2 | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount that corresponds to Value Code - 2 | Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable.  **EXAMPLE:**  150.00 is reported as 15000; 150.70 is reported as 15070 | Required when MC193 is populated | 100% | B |
| MC | 196 | MC195 | Value Code - 3 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Value Codes | char[2] | Value Code | Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here. | All | 1% | B |
| MC | 197 | MC196 | Value Amount - 3 | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount that corresponds to Value Code - 3 | Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable.  **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070 | Required when MC195 is populated | 100% | B |
| MC | 198 | MC197 | Value Code - 4 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Value Codes | char[2] | Value Code | Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here. | All | 1% | B |
| MC | 199 | MC198 | Value Amount - 4 | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount that corresponds to Value Code - 4 | Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:**  150.00 is reported as 15000; 150.70 is reported as 15070 | Required when MC197 is populated | 100% | B |
| MC | 200 | MC199 | Value Code - 5 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Value Codes | char[2] | Value Code | Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here. | All | 1% | B |
| MC | 201 | MC200 | Value Amount - 5 | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount that corresponds to Value Code - 5 | Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070 | Required when MC199 is populated | 100% | B |
| MC | 202 | MC201 | Value Code - 6 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Value Codes | char[2] | Value Code | Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here. | All | 1% | B |
| MC | 203 | MC202 | Value Amount - 6 | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount that corresponds to Value Code - 6 | Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable.  **EXAMPLE:**  150.00 is reported as 15000; 150.70 is reported as 15070 | Required when MC201 is populated | 100% | B |
| MC | 204 | MC203 | Value Code - 7 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Value Codes | char[2] | Value Code | Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here. | All | 1% | B |
| MC | 205 | MC204 | Value Amount - 7 | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount that corresponds to Value Code - 7 | Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:**  150.00 is reported as 15000; 150.70 is reported as 15070 | Required when MC203 is populated | 100% | B |
| MC | 206 | MC205 | Value Code - 8 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Value Codes | char[2] | Value Code | Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here. | All | 1% | B |
| MC | 207 | MC206 | Value Amount - 8 | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount that corresponds to Value Code - 8 | Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable.  **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070 | Required when MC205 is populated | 100% | B |
| MC | 208 | MC207 | Value Code - 9 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Value Codes | char[2] | Value Code | Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here. | All | 1% | B |
| MC | 209 | MC208 | Value Amount - 9 | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount that corresponds to Value Code - 9 | Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070 | Required when MC207 is populated | 100% | B |
| MC | 210 | MC209 | Value Code - 10 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Value Codes | char[2] | Value Code | Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here. | All | 1% | B |
| MC | 211 | MC210 | Value Amount - 10 | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount that corresponds to Value Code - 10 | Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:**  150.00 is reported as 15000; 150.70 is reported as 15070 | Required when MC209 is populated | 100% | B |
| MC | 212 | MC211 | Value Code - 11 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Value Codes | char[2] | Value Code | Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here. | All | 1% | B |
| MC | 213 | MC212 | Value Amount - 11 | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount that corresponds to Value Code - 11 | Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable.  **EXAMPLE:**  150.00 is reported as 15000; 150.70 is reported as 15070 | Required when MC211 is populated | 100% | B |
| MC | 214 | MC213 | Value Code - 12 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Value Codes | char[2] | Value Code | Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here. | All | 1% | B |
| MC | 215 | MC214 | Value Amount - 12 | 11/8/12 | Integer | Currency | **±**varchar[10] | Amount that corresponds to Value Code - 12 | Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070 | Required when MC213 is populated | 100% | B |
| MC | 216 | MC215 | Occurrence Code - 1 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Occurrence Codes | char[2] | Occurrence Code | Report the appropriate value that defines an occurrence category for the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 217 | MC216 | Occurrence Date - 1 | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Date that corresponds to Occurrence Code - 1 | Report the appropriate date that corresponds to the occurrence code in CCYYMMDD Format. | Required when MC215 is populated | 100% | B |
| MC | 218 | MC217 | Occurrence Code - 2 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Occurrence Codes | char[2] | Occurrence Code | Report the appropriate value that defines an occurrence category for the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 219 | MC218 | Occurrence Date - 2 | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Date that corresponds to Occurrence Code - 2 | Report the appropriate date that corresponds to the occurrence code in CCYYMMDD Format. | Required when MC217 is populated | 100% | B |
| MC | 220 | MC219 | Occurrence Code - 3 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Occurrence Codes | char[2] | Occurrence Code | Report the appropriate value that defines an occurrence category for the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 221 | MC220 | Occurrence Date - 3 | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Date that corresponds to Occurrence Code - 3 | Report the appropriate date that corresponds to the occurrence code in CCYYMMDD Format. | Required when MC219 is populated | 100% | B |
| MC | 222 | MC221 | Occurrence Code - 4 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Occurrence Codes | char[2] | Occurrence Code | Report the appropriate value that defines an occurrence category for the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 223 | MC222 | Occurrence Date - 4 | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Date that corresponds to Occurrence Code - 4 | Report the appropriate date that corresponds to the occurrence code in CCYYMMDD Format. | Required when MC221 is populated | 100% | B |
| MC | 224 | MC223 | Occurrence Code - 5 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Occurrence Codes | char[2] | Occurrence Code | Report the appropriate value that defines an occurrence category for the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 225 | MC224 | Occurrence Date - 5 | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Date that corresponds to Occurrence Code - 5 | Report the appropriate date that corresponds to the occurrence code in CCYYMMDD Format. | Required when MC223 is populated | 100% | B |
| MC | 226 | MC225 | Occurrence Span Code - 1 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Occurrence Span Codes | char[2] | Occurrence Span Code | Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 227 | MC226 | Occurrence Span Start Date - 1 | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Start Date that corresponds to Occurrence Span Code - 1 | Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format. | Required when MC225 is populated | 100% | B |
| MC | 228 | MC227 | Occurrence Span End Date - 1 | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | End Date that corresponds to Occurrence Span Code - 1 | Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format. | Required when MC226 is populated | 100% | B |
| MC | 229 | MC228 | Occurrence Span Code - 2 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Value Codes | char[2] | Occurrence Span Code | Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 230 | MC229 | Occurrence Span Start Date - 2 | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Start Date that corresponds to Occurrence Span Code - 2 | Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format. | Required when MC228 is populated | 100% | B |
| MC | 231 | MC230 | Occurrence Span End Date - 2 | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | End Date that corresponds to Occurrence Span Code - 2 | Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format. | Required when MC229 is populated | 100% | B |
| MC | 232 | MC231 | Occurrence Span Code - 3 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Value Codes | char[2] | Occurrence Span Code | Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here.. | All | 1% | B |
| MC | 233 | MC232 | Occurrence Span Start Date - 3 | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Start Date that corresponds to Occurrence Span Code - 3 | Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format. | Required when MC231 is populated | 100% | B |
| MC | 234 | MC233 | Occurrence Span End Date - 3 | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | End Date that corresponds to Occurrence Span Code - 3 | Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format. | Required when MC232 is populated | 100% | B |
| MC | 235 | MC234 | Occurrence Span Code - 4 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Value Codes | char[2] | Occurrence Span Code | Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 236 | MC235 | Occurrence Span Start Date - 4 | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Start Date that corresponds to Occurrence Span Code - 4 | Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format. | Required when MC234 is populated | 100% | B |
| MC | 237 | MC236 | Occurrence Span End Date - 4 | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | End Date that corresponds to Occurrence Span Code - 4 | Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format. | Required when MC235 is populated | 100% | B |
| MC | 238 | MC237 | Occurrence Span Code - 5 | 11/8/12 | External Code Source 14 - Text | External Code Source 14 - Value Codes | char[2] | Occurrence Span Code | Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here. | All | 1% | B |
| MC | 239 | MC238 | Occurrence Span Start Date - 5 | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Start Date that corresponds to Occurrence Span Code - 5 | Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format. | Required when MC237 is populated | 100% | B |
| MC | 240 | MC239 | Occurrence Span End Date - 5 | 11/8/12 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | End Date that corresponds to Occurrence Span Code - 5 | Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format. | Required when MC238 is populated | 100% | B |
| MC | 241 | MC240 | GIC ID | 11/8/12 | Text | ID GIC | varchar[9] | GIC Member ID | Report the GIC Member Identification number as provided to GIC Plan Submitters. If not applicable do not report any value here. | Required when MC241 = 3 | 100% | A0 |
| MC | 242 | MC241 | APCD ID Code | 11/8/12 | Lookup Table - Integer | tlkpADCDIdentifier | int[1] | Member Enrollment Type | Report the value that describes the member's / subscriber's enrollment into one of the predefined categories; aligns enrollment to appropriate editing and thresholds. **EXAMPLE:** 1 = FIG - Fully Insured Commercial Group Enrollee. | All | 100% | A2 |
|  |  |  |  |  |  |  |  | ***Value*** | ***Description*** |  |  |  |
|  |  |  |  |  |  |  |  | 1 | FIG - Fully-Insured Commercial Group Enrollee |  |  |  |
|  |  |  |  |  |  |  |  | 2 | SIG - Self-Insured Group Enrollee |  |  |  |
|  |  |  |  |  |  |  |  | 3 | GIC - Group Insurance Commission Enrollee |  |  |  |
|  |  |  |  |  |  |  |  | 4 | MCO - MassHealth Managed Care Organization Enrollee |  |  |  |
|  |  |  |  |  |  |  |  | 5 | Supplemental Policy Enrollee |  |  |  |
|  |  |  |  |  |  |  |  | 6 | ICO - Integrated Care Organization |  |  |  |
|  |  |  |  |  |  |  |  | 0 | Unknown / Not Applicable |  |  |  |
| MC | 243 | MC899 | Record Type | 6/24/10 | Text | ID File | char[2] | File Type Identifier | Report **MC** here. This validates the type of file and the data contained within the file. This must match HD004 . | All | 100% | A0 |
| TR-MC | 1 | TR001 | Record Type | 6/24/10 | Text | ID Record | char[2] | Trailer Record Identifier | Report **TR** here. Indicates the end of the data file. | Mandatory | 100% | TM |
| TR-MC | 2 | TR002 | Submitter | 11/8/12 | Integer | ID Submitter | varchar[6] | Trailer Submitter / Carrier ID defined by CHIA | Report the Unique Submitter ID as defined by CHIA here. This must match the Submitter ID reported in HD002. | Mandatory | 100% | TM |
| TR-MC | 3 | TR003 | National Plan ID | 11/8/12 | Integer | ID Nat'l PlanID | int[10] | CMS National Plan Identification Number (PlanID) | Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans. | Situational | 0% | TS |
| TR-MC | 4 | TR004 | Type of File | 6/24/10 | Text | ID File | char[2] | Validates the file type defined in HD004. | Report **MC** here. This must match the File Type reported in HD004. | Mandatory | 100% | TM |
| TR-MC | 5 | TR005 | Period Beginning Date | 6/24/10 | Date Period - Integer | Century Year Month - CCYYMM | int[6] | Trailer Period Start Date | Report the Year and Month of the reported submission period in CCYYMM format. This date period must match the date period reported in HD005 and HD006. | Mandatory | 100% | TM |
| TR-MC | 6 | TR006 | Period Ending Date | 6/24/10 | Date Period - Integer | Century Year Month - CCYYMM | int[6] | Trailer Period Ending Date | Report the Year and Month of the reporting submission period in CCYYMM format. This date period must match the date period reported in TR005 and HD005 and HD006. | Mandatory | 100% | TM |
| TR-MC | 7 | TR007 | Date Processed | 6/24/10 | Full Date - Integer | Century Year Month Day - CCYYMMDD | int[8] | Trailer Processed Date | Report the full date that the submission was compiled by the submitter in CCYYMMDD Format. | Mandatory | 100% | TM |

Appendix – External Code Sources

**1. Countries**

**American National Standards Institute**

[**http://webstore.ansi.org/SdoInfo.aspx?sdoid=39&source=iso\_member\_body**](http://webstore.ansi.org/SdoInfo.aspx?sdoid=39&source=iso_member_body)

|  |
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| **MC070** |

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

**U.S. Postal Service**

[**https://www.usps.com/**](https://www.usps.com/)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **MC015** | **MC016** | **MC034** | **MC035** |  |  |

**3. National Provider Identifiers**

**National Plan & Provider Enumeration System**

[**https://nppes.cms.hhs.gov/NPPES/**](https://nppes.cms.hhs.gov/NPPES/)

|  |  |  |  |
| --- | --- | --- | --- |
| **MC026** | **MC077** |  |  |

**5. Health Care Provider Taxonomy**

**Washington Publishing Company**

[**http://www.wpc-edi.com/reference/**](http://www.wpc-edi.com/reference/)

|  |
| --- |
| **MC032** |

**8. International Classification of Diseases 9 & 10**

**American Medical Association**

[**http://www.ama-assn.org/**](http://www.ama-assn.org/)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MC039** | **MC040** | **MC041** | **MC042** | **MC043** | **MC044** | **MC045** | **MC046** | **MC047** | **MC048** |
| **MC050** | **MC049** | **MC051** | **MC052** | **MC053** | **MC058** | **MC083** | **MC084** | **MC085** | **MC086** |
| **MC087** | **MC088** | **MC136** | **MC142** | **MC143** | **MC144** | **MC145** | **MC146** | **MC147** | **MC148** |
| **MC149** | **MC150** | **MC151** | **MC152** | **MC153** |  |  |  |  |  |

**9. HCPCS, CPTs and Modifiers**

**American Medical Association**

[**http://www.ama-assn.org/**](http://www.ama-assn.org/)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **MC055** | **MC056** | **MC057** | **MC108** | **MC109** |

**10. Dental Procedure Codes and Identifiers**

**American Dental Association**

[**http://www.ada.org/**](http://www.ada.org/)

|  |  |  |  |
| --- | --- | --- | --- |
| **MC055** |  |  |  |

**11. Logical Observation Identifiers Names and Codes**

**Regenstrief Institute**

[**http://loinc.org/**](http://loinc.org/)

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| --- |
| **MC090** |

**12. National Drug Codes and Names**

**U.S. Food and Drug Administration**

[**http://www.fda.gov/drugs/informationondrugs/ucm142438.htm**](http://www.fda.gov/drugs/informationondrugs/ucm142438.htm)

|  |  |
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| **MC075** |  |

**13. Standard Professional Billing Elements**

**Centers for Medicare and Medicaid Services (Rev. 10/26/12)**

[**http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf**](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf)

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| **MC037** |

**14. Standard Facility Billing Elements**

**National Uniform Billing Committee (NUBC)**

[**http://www.nubc.org/**](http://www.nubc.org/)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MC020** | **MC021** | **MC023** | **MC036** | **MC054** | **MC133** | **MC179** | **MC180** | **MC181** | **MC182** |
| **MC183** | **MC184** | **MC185** | **MC186** | **MC187** | **MC188** | **MC189** | **MC190** | **MC191** | **MC193** |
| **MC195** | **MC197** | **MC199** | **MC201** | **MC203** | **MC205** | **MC207** | **MC209** | **MC211** | **MC213** |
| **MC215** | **MC217** | **MC219** | **MC221** | **MC223** | **MC225** | **MC228** | **MC231** | **MC234** | **MC237** |

**15. DRGs, APCs and POA Codes**

**Centers for Medicare and Medicaid Services**

[**http://www.cms.gov/**](http://www.cms.gov/)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MC071** | **MC072** | **MC073** | **MC074** | **MC120** | **MC154** | **MC155** | **MC156** | **MC157** | **MC158** |
| **MC159** | **MC160** | **MC161** | **MC162** | **MC163** | **MC164** | **MC165** | **MC166** | **MC167** | **MC168** |
| **MC169** | **MC170** | **MC171** | **MC172** | **MC173** | **MC174** | **MC175** | **MC176** | **MC177** | **MC178** |

**16. Claim Adjustment Reason Codes**

**Washington Publishing Company**

[**http://www.wpc-edi.com/reference/**](http://www.wpc-edi.com/reference/)

|  |  |
| --- | --- |
| **MC080** | **MC124** |

The Commonwealth of Massachusetts



Center for Health Information and Analysis

Center for Health Information and Analysis

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