DIVISION OF
Health Care
Finance and Policy

The All-Payer Claims Database
Medical Claim File
Submission Guide

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Revision History

Date	Version	Description	Author
7/8/10	1.0	Medical	M. Prettenhofer
10/22/10	2.0	The APCD Monthly Medical Claims File Grid – file format and asterisk delimiter usage added for clarification	M. Prettenhofer
10/22/10	2.0	Provider ID Definition – narrative updated for clarification	M. Prettenhofer
10/22/10	2.0	MC002 – threshold reduction to 0% until CMS mandates National PlanID	M. Prettenhofer
10/22/10	2.0	MC007 – optional reporting removed from logic	M. Prettenhofer
10/22/10	2.0	MC031 – value added to lookup table for Unknown / Not Applicable	M. Prettenhofer
10/22/10	2.0	MC060 – refinement to broaden Date of Service-To definition for Inpatient claim scenarios	M. Prettenhofer
10/22/10	2.0	MC061 – quantity length increased to 15	M. Prettenhofer
10/22/10	2.0	MC063 – refinement to clarify that carrier payments are to be reported in this element	M. Prettenhofer
10/22/10	2.0	MC079 – refinement to indicate Product ID = the number reported on the Product File in PR001	M. Prettenhofer
10/22/10	2.0	MC101, MC102, MC103 – optional reporting removed from logic	M. Prettenhofer
10/22/10	2.0	MC124 – length of field increased to 10	M. Prettenhofer
10/22/10	2.0	MC127, MC129 – value added to lookup table for Unknown / Not Applicable	M. Prettenhofer
10/22/10	2.0	MC137, MC141 – definition update to clarify linking logic	M. Prettenhofer
10/22/10	2.0	Appendices A & B Column Update – 1) APCD Denom refined to Required When	M. Prettenhofer
10/22/10	2.0	Appendix C – MC090 mapping has been removed	M. Prettenhofer
10/22/10	2.0	Appendix D – External Code Source 15 has been added for NAICS coding	M. Prettenhofer

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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 Division of Health Care Finance and Policy (Division) 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, and Medicaid data. The Division will become 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, the Division has set up a dedicated APCD website (www.mass.gov/dhcfp/apcd) with resources that currently include the submission and release regulations, the technical submission guide with examples, and support for providing additional feedback. These resources will be periodically updated with materials and the Division staff will continue to work with all affected payers to ensure full compliance with the regulation.

While the Division is committed to establishing 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 the Division on the all payer claims database.

114.5 CMR 21.00 – Health Care Claims Submission
114.5 CMR 21.00 governs the reporting requirements for Health Care Payers to submit data and information to the Division 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. The Division will collect data essential for the Division to monitor health care cost trends, minimize the duplication of data submissions by payers to state entities, and to promote administrative simplification among state entities in Massachusetts.

Health care data and information submitted by Health Care Payers to the Division 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

The APCD Monthly Medical Claims File

As part of the new All Payer Claims Database (APCD) carriers will be required to submit a Medical Claims File. The Division of Healthcare Finance and Policy (Division), in an effort to decrease any programming burden, has adopted a file layout currently in use by another state. There are minor changes to this layout so that it will connect appropriately across other required filings for the APCD and in order to simplify the data submission.

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	The Division 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 a field in lieu of another character. Example: if the file includes "Smith*Jones" in the Last Name, the system will read an incorrect number of fields 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 the Division.	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.

Specification Question	Clarification	Rationale
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.	The Division is adopting the most widely used specification at this time. It is important to note that by 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.

Types of Data collected in the Medical Claims File

Carrier-assigned Identifiers

The Division requires various Carrier-assigned identifiers for matching-logic to the other files, i.e., Product File, Member Eligibility. Examples of this field include MC003, MC006, MC137 and MC141 will be used by the Division to aid with the matching algorithm to those other files.

Claims Data

The Division requires the line-level detail of all Medical Claims for analysis. The line-level data aids with understanding utilization within products across Carriers. The specific medical data reported in MC039 through MC062, MC071, MC072, MC075, MC083 through MC088, MC090, MC108, MC109, MC111, MC126, MC127, MC129, MC130, and MC136 would be the same elements that are reported to a Carrier on the UB04, HCFA 1500, the HIPAA 837I and 837P or a Carrier specific direct data entry system.

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

Provider data is outlined below.

Adjudication Data

The Division requires adjudication-centric data on the 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.

The Division 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 be not be required to submit denied claims effective July 1, 2010. The Division will issue an Administrative Bulleting notifying Payers when the requirement to submit denied claims will become effective, and will notify Payers about the procedures and due dates for submitting such claims.

The Provider ID

Element MC024 (Service Provider ID), MC134 (Plan Rendering Provider) and MC135 (Provider Location) are some of the most critical fields in the 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 field is:

The unique number for every service provider (persons, facilities or other entities involved in claims transactions) that a carrier has in its system. This field may or may not be the provider NPI. Also see instructions related to provider identifying claims elements including (MC024, MC026, MC076, MC077, MC112). This field is used to uniquely identify a provider and that provider's affiliation and a provider and a provider's practice location within this provider file.

The goal of PV002 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. The Division is committed to working with payers and their technical teams to ensure compliance with all applicable laws and regulations. The Division will continue to provide support through technical assistance calls and resources available on the Division's website.

File Layout

File	Col	Element	Data Element Name	Date Active (version)	Type	Type Description	Revised Length	Old Length	Description	Encrypt Upon Intake
HD-MC	1	HD001	Record Type	06/24/10	Text	ID	2	2	Header Record Identifier	No
HD-MC	2	HD002	Payer	06/24/10	Text	ID Carrier	8	8	Header Submitter/Carrier ID	No
HD-MC	3	HD003	National Plan ID	06/24/10	Text	ID Nat'l Plan	30	30	Header CMS National Plan Identification Number (PlanID)	No
HD-MC	4	HD004	Type of File	06/24/10	Text	ID	2	2	Header Type of File	No
HD-MC	5	HD005	Period Beginning Date	06/24/10	Date Period	Year Month	6	6	Header Period Start Date	No
HD-MC	6	HD006	Period Ending Date	06/24/10	Date Period	Year Month	6	6	Header Period Ending Date	No
HD-MC	7	HD007	Record Count	06/24/10	Integer	Counter	10	10	Header Record Count	No
HD-MC	8	HD008	Comments	06/24/10	Text	Free Text Field	80	80	Header Carrier Comments	No
MC	1	MC001	Payer	06/24/10	Text	ID Carrier	8	8	Carrier Specific Submitter Code as defined by APCD.	No
MC	2	MC002	National Plan ID	10/03/10	Text	ID Nat'l Plan	30	30	CMS National Plan Identification Number (PlanID)	No
MC	3	MC003	Insurance Type Code/Product	06/24/10	Text	Lookup Table	2	2	Type / Product Identification Code	No
MC	4	MC004	Payer Claim Control Number	06/24/10	Text	ID Claim Number	35	35	Payer Claim Control Identification	No
MC	5	MC005	Line Counter	06/24/10	Integer	ID	4	4	Incremental Line Counter	No
MC	6	MC005A	Version Number	06/24/10	Integer	Counter	4	4	Claim service line version number	No
MC	7	MC006	Insured Group or Policy Number	06/24/10	Text	ID Group	30	30	Carriers group or policy number	No
MC	8	MC007	Subscriber SSN	10/15/10	Text	Tax ID	9	128	Subscriber's Social Security Number	Yes
MC	9	MC008	Plan Specific Contract Number	06/24/10	Text	ID Contract	30	128	Plan Specific Contract Number	Yes
MC	10	MC009	Member Suffix or Sequence Number	06/24/10	Text	ID Sequence	20	20	Member/Patient's Contract Sequence Number	No
MC	11	MC010	Member SSN	06/24/10	Text	Tax ID	9	128	Member/Patient's Social Security Number	Yes
MC	12	MC011	Individual Relationship Code	06/24/10	Integer	Lookup Table	2	2	Member/Patient to Subscriber Relationship Code	No
MC	13	MC012	Member Gender	06/24/10	Text	Lookup Table	1	1	Member/Patient's Gender	No
MC	14	MC013	Member Date of Birth	06/24/10	Date	Date Complete	8	8	Member/Patient's date of birth	No
MC	15	MC014	Member City Name	06/24/10	Text	Address City	30	30	City name of the Member/Patient	No

MC	16	MC015	Member State or Province	06/24/10	Text	Address State	2	2	State of the Member/Patient	No
MC	17	MC016	Member ZIP Code	06/24/10	Text	Address Zip Code	11	11	Zip Code of the Member/Patient	No
MC	18	MC017	Date Service Approved (AP Date)	06/24/10	Date	Date Complete	8	8	Date Service Approved	No
MC	19	MC018	Admission Date	06/24/10	Date	Date Complete	8	8	Inpatient Admit Date	No
MC	20	MC019	Admission Hour	06/24/10	Integer	Time Period Hour Minutes	4	4	Admission Time	No
MC	21	MC020	Admission Type	06/24/10	Integer	ID	1	1	Admission Type Code	No
MC	22	MC021	Admission Source	06/24/10	Text	ID	1	1	Admission Source Code	No
MC	23	MC022	Discharge Hour	06/24/10	Integer	Time Period Hour Minutes			Discharge Time	No
MC	24	MC023	Discharge Status	06/24/10	Integer	ID	2	2	Inpatient Discharge Status Code	No
MC	25	MC024	Service Provider Number	06/24/10	Text	ID PV002	30	30	Service Provider Identification Number	No
MC	26	MC025	Service Provider Tax ID Number	06/24/10	Text	Tax ID	10	10	Service Provider's Tax ID number	No
MC	27	MC026	National Service Provider ID	06/24/10	Text	NPI	20	20	National Provider Identification (NPI) of the Service Provider	No
MC	28	MC027	Service Provider Entity Type Qualifier	06/24/10	Integer	Lookup Table	1	1	Service Provider Entity Identifier Code	No
MC	29	MC028	Service Provider First Name	06/24/10	Text	Name First	25	25	First name of Service Provider	No
MC	30	MC029	Service Provider Middle Name	06/24/10	Text	Name Middle	25	25	Middle initial of Service Provider	No
MC	31	MC030	Servicing Provider Last Name or Organization Name	06/24/10	Text	Name Last / Org	60	60	Last name or Organization Name of Service Provider	No
MC	32	MC031	Service Provider Suffix	10/15/10	Text	Lookup Table	10	10	Provider Name Suffix	No
MC	33	MC032	Service Provider Specialty	06/24/10	Text	Taxonomy	50	50	Specialty Code	No
MC	34	MC033	Service Provider City Name	06/24/10	Text	Address City	30	30	City Name of the Provider	No
MC	35	MC034	Service Provider State	06/24/10	Text	Address State	2	2	State of the Service Provider	No
MC	36	MC035	Service Provider ZIP Code	06/24/10	Text	Address Zip Code	11	11	Zip Code of the Service Provider	No
MC	37	MC036	Type of Bill - on Facility Claims	06/24/10	Integer	POS	2	2	Type of Bills as used on Institutional Claims	No

MC	38	MC037	Site of Service - on NSF/CMS 1500 Claims	06/24/10	Text	POS	2	2	Place of Service Code as used on Professional Claims	No
MC	39	MC038	Claim Status	06/24/10	Integer	Lookup Table	2	2	Claim Line Status	No
MC	40	MC039	Admitting Diagnosis	06/24/10	Text	ID	7	7	Admitting Diagnosis Code	No
MC	41	MC040	E-Code	06/24/10	Text	Med Diagnosis	7	5	ICD Diagnostic External Injury Code	No
MC	42	MC041	Principal Diagnosis	06/24/10	Text	Med Diagnosis	7	5	ICD Primary Diagnosis Code	No
MC	43	MC042	Other Diagnosis - 1	06/24/10	Text	Med Diagnosis	7	5	ICD Secondary Diagnosis Code	No
MC	44	MC043	Other Diagnosis - 2	06/24/10	Text	Med Diagnosis	7	5	ICD Other Diagnosis Code	No
MC	45	MC044	Other Diagnosis - 3	06/24/10	Text	Med Diagnosis	7	5	ICD Other Diagnosis Code	No
MC	46	MC045	Other Diagnosis - 4	06/24/10	Text	Med Diagnosis	7	5	ICD Other Diagnosis Code	No
MC	47	MC046	Other Diagnosis - 5	06/24/10	Text	Med Diagnosis	7	5	ICD Other Diagnosis Code	No
MC	48	MC047	Other Diagnosis - 6	06/24/10	Text	Med Diagnosis	7	5	ICD Other Diagnosis Code	No
MC	49	MC048	Other Diagnosis - 7	06/24/10	Text	Med Diagnosis	7	5	ICD Other Diagnosis Code	No
MC	50	MC049	Other Diagnosis - 8	06/24/10	Text	Med Diagnosis	7	5	ICD Other Diagnosis Code	No
MC	51	MC050	Other Diagnosis - 9	06/24/10	Text	Med Diagnosis	7	5	ICD Other Diagnosis Code	No
MC	52	MC051	Other Diagnosis - 10	06/24/10	Text	Med Diagnosis	7	5	ICD Other Diagnosis Code	No
MC	53	MC052	Other Diagnosis - 11	06/24/10	Text	Med Diagnosis	7	5	ICD Other Diagnosis Code	No
MC	54	MC053	Other Diagnosis - 12	06/24/10	Text	Med Diagnosis	7	5	ICD Other Diagnosis Code	No
MC	55	MC054	Revenue Code	06/24/10	Text	Rev Code	10	10	Revenue Code as defined for use on an Institutional Claim	No
MC	56	MC055	Procedure Code	06/24/10	Text	Line CPT	10	10	HCPCS / CPT Code	No
MC	57	MC056	Procedure Modifier - 1	06/24/10	Text	Line CPT	2	2	HCPCS / CPT Code Modifier	No
MC	58	MC057	Procedure Modifier - 2	06/24/10	Text	Line CPT	2	2	HCPCS / CPT Code Modifier	No
MC	59	MC058	ICD9-CM Procedure Code	06/24/10	Text	Med Procedure	6	4	ICD Primary Procedure Code	No
MC	60	MC059	Date of Service - From	06/24/10	Date	Date Complete	8	8	Date of Service	No
MC	61	MC060	Date of Service - To	10/03/10	Date	Date Complete	8	8	Date of Service	No
MC	62	MC061	Quantity	10/03/10	Integer	Counter	15	3	Claim line units of service	No
MC	63	MC062	Charge Amount	06/24/10	Integer	Currency	10	10	Amount of provider charges for the claim line	No
MC	64	MC063	Paid Amount	10/03/10	Integer	Currency	10	10	Amount paid by the carrier for the claim line	No
MC	65	MC064	Prepaid Amount	06/24/10	Integer	Currency	10	10	Amount carrier has prepaid towards claim line	No
MC	66	MC065	Copay Amount	06/24/10	Integer	Currency	10	10	Amount of Copay member/patient is responsible to pay	No
MC	67	MC066	Coinsurance Amount	06/24/10	Integer	Currency	10	10	Amount of coinsurance member/patient is responsible to pay	No
MC	68	MC067	Deductible Amount	06/24/10	Integer	Currency	10	10	Amount of deductible member/patient is responsible to pay on the claim line	No
MC	69	MC068	Patient Control Number	06/24/10	Text	ID Claim Number	20	20	Patient Control Number	No
MC	70	MC069	Discharge Date	06/24/10	Date	Date Complete	8	8	Discharge Date	No

MC	71	MC070	Service Provider Country Code	06/24/10	Text	Address Country	30	30	Country name of the Provider	No
MC	72	MC071	DRG	06/24/10	Text	DRG	10	10	Diagnostic Related Group (DRG) Code	No
MC	73	MC072	DRG Version	06/24/10	Text	DRG	2	2	Diagnostic Related Group (DRG) Code Version Number	No
MC	74	MC073	APC	06/24/10	Text	APC	4	4	Ambulatory Payment Classification (APC) Number	No
MC	75	MC074	APC Version	06/24/10	Text	APC	2	2	Ambulatory Payment Classification (APC) Version	No
MC	76	MC075	Drug Code	06/24/10	Text	NDC	11	11	National Drug Code (NDC)	No
MC	77	MC076	Billing Provider Number	06/24/10	Text	ID PV002	30	30	Billing Provider Number	No
MC	78	MC077	National Billing Provider ID	06/24/10	Text	NPI	20	20	National Provider Identification (NPI) of the Billing Provider	No
MC	79	MC078	Billing Provider Last Name or Organization Name	06/24/10	Text	Name Last / Org	60	60	Last name or Organization Name of Billing Provider	No
MC	80	MC079	Product ID Number	10/03/10	Text	ID PR001	20	20	Product Identification Number	No
MC	81	MC080	Reason for Adjustment	06/24/10	Text	ID	4	4	Reason for Adjustment Code	No
MC	82	MC081	Capitated Encounter Flag	06/24/10	Integer	Lookup Table	1	1	Indicates if the service is covered under a capitation arrangement.	No
MC	83	MC082	Member Street Address	06/24/10	Text	Address 1	50	50	Street address of the Member/Patient	No
MC	84	MC083	Other ICD-9-CM Procedure Code - 1	06/24/10	Text	Med Procedure	6	4	ICD Secondary Procedure Code	No
MC	85	MC084	Other ICD-9-CM Procedure Code - 2	06/24/10	Text	Med Procedure	6	4	ICD Other Procedure Code	No
MC	86	MC085	Other ICD-9-CM Procedure Code - 3	06/24/10	Text	Med Procedure	6	4	ICD Other Procedure Code	No
MC	87	MC086	Other ICD-9-CM Procedure Code - 4	06/24/10	Text	Med Procedure	6	4	ICD Other Procedure Code	No
MC	88	MC087	Other ICD-9-CM Procedure Code - 5	06/24/10	Text	Med Procedure	6	4	ICD Other Procedure Code	No
MC	89	MC088	Other ICD-9-CM Procedure Code - 6	06/24/10	Text	Med Procedure	6	4	ICD Other Procedure Code	No
MC	90	MC089	Paid Date	06/24/10	Date	Date Complete	8	8	Paid date of the claim line	No
MC	91	MC090	LOINC Code	06/24/10	Text	Line Lab	7	7	Logical Observation Identifiers, Names and Codes (LOINC) Code	No
MC	92	MC091	Filler	06/24/10	Filler	Filler	20	20	The APCD will reserve this field for possible future use. Please fill with null values in the format described.	No
MC	93	MC092	Covered Days	06/24/10	Integer	Days Covered	3	3	Covered Inpatient Days	No
MC	94	MC093	Non Covered Days	06/24/10	Integer	Days Noncovered	3	3	Noncovered Inpatient Days	No
MC	95	MC094	Type of Claim	06/24/10	Text	Lookup Table	3	3	Type of Claim Indicator	No

MC	96	MC095	Coordination of Benefits/TPL Liability Amount	06/24/10	Integer	Currency	10	10	Amount due from a Secondary Carrier when known	No
MC	97	MC096	Other Insurance Paid Amount	06/24/10	Integer	Currency	10	10	Amount paid by a Primary Carrier	No
MC	98	MC097	Medicare Paid Amount	06/24/10	Integer	Currency	10	10	Amount Medicare paid on claim	No
MC	99	MC098	Allowed amount	06/24/10	Integer	Currency	10	10	Allowed Amount	No
MC	100	MC099	Non-Covered Amount	06/24/10	Integer	Currency	10	10	Amount of claim line charge not covered	No
MC	101	MC100	Filler	06/24/10	Filler	Filler	10	10	The APCD will reserve this field for possible future use. Please fill with null values in the format described.	No
MC	102	MC101	Subscriber Last Name	10/15/10	Text	Name Last	60	128	Last name of Subscriber	Yes
MC	103	MC102	Subscriber First Name	10/15/10	Text	Name First	25	128	First name of the Subscriber	Yes
MC	104	MC103	Subscriber Middle Initial	10/15/10	Text	Name Middle	1	1	Middle initial of Subscriber	No
MC	105	MC104	Member Last Name	06/24/10	Text	Name Last	60	128	Last name of Member/Patient	Yes
MC	106	MC105	Member First Name	06/24/10	Text	Name First	25	128	First name of Member/Patient	Yes
MC	107	MC106	Member Middle Initial	06/24/10	Text	Name Middle	1	1	Middle initial of Member/Patient	No
MC	108	MC107	Filler	06/24/10	Filler	Filler	5	5	The APCD will reserve this field for possible future use. Please fill with null values in the format described.	No
MC	109	MC108	Procedure Modifier - 3	06/24/10	Text	Line CPT	2	2	HCPCS / CPT Code Modifier	No
MC	110	MC109	Procedure Modifier - 4	06/24/10	Text	Line CPT	2	2	HCPCS / CPT Code Modifier	No
MC	111	MC110	Claim Processed Date	06/24/10	Date	Date Complete	8	8	Claim Processed Date	No
MC	112	MC111	Diagnostic Pointer	06/24/10	Text	ID	1	1	Diagnostic Pointer Number	No
MC	113	MC112	Referring Provider ID	06/24/10	Text	ID PV002	28	28	Referring Provider Number	No
MC	114	MC113	Payment Arrangement Type	06/24/10	Text	Lookup Table	2	2	Payment Arrangement Code	No
MC	115	MC114	Excluded Expenses	06/24/10	Integer	Currency	10	10	Amount not covered at the claim line due to benefit/plan limitation	No
MC	116	MC115	Medicare Indicator	06/24/10	Text	Lookup Table	1	1	Medicare Payment Indicator	No
MC	117	MC116	Withhold Amount	06/24/10	Integer	Currency	10	10	Amount to be paid to the provider upon guarantee of performance	No
MC	118	MC117	Authorization Needed	06/24/10	Integer	Lookup Table	1	1	Indicates if the service required a pre-authorization number for payment.	No
MC	119	MC118	Referral Indicator	06/24/10	Text	Lookup Table	1	1	Referral Required Indicator	No
MC	120	MC119	PCP Indicator	06/24/10	Text	Lookup Table	1	1	PCP Service Performance Indicator	No
MC	121	MC120	DRG Level	06/24/10	Text	DRG	3	3	Diagnostic Related Group (DRG) Code Level	No
MC	122	MC121	Filler	06/24/10	Filler	Filler	5	5	The APCD will reserve this field for possible future use. Please fill with null values in the format described.	No
MC	123	MC122	Global Payment Flag	06/24/10	Text	Lookup Table	1	1	Global Payment Method Indicator	No

MC	124	MC123	Denied Flag	06/24/10	Text	Lookup Table	1	1	Denied Claim Line Indicator	No
MC	125	MC124	Denial Reason	10/14/10	Text	Carrier Table	10	2	Denial Reason Code	No
MC	126	MC125	Attending Provider	06/24/10	Text	ID PV002	28	28	Attending Provider ID number found in the Provider File (PV002). This number is defined in the carrier's systems and may be equal to any other identifier, i.e., NPI, State License Number	No
MC	127	MC126	Accident Indicator	06/24/10	Text	Lookup Table	1	1	Service is related to an accident	No
MC	128	MC127	Family Planning Indicator	10/15/10	Text	Lookup Table	1	1	Service is related to Family Planning	No
MC	129	MC128	Employment Related Indicator	06/24/10	Text	Lookup Table	1	1	Service related to Employment Injury	No
MC	130	MC129	EPSDT Indicator	10/15/10	Text	Lookup Table	1	1	Service related to Early Periodic Screening, Diagnosis and Treatment (EPSDT)	No
MC	131	MC130	Procedure Code Type	06/24/10	Text	Lookup Table	1	1	Claim line Procedure Code Type Identifier	No
MC	132	MC131	InNetwork Indicator	06/24/10	Text	Lookup Table	1	1	Network rates applied identifier	No
MC	133	MC132	Service Class	06/24/10	Text	MCO Carrier Table	2	2	Service Class Code	No
MC	134	MC133	Filler	06/24/10	Filler	Filler	2	2	The APCD will reserve this field for possible future use. Please fill with null values in the format described.	No
MC	135	MC134	Plan Rendering Provider Identifier	06/24/10	Text	ID PV002	28	28	Plan Rendering Number	No
MC	136	MC135	Provider Location	06/24/10	Text	ID PV002	28	28	Location of Provider	No
MC	137	MC136	Discharge Diagnosis	06/24/10	Text	Med Diagnosis	7	5	ICD Discharge Diagnosis Code	No
MC	138	MC137	CarrierSpecificUniqueMemberID	10/15/10	Text	ID	20	20	Member/Patient Carrier Unique Identification	Yes
MC	139	MC138	Claim Line Type	06/24/10	Text	Lookup Table	10	10	Claim Line Activity Type Code	No
MC	140	MC139	Former Claim Number	10/19/10	Text	ID	35	35	Previous Claim Number	No
MC	141	MC140	Member Address 2	06/24/10	Text	Address 2	50	50	Secondary Street Address of the Member/Patient	No
MC	142	MC141	CarrierSpecificUniqueSubscriberID	10/15/10	Text	ID	20	20	Subscriber Carrier Unique Identification	Yes
MC	143	MC899	Record Type	06/24/10	Text	ID	2	2	File Type Identifier	No
TR-MC	1	TR001	Record Type	06/24/10	Text	ID	2	2	Trailer Record Identifier	No
TR-MC	2	TR002	Payer	06/24/10	Text	ID Carrier	8	8	Carrier Specific Submitter Code as defined by APCD. This must match the Submitter Code reported in HD002	No
TR-MC	3	TR003	National Plan ID	06/24/10	Text	ID Nat'l Plan	30	30	CMS National Plan Identification Number (PlanID)	No
TR-MC	4	TR004	Type of File	06/24/10	Text	ID	2	2	This is an indicator that defines the type of file and the data contained within the file. This must match the File Type reported in HD004.	No

TR-MC	5	TR005	Period Beginning Date	06/24/10	Date Period	Year Month	6	6	Trailer Period Start Date	No
TR-MC	6	TR006	Period Ending Date	06/24/10	Date Period	Year Month	6	6	Trailer Period Ending Date	No
TR-MC	7	TR007	Date Processed	06/24/10	Date	Date Complete	8	8	Trailer Processed Date	No

Appendices

Appendix A – Submission Guideline

File	Col	Element	Data Element Name	Date Active (version)	Type	Format	Revised Length	Old Length	Element Submission Guideline	Required When	APCD Threshold	APCD - GIC Carrier Threshold	Encrypt Upon Intake
HD-MC	1	HD001	Record Type	06/24/10	Text	HD	2	2	This must have HD reported here. Indicates the beginning of the Header Elements of the file.	All	100%	same as APCD	No
HD-MC	2	HD002	Payer	06/24/10	Text		8	8	Carrier Specific Submitter Code as defined by APCD. This must match the Submitter Code reported in TR002	All	100%	same as APCD	No
HD-MC	3	HD003	National Plan ID	06/24/10	Text		30	30	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.	All	100%	same as APCD	No
HD-MC	4	HD004	Type of File	06/24/10	Text	MC	2	2	This must have MC reported here. This is an indicator that defines the type of file and the data contained within the file. This must match the File Type reported in TR004.	All	100%	same as APCD	No
HD-MC	5	HD005	Period Beginning Date	06/24/10	Date Period	CCYYMM	6	6	This is the start date period of the reported period in the submission file. This date period must match the date period reported in TR005	All	100%	same as APCD	No
HD-MC	6	HD006	Period Ending Date	06/24/10	Date Period	CCYYMM	6	6	This is the end date period of the reported period in the submission file; if the period reported is a single month of the same year then Period Begin Date and Period End Date will be the same date period. This date period must match the date period reported in TR006	All	100%	same as APCD	No
HD-MC	7	HD007	Record Count	06/24/10	Integer	#######	10	10	Total number of records submitted in this file	All	100%	same as APCD	No
HD-MC	8	HD008	Comments	06/24/10	Text	Free Text Comments	80	80	May be used to document the submission by assigning a filename, system source, compile identifier, etc.	All	0%	same as APCD	No

MC	1	MC001	Payer	06/24/10	Text		8	8	Payer submitting payments; APCD Submitter Code. This must match the Submitter Code reported in HD002	All	100%	same as APCD	No
MC	2	MC002	National Plan ID	10/03/10	Text		30	30	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.	All	0%	same as APCD	No
MC	3	MC003	Insurance Type Code/Product	06/24/10	Text	tlkpClaimInsuranceType	2	2	This field indicates the type of product the member has, such as HMO, PPO, POS, Auto Medical, Indemnity, and Workers Compensation.	All	92%	same as APCD	No
MC	4	MC004	Payer Claim Control Number	06/24/10	Text	Free Text Control Number	35	35	Unique identifier within the payer's system that applies to the entire claim	All	100%	same as APCD	No
MC	5	MC005	Line Counter	06/24/10	Integer		4	4	Line number for this service. Start with 1 and increment by 1 for each additional line of the claim	All	100%	same as APCD	No
MC	6	MC005A	Version Number	06/24/10	Integer	#######	4	4	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	All	100%	same as APCD	No
MC	7	MC006	Insured Group or Policy Number	06/24/10	Text		30	30	Do not report the number that uniquely identifies the subscriber	All	95%	same as APCD	No
MC	8	MC007	Subscriber SSN	10/15/10	Text	#########	9	128	Subscriber's social security number (set as null if unavailable); used to create unique member ID; will not be passed into analytic file. Do not use hyphen	All	79%	same as APCD	Yes
MC	9	MC008	Plan Specific Contract Number	06/24/10	Text		30	128	Plan assigned contract number (set as null if contract number = subscriber's social security number). Do not include values in this field that will distinguish one member of the family from another. If submitted, this should be the contract or certificate number for the subscriber and all of his/her dependents.	All	98%	same as APCD	Yes

MC	10	MC009	Member Suffix or Sequence Number	06/24/10	Text		20	20	Uniquely numbers the member within the contract	All	98%	same as APCD	No
MC	11	MC010	Member SSN	06/24/10	Text	#########	9	128	Member's social security number (set as null if unavailable). Do not use hyphen	All	73%	same as APCD	Yes
MC	12	MC011	Individual Relationship Code	06/24/10	Integer	tlkpIndividualRelathionshipCode	2	2	Indicator to define the Member/Patient's relationship to the Subscriber	All	98%	same as APCD	No
MC	13	MC012	Member Gender	06/24/10	Text	tlkpGender	1	1		All	98%	same as APCD	No
MC	14	MC013	Member Date of Birth	06/24/10	Date	CCYYMMDD	8	8	The date the member was born	All	98%	same as APCD	No
MC	15	MC014	Member City Name	06/24/10	Text	Free Text Address	30	30	City name of member	All	98%	same as APCD	No
MC	16	MC015	Member State or Province	06/24/10	Text	External Code Source 2	2	2	As defined by the US Postal Service	All	98%	same as APCD	No
MC	17	MC016	Member ZIP Code	06/24/10	Text	External Code Source 3	11	11	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; see External Code Source	All	98%	same as APCD	No
MC	18	MC017	Date Service Approved (AP Date)	06/24/10	Date	CCYYMMDD	8	8	This represents the date the service was approved for payment. This can be the same date as the Paid date when applicable.	All	93%	same as APCD	No
MC	19	MC018	Admission Date	06/24/10	Date	CCYYMMDD	8	8	Only applies to facility claims were Type of Bill = an inpatient setting. Date that the patient was admitted into an inpatient setting at the facility	Inpatient Admissions	98%	same as APCD	No
MC	20	MC019	Admission Hour	06/24/10	Integer	HHMM	4	4	Only applies to facility claims were Type of Bill = an inpatient setting. Time is expressed in military time. If only the hour is known, code the minutes as 00. 4 PM would be reported as 1600.	Inpatient	5%	same as APCD	No
MC	21	MC020	Admission Type	06/24/10	Integer	External Code Source 10	1	1	Only applies to facility claims were Type of Bill = an inpatient setting. This code indicates the type of admission into an inpatient setting.	Inpatient Admissions	98%	same as APCD	No

									Also known as Admission Priority.				
MC	22	MC021	Admission Source	06/24/10	Text	External Code Source 10	1	1	Only applies to facility claims were Type of Bill = an inpatient setting. This code indicates how the patient was referred into an inpatient setting at the facility.	Inpatient Admissions	80%	98%	No
MC	23	MC022	Discharge Hour	06/24/10	Integer	HHMM			HHMM.	Inpatient Discharges	5%	same as APCD	No
MC	24	MC023	Discharge Status	06/24/10	Integer	External Code Source 10	2	2	Discharge Status code of the patient as defined by External Code Source	Inpatient Discharges	98%	same as APCD	No
MC	25	MC024	Service Provider Number	06/24/10	Text		30	30	Payer assigned provider number. This field should capture the provider that rendered the service. This field should have a matching record in the provider file, and should be present in field (PV002) Provider ID.	All	99%	same as APCD	No
MC	26	MC025	Service Provider Tax ID Number	06/24/10	Text	#########	10	10	Do not use hyphen	All	97%	same as APCD	No
MC	27	MC026	National Service Provider ID	06/24/10	Text	External Code Source 4	20	20	NPI of the Servicing Provider in MC024. This information also needs to be in PV039 for the provider identified in MC024.	All	95%	98%	No
MC	28	MC027	Service Provider Entity Type Qualifier	06/24/10	Integer	tlkpServProvEntityTypeQualifier	1	1	HIPAA Provider Taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as “Person”.	All	98%	same as APCD	No
MC	29	MC028	Service Provider First Name	06/24/10	Text	Free Text Name	25	25	Individual first name. Set to null if provider is a facility or organization.	All	92%	same as APCD	No
MC	30	MC029	Service Provider Middle Name	06/24/10	Text	Free Text Name	25	25	Individual middle name or initial. Set to null if provider is a facility or organization.	All	2%	same as APCD	No

MC	31	MC030	Servicing Provider Last Name or Organization Name	06/24/10	Text	Free Text Name	60	60	Full name of provider organization or last name of individual provider	All	94%	same as APCD	No
MC	32	MC031	Service Provider Suffix	10/15/10	Text	tlkpLastNameSuffix	10	10	Suffix to individual name. Should be used to capture the generation of the individual clinician (e.g., Jr. Sr., III), if applicable, rather than the clinician's degree [e.g., 'MD', 'LICSW'].	All	2%	same as APCD	No
MC	33	MC032	Service Provider Specialty	06/24/10	Text	External Code Source 13 - AND/OR - Carrier Defined Reference Table	50	50	As defined by payer. Dictionary for specialty code values must be supplied to DHCFP. Specialty codes shall include specialties for all medical, vision, behavioral health and dental providers.	All	98%	same as APCD	No
MC	34	MC033	Service Provider City Name	06/24/10	Text	Free Text Address	30	30	City name of provider - preferably practice location	All	98%	same as APCD	No
MC	35	MC034	Service Provider State	06/24/10	Text	External Code Source 2	2	2	As defined by the US Postal Service	All	98%	same as APCD	No
MC	36	MC035	Service Provider ZIP Code	06/24/10	Text	External Code Source 3	11	11	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; see External Code Source	All	98%	same as APCD	No
MC	37	MC036	Type of Bill - on Facility Claims	06/24/10	Integer	External Code Source 10	2	2	Type of bill - see lookup table for valid values	Facility Claims Only	90%	98%	No
MC	38	MC037	Site of Service - on NSF/CMS 1500 Claims	06/24/10	Text	External Code Source 9	2	2	Should be coded on professional claims, such as those submitted using NSF [CMS 1500 forms].	Non-Facility	65%	same as APCD	No
MC	39	MC038	Claim Status	06/24/10	Integer	tlkpClaimStatus	2	2	Actually describes the payment status of the specific service line record. See lookup for valid values.	All	98%	same as APCD	No
MC	40	MC039	Admitting Diagnosis	06/24/10	Text	External Code Source 5	7	7	Diagnostic code assigned by provider that supported admission into an inpatient setting. This is not	Admissions	98%	same as APCD	No

									the same as Patient Reason for Visit.				
MC	41	MC040	E-Code	06/24/10	Text	External Code Source 5	7	5	The External Injury code for patients with trauma or accidents (ICD-9-CM)	All	3%	same as APCD	No
MC	42	MC041	Principal Diagnosis	06/24/10	Text	External Code Source 5	7	5	Primary ICD 9 Diagnosis Code	All	99%	same as APCD	No
MC	43	MC042	Other Diagnosis - 1	06/24/10	Text	External Code Source 5	7	5	Secondary Diagnosis Code	All	70%	same as APCD	No
MC	44	MC043	Other Diagnosis - 2	06/24/10	Text	External Code Source 5	7	5	ICD-9-CM	All	24%	same as APCD	No
MC	45	MC044	Other Diagnosis - 3	06/24/10	Text	External Code Source 5	7	5	ICD-9-CM	All	13%	same as APCD	No
MC	46	MC045	Other Diagnosis - 4	06/24/10	Text	External Code Source 5	7	5	ICD-9-CM	All	7%	same as APCD	No
MC	47	MC046	Other Diagnosis - 5	06/24/10	Text	External Code Source 5	7	5	ICD-9-CM	All	4%	same as APCD	No
MC	48	MC047	Other Diagnosis - 6	06/24/10	Text	External Code Source 5	7	5	ICD-9-CM	All	3%	same as APCD	No
MC	49	MC048	Other Diagnosis - 7	06/24/10	Text	External Code Source 5	7	5	ICD-9-CM	All	3%	same as APCD	No
MC	50	MC049	Other Diagnosis - 8	06/24/10	Text	External Code Source 5	7	5	ICD-9-CM	All	2%	same as APCD	No
MC	51	MC050	Other Diagnosis - 9	06/24/10	Text	External Code Source 5	7	5	ICD-9-CM	All	1%	same as APCD	No
MC	52	MC051	Other Diagnosis - 10	06/24/10	Text	External Code Source 5	7	5	ICD-9-CM	All	1%	same as APCD	No

MC	53	MC052	Other Diagnosis - 11	06/24/10	Text	External Code Source 5	7	5	ICD-9-CM	All	1%	same as APCD	No
MC	54	MC053	Other Diagnosis - 12	06/24/10	Text	External Code Source 5	7	5	ICD-9-CM	All	1%	same as APCD	No
MC	55	MC054	Revenue Code	06/24/10	Text	External Code Source 10	10	10	National Uniform Billing Committee Codes. Code using leading zeroes, left-justified, and four digits.	Hospital Claims	90%	98%	No
MC	56	MC055	Procedure Code	06/24/10	Text	External Code Source 7	10	10	Procedure code for the claim line	All	92%	98%	No
MC	57	MC056	Procedure Modifier - 1	06/24/10	Text	External Code Source 7	2	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.	All	20%	same as APCD	No
MC	58	MC057	Procedure Modifier - 2	06/24/10	Text	External Code Source 7	2	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.	All	3%	same as APCD	No
MC	59	MC058	ICD9-CM Procedure Code	06/24/10	Text	External Code Source 5	6	4	Primary ICD-9-CM surgical procedure code given on the claim header. Do not code Integer point.	Inpatient or OP Surgery Claims	66%	98%	No
MC	60	MC059	Date of Service - From	06/24/10	Date	CCYYMMDD	8	8	The date of service for the claim line	All	98%	same as APCD	No
MC	61	MC060	Date of Service - To	10/03/10	Date	CCYYMMDD	8	8	The end date of service for the claim. For inpatient claims, the room and board line may or may not equal the discharge date. Procedures delivered during the visit should indicate which date they occurred.	All	98%	same as APCD	No
MC	62	MC061	Quantity	10/03/10	Integer	#######	15	3	Count of services/units performed.	All	98%	same as APCD	No
MC	63	MC062	Charge Amount	06/24/10	Integer	DDDDCC	10	10	Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	All	99%	same as APCD	No
MC	64	MC063	Paid Amount	10/03/10	Integer	DDDDCC	10	10	Do not include withhold amounts in this field. Withhold amount will be collected in MC116. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	All	99%	same as APCD	No

MC	65	MC064	Prepaid Amount	06/24/10	Integer	DDDDCC	10	10	For capitated services, the fee for service equivalent amount. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	All	99%	same as APCD	No
MC	66	MC065	Copay Amount	06/24/10	Integer	DDDDCC	10	10	Defined as a preset, fixed amount. Example: $25.00 Copay for Office Visits. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	All	99%	same as APCD	No
MC	67	MC066	Coinsurance Amount	06/24/10	Integer	DDDDCC	10	10	The coinsurance amount here is defined as the amount calculated by the submitting Carrier. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	All	99%	same as APCD	No
MC	68	MC067	Deductible Amount	06/24/10	Integer	DDDDCC	10	10	The deductible amount here is defined as the amount calculated by the submitting Carrier. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	All	99%	same as APCD	No
MC	69	MC068	Patient Control Number	06/24/10	Text	Free Text Control Number	20	20	Encounter/Visit number assigned by a provider to identify patient treatment. Also known as the Patient Account Number	Hospital Claims	10%	same as APCD	No
MC	70	MC069	Discharge Date	06/24/10	Date	CCYYMMDD	8	8	The date the member was discharged from the facility	Inpatient Discharges where Discharge Status indicates a discharge	98%	same as APCD	No
MC	71	MC070	Service Provider Country Code	06/24/10	Text	External Code Source 1	30	30	Country name of provider – preferably practice location. Code US for United States.	All	98%	same as APCD	No

MC	72	MC071	DRG	06/24/10	Text	External Code Source 11	10	10	Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to DRGs transmitted from the hospital provider. 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 field with an “A” prefix, and with a hyphen separating the DRG and the complexity level (e.g. AXXX-XX).	Inpatient Discharges	20%	98%	No
MC	73	MC072	DRG Version	06/24/10	Text	External Code Source 11	2	2	Version number of the grouper used	Inpatient Discharges	20%	same as APCD	No
MC	74	MC073	APC	06/24/10	Text	External Code Source 16	4	4	Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to APCs transmitted from the health care provider.	Ambulatory claims	20%	same as APCD	No
MC	75	MC074	APC Version	06/24/10	Text	External Code Source 16	2	2	Version number of the grouper used	Ambulatory claims	20%	same as APCD	No
MC	76	MC075	Drug Code	06/24/10	Text	5-4-2 standard. Do not include hyphens	11	11	An NDC code used only when a medication is paid for as part of a medical claim pr 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 without hyphenation	All	1%	same as APCD	No
MC	77	MC076	Billing Provider Number	06/24/10	Text		30	30	Payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. This value in this field needs to be a record in the provider file, and the value should be in PV002 Provider ID.	All	99%	same as APCD	No

MC	78	MC077	National Billing Provider ID	06/24/10	Text	External Code Source 4	20	20	National Provider ID (NPI). This field should be found on the Provider File in the NPI field (PV039)	All	99%	same as APCD	No
MC	79	MC078	Billing Provider Last Name or Organization Name	06/24/10	Text	Free Text Name	60	60	Full name of provider organization or last name of individual provider	All	99%	same as APCD	No
MC	80	MC079	Product ID Number	10/03/10	Text	ID PR001	20	20	Must correspond to the ProductID (PR001) on the Product file. This number should allow the Division to understand what product a member is enrolled in during the timeframe of the claim submission and must equal a value on the product file.	All	100%	same as APCD	No
MC	81	MC080	Reason for Adjustment	06/24/10	Text	External Code Source 14	4	4	Describes the reason for the claims adjustment. Carriers shall submit a list of codes and descriptions for this field	Adjusted claims	80%	98%	No
MC	82	MC081	Capitated Encounter Flag	06/24/10	Integer	tlkpFlagIndicators	1	1	1 = Yes payment for this service is covered under a capitated arrangement.	All	100%	same as APCD	No
MC	83	MC082	Member Street Address	06/24/10	Text	Free Text Address	50	50	The member should always be the patient except if it is a newborn.	All	90%	same as APCD	No
MC	84	MC083	Other ICD-9-CM Procedure Code - 1	06/24/10	Text	External Code Source 5	6	4	This is used to report the second ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary.	Facility Claims	1%	same as APCD	No
MC	85	MC084	Other ICD-9-CM Procedure Code - 2	06/24/10	Text	External Code Source 5	6	4	This is used to report the third ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary.	Facility Claims	1%	same as APCD	No
MC	86	MC085	Other ICD-9-CM Procedure Code - 3	06/24/10	Text	External Code Source 5	6	4	This is used to report the fourth ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary.	Facility Claims	1%	same as APCD	No

MC	87	MC086	Other ICD-9-CM Procedure Code - 4	06/24/10	Text	External Code Source 5	6	4	This is used to report the fifth ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary.	Facility Claims	1%	same as APCD	No
MC	88	MC087	Other ICD-9-CM Procedure Code - 5	06/24/10	Text	External Code Source 5	6	4	This is used to report the sixth ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary.	Facility Claims	1%	same as APCD	No
MC	89	MC088	Other ICD-9-CM Procedure Code - 6	06/24/10	Text	External Code Source 5	6	4	This is used to report the seventh ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary.	Facility Claims	1%	same as APCD	No
MC	90	MC089	Paid Date	06/24/10	Date	CCYYMMDD	8	8	Date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment. This can be the same date as Processed Date. Example: Claims paid in full, partial or zero paid	All	98%	same as APCD	No
MC	91	MC090	LOINC Code	10/08/10	Text		7	7	LOINC code, 'National' test code (lab work)	All	0%	same as APCD	No
MC	92	MC091	Filler	06/24/10	Filler	Filler	20	20	The APCD will reserve this field for possible future use. Please fill with null values in the format described.	All	0%	same as APCD	No
MC	93	MC092	Covered Days	06/24/10	Integer	###	3	3	Amount of inpatient days paid for by the carrier. If not available, the number of days authorized by the carrier for the admission.	Inpatient Claim Lines	80%	98%	No
MC	94	MC093	Non Covered Days	06/24/10	Integer	###	3	3	Amount of inpatient days that were not paid for by plan for the inpatient event. Enter 0 when not applicable	Inpatient Claim Lines	80%	98%	No
MC	95	MC094	Type of Claim	06/24/10	Text	tlkpTypeOfClaim	3	3	Indicates what type of claim was submitted for payment	All	100%		No

MC	96	MC095	Coordination of Benefits/TPL Liability Amount	06/24/10	Integer	DDDDCC	10	10	The amount that another carrier/insurer is liable for. Example is known 'gap coverage' where Payer-to-Payer transactions took place. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	All claim lines where there is secondary payer liability	0%	98%	No
MC	97	MC096	Other Insurance Paid Amount	06/24/10	Integer	DDDDCC	10	10	The amount paid/collected for the claim line that another carrier paid. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	Where claim status indicates paid as secondary payer	90%	98%	No
MC	98	MC097	Medicare Paid Amount	06/24/10	Integer	DDDDCC	10	10	If no Medicare payment is on the claim, code with 0. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	Claims with Medicare benefit (Medicare Benefit = Y)	98%	98%	No
MC	99	MC098	Allowed amount	06/24/10	Integer	DDDDCC	10	10	The maximum amount contractually allowed, which 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. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	All	99%	same as APCD	No
MC	100	MC099	Non-Covered Amount	06/24/10	Integer	DDDDCC	10	10	Dollar amount that was charged on a claim that is above the plans limitations. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	All	98%	98%	No
MC	101	MC100	Filler	06/24/10	Filler	Filler	10	10	The APCD will reserve this field for possible future use. Please fill with null values in the format described.	All	0%	same as APCD	No

MC	102	MC101	Subscriber Last Name	10/15/10	Text	Free Text Name	60	128	Used to create unique member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. Example: O'Brien becomes OBRIEN; Carlton-Smythe become CARLTONSMYTHE	All	98%	same as APCD	Yes
MC	103	MC102	Subscriber First Name	10/15/10	Text	Free Text Name	25	128	Used to create unique member ID. First 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: Anne-Marie becomes ANNEMARIE	All	98%	same as APCD	Yes
MC	104	MC103	Subscriber Middle Initial	10/15/10	Text	Free Text Name	1	1	Used to create unique member ID.	All	2%	same as APCD	No
MC	105	MC104	Member Last Name	06/24/10	Text	Free Text Name	60	128	Member Last Name. Used to create unique member ID. Name should exclude all punctuation including hyphens and apostrophes and be reported all in upper case.	All	98%	same as APCD	Yes
MC	106	MC105	Member First Name	06/24/10	Text	Free Text Name	25	128	Member First Name. Used to create unique member ID. Name should exclude all punctuation including hyphens and apostrophes and be reported all in upper case.	All	98%	same as APCD	Yes
MC	107	MC106	Member Middle Initial	06/24/10	Text	Free Text Name	1	1	Used to create unique member ID	All	2%	same as APCD	No
MC	108	MC107	Filler	06/24/10	Filler	Filler	5	5	The APCD will reserve this field for possible future use. Please fill with null values in the format described.	All	0%	same as APCD	No
MC	109	MC108	Procedure Modifier - 3	06/24/10	Text	External Code Source 7	2	2	Procedure modifier (3rd) required when a modifier clarifies/improves the reporting accuracy of the associated procedure code in MC055.	All	0%	same as APCD	No
MC	110	MC109	Procedure Modifier - 4	06/24/10	Text	External Code Source 7	2	2	Procedure modifier (4th) required when a modifier clarifies/improves the reporting accuracy of the	All	0%	same as APCD	No

									associated procedure code in MC055.				
MC	111	MC110	Claim Processed Date	06/24/10	Date	CCYYMMDD	8	8	This is the date the claim was processed by the carrier. This date can be equal to Paid Date, but cannot be after Paid Date.	All	98%	98%	No
MC	112	MC111	Diagnostic Pointer	06/24/10	Text	#	1	1	Indicates which diagnosis a procedure is related to for a professional claim	Professional Claims	90%	98%	No
MC	113	MC112	Referring Provider ID	06/24/10	Text		28	28	The identifier of the provider that submitted the referral for the service or ordered the test that is on the claim (if applicable). This can be an internal identifier or can be the NPI. The value in this field must have a corresponding Provider ID (PV002) on the provider file.	Where MC118=1	98%	98%	No
MC	114	MC113	Payment Arrangement Type	06/24/10	Text	tlkpPaymentArrangementType	2	2	Capitation, Fee for service, Percent of Charges, DRG, P4P, Global Payment, Other. See lookup for valid domain of values.	All	90%	98%	No
MC	115	MC114	Excluded Expenses	06/24/10	Integer	DDDDCC	10	10	Example: Patient has over utilized number of Physical Therapy units. Authorized for 15, utilized 20. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	All	80%	98%	No
MC	116	MC115	Medicare Indicator	06/24/10	Text	tlkpFlagIndicators	1	1	1 = Yes, Medicare paid for part or all of services.	All	100%	98%	No
MC	117	MC116	Withhold Amount	06/24/10	Integer	DDDDCC	10	10	The amount paid to provider for this service if the provider qualifies/meets performance guarantees. Code zero cents (00) where applicable. Example: 150.00 will be reported as 15000.	All	80%	98%	No
MC	118	MC117	Authorization Needed	06/24/10	Integer	tlkpFlagIndicators	1	1	1 = Yes service required a pre-authorization.	All	100%	100%	No
MC	119	MC118	Referral Indicator	06/24/10	Text	tlkpFlagIndicators	1	1	1 = Yes service was preceded by a referral.	All	100%	100%	No
MC	120	MC119	PCP Indicator	06/24/10	Text	tlkpFlagIndicators	1	1	1 = Yes service was performed by members PCP.	All plans that require PCPs	100%	100%	No

MC	121	MC120	DRG Level	06/24/10	Text	External Code Source 11	3	3	Applicable if additional level used for severity adjustment (1-4 mild, moderate, major and extreme)	Hospital Claims where DRG field is reported	80%	same as APCD	No
MC	122	MC121	Filler	06/24/10	Filler	Filler	5	5	The APCD will reserve this field for possible future use. Please fill with null values in the format described.	All	0%	same as APCD	No
MC	123	MC122	Global Payment Flag	06/24/10	Text	tlkpFlagIndicators	1	1	1 = Yes the claim line was paid under a global payment arrangement.	All	100%	same as APCD	No
MC	124	MC123	Denied Flag	06/24/10	Text	tlkpFlagIndicators	1	1	1 = Yes, Claim Line was denied.	Denied claims	100%	98%	No
MC	125	MC124	Denial Reason	10/14/10	Text	Carrier Defined Reference Table	10	2	Reason for denial of the claim line. Carrier must submit denial reason codes in separate table to Division.	Denied claim lines	80%	98%	No
MC	126	MC125	Attending Provider	06/24/10	Text		28	28	Attending provider for hospital claims. 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.	Inpatient	98%	same as APCD	No
MC	127	MC126	Accident Indicator	06/24/10	Text	tlkpFlagIndicators	1	1	1 = Yes, Claim Line is Accident related.	All	100%	100%	No
MC	128	MC127	Family Planning Indicator	10/15/10	Text	tlklpFamilyPlanning	1	1	Flag indicating if family planning services were provided (values based on MassHealth encounter table). The threshold for this field applies to Medicaid lines of business only. See lookup table for valid values.	Medicaid MCOs only	90%	98%	No
MC	129	MC128	Employment Related Indicator	06/24/10	Text	tlkpFlagIndicators	1	1	1 = Yes, Claim Line was related to employment accident.	All	100%	100%	No
MC	130	MC129	EPSDT Indicator	10/15/10	Text	tlkpEPSDTIndicator	1	1	A flag that indicates if service was related to EPSDT and the type of EPSDT service such as 'screening', 'treatment' or 'referral'. The threshold for this field applies to Medicaid lines of business only. See lookup table for valid values.	Medicaid MCOs only	90%	98%	No

MC	131	MC130	Procedure Code Type	06/24/10	Text	tlkpProcedureCodeType	1	1	For field MC055 Procedure Code, the type of code represented in that field such as CPT, HCPCS, Homegrown, etc. See lookup for valid values	All	80%	98%	No
MC	132	MC131	InNetwork Indicator	06/24/10	Text	tlkpFlagIndicators	1	1	1 = Yes claim was paid at in or out of network rates.	All	100%	100%	No
MC	133	MC132	Service Class	06/24/10	Text	Carrier Defined Reference Table	2	2	Field used to define service class for Medicaid PCC members receiving behavioral health (values based on MassHealth encounter table)	Medicaid MCOs only	10%	same as APCD	No
MC	134	MC133	Filler	06/24/10	Filler	Filler	2	2	The APCD will reserve this field for possible future use. Please fill with null values in the format described.	All	0%	same as APCD	No
MC	135	MC134	Plan Rendering Provider Identifier	06/24/10	Text		28	28	Unique code which identifies for the carrier 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%	same as APCD	No
MC	136	MC135	Provider Location	06/24/10	Text		28	28	Unique code which identifies the location/site of the service provided by the 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 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%	same as APCD	No
MC	137	MC136	Discharge Diagnosis	06/24/10	Text	External Code Source 5	7	5	The ICD9 diagnosis code given to a member upon discharge, which may or may not be the same as the primary diagnosis and admitting diagnosis.	Discharges	80%	same as APCD	No

MC	138	MC137	CarrierSpecificUniqueMemberID	10/15/10	Text		20	20	This is the number the carrier uses internally to uniquely identify the member. This field will be encrypted upon intake. The value in this field must match the value in the carrier-specific, unique member ID field in the eligibility file (ME107).	All	100%	same as APCD	Yes
MC	139	MC138	Claim Line Type	06/24/10	Text	tlkpClaimLineType	10	10	Code Indicating Type of Record. Example: Original, Void, Replacement, Back Out, Amendment	All	90%	same as APCD	No
MC	140	MC139	Former Claim Number	10/14/10	Text	ID	35	35	Use of "Former Claim Number" to version claims can **only** be used if approved by DHCFP. Contact Paul Smith or your Carrier specific assigned APCD liaison at DHCFP. Most Carriers should **not** be using this field – see "Claim Voids and Replacements – Versioning Protocol.doc" for the standard protocol.	All	0%	same as APCD	No
MC	141	MC140	Member Address 2	06/24/10	Text	Free Text Address	50	50	Often used to capture apartment numbers, suites, etc.	All	1%	same as APCD	No
MC	142	MC141	CarrierSpecificUniqueSubscriberID	10/15/10	Text		20	20	This is the number the carrier uses internally to uniquely identify the subscriber. This field will be encrypted upon intake. The value in this field must match the value in the carrier-specific, unique subscriber ID field in the eligibility file (ME117).	All	100%	same as APCD	Yes
MC	143	MC899	Record Type	06/24/10	Text	MC	2	2	This must be reported as MC here. This is an indicator that defines the type of file and the data contained within the file. This must match the File Type reported in HD004.	All	100%	same as APCD	No
TR-MC	1	TR001	Record Type	06/24/10	Text	TR	2	2	This must be reported as TR here	All	100%	same as APCD	No
TR-MC	2	TR002	Payer	06/24/10	Text		8	8	Payer submitting payments; Council Submitter Code	All	100%	same as APCD	No
TR-MC	3	TR003	National Plan ID	06/24/10	Text		30	30	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.	All	100%	same as APCD	No
TR-MC	4	TR004	Type of File	06/24/10	Text	MC	2	2	This must have MC reported here	All	100%	same as APCD	No

TR-MC	5	TR005	Period Beginning Date	06/24/10	Date Period	CCYYMM	6	6	This is the start date period of the reported period in the submission file. This date period must match the date period reported in HD005	All	100%	same as APCD	No
TR-MC	6	TR006	Period Ending Date	06/24/10	Date Period	CCYYMM	6	6	This is the end date period of the reported period in the submission file; if the period reported is a single month of the same year then Period Begin Date and Period End Date will be the same date. This date period must match the date period reported in HD006	All	100%	same as APCD	No
TR-MC	7	TR007	Date Processed	06/24/10	Date	CCYYMMDD	8	8	This is the date that the submission was processed by the carrier for submission	All	100%	same as APCD	No

Appendix B – Lookup Tables by Element

File	Col	Element	Data Element Name	Date Active (version)	Type	Type Description	Revised Length	Format	Description	Element Submission Guideline	Required When	APCD Threshold	APCD - GIC Carrier Threshold
MC	3	MC003	Insurance Type Code/Product	06/24/10	Text	Lookup Table	2	tlkpClaimInsuranceType	Type / Product Identification Code	This field indicates the type of product the member has, such as HMO, PPO, POS, Auto Medical, Indemnity, and Workers Compensation.	All	92%	Same as APCD

Claim Insurance Type Code	*Claim Insurance Type*
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
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
TV	Title V
VA	Veterans Administration Plan

									WC	Workers' Compensation				
MC	12	MC011	Individual Relationship Code	06/24/10	Integer	Lookup Table	2	tlkpIndividualRelationshipCode	Member/Patient to Subscriber Relationship Code	Indicator to define the Member/Patient's relationship to the Subscriber	All	98%	Same as APCD
									Individual Relationship Code	***Individual Relationship***			
									1	Spouse			
									4	Grandfather or Grandmother			
									5	Grandson or Granddaughter			
									7	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	06/24/10	Text	Lookup Table	1	tlkpGender	Member/Patient's Gender		All	98%	Same as APCD
									Gender Code	***Gender***			
									F	Female			
									M	Male			
									O	Other			
									U	Unknown			

MC	28	MC027	Service Provider Entity Type Qualifier	06/24/10	Integer	Lookup Table	1	tlkpServProvEntityTypeQualifierCode	Service Provider Entity Identifier Code	HIPAA Provider Taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as "Person".	All	98%	Same as APCD
									Service Provider Entity Type Qualifier Code	***Service Provider Entity Type Qualifier***			
									1	Person			
									2	Non-person entity			
MC	32	MC031	Service Provider Suffix	10/15/10	Text	Name Suffix	10	tlkpLastNameSuffix	Provider Name Suffix	Suffix to individual name. Should be used to capture the generation of the individual clinician (e.g., Jr. Sr., III), if applicable, rather than the clinician's degree [e.g., 'MD', 'LICSW'].	All	2%	Same as APCD
									Last Name Suffix ID	***Last Name Suffix***			
									0	Unknown / Not Applicable			
									1	I.			
									2	II.			
									3	III.			
									4	Jr.			
									5	Sr.			
MC	39	MC038	Claim Status	06/24/10	Integer	Lookup Table	2	tlkpClaimStatus	Claim Line Status	Actually describes the payment status of the specific service line record. See lookup for valid values.	All	98%	Same as APCD
									Claim Status Code	***Claim Status***			
									01	Processed as primary			
									02	Processed as secondary			
									03	Processed as tertiary			
									04	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			

MC	82	MC081	Capitated Encounter Flag	06/24/10	Integer	Lookup Table	1	tlkpFlagIndicators	Indicates if the service is covered under a capitation arrangement.	1 = Yes payment for this service is covered under a capitated arrangement.	All	100%	Same as APCD
									Value	***Description***			
									1	Yes			
									2	No			
									3	Unknown			
									4	Other			
									5	Not Applicable			
MC	95	MC094	Type of Claim	06/24/10	Text	Lookup Table	3	tlkpTypeOfClaim	Type of Claim Indicator	Indicates what type of claim was submitted for payment	All	100%	
									Type Of Claim Code	***Type Of Claim***			
									001	Professional			
									002	Hospital			
									003	Reimbursement Form			
MC	114	MC113	Payment Arrangement Type	06/24/10	Text	Lookup Table	2	tlkpPaymentArrangementType	Payment Arrangement Code	Capitation, Fee for service, Percent of Charges, DRG, P4P, Global Payment, Other. See lookup for valid domain of values.	All	90%	98%
									Payment Arrangement Type Code	***Payment Arrangement Type***			
									01	Capitation			
									02	Fee for Service			
									03	Percent of Charges			
									04	DRG			
									05	Pay for Performance			
									06	Global Payment			
									07	Other			
MC	116	MC115	Medicare Indicator	06/24/10	Text	Lookup Table	1	tlkpFlagIndicators	Medicare Payment Indicator	1 = Yes, Medicare paid for part or all of services.	All	100%	98%
									Value	***Description***			
									1	Yes			
									2	No			
									3	Unknown			
									4	Other			
									5	Not Applicable			

MC	118	MC117	Authorization Needed	06/24/10	Integer	Lookup Table	1	tlkpFlagIndicators	Indicates if the service required a pre-authorization number for payment.	1 = Yes service required a pre-authorization.	All	100%	100%
									Value	***Description***			
									1	Yes			
									2	No			
									3	Unknown			
									4	Other			
									5	Not Applicable			
MC	119	MC118	Referral Indicator	06/24/10	Text	Lookup Table	1	tlkpFlagIndicators	Referral Required Indicator	1 = Yes service was preceded by a referral.	All	100%	100%
									Value	***Description***			
									1	Yes			
									2	No			
									3	Unknown			
									4	Other			
									5	Not Applicable			
MC	120	MC119	PCP Indicator	06/24/10	Text	Lookup Table	1	tlkpFlagIndicators	PCP Service Performance Indicator	1 = Yes service was performed by members PCP.	All plans that require PCPs	100%	100%
									Value	***Description***			
									1	Yes			
									2	No			
									3	Unknown			
									4	Other			
									5	Not Applicable			
MC	123	MC122	Global Payment Flag	06/24/10	Text	Lookup Table	1	tlkpFlagIndicators	Global Payment Method Indicator	1 = Yes the claim line was paid under a global payment arrangement.	All	100%	Same as APCD
									Value	***Description***			
									1	Yes			
									2	No			
									3	Unknown			
									4	Other			
									5	Not Applicable			

MC	124	MC123	Denied Flag	06/24/10	Text	Lookup Table	1	tlkpFlagIndicators	Denied Claim Line Indicator	1 = Yes, Claim Line was denied.	Denied claims	100%	98%
									Value	***Description***			
									1	Yes			
									2	No			
									3	Unknown			
									4	Other			
									5	Not Applicable			
MC	127	MC126	Accident Indicator	06/24/10	Text	Lookup Table	1	tlkpFlagIndicators	Service is related to an accident	1 = Yes, Claim Line is Accident related.	All	100%	100%
									Value	***Description***			
									1	Yes			
									2	No			
									3	Unknown			
									4	Other			
									5	Not Applicable			
MC	128	MC127	Family Planning Indicator	06/24/10	Text	ID	1	tlkpFamilyPlanning	Service is related to Family Planning	Flag indicating if family planning services were provided (values based on MassHealth encounter table). The threshold for this field applies to Medicaid lines of business only. See lookup table for valid values.	Medicaid MCO Required Reporting	90%	98%
									Family Planning Code	***Family Planning***			
									0	Unknown / Not Applicable / Not Avail			
									1	Family planning services provided			
									2	Abortion services provided			
									3	Sterilization services provided			
									4	No family planning services provided			
MC	129	MC128	Employment Related Indicator	06/24/10	Text	Lookup Table	1	tlkpFlagIndicators	Service related to Employment Injury	1 = Yes, Claim Line was related to employment accident.	All	100%	100%
									Value	***Description***			
									1	Yes			
									2	No			
									3	Unknown			
									4	Other			
									5	Not Applicable			

MC	130	MC129	EPSDT Indicator	10/15/10	Text	ID	1	tlkpEPSDTIndicator	Service related to Early Periodic Screening, Diagnosis and Treatment (EPSDT)	A flag that indicates if service was related to EPSDT and the type of EPSDT service such as 'screening', 'treatment' or 'referral'. The threshold for this field applies to Medicaid lines of business only. See lookup table for valid values.	Medicaid MCO Required Reporting	90%	98%
									EPSDT Indicator Code	***EPSDT Indicator***			
									0	Unknown / Not Applicable / Not Avail			
									1	EPSDT Screen			
									2	EPSDT Treatment			
									3	EPSDT Referral			
MC	131	MC130	Procedure Code Type	06/24/10	Text	Lookup Table	1	tlkpProcedureCodeType	Claim line Procedure Code Type Identifier	For field MC055 Procedure Code, the type of code represented in that field such as CPT, HCPCS, Homegrown, etc. See lookup for valid values	All	80%	98%
									Procedure Code Type Code	***Procedure Code Type***			
									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			
MC	132	MC131	InNetwork Indicator	06/24/10	Text	Lookup Table	1	tlkpFlagIndicators	Network rates applied identifier	1 = Yes claim was paid at in or out of network rates.	All	100%	100%
									Value	***Description***			
									1	Yes			
									2	No			
									3	Unknown			
									4	Other			
									5	Not Applicable			
MC	139	MC138	Claim Line Type	06/24/10	Text	Lookup Table	10	tlkpClaimLineType	Claim Line Activity Type Code	Code Indicating Type of Record. Example: Original, Void, Replacement, Back Out, Amendment	All	90%	Same as APCD

	Claim Line Type Code	Claim Line Type	
	O	Original	
	V	Void	
	R	Replacement	
	B	Back Out	
	A	Amendment	

Appendix C – Claim Mapping Reference

File	Col	Element	Data Element Name	Description	Revised Length	837/835 Mapping	UB04 Mapping	1500 Mapping
HD	1	HD001	Record Type	Header Record Identifier	2	N/A	N/A	N/A
HD	2	HD002	Payer	Header Submitter/Carrier ID	8	N/A	N/A	N/A
HD	3	HD003	National Plan ID	Header CMS National Plan Identification Number (PlanID)	30	N/A	N/A	N/A
HD	4	HD004	Type of File	Header Type of File	2	N/A	N/A	N/A
HD	5	HD005	Period Beginning Date	Header Period Start Date	6	N/A	N/A	N/A
HD	6	HD006	Period Ending Date	Header Period Ending Date	6	N/A	N/A	N/A
HD	7	HD007	Record Count	Header Record Count	10	N/A	N/A	N/A
HD	8	HD008	Comments	Header Carrier Comments	80	N/A	N/A	N/A
M	1	MC001	Payer	Carrier Specific Submitter Code as defined by APCD.	8	N/A	N/A	N/A
M	2	MC002	National Plan ID	CMS National Plan Identification Number (PlanID)	30	N/A	N/A	N/A
M	3	MC003	Insurance Type Code/Product	Type / Product Identification Code	2	N/A	N/A	N/A
M	4	MC004	Payer Claim Control Number	Payer Claim Control Identification	35	Loop 2300 REF02 where REF01 = F8	FL 64A, 64B, 64C	N/A
M	5	MC005	Line Counter	Incremental Line Counter	4	Loop 2400 LX01	Default spacing	Default spacing
M	6	MC005A	Version Number	Claim service line version number	4	N/A	N/A	N/A
M	7	MC006	Insured Group or Policy Number	Carriers group or policy number	30	Loop 2010BA REF02 where REF01 = IG	FL 62	Box 11
M	8	MC007	Subscriber SSN	Subscriber's Social Security Number	9	Loop 2010BA REF02 where REF01 = SY	FL 60a, 60b, 60c	N/A
M	9	MC008	Plan Specific Contract Number	Plan Specific Contract Number	30	N/A	N/A	N/A
M	10	MC009	Member Suffix or Sequence Number	Member/Patient's Contract Sequence Number	20	Loop 2010CA REF02 where REF01 = IG	FL 62	Box 11
M	11	MC010	Member SSN	Member/Patient's Social Security Number	9	Loop 2010CA REF02 where REF01 = SY	N/A	N/A

M	12	MC011	Individual Relationship Code	Member/Patient to Subscriber Relationship Code	2	Loop 2000C PAT01	FL 59	Box 6
M	13	MC012	Member Gender	Member/Patient's Gender	1	Loop 2010CA DMG 03	FL 11	Box 3 this is concatenated with Birthdate and only M or F is allowed
M	14	MC013	Member Date of Birth	Member/Patient's date of birth	8	Loop 2010CA DMG 02	FL 10	Box 3 this is concatenated with Gender
M	15	MC014	Member City Name	City name of the Member/Patient	30	Loop 2010CA N401	FL 9b	Box that follows Box 5 - no enumeration
M	16	MC015	Member State or Province	State of the Member/Patient	2	Loop 2010CA N402	FL 9c	Box that follows Box 5 - no enumeration
M	17	MC016	Member ZIP Code	State of the Member/Patient	11	Loop 2010CA N403	FL 9d	Box that follows Box 5 - no enumeration
M	18	MC017	Date Service Approved (AP Date)	Date Service Approved	8	N/A	N/A	N/A
M	19	MC018	Admission Date	Inpatient Admit Date	8	Loop 2300 DTP02 where DTP01 = 435	FL 12	Box 18 concatenated with Discharge Date
M	20	MC019	Admission Hour	Admission Time	4	Loop 2300 DTP02 where DTP01 = 435 (not available on the 837P)	FL 13	N/A
M	21	MC020	Admission Type	Admission Type Code	1	Loop 2300 CL101 (not available on the 837P)	FL 14	N/A
M	22	MC021	Admission Source	Admission Source Code	1	Loop 2300 CL102 (not available on the 837P)	FL 15	N/A
M	23	MC022	Discharge Hour	Discharge Time		Loop 2300 DTP03 where DTP01 = 096	FL 16	N/A
M	24	MC023	Discharge Status	Inpatient Discharge Status Code	2	Loop 2300 CL103	FL 17	N/A
M	25	MC024	Service Provider Number	Service Provider Identification Number	30	N/A	N/A	N/A
M	26	MC025	Service Provider Tax ID Number	Service Provider's Tax ID number	10	835 Loop 2100 NM109 where NM108 = FI	N/A	N/A
M	27	MC026	National Service Provider ID	National Provider Identification (NPI) of the Service Provider	20	835 Loop 2100 NM109 where NM108 = XX	N/A	N/A
M	28	MC027	Service Provider Entity Type Qualifier	Service Provider Entity Identifier Code	1	N/A	N/A	N/A

M	29	MC028	Service Provider First Name	First name of Service Provider	25	835 Loop 2100 NM104 where NM101 = 82 and NM102 = 1	N/A	N/A
M	30	MC029	Service Provider Middle Name	Middle initial of Service Provider	25	835 Loop 2100 NM105 where NM101 = 82 and NM102 = 1	N/A	N/A
M	31	MC030	Servicing Provider Last Name or Organization Name	Last name or Organization Name of Service Provider	60	835 Loop 2100 NM103 where NM101 = 82 and NM102 = 1 for Person or NM102 = 2 for Organization	N/A	N/A
M	32	MC031	Service Provider Suffix	Provider Name Suffix	10	835 Loop 2100 NM107 where NM101 = 82 and NM102 = 1	N/A	N/A
M	33	MC032	Service Provider Specialty	Specialty Code	50	N/A	N/A	N/A
M	34	MC033	Service Provider City Name	City Name of the Provider	30	835 Loop 1000A N401	N/A	N/A
M	35	MC034	Service Provider State	State of the Service Provider	2	835 Loop 1000A N402	N/A	N/A
M	36	MC035	Service Provider ZIP Code	State of the Service Provider	11	835 Loop 1000A N403	N/A	N/A
M	37	MC036	Type of Bill - on Facility Claims	Type of Bills as used on Institutional Claims	2	Loop 2300 CLM05 - 1	FL 4	N/A
M	38	MC037	Site of Service - on NSF/CMS 1500 Claims	Place of Service Code as used on Professional Claims	2	Loop 2300 CLM05 - 1	N/A	Box 24b
M	39	MC038	Claim Status	Claim Line Status	2	N/A	N/A	N/A
M	40	MC039	Admitting Diagnosis	Admitting Diagnosis Code	7	Loop 2300 HI02-2 where HI02-1 = BJ	FL 69	Box 21.1
M	41	MC040	E-Code	ICD Diagnostic External Injury Code	7	Loop 2300 HI03-2 where HI03-1 = BN	FL 72A	Box 21.2, .3 or .4
M	42	MC041	Principal Diagnosis	ICD Primary Diagnosis Code	7	Loop 2300 HI01-2 where HI01-1 = BK	FL 67	Box 21.1
M	43	MC042	Other Diagnosis - 1	ICD Secondary Diagnosis Code	7	Loop 2300 HI01-2 where HI01-1 = BF	FL 67A	Box 21.2
M	44	MC043	Other Diagnosis - 2	ICD Other Diagnosis Code	7	Loop 2300 HI02-2 where HI02-1 = BF	FL 67B	Box 21.3
M	45	MC044	Other Diagnosis - 3	ICD Other Diagnosis Code	7	Loop 2300 HI03-2 where HI03-1 = BF	FL 67C	N/A
M	46	MC045	Other Diagnosis - 4	ICD Other Diagnosis Code	7	Loop 2300 HI04-2 where HI04-1 = BF	FL 67D	Box 21.4

M	47	MC046	Other Diagnosis - 5	ICD Other Diagnosis Code	7	Loop 2300 HI05-2 where HI05-1 = BF	FL 67E	N/A
M	48	MC047	Other Diagnosis - 6	ICD Other Diagnosis Code	7	Loop 2300 HI06-2 where HI06-1 = BF	FL 67F	N/A
M	49	MC048	Other Diagnosis - 7	ICD Other Diagnosis Code	7	Loop 2300 HI07-2 where HI07-1 = BF	FL 67G	N/A
M	50	MC049	Other Diagnosis - 8	ICD Other Diagnosis Code	7	Loop 2300 HI08-2 where HI08-1 = BF	FL 67H	N/A
M	51	MC050	Other Diagnosis - 9	ICD Other Diagnosis Code	7	Loop 2300 HI09-2 where HI09-1 = BF	FL 67I	N/A
M	52	MC051	Other Diagnosis - 10	ICD Other Diagnosis Code	7	Loop 2300 HI10-2 where HI10-1 = BF	FL 67J	N/A
M	53	MC052	Other Diagnosis - 11	ICD Other Diagnosis Code	7	Loop 2300 HI11-2 where HI11-1 = BF	FL 67K	N/A
M	54	MC053	Other Diagnosis - 12	ICD Other Diagnosis Code	7	Loop 2300 HI12-2 where HI12-1 = BF	FL 67L	N/A
M	55	MC054	Revenue Code	Revenue Code as defined for use on an Institutional Claim	10	Loop 2400 SV201	FL 42	N/A
M	56	MC055	Procedure Code	HCPCS / CPT Code	10	Hospital: Loop 2400 SV202-2 Professional: Loop 2400 SV102-2	FL 44	Box 24d
M	57	MC056	Procedure Modifier - 1	HCPCS / CPT Code Modifier	2	Loop 2400 SV202-3	FL 44	Box 24d
M	58	MC057	Procedure Modifier - 2	HCPCS / CPT Code Modifier	2	Loop 2400 SV202-4	FL 44	Box 24d
M	59	MC058	ICD9-CM Procedure Code	ICD Primary Procedure Code	6	Loop 2300 HI01-2 where HI01-1 = BP or BR	FL 74	N/A
M	60	MC059	Date of Service - From	Date of Service	8	Outpatient 835 Loop 2110 DTM02 where DTM01 = 472 Inpatient 835 Loop 2100 DTM 02 where DTM01 = 232	Outpatient FL 45 Inpatient FL 06	Box 24A
M	61	MC060	Date of Service - To	Date of Service	8	Outpatient 835 Loop 2110 DTM02 where DTM01 = 472 Inpatient 835 Loop 2100 DTM02 where DTM01 = 233	Outpatient FL 45 Inpatient FL 06	Box 24A
M	62	MC061	Quantity	Claim line units of service	15	Loop 2400 SV205	FL 46	N/A
M	63	MC062	Charge Amount	Amount of provider charges for the claim line	10	837I Loop 2400 SV203 837P Loop 2400 SV102.	FL 47	Box 24f
M	64	MC063	Paid Amount	Amount paid by the carrier for the claim line	10	835 Loop 2110 SVC03	N/A	N/A

M	65	MC064	Prepaid Amount	Amount carrier has prepaid towards claim line	10	N/A	N/A	N/A
M	66	MC065	Copay Amount	Amount of Copay member/patient is responsible to pay	10	835 Loop 2110 CAS03 where CAS02 = 3	N/A	N/A
M	67	MC066	Coinsurance Amount	Amount of coinsurance member/patient is responsible to pay	10	835 Loop 2110 CAS03 where CAS02 = 2	N/A	N/A
M	68	MC067	Deductible Amount	Amount of deductible member/patient is responsible to pay on the claim line	10	835 Loop 2110 CAS03 where CAS02 = 1	N/A	N/A
M	69	MC068	Patient Control Number	Patient Control Number	20	Loop 2300 CLM01	FL 3a	Box 25
M	70	MC069	Discharge Date	Discharge Date	8	Loop 2300 DPT03 last eight digits when DTP02 = RD8	FL 6	Box 18 concatenated with Admit Date
M	71	MC070	Service Provider Country Code	Country name of the Provider	30	N/A	N/A	N/A
M	72	MC071	DRG	Diagnostic Related Group (DRG) Code	10	N/A	N/A	N/A
M	73	MC072	DRG Version	Diagnostic Related Group (DRG) Code Version Number	2	N/A	N/A	N/A
M	74	MC073	APC	Ambulatory Payment Classification (APC) Number	4	N/A	N/A	N/A
M	75	MC074	APC Version	Ambulatory Payment Classification (APC) Version	2	N/A	N/A	N/A
M	76	MC075	Drug Code	National Drug Code (NDC)	11	Loop 2410 LIN03 where LIN02 = N4	FL 44 with conditional coding in FL42 for appropriate Revenue Code.	N/A
M	77	MC076	Billing Provider Number	Billing Provider Number	30	Loop 2010AA REF02 where REF01 = 1A, 1B, 1C, 1D, 1G, 1H, B3, BQ, EI, FH, G2, G5, LU, SY, X5	Unassigned	Box 33a
M	78	MC077	National Billing Provider ID	National Provider Identification (NPI) of the Billing Provider	20	Loop 2010AA NM109 where NM101 = 85 and NM108 = XX	Unassigned	Box 33a
M	79	MC078	Billing Provider Last Name or Organization Name	Last name or Organization Name of Billing Provider	60	Loop 2010AA NM103 where NM101 = 85	FL 1	Box 33

M	80	MC079	Product ID Number	Product Identification Number	20	N/A	N/A	N/A
M	81	MC080	Reason for Adjustment	Reason for Adjustment Code	4	N/A	N/A	N/A
M	82	MC081	Capitated Encounter Flag	Indicates if the service is covered under a capitation arrangement.	1	Loop 2300 CN101 = 05	N/A	N/A
M	83	MC082	Member Street Address	Street address of the Member/Patient	50	Loop 2010CA N301	FL 9a	Box 5
M	84	MC083	Other ICD-9-CM Procedure Code - 1	ICD Secondary Procedure Code	6	Loop 2300 HI01-2 where HI01-1 = BO or BQ	FL 74a	N/A
M	85	MC084	Other ICD-9-CM Procedure Code - 2	ICD Other Procedure Code	6	Loop 2300 HI02-2 where HI02-1 = BO or BQ	FL 74b	N/A
M	86	MC085	Other ICD-9-CM Procedure Code - 3	ICD Other Procedure Code	6	Loop 2300 HI03-2 where HI03-1 = BO or BQ	FL 74c	N/A
M	87	MC086	Other ICD-9-CM Procedure Code - 4	ICD Other Procedure Code	6	Loop 2300 HI04-2 where HI04-1 = BO or BQ	FL 74d	N/A
M	88	MC087	Other ICD-9-CM Procedure Code - 5	ICD Other Procedure Code	6	Loop 2300 HI05-2 where HI05-1 = BO or BQ	FL 74e	N/A
M	89	MC088	Other ICD-9-CM Procedure Code - 6	ICD Other Procedure Code	6	Loop 2300 HI06-2 where HI06-1 = BO or BQ	N/A	N/A
M	90	MC089	Paid Date	Paid date of the claim line	8	Loop 2430 DTP03 where DTP01 = 573	N/A	N/A
M	91	MC090	LOINC Code	Logical Observation Identifiers, Names and Codes (LOINC) Code	7	N/A	N/A	N/A
M	92	MC091	Filler	The APCD will reserve this field for possible future use. Please fill with null values in the format described.	20	N/A	N/A	N/A
M	93	MC092	Covered Days	Covered Inpatient Days	3	Loop 2300 HI01-3 where HI01-1 = BE and HI01-2 = 80	FL39, FL40. FL41, a,b,c,d	N/A
M	94	MC093	Non Covered Days	Noncovered Inpatient Days	3	Loop 2300 HI01-3 where HI01-1 = BE and HI01-2 = 81	FL39, FL40. FL41, a,b,c,d	N/A

M	95	MC094	Type of Claim	Type of Claim Indicator	3	N/A	N/A	N/A
M	96	MC095	Coordination of Benefits/TPL Liability Amount	Amount due from a Secondary Carrier when known	10	N/A	N/A	N/A
M	97	MC096	Other Insurance Paid Amount	Amount paid by a Primary Carrier	10	Loop 2320 AMT02 where AMT01 = C4	FL 54A, 54B, 54C	Box 29
M	98	MC097	Medicare Paid Amount	Amount Medicare paid on claim	10	This can be obtained in the following loops: Loop 2320 AMT02 where AMT01 = C4, Loop 2320 AMT02 where AMT01 = N1 [defined as Total Medicare Paid]; Loop 2320 AMT02 where AMT01 = KF [defined as Medicare Paid 100%]; Loop 2320 AMT02 where AMT01 = PG [defined as Medicare Paid 80%]; Loop 2320 AMT02 where AMT01 = AA [defined as Medicare A Trust Fund Payment]; Loop 2320 AMT02 where AMT01 = B1 [defined as Medicare B Trust Fund Payment]	FL 54 at the line designation where Medicare is identified, usually 54a	Box 29
M	99	MC098	Allowed amount	Allowed Amount	10	Loop 2320 AMT02 where AMT01 = B6	Undefined, payers may be using Value Codes and Amounts to have this relayed back to them	N/A
M	100	MC099	Non-Covered Amount	Amount of claim line charge not covered	10	Noncovered Amount is reported in Loop 2320 AMT02 where AMT01 = A8. However, denied amount is reported in Loop 2320 AMT02 where AMT01 = YT	FL 48	N/A
M	101	MC100	Filler	The APCD will reserve this field for possible future use. Please fill with null values in the format described.	10	N/A	N/A	N/A
M	102	MC101	Subscriber Last Name	Last name of Subscriber	60	Loop 2000B NM103 where NM102 = IL	FL 59a, 59b, 59c and concatenated with First & Middle Name	Box 4 and concatenated with First & Middle Names
M	103	MC102	Subscriber First Name	First name of the Subscriber	25	Loop 2000B NM104 where NM102 = IL	FL 59a, 59b, 59c and concatenated with Last & Middle Name	Box 4 and concatenated with Last & Middle Names

M	104	MC103	Subscriber Middle Initial	Middle initial of Subscriber	1	Loop 2000B NM105 where NM102 = IL	FL 59a, 59b, 59c and concatenated with Last & First Name	Box 4 and concatenated with First & Last Names
M	105	MC104	Member Last Name	Last name of Member/Patient	60	Loop 2000C NM103 where NM101 = QC	FL 08b and concatenated with First & Middle Names	Box 2 and concatenated with First & Middle Names
M	106	MC105	Member First Name	First name of Member/Patient	25	Loop 2000C NM104 where NM101 = QC	FL 08b and concatenated with Last & Middle Names	Box 2 and concatenated with Last & Middle Names
M	107	MC106	Member Middle Initial	Middle initial of Member/Patient	1	Loop 2000C NM105 where NM101 = QC	FL 08b and concatenated with First & Last Names	Box 2 and concatenated with First & Last Names
M	108	MC107	Filler	The APCD will reserve this field for possible future use. Please fill with null values in the format described.	5	N/A	N/A	N/A
M	109	MC108	Procedure Modifier - 3	HCPCS / CPT Code Modifier	2	This is Line Level Data. Hospital HCPCS are reported in Loop 2400 SV202-2 where SV202-1 = HC its modifiers appear in SV202-3, SV202-4, SV202-5 and SV202-6. Professional HCPCS are reported in Loop 2400 SV101-2 where SV101-1 = HC its modifiers appear in SV101-3, SV101-4, SV101-5 and SV101-6	FL 44 and concatenated with HCPCS/CPTs	Box 24d and concatenated with HCPCS/CPTs
M	110	MC109	Procedure Modifier - 4	HCPCS / CPT Code Modifier	2	This is Line Level Data. Hospital HCPCS are reported in Loop 2400 SV202-2 where SV202-1 = HC its modifiers appear in SV202-3, SV202-4, SV202-5 and SV202-6. Professional HCPCS are reported in Loop 2400 SV101-2 where SV101-1 = HC its modifiers appear in SV101-3, SV101-4, SV101-5 and SV101-6	FL 44 and concatenated with HCPCS/CPTs	Box 24d and concatenated with HCPCS/CPTs
M	111	MC110	Claim Processed Date	Claim Processed Date	8	Loop 2330B DTP03 where DTP01 = 573	N/A	N/A
M	112	MC111	Diagnostic Pointer	Diagnostic Pointer Number	1	837P Loop 2400 SV107	N/A	Box 24e
M	113	MC112	Referring Provider ID	Referring Provider Number	28	N/A	N/A	N/A

M	114	MC113	Payment Arrangement Type	Payment Arrangement Code	2	Loop 2300 CN101	N/A	N/A
M	115	MC114	Excluded Expenses	Amount not covered at the claim line due to benefit/plan limitation	10	N/A	FL 48 or use of Value Codes	N/A
M	116	MC115	Medicare Indicator	Medicare Payment Indicator	1	N/A	FL 54A, 54B, 54C and must align to Medicare in FL 50A, B or C	N/A
M	117	MC116	Withhold Amount	Amount to be paid to the provider upon guarantee of performance	10	N/A	N/A	N/A
M	118	MC117	Authorization Needed	Indicates if the service required a pre-authorization number for payment.	1	Loop 2300 REF01 = G1	FL 63a, 63b, 63c	Box 23
M	119	MC118	Referral Indicator	Referral Required Indicator	1	Loop 2300 REF01 = 9F	FL 63a, 63b, 63c	Box
M	120	MC119	PCP Indicator	PCP Service Performance Indicator	1	N/A	N/A	N/A
M	121	MC120	DRG Level	Diagnostic Related Group (DRG) Code Level	3	N/A	N/A	N/A
M	122	MC121	Filler	The APCD will reserve this field for possible future use. Please fill with null values in the format described.	5	N/A	N/A	N/A
M	123	MC122	Global Payment Flag	Global Payment Method Indicator	1	N/A	N/A	N/A
M	124	MC123	Denied Flag	Denied Claim Line Indicator	1	N/A	N/A	N/A
M	125	MC124	Denial Reason	Denial Reason Code	10	N/A	N/A	N/A
M	126	MC125	Attending Provider	Attending Provider ID number found in the Provider File (PV002). This number is defined in the carrier's systems and may be equal to any other identifier, i.e., NPI, State License Number	28	N/A	N/A	N/A
M	127	MC126	Accident Indicator	Service is related to an accident	1	N/A	FL 29 [Accident State] used with FL 31-34 and Occ Code 01, 02, 03, 04, 05 [various accident types] and FL 39-41 and Val Code 45 (to report accident hour)	Box 10b

M	128	MC127	Family Planning Indicator	Service is related to Family Planning	1	N/A	N/A	N/A
M	129	MC128	Employment Related Indicator	Service related to Employment Injury	1	N/A	N/A	Box 8
M	130	MC129	EPSDT Indicator	Service related to Early Periodic Screening, Diagnosis and Treatment (EPSDT)	1	N/A	N/A	Box 24h
M	131	MC130	Procedure Code Type	Claim line Procedure Code Type Identifier	1	N/A	N/A	N/A
M	132	MC131	InNetwork Indicator	Network rates applied identifier	1	N/A	N/A	N/A
M	133	MC132	Service Class	Service Class Code	2	N/A	N/A	N/A
M	134	MC133	Filler	The APCD will reserve this field for possible future use. Please fill with null values in the format described.	2	N/A	N/A	N/A
M	135	MC134	Plan Rendering Provider Identifier	Plan Rendering Number	28	N/A	N/A	N/A
M	136	MC135	Provider Location	Location of Provider	28	N/A	N/A	N/A
M	137	MC136	Discharge Diagnosis	ICD Discharge Diagnosis Code	7	N/A	N/A	N/A
M	138	MC137	CarrierSpecificUniqueMemberID	Member/Patient Carrier Unique Identification	20	N/A	N/A	N/A
M	139	MC138	Claim Line Type	Claim Line Activity Type Code	10	N/A	N/A	N/A
M	140	MC139	Former Claim Number	Previous Claim Number	35	N/A	N/A	N/A
M	141	MC140	Member Address 2	Secondary Street Address of the Member/Patient	50	Loop 2010CA N302	FL 9a	Box 5
M	142	MC141	CarrierSpecificUniqueSubscriberID	Subscriber Carrier Unique Identification	20	N/A	N/A	N/A
M	143	MC899	Record Type	File Type Identifier	2	N/A	N/A	N/A
TR	1	TR001	Record Type	Trailer Record Identifier	2	N/A	N/A	N/A
TR	2	TR002	Payer	Carrier Specific Submitter Code as defined by APCD. This must match the Submitter Code reported in HD002	8	N/A	N/A	N/A
TR	3	TR003	National Plan ID	CMS National Plan Identification Number (PlanID)	30	N/A	N/A	N/A

TR	4	TR004	Type of File	This is an indicator that defines the type of file and the data contained within the file. This must match the File Type reported in HD004.	2	N/A	N/A	N/A
TR	5	TR005	Period Beginning Date	Trailer Period Start Date	6	N/A	N/A	N/A
TR	6	TR006	Period Ending Date	Trailer Period Ending Date	6	N/A	N/A	N/A
TR	7	TR007	Date Processed	Trailer Processed Date	8	N/A	N/A	N/A

Appendix D – External Code Sources

External Code Sources

1 Countries

American National Standards Institute
11 West 42nd Street, 13th Floor
New York, NY 10036

2 States and Other Areas of the US

U.S. Postal Service
National Information Data Center
P.O. Box 2977
Washington, DC 20013

3 Zip Codes

U.S. Postal Service
Washington, DC 20260

4 Centers for Medicare and Medicaid Services National Provider Identifier

Centers for Medicare and Medicaid Services
Office of Financial Management
Division of Provider/Supplier Enrollment
C4-10-07

7500 Security Boulevard
Baltimore, MD 21244-1850

5 International Classification of Diseases Clinical Modification, 9th Revision

U.S. Government Printing Office
P.O. Box 371954
Pittsburgh, PA 15250

6 International Classification of Diseases Clinical Modification, 10th Revision

National Center for Health Statistics
3311 Toledo Road
Hyattsville, MD 20782

7 Healthcare Common Procedural Coding System

Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MC 21244

8 American Dental Association

Salable Materials
American Dental Association
211 East Chicago Avenue
Chicago, IL 60611-2678

9 Place of Service Codes for Professional Claims

Centers for Medicare and Medicaid Services
CMSO, Mail Stop S2-01-16
7500 Security Blvd
Baltimore, MD 21244-1850

10 National Uniform Billing Committee (NUBC) Codes

National Uniform Billing Committee
American Hospital Association
One North Franklin
Chicago, IL 60606

11 Diagnosis Related Group Number (DRG)

Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402

12 National Drug Code Format

Federal Drug Listing Branch HFN-315
5600 Fishers Lane
Rockville, MD 20857

13 Health Care Provider Taxonomy

The National Uniform Claim Committee
c/o American Medical Association
515 North State Street
Chicago, IL 60610

14 Claim Adjustment Reason Codes

Blue Cross / Blue Shield Association
Interplan Teleprocessing Services Division
676 N. St. Clair Street
Chicago, IL 60611

15 North American Industry Classification System (NAICS)

National Technical Information Service
Alexandria, VA 22312

Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116-4737
Phone: (617) 988-3100
Fax: (617) 727-7662
Website: http://www.mass.gov/dhcfp

Publication Number: 10-295-HCF-02
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