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CENTER FOR IMPROVING VALUE IN HEALTH CARE (CIVHC)

Colorado All-Payer Claims Database DATA SUBMISSION GUIDE

Version 17 2025

REVISION HISTORY

Date	Version	Description	Author
2/2011	A/B	Initial draft; Added section on Data Quality Requirements and added Employer Name to the Eligibility Data File. Added Provider File and Pharmacy Eligibility File, with placeholder for Plan Details File.	A. Graziano
3/1/2011	C/D	General revisions and updates Added section numbering and data elements to insurance plan file. Added decisions reached during payer weekly DSG meeting	A. Graziano
4/27/2011	0	Incorporated decisions reached during payer weekly meetings including a revision to submission timelines, modification to data element definitions	A. Graziano
6/10/2011	0	Final adjustments made based on feedback from Cigna and United Healthcare. Modified timeline for data submission.	A. Graziano
7/14/11	1	Removed elements that are stated in the rule and removed certain data values in several data elements that are not relevant. Included the requirement to filter claims based on CRS 10-16-104(5)(d)(I)	A. Graziano
8/11	2/3/4d	Modified data element types, removed reference to small group plan types and filtering of mental health related claims. Provided definitions for field types. Corrected minor typos throughout the document and clarified the purpose of the header and trailer records. Incorporated decisions reached at the rules hearing on 8/23/11.	A. Graziano
1/22/13	4d	Added IP Procedure Code/Date, Present on Admission (POA), Dental columns, File Naming Convention Updates based on phase 1A and 1B experience.	S. Murphy
1/23/13	5 Draft	Added clarifications to required fields	L. Green
3/11/13	5 Draft	Final DSG approved at rules hearing	T. Campbell
2/14/2014	6 Draft	Added Address two, Provider Telephone Number, Added clarification to required and optional fields.	E. Perry
7/29/2015	7 Draft	Added new fields for the incorporation of self-funded claims.	E. Perry
4/1/2016	8 Draft	Amended the definition of SMG to align with federal regulation.	E. Perry

3/27/2017	9 Draft	Several changes made to fields to improve the comprehensiveness of the data.	E. Perry M. Tahir
5/1/2017	9 Draft	Final DSG 9 approved at rules hearing	E. Perry M. Tahir
5/25/2018	10 Draft	Added provision for the collection of additional data elements including: alternative payment models and prescription rebate information. Also added the collection of Medicare Beneficiary Identifiers and corrected typos.	
8/24/2018	10 Draft	Revisions on new data elements including APM and table B.1.J, corrected typos.	J. Tremaroli
10/17/2019	11 Draft	Modified definition, field type or field length to improve the quality of the data submitted for several data elements. Changed criteria for data elements that are important for measurement of healthcare cost, utilization or quality from being optional to being required. Modified definition of several data elements to be consistent with national standards from the APCD Council Common Data Layout and added useful data elements that are currently included in the CDL.	J. Tremaroli E. Perry
3/27/2020	11.5 Draft	Updated APM file to include Insurance Product Type Code, removed redundant fields, added year and payment arrangement type to Control Total file. Added Other Drugs to Drug Rebate file, added PBM contract information addendum, revised primary care definition for APM filings	J. Tremaroli
10/14/2020	12 Draft	Added APM contract information tab to Control Total file, cleaned up field instructions for clarity, added fields for HCPF parity work, added service facility address	J. Tremaroli
12/11/2020	12 Draft	Added fields to Drug Rebate file to capture volume of prescriptions, added expenditures/rebates associated with Value Based Payments (VBP) to the Drug Rebate file, added a VBP flag to the Pharmacy Claims file, added a Federal Poverty Level flag to the eligibility file	J. Tremaroli
1/26/2021	12 draft	Adjusted field requirements for added VBP files on MC and PC files from decision made at ED hearing on 1/21/21. Also added language that CIVHC will collect list of NDCs and other information associated with VBPs.	J. Tremaroli

8/16/2021	13 draft	Added VBPC file type, added PDAB file type, clarified definitions and instructions, added Market Option code to ME file, updated lookup tables, changed due date for annual files to September 1st instead of 30th	J. Tremaroli
9/29/2021	13 draft	Added collection of premiums, deductibles, and out of pocket maximums to ME file; added collection of rebates by drug manufacturer and therapeutic class in the DR file; added collection of provider recoupments on AM file	J. Tremaroli
11/1/2021	13 draft	Incorporated payer feedback, updated lookup table for Market Options field, adjusted field collection for PDAB file, added the collection of a flag to identify CO Option plans in the ME file, changed file collection standards for DR, AM, and CT files to .txt file format	J. Tremaroli
12/21/2021	13 draft	Cleaned up errors, updated definition of Drug Rebates/all other compensation, added and adjusted fields on the VBPC collection	J. Tremaroli
1/27/2022	13 draft	Added phrase in VB004 to clarify how to report NDCs in the case that a Value-Based Pharmaceutical Contract is negotiated at the drug level instead of the NDC level.	J. Tremaroli
7/8/2022	14 draft	Added RAE/MCO identification to ME file; clarified definitions and instructions for premiums, deductibles, out of pocket maximums, and language preference; added Payer Code field to AM file; clarified definition and instructions for Drug Manufacturer NDC/NHRIC Labeler Code field; Updated timelines and collection periods	A. Aguirre / M. Nam
8/30/2022	**14 draft**	**ME, MC, PC, MP file formats updated to reflect APCD CDL v2 field order. RAE breakout added to CT and AM files. Added clarification around expected value formatting for currency fields in CT and DR files. Added clarification for member premium and out of pocket fields in ME file.**	**A. Aguirre**
9/20/2022	14 draft	Reverted field order back to original DSG ordering	**A. Aguirre**
9/27/2022	14 draft	Added HIOS Plan ID field to ME file	**A. Aguirre**
3/9/2023	15 draft	Vision coverage indicator added to ME file.Vision claim indicator added to MC file	**A. Aguirre**
6/5/2023	15 draft	Denial reason field added to MC file to capture reason for fully denied claims. Provider Health System Affiliation field added to MC file.	**A. Aguirre**

		Definition of Health System added to A-4 Provider Data submission requirements. Added Claim Status values 04 – Denied and 23 – Not our claim; forwarded to additional payer(s) to table B.1.F. Percent of providers participating in APM by payer field added to CT file.	
Aug 2023	15 draft	Cleaned up errors and provided clarification per submitter feedback.	**A. Aguirre**
9/13/2023	15 draft	Reporting instructions added to CT file for RAE reporting where applicable	**A. Aguirre**
11/28/2023	15 draft	Provider Health System Affiliation removed from MC file and placed on MP file with instructions on how to populate the field.	**A. Aguirre**
2/19/2024	16 draft	Service Location NPI (MC222) added to MC file to provide more robust analysis.	**A. Aguirre**
5/7/2024	16 draft	Added more clarification to file specifications for PDAB. Added comments around date specifications for DR, PDAB and VBPC annual submissions.	**L. Wilkins**
5/10/2024	16 draft	Removed values '18' and 'DN' from Table B.1.A Insurance Type	**D. Velez**
5/10/2024	16 draft	Removed PC201 data element language referencing 'YYMM'.	**T. Musall**
6/2024	16 draft	Added reporting requirements clarification for ME149 and ME151,	**A. Aguirre**
06/13/2024	16 draft	Removed the 'x12' reference link from PC208.	**T.Musall**
06/14/2024	16 draft	Removed POS: Place of Service Reference Table B.1.E and replaced with link to the acceptable CMS place of service codes in MC037	**T.Musall**
6/26/2024	16 draft	Added clarification for CT019	**T.Giang**
7/2/2024	16 draft	Added PMPM (HD007) field to ME, MC, PC, MP, CT, AM, and DR header tables. Added Colorado PBM Registration Number (ME153) field. Added Formulary Tier (PC209). Submission of annual file waivers language added. Edited language around field labels for first row under File Format subsection.	**D. Velez**

7/15/2024	16 draft	Added CDL-NCP fields to AM/CT/AC files. Added test file submission requirements. Added Member Capitation File (CF). Table of Contents updates to include reference to table B.1.J.A APM Payment Subcategory values.	**A. Aguirre**
8/14/2024	16 draft	Added reporting clarification to Quantity field (MC061)	
8/15/2024	16 draft	Added header and trailer records to CF table. Added Benefit Plan Code field to MC and PC files.	**D. Velez**
9/3/2024	16 draft	Updated header records to include PMPM reporting by coverage type. HD007 – HD009	**A. Aguirre**
9/12/2024	16 draft	Removed Summary Report requirement for historical files	**D. Velez**
9/30/2024	16 draft	Corrected various field errors and added reporting clarifications. Added header record for vision PMPM (HD010) reporting to all file header records. Updated MC and PC PMPM fields with data elements to use in calculations.	**A. Aguirre**
10/2/2024	16 draft	PC201 default field format YYMM re-added to the field description. HCPF-only Benefit Plan Code Description added to MC and PC files.	**A. Aguirre**
12/11/2024	17 draft	Updated values for PC207 to match MC038B	**T.Giang**
12/30/2024	17 draft	Updated Section A-2 Medical Claims Data reporting requirements to include paid and denied claims.	**A. Aguirre**
01/02/2025	17 draft	Revised fields with instructions to leave blank to ensure consistency. Updated Section A-2 Medical	**D. Velez** Claims Data and A-3 Pharmacy Claims Data to revise wording.
4/15/2025	17 draft	Updated table B.1.J Alternative Payment Model (apm) Payment Category to include categories to report payment NOT linked to quality.	**A. Aguirre**
7/9/2025	16	Missed revision update of MC038B values changed from '1'/'2' to 'Y'/'N' in DSG v16.	**A. Aguirre**
7/15/2025	17 draft	Added requirement for annual test file submissions. Added annual file requirements timelines to all annual file types. Added DSNP IPT codes to B.1.A Insurance Product Type List. Added	**D. Velez**

		3N and 4N to B.1.J Alternative Payment Model (APM) Payment Category.	
9/5/2025	17 draft	Revisions include the addition of annual test file requirements and associated timelines, clarification of CSV file submission standards, inclusion of a "Methodology" field in the PDAB table, a requirement for annual registration, and defined offboarding procedures. CDT requirements have been added to the HCPCS list and to MC055 Outpatient Procedure Codes. Additional changes include a prohibition on submitting header names in files and updated naming conventions for both monthly and annual file submissions.	**D. Velez**
9/5/2025	17 draft	Therapeutic Class DR007 reporting requirement updated from required to optional in the Drug Rebate file.	**A. Aguirre**
9/15/2025	17 draft	Adding APM, DR, PB, VB, PB, and CT to annual file naming convention and requiring PC017 to be reported for all claims.	**D. Velez**
10/21/2025	17 draft	Noting previously made changes to DSGv17 for Onpoint transition: - Requirement of all files previously submitted as Excel files to be submitted as CSV files - Requirement to not include names of data element in files - Requirement to not include extended ASCII or non-printable characters - Changes to monthly file naming convention - Changes to annual file naming convention - Changes to payer code naming convention - Adding "File Type" and "Test File Flag" fields in all header records - Adding "Test File Flag" field in all trailer records - MC017 - Added "Denial Processed Date" to Data Element Name. Now required for all claims, including fully denied claims. - PC017 - Added "Denial Processed Date" to Data Element Name. Now required for all claims, including fully denied claims.	**D. Velez**

11/11/2025	17 draft	Adding that RowCount is required in the naming file convention for AC, VB, PD, and PB files.	**D. Velez**

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1.0 DATA SUBMISSION REQUIREMENTS - GENERAL

Data submissions detailed below will include eligibility, medical claims, pharmacy claims, provider data (Health Care Data), Alternative Payments, Drug Rebates, Value-Based Pharmacy Contracts, and Pharmacy Drug Affordability Board data. Field definitions and other relevant data associated with these submissions are specified in Exhibit A. These datasets have been developed by the APCD Council in collaboration with stakeholders across the nation. Refer to APCD Rule 0615 for definitions and other requirements.

Each payer will be required to submit to the Colorado All Payer Claims Database Administrator (CO PCD Administrator) documentation supporting their standard data extract files that will include a data dictionary mapping internal system data elements to the data elements defined in this DSG. The documentation should include a detailed description of how the data extracts are created and how the requirements of this DSG and the rule are accomplished, including specifications on what data is being excluded and the parameters that define that excluded data.

Any thresholds regarding the number of enrolled lives, as related to payer data submissions (or a payer's third-party administrator, administrative services only organization, or pharmacy benefit manager ("TPA/ASO/PBM"), should be calculated by the payer (or its TPA/ASO/PBM) on a minimum annual basis, reflecting a 12-month average. The method for calculating any such thresholds, and the results, must be provided in any payer supporting documentation or upon the CO APCD Administrator's request.

New payers must complete an initial registration and all payers must register annually. Registration must be completed within ten (10) business days of a request from the CO APCD Administrator and includes submission of the completed form.

1.1 DATA TO BE SUBMITTED

1.1.1 MEDICAL CLAIMS DATA

a) Payers shall report health care service claims that are paid, partially paid, and fully denied and encounters for all Colorado residents. Payers may be required to identify encounters corresponding to a capitation payment (Exhibit A-2).
b) A Colorado resident is defined as any eligible member whose residence is within the State of Colorado, and all covered dependents. An exception to this is subscribers covered under a student plan. In this case, any student enrolled in a student plan for a Colorado college/university would be considered a Colorado resident regardless of their address of record.
c) Payers must provide information to identify the type of service and setting in which the service was provided. Each submitted data file shall have control totals and transmission control data as defined in the Header and Trailer Record for each defined

file. (See Exhibit A for specifics).

Claim data is required for submission for each month during which some action has been taken on that claim (i.e. payment, adjustment or other modification). Any claims that have been "soft" denied (denied for incompleteness, being incorrect or for other administrative reasons) which the data supplier expects to be resubmitted upon correction, do not have to be submitted until corrections have been completed and the claim paid, partially paid or fully denied (other than "soft" denial). It is desirable that payers provide a reference that links the original claim to all subsequent actions associated with that claim (see Exhibit A-2 for specifics).

d) ICD-9/ICD-10 Diagnosis and Procedure Codes are required to accurately report risk factors related to the Episode of Care. Level I HCPCS codes, (Current Procedural Terminology, CPT) and Level II HCPCS codes are also required as applicable on all claim types.
e) For historical data submitted during the onboarding process, payers shall provide, as a separate report, monthly totals of covered members (Colorado residents) for the periods associated with the Historical Data.
f) Dental Claims: Standalone dental carriers should provide contact information to the Colorado APCD when these rules become effective. The Colorado APCD will notify standalone dental carriers of the process for submitting test files and regular updates. The process will include opportunities to discuss submission requirements prior to due dates. Reporting requirements for dental claims include reporting of the Current Dental Terminology (CDT) code in addition to the applicable fields in the medical claims file layout.
g) Off-boarding Payers: Colorado regulation defines criteria that determines whether a Payer is required to submit data to the CO APCD. When a payer no longer meets the regulatorily-defined criteria, the CO APCD Administrator will require a six-month claim run out submission. Payers will continue to report applicable claims and any new eligibility data per month over a continuous six-month period to ensure collection of all relevant information. This timeline may be modified on a case-by-case basis at the discretion of the CO APCD Administrator.

1.1.2 Pharmacy Claims Data

a) Health Care Payers must provide data for all pharmacy claims for prescriptions that were either paid, partially paid, or denied for all Colorado residents (Exhibit A-3).
b) A Colorado resident is defined as any eligible member whose residence is within the State of Colorado, and all covered dependents. An exception to this is subscribers covered under a student plan. In this case, any student enrolled in a student plan for a Colorado college/university would be considered a Colorado resident regardless of their address of record.

c) If your health plan allows for medical coverage without pharmacy (or vice versa), ME018 - ME020 in Exhibit A-1 provides data elements in which such options must be identified in order to effectively and accurately aggregate claims based on Episodes of Care.
d) Claim data is required for submission for each month during which some action has been taken on that claim (i.e., payment, adjustment or other modification).
e) Off-boarding Payers: When a payer no longer meets the APCD Rule reporting requirements, the CO APCD Administrator will initiate off-boarding procedures with the Payer. As part of the off-boarding process, the payer will be required to provide six months of claim run-out submissions. Run-out submissions must include applicable claims and any new eligibility data per month over a continuous six-month period after the final month of coverage to ensure collection of all relevant information. Payers are expected to submit this six-month run-out data within nine months of the final month of coverage. For example, if coverage ends in December 2025, the run-out period must include data through July 2026, and the final submission would be due by September 30, 2026. This timeline may be modified on a case-by-case basis at the discretion of the CO APCD Administrator.

1.1.3 Member Eligibility Data

a) Health Care Payers must provide a dataset that contains information on every covered plan member who is a Colorado resident (see paragraph 1.1.1.b and 1.1.2.b above) whether or not the member utilized services during the reporting period. The file must include member identifiers, subscriber name and identifier, member relationship to subscriber, residence, age, race, ethnicity and language, and other required fields to allow retrieval of related information from pharmacy and medical claims data sets (Exhibit A).
b) If dual coverage exists, send coverage of eligible members where payer insurance is primary or tertiary. ME028 is a flag to indicate whether this insurance is primary coverage.
c) Information, such as patient address, should be submitted accurately based on the time of eligibility identified in ME004 and ME005. For example, if a payer submits historical data back to 2017 and a given member changed addresses in 2018, the 2017 eligibility data should contain the 2017 address and the 2018-forward data should reflect the updated address information.

1.1.4 Provider Data

a) Health Care Payers must provide a dataset that contains information on every provider for whom claims were adjudicated during the targeted reporting period or for whom were reported on the eligibility file during the targeted reporting period.

b) A provider file is a data file composed of information including but not limited to: provider IDs, provider names, National Provider Identifiers (NPI), specialty codes, and practice location(s) for all providers as indicated by the payer on the eligibility and on the claim.

c) Data suppliers must provide a dataset that contains information for all providers as indicated on the eligibility file and on every provider that a claim (Medical, Dental, and Pharmacy) was adjudicated for in the targeted reporting period. Third party administrators (including pharmacy benefit managers, etc.) who may not contract directly with providers, are expected to include providers who are on the claims file for the time period of the corresponding reporting period.

d) In the event the same provider delivered and was reimbursed for services rendered from two different physical locations, then the provider data file shall contain two separate records for that same provider reflecting each of those physical locations. One record shall be provided for each unique physical location for a provider who was reported during the period.

1.1.5 Alternative Payment Model data (APM)

a) Health care payers must provide a file that includes information related to payments made under different payment models (Exhibit A-5).
b) Payments reported in the Alternative Payment Model filing should be for care provided to Colorado residents only and based on the date of service.
c) Alternative Payment Model files should include three years of historical data, separated by year.
d) APM files are submitted on an annual basis in .txt format.

1.1.6 Alternative Payment Model Control Total data

a) Health care payers must provide a file that includes summary information for payments reported in the Alternative Payment Model filing (Exhibit A-6 – A-7).
b) Control Total files should include three years of historical data, separated by year.
c) APM Control Total files are submitted on an annual basis in .txt format.

1.1.7 Alternative Payment Model Contract Supplement Data

a) Health care payers must provide a file that includes high-level information describing various alternative payment contracts (ExhibitA-7).
b) APM Contract Supplement files are submitted on an annual basis in CSV format. Pipe (|) and comma (,) delimiters are allowed. Note: do not include column headers within the CSV. Do not include commas (,) or double quotes (”) within the CSV’s field contents.

1.1.8 Drug Rebate (DR) Data

a) Health care payers must provide a file that includes aggregated information for pharmacy expenditures and rebates/other compensation received. (Exhibit A-8).
b) Drug Rebate files should include three years of historical data, separated by year.
c) Drug Rebate files are submitted on an annual basis in .txt format.

1.1.9 Pharmacy Benefit Managers (PBM) Contract Information Data

a) Health care payers that utilize PBMs must provide a file with high-level information describing contracts with pharmacy benefit managers (Exhibit A-8).
b) PBM Contract files should include three years of historical data, separated by year.
c) PBM Contract files are submitted on an annual basis in CSV format. Pipe (|) and comma (,) delimiters are allowed. Note: do not include column headers within the CSV. Do not include commas (,) or double quotes (") within the CSV's field contents.

1.1.10 Data Collection for the Prescription Drug Affordability Board (PDAB)

a) Health care payers and PBMs must provide a file that includes aggregated information about prescription drugs as designated in SB21-175 (Exhibit A-10).
b) PDAB files should include the immediately preceding one year of historical data.
i. PDAB files are submitted on an annual basis in CSV format. Pipe (|) and comma (,) delimiters are allowed. Note: do not include column headers within the CSV. Do not include commas (,) or double quotes (") within the CSV's field contents.

1.1.11 Pharmacy Value Based Purchasing Contract Data (VBPC)

a) Health care payers and PBMs must provide a file that includes aggregated information related to Pharmacy Value Based Purchasing Contracts (VBPCs) (Exhibit A-7).
b) VBPC files should include four years of historical data.
c) VBPC files are submitted on an annual basis in CSV format. Pipe (|) and comma (,) delimiters are allowed. Note: do not include column headers within the CSV. Do not include commas (,) or double quotes (") within the CSV's field contents.

1.1.12 Member Capitation File (CF)

a) Health care payers must provide a file that includes information related to member capitated payments made under different payment models (Exhibit A-5).
b) Payments reported in the Member Capitation filing should be for care provided to Colorado residents only and based on the date of service.
c) Member Capitation file should include three years of historical data, separated by year.
d) CF file is submitted on an annual basis in .txt format.

1.2 Coordination of Submissions

a) In the event that the health plan contracts with a pharmacy benefits manager or other service entity that manages claims for Colorado residents, the health plan shall be responsible for ensuring that complete and accurate files are submitted to the CO APCD by the subcontractor. The health plan shall ensure that the member identification

information on the subcontractor's file(s) is consistent with the member identification information on the health plan's eligibility, medical claims and dental claims files. The health plan shall include utilization and cost information for all services provided to members under any financial arrangement, including sub-capitated, bundled and global payment arrangements.

1.3 TEST, HISTORICAL AND PARTIAL YEAR INITIAL SUBMISSION

For payers required to begin submitting files to the CO APCD, the CO APCD Administrator will identify:

(1) the calendar month to be reported in test files;
(2) the specific full calendar years of data to be reported in the historical submission; and
(3) at the CO APCD Administrator's direction, a partial year submission for the current calendar year.

2.0 FILE SUBMISSION METHODS

2.1 SFTP - Secure File Transport Protocol involves logging on to the appropriate FTP site and sending or receiving files using the SFTP client.

2.2 Web Upload - This method allows the sending and receiving of files and messages without the installation of additional software. This method requires internet access, a username and password.

2.3 All files submitted through SFTP or Web Upload must use PGP encryption, as required by the CO APCD's data administrator.

3.0 DATA QUALITY REQUIREMENTS

3.1 The data elements in Exhibit A provide, in addition to field definitions, an indicator regarding data elements that are required. A data element that is required must contain a value unless an override is put in place with a specific payer who is unable to provide that data element due to system limitations. A data element marked as "TH" means that a % of all records must have a value in this field based on the expected frequency that this data element is available. Data files that do not achieve this threshold percentage for that data element may be rejected or require follow up prior to load into the CO APCD. A data element marked as "O" is an optional data element that should be provided when available, but otherwise may contain a null value.

3.2 Data validation and quality edits will be developed in collaboration with payers and refined as test data and production data are brought into the CO APCD. Data files missing

required fields, or when claim line/record line totals don't match, may be rejected on submission. Other data elements will be validated against established ranges as the database is populated and may require manual intervention in order to ensure the data is correct.

The objective is to populate the CO APCD with quality data and each payer will need to work interactively with CIVHC to develop data extracts that achieve validation and quality specifications. This is the purpose of test data submissions early in the implementation process. Overrides may be granted, at the discretion of CIVHC, for data variances that cannot be corrected due to systematic issues that require substantial effort to correct.

3.3 Proper logic must be followed to indicate versions of both medical and pharmacy claims. Claim versioning entails the processes by which the best and final claim is determined. The best and final claim version is what is displayed in the valid set of CO APCD data. If proper versioning logic is not followed, a multitude of data quality issues will emerge that impacts the integrity and quality of the CO APCD.

The CO APCD follows the industry standard of fully reversing a previously-submitted claim before issuing a new version. The standard versioning logic uses the Claim Status field (MC038/PC025) to differentiate between paid versions and reversal versions. For a reversal version, the Claim Status field should equal "22." Additionally, the payment fields (copay, deductible, paid amount, coinsurance, etc.) on reversal versions must be the inverse of what was submitted on the previously-submitted claim. The logic then looks for the claim lines associated with the highest observed non-reversal claim version number (MC005A/PC201) for the associated Payer Claim Control Number (MC004/PC004). This is considered to be the most recent forward claim.

The system includes all claim lines associated with the most recent forward claim in the valid set as well as any reversal claim lines with a version number higher than the most recent forward claim. This allows previously paid claims to be zeroed out if they haven't yet had a forward claim reissued.

Note that the Payer Claim Control Numbers (MC004/PC004) must be consistent with each version of a claim in order for the logic to work effectively.

If a payer is unable to follow the proper claim versioning logic, the payer must reach out to submissions@civhc.org.

3.4 The system includes all denied claims including fully denied claims and partially denied claims, claims denied when first received (with version number=0) and denied after some

back and forth (with version number>0). These claims or claim lines are expected to have claim status equals 04 or 23, Denied Claim Line Indicator is 'Y' or Claim Line Type is D. The payment fields (copay, deductible, paid amount, coinsurance, etc.) on denied claim lines must be 0 and they will be excluded from the valid sets.

3.5 CIVHC conducts data quality reviews on all submitted files to ensure compliance with the DSG and to identify any structural, format, or content-level issues. Once a file is reviewed, CIVHC will notify the payer of any required corrections or clarifications.

To maintain timely progress through the validation process, payers are required to acknowledge notification from CIVHC for the need of corrected files or explanation of identified issue within three (3) business days of the communicated issue for all files. Failure to respond within this timeframe may delay overall validation and impact reporting deadlines and would begin non-compliance procedures.

4.0 FILE FORMAT

4.1 Member Eligibility (ME), Medical Claims (MC), Pharmacy Claims (PC), Medical Provider (MP), Alternative Payment Model (AM), Control Total (CT), Member Capitation (CF), and Drug Rebate (DR) files submitted to the CO APCD will be formatted as standard text files.

Text files all comply with the following standards:

a) Always one-line item per row; no single line item of data may contain carriage return or line feed characters.
b) All rows delimited by the carriage return + line feed character combination.
c) All fields are variable field length, delimited using the pipe character (ASCII=124). It is imperative that no pipes ('|') appear in the data itself. If your data contains pipes, either remove them or discuss using an alternate delimiter character.
d) Text fields are *never* demarcated or enclosed in single or double quotes. Any quotes detected are regarded as a part of the actual data.
e) The first row *never* contains the names of data element label (e.g. MC001).
f) Unless otherwise stipulated, numbers (e.g. ID numbers, account numbers, etc.) do not contain spaces, hyphens or other punctuation marks.
g) Text fields are never padded with leading or trailing spaces or tabs.
h) Numeric fields are never padded with leading or trailing zeroes.
i) If a field is not available, or is not applicable, leave it blank. 'Blank' means do not supply any value at all between pipes (including quotes or other characters).
j) Data submitted should only contain standard ascii characters; extended ascii or non-printable characters should be removed from data prior to submission.

k) Files submitted in CSV format must not contain commas (,) or double quotes (") within field contents. Acceptable delimiters are limited to pipe (|) and comma (,). In addition, CSV submissions must not include column headers.

4.2 Monthly File Naming Convention - All monthly files submitted to the CO APCD shall have a naming convention developed to facilitate file management without requiring access to the contents.

All file names will follow the template:

- *PayerCode_FileType_PeriodStartDate_PeriodEndDate_RowCount_ProdFlag_FixedWidthInd_Create Date*

Examples:

i. COCXXXX_ME_202201_202201_45000_T_DL_20250422

ii. COCXXXX_ME_202201_202201_45000_P_DL_20250422

- Payer Code = Unique identifier assigned to each payer by the CO APCD's data administrator
    - FileType = A two-character code that indicates which file is being submitted:
        i. 'ME' = Eligibility
        ii. 'MC' = Medical Claims
        iii. 'PC' = Pharmacy Claims
        iv. 'MP' = Provider
- PeriodStartDate (YYYYMM format)
    i. For claims data, this will be the very first Paid Date year-month reported in the file
    ii. For eligibility data, this will be the very first year-month of enrollment reported in the file, based on the first field in the eligibility file that dictates year-months of coverage
    - PeriodEndDate (YYYYMM format)
        i. For claims data, this will be the very last Paid Date year-month reported in the file
        ii. For eligibility data, this will be the very last year-month of enrollment reported in the file, based on the first field in the eligibility file that dictates year-months of coverage
    - RowCount (no commas)

i. Total number of records submitted in the file, excluding header and trailer records
ii. For all monthly files, if payer cannot fill in the "RowCount" section of the file naming convention, then a "0" can be used instead. For example:

COCXXXX_ME_202201_202201_0_T_DL_202504

- ProdFlag = A one-character code that indicates whether a file is a 'Test' file or a 'Production' file:
  i. 'T' = Test
  ii. 'P' = Production
- DelimitedFileInd = A two-character code that indicates whether a file is reported with delimiters:
  i. 'DL' = Delimiters included
- CreateDate (YYYYMMDD)

4.3 PBM Contract (PB), Prescription Drug Affordability Board (PD), APM Contract (AC), and Value Based Pharmaceutical Contract (VB) files submitted to the CO APCD will be formatted as standard CSV file. Pipe (|) and comma (,) delimiters are allowed. Note: do not include column headers within the CSV. Do not include commas (,) or double quotes (") within the CSV's field contents.

Payers should complete the blank template file distributed for each annual file submission.

4.4 Annual File Naming Convention - All annual files submitted to the CO APCD shall have a naming convention to facilitate file management without requiring access to the contents.

All file names will follow the template:

PayerCode_FileType_PeriodStartDate_PeriodEndDate_RowCount_ProdFlag_FixedWidthInd_Create Date

- Examples
  i. COCXXXX_AM_202201_202412_45000_T_DL_20250422
  ii. COCXXXX_AM_202201_202412_45000_P_DL_20250422
- Payer Code = Unique identifier assigned to each payer by the CO APCD's data administrator
- FileType = A two-character code that indicates which file is being submitted:
  i. 'AM' = Alternative Payment Model

ii. ‘CT’ = Control Total
iii. ‘CF’ = Member Capitation
iv. ‘DR’ = Drug Rebate
v. ‘PB’ = PBM Contract Supplement
vi. ‘PD’ = PDAB
vii. ‘VB’ = Value Based Purchasing Contract

- PeriodStartDate (YYYYMM format)
  i. For claims data, this will be the very first Paid Date year-month reported in the file
  ii. For eligibility data, this will be the very first year-month of enrollment reported in the file, based on the first field in the eligibility file that dictates year-months of coverage (eff_dt)
- PeriodEndDate (YYYYMM format)
  i. For claims data, this will be the very last Paid Date year-month reported in the file
  ii. For eligibility data, this will be the very last year-month of enrollment reported in the file, based on the first field in the eligibility file that dictates year-months of coverage (eff_dt)
- RowCount (no commas)
  i. Total number of records submitted in the file, excluding header and trailer records
  ii. For AM, CT, DR, and CF files if payer cannot fill in the “RowCount” section of the file naming convention, then a “0” can be used instead. For example:
  COCXXXX_AM_202201_202401_0_T_DL_20250422
  iii. For AC, PB, PD, and VB files, a nonzero integer is required
- ProdFlag = A one-character code that indicates whether a file is a ‘Test’ file or a ‘Production’ file:
  i. ‘T’ = Test
  ii. ‘P’ = Production
- DelimitedFileInd = A two-character code that indicates whether a file is reported with delimiters:
  i. ‘DL’ = Delimiters included

5.0 DATA ELEMENT TYPES

date - date data type for dates from 1/1/0001 through 12/31/9999

int - integer (whole number)

decimal/numeric - fixed precision and scale numeric data

char - fixed length non-unicode data with a max of 8,000 characters

varchar - variable length non-unicode data with a maximum of 8,000 characters

text - variable length non-unicode data with a maximum of 2^31 -1 characters

year- 4-digit year for which eligibility is reported in this submission

month - month for which eligibility is reported in this submission expressed numerical from 01 to 12

time - time expressed in military time = HHMM

6.0 DATES FOR MONTHLY CLAIMS DATA SUBMISSION

30 days after the end of the reporting month.

Date That Supplier Must Submit Data to CO APCD	**Period Begin date of Paid Claims Data**	**Period End date of Paid Claims Data**	**Period Begin date of Eligibility Data**	**Period End date of Eligibility Data**
By March 1	*January 1*	*January 31*	*January 1*	*January 31*
By April1	*February 1*	*February 28/29*	*February 1*	*February 28/29*
By May 1	*March 1*	*March 31*	*March 1*	*March 31*
By June 1	*April 1*	*April 30*	*April 1*	*April 30*
By July 1	*May 1*	*May 31*	*May 1*	*May 31*
By August 1	*June 1*	*June 30*	*June 1*	*June 30*
By September 1	*July 1*	*July 31*	*July 1*	*July 31*
By October 1	*August 1*	*August 31*	*August 1*	*August 31*
By November 1	*September 1*	*September 30*	*September 1*	*September 30*
By December 1	*October 1*	*October 31*	*October 1*	*October 31*

By January 1	*November 1*	*November 30*	*November 1*	*November 31*
By February 1	*December 1*	*December 31*	*December 1*	*December 31*

EXHIBIT A - DATA ELEMENTS

A-1 ELIGIBILITY FOR MEDICAL CLAIMS DATA

Frequency: Monthly Upload via FTP or Web Portal

It is extremely important that the member ID (Member Suffix or Sequence Number) is unique to an individual and that this unique identifier in the eligibility file is consistent with the unique identifier in the medical claims/pharmacy file. This provides linkage between medical and pharmacy claims during established coverage periods and is critical for the implementation of Episode of Care reporting.

For historic data collected, eligibility is to be reported for all Colorado residents who were covered members during that reporting month. In the event historical address data is not available, eligibility data for historical months shall be reported based on member's last known or current address. It is acknowledged that for some payers there may not be an eligibility record for each member identified in the medical claims file for that same period.

Additional formatting requirements:

- Eligibility files are formatted to provide one record per member per month. Member is either the subscriber or the subscriber's dependents.
- Data for administration fees, premiums, and capitation fees are contained on the eligibility file and are pre-allocated (i.e. broken out by employee by month) to match the eligibility data
- Payers submit data in a single, consistent format for each data type.

MEDICAL ELIGIBILITY FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	HD
HD002	File Type	char	2	ME
HD003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
HD004	Payer Name	varchar	75	Distributed by CIVHC
HD005	Beginning Month	date	6	YYYYMM
HD006	Ending Month	date	6	YYYYMM
HD007	Record count	int	10	Total number of records submitted in the medical eligibility file, excluding header and trailer records
HD008	Med_BH PMPM	int	7	Place holder. Leave field value blank.
HD009	Pharmacy PMPM	int	7	Place holder. Leave field value blank.
HD010	Dental PMPM	int	7	Place holder. Leave field value blank.
HD011	Vision PMPM	int	7	Place holder. Leave field value blank.
HD012	Test File Flag	char	1	T=File submitted is a test file; P=File submitted is a production file.

MEDICAL ELIGIBILITY FILE TRAILER RECORD

Data Element #	Date Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	TR
TR002	File Type	char	2	ME
TR003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
TR004	Payer Name	varchar	75	Distributed by CIVHC
TR005	Beginning Month	date	6	YYYYMM
TR006	Ending Month	date	6	YYYYMM
TR007	Extraction Date	date	8	YYYYMMDD

A-1.1 MEDICAL ELIGIBILITY FILE

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME001	N/A	Payer Code	varchar	7	Distributed by CIVHC's data administrator	R
ME002	N/A	Payer Name	varchar	30	Distributed by CIVHC	R
ME003	271/2110C/EB/ /04, 271/2110D/EB/ /04	Insurance Type Code/Product	Char	2	See Lookup Table B.1.A	R
ME004	N/A	Year	Year	4	4-digit Year for which eligibility is reported in this submission	R
ME005	N/A	Month	Month	2	Month for which eligibility is reported in this submission expressed numerical from 01 to 12. One record, per member, per month, per plan, is required.	R
ME006	271/2100C/REF/1L/02, 271/2100C/REF/IG/02, 271/2100C/REF/6P/02, 271/2100D/REF/1L/02, 271/2100D/REF/IG/02, 271/2100D/REF/6P/02	Insured Group or Policy Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber Ensure continuity across file types. Note that ME006 = MC006; PC006.	R
ME007	271/2110C/EB/ /02, 271/2110D/EB/ /02	Coverage Level Code	Char	3	See Lookup Table B.1.I	R
ME008	271/2100C/NM1/MI/09	Subscriber Social Security Number	varchar	9	Subscriber's social security number; Set as null if unavailable Ensure continuity across file types. Note that ME008 = MC007; PC007.	O
ME009	271/2100C/NM1/MI/09	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract number; may use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber. Ensure continuity across file types. Note that ME009 = MC008; PC008	R
ME010	N/A	Member Number	varchar	128	Unique number of the member within the contract. Must be an identifier that is unique to the member. May include a combination of contract number and suffix number in order to be unique. This column is the unique identifying column for membership and related medical and pharmacy claims. Only one record per eligibility month. Ensure continuity across file types. Note that ME010 = MC009; PC009	R
ME011	271/2100C/NM1/MI/09, 271/2100D/NM1/MI/09	Member Identification Code	varchar	9	Member's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member. Ensure continuity across file types. Note that ME011 = MC010; PC010	O
ME012	271/2100C/INS/Y/02, 271/2100D/INS/N/02	Individual Relationship Code	Char	2	Member's relationship to insured - see Lookup Table B.1.B Ensure continuity across file types. Note that ME012 = MC011; PC011	R
ME013	271/2100C/DMG/ /03, 271/2100D/DMG/ /03	Member Gender	Char	1	M = Male F = Female X = Non-binary U = UNKNOWN	R
ME014	271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02	Member Date of Birth	Date	8	YYYYMMDD	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME015	271/2100C/N4/ /01, 271/2100D/N4/ /01	Member City Name of Residence	varchar	30	City name of member residence	R
ME016	271/2100C/N4/ /02, 271/2100D/N4/ /02	Member State or Province	Char	2	As defined by the US Postal Service	R
ME017	271/2100C/N4/ /03, 271/2100D/N4/ /03	Member ZIP Code	varchar	11	ZIP Code of member - may include non-US codes. Do not include dash. Plus 4 optional but desired.	R
ME018	N/A	Medical Coverage	Char	1	Y = YES N = NO 3 = UNKNOWN Corresponds to coverage provided by payer code associated with record. If member has coverage type through separate entity (TPA, ASO, PBM, stand-alone coverage, etc.), then submit "N." Only submit "Y" if carrier provides coverage.	R
ME019	N/A	Prescription Drug Coverage	Char	1	Y = YES N = NO 3 = UNKNOWN Corresponds to coverage provided by payer code associated with record. If member has coverage type through separate entity (TPA, ASO, PBM, stand-alone coverage, etc.), then submit "N." Only submit "Y" if carrier provides coverage.	R
ME020	N/A	Dental Coverage	Char	1	Y = YES N = NO 3 = UNKNOWN Corresponds to coverage provided by payer code associated with record. If member has coverage type through separate entity (TPA, ASO, PBM, stand-alone coverage, etc.), then submit "N." Only submit "Y" if carrier provides coverage.	R
ME123	N/A	Behavioral Health	Char	1	Y = YES N = NO 3 = UNKNOWN Corresponds to coverage provided by payer code associated with record. If member has coverage type through separate entity (TPA, ASO, PBM, stand-alone coverage, etc.), then submit "N." Only submit "Y" if carrier provides coverage.	R
ME021	N/A	Race 1	varchar	6	R1 American Indian/Alaska Native R2 Asian R3 Black/African American R4 Native Hawaiian or other Pacific Islander R5 White R9 Other Race UNKNOW Unknown/Not Specified The code value 'UNKNOW' (unknown/not specified) should be used ONLY when member answers unknown, or refuses to answer. If not available or not collected from members, leave this field blank.	R
ME022	N/A	Race 2	varchar	6	See code set for ME021.	O
ME023	N/A	Other Race	varchar	15	List race if ME021 or ME022 are coded as R9.	O

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME024	N/A	Hispanic Indicator	Char	1	Y = Patient is Hispanic/Latino/Spanish N = Patient is not Hispanic/Latino/Spanish U = Unknown The code value 'U' (unknown) should be used ONLY when member answers unknown, or refuses to answer. If not available or not collected from members, leave this field blank.	R
ME025	N/A	Ethnicity 1	varchar	6	2182-4 Cuban 2184-0 Dominican 2148-5 Mexican, Mexican American, Chicano 2180-8 Puerto Rican 2161-8 Salvadoran 2155-0 Central American (not otherwise specified) 2165-9 South American (not otherwise specified) 2060-2 African 2058-6 African American AMERCN American 2028-9 Asian 2029-7 Asian Indian BRAZIL Brazilian 2033-9 Cambodian CVERDN Cape Verdean CARIBI Caribbean Island 2034-7 Chinese 2169-1 Columbian 2108-9 European 2036-2 Filipino 2157-6 Guatemalan 2071-9 Haitian 2158-4 Honduran 2039-6 Japanese 2040-4 Korean 2041-2 Laotian 2118-8 Middle Eastern or North African PORTUG Portuguese RUSSIA Russian EASTEU Eastern European 2047-9 Vietnamese OTHER Other Ethnicity UNKNOW Unknown/Not Specified The code value 'UNKNOW' (unknown/not specified) should be used ONLY when member answers unknown, or refuses to answer. If not available or not collected from members, leave this field blank.	O
ME026	N/A	Ethnicity 2	varchar	6	See code set for ME025.	O
ME027	N/A	Other Ethnicity	varchar	20	List ethnicity if ME025 or ME026 are coded as OTHER.	O
ME028	N/A	Primary Insurance Indicator	Char	1	Y - Yes, primary insurance N - No, secondary or tertiary insurance	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME029	N/A	Coverage Type	Char	3	This field identifies which entity holds the risk: ASW = Self-funded plans administered by a TPA, where the employer has purchased stop-loss, or group excess insurance coverage ASO = Self-funded plans administered by a TPA, where the employer has not purchased stop-loss, or group excess insurance coverage STN = Short-term, non-renewable health insurance (e.g., COBRA) UND = Plans underwritten by the insurer (fully insured group and individual policies) MEW = Associations/Trusts and Multiple Employer Welfare Arrangements OTH = Any other plan (for example-student health plan). Insurers using this code shall obtain prior approval --- Note: Use of 'OTH' (upon approval) will result in requesting an exemption request for this field.	R
ME030	N/A	Market Category Code	varchar	4	Market Category Codes define the market category by size and or association to which the policy is directly sold and issued. Report subscribers (not employees). See Lookup Table B.1.L	R
ME032	N/A	Employer Tax ID	varchar	9	Subscriber's employer EIN. Remove dash. If coverage not purchased through or obtained from an employer (Medicaid, IND, etc.), leave this field blank.	R for employer-based coverage
ME032A	N/A	Employer ZIP Code	varchar	9	Report the 5- or 9-digit Zip Code of the employer (as reported in ME032) as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. If coverage not purchased through or obtained from an employer (Medicaid, IND, etc.), leave this field blank.	R for employer-based coverage
ME043	271/2100C/N3/ /01, 02 271/2100D/N3/ /01, 02	Member Street Address	varchar	50	Physical street address of the covered member	R
ME044	N/A	Employer Group Name	varchar	128	Name of the group that is covering the member (the name established in the payer's system and not the full legal name). Do not put individual names in this field. If coverage not purchased through or obtained from an employer (Medicaid, IND, etc.), leave this field blank.	R for employer-based coverage
ME101	271/2100C/NM1/ /03	Subscriber Last Name	varchar	128	The subscriber last name	R
ME102	271/2100C/NM1/ /04	Subscriber First Name	varchar	128	The subscriber first name	R
ME103	271/2100C/NM1/ /05	Subscriber Middle Initial	Char	1	The subscriber middle initial	O
ME104	271/2100D/NM1/ /03	Member Last Name	varchar	128	The member last name	R
ME105	271/2100D/NM1/ /04	Member First Name	varchar	128	The member first name	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME897	N/A	Plan Effective Date	Date	8	YYYYMMDD Date eligibility started for this member under this plan type. The purpose of this data element is to maintain eligibility span for each member.	R
ME897A	N/A	Plan Term Date	Date	8	YYYYMMDD Last continuous day of coverage (date eligibility ended) for this member under this plan. The purpose of this data element is to maintain an eligibility span for each member. For open contracts, leave this field blank.	R
ME045		Exchange Offering	Char	1	Identifies whether or not a policy was purchased through the Colorado Health Benefits Exchange (COHBE). Y = Commercial small or non-group QHP purchased through the Exchange N = Commercial small or non-group QHP purchased outside the Exchange U = Not applicable (plan/product is not offered in the commercial small or non-group market or grandfathered)	R
ME106	N/A	Leave blank				
ME107	N/A	Risk Basis	Char	1	S = Self-insured F = Fully insured Default to "F" for grandfathered Plans	R
ME108	N/A	High Deductible/ Health Savings Account Plan	Char	1	Y = Plan is High Deductible/HSA eligible N = Plan is not High Deductible/HSA eligible Default to "N" for grandfathered Plans	R
ME120	N/A	Actuarial Value	decimal	6	Report value as calculated in the most recent version of the HHS Actuarial Value Calculator available at http://cciio.cms.gov/resources/regulations/index.html Size includes decimal point. Required for small group and non-group (individual) plans sold inside or outside the Exchange. Default to "0" for Grandfathered plans	R for plans where ME 030 = IND, FCH, GCV, GS_1, GS_2, GS_3, GS_4 or GLG_1; otherwise Optional
ME121	N/A	Metallic Value	Int	1	Metal Level (percentage of Actuarial Value) per federal regulations. Valid values are: 1 = Platinum 2 = Gold 3 = Silver 4 = Bronze 5 = Catastrophic 0 = Not Applicable Required for small group and non-group (individual) plans sold inside or outside the Exchange. Use values provided in the most recent version of the HHS Actuarial Value Calculator available at http://cciio.cms.gov/resources/regulations/index.html Default to "0" for Grandfathered plans	R for plans where ME 030 = IND, FCH, GCV, GS_1, GS_2, GS_3, GS_4 or GLG_1; otherwise Optional

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME122	N/A	Grandfather Status	Char	1	See definition of “grandfathered plans” in HHS rules CFR 147.140 Y = Yes N = No Required for small group and non-group (individual) plans sold inside or outside the Exchange. Default to “N” if unknown.	O
ME124	N/A	PCP NPI	Char	10	NPI of member’s PCP NA = if the eligibility does not require a PCP Unknown = if PCP is unknown	R
ME125	N/A	Medicare Beneficiary Identifier (MBI)	Char	11	Medicare Beneficiary Identifier Required for Medicare. Do not submit HICN identifiers. If unavailable, leave this field blank.	R for Medicare members
ME126	N/A	NAIC ID	char	5	Report the NAIC Code associated with the entity that maintains this product. Leave this field blank if entity does not have a NAIC Code.	R
ME127	N/A	ERISA indicator	Char	1	Y = member’s plan is under ERISA N = member’s plan is not under ERISA Includes fully insured and self-funded ERISA plans	R
ME130	N/A	Medicaid AID category	Char	4	For Medicaid only. Provide the Medicaid AID category code for the member. Codes are determined by the state’s Medicaid agency. Contact CIVHC for acceptable codes. If not applicable, leave this field blank.	R for Medicaid members
ME131	N/A	Purchasing Alliance Indicator	Char	1	Y = member is part of a purchasing alliance N = member is not part of a purchasing alliance Default to N unless otherwise directed by CIVHC.	R
ME132	N/A	Purchasing Alliance Organization	Char	4	Use this field to identify which purchasing alliance organization the member with which the member is associated. PHA = Peak Health Alliance LFT = Local First TCPA = The Colorado Purchasing Alliance VHA = Valley Health Alliance	O
ME133	N/A	Federal Poverty Level Indicator	Char	1	A = member’s income falls above the federal poverty line at the time of eligibility B = member’s income falls below the federal poverty line at the time of eligibility	O
ME143	834/2100/ LUI/02	Language Preference	Char	3	Report the primary language of the member. ANSI/NISO Z39.53-2001 standard. Leave this field blank if this information is not available.	R
ME144	N/A	Market Option	Char	2	See Lookup Table B.1.O If not applicable, submit “NA”	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME145	N/A	Total Monthly Premium Amount	Int	12	For fully-insured and self-funded plan premiums, report the monthly fee paid by a subscriber and/or employer for health insurance coverage for a given number of members (e.g. individual, individual plus one, family), prior to any medical loss ratio rebate payments, but inclusive of any fees paid to a third party (e.g., exchange fees, reinsurance). Report the total monthly premium at the subscriber level only. Do not report on member lines. Report 0 if no premium is charged. Do not code decimal point or provide any punctuation (e.g.,$1,000.25 converted to 100025). You may leave the field blank if your system does not collect or store this information and submit an exemption request for this field **after** file submission.	R
ME146	N/A	Subscriber Monthly Premium Amount	Int	12	Following instruction from ME145, report the subscriber's share of the total monthly premium amount. Subtract amount paid by employer, if applicable. Report 0 if 0 reported in ME145. You may leave the field blank if your system does not collect or store this information and submit an exemption request for this field after submissions.	R
ME147	N/A	Out of Pocket Maximum	int	12	The dollar amount of the maximum OOP expenses for services within network for an individual (single) policy. The OOP maximum should include any deductibles, where applicable. In cases of PPO, POS, and/or tiered network products, please report the OOP limit for the most utilized tier. Leave the field blank if Out of Pocket Maximum does not apply.	R
ME148	N/A	Member Deductible	int	12	Report the total maximum amount of member/ subscriber's annual deductible for each benefit type (medical, RX, vision, behavioral health, dental etc.) before certain services are covered. Report only In-Network Deductibles here if plan has an In and Out-of-Network Deductible. Report 0 when there is no deductible applied to all benefits for this eligibility.	R
ME149	N/A	Colorado Option Indicator	char	1	Y = Plan is associated with a standardized Colorado Option plan under C.R.S. 10-16-1304 N = Plan is not associated with a standardized Colorado Option plan Blank or NULL is not acceptable.	R
ME150	N/A	RAE Indicator	Char	2	Identify which Medicaid Regional Accountable Entity the member is associated with 1 = RAE Region 1 2 = RAE Region 2 3 = RAE Region 3 4 = RAE Region 4 5 = RAE Region 5 6 = RAE Region 6 7 = RAE Region 7 8 = RAE Region 8 Leave this field blank if non-MCO/RAE payer	R for RAE and MCOs

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME151	N/A	HIOS Plan ID	varchar	14	Health Insurance Oversight System (HIOS) Plan ID is a 14-digit alphanumeric value that has a health insurer and product component included. This ID is required for all DOI/CMS rate filings. Example: 21032CO1040003 or 76680CO220020 where the first five digits identify the carrier, and the last 9 digits identify the product/plan. Leave this field blank if not applicable	R when: ME007 = 'IND'ANDME045 = 'Y' OR 'N'; ME149 = 'Y'; O if ME149 = 'N'
ME152	N/A	Vision Coverage	char	1	Y = YES N = NO 3 = UNKNOWN Corresponds to coverage provided by payer code associated with record. If member has coverage type through separate entity (TPA, ASO, PBM, stand-alone coverage, etc.), then submit "N." Only submit "Y" if carrier provides coverage.	R
ME153	N/A	Colorado PBM Registration Number	varchar	10	The identifier assigned by the Colorado Division of Insurance (DOI) for registered Pharmacy Benefit Managers (PBM).	R for PBMs
ME899	N/A	Record Type	char	2	Value = ME	R

A-2 Medical Claims Data

Frequency: Monthly Upload via FTP or Web Portal

Additional formatting requirements:

- Include paid, partially paid, and fully denied claims.
- Payers submit data in a single, consistent format for each data type.

Medical Claims File Header Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	HD
HD002	File Type	char	2	MC
HD003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
HD004	Payer Name	varchar	75	Distributed by CIVHC
HD005	Beginning Month	date	6	YYYYMM
HD006	Ending Month	date	6	YYYYMM
HD007	Record count	int	10	Total number of records submitted in the medical claims file, excluding header and trailer records
HD008	Med_BH PMPM	int	7	Sum of MC063(Paid Amount) + MC064(Prepaid Amount) + MC065(Co-pay Amount) + MC066(Coinsurance Amount) + MC067(Deductible Amount) (as applicable) in medical claims divided by the total distinct member IDs in the member eligibility, where medical coverage (ME018) = 'Y' or behavioral health (ME123) = 'Y' when MC209 or MC220 **does not** = 'Y'. Do not code decimal point or provide any punctuation where $1,000.00 converted to 100000 Two decimal places implied. Leave blank if above condition does not apply.
HD009	Pharmacy PMPM	int	7	Place holder. Leave this field blank.
HD010	Dental PMPM	int	7	Sum of MC063(Paid Amount) + MC064(Prepaid Amount) + MC065(Co-pay Amount) + MC066(Coinsurance Amount) + MC067(Deductible Amount) (as applicable) in dental claims divided by the total distinct member IDs in the member eligibility where dental coverage (ME020) = 'Y' when MC209 = 'Y'. Do not code decimal point or provide any punctuation where $1,000.00 converted to 100000 Two decimal places implied. Leave blank if above condition does not apply.

HD011	Vision PMPM	int	7	Sum of MC063(Paid Amount) + MC064(Prepaid Amount) + MC065(Co-pay Amount) + MC066(Coinsurance Amount) + MC067(Deductible Amount) (as applicable) in vision claims divided by the total distinct member IDs in the member eligibility where vision coverage (ME152) = 'Y' when MC220 = 'Y'. Do not code decimal point or provide any punctuation where $1,000.00 converted to 100000 Two decimal places implied. Leave blank if above condition does not apply.
HD012	Test File Flag	char	1	T=File submitted is a test file; P=File submitted is a production file.

MEDICAL CLAIMS FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	TR
TR002	File Type	char	2	MC
TR003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
TR004	Payer Name	varchar	75	Distributed by CIVHC
TR005	Beginning Month	date	6	YYYYMM
TR006	Ending Month	date	6	YYYYMM
TR007	Extraction Date	date	8	YYYYMMDD

A-2.1 MEDICAL CLAIMS FILE

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC001	N/A	Payer Code	varchar	7	Distributed by CIVHC's data administrator	R
MC002	N/A	Payer Name	varchar	30	Distributed by CIVHC	R
MC003	837/2000B/SBR/ /09	Insurance Type/Product Code	char	2	See Lookup Table B.1.A	R
MC004	835/2100/CLP/ /07	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system. No partial claims. Include all claim lines whether paid or denied.	R
MC004A	N/A	Cross Reference Claims ID	varchar	35	The original Payer Claim Control Number (MC004). Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Version Number (MC005A) is not used. MC004A and MC004 should be identical when MC038C = O.	R
MC005	837/2400/LX/ /01	Line Counter	int	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim. All claims must contain a line 1.	R
MC005A	N/A	Version Number	int	4	The version number of this claim service line. The original claim will have a version number of 0, with the next version being assigned a 1, and each subsequent version being incremented by 1 for that service line.	R
MC006	837/2000B/SBR/ /03	Insured Group or Policy Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber. Ensure continuity across file types. Note that ME006 = MC006; PC006.	R
MC007	835/2100/NM1/34/ 09	Subscriber Social Security Number	varchar	9	Subscriber's social security number; set as null if unavailable Ensure continuity across file types. Note that ME008 = MC007; PC007.	O

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC008	835/2100/NM1/HN/09	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract number; may use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber. Ensure continuity across file types. Note that ME009 = MC008; PC008	R
MC009	N/A	Member Number	varchar	128	Unique number of the member within the contract. Must be an identifier that is unique to the member. May include a combination of contract number and suffix number in order to be unique. This column is the unique identifying column for membership and related medical and pharmacy claims. Only one record per eligibility month per eligibility year. Ensure continuity across file types. Note that MC009 = ME010; PC009	R
MC010	835/2100/NM1/MI/08~~8~~9	Member Identification Code (patient)	varchar	9	Member's social security number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member. Ensure continuity across file types. Note that ME011 = MC010; PC010	O
MC011	837/2000B/SBR//02, 837/2000C/PAT//01, 837/2320/SBR//02	Individual Relationship Code	char	2	Member's relationship to insured - payers will map their available codes to those listed in Lookup Table B.1.B Ensure continuity across file types. Note that ME012 = MC011; PC011	R
MC012	837/2010CA/DMG//03	Member Gender	char	1	M = Male F = Female X = Non-binary U = Unknown	R
MC013	837/2010CA/DMG/D8/02	Member Date of Birth	date	8	YYYYMMDD	R
MC014	837/2010CA/N4//01	Member City Name of Residence	varchar	30	City name of member's residence	R
MC107	271/2100C/N3/ /01, 02 271/2100D/N3//01, 02	Member Street Address	varchar	50	Physical street address of the covered member	R
MC015	837/2010CA/N4//02	Member State or Province	char	2	As defined by the US Postal Service	R
MC016	837/2010CA/N4//03	Member ZIP Code	varchar	11	ZIP Code of member - may include non-US codes. Do not include dash. Plus 4 optional but desired.	R
MC017	N/A	Date Service Approved/Accounts Payable Date/Actual Paid Date/Denial Processed Date	date	8	YYYYMMDD	R
MC018	837/2300/DTP/435/03	Admission Date	date	8	Required for all inpatient claims. YYYYMMDD	R for all inpatient claims O for outpatient

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC019	837/2300/DTP/435/03	Admission Hour	char	4	Required for all inpatient claims. Time is expressed in military time - HHMM	R for all inpatient claims O for outpatient
MC020	837/2300/CL1/ /01	Admission Type	int	1	Required for all inpatient claims (SOURCE: National Uniform Billing Data Element Specifications) 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma Center 9 Information not available	R for all inpatient claims O for outpatient
MC021	837/2300/CL1/ /02	Admission Source	char	1	A code indicating the point of patient origin for this admission or visit. Required for all institutional claims. Admission Type codes are maintained by the National Uniform Billing Committee. See Lookup Table B.1.M	R for all inpatient claims O for outpatient
MC022	837/2300/DTP/096/03	Discharge Hour	time	4	Time expressed in military time = HHMM	R for all inpatient claims O for outpatient
MC023	837/2300/CL1/ /03	Discharge Status	char	2	Required for all inpatient claims. defaults: Professional: default '00' = unknown See Lookup Table B.1.C	R
MC024	835/2100/NM1/BD/09, 835/2100/NM1/BS/09, 835/2100/NM1/MC/09, 835/2100/NM1/PC/09	Service Provider Number	varchar	30	Payer assigned service provider number. Submit facility for institutional claims; physician or healthcare professional for professional claims.	R
MC025	835/2100/NM1/FI/09	Service Provider Tax ID Number	int	9	Federal taxpayer's identification number	R
MC026	Professional: 837/2420A/NM1/XX/09; 837/2310B/NM1/XX/09; Institutional: 837/2420A/NM1/XX/09; 837/2420C/NM1/XX/09; 837/2310A/NM1/XX/09	Service National Provider ID	varchar	20	National Provider ID. This data element pertains to the entity or individual directly providing the service.	R
MC027	Professional: 837/2420A/NM1/82/02; 837/2310B/NM1/82/02; Institutional: 837/2420A/NM1/72/02; 837/2420C/NM1/82/02; 837/2310A/NM1/71/02	Service Provider Entity Type Qualifier	char	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 a "person", and these shall be coded as a person. Health care claims processors shall code according to: 1 Person 2 Non-Person Entity	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC028	Professional: 837/2420A/NM1/82/04; 837/2310B/NM1/82/04; Institutional: 837/2420A/NM1/72/04; 837/2420C/NM1/82/04; 837/2310A/NM1/71/04	Service Provider First Name	varchar	25	Individual first name. Leave this field blank if provider is a facility or organization.	R
MC029	Professional: 837/2420A/NM1/82/05; 837/2310B/NM1/82/05; Institutional: 837/2420A/NM1/72/05; 837/2420C/NM1/82/05; 837/2310A/NM1/71/05	Service Provider Middle Name	varchar	25	Individual middle name or initial. Leave this field blank if provider is a facility or organization.	O
MC030	Professional: 837/2420A/NM1/82/03; 837/2310B/NM1/82/03; Institutional: 837/2420A/NM1/72/03; 837/2420C/NM1/82/03; 837/2310A/NM1/71/03	Service Provider Last Name or Organization Name	varchar	60	Full name of provider organization or last name of individual provider	R
MC031	Professional: 837/2420A/NM1/82/07; 837/2310B/NM1/82/07; Institutional: 837/2420A/NM1/72/07; 837/2420C/NM1/82/07; 837/2310A/NM1/71/07	Service Provider Suffix	varchar	10	Suffix to individual name. Leave this field blank if provider is a facility or organization. The service provider suffix shall 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, LCSW).	O
MC032	Professional: 837/2420A/PRV/PE/03; 837/2310B/PRV/PE/03; Institutional: 837/2310A/PRV/AT/03	Service Provider Specialty	varchar	10	Prefer CMS specialty or taxonomy codes. Homegrown codes can be used but a lookup is required. A dictionary for homegrown codes must be supplied during testing.	R
MC108	Professional: 837/2420C/N3/ /01 837/2310C/N3/ /01 Institutional: 837/2310E/N3/ /01	Service Facility Street Address	varchar	50	Physical location street address of where service was performed	R
MC033	Professional: 837/2420C/N4/ /01; 837/2310C/N4/ /01; Institutional: 837/2310E/N4/ /01	Service Facility City Name	varchar	30	City name of physical location where service was performed	R
MC034	Professional: 837/2420C/N4/ /02; 837/2310C/N4/ /02; Institutional: 837/2310E/N4/ /02	Service Facility State or Province	char	2	As defined by the US Postal Service, state or province associated with physical location where service was performed	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC035	Professional: 837/2420C/N4/ /03; 837/2310C/N4/ /03; Institutional: 837/2310E/N4/ /03	Service Facility ZIP Code	varchar	11	ZIP Code associated with location service was performed - may include non-US codes; do not include dash. Plus 4 optional but desired.	R
MC036	837/2300/CLM/ /05-1	Type of Bill - Institutional	char	3	Required for institutional claims; Not to be used for professional claims See Lookup Table B.1.D	R (institutional claims only)
MC037	837/2300/CLM/ /05-1	Place of Service	char	2	Required for professional claims. Not to be used for institutional claims. Map where you can and default to "99" for all others. See Place of Service Code Set | CMS(https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets)	R (professional claims only)
MC038	835/2100/CLP/ /02	Claim Status	char	2	See Lookup Table B.1.F	R
MC038A	N/A	COB/TPL Amount	int	12	Amount due from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	R if MC038 = 19, 20, or 21
MC038B	N/A	Denied Claim Line Indicator	char	1	Use this field to indicate whether the payer denied this specific line on this specific claim. Valid codes are: Y=Yes (denied). N= No (not denied).	R
MC038C	N/A	Claim Line Type	char	1	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O = original (original claim with no amendments or reversals) V = void (claim is voided and no amendment or replacement is expected) R = replacement (replaced claim) B = back out (claim is backed out and an amendment or replacement is expected) A = amendment (amended claim after original claim was backed out) D = Denied	R
MC039	837/2300/HI/BJ/01-2	Admitting Diagnosis	varchar	7	Required on all inpatient admission claims and encounters. ICD-9-CM or ICD-10-CM. Do not code decimal point.	R- inpatient claims O- outpatient
MC898	N/A	ICD-9 / ICD-10 Flag	char	1	0 This claim contains ICD-9-CM codes 1 This claim contains ICD-10-CM codes The purpose of this field is to identify which code set is being utilized.	R
MC040	837/2300/HI/BN/01-2	E-Code	varchar	7	Describes an injury, poisoning or adverse effect. ICD-9-CM or ICD-10-CM. Do not code decimal point.	O
MC041	837/2300/HI/BK/01-2	Principal Diagnosis	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	R
MC042	837/2300/HI/BF/01-2	Other Diagnosis - 1	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC043	837/2300/HI/BF/02-2	Other Diagnosis - 2	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC044	837/2300/HI/BF/03-2	Other Diagnosis - 3	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC045	837/2300/HI/BF/04-2	Other Diagnosis - 4	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC046	837/2300/HI/BF/05-2	Other Diagnosis - 5	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC047	837/2300/HI/BF/06-2	Other Diagnosis - 6	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC048	837/2300/HI/BF/07-2	Other Diagnosis - 7	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC049	837/2300/HI/BF/08-2	Other Diagnosis - 8	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC050	837/2300/HI/BF/09-2	Other Diagnosis - 9	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC051	837/2300/HI/BF/10-2	Other Diagnosis - 10	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC052	837/2300/HI/BF/11-2	Other Diagnosis - 11	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC053	837/2300/HI/BF/12-2	Other Diagnosis - 12	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC054	835/2110/SVC/NU/01-2	Revenue Code	char	4	National Uniform Billing Committee Codes. Code using leading zeroes, left justified, and four digits.	R for Institutional Claims only, otherwise leave blank
MC055	835/2110/SVC/HC/01-2	Outpatient Procedure Code	varchar	10	Health Care Common Procedural Coding System (HCPCS); refer to Section 1.1 for HCPCS reporting requirements. Required for Outpatient, Professional, Vision, and Dental claims.	R for Outpatient, Professional, Vision, and Dental Claims; otherwise leave blank
MC056	835/2110/SVC/HC/01-3	Procedure Modifier - 1	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. Required for Outpatient and Professional claims only.	R for Outpatient and Professional Claims only; otherwise leave blank
MC057	835/2110/SVC/HC/01-4	Procedure Modifier - 2	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. Required for Outpatient and Professional claims only.	R for Outpatient and Professional Claims only; otherwise leave blank
MC214	835/2110/SVC/HC/01-5	Procedure Modifier - 3	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. Required for Outpatient and Professional claims only.	R for Outpatient and Professional Claims only; otherwise leave blank
MC215	835/2110/SVC/HC/01-6	Procedure Modifier - 4	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. Required for Outpatient and Professional claims only.	R for Outpatient and Professional Claims only; otherwise leave blank
MC058	835/2110/SVC/ID/01-2	ICD-9-CM or ICD-10 Procedure Code	char	7	Primary procedure code for this line of service. Do not code decimal point. Default to Blank	R for Inpatient Claims only; otherwise leave blank
MC059	835/2110/DTM/150/02	Date of Service - From	date	8	First date of service for this service line. YYYYMMDD	R
MC060	835/2110/DTM/151/02	Date of Service - Thru	date	8	Last date of service for this service line. YYYYMMDD	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC061	835/2110/SVC/ /05	Quantity	dec	12	Count of services performed. The Unit of Measure is typically based on the relevant reporting code (e.g., CPT, revenue, HCPCS) For example: Anesthesiology = minutes Ambulance = Miles Room and board = Days Do code decimal point when applicable. For denied claims/claim lines, enter quantity as a positive value.	R
MC061A	N/A	Unit of Measure	varchar	2	Types of units for quantity reported in MC061. For drugs, report the code that defines the unit of measure for the drug dispensed in MC075. See Lookup Table B.1.N	R
MC062	835/2110/SVC/ /02	Charge Amount	int	11	Do not code decimal point or provide any punctuation where $1,000.00 converted to 100000. Do not code decimal point. Two decimal places implied. Same for all financial data that follows. For denied claims/claim lines, enter charge amount as a positive value.	R
MC063	835/2110/SVC/ /03	Paid Amount	int	10	Includes any withhold amounts. Do not code decimal point. Two decimals implied. For capitated claims set to zero. For denied claims/claim lines, paid amount should be $0.	R
MC064	N/A	Prepaid Amount	int	10	For capitated services, the fee for service equivalent amount. Do not code decimal point. Two decimals implied. For denied claims/claim lines, prepaid amount can be a positive amount or $0.	R
MC065	N/A	Co-pay Amount	int	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point. Two decimals implied. For denied claims/claim lines, co-pay amount should be $0.	R
MC066	N/A	Coinsurance Amount	int	10	The dollar amount an individual is responsible for - not the percentage. Do not code decimal point. Two decimals implied. For denied claims/claims lines, coinsurance amount should be $0.	R
MC067	N/A	Deductible Amount	int	10	Do not code decimal point. Two decimals implied. For denied claims/claims lines, deductible amount should be $0.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC213	N/A	Payment Arrangement Type Flag	char	2	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 03=Percent of Charges; 04=DRG; 05=Pay for Performance; 06=Global Payment; 07=Other; 08=Bundled Payment.	R
MC068	837/2300/CLM/ /01	Patient Account/Control Number	varchar	20	Number assigned by hospital	O
MC069	N/A	Discharge Date	date	8	Date patient discharged. Required for all inpatient claims. YYYYMMDD	R for all Inpatient Claims O for Outpatient
MC070	N/A	Service Provider Country Name	varchar	30	Code US for United States.	R
MC071	837/2300/HI/DR/01-2	DRG	varchar	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 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).	O
MC072	N/A	DRG Version	char	2	Version number of the grouper used	O
MC073	835/2110/REF/APC/02	APC	char	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.	O
MC074	N/A	APC Version	char	2	Version number of the grouper used	O
MC075	837/2410/LIN/N4/03	NDC Drug Code	varchar	11	Report the NDC code used only when a medication is paid for as part of a medical claim or when a DME device has an NDC code. J codes should be submitted under procedure code (MC055), and have a procedure code type of ‘HCPCS.	R; set as null if unavailable
MC076	837/2010AA/NM1/ID/09	Billing Provider Number	varchar	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.	R
MC077	837/2010AA/NM1/XX/09	National Billing Provider ID	varchar	20	National Provider ID	R
MC078	837/2010AA/NM1/ /03	Billing Provider Last Name or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.	R
MC101	837/2010BA/NM1/ /03	Subscriber Last Name	varchar	128	Subscriber last name	R
MC102	837/2010BA/NM1/ /04	Subscriber First Name	varchar	128	Subscriber first name	R
MC103	837/2010BA/NM1/ /05	Subscriber Middle Initial	char	1	Subscriber middle initial	O
MC104	837/2010CA/NM1/ /03	Member Last Name	varchar	128	Member last name	R
MC105	837/2010CA/NM1/ /04	Member First Name	varchar	128	Member first name	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC106	837/2010CA/NM1//05	Member Middle Initial	char	1	Member middle initial	O
MC201A	N/A	Present on Admission - PDX	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201B	N/A	Present on Admission - DX1	varchar	1	Code indicating the presence of diagnosis at the time of admission for MC201A See Table B.1.G for valid values.	R if 201A has a value (Inpatient only, otherwise leave blank)
MC201C	N/A	Present on Admission - DX2	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201D	N/A	Present on Admission - DX3	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201E	N/A	Present on Admission - DX4	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201F	N/A	Present on Admission - DX5	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201G	N/A	Present on Admission - DX6	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201H	N/A	Present on Admission - DX7	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201I	N/A	Present on Admission - DX8	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201J	N/A	Present on Admission - DX9	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201K	N/A	Present on Admission - DX10	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC201L	N/A	Present on Admission - DX11	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC201M	N/A	Present on Admission - DX12	varchar	1	Code indicating the presence of diagnosis at the time of admission See Table B.1.G for valid values.	R (Inpatient only, otherwise leave blank)
MC202	837D/2400/TOO/02	Tooth Number	char	20	Tooth Number or Letter Identification	R for Dental Claims only
MC203	837D/2400/SV/304 1-5	Dental Quadrant	char	2	Dental Quadrant	R for Dental Claims only
MC204	837D/2400/TOO/03 1 -5	Tooth Surface	char	7	Tooth Surface Identification	R for Dental Claims only
MC205	N/A	ICD-9-CM or ICD-10-CM Procedure Date	date	8	Date MC058 was performed	R
MC058A	835/2110/SVC/ID/0 1-2	ICD-9-CM Procedure Code or ICD-10-CM Procedure code	char	7	Secondary procedure code for this line of service. Do not code decimal point.	R Inpatient only, optional for O/P Default to blank
MC205A	N/A	ICD-9-CM or ICD-10-CM Procedure Date	date	8	Date MC058A was performed	R when MC058A is populated Default to blank if not present
MC058B	835/2110/SVC/ID/0 1-2	ICD-9-CM Procedure Code or ICD-10-CM Procedure code	char	7	Secondary procedure code for this line of service. Do not code decimal point.	R Inpatient Only, optional for O/P Default to blank if not present
MC205B	N/A	ICD-9-CM or ICD-10-CM Procedure Date	date	8	Date MC058B was performed	R when MC058B is populated Default to blank if not present
MC058C	835/2110/SVC/ID/0 1-2	ICD-9-CM Procedure Code or ICD-10-CM Procedure code	char	7	Secondary procedure code for this line of service. Do not code decimal point.	R Inpatient Only, optional for O/P. Default to blank if not present
MC205C	N/A	ICD-9-CM or ICD-10-CM Procedure Date	date	8	Date MC058C was performed	R when MC058C is populated. Default to blank if not present
MC058D	835/2110/SVC/ID/0 1-2	ICD-9-CM Procedure Code or ICD-10-CM Procedure code	char	7	Secondary procedure code for this line of service. Do not code decimal point.	R Inpatient Only, optional for O/P. Default to blank if not present
MC205D	N/A	ICD-9-CM or ICD-10-CM Procedure Date	date	8	Date MC058E was performed	R when MC058D is populated. Default to blank if not present
MC058E	835/2110/SVC/ID/0 1-2	ICD-9-CM Procedure Code or ICD-10-CM Procedure code	char	7	Secondary procedure code for this line of service. Do not code decimal point.	R Inpatient Only, optional for O/P. Default to blank if not present

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC205E	N/A	ICD-9-CM or ICD-10-CM Procedure Date	date	8	Date MC058E was performed	R when MC058E is populated. Default to blank if not present
MC206	N/A	Capitated Service Indicator	char	1	Y = services are paid under a capitated arrangement N = services are not paid under a capitated arrangement U = unknown	R
MC207	N/A	Provider network indicator	char	1	Servicing provider is a participating provider. Y = Yes N = No U = unknown	R
MC208	N/A	Self-Funded Claim Indicator	char	1	Y = Yes, Self-Funded claim N = No, Other	R
MC209	N/A	Dental Claim Indicator	char	1	Y = Yes, Dental claim N = No, Other	R
MC210	N/A	Medicare Beneficiary Identifier (MBI)	char	11	Medicare Beneficiary Identifier Required for Medicare, leave this field blank if unavailable. Do not submit HICN identifiers.	R for Medicare claims
MC211	N/A	NAIC ID	char	5	Report the NAIC Code associated with the entity that maintains this product. Leave this field blank if entity does not have a NAIC Code.	R
MC212	N/A	Medicaid AID Category	char	4	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. Contact CIVHC for acceptable codes. If not applicable, leave this field blank.	R for Medicaid claims
MC216	N/A	Managed Care Coordination Flag (HCPF-specific)	char	1	Y = claim is associated with managed care coordination HCPF-defined "encounter claim" N = claim is not associated with managed care coordination Leave this field blank if non-HCPF payer	R for HCPF
MC217	N/A	Claim Type Code (HCPF-specific)	char	1	HCPF-defined Claim Type Code Leave this field blank if non-HCPF payer	R for HCPF
MC218	N/A	Claim Type Code Description (HCPF-specific)	varchar	50	HCPF-defined Claim Type Code description Leave this field blank if non-HCPF payer	R for HCPF
MC219	N/A	Value-Based Payment (VBP) Indicator	char	1	Y = claim was adjudicated under a value-based payment (VBP) N = claim was not adjudicated under a value-based payment (VBP)	R
MC220	N/A	Vision Claim Indicator	char	1	Y = Yes, Vision claim N = No, Other	R
MC221	N/A	Denial Reason	char	5	Report the Claim Adjustment Reason Code (CARC) that defines the reason why the claim was denied. (https://x12.org/codes/claim-adjustment-reason-codes)	R when MC038 = 04
MC222	N/A	Service Location NPI	varchar	20	The National Provider Identifier (NPI) of the location where the services were provided.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC223	N/A	Benefit Plan Code (HCPF-specific)	varchar	6	For HCPF only. Provide the Benefit Plan Code for which the member is eligible and applies to this claim. Codes are determined by the state's Medicaid agency. Leave this field blank if non-HCPF payer	R for HCPF
MC224	N/A	Benefit Plan Code Description (HCPF - specific)	varchar	100	HCPF-defined Benefit Plan Code description Leave this field blank if non-HCPF payer	R for HCPF
MC899	N/A	Record Type	char	2	Value = MC	

A-3 PHARMACY CLAIMS DATA

Frequency: Monthly Upload via FTP or Web Portal

Additional formatting requirements:

- Include paid and denied claims.
- Payers submit data in a single, consistent format for each data type.

PHARMACY CLAIMS FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	HD
HD002	File Type	char	2	PC
HD003	Payer Code	char	7	Distributed by CIVHC's data administrator
HD004	Payer Name	char	75	Distributed by CIVHC
HD005	Beginning Month	date	6	YYYYMM
HD006	Ending Month	date	6	YYYYMM
HD007	Record count	int	10	Total number of records submitted in the Pharmacy Claims file, excluding header and trailer records
HD008	Med_BH PMPM	int	7	Place holder. Leave this field blank.
HD009	Pharmacy PMPM	int	7	Sum of PC036(Paid Amount) + PC040(Co-pay Amount) + PC041(Coinsurance Amount) + PC042(Deductible Amount) in pharmacy claims divided by the total distinct member IDs in the member eligibility, where prescription drug coverage flag (ME019) = 'Y'. Do not code decimal point or provide any punctuation where $1,000.00 converted to 100000 Two decimal places implied. Leave blank if above condition does not apply.
HD010	Dental PMPM	int	7	Place holder. Leave this field blank.
HD011	Vision PMPM	int	7	Place holder. Leave this field blank.
HD012	Test File Flag	char	1	T=File submitted is a test file; P=File submitted is a production file.

PHARMACY CLAIMS FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	TR
TR002	File Type	char	2	PC
TR003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
TR004	Payer Name	varchar	75	Distributed by CIVHC
TR005	Beginning Month	date	6	YYYYMM
TR006	Ending Month	date	6	YYYYMM
TR007	Extraction Date	date	8	YYYYMMDD

A-3.1 PHARMACY CLAIMS FILE

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC001	N/A	Payer Code	varchar	7	Distributed by CIVHC's data administrator	R
PC002	N/A	Payer Name	varchar	30	Distributed by CIVHC	R
PC003	N/A	Insurance Type/Product Code	char	2	See lookup table B.1.A	R
PC004	N/A	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system. Required for all paid, partially paid and fully denied claims.	R
PC204	N/A	Script number	int	18	Script number of prescription	R
PC005	N/A	Line Counter	int	4	Line number for this service. The line counter begins with 1 and is incremented	R

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
					by 1 for each additional service line of a claim.	
PC006	301-C1	Insured Group or Policy Number	varchar	30	Group or policy number – not the number that uniquely identifies the subscriber Ensure continuity across file types. Note that ME006 = MC006; PC006.	R
PC007	302-C2	Subscriber Social Security Number	varchar	9	Subscriber's social security number; Set as null if unavailable Ensure continuity across file types. Note that ME008 = MC007; PC007.	O
PC008	N/A	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract number; may use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber. Ensure continuity across file types. Note that ME009 = MC008; PC008	R
PC009	303-C3	Member Number	varchar	128	Unique number of the member within the contract. Must be an identifier that is unique to the member. May include a combination of contract number and suffix number in order to be unique. This column is the unique identifying column for membership and related medical and pharmacy claims. Only one record per eligibility month per eligibility year. Ensure continuity across file types. Note that ME010 = MC009; PC009	R
PC010	302-C2	Member Identification Code	varchar	128	Member's social security number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member. Ensure continuity across file types. Note that ME011 = MC010; PC010	O
PC011	N/A	Individual Relationship Code	char	2	Member's relationship to insured Use Lookup Table B.1.B Ensure continuity across file types. Note that ME012 = MC011; PC011	R
PC012	305-C5	Member Gender	char	1	M = Male F = Female X = Non-binary U = UNKNOWN	R
PC013	304-C4	Member Date of Birth	date	8	YYYYMMDD	R
PC014	N/A	Member City Name of Residence	varchar	50	City name of member's residence	R
PC015	N/A	Member State or Province	char	2	As defined by the US Postal Service	R
PC016	N/A	Member ZIP Code	varchar	11	ZIP Code of member – may include non-US codes. Do not include dash. Plus 4 optional but desired.	R
PC017	N/A	Paid date/Denial processed date	date	8	CCYYMMDD – date claim paid or denial processed if available, otherwise set to date prescription filled	R
PC018	201-B1	Pharmacy Number	varchar	30	Payer assigned pharmacy number. AHFS number is acceptable.	R

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC019	N/A	Pharmacy Tax ID Number	int	9	Federal taxpayer's identification number coded with no punctuation (carriers that contract with outside PBM's will not have this)	R
PC020	833-5P	Pharmacy Name	varchar	50	Name of pharmacy	R
PC021	N/A	Pharmacy National Provider ID Number	varchar	20	National Provider ID of pharmacy. This data element pertains to the entity or individual directly providing the service.	R
PC048	N/A	Pharmacy Location Street Address	varchar	50	Street address of pharmacy	O
PC022	831-5N	Pharmacy Location City	varchar	30	City name of pharmacy - preferably pharmacy location (if mail order null)	R
PC023	832-5O	Pharmacy Location State	char	2	As defined by the US Postal Service (if mail order null)	R
PC024	835-5R	Pharmacy ZIP Code	varchar	10	ZIP Code of pharmacy - may include non-US codes. Do not include dash. Plus 4 optional but desired (if mail order null)	R
PC024d	N/A	Pharmacy Country Name	varchar	30	Code US for United States	R
PC025	N/A	Claim Status	char	2	See Lookup Table B.1.F	R
PC025A	N/A	COB/TPL Amount	int	12	Amount due from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	R if PC025 = 19, 20, 21
PC025B	N/A	Claim Line Type	char	1	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O = original (original claim with no amendments or reversals) V = void (claim is voided and no amendment or replacement is expected) R = replacement (replaced claim) B = back out (claim is backed out and an amendment or replacement is expected) A = amendment (amended claim after original claim was backed out) D = denied	R
PC026	407-D7	NDC Drug Code	varchar	11	NDC Code	R
PC027	516-FG	Drug Name	varchar	80	Text name of drug	R
PC053	N/A	Formulary Indicator	char	1	Use this field to report if the prescribed drug was on the carrier's formulary list. Valid codes include: 1 =Yes; 2 = No; 3 = Unknown; 4 = Other; 5 = Not applicable.	R
PC028	403-D3	New Prescription or Refill	varchar	2	Older systems provide only an "N" for new or an "R" for refill, otherwise provide refill # 01 = New prescription 02 = Refill	R
PC028A	N/A	Refill Number	varchar	2	01-99 = Number of refill	R
PC029	425-DP	Generic Drug Indicator	char	2	01 = Branded drug 02 = Generic drug Should represent the generic/brand status at the time of adjudication.	R
PC029A	N/A	Specialty Drug Indicator	char	1	Y = Drug is a specialty drug based on payer formulary	R

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
					N = Drug is not a specialty drug based on payer formulary	
PC030	408-D8	Dispense as Written Code	char	1	Please use Table B.1.H	R
PC031	406-D6	Compound Drug Indicator	char	1	N = Non-compound drug Y = Compound drug U = Non-specified drug compound	R
PC031A	N/A	Compound Drug Name or Compound Drug Ingredient List	char	255	If PC031 = Y, then provide the name of the compound drug. If no compound drug name is identified, include the names of the compound drug ingredients. Do not include drug NDCs. Use spaces between multiple drugs.	O
PC032	401-D1	Date Prescription Filled	date	8	YYYYMMDD	R
PC033	404-D4	Quantity Dispensed	dec	10	Number of metric units of medication dispensed. Code decimal point. For denied claims/claim lines, enter quantity dispensed as 0.	R
PC034	405-D5	Days Supply	int	4	Estimated number of days the prescription will last. For denied claims/claim lines, enter days supply as 0.	R
PC035	804-5B	Charge Amount	int	10	Do not code decimal point or provide any punctuation where $1,000.00 converted to 100000. Two decimal places implied. Same for all financial data that follows. For denied claims/claim lines, enter charge amount as a positive value.	R
PC036	876-4B	Paid Amount	int	10	Includes all health plan payments and excludes all member payments. Do not code decimal point. Two decimal places implied. Do not deduct POS rebate amount, if applicable. For denied claims/claim lines, paid amount should be $0.	R
PC037	506-F6	Ingredient Cost/List Price	int	10	Cost of the drug dispensed. Do not code decimal point. Two decimal places implied.	R
PC038	428-DS	Postage Amount Claimed	int	10	Do not code decimal point. Two decimal places implied. Not typically captured. For denied claims/claim lines, postage amount claimed should be $0.	O
PC039	412-DC	Dispensing Fee	int	10	Do not code decimal point. Two decimal places implied. For denied claims/claim lines, dispensing fee should be $0.	R
PC040	817-5E	Co-pay Amount	int	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point. Two decimal places implied. Do not deduct POS rebate amount, if applicable. For denied claims/claim lines, co-pay amount should be $0.	R
PC041	N/A	Coinsurance Amount	int	10	The dollar amount an individual is responsible for - not the percentage. Do not code decimal point. Two decimal places implied. Do not deduct POS rebate amount, if applicable.	R

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
					For denied claims/claim lines, coinsurance amount should be $0.	
PC042	N/A	Deductible Amount	int	10	Do not code decimal point. Two decimal places implied. Do not deduct POS rebate amount, if applicable. For denied claims/claim lines, deductible amount should be $0.	R
PC043	N/A	Total POS Rebate Amount	int	10	The dollar amount of the total POS (point-of-sale) rebate. The total POS rebate amount should be reported in full and should not be deducted from either plan paid or member copay, deductible, or coinsurance amounts. Do not code decimal point. Two decimal places implied.	R
PC043A	N/A	Member POS Rebate Amount	int	10	The dollar amount of the total POS rebate that was received by the member. The member POS rebate amount should not be deducted from member copay, deductible, or coinsurance amounts. Do not code decimal point. Two decimal places implied.	R
PC044	N/A	Prescribing Physician First Name	varchar	25	Physician first name.	O if PC047 is filled with DEA #
PC045	N/A	Prescribing Physician Middle Name	varchar	25	Physician middle name or initial.	O if PC047 is filled with DEA #
PC046	427-DR	Prescribing Physician Last Name	varchar	60	Physician last name	O if PC047 is filled with DEA #; R if PC047 is not filled or contains NPI number
PC047	421-DZ	Prescribing Physician NPI	varchar	20	NPI number for prescribing physician	R
PC049	N/A	Member Street Address	varchar	50	Physical street address of the covered member	R
PC101	313-CD	Subscriber Last Name	varchar	128	Subscriber last name	R
PC102	312-CC	Subscriber First Name	varchar	128	Subscriber first name	R
PC103	N/A	Subscriber Middle Initial	char	1	Subscriber middle initial	O
PC104	311-CB	Member Last Name	varchar	128	Member last name	R
PC105	310-CA	Member First Name	varchar	128	Member first name	R
PC106	N/A	Member Middle Initial	char	1	Member middle initial	O
PC201	N/A	Version Number	int	4	The version number of this claim service line. The original claim will have a version number of 0, with the next version being assigned a 1, and each subsequent version being incremented by 1 for that service line. Required default YYMM	R
PC202	N/A	Prescription Written Date	date	8	Date prescription was written	R
PC047a	421-DZ	Prescribing Physician Provider ID	varchar	30	Provider ID for the prescribing physician	R
PC047b	421-DZ	Prescribing Physician DEA	varchar	20	DEA number for prescribing physician	O
PC050	N/A	Medicare Beneficiary Identifier (MBI)	char	11	Medicare Beneficiary Identifier Required for Medicare, set as null if unavailable. Do not submit HICN identifiers.	R for Medicare claims
PC051	N/A	NAIC ID	char	5	Report the NAIC Code associated with the entity that maintains this product. For each	R

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
					claim, use the NAIC code of the carrier when a PBM processes claims on behalf of the carrier. Leave this field blank if entity does not have a NAIC Code.	
PC052	N/A	Medicaid AID category	char	4	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. Contact CIVHC for acceptable codes. If not applicable, leave this field blank.	R for HCPF
PC203	N/A	Managed Care Coordination Flag	char	1	Y = claim is associated with managed care coordination, HCPF-defined "encounter claim" N = claim is not associated with managed care coordination Leave this field blank if payer is not HCPF	R for HCPF
PC205	N/A	Mail Order Pharmacy Indicator	char	1	Y = prescription was filled using a mail order pharmacy N = prescription was not filled using a mail order pharmacy	R
PC206	N/A	Value-Based Payment (VBP) Indicator	char	1	Y = claim was adjudicated under a value-based payment (VBP) N = claim was not adjudicated under a value-based payment (VBP)	O for six months (R in January 2022)
PC207	N/A	Denied Claim Line Indicator	char	1	Use this field to indicate whether the payer denied this specific line on this specific claim. Valid codes are: Y=Yes (denied). N= No (not denied).	R
PC208	N/A	Denial Reason	char	5	Report the **National Council for Prescription Drug Programs**, (**NCPDP**) reject code that defines the reason why the claim was denied.	R when PC025 = 04
PC209	N/A	Formulary Tier	int	1	The level of coverage based on the type or usage of the medication. For drugs on the carrier's formulary list only. 1 = Tier 1 Preferred generic drugs (Lower-cost, commonly used generic drugs) 2 = Tier 2 Generic drugs (High-cost, commonly used generic drugs) 3 = Tier 3 Preferred brand drugs (Brand-name drugs without a lower-cost generic therapeutic equivalent) 4 = Tier 4 Non-preferred generic and brand drugs (Higher-cost generic and brand-name drugs with a lower-cost generic therapeutic equivalent) 5 = Tier 5 Specialty drugs (Unique and/or high-cost generic and brand-name drugs)	R when PC053 = 1
PC210	N/A	Benefit Plan Code (HCPF -specific)	varchar	6	For HCPF only. Provide the Benefit Plan Code for which the member is eligible and applies to this claim. Codes are determined by the state's Medicaid agency. Leave this field blank if non-HCPF payer	R for HCPF
PC211	N/A	Benefit Plan Code Description (HCPF -specific)	varchar	100	HCPF-defined Benefit Plan Code description Leave this field blank if non-HCPF payer	R for HCPF
PC899	N/A	Record Type	char	2	PC	R

A-4 PROVIDER DATA

Frequency: Monthly Upload via FTP or Web Portal

Additional formatting requirements:

- Payers submit data in a single, consistent format for each data type.
- A provider means a health care facility, health care practitioner, health product manufacturer, health product vendor or pharmacy.
- A billing provider means a provider or other entity that submits claims to health care claims processors for health care services directly or provided to a subscriber or member by a service provider.
- A service provider means the provider who directly performed or provided a health care service to a subscriber of member.
- One record submitted for each provider for each unique physical address.
- Provider health system affiliation means a provider who is employed by a hospital or health system, or under a professional services agreement, faculty agreement, or management agreement with a hospital or health system that permits the hospital or health system to bill on behalf of the affiliated entity.
- Health System means a corporation or other organization that owns, contains, or operates three or more hospitals CRS 10-16-1303 (9)

PROVIDER FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	HD
HD002	File Type	char	2	MP
HD003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
HD004	Payer Name	varchar	75	Distributed by CIVHC
HD005	Beginning Month	date	6	YYYYMM (Example: 200801)
HD006	Ending Month	date	6	YYYYMM (Example: 200812)
HD007	Record count	int	10	Total number of records submitted in the Provider file, excluding header and trailer records
HD008	Med_BH PMPM	int	7	Place holder. Leave this field blank.
HD009	Pharmacy PMPM	int	7	Place holder. Leave this field blank.
HD010	Dental PMPM	int	7	Place holder. Leave this field blank.
HD011	Vision PMPM	int	7	Place holder. Leave this field blank.
HD012	Test File Flag	char	1	T=File submitted is a test file; P=File submitted is a production file.

PROVIDER FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	HD
TR002	File Type	char	2	MP
TR003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
TR004	Payer Name	varchar	75	Distributed by CIVHC
TR005	Beginning Month	date	6	YYYYMM (Example: 200801)
TR006	Ending Month	date	6	YYYYMM (Example: 200812)
TR007	Extraction Date	date	8	YYYYMMDD

A-4.1 PROVIDER FILE

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MP001A	N/A	Payer Code	varchar	7	Distributed by CIVHC's data administrator	R
MP001B	N/A	Year	year	4	4-digit Year for which the provider is reported in this submission	R
MP001C	N/A	Month	month	2	Month for which the provider is reported in this submission expressed numerical from 01 to 12.	R
MP001	N/A	Provider ID	varchar	30	A unique identifier for the provider as assigned by the reporting entity. Needs to be unique within the MP file. One unique ID Per Provider. May include a unique combination of NPI and tax ID. MP001= MC024, PC047A	R
MP002	N/A	Provider Tax ID	int	9	Tax ID of the provider. Do not code punctuation. Report employer TIN when entity is a practitioner.	R
MP003	N/A	Provider Entity	char	1	F = Facility G = Provider group I = IPA P = Practitioner	R
MP004	N/A	Provider First Name	varchar	25	Individual first name. Set to null if provider is a facility or organization.	R
MP005	N/A	Provider Middle Name or Initial	varchar	25	Provider middle name or initial	O
MP006	N/A	Provider Last Name or Organization Name	varchar	60	Full name of provider organization or last name of individual provider	R
MP007	N/A	Provider Suffix	varchar	10	Example: Jr.; leave this field blank if provider is an organization. Do not use credentials such as MD or PhD	O
MP008	N/A	Provider Specialty	varchar	50	Report the HIPAA-compliant health care provider taxonomy code. Code set is freely available at the National Uniform Claims Committee's web site https://taxonomy.nucc.org/	R
MP009	N/A	Provider Office Street Address	varchar	50	Physical address line 1- street address where provider delivers health care services: street name and number	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MP010	N/A	Provider Office City	varchar	30	Physical address - city where provider delivers health care services	R
MP011	N/A	Provider Office State	char	2	Physical address - state where provider delivers health care services. Use postal service standard 2 letter abbreviations.	R
MP012	N/A	Provider Office Zip	varchar	11	Physical address - zipcode where provider delivers health care services. Minimum 5-digit code.	R
MP013	N/A	Provider DEA Number	varchar	12	Provider Drug Enforcement Agency number. For all prescribing providers (PC047A) that have a DEA number.	R
MP014	N/A	Provider NPI	varchar	20	NPI for provider as enumerated in the Center for Medicaid and Medicare Services NPPES.	R
MP015	N/A	Provider State License Number	varchar	30	Prefix with two-character state of licensure with no punctuation. Example COLL12345	R
MP016	N/A	Provider office Address	varchar	50	Physical address line 2 – office address where provider delivers health care services: Suite number, floor number, Unit number, etc.	O
MP017	N/A	Provider Office phone number	varchar	10	Provider Office number: Telephone number for office where provider delivers health care services.	O
MP018	N/A	Provider Health System Affiliation	char	250	Name of Health System provider (professional or facility) is affiliated or employed through. Leave this field blank if affiliation is unknown. Enter NA if not applicable.	R
MP899	N/A	Record Type	char	2	MP	R

A-5 Annual Supplemental Provider Level Alternative Payment Model (APM) Data

Frequency: Submit annually in .txt format to CIVHC via SFTP by September 1st of each year.

Test files covering the same three most recent and complete calendar-year periods are required by July 1 to identify and resolve issues prior to final production submission. Annual submissions must include accurate and complete data for the three most recent calendar years. During both testing and production, submitters are expected to communicate with CIVHC for clarification, feedback, and resubmission guidance, and to take timely corrective action to ensure submissions meet reporting requirements. Payers must also provide explanations for discrepancies, including but not limited to those between files covering the same reporting years, between CO APCD monthly and annual file data, or within reporting years contained in the same submission file. Detailed timelines for both test and production submissions are provided in the tables below.

To request a one-year waiver from the annual submission requirement, payers must send the waiver to **submissions@civhc.org** by April 1st. Waivers apply to production files due September 1st of the same calendar year and must be submitted separately for each payer code.

Date That Payer Must Submit APM file to CO APCD	Period Begin date	Period End date
120 days after the effective date of the rule	*N/A*	*N/A*
July 1, 2019	*January 1, 2016*	*December 31, 2016*
September 30, 2019	*January 1, 2016*	*December 31, 2018*
September 30, 2020	*January 1, 2017*	*December 31, 2019*

September 30, 2021	*January 1, 2018*	*December 1 2020*
September 1, 2022	*January 1, 2019*	*December 31, 2021*
September 1, 2023	*January 1, 2020*	*December 31, 2022*
September 1, 2024	*January 1 2021*	*December 31, 2023*
September 1, 2025	*January 1 2022*	*December 31, 2024*
September 1, 2026	*January 1 2023*	*December 31, 2025*

AM, CT, and AC Annual Data File Submission Requirements Timeline	
Annual files waiver requests due	April 1st
Annual **test** AM, CT, and AC files due for the three preceding calendar years from the year of submission	July 1st
Annual test files must be passing all intake validations	July 15th
Annual **production** AM, CT, and AC files due for the three preceding calendar years from the year of submission	September 1st
All APM files (CT, AM, AC) must pass CIVHC QC validations	October 15th
Signed attestation form must be received by CIVHC for APM (CT, AM, and AC) files	October 31st

All definitions for APM types are included in look up table B.1.J

- Payers submit data in a single, consistent format for each data type.
- Payers submit APM data for members residing in Colorado.
- Include all payments made related to care during the previous three calendar years. Payments related to care include:
  - A: Population health and practice infrastructure payments
  - B: Performance payments
  - C: Payments with shared savings and recoupments
  - D: Capitation and full risk payments
  - E: Other non-claims payments
  - X: Fee for service
  - Z: Member count

APM File Header Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	HD
HD002	File Type	char	2	AM
HD003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
HD004	Payer Name	varchar	75	Distributed by CIVHC
HD005	Beginning Month	date	6	YYYYMM (Example: 200801)
HD006	Ending Month	date	6	YYYYMM (Example: 200812)
HD007	Record Count	int	10	Total number of records submitted in the APM file, excluding header and trailer records
HD008	Med_BH PMPM	int	7	Place holder. Leave this field blank.
HD009	Pharmacy PMPM	int	7	Place holder. Leave this field blank.
HD010	Dental PMPM	int	7	Place holder. Leave this field blank.
HD011	Vision PMPM	int	7	Place holder. Leave this field blank.
HD012	Test File Flag	char	1	T=File submitted is a test file; P=File submitted is a production file.

APM File Trailer Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	TR
TR002	File Type	char	2	AM
TR003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
TR004	Payer Name	varchar	75	Distributed by CIVHC
TR005	Beginning Month	date	6	YYYYMM (Example: 200801)
TR006	Ending Month	date	6	YYYYMM (Example: 200812)

TR007	Extraction Date	date	8	YYYYMMDD

A-5.1 APM FILE

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM001	N/A	Payer Code	varchar	7	Distributed by CIVHC's data administrator	R
AM002	N/A	Billing Provider Number	varchar	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 number should align with billing provider numbers in the MC file.	R
AM003	N/A	National Billing Provider ID	varchar	20	National Provider ID	R
AM004	N/A	Billing Provider Tax ID	varchar	9	Tax ID of billing provider. Do not code punctuation.	R
AM005	N/A	Billing Provider Last Name or Organization Name	varchar	128	Full name of provider billing organization or last name of individual billing provider.	R
AM006	N/A	Billing Provider Entity	char	1	F = Facility G = Provider group I = IPA P = Practitioner	R
AM007	CDLAP012	Payment Arrangement Category	char	1	See look up table B.1.J Payment arrangement type reported. If there is more than one payment arrangement type with a billing provider/organization, then separately report each payment arrangement type.	R
AM008	N/A	Prospective Payment Flag	char	1	Y = Payment to provider for services was made prospectively; populate field with 'Y' even when retrospective reconciliation is part of contract N = Payment to provider for services was not made prospectively	R
AM009	N/A	Performance Year	year	4	Effective year of performance period for reported Insurance Product Type Code and Payment Arrangement Type. YYYY format	R
AM010	N/A	Insurance Product Type Code	char	2	See lookup table B.1.A	R
AM011	N/A	Member Months	int	12	Total number of members in reported stratification attributed to given billing provider that participate in the reported payment arrangement in given year, expressed in months of membership No decimal places; round to nearest integer. Example: 12345	R
AM012	N/A	Total Primary Care Claims Payments	numeric	15	Sum of all associated payments tied to a claim, including patient cost-sharing amounts that pertain to primary care. Primary care services are to be identified based on the definition provided in table B.1.K. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no primary care claims payments made. This value should never exceed the amount of Total Claims Payments (AM016).	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM013	N/A	Payer Portion: Total Primary Care Claims Payments	numeric	15	Payer portion of total primary care payments tied to a claim reported in AM012. Exclude member portion (copay, coinsurance, deductible). Should be a sub-set of AM012. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no primary care claims payments made by payer.	R
AM014	N/A	Total Primary Care Non-Claims Payments	numeric	15	Sum of all associated non-claims payments that pertain to primary care. Primary care services are to be identified based on the definition provided in table B.1.K. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no primary care non-claims payments made. Amount reported should be net of any provider recoupments. This value should never exceed the amount of Total Non-Claims Payments (AM018).	R
AM015	N/A	Payer portion: Total Primary Care Non-Claims Payments	numeric	15	Payer portion of Total Primary Care Non-Claims Payments reported in AM014. Exclude member portion (copay, coinsurance, deductible). Should be a sub-set of AM014. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Amount reported should be net of any provider recoupments. Enter 0 if no primary care non-claims payments made by payer.	R
AM016	N/A	Total Claims Payments	numeric	15	Sum of all associated payments tied to a claim, including patient cost-sharing amounts. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no claims payments made.	R
AM017	N/A	Payer Portion: Total Claims Payments	numeric	15	Payer portion of total payments tied to a claim reported in AM016. Exclude member portion (copay, coinsurance, deductible). Should be a sub-set of AM016. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no claims payments made by payer.	R
AM018	N/A	Total Non-Claims Payments	numeric	15	Sum of all associated non-claims payments. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Amount reported should be net of any provider recoupments. Enter 0 if no non- claims payments made.	R
AM019	N/A	Payer Portion: Total Non-Claims Payments	numeric	15	Payer portion of Total Non-Claims Payments reported in AM018. Exclude member portion (copay, coinsurance, deductible). Should be a	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					sub-set of AM018. Amount reported should be net of any provider recoupments. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no non-claims payments made by payer.	
AM020	N/A	Recoupments from Provider	numeric	15	Any funds that were refunded to carrier from provider as a result of missed quality metrics, missed spending targets, or APM reconciliation payments. Do not report claim reversals or any other recoupments that occurred as a result of accounting errors.	R
AM021	N/A	Billing Provider Office City	varchar	30	Physical address – name of city	R
AM022	N/A	Billing Provider Office State	char	2	Physical address – name of state. Use postal service standard 2 letter abbreviations.	R
AM023	N/A	Billing Provider Office Zip	varchar	11	Physical address - Minimum 5-digit zip code.	R
AM024	N/A	RAE Indicator	char	2	Identify which Medicaid Regional Accountable Entity the provider is associated with 1 = RAE Region 1 2 = RAE Region 2 3 = RAE Region 3 4 = RAE Region 4 5 = RAE Region 5 6 = RAE Region 6 7 = RAE Region 7 8 = RAE Region 8 Leave this field blank if non-MCO/RAE payer	R for RAE and MCOs
AM025	CDLAP005	Contract Number	varchar	80	The unique number identifying a contract between the payer and the billing provider for the reported payment model.	R
AM026	CDLAP011	Billing Provider First Name	varchar	35	Individual first name. If provider is a facility or organization, leave this field blank.	R
AM027	CDLAP012	Payment Subcategory	char	2	Report a Payment Subcategory corresponding to the initial character in the Payment Arrangement Category in AM007. See table B.1.J.A	R
AM028	CDLAP014	Member Count	int	12	The total number of members enrolled during the reporting period. Report when Payment Category (AM007) = ‘B’, ‘D’, or ‘Z’: 1. Category = 'B': Total number of members associated with the incentive payments. 2. Category = 'D': Total number of members associated with the capitated payments reported. 3. Category = 'Z': Total number of months enrolled for members reported in Member Count (members for payer’s entire book of business for the year). This record is not expected to have any associated dollar amounts reported.	R
AM029	CDLAP017	Total Member Responsibility Amount	numeric	15	Total of all member responsibility amounts (copay, coinsurance, and deductibles). Two explicit decimal places (e.g., 200.00).If the value for this field is zero, report as "0.00", not as null. This field may contain a negative value.	R
AM030	CDLAP019	Total Amount Paid for Behavioral Health	numeric	15	Total of all payments made to a billing provider for behavioral health services during the Reporting/Performance Period.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member responsibility amounts (copay, coinsurance, and deductibles). Two explicit decimal places (e.g., 200.00). If the value for this field is zero, report as "0.00", not as null. This field may contain a negative value.	
AM999	N/A	Record Type	char	2	AM	R

A-6.0 CONTROLS TOTALS FOR ANNUAL SUPPLEMENTAL PROVIDER LEVEL APM SUMMARY

Frequency: Submit annually in .txt format to CIVHC via SFTP by September 1st of each year.

Test files covering the same three most recent and complete calendar-year periods are required by July 1 to identify and resolve issues prior to final production submission. Annual submissions must include accurate and complete data for the three most recent calendar years. During both testing and production, submitters are expected to communicate with CIVHC for clarification, feedback, and resubmission guidance, and to take timely corrective action to ensure submissions meet reporting requirements. Payers must also provide explanations for discrepancies, including but not limited to those between files covering the same reporting years, between CO APCD monthly and annual file data, or within reporting years contained in the same submission file. Detailed timelines for both test and production submissions are provided in the tables below.

To request a one-year waiver from the annual submission requirement, payers must send the waiver to **submissions@civhc.org** by April 1st. Waivers apply to production files due September 1st of the same calendar year and must be submitted separately for each payer code.

Date That Supplier Must Submit Control Total file to CO APCD	Period Begin date	Period End date
120 days after the effective date of the rule	*N/A*	*N/A*
July 1, 2019	*January 1, 2016*	*December 31, 2016*
September 30, 2019	*January 1, 2016*	*December 31, 2018*
September 30, 2020	*January 1, 2017*	*December 31, 2019*
September 30, 2021	*January 1, 2018*	*December 1 2020*
September 1, 2022	*January 1, 2019*	*December 31, 2021*
September 1, 2023	*January 1, 2020*	*December 31, 2022*
September 1, 2024	*January 1 2021*	*December 31, 2023*
September 1, 2025	*January 1 2022*	*December 31, 2024*
September 1, 2026	*January 1 2023*	*December 31, 2025*

AM, CT, and AC Annual Data File Submission Requirements Timeline	
Annual files waiver requests due	April 1st
Annual **test** AM, CT, and AC files due for the three preceding calendar years from the year of submission	July 1st
Annual test files must be passing all intake validations	July 15th
Annual **production** AM, CT, and AC files due for the three preceding calendar years from the year of submission	September 1st
All APM files (CT, AM, AC) must pass CIVHC QC validations	October 15th
Signed attestation form must be received by CIVHC for APM (CT, AM, and AC) files	October 31st

CONTROL TOTAL FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	HD

HD002	File Type	char	2	CT
HD003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
HD004	Payer Name	varchar	75	Distributed by CIVHC
HD005	Beginning Month	date	6	YYYYMM (Example: 200801)
HD006	Ending Month	date	6	YYYYMM (Example: 200812)
HD007	Record count	Int	10	Total number of records submitted in the Drug Rebate file, excluding header and trailer records
HD008	Med_BH PMPM	int	7	Place holder. Leave this field blank.
HD009	Pharmacy PMPM	int	7	Place holder. Leave this field blank.
HD010	Dental PMPM	int	7	Place holder. Leave this field blank.
HD011	Vision PMPM	int	7	Place holder. Leave this field blank.
HD012	Test File Flag	char	1	T=File submitted is a test file; P=File submitted is a production file.

CONTROL TOTAL FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	TR
TR002	File Type	char	2	CT
TR003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
TR004	Payer Name	varchar	75	Distributed by CIVHC
TR005	Beginning Month	date	6	YYYYMM (Example: 200801)
TR006	Ending Month	date	6	YYYYMM (Example: 200812)
TR007	Extraction Date	date	8	YYYYMMDD

A 6.1 - APM FILE CONTROL RECORD

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
CT001	N/A	Payer Code	varchar	7	Distributed by CIVHC's data administrator	R
CT002	N/A	Payer Name	varchar	75	Distributed by CIVHC	R
CT003	N/A	Submitted File	varchar	25	File name of the APM file. Note, please do not include file extension in the corresponding APM file name, i.e., '.txt'. If your organization resubmits AM under v02, the reference in CT003 should also reflect v02. The value should be case sensitive. For example, if the AM file name is *PROD_0000_2024AMv02*, CT003 should be *PROD_0000_2024AMv02* and not *PROD_0000_2024AMV02*.	R
CT004	N/A	Performance Year	year	4	Year of reporting, submit in YYYY format	R
CT005	N/A	Insurance Product Type Code	char	2	See lookup table B.1.A	R
CT006	N/A	Payment Arrangement Category	varchar	2	See look up table B.1.J Payment arrangement type reported.	R
CT007	N/A	Payment Arrangement Category Member Months	int	12	Total, de-duplicated member months associated with payment arrangement category identified in CT006 & CT020 and Medicaid Regional Accountable Entity (RAE) identified in CT018, if applicable . No decimal places; round to nearest integer Example: 12345 Enrollment should be reported as de-duplicated member months and should only be reported for those members for whom the mandatory reporter was the primary payer	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
CT008	N/A	All Member Months	int	12	Total enrollment during the previous calendar year, regardless of payment arrangement type. No decimal places; round to nearest integer. Example: 12345 Enrollment should be reported as de-duplicated member months and should only be reported for those members for whom the mandatory reporter was the primary payer. The value in this field will repeat in the Control Total file for each reported year/insurance product type code/RAE (if applicable) combination.	R
CT009	N/A	Total Alternative Arrangement Member Months	int	12	Total enrollment in alternative payment arrangements during the previous calendar year. No decimal places; round to nearest integer Example: 12345 Enrollment should be reported as de-duplicated member months and should only be reported for those members for whom the mandatory reporter was the primary payer. The value in this field will repeat in the Control Total file for each reported year/insurance product type code/RAE (if applicable) combination.	R
CT010	N/A	Sum of Primary Care Claims Payments	numeric	15	Sum of Total Primary Care Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).	R
CT011	N/A	Sum of Payer Portion of Primary Care Claims Payments	numeric	15	Sum of Payer Portion of Total Primary Care Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).	R
CT012	N/A	Sum of Primary Care Non-Claims Payments	numeric	15	Sum of Total Primary Care Non-Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).	R
CT013	N/A	Sum of Payer Portion of Primary Care Non-Claims Payments	numeric	15	Sum of Payer Portion of Total Primary Care Non-Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
CT014	N/A	Sum of Claims Payments	numeric	15	Sum of Total Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).	R
CT015	N/A	Sum of Payer Portion of Claims Payments	numeric	15	Sum of Payer Portion of Total Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).	R
CT016	N/A	Sum of Non-Claims Payments	numeric	15	Sum of Total Non-Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).	R
CT017	N/A	Sum of Payer Portion of Non-Claims Payments	numeric	15	Sum of Payer Portion of Total Non-Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).	R
CT018	N/A	RAE Indicator	char	2	Identify which Medicaid Regional Accountable Entity the provider is associated with 1 = RAE Region 1 2 = RAE Region 2 3 = RAE Region 3 4 = RAE Region 4 5 = RAE Region 5 6 = RAE Region 6 7 = RAE Region 7 8= RAE Region 8 Leave this field blank if non-MCO/RAE payer	R for RAE and MCOs
CT019	N/A	Percent of Providers Participating in at Least One APM	numeric	3	Percent of providers under at least one APM contract with the payer. Report the percentage for the Performance Year (CT004) CT019 = (Count of providers that participate in at least one APM contract) / (Count of providers that have at least one claim adjudicated or at least one APM payment during the performance year (CT004)) Two explicit decimal places (e.g., 78.05)	R
CT020	CDLAP012	Payment Subcategory	char	2	Report a Payment Subcategory corresponding to the initial character in the Payment Category in CT006. See table B.1.J.A	R
CT021		Payment Arrangement	int	12	Total, de-duplicated member count associated with payment arrangement category identified in CT006 & CT020 and Medicaid	

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
		Category Member Count			Regional Accountable Entity (RAE) identified in CT018, if applicable. No decimal places; round to nearest integer Example: 12345 Count should be reported as de-duplicated member counts and should only be reported for those members for whom the mandatory reporter was the primary payer	
CT022		All Member Count	int	12	Total member count during the previous calendar year, regardless of payment arrangement type. No decimal places; round to nearest integer. Example: 12345 Count should be reported as de-duplicated member counts and should only be reported for those members for whom the mandatory reporter was the primary payer. The value in this field will repeat in the Control Total file for each reported year/insurance product type code/RAE (if applicable) combination.	R
CT023		Total Alternative Arrangement Member Count	int	12	Total enrollment in alternative payment arrangements during the previous calendar year. No decimal places; round to nearest integer Example: 12345 Count should be reported as de-duplicated member counts and should only be reported for those members for whom the mandatory reporter was the primary payer. The value in this field will repeat in the Control Total file for each reported year/insurance product type code/RAE (if applicable) combination.	R
CT024	CDLAP017	Total Member Responsibility Amount	numeric	15	Total of all member responsibility amounts (copay, coinsurance, and deductibles). Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00).If the value for this field is zero, report as "0.00", not as null. This field may contain a negative value.	R
CT025	CDLAP019	Total Amount Paid for Behavioral Health	numeric	15	Total of all payments made to a billing provider for behavioral health services during the Reporting/Performance Period. For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member responsibility amounts (copay, coinsurance, and deductibles).	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00). If the value for this field is zero, report as "0.00", not as null. This field may contain a negative value.	
CT999	N/A	Record Type	char	2	CT	R

A-7 ANNUAL APM CONTRACT INFORMATION

Frequency: Submit annually in CSV format to CIVHC via SFTP by September 1st of each year. Pipe (|) and comma (,) delimiters are allowed. Note: do not include column headers within the CSV. Do not include commas (,) or double quotes (”) within the CSV’s field contents.

Test files covering the same three most recent and complete calendar-year periods are required by July 1 to identify and resolve issues prior to final production submission. Annual submissions must include accurate and complete data for the three most recent calendar years. During both testing and production, submitters are expected to communicate with CIVHC for clarification, feedback, and resubmission guidance, and to take timely corrective action to ensure submissions meet reporting requirements. Payers must also provide explanations for discrepancies, including but not limited to those between files covering the same reporting years, between CO APCD monthly and annual file data, or within reporting years contained in the same submission file. Detailed timelines for both test and production submissions are provided in the tables below.

To request a one-year waiver from the annual submission requirement, payers must send the waiver to **submissions@civhc.org** by April 1st. Waivers apply to production files due September 1st of the same calendar year and must be submitted separately for each payer code.

AM, CT, and AC Annual Data File Submission Requirements Timeline	
Annual files waiver requests due	April 1st
Annual **test** AM, CT, and AC files due for the three preceding calendar years from the year of submission	July 1st
Annual test files must be passing all intake validations	July 15th
Annual **production** AM, CT, and AC files due for the three preceding calendar years from the year of submission	September 1st
All APM files (CT, AM, AC) must pass CIVHC QC validations	October 15th
Signed attestation form must be received by CIVHC for APM (CT, AM, and AC) files	October 31st

A 7.1 Annual APM Contract Information

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
AC001	Payer Code	varchar	7	Distributed by CIVHC’s data administrator	R
AC002	Payer Name	varchar	75	Distributed by CIVHC	R
AC003	Contract Type Name	varchar	75	The unique name of the alternative payment contract type between the payer and providers.	R
AC004	Contract Description	varchar	500	Description of the alternative payment model contract 3-5 sentences describing the nature of the contract including a summary of services provided, provider reimbursement method, and any other important details related to the purpose and structure of the contract. If AC007 = “Y,” then describe quality metrics associated with arrangement	R
AC005	Involves both claims and non-claims payments	char	1	C = Claims only N = Non-Claims only B = Both claims and non-claims	R
AC006	Services Covered	char	1	N = Non-medical activities only S = Specific set of medical services M = Comprehensive medical services	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
AC007	Involves Measurement of Quality	char	1	Y = Quality measurement N = No quality measurement	R
AC008	Involves Measurement of Spending Targets	char	1	Y = Spending targets N = No spending targets	R
AC009	Payments are Prospective or Retrospective	char	3	PR = Prospective with retrospective reconciliation PN = Prospective with no retrospective reconciliation RT = Retrospective N/A = Not Applicable	R
AC010	Payment is Population-based	char	1	Y = Population-Based N = Not Population-Based	R
AC011	Risk to Provider	char	3	U = Upside Only D = Downside Only B = Both Upside and Downside N/A = Not Applicable	R
AC012	Payment Model Involves Quality Measurement of Drug Utilization or Spending	char	1	Y = Drug spending/utilization targets N = No drug spending/utilization targets	R
AC013	Provider Type	char	2	PC = Primary care provider BH = Behavioral health provider OT = Other provider	R
AC014	Assigned Payment Subcategory	char	2	See look up table B.1.J.A Payment arrangement type reported.	R
AC015	Comments	varchar	1000	Use this field to provide additional information or describe any caveats	O
AC016	Contract Number	varchar	80	The unique number identifying a contract between the payer and the billing provider for the reported payment model as reported in AM025.	
AC017	Contract Type	char	1	Use this field to indicate whether the payments reported were administered as part of a medical benefits contract or a dental benefits contract. The only valid codes for this field are: M = Medical: Payments made under a medical benefits contract, including all payments made to providers for medical, pharmacy, and dental services incurred under medical stand-alone coverage. D = Dental: Payments made under a dental benefits contract; this should include only payments made to providers for members on dental stand-alone coverage.	R

A-8 Annual Prescription Drug Rebate Data File

Frequency: Submit annually in .txt format to CIVHC via SFTP by September 1st of each year.

If discrepancies exist between the same years on different files, an explanation will be required.

Additional formatting requirements:

- Payers submit aggregate level data in a single, consistent format for each data type.
- Include the total amount of any prescription drug rebates, discounts and other pharmaceutical manufacturer compensation or price concessions paid by pharmaceutical manufacturers to a payer or their pharmacy benefit manager(s) during the previous three calendar years. Data elements to be included in the prescription drug rebate file are listed in Table A7.1 Annual Prescription Drug Rebate Data.
- The definition of prescription drug rebates, discounts and all other pharmaceutical manufacturer compensation or price concessions to be used for implementation of the Annual Prescription Drug Rebate Data File requirement is as follows:
    - Rebates: "Rebates" will include price concessions, price discounts, or discounts of any sort that reduce payments, a partial refund of payments or any reductions to the ultimate amount paid; a performance based financial reward; a financial reward for inclusion of a drug in a preferred drug list or formulary or preferred formulary position; market share incentive payments

and rewards; credits; remuneration or payments for the provision of utilization or claim data to manufacturers for rebating, marketing, outcomes insights, or any other purpose; rebates, regardless of how categorized, and all Other Compensation to carriers, their PBMs, rebate aggregators, subsidiaries, any affiliated holding and/or parent company or within the parent organization, and all other organizational affiliates. The rebate terms of the reduction must be fixed and disclosed in writing to the payer.

- All Other Compensation: "All Other Compensation" includes, but is not limited to, all remuneration from the manufacturer to pay for services, actions, activities or trade or fees for an item or service as part of an arms-length transaction; educational grants or other commissions; manufacturer administrative fees; and administrative management fees.

Test files covering the same three most recent and complete calendar-year periods are required by July 1 to identify and resolve issues prior to final production submission. Annual submissions must include accurate and complete data for the three most recent calendar years. During both testing and production, submitters are expected to communicate with CIVHC for clarification, feedback, and resubmission guidance, and to take timely corrective action to ensure submissions meet reporting requirements. Payers must also provide explanations for discrepancies, including but not limited to those between files covering the same reporting years, between CO APCD monthly and annual file data, or within reporting years contained in the same submission file. Detailed timelines for both test and production submissions are provided in the tables below.

To request a one-year waiver from the annual submission requirement, payers must send the waiver to **submissions@civhc.org** by April 1st. Waivers apply to production files due September 1st of the same calendar year and must be submitted separately for each payer code.

Additionally, the administrator may choose to request information related to pharmaceutical alternative payment models.

Date That Supplier Must Submit Drug Rebate file to CO APCD	**Period Begin date**	**Period End date**
120 days after the effective date of the rule	*N/A*	*N/A*
July 1, 2019	*January 1, 2016*	*December 31, 2016*
September 30, 2019	*January 1, 2016*	*December 31, 2018*
September 30, 2020	*January 1, 2017*	*December 31, 2019*
September 30, 2021	*January 1, 2018*	*December 1 2020*
September 1, 2022	*January 1, 2019*	*December 31, 2021*
September 1, 2023	*January 1, 2020*	*December 31, 2022*
September 1, 2024	*January 1 2021*	*December 31, 2023*
September 1, 2025	*January 1 2022*	*December 31, 2024*
September 1, 2026	*January 1 2023*	*December 31, 2025*

DR and PB Annual Data File Submission Requirements Timeline	
Annual files waiver requests due	April 1st
Annual **test** files due for DR and PB files for the three preceding calendar years from the year of submission	July 1st
Annual test files must be passing all intake validations	July 15th
Annual **production** files due for DR and PB files for the three preceding calendar years from the year of submission	September 1st
DR and PB production files must pass level 2 post-intake validations	November 1st
Signed attestation form must be received by CIVHC for DR and PB files	November 15th

DRUG REBATE FILE HEADER RECORD

Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/valid values**
HD001	Record Type	char	2	HD
HD002	File Type	char	2	DR
HD003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
HD004	Payer Name	varchar	75	Distributed by CIVHC
HD005	Beginning Month	date	6	YYYYMM (Example: 200801)
HD006	Ending Month	date	6	YYYYMM (Example: 200812)
HD007	Record Count	int	10	Total number of records submitted in the Drug Rebate file, excluding header and trailer records

HD008	Med_BH PMPM	int	7	Place holder. Leave this field blank.
HD009	Pharmacy PMPM	int	7	Place holder. Leave this field blank.
HD010	Dental PMPM	int	7	Place holder. Leave this field blank.
HD011	Vision PMPM	int	7	Place holder. Leave this field blank.
HD012	Test File Flag	char	1	T=File submitted is a test file; P=File submitted is a production file.

DRUG REBATE FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	TR
TR002	File Type	char	2	DR
TR003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
TR004	Payer Name	varchar	75	Distributed by CIVHC
TR005	Beginning Month	date	6	YYYYMM (Example: 200801)
TR006	Ending Month	date	6	YYYYMM (Example: 200812)
TR007	Extraction Date	date	8	YYYYMMDD

A 8.1 ANNUAL PRESCRIPTION DRUG REBATE DATA

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
DR001	Payer Code	varchar	7	Distributed by CIVHC's data administrator	R
DR002	Payer Name	varchar	75	Distributed by CIVHC	R
DR003	Insurance Type Code/Product	char	2	See Lookup Table B.1.A	R
DR004	Calendar Year	year	4	4-digit year for the most recent calendar year time period reported in this submission	R
DR005	Drug Manufacturer NDC/NHRIC Labeler Code	varchar	5	The first four or five digits in the 11-digit national drug code (NDC) format that is assigned to the manufacturer by the Food & Drug Administration (FDA). Include leading zeros Labeler code can be found on the FDA website. https://www.fda.gov/industry/structured-product-labeling-resources/ndcnhric-labeler-codes	R
DR006	Labeler Code Firm Name	varchar	200	Firm name associated with NDC/NHRIC labeler code	R
DR007	Therapeutic Class	varchar	70	Therapeutic class of drug, e.g., 28:00. Leave the field blank if there is no available drug class for a reported NDC.	O
DR008	Total Pharmacy Expenditure Amount	numeric	15	The sum of all incurred claim allowed payment amounts to pharmacies for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit in a given calendar year. This amount shall include member cost sharing amounts. This shall also include all incurred claims for individuals included in the member population regardless of where the prescription drugs are dispensed (i.e., includes claims from in-state and out-of-state providers). Claims should be attributed to a calendar year based on the date of fill. (Allowed amount should include direct drug costs and exclude non-claim costs. This amount will not reflect prescription drug rebates in any way) Two explicit decimal places (e.g., 200.00).	R
DR009	Pharmacy Expenditure Amount: Specialty Drugs	numeric	15	The total expenditure for a specialty drug. Specialty drug expenditure and rebate amounts should be mutually exclusive from non-specialty brand drug and non-specialty generic drug expenditure and rebate amounts.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				Drug defined as a specialty drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00).	
DR010	Pharmacy Expenditure Amount: Non-Specialty Brand Drugs	numeric	15	The total expenditure for Non-Specialty Brand Drugs. Non-specialty brand drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty generic drug expenditure and rebate amounts. A drug defined as a non-specialty brand drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00).	R
DR011	Pharmacy Expenditure Amount: Non-Specialty Generic Drugs	numeric	15	The total expenditure for Non-Specialty Generic Drugs. Non-specialty generic drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty brand drug expenditure and rebate amounts. A drug defined as a non-specialty generic drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00).	R
DR012	Total Prescription Drug Rebate/Other Compensation Amount	numeric	15	Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts (including concessions from price protection and hold harmless contract clauses) provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, excluding manufacturer-provided, fair market value, bona fide service fees. Two explicit decimal places (e.g., 200.00).	R
DR013	Prescription Drug Rebate/Other Compensation Amount: Specialty Drugs	numeric	15	Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts for all specialty drugs. Specialty drug expenditure and rebate amounts should be mutually exclusive from non-specialty brand drug and non-specialty generic drug expenditure and rebate amounts. Drug defined as a specialty drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00).	R
DR014	Prescription Drug Rebate/Other Compensation Amount: Non-Specialty Brand Drugs	numeric	15	Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts for all Non-Specialty Brand Drugs. Non-specialty brand drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty generic drug expenditure and rebate amounts. A drug defined as a non-specialty brand drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00).	R
DR015	Prescription Drug Rebate/Other Compensation Amount: Non-Specialty Generic Drugs	numeric	15	Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts for all Non-Specialty Generic Drugs. Non-specialty generic drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				specialty brand drug expenditure and rebate amounts. A drug defined as a non-specialty generic drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00).	
DR016	Total Count of Prescriptions Filled	int	15	Total count of all prescriptions filled by members.	R
DR017	Count of Prescriptions Filled: Specialty Drugs	int	15	Total count of all specialty prescriptions filled by members. A drug defined as a specialty drug under the terms of a payer's contract with its PBM.	R
DR018	Count of Prescriptions Filled: Non-Specialty Brand Drugs	int	15	Total count of all non-specialty brand prescriptions filled by members. A drug defined as a non-specialty brand drug under the terms of a payer's contract with its PBM.	R
DR019	Count of Prescriptions Filled: Non-Specialty Generic Drugs	int	15	Total count of all non-specialty generic prescriptions filled by members. A drug defined as a non-specialty generic drug under the terms of a payer's contract with its PBM.	R
DR020	Comments	varchar	1000	Use this field to provide additional information or describe any caveats regarding data in the Drug Rebate submission.	O
DR999	Record Type	char	2	DR	R

A-9 Annual PBM Contract Information

Frequency: Submit annually in CSV format to CIVHC via SFTP by September 1st of each year. Pipe (|) and comma (,) delimiters are allowed. Note: do not include column headers within the CSV. Do not include commas (,) or double quotes (") within the CSV's field contents.

Test files covering the same three most recent and complete calendar-year periods are required by July 1 to identify and resolve issues prior to final production submission. Annual submissions must include accurate and complete data for the three most recent calendar years. During both testing and production, submitters are expected to communicate with CIVHC for clarification, feedback, and resubmission guidance, and to take timely corrective action to ensure submissions meet reporting requirements. Payers must also provide explanations for discrepancies, including but not limited to those between files covering the same reporting years, between CO APCD monthly and annual file data, or within reporting years contained in the same submission file. Detailed timelines for both test and production submissions are provided in the tables below.

To request a one-year waiver from the annual submission requirement, payers must send the waiver to **submissions@civhc.org** by April 1st. Waivers apply to production files due September 1st of the same calendar year and must be submitted separately for each payer code.

DR and PB Annual Data File Submission Requirements Timeline	
Annual files waiver requests due	April 1st
Annual **test** DR and PB files due for the three preceding calendar years from the year of submission	July 1st
Annual test files must be passing all intake validations	July 15th
Annual **production** DR and PB files due for the three preceding calendar years from the year of submission	September 1st
DR and PB production files must pass level 2 post-intake validations	November 1st
Signed attestation form must be received by CIVHC for DR and PB files	November 15th

A 9.1 Annual PBM Contract Information

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PB001	Payer Code	varchar	7	Distributed by CIVHC's data administrator	R
PB002	Payer Name	varchar	75	Distributed by CIVHC	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PB003	Pharmacy Benefit Manager Name	varchar	75	The name of a pharmacy benefit manager (PBM) that provided any of the following services in a given insurance category and calendar year: claims processing, drug formulary management, or manufacturer drug rebate contracting.	R
PB004	Insurance Product Type code	char	2	See lookup table B.1.A Payers shall report for all insurance categories for which they have business.	R
PB005	Calendar Year	year	4	4-digit year for the calendar year time period reported in this submission	R
PB006	Drug Formulary Management?	varchar	4	Identify whether an individual PBM organization performed all, some, or none of the drug formulary management for its pharmacy benefit within a given insurance category and year. Three possible responses: All, Some, None	R
PB007	Manufacturer Drug Rebate Contracting?	varchar	4	Identify whether an individual PBM organization performed all, some, or none of the manufacturer drug rebate contracting for its pharmacy benefit within a given insurance category and year. Three possible responses: All, Some, None	R
PB008	Percent Rebate Passed to Carrier	decimal	4	Identify the proportion of total rebates and other compensation that is passed through to the carrier from the PBM. If the percent passed to carrier is 90%, submit as .9.	R
PB009	Comments	varchar	1000	Use this field to provide additional information or describe any caveats regarding data in the PBM Contract submission	O

A-10 Annual Collection for the Prescription Drug Affordability Board (PDAB)

Frequency: Submit annually in CSV format to CIVHC via SFTP by September 1st of each year. Pipe (|) and comma (,) delimiters are allowed. Note: do not include column headers within the CSV. Do not include commas (,) or double quotes (") within the CSV's field contents.

Test files covering the same most recent and complete calendar-year is required by July 1 to identify and resolve issues prior to final production submission. Annual submissions must include accurate and complete data for the most recent calendar year. During both testing and production, submitters are expected to communicate with CIVHC for clarification, feedback, and resubmission guidance, and to take timely corrective action to ensure submissions meet reporting requirements. Payers must also provide explanations for discrepancies, including but not limited to those between files covering the same reporting years, between CO APCD monthly and annual file data, or within reporting years contained in the same submission file. Detailed timelines for both test and production submissions are provided in the tables below.

To request a one-year waiver from the annual submission requirement, payers must send the waiver to **submissions@civhc.org** by April 1st. Waivers apply to production files due September 1st of the same calendar year and must be submitted separately for each payer code.

PDAB Annual Data File Submission Requirements Timeline	
Annual files waiver requests due	April 1st
Annual **test** PDAB file due for the preceding calendar year from the year of submission	July 1st
Annual test files must be passing all intake validations	July 15th
Annual **production** PDAB file due for the preceding calendar year from the year of submission	September 1st
PDAB production file must pass level 2 post-intake validations	November 1st
Signed attestation form must be received by CIVHC for PDAB file	November 15th

A 10.1 Annual PDAB Collection Information

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PD001	Payer Code	varchar	7	Distributed by CIVHC's data administrator	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PD002	Payer Name	varchar	75	Distributed by CIVHC	R
PD003	Year	Year	4	Immediately preceding year (Paid_Date_Year)	R
PD004	Legislative Reference	varchar	4	See table B.1.P	R
PD005	Rank	int	3	Populate field with rank of 1-15	R
PD006	NDC	varchar	11	11-digit NDC of associated drug	R
PD007	Drug Name	varchar	80	Name of associated NDC	R
PD008	Methodology	varchar	1000	Detailed methodological description for each legislative requirement.	R

A-11 Annual Pharmacy Value Based Purchasing Contracts (VBPC) Collection

Frequency: Submit annually in CSV format to CIVHC via SFTP by September 1st of each year. Pipe (|) and comma (,) delimiters are allowed. Note: do not include column headers within the CSV. Do not include commas (,) or double quotes (") within the CSV's field contents.

Test files covering the same four most recent and complete calendar-year periods are required by July 1 to identify and resolve issues prior to final production submission. Annual submissions must include accurate and complete data for the four most recent calendar years. During both testing and production, submitters are expected to communicate with CIVHC for clarification, feedback, and resubmission guidance, and to take timely corrective action to ensure submissions meet reporting requirements. Payers must also provide explanations for discrepancies, including but not limited to those between files covering the same reporting years, between CO APCD monthly and annual file data, or within reporting years contained in the same submission file. Detailed timelines for both test and production submissions are provided in the tables below.

To request a one-year waiver from the annual submission requirement, payers must send the waiver to **submissions@civhc.org** by April 1st. Waivers apply to production files due September 1st of the same calendar year and must be submitted separately for each payer code.

Payers should submit data based on Fill Date.

VBPC Annual Data File Submission Requirements Timeline	
Annual files waiver requests due	April 1st
Annual **test** VBPC file due for the four preceding calendar years from the year of submission	July 1st
Annual test files must be passing all intake validations	July 15th
Annual **production** VBPC file due for the four preceding calendar years from the year of submission	September 1st
VBPC annual production file must pass level 2 post-intake validations	November 1st
Signed attestation form must be received by CIVHC for VBPC file	November 15th

A 11.1 Annual VBPC Collection Information

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
VB001	Payer Code	varchar	7	Distributed by CIVHC's data administrator	R
VB002	Payer Name	varchar	75	Distributed by CIVHC	R
VB003	Drug Name	varchar	80	Name of drug associated with pharmacy VBPC	R
VB004	NDC	varchar	200	NDC(s) for associated drug If multiple NDCs are associated with a given contract for a drug name, list each NDC separated by a semicolon (;).If carrier is unable to break out VB008-VB012 fields by NDC, then report VB008-VB012 on the first line associated with Drug Name (VB003).	R
VB005	Manufacturer	varchar	75	Name of associated drug's manufacturer	R
VB006	Start Date	varchar	8	Date when outcomes of treatment begin to be measured. YYYYMMDD	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
VB007	End Date	varchar	8	Date when outcomes of treatment are no longer measured. YYYYMMDD	R
VB008	Metric measured	int	2	Metrics measured under contract: 1 = Reduced hospitalization 2 = Reduced relapse rate 3 = Qualifying event 4 = Discontinuation 5 = Disease prevalence 99 = Other	R
VB009	Total Count of Members on Drug	int	12	Distinct number of members who have taken drug in specified time period, whether under the VBPC or not	R
VB010	Count of Measured Members on Drug	int	12	Distinct number of members who have taken drug in specified time period and whose outcomes are measured by contract	R
VB011	Total Spend	numeric	15	Total spend on claims associated with drug in specified time period, whether under the VBPC or not Do not deduct any VBPC rebates Two explicit decimal places (e.g., 200.00)	R
VB012	Total Measured Spend	numeric	15	Total spend on claims associated with drug in specified time period for members whose outcomes are measured by contract Do not deduct any VBPC rebates Two explicit decimal places (e.g., 200.00)	R
VB013	Total VBPC Rebate	numeric	15	Total dollars received as a result of the VBPC contracts Two explicit decimal places (e.g., 200.00)	R
VB014	Comments	varchar	1000	Any additional information regarding a particular contract	O

A-12 Annual Member Capitation File (CF)

Frequency: Submit annually in .txt format to CIVHC via SFTP by September 1st of each year.

Test files covering the same three most recent and complete calendar-year periods are required by July 1 to identify and resolve issues prior to final production submission. Annual submissions must include accurate and complete data for the three most recent calendar years. During both testing and production, submitters are expected to communicate with CIVHC for clarification, feedback, and resubmission guidance, and to take timely corrective action to ensure submissions meet reporting requirements. Payers must also provide explanations for discrepancies, including but not limited to those between files covering the same reporting years, between CO APCD monthly and annual file data, or within reporting years contained in the same submission file. Detailed timelines for both test and production submissions are provided in the tables below.

To request a one-year waiver from the annual submission requirement, payers must send the waiver to **submissions@civhc.org** by April 1st. Waivers apply to production files due September 1st of the same calendar year and must be submitted separately for each payer code.

Annual Data File CF Submission Requirements Timeline	
Annual files waiver requests due	April 1st
Annual **test** CF file due for the three preceding calendar years from the year of submission	July 1st
Annual test files must be passing all intake validations	July 15th
Annual **production** CF file due for the three preceding calendar years from the year of submission	September 1st
CF annual production file must pass level 2 post-intake validations	November 1st
Signed attestation form must be received by CIVHC for CF file	November 15th

CF File Header Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	HD
HD002	File Type	char	2	CF
HD003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
HD004	Payer Name	varchar	75	Distributed by CIVHC
HD005	Beginning Month	date	6	YYYYMM (Example: 200801)
HD006	Ending Month	date	6	YYYYMM (Example: 200812)
HD007	Record Count	int	10	Total number of records submitted in the Drug Rebate file, excluding header and trailer records
HD008	Med_BH PMPM	int	7	Place holder. Leave this field blank.
HD009	Pharmacy PMPM	int	7	Place holder. Leave this field blank.
HD010	Dental PMPM	int	7	Place holder. Leave this field blank.
HD011	Vision PMPM	int	7	Place holder. Leave this field blank.
HD012	Test File Flag	char	1	T=File submitted is a test file; P=File submitted is a production file.

CF File Trailer Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	TR
TR002	File Type	char	2	CF
TR003	Payer Code	varchar	7	Distributed by CIVHC's data administrator
TR004	Payer Name	varchar	75	Distributed by CIVHC
TR005	Beginning Month	date	6	YYYYMM (Example: 200801)
TR006	Ending Month	date	6	YYYYMM (Example: 200812)
TR007	Extraction Date	date	8	YYYYMMDD

A 12.1 Annual Member Capitation Collection Information

Data Element	Name	Type	Max Length	Description/Valid Values
CF001	Payer Code	varchar	7	Distributed by CIVHC's data administrator
CF002	Reporting Period Start Date	int	6	YYYYMM. Beginning of reporting period covered for contract performance.
CF003	Reporting Period End Date	int	6	YYYYMM. End of reporting period covered for contract performance.
CF004	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier/payer uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's/payer's files for reporting and aggregation.
CF005	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.
CF006	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name
CF007	Member Middle Initial	varchar	1	The member's middle initial. If the member is the subscriber, report the subscriber's middle initial.
CF008	Member Sex	char	1	Sex of the member. M=Male F=Female U=UNKNOWN Member sex represents biological or administrative sex. Where available, payers should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, payers may provide the values they have access to regarding physical or legal sex (e.g., administrative sex as categorized by X12 values)
CF009	Member Date of Birth	date	8	Date of birth of the member. If the member is the subscriber, report the subscriber's date of birth. YYYYMMDD.

CF010	Member Identification Code	char	9	Member's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member.
CF011	Billing Provider ID	varchar	35	Unique code assigned to the provider by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes and does not routinely change.
CF012	Billing Provider NPI	char	10	National Provider Identifier (NPI) for the billing provider as enumerated in the Center for Medicaid and Medicare Services National Plan & Provider Enumeration System (NPPES).
CF013	Billing Provider Tax ID	char	9	Tax ID of the billing provider. Do not code punctuation.
CF014	Billing Provider Last Name or Organization	varchar	60	Full name of provider billing organization or last name of individual billing provider.
CF015	Billing Provider First Name	varchar	35	Individual first name. If provider is a facility or organization, leave this field blank.
CF016	Insurance/Product Category Code	char	2	See B.1.A Insurance Type for codes. Use the most granular choice available.
CF017	Payment Subcategory	char	2	D1 = Primary care capitation D2 = Professional capitation D3 = Facility Capitation D4 = Behavioral health capitation D5 = Global capitation D6 = Payment to integrated, comprehensive payment and delivery systems D7 = Laboratory capitation D8 = Radiology capitation
CF018	Total Paid Amount	numeric	15	Total of all payments made to a contractor during the Reporting/Performance Period. Two explicit decimal places (e.g., 200.00). This field may contain a negative value.
CF999	Record Type	char	2	Value = CF

EXHIBIT B – LOOKUP TABLES

B.1.A INSURANCE TYPE

12 Preferred Provider Organization (PPO) – Commercial
13 Point of Service (POS) – Commercial
15 Indemnity Insurance – Commercial
16 Health Maintenance Organization (HMO) Medicare Advantage
17 Dental Maintenance Organization (DMO)
HM Health Maintenance Organization – Commercial
19 Prescription Drug Only Insurance – Commercial
EP Exclusive Provider Organization (EPO) – Commercial
MA Medicare Part A
MB Medicare Part B
MC Medicaid
MD Medicare Part D
MP Medicare Primary
QM Qualified Medicare Beneficiary
TV Title V
99 Other
SP Medicare Supplemental (Medi-gap) plan
CP Medicaid CHIP
MS Medicaid Fee for service
MM Medicaid Managed care
CS Commercial Supplemental plan
ME Medicare Advantage Preferred Provider Organization (PPO)
ML Medicare Advantage Indemnity Plan
MO Medicare Advantage Point of Service (POS) Plan
S1 Medicare Special Needs Plan – Chronic Condition
S2 Medicare Special Needs Plan – Institutionalized
S3 Medicare Special Needs Plan – Dual Eligible

B.1.B RELATIONSHIP CODES

01 Spouse
04 Grandfather or Grandmother
05 Grandson or Granddaughter
07 Nephew or Niece
10 Foster Child
14 Brother or Sister
15 Ward
17 Stepson or Stepdaughter
19 Child
20 Employee/Self
21 Unknown
22 Handicapped Dependent
23 Sponsored Dependent
24 Dependent of a Minor Dependent
25 Ex-Spouse
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

B.1.C DISCHARGE STATUS

01 Discharged to home or self-care
02 Discharged/transferred to another short-term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF)
04 Discharged/transferred to nursing facility (NF)
05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution
06 Discharged/transferred to home under care of organized home health service organization
07 Left against medical advice or discontinued care
08 Discharged/transferred to home under care of a Home IV provider
09 Admitted as an inpatient to this hospital
20 Expired
21 Discharged/transferred to court/law enforcement
30 Still patient or expected to return for outpatient services
40 Expired at home
41 Expired in a medical facility
42 Expired, place unknown
43 Discharged/ transferred to a Federal Hospital
50 Hospice – home
51 Hospice - medical facility
61 Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital
63 Discharged/transferred to a long-term care hospital
64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66 Discharged/transferred to a Critical Access Hospital (CAH)
69 Discharged/transferred to a designated disaster alternative care site (effective 10/1/13)
70 Discharged/transferred to another type of health care institution not defined elsewhere in this code list
81 Discharged to home or self-care with a planned acute care hospital inpatient readmission (effective 10/1/13)
82 Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission (effective 10/1/13)
83 Discharged/transferred to a Skilled Nursing Facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (effective 10/1/13)
84 Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (effective 10/1/13)
85 Discharged/transferred to a designated cancer center or children’s hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
86 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care with a planned acute care hospital inpatient readmission (effective 10/1/13)
87 Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission (effective 10/1/13)
88 Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission (effective 10/1/13)
89 Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission (effective 10/1/13)
90 Discharged/transferred to an Inpatient Rehabilitation Facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
91 Discharged/transferred to a Medicare Certified Long Term Care Hospital (LTCH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
92 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (effective 10/1/13)
93 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
94 Discharged/transferred to a Critical Access Hospital (CAH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
95 Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission (effective 10/1/13)
P: default ‘00’ = unknown

B.1.D TYPE OF BILL (INSTITUTIONAL CLAIMS ONLY)

Type of Facility First Digit	Bill Classification (Second digit if first is 1-6)	Bill Classification (Second Digit if First Digit = 7)	Bill Classification (Second Digit if First Digit = 8)	Frequency (Third digit)
1 Hospital	1 Inpatient (Including Medicare Part A)	1 Rural Health	1 Hospice (Non-Hospital Based)	1 admit through discharge
2 Skilled Nursing	2 Inpatient (Medicare Part B Only)	2 Hospital Based or Independent Renal Dialysis Center	2 Hospice (Hospital-Based)	2 interim - first claim used for the…
3 Home Health	3 Outpatient	3 Free Standing Outpatient Rehabilitation Facility (ORF)	3 Ambulatory Surgery Center	3 interim - continuing claims
4 Christian Science Hospital	4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)	5 Comprehensive Outpatient Rehabilitation Facilities (CORFs)	4 Free Standing Birthing Center	4 interim - last claim
5 Christian Science Extended Care	5 Nursing Facility Level I	6 Community Mental Health Center	9 Other	5 late charge only
6 Intermediate Care	6 Nursing Facility Level II	9 Other		7 replacement of prior claim
7 Clinic	7 Intermediate Care - Level III Nursing Facility			8 void/cancel of a prior claim
8 Special Facility	8 Swing Beds			9 final claim for a home

B.1.F 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
23 Not our claim, forwarded to additional payer(s)

B.1.G Present On Admission Codes

POA_Code	POA_Desc
1	Exempt from POA reporting
N	Diagnosis was not present at time of inpatient admission
U	Documentation insufficient to determine if condition was present at time of inpatient admission
W	Clinically undetermined
Y	Diagnosis was present at time of inpatient admission

B.1.H Dispense as Written Code

0 Not Dispensed as written
1 Physician dispense as written
2 Member dispense as written
3 Pharmacy dispense as written
4 No generic available
5 Brand dispensed as generic
6 Override
7 Substitution not allowed - brand drug mandated by law
8 Substitution allowed - generic drug not available in marketplace
9 Other

B.1.I Benefit Coverage Level

CHD Children Only
DEP Dependents Only
ECH Employee and Children EMP/CH, EC, EE/CH
EPN Employee plus N where N equals the number of other covered dependents
ELF Employee and Life Partner
EMP Employee Only E, EE, EO
ESP Employee and Spouse EMP/SP, ES, EE/SP
FAM Family ESC
IND Individual
SPC Spouse and Children
SPO Spouse Only

B.1.J Alternative Payment Model (APM) Payment Category

Code	Value
A	Population health and practice infrastructure payments
B	Performance payments
C	Payments with shared savings and recoupments
D	Capitation and full risk payments
E	Other non-claims payments
X	Fee for service
Z	Member count
3N	Risk based payments NOT linked to Quality
4N	Capitated payments NOT linked to Quality

B.1.J.A Alternative Payment Model (apm) Payment Subcategory

Code	Value
A1	Care management/care coordination/population health/medication reconciliation
A2	Primary care and behavioral health integration
A3	Social care integration
A4	Practice transformation payments
A5	EHR/HIT infrastructure payments
B1	Retrospective/prospective incentive payments: pay-for-reporting
B2	Retrospective/prospective incentive payments: pay-for-performance
C1	Procedure-related episode-based payments with shared savings
C2	Procedure-related episode-based payments with risk of recoupments
C3	Condition-related episode-based payments with shared savings
C4	Condition-related episode-based payments with risk of recoupments
C5	Risk for total cost of care (e.g. ACO) with shared savings
C6	Risk for total cost of care (e.g. ACO) with risk of recoupments
D1	Primary care capitation
D2	Professional capitation
D3	Facility capitation
D4	Behavioral health capitation
D5	Global capitation
D6	Payment to integrated comprehensive payment and delivery systems
D7	Laboratory Capitation *
D8	Radiology Capitation *
E9	Other non-claims payments
X9	Fee for service
Z9	Member count
3N	Risk based payments NOT linked to Quality
4N	Capitated payments NOT linked to Quality

*Payment Subcategories are only applicable to CF file. They are not a part of the standard sub-categories for Expanded Framework's category D - Capitation payment. However, they should be used for reporting as appropriate.

B.1.K Primary Care Provider Definition

The primary care definition for the purposes of the Alternative Payment Model filing in Data Submission Guide v 11.5 consists of two components that should be summed to produce total primary care payments:

A. Outpatient services delivered by primary care providers (which includes OB/GYN providers), defined by a combination of provider taxonomy (Table B.1.K.A) and CPT-4 procedure codes (Table B.1.K.C).
B. Outpatient services delivered by behavioral health providers, nurse practitioners and physician assistants, defined by a combination of provider taxonomy (Table B.1.K.B) and CPT-4 procedure codes (Table B.1.K.C) AND billed by a primary care provider (defined by primary care taxonomy in Table B.1.K.A).

B.1.K.A: Primary Care Provider Taxonomies

Sum the allowed amounts for services (defined by the procedure code list in B.1.K.C) delivered by the providers defined by the taxonomies listed below. Include services delivered in an outpatient setting and exclude facility claims and inpatient services.

Taxonomy Code	Description	Taxonomy Type
261QF0400X	Federally Qualified Health Center	Organization
261QP2300X	Primary care clinic	Organization
261QR1300X	Rural Health Center	Organization
261QC1500X	Community Health	Organization
261QM1000X	Migrant Health	Organization
261QP0904X	Public Health, Federal	Organization
261QS1000X	Student Health	Organization
207Q00000X	Physician, family medicine	Individual
207R00000X	Physician, general internal medicine	Individual
208000000X	Physician, pediatrics	Individual
208D00000X	Physician, general practice	Individual
363LA2200X	Nurse practitioner, adult health	Individual
363LF0000X	Nurse practitioner, family	Individual
363LP0200X	Nurse practitioner, pediatrics	Individual
363LP2300X	Nurse practitioner, primary care	Individual
363LW0102X	Nurse practitioner, women's health	Individual
363AM0700X	Physician's assistant, medical	Individual
207RG0300X	Physician, geriatric medicine, internal medicine	Individual
2083P0500X	Physician, preventive medicine	Individual
364S00000X	Certified clinical nurse specialist	Individual
163W00000X	Nurse, non-practitioner	Individual
207QG0300X	Allopathic & Osteopathic Physicians/Family Medicine, Geriatric Medicine	Individual
207QA0000X	Family Medicine - Adolescent Medicine	Individual
207QA0505X	Family Medicine - Adult Medicine	Individual
207QB0002X	Family Medicine - Obesity Medicine	Individual
207QG0300X	Family Medicine - Geriatric Medicine	Individual
207QS0010X	Family Medicine - Sports Medicine	Individual
207RA0000X	Internal Medicine - Adolescent Medicine	Individual
207RB0002X	Internal Medicine - Obesity Medicine	Individual
207RS0010X	Internal Medicine - Sports Medicine	Individual
2080A0000X	Pediatrics - Adolescent Medicine	Individual
2080B0002X	Pediatrics - Obesity Medicine	Individual
2080S0010X	Pediatrics - Sports Medicine	Individual
363LC1500X	Nurse Practitioner - Community Health	Individual
363LG0600X	Nurse Practitioner – Gerontology	Individual
363LS0200X	Nurse Practitioner – School	Individual
364SA2200X	Clinical Nurse Specialist - Adult Health	Individual
364SC1501X	Clinical Nurse Specialist - Community Health/Public Health	Individual
364SC2300X	Clinical Nurse Specialist - Chronic Health	Individual
364SF0001X	Clinical Nurse Specialist - Family Health	Individual
364SG0600X	Clinical Nurse Specialist - Gerontology	Individual
364SH1100X	Clinical Nurse Specialist - Holistic	Individual
364SP0200X	Clinical Nurse Specialist - Pediatrics	Individual
364SS0200X	Clinical Nurse Specialist - School	Individual
364SW0102X	Clinical Nurse Specialist - Women's Health	Individual
207V00000X	Physician, obstetrics and gynecology	OB/GYN
207VG0400X	Physician, gynecology	OB/GYN
363LX0001X	Nurse practitioner, obstetrics and gynecology	OB/GYN
367A00000X	Physician Assistants & Advanced Practice Nursing Providers/Midwife, Certified Nurse	OB/GYN
207VX0000X	OB/GYN- Obstetrics	OB/GYN

B.1.K.B: Other Primary Care Provider Taxonomies: Behavioral Health. Nurse Practitioners, and Physician Assistants

Sum the allowed amounts for services (defined by the procedure code list in B.1.K.C) delivered by Physician Assistants, Nurse Practitioners and Behavioral Health providers, defined by the taxonomies listed below ONLY when the billing provider for these services has a primary care taxonomy (defined by primary care taxonomy B.1.K.A.) Include services delivered in an outpatient setting and exclude facility claims and inpatient services.

Taxonomy Code	Description	Taxonomy Type
363L00000X	Nurse practitioner	Nurse Practitioner
363A00000X	Physician's assistant	Physician's Assistant
2084P0800X	Physician, general psychiatry	Behavioral Health
2084P0804X	Physician, child and adolescent psychiatry	Behavioral Health
363LP0808X	Nurse practitioner, psychiatric	Behavioral Health
1041C0700X	Behavioral Health & Social Service Providers/Social Worker, Clinical	Behavioral Health
2084P0805X	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Geriatric Psychiatry	Behavioral Health
2084H0002X	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Hospice & Palliative Medicine	Behavioral Health
261QM0801X	Ambulatory Health Care Facilities/Clinic/Center, Mental Health- CMHC	Behavioral Health
101Y00000X	Counselor	Behavioral Health
101YA0400X	Counselor - Addiction (SUD)	Behavioral Health
101YM0800X	Counselor - Mental Health (Note: Counselor working in MAT programs in FQHC)	Behavioral Health
101YP1600X	Counselor - Pastoral	Behavioral Health
101YP2500X	Counselor - Professional (Note: Counselor in FQHC)	Behavioral Health
101YS0200X	Counselor - School	Behavioral Health
102L00000X	Psychoanalyst	Behavioral Health
103T00000X	Psychologist (Note: Clinical Psychologist in FQHC)	Behavioral Health
103TA0400X	Psychologist - Addiction	Behavioral Health
103TA0700X	Psychologist - Adult Development and Aging (Note: Clinical Psychologist in FQHC)	Behavioral Health
103TB0200X	Psychologist - Cognitive and Behavioral	Behavioral Health
103TC0700X	Psychologist - Clinical	Behavioral Health
103TC1900X	Psychologist - Counseling	Behavioral Health
103TC2200X	Psychologist - Clinical Child & Adolescent	Behavioral Health
103TE1000X	Psychologist - Educational	Behavioral Health
103TE1100X	Psychologist - Exercise & Sports	Behavioral Health
103TF0000X	Psychologist - Family	Behavioral Health
103TH0004X	Psychologist - Health	Behavioral Health
103TH0100X	Psychologist - Health Service	Behavioral Health
103TM1700X	Psychologist - Men & Masculinity	Behavioral Health
103TM1800X	Psychologist - Mental Retardation & Developmental Disabilities	Behavioral Health
103TP0016X	Psychologist - Prescribing (Medical)	Behavioral Health
103TP0814X	Psychologist - Psychoanalysis	Behavioral Health
103TP2700X	Psychologist - Psychotherapy	Behavioral Health
103TP2701X	Psychologist - Group Psychotherapy	Behavioral Health
103TR0400X	Psychologist - Rehabilitation	Behavioral Health
103TS0200X	Psychologist - School	Behavioral Health
103TW0100X	Psychologist - Women	Behavioral Health
104100000X	Social Worker	Behavioral Health
1041S0200X	Social Worker - School	Behavioral Health
106H00000X	Marriage & Family Therapist (Note: Psychotherapist in FQHC)	Behavioral Health

B.1.K.C: Primary Care Procedure Codes

Procedure Code	Description
10060	DRAINAGE OF SKIN ABSCESS
10061	DRAINAGE OF SKIN ABSCESS
10080	DRAINAGE OF PILONIDAL CYST
10120	REMOVE FOREIGN BODY
10121	REMOVE FOREIGN BODY
10160	PUNCTURE DRAINAGE OF LESION
11000	DEBRIDE INFECTED SKIN
11055	TRIM SKIN LESION
11056	TRIM SKIN LESIONS 2 TO 4
11100	BIOPSY SKIN LESION
11101	BIOPSY SKIN ADD-ON
11200	REMOVAL OF SKIN TAGS <W/15

Procedure Code	Description
11201	REMOVE SKIN TAGS ADD-ON
11300	SHAVE SKIN LESION 0.5 CM/<
11301	SHAVE SKIN LESION 0.6-1.0 CM
11302	SHAVE SKIN LESION 1.1-2.0 CM
11303	SHAVE SKIN LESION >2.0 CM
11305	SHAVE SKIN LESION 0.5 CM/<
11306	SHAVE SKIN LESION 0.6-1.0 CM
11307	SHAVE SKIN LESION 1.1-2.0 CM
11310	SHAVE SKIN LESION 0.5 CM/<
11311	SHAVE SKIN LESION 0.6-1.0 CM
11400	EXC TR-EXT B9+MARG 0.5 CM<
11401	EXC TR-EXT B9+MARG 0.6-1 CM
11402	EXC TR-EXT B9+MARG 1.1-2 CM
11403	EXC TR-EXT B9+MARG 2.1-3CM
11420	EXC H-F-NK-SP B9+MARG 0.5/<
11421	EXC H-F-NK-SP B9+MARG 0.6-1
11422	EXC H-F-NK-SP B9+MARG 1.1-2
11423	EXC H-F-NK-SP B9+MARG 2.1-3
11720	DEBRIDE NAIL 1-5
11730	REMOVAL OF NAIL PLATE
11750	REMOVAL OF NAIL BED
11765	EXCISION OF NAIL FOLD TOE
11900	INJECT SKIN LESIONS </W 7
11976	REMOVE CONTRACEPTIVE CAPSULE
11980	IMPLANT HORMONE PELLET(S)
11981	INSERT DRUG IMPLANT DEVICE
11982	REMOVE DRUG IMPLANT DEVICE
11983	REMOVE/INSERT DRUG IMPLANT
12001	RPR S/N/AX/GEN/TRNK 2.5CM/<
12042	INTMD RPR N-HF/GENIT2.6-7.5
15839	EXCISE EXCESS SKIN & TISSUE
17000	DESTRUCT PREMALG LESION
17003	DESTRUCT PREMALG LES 2-14
17004	DESTROY PREMAL LESIONS 15/>
17110	DESTRUCT B9 LESION 1-14
17111	DESTRUCT LESION 15 OR MORE
17250	CHEM CAUT OF GRANLTJ TISSUE
17281	DESTRUCTION OF SKIN LESIONS
17340	CRYOTHERAPY OF SKIN
19000	DRAINAGE OF BREAST LESION
20005	I&D ABSCESS SUBFASCIAL
20520	REMOVAL OF FOREIGN BODY
20550	INJ TENDON SHEATH/LIGAMENT
20551	INJ TENDON ORIGIN/INSERTION
20552	INJ TRIGGER POINT 1/2 MUSCL
20553	INJECT TRIGGER POINTS 3/>
20600	DRAIN/INJ JOINT/BURSA W/O US
20605	DRAIN/INJ JOINT/BURSA W/O US
20610	DRAIN/INJ JOINT/BURSA W/O US
20612	ASPIRATE/INJ GANGLION CYST
36415	ROUTINE VENIPUNCTURE
36416	CAPILLARY BLOOD DRAW
54050	DESTRUCTION PENIS LESION(S)
54056	CRYOSURGERY PENIS LESION(S)
55250	REMOVAL OF SPERM DUCT(S)
56405	I & D OF VULVA/PERINEUM
56420	DRAINAGE OF GLAND ABSCESS
56501	DESTROY VULVA LESIONS SIM
56515	DESTROY VULVA LESION/S COMPL
56605	BIOPSY OF VULVA/PERINEUM
56606	BIOPSY OF VULVA/PERINEUM
56820	EXAM OF VULVA W/SCOPE
56821	EXAM/BIOPSY OF VULVA W/SCOPE
57061	DESTROY VAG LESIONS SIMPLE

Procedure Code	Description
57100	BIOPSY OF VAGINA
57105	BIOPSY OF VAGINA
57135	REMOVE VAGINA LESION
57150	TREAT VAGINA INFECTION
57170	FITTING OF DIAPHRAGM/CAP
57410	PELVIC EXAMINATION
57420	EXAM OF VAGINA W/SCOPE
57421	EXAM/BIOPSY OF VAG W/SCOPE
57452	EXAM OF CERVIX W/SCOPE
57454	BX/CURETT OF CERVIX W/SCOPE
57455	BIOPSY OF CERVIX W/SCOPE
57456	ENDOCERV CURETTAGE W/SCOPE
57500	BIOPSY OF CERVIX
57505	ENDOCERVICAL CURETTAGE
58100	BIOPSY OF UTERUS LINING
58110	BX DONE W/COLPOSCOPY ADD-ON
58120	DILATION AND CURETTAGE
58300	INSERT INTRAUTERINE DEVICE
58301	REMOVE INTRAUTERINE DEVICE
59025	FETAL NON-STRESS TEST
59200	INSERT CERVICAL DILATOR
59300	EPISIOTOMY OR VAGINAL REPAIR
59400	OBSTETRICAL CARE
59409	OBSTETRICAL CARE
59410	OBSTETRICAL CARE
59412	Vaginal Delivery, Antepartum and Postpartum Care Procedures * 60% of payment
59414	Under Vaginal Delivery, Antepartum and Postpartum Care Procedures * 60% of payment
59425	ANTEPARTUM CARE ONLY
59426	ANTEPARTUM CARE ONLY
59430	CARE AFTER DELIVERY
59510	CESAREAN DELIVERY
59514	CESAREAN DELIVERY ONLY
59515	CESAREAN DELIVERY
59515	Cesarean delivery only *** 60% of payment**
59610	Routine obstetric care incl. VBAC delivery *** 60% of payment**
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps) *** 60% of payment**
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care *** 60% of payment**
59618	ATTEMPTED VBAC DELIVERY
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery * 60% of payment
59622	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care *** 60% of payment**
59820	CARE OF MISCARRIAGE
69200	CLEAR OUTER EAR CANAL
69209	REMOVE IMPACTED EAR WAX UNI
69210	REMOVE IMPACTED EAR WAX UNI
76801	OB US < 14 WKS SINGLE FETUS
76802	OB US < 14 WKS ADDL FETUS
76805	OB US >= 14 WKS SNGL FETUS
76810	OB US >= 14 WKS ADDL FETUS
76811	OB US DETAILED SNGL FETUS
76812	OB US DETAILED ADDL FETUS
76813	OB US NUCHAL MEAS 1 GEST
76814	OB US NUCHAL MEAS ADD-ON
76815	OB US LIMITED FETUS(S)
76816	OB US FOLLOW-UP PER FETUS
76817	TRANSVAGINAL US OBSTETRIC
76818	FETAL BIOPHYS PROFILE W/NST
76819	FETAL BIOPHYS PROFIL W/O NST
90460	IM ADMIN 1ST/ONLY COMPONENT
90461	IM ADMIN EACH ADDL COMPONENT
90471	IMMUNIZATION ADMIN
90472	IMMUNIZATION ADMIN EACH ADD

Procedure Code	Description
90473	IMMUNE ADMIN ORAL/NASAL
90474	IMMUNE ADMIN ORAL/NASAL ADDL
90785	PSYTX COMPLEX INTERACTIVE
90791	PSYCH DIAGNOSTIC EVALUATION
90792	PSYCH DIAG EVAL W/MED SRVCS
90832	PSYTX W PT 30 MINUTES
90833	PSYTX W PT W E/M 30 MIN
90834	PSYTX W PT 45 MINUTES
90837	PSYTX W PT 60 MINUTES
90846	FAMILY PSYTX W/O PT 50 MIN
90847	FAMILY PSYTX W/PT 50 MIN
92551	PURE TONE HEARING TEST AIR
92552	PURE TONE AUDIOMETRY AIR
92558	EVOKED AUDITORY TEST QUAL
92567	TYMPANOMETRY
92585	AUDITOR EVOKE POTENT COMPRE
92587	EVOKED AUDITORY TEST LIMITED
92588	EVOKED AUDITORY TST COMPLETE
94010	BREATHING CAPACITY TEST
94014	PATIENT RECORDED SPIROMETRY
94015	PATIENT RECORDED SPIROMETRY
94016	REVIEW PATIENT SPIROMETRY
94060	EVALUATION OF WHEEZING
94070	EVALUATION OF WHEEZING
94375	RESPIRATORY FLOW VOLUME LOOP
96101	PSYCHO TESTING BY PSYCH/PHYS
96102	PSYCHO TESTING BY TECHNICIAN
96103	PSYCHO TESTING ADMIN BY COMP
96110	DEVELOPMENTAL SCREEN W/SCORE
96111	DEVELOPMENTAL TEST EXTEND
96127	BRIEF EMOTIONAL/BEHAV ASSMT
96150	ASSESS HLTH/BEHAVE INIT
96151	ASSESS HLTH/BEHAVE SUBSEQ
96156	Health behavior assessment or re-assessment
96160	PT-FOCUSED HLTH RISK ASSMT
96161	CAREGIVER HEALTH RISK ASSMT
96372	THER/PROPH/DIAG INJ SC/IM
97802	MEDICAL NUTRITION INDIV IN
97803	MED NUTRITION INDIV SUBSEQ
97804	MEDICAL NUTRITION GROUP
98925	OSTEOPATH MANJ 1-2 REGIONS
98926	OSTEOPATH MANJ 3-4 REGIONS
98927	OSTEOPATH MANJ 5-6 REGIONS
98928	OSTEOPATH MANJ 7-8 REGIONS
98929	OSTEOPATH MANJ 9-10 REGIONS
98960	SELF-MGMT EDUC & TRAIN 1 PT
98961	SELF-MGMT EDUC/TRAIN 2-4 PT
98962	5-8 patients
98966	HC PRO PHONE CALL 5-10 MIN
98969	ONLINE SERVICE BY HC PRO
99000	SPECIMEN HANDLING OFFICE-LAB
99024	POSTOP FOLLOW-UP VISIT
99050	MEDICAL SERVICES AFTER HRS
99051	MED SERV EVE/WKEND/HOLIDAY
99056	MED SERVICE OUT OF OFFICE
99058	OFFICE EMERGENCY CARE
99071	PATIENT EDUCATION MATERIALS
99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity or diabetic instructions)
99173	VISUAL ACUITY SCREEN
99174	OCULAR INSTRUMNT SCREEN BIL
99177	OCULAR INSTRUMNT SCREEN BIL
99188	APP TOPICAL FLUORIDE VARNISH

Procedure Code	Description
99201	OFFICE/OUTPATIENT VISIT NEW
99202	OFFICE/OUTPATIENT VISIT NEW
99203	OFFICE/OUTPATIENT VISIT NEW
99204	OFFICE/OUTPATIENT VISIT NEW
99205	OFFICE/OUTPATIENT VISIT NEW
99211	OFFICE/OUTPATIENT VISIT EST
99212	OFFICE/OUTPATIENT VISIT EST
99213	OFFICE/OUTPATIENT VISIT EST
99214	OFFICE/OUTPATIENT VISIT EST
99215	OFFICE/OUTPATIENT VISIT EST
99334	DOMICIL/R-HOME VISIT EST PAT
99336	DOMICIL/R-HOME VISIT EST PAT
99337	DOMICIL/R-HOME VISIT EST PAT
99339	Individual physician supervision of a patient requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans; review of subsequent reports of patient status; review of related laboratory and other studies; communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (e.g., legal guardian), and/or key caregiver(s) involved in patient's care; integration of new information into the medical treatment plan; and/or adjustment of medical therapy, within a calendar month; 15-29 minutes
99340	30 minutes or more
99341	HOME VISIT NEW PATIENT
99342	HOME VISIT NEW PATIENT
99343	HOME VISIT NEW PATIENT
99344	HOME VISIT NEW PATIENT
99345	HOME VISIT NEW PATIENT
99347	HOME VISIT EST PATIENT
99348	HOME VISIT EST PATIENT
99349	HOME VISIT EST PATIENT
99350	HOME VISIT EST PATIENT
99354	PROLONG E&M/PSYCTX SERV O/P
99355	PROLONG E&M/PSYCTX SERV O/P
99358	PROLONG SERVICE W/O CONTACT
99359	PROLONG SERV W/O CONTACT ADD
99366	TEAM CONF W/PAT BY HC PROF
99367	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician
99368	With interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional
99381	INIT PM E/M NEW PAT INFANT
99382	INIT PM E/M NEW PAT 1-4 YRS
99383	PREV VISIT NEW AGE 5-11
99384	PREV VISIT NEW AGE 12-17
99385	PREV VISIT NEW AGE 18-39
99386	PREV VISIT NEW AGE 40-64
99387	INIT PM E/M NEW PAT 65+ YRS
99391	PER PM REEVAL EST PAT INFANT
99392	PREV VISIT EST AGE 1-4
99393	PREV VISIT EST AGE 5-11
99394	PREV VISIT EST AGE 12-17
99395	PREV VISIT EST AGE 18-39
99396	PREV VISIT EST AGE 40-64
99397	PER PM REEVAL EST PAT 65+ YR
99401	PREVENTIVE COUNSELING INDIV
99402	PREVENTIVE COUNSELING INDIV
99403	PREVENTIVE COUNSELING INDIV
99404	PREVENTIVE COUNSELING INDIV
99406	BEHAV CHNG SMOKING 3-10 MIN
99407	BEHAV CHNG SMOKING > 10 MIN
99408	AUDIT/DAST 15-30 MIN
99409	Alcohol and/or drug assessment or screening
99411	PREVENTIVE COUNSELING GROUP
99412	PREVENTIVE COUNSELING GROUP
99420	Administration and interpretation of health risk assessments
99421	Online digital evaluation and management service for an established patient for up to 7 days cumulative time during the 7 days, 5-10 minutes

Procedure Code	Description
99422	Online digital evaluation and management service for an established patient for up to 7 days cumulative time during the 7 days, 11-20 minutes
99423	Online digital evaluation and management service for an established patient for up to 7 days cumulative time during the 7 days, 21 or more minutes
99429	UNLISTED PREVENTIVE SERVICE
99441	PHONE E/M PHYS/QHP 5-10 MIN
99442	PHONE E/M PHYS/QHP 11-20 MIN
99443	PHONE E/M PHYS/QHP 21-30 MIN
99444	ONLINE E/M BY PHYS/QHP
99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time
99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, > 16 minutes
99455	WORK RELATED DISABILITY EXAM
99456	DISABILITY EXAMINATION
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
99458	each additional 20 minutes (List separately in addition to code for primary procedure
99461	INIT NB EM PER DAY NON-FAC
99473	Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
99474	separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient
99484	CARE MGMT SVC BHVL HLTH COND
99487	CMPLX CHRON CARE W/O PT VSIT
99489	CMPLX CHRON CARE ADDL 30 MIN
99490	CHRON CARE MGMT SRVC 20 MIN
99491	Chronic care management services at least 30 minutes
99492	1ST PSYC COLLAB CARE MGMT
99493	SBSQ PSYC COLLAB CARE MGMT
99494	1ST/SBSQ PSYC COLLAB CARE
99495	TRANS CARE MGMT 14 DAY DISCH
99496	TRANS CARE MGMT 7 DAY DISCH
99497	ADVNCD CARE PLAN 30 MIN
99498	ADVNCD CARE PLAN ADDL 30 MIN
0500F	INITIAL PRENATAL CARE VISIT
0501F	PRENATAL FLOW SHEET
0502F	SUBSEQUENT PRENATAL CARE
0503F	POSTPARTUM CARE VISIT
1000F	TOBACCO USE ASSESSED
1031F	SMOKING & 2ND HAND ASSESSED
1032F	PT received Tobacco Cessation Information
1033F	TOBACCO NONSMOKER NOR 2NDHND
1034F	CURRENT TOBACCO SMOKER
1035F	SMOKELESS TOBACCO USER
1036F	TOBACCO NON-USER
1111F	DSCHRG MED/CURRENT MED MERGE
1220F	PT SCREENED FOR DEPRESSION
3016F	PT SCRND UNHLTHY OH USE
3085F	SUICIDE RISK ASSESSED
3351F	NEG SCRN DEP SYMP BY DEPTOOL
3352F	NO SIG DEP SYMP BY DEP TOOL
3353F	MILD-MOD DEP SYMP BY DEPTOOL
3354F	CLIN SIG DEP SYM BY DEP TOOL
3355F	CLIN SIG DEP SYM BY DEP TOOL
4000F	TOBACCO USE TXMNT COUNSELING
4001F	TOBACCO USE TXMNT PHARMACOL
4004F	PT TOBACCO SCREEN RCVD TLK
4290F	Alcohol and/or drug assessment or screening
4293F	Pt screened for high risk sexual behavior
4306F	Alcohol and/or Drug use counseling services

Procedure Code	Description
4320F	Alcohol and/or Drug use counseling services
90848 - 90899	Services to patients for evaluation and treatment of mental illnesses that require psychiatric services
96158-96159	Health behavior intervention, individual face-to-face
96164-96165	Health behavior intervention, group (two or more patients), face-to-face
96167-96168	Health behavior intervention, family (with the patient present), face-to-face
96170-96171	Health behavior intervention, family (without the patient present), face-to-face
97151-97158	Behavior Identification Assessment, administered by QHP, each 15 minutes of QHP's time face-to-face with patient and/or guardian(s)/caregivers(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan
98967-98968	Non-physician telephone services
G0008	ADMIN INFLUENZA VIRUS VAC
G0009	ADMIN PNEUMOCOCCAL VACCINE
G0010	ADMIN HEPATITIS B VACCINE
G0101	CA SCREEN; PELVIC/BREAST EXAM
G0123	SCREEN CERV/VAG THIN LAYER
G0179	MD RECERTIFICATION HHA PT
G0180	MD CERTIFICATION HHA PATIENT
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
G0271	Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes
G0396	ALCOHOL/SUBS INTERV 15-30MN
G0397	Alcohol or substance abuse assessment
G0402	INITIAL PREVENTIVE EXAM
G0403	EKG FOR INITIAL PREVENT EXAM
G0404	EKG TRACING FOR INITIAL PREV
G0405	EKG INTERPRET & REPORT PREVE
G0438	PPPS, INITIAL VISIT
G0439	PPPS, SUBSEQ VISIT
G0442	ANNUAL ALCOHOL SCREEN 15 MIN
G0443	BRIEF ALCOHOL MISUSE COUNSEL
G0444	DEPRESSION SCREEN ANNUAL
G0445	HIGH INTEN BEH COUNS STD 30M
G0447	BEHAVIOR COUNSEL OBESITY 15M
G0463	HOSPITAL OUTPT CLINIC VISIT
G0476	HPV COMBO ASSAY CA SCREEN
G0502	Initial psychiatric collaborative care management
G0503	Subsequent psychiatric collaborative care management
G0504	Initial or subsequent psychiatric collaborative care management
G0505	Cognition and functional assessment
G0506	COMP ASSES CARE PLAN CCM SVC
G0507	Care management services for behavioral health conditions
G0513	PROLONG PREV SVCS, FIRST 30M
G0514	Prolonged preventive service
G2058	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month;
G2064-G2065	Comprehensive care management services for a single high-risk disease
H0002	ALCOHOL AND/OR DRUG SCREENIN
H0031	MH HEALTH ASSESS BY NON-MD
H0049	ALCOHOL/DRUG SCREENING
H1000	PRENATAL CARE ATRISK ASSESSM
H1001	ANTEPARTUM MANAGEMENT
Q0091	OBTAINING SCREEN PAP SMEAR
S0610	ANNUAL GYNECOLOGICAL EXAMINA
S0612	ANNUAL GYNECOLOGICAL EXAMINA
S0613	ANN BREAST EXAM
S0622	PHYS EXAM FOR COLLEGE
S9444	Parenting Classes, non-physician provider, per session
S9445	PT EDUCATION NOC INDIVID
S9446	PT EDUCATION NOC GROUP
S9447	Infant safety (including cardiopulmonary resuscitation classes nonphysician provider, per session)
S9449	WEIGHT MGMT CLASS

Procedure Code	Description
S9451	EXERCISE CLASS
S9452	Nutrition classes non-physician provider per session
S9454	Stress management classes non-physician provider per session
S9470	NUTRITIONAL COUNSELING, DIET
T1015	CLINIC SERVICE

B.1.L: MARKET CATEGORY CODES

Code	Description
IND	Individuals (non-group)
FCH	Individuals on a franchise basis
GCV	Individuals as group conversion Policies
GS1	Employers having exactly 1 employee
GS2	Employers having 2 thru 9 employees
GS3	Employers having 10 thru 25 employees
GS4	Employers having 26 thru 50 employees
GLG1	Employers having 51 thru 100 employees
GLG2	Employers having 101 thru 250 employees
GLG3	Employers having 251 thru 500 employees
GLG4	Employers having more than 500 employees
GSA	Small employers through a qualified association trust
OTH	Other types of entities. Insurers using this market code shall obtain prior approval.

B.1.M ADMISSION SOURCE CODES

Code	Description
1	Non-Health Care Facility Point of Origin
2	Clinic or physician's office
4	Transfer from a hospital (different facility)
5	Transfer from a SNF, ICF, or ALF
6	Transfer from another health care facility
8	Court/law enforcement
9	Information not available
D	Transfer from One Distinct Unit of the Hospital to Another Distinct Unit of the Same Hospital
E	Transfer from Ambulatory Surgery Center (ASC)
F	Transfer from Hospice Facility
G	Transfer from a designated disaster alternate care site
In the Case of Newborn	
5	Born inside this hospital
6	Born outside this hospital

B.1.N UNIT OF MEASURE

Code	Description
DA	Days
MJ	Minutes
HR	Hours
FM	15-minute increments
PT	Pints
RM	Rental months
SN	Sessions
VT	Visits
PR	Procedures
IT	Items
UN	Units
OT	Other
For drugs	
EA	Each
IU	International units
GM	Grams
ML	Milliliters
MG	Milligrams
MEQ	Milliequivalents
MM	Millimeter
UG	Microgram
UU	Unit
OT	Other

B.1.O MARKET OPTIONS

Code	Description
MU	Municipality: defined in C.R.S 31-1-101(6)
ST	Student Health: defined in C.R.S. 10-16-102(65)
SD	STLD (Short Term Limited Duration): defined in C.R.S. 10-16-102(60)
TH	Taft Hartley: defined in ERISA Section 3(37), 29 U.S.C. §1002(3)(37)

B.1.P PDAB LEGISLATIVE REFERENCE

Code	Description
IV	The fifteen prescription drugs that caused the greatest increases in the carrier's premiums
V	The fifteen prescription drugs for which the carrier paid most frequently and for which the carrier received a rebate from manufacturers
VI	The fifteen prescription drugs for which the carrier received the highest rebates, as determined by percentages of the price of the prescription drug
VII	The fifteen prescription drugs for which the carrier received the largest rebates