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CENTER FOR IMPROVING VALUE IN HEALTH CARE (CIVHC)

Colorado All-Payer Claims Database DATA SUBMISSION GUIDE

Version 12 2020

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

Date	Version	Description	Author
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

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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 and Drug Rebates. 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 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 administrator's request.

1.1 DATA TO BE SUBMITTED

1.1.1 MEDICAL CLAIMS DATA

a) Payers shall report health care service paid claims and encounters for all Colorado resident members. 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. 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. CPT/HCPCS codes are also required.
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.

1.1.2 PHARMACY CLAIMS

a) Health Care Payers must provide data for all pharmacy paid claims for prescriptions that were actually dispensed to members and paid (Exhibit A-3).
b) 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.
c) 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).

1.1.3 MEMBER ELIGIBILITY DATA

a) Health Care Payers must provide a data set that contains information on every covered plan member who is a Colorado resident (see paragraph 1.2.1.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.

1.1.4 PROVIDER DATA

a) Health Care Payers must provide a data set 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 data set 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

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' worth of historical data, separated by year.
d) Files are submitted on an annual basis.

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' worth of historical data, separated by year.
c) Control Total files should include a supplemental tab with high-level information describing various alternative payment contracts.
d) Files are submitted on an annual basis.

1.1.7 Drug Rebate Data

a) Health care payers must provide a file that includes aggregated information for pharmacy expenditures and rebates/other compensation received. (Exhibit A-7).
b) Drug Rebate files should include three years' worth of historical data, separated by year.
c) Drug Rebate files should include a supplemental tab with high-level information describing contracts with pharmacy benefit managers (PBMs).
d) Files are submitted on an annual basis.

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 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 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.

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 is 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.

4.0 FILE FORMAT

4.1 All monthly files submitted to the CO APCD will be formatted as standard text file.

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 *always* contains the names of data columns.
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).

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 files names will follow the template:

TESTorPROD_PayerID_PeriodEndingDateFileTypeVersionNumber.txt

- Examples
    i. TEST_0000_201606MEv01.txt
    ii. PROD_0000_201606MEv02.txt

- TEST or PROD - TEST for test files; PROD for production files
- PayerID - The payer ID assigned to each submitter
- Period ending date, expressed as CCYYMM (four-digit calendar year and two-digit month; for example, 201403 indicates a March 2014 end date).
- File Type - Member Eligibility (ME), Medical Claims (MC), Pharmacy Claims (PC), Provider (MP), Specialty Crosswalk (SC).
- Version number: Used to differentiate multiple submissions of the same file. This is important when a file must be resubmitted to resolve an issue, such as a validation failure. The letter v should be used, followed by two digits, starting with v01. Please include the leading zero. Original submissions of all files should be labeled v01. The Portal will not accept files that have the same name as an existing file.
- File extension (.txt)

4.3 All annual files submitted to the CO APCD will be formatted as standard excel file.

Submitters 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 files names will follow the template:

TESTorPROD_PayerID_SubmissionYearDueFileTypeVersionNumber.txt

a. Examples
    iii. TEST_0000_2019AMv01.txt
    iv. PROD_0000_2019DRv02.txt

- TEST or PROD - TEST for test files; PROD for production files
- PayerID - The payer ID assigned to each submitter
- Submission year due, expressed as CCYY (four-digit calendar year).

- File Type - APM File (AM), Control Total (CT), Drug Rebate (DR).
- Version number: Used to differentiate multiple submissions of the same file. This is important when a file must be resubmitted to resolve an issue, such as a validation failure. The letter v should be used, followed by two digits, starting with v01. Please include the leading zero. Original submissions of all files should be labeled v01. The Portal will not accept files that have the same name as an existing file.
- File extension (.xlsx)

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. In order to reconcile the total number of Colorado resident covered members for this 3-year period, each payer is to submit a summary report that totals the number of Colorado resident covered members for each month for Historic Data.

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 is contained on the eligibility file is 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	ME
HD002	Payer Code	varchar	4	Distributed by CIVHC
HD003	Payer Name	varchar	75	Distributed by CIVHC
HD004	Beginning Month	date	6	CCYYMM
HD005	Ending Month	date	6	CCYYMM
HD006	Record count	int	10	Total number of records submitted in the medical eligibility file, excluding header and trailer records

A-1.1 MEDICAL ELIGIBILITY FILE

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME001	N/A	Payer Code	varchar	4	Distributed by CIVHC	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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME005	N/A	Month	month	2	Month for which eligibility is reported in this submission expressed numerical from 01 to 12.	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	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	O

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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.	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. 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.	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	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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	CCYYMMDD	R
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	R
ME019	N/A	Prescription Drug Coverage	char	1	Y = YES N = NO 3 = UNKNOWN	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME020	N/A	Dental Coverage	char	1	Y = YES N = NO 3 = UNKNOWN	R
ME123	N/A	Behavioral Health	char	1	Y = YES N = NO 3 = UNKNOWN	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 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 MC021 or MC022 are coded as R9.	O
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 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 PORTUG Portuguese	O

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					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 blank.	
ME026	N/A	Ethnicity 2	varchar	6	See code set for ME025.	O
ME027	N/A	Other Ethnicity	varchar	20	List ethnicity if MC025 or MC026 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 ---	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 blank.	R for employer-based coverage

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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 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 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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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
ME897	N/A	Plan Effective Date	date	8	CCYYMMDD 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	CCYYMMDD 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 null.	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				

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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 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
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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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, Set as null if unavailable. Do not submit HICN identifiers.	R for Medicare members
ME126	N/A	NAIC ID	char	5	Report the NAIC Code associated with the entity that maintains this product. Leave 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. Null if not applicable	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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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	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
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:

- Claims are paid claims. Non-covered or denied claims (e.g. duplicate or patient ineligible claims) are not included.
- 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	MC
HD002	Payer Code	varchar	4	Distributed by CIVHC
HD003	Payer Name	varchar	75	Distributed by CIVHC
HD004	Beginning Month	date	6	CCYYMM
HD005	Ending Month	date	6	CCYYMM
HD006	Record count	int	10	Total number of records submitted in the medical claims file, excluding header and trailer records

MEDICAL CLAIMS FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	MC
TR002	Payer Code	varchar	4	Distributed by CIVHC
TR003	Payer Name	varchar	75	Distributed by CIVHC
TR004	Beginning Month	date	6	CCYYMM
TR005	Ending Month	date	6	CCYYMM
TR006	Extraction Date	date	8	CCYYMMDD

A-2.1 MEDICAL CLAIMS FILE

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC001	N/A	Payer Code	varchar	4	Distributed by CIVHC	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. Only paid (or partially paid) claims	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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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. Plans that cannot increment this column may opt to use YYMM as the version number.	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.	R
MC007	835/2100/NM1/34/09	Subscriber Social Security Number	varchar	9	Subscriber's social security number; Set as null if unavailable	O
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.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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. MC009 = ME010; PC009	R
MC010	835/2100/NM1/MI/08~~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.	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	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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	CCYYMMDD	R
MC014	837/2010CA/N4/ /01	Member City Name of Residence	varchar	30	City name of member of 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	date	8	CCYYMMDD	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC018	837/2300/DTP/435/03	Admission Date	date	8	Required for all inpatient claims. CCYYMMDD	R for all inpatient claims O for outpatient
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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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. Set to null 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. Set to null if provider is a facility or organization.	O

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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. Set to null 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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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
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 Lookup Table B.1.E	R (professional claims only)
MC038	835/2100/CLP/ /02	Claim Status	char	2	See Lookup Table B.1.F	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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: 1=Yes (denied); 2= No (not denied).	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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 (claim was denied)	R
MC039	837/2300/HI/BJ/02-1-2	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/03-1-2	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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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
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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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); this includes the CPT codes of the American Medical Association. Required for Outpatient and Professional claims only.	R for Outpatient and Professional Claims only; 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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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. CCYYMMDD	R
MC060	835/2110/DTM/151/02	Date of Service - Thru	date	8	Last date of service for this service line. CCYYMMDD	R
MC061	835/2110/SVC//05	Quantity	dec	12	Count of services performed. Do code decimal point when applicable.	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.	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.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC064	N/A	Prepaid Amount	int	10	For capitated services, the fee for service equivalent amount. Do not code decimal point. Two decimals implied.	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.	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.	R
MC067	N/A	Deductible Amount	int	10	Do not code decimal point. Two decimals implied.	R
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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC069	N/A	Discharge Date	date	8	Date patient discharged. Required for all inpatient claims. CCYYMMDD	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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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)

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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)

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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)
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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC058A	835/2110/SVC/ID/ 01-2	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/ 01-2	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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC058C	835/2110/SVC/ID/ 01-2	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/ 01-2	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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC058E	835/2110/SVC/ID/ 01-2	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
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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC210	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
MC211	N/A	NAIC ID	char	5	Report the NAIC Code associated with the entity that maintains this product. Leave 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 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 blank if non-HCPF submitter	R for HCPF
MC217	N/A	Claim Type Code (HCPF-specific)	char	1	HCPF-defined Claim Type Code Leave blank if non-HCPF submitter	R for HCPF
MC218	N/A	Claim Type Code Description (HCPF-specific)	varchar	50	HCPF-defined Claim Type Code description Leave blank if non-HCPF submitter	R for HCPF

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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)	O for six months (R in January 2022)
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:

- 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	PC
HD002	Payer Code	char	4	Distributed by CIVHC
HD003	Payer Name	char	75	Distributed by CIVHC
HD004	Beginning Month	date	6	CCYYMM
HD005	Ending Month	date	6	CCYYMM
HD006	Record count	int	10	Total number of records submitted in the Pharmacy claims file, excluding header and trailer records

PHARMACY CLAIMS FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	PC
TR002	Payer Code	varchar	4	Distributed by CIVHC
TR003	Payer Name	varchar	75	Distributed by CIVHC
TR004	Beginning Month	date	6	CCYYMM
TR005	Ending Month	date	6	CCYYMM
TR006	Extraction Date	date	8	CCYYMMDD

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	4	Distributed by CIVHC	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.	R
PC204	N/A	Script number	int	20	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	R
PC007	302-C2	Subscriber Social Security Number	varchar	9	Subscriber's social security number; Set as null if unavailable	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.	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. PC009 = ME010 and MC009	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	O

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
					identifier such as Medicaid ID. Must be an identifier that is unique to the member.	
PC011	N/A	Individual Relationship Code	char	2	Member's relationship to insured Use Lookup Table B.1.B	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	CCYYMMDD	R
PC014	N/A	Member City Name of Residence	varchar	50	City name of member	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	date	8	CCYYMMDD – date claim paid 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
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

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
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

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
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 (claim was 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	R

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
					02 = Refill	
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 N = Drug is not a specialty drug based on payer formulary	R
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	CCYYMMDD	R
PC033	404-D4	Quantity Dispensed	dec	10	Number of metric units of medication dispensed. Code decimal point.	R
PC034	405-D5	Days Supply	int	4	Estimated number of days the prescription will last	R

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC035	804-5B	Charge Amount	int	10	Do not code decimal point or provide any punctuation where $1,000.00 converted to 100000 Same for all financial data that follows.	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.	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.	O
PC039	412-DC	Dispensing Fee	int	10	Do not code decimal point. Two decimal places implied.	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.	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
PC042	N/A	Deductible Amount	int	10	Do not code decimal point. Two decimal places implied. Do not deduct POS rebate amount, if applicable.	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

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
						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

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
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 claim, use the NAIC code of the carrier when a PBM processes claims on behalf of the carrier. Leave blank if entity does not have a NAIC Code.	R
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 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	R for HCPF

Data Element #	National Council for Prescription Drug Programs Field #	Data Element Name	Type	Length	Description/Codes/Sources	Required
					Leave blank if submitter is not 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)
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 FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	MP
HD002	Payer Code	varchar	4	Distributed by CIVHC
HD003	Payer Name	varchar	75	Distributed by CIVHC
HD004	Beginning Month	date	6	CCYYMM (Example: 200801)
HD005	Ending Month	date	6	CCYYMM (Example: 200812)
HD006	Record count	int	10	Total number of records submitted in the Provider file, excluding header and trailer records

PROVIDER FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	MP
TR002	Payer Code	varchar	4	Distributed by CIVHC
TR003	Payer Name	varchar	75	Distributed by CIVHC
TR004	Beginning Month	date	6	CCYYMM (Example: 200801)
TR005	Ending Month	date	6	CCYYMM (Example: 200812)
TR006	Extraction Date	date	8	CCYYMMDD

A-4.1 PROVIDER FILE

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MP001A	N/A	Payer Code	varchar	4	Distributed by CIVHC	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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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.; NULL 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	R
MP009	N/A	Provider Office Street Address	varchar	50	Physical address line 1- address where provider delivers health care services: street name and number	R
MP010	N/A	Provider Office City	varchar	30	Physical address - address where provider delivers health care services	R
MP011	N/A	Provider Office State	char	2	Physical address - address where provider delivers health care services. Use postal service standard 2 letter abbreviations.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MP012	N/A	Provider Office Zip	varchar	11	Physical address - address 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 - 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 where provider delivers health care services.	O
MP899	N/A	Record Type	char	2	MP	R

A-5 ANNUAL SUPPLEMENTAL PROVIDER LEVEL ALTERNATIVE PAYMENT MODEL (APM) DATA

Frequency: Submit annually in Excel format to CIVHC via SFTP by September 30th of each year. Additional formatting requirements:

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

Initially, payers shall submit a complete and accurate historical test file for the 2016 calendar year to the administrator. These historical submissions must conform to submission guide requirements and be received by no later than July 1, 2019. On a yearly basis thereafter, Payers will transmit complete and accurate APM data for the most recent and complete three calendar-year periods by no later than September 30th of the following year. Please see an example of the timeline below. Please note that the administrator may choose to require test files to be submitted prior to the annual due date of September 30th.

Date That Supplier 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 30, 2022	*January 1, 2019*	*January 1, 2021*

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:
    - 1: Fee for Service – No link to Quality and Value
    - 2A: Foundation Payments for Infrastructure and Operations
    - 2B: Pay for Reporting
    - 2C: Pay for Performance
    - 3A: Shared Savings
    - 3B: Shared Savings and Downside Risk
    - 3N: Risk Based Payments NOT Linked to Quality
    - 4A: Condition-Specific Population-Based Payment
    - 4B: Comprehensive Population-Based Payment
    - 4C: Integrated Finance and Delivery Systems
    - 4N: Capitated Payments NOT Linked to Quality

APM File Header Record

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	N/A – Excel file	AM
HD002	Payer Code	varchar	N/A – Excel file	Distributed by CIVHC
HD003	Payer Name	varchar	N/A – Excel file	Distributed by CIVHC
HD004	Beginning Month	date	N/A – Excel file	CCYYMM (Example: 200801)
HD005	Ending Month	date	N/A – Excel file	CCYYMM (Example: 200812)

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD006	Record count	int	N/A – Excel file	Total number of records submitted in the APM file, excluding header and trailer records

APM FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	N/A – Excel file	AM
TR002	Payer Code	varchar	N/A – Excel file	Distributed by CIVHC
TR003	Payer Name	varchar	N/A – Excel file	Distributed by CIVHC
TR004	Beginning Month	date	N/A – Excel file	CCYYMM (Example: 200801)
TR005	Ending Month	date	N/A – Excel file	CCYYMM (Example: 200812)
TR006	Extraction Date	date	N/A – Excel file	CCYYMMDD

A 5.1 - APM FILE

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM001	N/A	Billing Provider Number	varchar	N/A – Excel file	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
AM002	N/A	National Billing Provider ID	varchar	N/A – Excel file	National Provider ID	R
AM003	N/A	Billing Provider Tax ID	varchar	N/A – Excel file	Tax ID of billing provider. Do not code punctuation.	R
AM004	N/A	Billing Provider Last Name or Organization Name	varchar	N/A – Excel file	Full name of provider billing organization or last name of individual billing provider.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM005	N/A	Billing Provider Entity	char	N/A – Excel file	F = Facility G = Provider group I = IPA P = Practitioner	R
AM006	N/A	Payment Arrangement Category	varchar	N/A – Excel file	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
AM006A	N/A	Prospective Payment Flag	char	N/A – Excel file	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
AM007	N/A	Performance Year	int	N/A – Excel file	Effective year of performance period for reported Insurance Product Type Code and Payment Arrangement Type. CCYY format	R
AM008	N/A	Insurance Product Type Code	varchar	N/A – Excel file	See lookup table B.1.A	R
AM009	N/A	Member Months	int	N/A – Excel file	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	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					No decimal places; round to nearest integer. Example: 12345	
AM010	N/A	Total Primary Care Claims Payments	numeric	N/A – Excel file	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 (AM012).	R
AM010A	N/A	Payer Portion: Total Primary Care Claims Payments	numeric	N/A – Excel file	Payer portion of total primary care payments tied to a claim reported in AM010. Exclude member portion (copay, coinsurance, deductible). Should be a sub-set of AM010. 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

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM011	N/A	Total Primary Care Non-Claims Payments	numeric	N/A – Excel file	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. This value should never exceed the amount of Total Non-Claims Payments (AM013).	R
AM011A	N/A	Payer portion: Total Primary Care Non-Claims Payments	numeric	N/A – Excel file	Payer portion of Total Primary Care Non-Claims Payments reported in AM011. Exclude member portion (copay, coinsurance, deductible). Should be a sub-set of AM011. 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 by payer.	R
AM012	N/A	Total Claims Payments	numeric	N/A – Excel file	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	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					organization has to pay the mandatory reporter. Enter 0 if no claims payments made.	
AM012A	N/A	Payer Portion: Total Claims Payments	numeric	N/A – Excel file	Payer portion of total 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 claims payments made by payer.	R
AM013	N/A	Total Non-Claims Payments	numeric	N/A – Excel file	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. Enter 0 if no non- claims payments made	R
AM013A	N/A	Payer Portion: Total Non-Claims Payments	numeric	N/A – Excel file	Payer portion of Total Non-Claims Payments reported in AM013. Exclude member portion (copay, coinsurance, deductible). Should be a sub-set of AM013. 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.	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
AM014	N/A	Billing Provider Office City	varchar	N/A – Excel file	Physical address	R
AM015	N/A	Billing Provider Office State	char	N/A – Excel file	Physical address - Use postal service standard 2 letter abbreviations.	R
AM016	N/A	Billing Provider Office Zip	varchar	N/A – Excel file	Physical address - Minimum 5-digit code.	R
AM017	N/A	Record Type	char	N/A – Excel file	AM	R

A-6 CONTROLS TOTALS FOR ANNUAL SUPPLEMENTAL PROVIDER LEVEL APM SUMMARY

Frequency: Submit annually in Excel format to CIVHC via SFTP by September 30th 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.
- Control Total file should be submitted as the first tab in the same excel document as the APM Contract data
- Drug Rebate tab should be labeled "CT"
- PBM Contract tab should be labeled "Contract"

Initially, payers shall submit a complete and accurate historical test file for the 2016 calendar year to the administrator. These submissions must conform to submission guide requirements and be received by no later than July 1, 2019. On a yearly basis thereafter, Payers will transmit complete and accurate APM data for the most recent and complete three calendar-year periods by no later than September 30th of the following year. Please see an example of the timeline below. Please note that the administrator may choose to require test files to be submitted prior to the annual due date of September 30th.

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 30, 2022	*January 1, 2019*	*January 1, 2021*

CONTROL TOTALS FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	N/A – Excel file	CT
HD002	Payer Code	varchar	N/A – Excel file	Distributed by CIVHC
HD003	Payer Name	varchar	N/A – Excel file	Distributed by CIVHC
HD004	Beginning Month	date	N/A – Excel file	CCYYMM (Example: 200801)
HD005	Ending Month	date	N/A – Excel file	CCYYMM (Example: 200812)
HD006	Record count	int	N/A – Excel file	Total number of records submitted in the Control Total file, excluding header and trailer records

CONTROL TOTALS FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	N/A – Excel file	CT
TR002	Payer Code	varchar	N/A – Excel file	Distributed by CIVHC
TR003	Payer Name	varchar	N/A – Excel file	Distributed by CIVHC
TR004	Beginning Month	date	N/A – Excel file	CCYYMM (Example: 200801)
TR005	Ending Month	date	N/A – Excel file	CCYYMM (Example: 200812)
TR006	Extraction Date	date	N/A – Excel file	CCYYMMDD

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	N/A – Excel file	Distributed by CIVHC	R
CT002	N/A	Payer Name	varchar	N/A – Excel file	Distributed by CIVHC	R
CT003	N/A	Submitted File	text	N/A – Excel file	File name of the APM file	R
CT004	N/A	Performance Year	numeric	N/A – Excel file	Year of reporting, submit in YYYY format	R
CT005	N/A	Insurance Product Type Code	varchar	N/A – Excel file	See lookup table B.1.A	R
CT006	N/A	Payment Arrangement Category	varchar	N/A – Excel file	See look up table B.1.J Payment arrangement type reported.	R
CT007	N/A	Payment Arrangement Category Member Months	numeric	N/A – Excel file	Total, de-duplicated member months associated with payment arrangement category identified in CT006 No decimal places; round to nearest integer Example: 12345	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					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	
CT008	N/A	All Member Months	numeric	N/A – Excel file	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 combination.	R
CT009	N/A	Total Alternative Arrangement Member Months	numeric	N/A – Excel file	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	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
					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 combination.	
CT010	N/A	Sum of Primary Care Claims Payments	numeric	N/A – Excel file	Sum of Total Primary Care Claims Payments, as reported in AM file	R
CT010A	N/A	Sum of Payer Portion of Primary Care Claims Payments	numeric	N/A – Excel file	Sum of Payer Portion of Total Primary Care Claims Payments, as reported in AM file	R
CT011	N/A	Sum of Primary Care Non-Claims Payments	numeric	N/A – Excel file	Sum of Total Primary Care Non-Claims Payments, as reported in AM file	R
CT011A	N/A	Sum of Payer Portion of Primary Care Non-Claims Payments	numeric	N/A – Excel file	Sum of Payer Portion of Total Primary Care Non-Claims Payments, as reported in AM file	R
CT012	N/A	Sum of Claims Payments	numeric	N/A – Excel file	Sum of Total Claims Payments, as reported in AM file	R

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
CT012A	N/A	Sum of Payer Portion of Claims Payments	numeric	N/A – Excel file	Sum of Payer Portion of Total Claims Payments, as reported in AM file	R
CT013	N/A	Sum of Non-Claims Payments	numeric	N/A – Excel file	Sum of Total Non-Claims Payments, as reported in AM file	R
CT013A	N/A	Sum of Payer Portion of Non-Claims Payments	numeric	N/A – Excel file	Sum of Payer Portion of Total Non-Claims Payments, as reported in AM file	R
CT014	N/A	Record Type	char	N/A – Excel file	CT	R

A-7 ANNUAL APM CONTRACT INFORMATION

Frequency: Submit annually in Excel format, as second tab in Control Total file, to CIVHC via SFTP by September 30th of each year.

Additional formatting requirements:

- APM Contract information is a supplement to the Control Total File and should be submitted as a second tab
- APM Contract tab should be labeled "Contract"
- Control Total tab should be labeled "CT"

A 7.1 ANNUAL APM CONTRACT INFORMATION

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
AC001	Payer Code	varchar	N/A – Excel file	Distributed by CIVHC	R
AC002	Payer Name	varchar	N/A – Excel file	Distributed by CIVHC	R
AC003	Contract Type Name	varchar	N/A – Excel file	The unique name of the alternative payment contract type between the payer and providers.	R
AC004	Contract Description	varchar	N/A – Excel file	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	R
AC005	Involves both claims and non-claims payments	char	N/A – Excel file	C = Claims only N = Non-Claims only B = Both claims and non-claims	R
AC006	Services Covered	char	N/A – Excel file	N = Non-medical activities only S = Specific set of medical services	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				M = Comprehensive medical services	
AC007	Involves measurement of quality	char	N/A – Excel file	Y = Quality measurement N = No quality measurement	R
AC008	Involves measurement of spending targets	char	N/A – Excel file	Y = Spending targets N = No spending targets	R
AC009	Payments are prospective or retrospective	char	N/A – Excel file	PR = Prospective with retrospective reconciliation PN = Prospective with no retrospective reconciliation RT = Retrospective N/A = Not Applicable	R
AC010	Payment is population-based	char	N/A – Excel file	Y = Population-Based N = Not Population-Based	R
AC011	Risk to Provider	char	N/A – Excel file	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	N/A – Excel file	Y = Drug spending/utilization targets N = No drug spending/utilization targets	R
AC013	Assigned LAN category	char	N/A – Excel file	See look up table B.1.J Payment arrangement type reported.	R
AC014	Comments	varchar	N/A – Excel file	Use this field to provide additional information or describe any caveats	O

A-8 ANNUAL PRESCRIPTION DRUG REBATE DATA FILE

Frequency: Submit annually in Excel format to CIVHC via SFTP by September 30th 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.
- Drug Rebate file should be submitted as the first tab in the same excel document as the PBM Contract data
- Drug Rebate tab should be labeled "DR"
- PBM Contract tab should be labeled "PBM"
- 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 other pharmaceutical manufacturer compensation or price concessions to be used for implementation of the Annual Prescription Drug Rebate Data File requirement is as follows:
- Prescription Drug Rebates: Total rebates, compensation (defined below), remuneration, and any other price concessions (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. This amount shall include rebate guarantee amounts as well as any additional rebate amounts collected by the payer. This amount shall include the total amount of prescription drug rebates and price concessions provided by pharmaceutical manufacturers, regardless of whether they are conferred to the payer directly by the manufacturer, a PBM, or any other entity. In addition, this amount shall include the total amount of prescription drug rebates and price concessions provided by pharmaceutical manufacturers, regardless of whether the they are conferred to the payer through regular aggregate payments, on a claim-by-claim basis at the point-of-sale, as part of retrospective financial reconciliations (including

reconciliations that also reflect other contractual arrangements), or by any other method. Payers should apply incurred but not reported (IBNR) factors to preliminary prescription drug rebate data. Rebates will exclude claims paid under the benefit plan as qualified 340b pricing.

- Rebates and other price concessions: A reduction in the amount a payer pays for an item or service based on an arms-length transaction. The terms of the reduction must be fixed and disclosed in writing to the payer at the time of the initial purchase to which the reduction applies, and the reduction or concession must result in cash flow from the manufacturer to the payer.
- For the purposes of this data collection, Medicare Part D coverage gap discounts shall be treated in the same manner as they are treated for pharmacy expenditures. If coverage gap discounts are excluded from pharmacy expenditures, they should be excluded from 957 CMR 2.00 Payer Reporting of Prescription Drug Rebates Data Specification Manual 8 prescription drug rebates. If coverage gap discounts are included in pharmacy expenditures, they should be included in prescription drug rebates.
- Fair market value bona fide service fees: Fees paid by a manufacturer to a third party (e.g., payers, PBMs, payer- or PBM-owned pharmacies), that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs), etc.).
- Compensation: Compensation includes, but is not limited to, discounts; credits; rebates, regardless of how categorized; fees; educational grants received from manufacturers in relation to the provision of utilization data to manufacturers for rebating, marketing and related purposes; market share incentives; commissions; manufacturer administrative fees; and administrative management fees.

Initially, payers shall submit a complete and accurate historical test file for the 2016 calendar year to the administrator. These submissions must conform to submission guide requirements and be received by no later than July 1, 2019. On a yearly basis thereafter, Payers will transmit complete and accurate drug rebate data for the most recent and complete three calendar-year periods by no later than September 30th of the following year. Please see an example of the timeline below. Please note that the administrator may choose to require test files to be submitted prior to the annual due date of September 30th. 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 30, 2022	*January 1, 2019*	*January 1, 2021*

DRUG REBATE FILE HEADER RECORD

Data Element #	**Data Element Name**	**Type**	**Max Length**	**Description/valid values**
HD001	Record Type	char	N/A – Excel file	DR
HD002	Payer Code	varchar	N/A – Excel file	Distributed by CIVHC
HD003	Payer Name	varchar	N/A – Excel file	Distributed by CIVHC
HD004	Beginning Month	date	N/A – Excel file	CCYYMM (Example: 200801)
HD005	Ending Month	date	N/A – Excel file	CCYYMM (Example: 200812)
HD006	Record count	int	N/A – Excel file	Total number of records submitted in the Drug Rebate file, excluding header and trailer records

DRUG REBATE FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	N/A – Excel file	DR
TR002	Payer Code	varchar	N/A – Excel file	Distributed by CIVHC
TR003	Payer Name	varchar	N/A – Excel file	Distributed by CIVHC
TR004	Beginning Month	date	N/A – Excel file	CCYYMM (Example: 200801)
TR005	Ending Month	date	N/A – Excel file	CCYYMM (Example: 200812)
TR006	Extraction Date	date	N/A – Excel file	CCYYMMDD

A 8.1 ANNUAL PRESCRIPTION DRUG REBATE DATA

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
DR001	Payer Code	varchar	N/A – Excel file	Distributed by CIVHC	R
DR002	Payer Name	varchar	N/A – Excel file	Distributed by CIVHC	R
DR003	Insurance Type Code/Product	char	N/A – Excel file	See Lookup Table B-1.A	R
DR004	Calendar Year	year	N/A – Excel file	4 digit Year for the most recent calendar year time period reported in this submission	R
DR005	Member population	int	N/A – Excel file	The population of covered members for all data provided in this data filing. Payers should only include information pertaining to members for which they are the primary payer, and exclude information for members for which they were the secondary or tertiary payer. All Colorado resident members for whom a payer provides primary coverage should be included in the	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				member population, regardless of product or funding type.	
DR006	Member Months	int	N/A – Excel file	The number of members receiving primary health insurance coverage by a plan over the specified period of time expressed in months of membership. The member months provided in this field should correspond to the patient population identified in Member Population. All members in the defined member population must be counted in the member month value. Sum of member months. No decimal places; round to nearest integer. Example: 12345	R
DR007	Total Pharmacy Expenditure Amount	numeric	N/A – Excel file	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	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				amount will not reflect prescription drug rebates in any way)	
DR008	Pharmacy Expenditure Amount: Specialty Drugs	numeric	N/A – Excel file	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. Drug defined as a specialty drug under the terms of a payer's contract with its PBM.	R
DR009	Pharmacy Expenditure Amount: Non-Specialty Brand Drugs	numeric	N/A – Excel file	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.	R
DR010	Pharmacy Expenditure Amount: Non-Specialty Generic Drugs	numeric	N/A – Excel file	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.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
DR011	Total Prescription Drug Rebate/Other Compensation Amount	numeric	N/A – Excel file	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.	R
DR012	Prescription Drug Rebate/Other Compensation Amount: Specialty Drugs	numeric	N/A – Excel file	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.	R
DR013	Prescription Drug Rebate/Other Compensation Amount: Non-Specialty Brand Drugs	numeric	N/A – Excel file	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.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				A drug defined as a non-specialty brand drug under the terms of a payer's contract with its PBM.	
DR014	Prescription Drug Rebate/Other Compensation Amount: Non-Specialty Generic Drugs	numeric	N/A – Excel file	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-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.	R
DR015	Total Count of Prescriptions Filled	int	N/A – Excel file	Total volume of all prescriptions filled by members.	R
DR016	Count of Prescriptions Filled: Specialty Drugs	int	N/A – Excel file	Total volume 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
DR017	Count of Prescriptions Filled: Non-Specialty Brand Drugs	int	N/A – Excel file	Total volume 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

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
DR018	Count of Prescriptions Filled: Non-Specialty Generic Drugs	int	N/A – Excel file	Total volume 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
DR019	Total VBP Pharmacy Expenditure Amount	numeric	N/A – Excel file	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 paid out under a Value Based Payment (VBP) 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)	R
DR020	VBP Pharmacy Expenditure Amount: Specialty Drugs	numeric	N/A – Excel file	The total expenditures paid out under a Value Based Payment (VBP) 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.	
DR021	VBP Pharmacy Expenditure Amount: Non-Specialty Brand Drugs			The total expenditure s paid out under a Value Based Payment (VBP) 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.	R
DR022	VBP Pharmacy Expenditure Amount: Non-Specialty Generic Drugs			The total expenditure s paid out under a Value Based Payment (VBP) 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.	R
DR023	Total VBP Pharmacy Rebate/Other Compensation Amount			Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts (including concessions from price protection and hold harmless contract clauses) associated with a Value Based Payment (VBP) provided by pharmaceutical manufacturers	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				for prescription drugs with specified dates of fill, excluding manufacturer-provided, fair market value, bona fide service fees.	
DR024	VBP Pharmacy Rebate/Other Compensation Amount: Specialty Drugs			Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts associated with a Value Based Payment (VBP) 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.	R
DR025	VBP Pharmacy Rebate/Other Compensation Amount: Non-Specialty Brand Drugs			Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts associated with a Value Based Payment (VBP) 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.	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
DR026	VBP Pharmacy Rebate/Other Compensation Amount: Non-Specialty Generic Drugs			Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts associated with a Value Based Payment (VBP) for all 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.	R
DR027	Combined Rebate Identifier	varchar	N/A – Excel file	If rebate data is only available to a payer at an aggregated level and cannot be separated to provide unique information for each of the insurance categories for which the payer has business, the payer shall report data at the most granular level available. In such instances, the payer shall report a separate observation with all required data elements for each insurance category.	O
DR028	Comments	varchar	N/A – Excel file	Use this field to provide additional information or describe any caveats regarding data in the Drug Rebate submission.	0
DR029	Record Type	char	2	DR	R

A-9 ANNUAL PBM CONTRACT INFORMATION

Frequency: Submit annually in Excel format, as second tab in Drug Rebate file, to CIVHC via SFTP by September 30th of each year.

Additional formatting requirements:

- PBM Contract information is a supplement to the Drug Rebate File and should be submitted as a second tab
- PBM Contract tab should be labeled "PBM"
- Drug Rebate tab should be labeled "DR"

A 9.1 ANNUAL PBM CONTRACT INFORMATION

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PB001	Payer Code	varchar	N/A – Excel file	Distributed by CIVHC	R
PB002	Payer Name	varchar	N/A – Excel file	Distributed by CIVHC	R
PB003	Pharmacy Benefit Manager Name	char	N/A – Excel file	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	varchar	N/A – Excel file	See lookup table B.1.A Payers shall report for all insurance categories for which they have business.	R
PB005	Calendar Year	int	N/A – Excel file	4 digit year for the calendar year time period reported in this submission	R
PB006	Drug Formulary Management?	varchar	N/A – Excel file	Identify whether an individual PBM organization performed all, some, or none of the drug	R

Data Element #	Data Element Name	Type	Length	Description/Codes/Sources	Required
				formulary management for its pharmacy benefit within a given insurance category and year. Three possible responses: All, Some, None	
PB007	Manufacturer Drug Rebate Contracting?	varchar	N/A – Excel file	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	N/A – Excel file	Identify the percentage of total rebates and other compensation that is passed through to the carrier from the PBM. This field should be in decimal format.	R
PB009	Comments	varchar	N/A – Excel file	Use this field to provide additional information or describe any caveats regarding data in the PBM Contract submission	O

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)
18 Vision Insurance
DN Dental
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

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.E PLACE OF SERVICE

01 Pharmacy
02 Tele-health
03 School
04 Homeless Shelter
05 Indian Health Service Free-standing Facility
06 Indian Health Service Provider-based Facility
07 Tribal 638 Free-standing Facility
08 Tribal 638 Provider-based Facility
09 Prison/Correctional Facility
11 Office
12 Home
13 Assisted Living Facility
14 Group Home
15 Mobile Unit
16 Temporary Lodging
17 Walk-in Retail Health Clinic
18 Place of Employment-Worksite
19 Off Campus-Outpatient Hospital
20 Urgent care Facility
21 Inpatient Hospital
22 On Campus-Outpatient Hospital
23 Emergency Room – Hospital
24 Ambulatory Surgery Center
25 Birthing Center
26 Military Treatment Facility
31 Skilled Nursing Facility
32 Nursing Facility

33 Custodial Care Facility
34 Hospice
41 Ambulance – Land
42 Ambulance - Air or Water
49 Independent Clinic
50 Federally Qualified Health Center
51 Inpatient Psychiatric Facility
52 Psychiatric Facility Partial Hospitalization
53 Community Mental Health Center
54 Intermediate Care Facility/Mentally Retarded
55 Residential Substance Abuse Treatment Facility
56 Psychiatric Residential Treatment Center
57 Non-residential Substance Abuse Treatment Facility
60 Mass Immunization Center
61 Comprehensive Inpatient Rehabilitation Facility
62 Comprehensive Outpatient Rehabilitation Facility
65 End Stage Renal Disease Treatment Facility
71 State or Local Public Health Clinic
72 Rural Health Clinic
81 Independent Laboratory
99 Other Unlisted Facility

B.1.F Claim Status

01 Processed as primary
02 Processed as secondary
03 Processed as tertiary
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

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) Category Definitions

Code	Value	Definition/Example
01	Fee for Service	Payments made on a traditional fee-for-service model, no link to quality and value. These are traditional FFS payments that are not adjusted to account for infrastructure investments, provider reporting of quality data, for provider performance on cost and quality metrics. Diagnosis-related groups (DRGs) that are not linked to quality are in Category 1.
2A	Foundational Payments for Infrastructure and Operations	Payments for infrastructure investments that can improve the quality of patient care. (e.g., payments designated for staffing a care coordination nurse or upgrading to electronic health records).
2B	Pay for Reporting	Payments (incentives or penalties) to report quality measurement results
2C	Pay-for-Performance	Payments (incentives or penalties) based on performance in meeting goals for quality measures (e.g. bonuses for quality performance)
3A	APMs with Shared Savings	Payments representing a share of the savings generated when a cost or utilization target is met and if quality targets are met. Does not include penalties when cost or utilization targets are not met. (e.g., shared savings with upside risk only)
3B	APMs with Shared Savings and Downside Risk	Payments representing a share of the savings generated when a cost or utilization target is met and if quality targets are met. Includes penalties representing a portion of the losses that result when a cost or utilization target is not met. (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)
3N	Risk Based Payments NOT Linked to Quality	Payments representing a share of savings generated when a cost or utilization target is met and no quality targets exist (e.g., episode-based payments for procedures without quality measures and targets)
4A	Condition-Specific Population-Based Payment	Payments for the comprehensive treatment of specific conditions (e.g., payments for specialty services, such as oncology or mental health). Bundled payments for cancer care fall under Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering only chemotherapy payments. Also, payments that are prospective and population-based and cover all care delivered by particular types of clinicians (e.g., orthopedics).

Code	Value	Definition/Example
4B	Comprehensive Population-Based Payment	Payments that are prospective and population-based, and cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct, (e.g. global budgets or full/percent of premium payments)
4C	Integrated Finance and Delivery System	Payments that also cover comprehensive care, but unlike Category 4B payments, they move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization. In some cases, these integrated arrangements consist of insurance companies that own provider networks, while in other cases they consist of delivery systems that offer their own insurance products (e.g. global budgets or full/percent of premium payments in integrated systems)
4N	Capitated Payments NOT Linked to Quality	Payments that are prospective and population-based, but not linked to quality.

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

Taxonomy Code	Description	Taxonomy Type
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

Taxonomy Code	Description	Taxonomy Type
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

Taxonomy Code	Description	Taxonomy Type
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

Procedure Code	Description
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
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

Procedure Code	Description
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

Procedure Code	Description
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
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

Procedure Code	Description
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

Procedure Code	Description
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
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

Procedure Code	Description
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

Procedure Code	Description
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

Procedure Code	Description
99177	OCULAR INSTRUMNT SCREEN BIL
99188	APP TOPICAL FLUORIDE VARNISH
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

Procedure Code	Description
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

Procedure Code	Description
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
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

Procedure Code	Description
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

Procedure Code	Description
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
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

Procedure Code	Description
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

Procedure Code	Description
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
S9451	EXERCISE CLASS

Procedure Code	Description
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	Physician referral
2	Clinic referral
3	Managed care plan referral
4	Transfer from a hospital
5	Transfer from a SNF
6	Transfer from another health care facility
7	Emergency room

8	Court/law enforcement
9	Information not available
In the Case of Newborn	
1	Normal delivery
2	Premature delivery
3	Sick baby
4	Extramural birth

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