Utah Department of Health & Human Services

Utah All-payer Claims Database (APCD) Data submission guide

Version 4.1

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Revision history

Date	Version	Description	Author(s)
Oct 2013	A	Initial draft	S. Murphy
Oct 2013	B	Changes based on payer comments	C. Hawley
Sept 2014	2.1	Incorporated changes approved by HDC	C. Hawley
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March 2023	4.1	Variable alignment with national standards	B. Scott

General data submission requirements

Data submissions outlined below will include eligibility, medical/dental claims, pharmacy claims, and provider data. Field definitions and other relevant data associated with these submissions are specified in Exhibit A. This specification is based on recommendations from the All-payer Claims Database (APCD) Council developed in collaboration with partners across the nation.

Data to be submitted

1. Member eligibility

- Payers must provide a data set that contains information on every covered plan member who is a Utah resident regardless of whether the member used services during the reporting period. The file must include member identifiers, subscriber name and identifier, member relationship to subscriber, residence, age, race, ethnicity, and other required fields to allow retrieval of related information from pharmacy and medical/dental claims data sets (Exhibit A).
- A Utah resident is defined as any eligible member whose residence is within the state of Utah, 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 Utah college/university would be considered a Utah resident regardless of their address of record.
- 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 or tertiary coverage.

2. Medical/dental claims

- Payers shall report healthcare service paid claims and encounters for all Utah resident members (see requirements and definitions above). Payers may be required to identify encounters corresponding to a capitated payment (Exhibit A-2).
- Payers must provide information to identify the type of service and setting in which the service was provided.

- Claim data is required for submission for each month during which some action has been taken on that claim (payment, adjustment, or other modification). Any claims that have been "soft" denied (denied for incompleteness, incorrect, or 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 to link the original claim to all subsequent actions associated with that claim (see Exhibit A-2 for specifics).
- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) and ICD-10, Procedure Coding System (ICD-10-PCS) are required to accurately report patients' risk factors. Healthcare Common Procedural Coding System (HCPCS) and Current Procedural Terminology (CPT) codes are also required.
- Stand-alone dental carriers should provide contact information to HCS as required by Utah Administrative Code and submit claims in compliance with this manual.

3. Pharmacy claims

- Payers must provide data for all paid pharmacy claims for prescriptions that were dispensed to members during the reporting period (Exhibit A-3).
- If your health plan allows for medical coverage without pharmacy (or vice versa), ME018–ME020 in Exhibit A-1 provides data elements which must accurately represent a member's coverage.

4. Providers

- Payers must provide a data set that contains information on every healthcare provider for whom claims were adjudicated during the reporting period.
- In the event the same healthcare provider delivered and was reimbursed for services rendered from 2 different physical locations, then the provider data file shall contain 2 separate records for that same provider to reflect each of those physical locations. One record shall be provided for each unique physical location for a provider.

Coordination of submissions

In the event that the health plan contracts with a pharmacy benefits manager or other service entity that manages claims for Utah residents, the health plan is responsible to make sure that complete and accurate files are submitted to the APCD by the subcontractor. The health plan shall make sure 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.

File submission methods

1. Secure File Transport Protocol (SFPT)

SFTP involves logging on to the appropriate FTP site and sending or receiving files using the SFTP client.

2. Web upload

This method allows files and messages to be sent and received without the installation of additional software. This method requires internet access, a username, and password.

Data quality requirements

1. Required elements

Exhibit A provides a list of required data elements. A data element that is required must contain a valid value unless a waiver is put in place with a specific payer who is unable to provide that data element due to system limitations. A "valid value" means that a percentage of all records have a value in the field based on the expected frequency 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 before they can be loaded into the APCD.

2. Validation and quality checks

Data validation and quality edits will be developed in collaboration with each payer and refined as test data and production data is brought into the APCD. Data files missing required fields or containing mismatched claim line/record line totals may be rejected on submission. Other data elements will be validated against established ranges as the database is populated and may require manual intervention to make sure the data is correct. The objective is to populate the APCD with quality data and each payer will need to work interactively with the Utah Department of Health and Human Services (DHHS) Healthcare Statistics program (HCS) to develop data extracts that achieve validation and quality specifications. Waivers may be granted at the discretion of HCS, for data variances that cannot be corrected due to systematic issues that require substantial effort to correct.

File format

1. Standards for text files

- Always 1 line item per row; no single line item of data may contain carriage return or line feed characters.
- All rows delimited by the carriage return + line feed character combination.
- 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.
- Text fields are never demarcated or enclosed in single or double quotes. Any quotes detected are regarded as a part of the actual data.
- The first row always contains the names of data columns.
- Unless otherwise stipulated, numbers such as ID numbers and account numbers do not contain spaces, hyphens, or other punctuation marks.
- Text fields are never padded with leading or trailing spaces or tabs.
- Numeric fields are never padded with leading or trailing zeros.
- 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).

2. File naming convention

All files submitted to the APCD shall have a naming convention developed to facilitate file management without requiring access to the contents. All file names will follow the template:

```
UTAPCD\_PayerID\_TestorProd\_EntityAbreviation\_SubmisionDate\_CoveragePeriodDate.txt
```

PayerID—This is the payer ID assigned to each submitter

TestorProd—Test for test files; Prod for production

EntityAbbreviation—ME, MC, PC, MP (ME—member eligibility, MC—medical/dental claims, PC—pharmacy claims, MP—medical/dental provider)
SubmissionDate—Date file was produced. This date should be in the YYYYMMDD format.

CoveragePeriodDate—The coverage period for the transmission. This date should be in the YYYYMMDD format.

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

Utah Department of Health & Human Services

Exhibit A data elements

A-1 Member eligibility for claims data

Frequency: monthly upload via FTP or web portal

It is critical 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/dental claims and pharmacy claims file. Additional formatting requirements:

- One record, per member, per month, per insurance type, is required. For example, if a member is covered as both a subscriber and a dependent on 2 different policies during the same month, 2 records must be submitted. If a member has two contract numbers for two different coverage types, two member eligibility records must be submitted.
- In order to accurately capture eligibility end dates, payers will submit the previous 3 months eligibility monthly. This will provide a run out to make sure ME005B is populated with a valid last day of eligibility for all members during the previous 3 months.
- If a carrier has submitted an eligibility record for a person, and later learns the member was never eligible for 1 of the months submitted previously, in a subsequent submission, a record should be submitted for the person with:
    - the eligibility year (ME004) and eligibility month (ME005) set to the month in question;
    - eligibility start and end day variables (ME005A and ME005B) set to '0;'
    - medical, prescription drug, and dental coverage indicators (ME018-ME020) set to 'N.'
- Payers submit data in a single consistent format for each data type.

A-1.1 Member eligibility file layout

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
1	ME001	Payer code	varchar	8	Distributed by HCS
2	ME002	Payer name insurance	varchar	30	Distributed by HCS
3	ME003	Type code/product	char	2	See lookup table B-1.A
4	ME004	Year	int	4	4-digit year for which eligibility is reported in this submission
5	ME005	Month	char	2	Month for which eligibility is reported in this submission expressed numerically from 01 to 12.
6	ME006	Insured group or policy number	varchar	30	Group or policy number—not the number that uniquely identifies the subscriber. Medicaid fee for service will populate this field with the aid category code.
7	ME007	Coverage level code subscriber	char	3	Benefit coverage level. See lookup table B-1.B
8	ME008	Social security number	varchar	9	Subscriber's social security number; leave blank if unavailable
9	ME009	Plan specific contract number	varchar	128	Plan assigned subscriber's contract number; leave blank if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier unique to the subscriber.
10	ME010	Member sequence number	varchar	128	Unique number of the member. This column is the unique identifying column for membership and related medical and pharmacy claims. Only 1 record per insurance product type, per eligibility month. Must match MC009 and PC009.
11	ME011	Member identification code	varchar	9	Member's social security number; leave blank if unavailable.

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
12	ME012	Individual relationship code	char	2	Member's relationship to insured. Individual relationship code is maintained by ANSI ASC X12 https://standard.x12.org/Home/Default/008030).
13	ME013	Member gender	char	1	M—male F—female U—unknown
14	ME014	Member date of birth	date	8	YYYYMMDD
15	ME015	Member city name	varchar	30	City location of member
16	ME016	Member state or province	char	2	As defined by the US Postal Service
17	ME017	Member ZIP code	varchar	11	ZIP code of member—may include non-US codes. Do not include dash. Plus 4 optional, but desired.
18	ME018	Medical coverage under this plan	char	1	Use this field to indicate whether medical coverage is part of this member's plan (note: medical coverage may be bundled with other types of coverage) Y = yes; N = no.
19	ME019	Pharmacy coverage under this plan	char	1	Use this field to indicate whether pharmacy coverage is part of this member's plan (note: pharmacy coverage may include prescription drugs, supplies and DME; and may be bundled with other types of coverage) Y = yes; N = no.
20	ME020	Dental coverage under this plan	char	1	Use this field to indicate whether dental coverage is part of this member's plan (note: dental coverage may be bundled with other types of coverage) Y = yes; N = no.
21	ME021	Race 1	varchar	6	See lookup table B-1.D
22	ME022	Race 2	varchar	6	See lookup table B-1.D

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
23	ME023	Other race	varchar	15	List race if MC021 or MC022 are coded as R9.
24	ME024	Hispanic indicator	char	1	Y = patient is Hispanic/Latino/Spanish N = patient is not Hispanic/Latino/Spanish U = unknown
25	ME025	Ethnicity 1	varchar	6	See lookup table B-1.E
26	ME026	Ethnicity 2	varchar	6	See code set for ME025.
27	ME027	Other ethnicity	varchar	20	List ethnicity if MC025 or MC026 are coded as OTHER.
28	ME028	Primary insurance indicator	char	1	Y—yes, primary insurance N—no, secondary or tertiary insurance
29	ME029	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 (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
30	ME030	Market category code	varchar	4	See lookup table B-1.C
31	ME032	Group name member	varchar	128	Group name or IND for individual policies

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
32	ME043	Member street address	varchar	50	Street address of member
33	ME044	Employer name	varchar	50	Name of the employer, or if same as group name, leave blank
34	ME101	Subscriber last name	varchar	128	The subscriber last name
35	ME102	Subscriber first name	varchar	128	The subscriber first name
36	ME103	Subscriber middle initial	char	1	The subscriber middle initial
37	ME104	Member last name	varchar	128	The member last name
38	ME105	Member first name	varchar	128	The member first name
39	ME897	Plan effective date	date	8	YYYYMMDD date eligibility started for this member under this plan type. The purpose of this data element is to maintain eligibility span for each member.
40	ME045	Exchange offering	char	1	Identifies whether a policy was purchased through the Utah Health Benefits Exchange (UBHE). 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)
41	ME106	Group size	char	2	Code indicating group size consistent with Utah insurance law and regulation A—1 B—2 to 50 C—51 to 100 D—100+ Required only for plans sold in the commercial large, small, and non-group

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
					markets. The following plan/products do not need to report this value: student plans Medicare supplemental Medicaid-funded plans stand-alone behavioral health, dental, and vision
42	ME107	Risk basis	char	1	S—self-insured F—fully insured
43	ME108	High deductible/health savings account plan	char	1	Y—plan is high deductible/HSA eligible N—plan is not high deductible/HSA eligible
44	ME120	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 (http://cciio.cms.gov/resources/regulations/index.html). Size includes decimal point. Required as of January 1, 2014 for small group and non-group (individual) plans sold inside or outside the Exchange.e Required if ME106 IN ('A','B'), optional otherwise
45	ME121	Metallic tier	int	1	For non-grandfathered health plans for the individual and small group markets (under ACA) only. Health benefit plan metal tier for qualified health plans (QHPs) and catastrophic plans as defined in the Patient Protection and Affordable Care Act, public law 111-148, section 1302: Essential health benefits requirements: 0=not a QHP or catastrophic plan; 1=catastrophic; 2=bronze;

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
					3=silver; 4=gold; 5=platinum. If not applicable, leave blank. Required if ME106 in ('A','B'), optional otherwise.
46	ME122	Grandfather status	char	1	See definition of “grandfathered plans” in HHS rules CFR 147.140 Y = yes N = no Required as of January 1, 2014 for small group and non-group (individual) plans sold inside or outside the exchange. Required if ME106 IN (‘A’, “B’), optional otherwise.
47	ME899	Record type	char	2	Value = ME
48	ME123	HIOS SCID	char	17	HIOS standard component ID with CSR variant, such as 12345UT0010001-00 where 12345 is the unique issuer HIOS ID UT is the state code for Utah 0010001 is issuer defined and indicates a specific plan -00 is the cost sharing variant such that -00 off exchange -01 on exchange -02 zero cost sharing -03 limited cost sharing -04 73% AV Silver -05 87% AV Silver -06 94% AV Silver Required if subject to ACA risk adjustment, optional otherwise
49	ME124	ACA rating area	int	1	Geographic rating areas associated with the plan premium. Value = 1, 2, 3, 4, 5 or 6 1—Cache, RIch 2—Box Elder, Morgan, Weber

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
					3—Davis, Salt Lake, Summit, Tooele, Wasatch 4—Utah 5—Iron, Washington 6—Beaver, Carbon, Daggett, Duchesne, Emery, Garfield, Grand, Juab, Kane, Millard, Piute, San Juan, Sanpete, Sevier, Uintah, Wayne Required if subject to ACA risk adjustment, optional otherwise.
50	ME125	Subscriber premium	int	10	Monthly subscriber premium, include up to hundredths place, but do not code decimal point (e.g. for $1,123.58 input 112358). Only subscriber records should show a premium amount other than 0. Code as 0 for records where ME012 Individual relationship code is not “20 Employee/Self.” Required if subject to ACA risk adjustment, optional otherwise.
51	ME005A	First day of eligibility in the month	int	2	Day in the month when eligibility began. The first day in the month the member was eligible. Example: a member eligible for the entire month of February will have a value of 1.
52	ME005B	Last day of eligibility in the month	int	2	Day in the month when eligibility ends. The last day in the month the member was eligible. Example: a member eligible for the entire month of February will have a value of 28.
53	ME990	PBM provider			For insurance plans that have PBMs, specify the member’s PBM, If no PBM for this member’s plan leave blank.
54	ME991	Unassigned			Reserved for future use.
55	ME992	Unassigned			Reserved for future use.
56	ME993	Unassigned			Reserved for future use.

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
57	ME994	Unassigned			Reserved for future use.

A-2 Medical/dental claims data

Frequency: monthly upload via FTP or web portal

Additional formatting requirements:

- Claims are paid claims. Non-covered or denied claims (duplicate or patient ineligible claims) are not included.
    - It is assumed that a complete snapshot of the claim is submitted at the time of final payment.
    - All claim lines submitted are processed as a unit.
    - Modifications to any previously submitted claim are submitted 1 of 2 ways:
        - Reversals—reverse the entire original claim (using MC038) and a new claim may be submitted as a replacement, or
        - Update with new version—replace the original claim with a new version (using MC005A).
        - If a claim reversal is submitted in the same month as the original claim, submission of claims is unnecessary since neither were paid. However, if necessary in the payer system, the version (MC005A) shall be incremented to indicate the reversal (MC038) regardless of method used to modify previously submitted claims.
- Financial amount data elements (MC062-MC067) assume the following:
    - The sum of all claim lines for a given data element will equal the total charge, paid, prepaid, co-pay, coinsurance, or deductible amounts for the entire claim.
    - The paid amount provided for each non-charge financial amount data element is mutually exclusive.
- Payers submit data in a single consistent format for each data type.

A-2.1 Medical/dental claims file layout

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
1	MC001	Payer code	varchar	8	Distributed by HCS
2	MC002	Payer name	varchar	30	Distributed by HCS
3	MC003	Insurance type/product code	char	2	See lookup table B-1.A
4	MC004	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
5	MC005	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.
6	MC005A	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.
7	MC006	Insured group or policy number	varchar	30	Group or policy number—not the number that uniquely identifies the subscriber.
8	MC007	Subscriber social security number	varchar	9	Subscriber's social security number; leave blank if unavailable.
9	MC008	Plan specific contract number	varchar	128	Plan assigned subscriber's contract number; leave blank if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier unique to the subscriber.
10	MC009	Member sequence number	varchar	128	Unique number of the member within the contract. Must be an identifier unique to the member. Must match ME010.

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
11	MC010	Member identification code (patient)	varchar	9	Member's social security number; leave blank if unavailable.
12	MC011	Individual relationship code	char	2	Member's relationship to insured. Individual relationship codes are maintained by ANSI ASC X12 (https://standard.x12.org/Home/Default/008030).
13	MC012	Member gender	char	1	M—male F—female U—unknown
14	MC013	Member date of birth	date	8	YYYYMMDD
15	MC014	Member city name	varchar	30	City name of member
16	MC107	Member street address	varchar	50	Physical street address of the covered member
17	MC015	Member state or province	char	2	As defined by the US Postal Service
18	MC016	Member ZIP code	varchar	11	ZIP code of member—may include non-US codes. Plus 4 optional, but desired.
19	MC017	Date service approved/accounts payable date/actual paid date	date	8	YYYYMMDD
20	MC018	Admission date	date	8	YYMMDD. Required for institutional claims.
21	MC019	Admission hour	char	4	Time is expressed in military time —HHMM. Required for institutional claims.
22	MC020	Admission type	int	1	Required for institutional claims. Source: National Uniform Billing Data Element Specifications

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
23	MC021	Admission source	char	1	Required for institutional claims. Source: National Uniform Billing Data Element Specifications
24	MC022	Discharge hour	int	4	Time expressed in military time—HHMM. Required for institutional claims.
25	MC023	Discharge status	char	2	Required for institutional claims. See lookup table B-1.F
26	MC024	Service provider number	varchar	30	Payer assigned service provider number. Submit facility for institutional claims; physician or healthcare professional for professional claims. Must match MP001.
27	MC025	Service provider tax ID number	varchar	10	Federal taxpayer's identification number
28	MC026	Service national provider ID	varchar	20	National provider ID. This data element pertains to the entity or individual directly providing the service.
29	MC027	Service provider entity type qualifier	char	1	1 person 2 non-person entity 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 1 provider) as a "person," and these shall be coded as a person.
30	MC916	In plan network indicator	char	1	A yes/no indicator that specifies if the provider (not the benefit) is within the health plan network. Valid codes are: N = no Y = yes L = leased network
31	MC028	Service provider first name	varchar	25	Individual first name. Leave blank if provider is a facility or organization.
32	MC029	Service provider middle name	varchar	25	Individual middle name or initial. Leave blank if provider is a facility or organization.

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
33	MC030	Service provider last name or organization name	varchar	60	Full name of provider organization or last name of individual provider.
34	MC031	Service provider suffix	varchar	10	Suffix to individual name. Leave blank if the provider is a facility or organization. The service provider suffix shall be used to capture the generation of the individual clinician (Jr., Sr., III), if applicable, rather than the clinician's degree (MD, LCSW).
35	MC032	Service provider specialty	varchar	50	Report the HIPAA-compliant healthcare provider taxonomy code. Code set is freely available at the National Uniform Claims Committee's website at http://www.nucc.org/
36	MC108	Service provider street address	varchar	50	Physical practice location street address of the provider administering the services
37	MC033	Service provider city name	varchar	30	Physical practice location city name
38	MC034	Service provider state or province	char	2	As defined by the US Postal Service
39	MC035	Service provider ZIP code	varchar	11	ZIP code of provider—may include non-US codes; do not include dash. Plus 4 optional, but desired.
40	MC036	Type of bill—institutional	char	3	See lookup table B-1G. Required for institutional claims. Do not use for professional claims.
41	MC037	Facility type—professional	char	2	Use CMS place of service codes for professional claims. ADA Dental Claim Form completion instructions requests the same codes for place of treatment. Required for professional and dental claims. Do not use for institutional claims.
42	MC038	Claim status	char	2	X12 mapping should reference the proper claim status codes 835/2100/CLP/ /02. Valid codes listed in lookup table B-1.H

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
43	MC039	Admitting diagnosis	varchar	7	ICD-10-CM. Do not code decimal point. Required for institutional claims.
44	MC898	ICD-9/ICD-10 flag	char	1	The purpose of this field is to identify which code set is being utilized. 9 = This claim contains ICD-9-CM codes. 0 = This claim contains ICD-10-CM codes.
45	MC040	E-code	varchar	7	Describes an injury, poisoning, or adverse effect. Do not code decimal point.
46	MC041	Principal diagnosis	varchar	7	ICD-10-CM. Do not code decimal point.
47	MC042	Other diagnosis—1	varchar	7	ICD-10-CM. Do not code decimal point.
48	MC043	Other diagnosis—2	varchar	7	ICD-10-CM. Do not code decimal point.
49	MC044	Other diagnosis—3	varchar	7	ICD-10-CM. Do not code decimal point.
50	MC045	Other diagnosis—4	varchar	7	ICD-10-CM. Do not code decimal point.
51	MC046	Other diagnosis—5	varchar	7	ICD-10-CM. Do not code decimal point.
52	MC047	Other diagnosis—6	varchar	7	ICD-10-CM. Do not code decimal point.
53	MC048	Other diagnosis—7	varchar	7	ICD-10-CM. Do not code decimal point.
54	MC049	Other diagnosis—8	varchar	7	ICD-10-CM. Do not code decimal point.
55	MC050	Other diagnosis—9	varchar	7	ICD-10-CM. Do not code decimal point.
56	MC051	Other diagnosis—10	varchar	7	ICD-10-CM. Do not code decimal point.
57	MC052	Other diagnosis—11	varchar	7	ICD-10-CM. Do not code decimal point.
58	MC053	Other diagnosis—12	varchar	7	ICD-10-CM. Do not code decimal point.
59	MC054	Revenue code	char	10	National Uniform Billing Committee codes. Code using leading zeros, left

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
					justified, and 4 digits. Required for institutional claims.
60	MC055	HCPCS/CPT procedure code	varchar	10	Healthcare Common Procedural Coding System (HCPCS). This includes the CPT codes maintained by the American Medical Association.
61	MC056	Procedure modifier – 1	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code (MC055).
62	MC057	Procedure modifier – 2	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code (MC055).
63	MC058	ICD-10-PCS procedure code	char	7	Primary procedure code for this line of service. Do not code decimal point. Required for institutional claims. Leave blank if not an institutional claim.
64	MC059	Date of service – from	date	8	First date of service for this service line. YYYYMMDD
65	MC060	Date of service – thru	date	8	Last date of service for this service line. YYYYMMDD
66	MC061	Quantity	int	10	Count of services performed.
67	MC062	Charge amount	int	10	Do not code decimal point or provide any punctuation. For example, $1,000.00 converted to 100000. Same format for all financial data that follows.
68	MC063	Plan paid amount	int	10	Set to 0 for capitated claims. Do not code decimal point.
69	MC064	Prepaid amount	int	10	For capitated services, the fee for service equivalent amount. Do not code decimal point.
70	MC065	Co-pay amount	int	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
71	MC066	Coinsurance amount	int	10	The dollar amount an individual is responsible for—not the percentage. Do not code decimal point.
72	MC067	Deductible amount	int	10	Do not code decimal point.
73	MC955	Allowed amount	int	10	The maximum amount a plan will pay for a covered health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.” Do not code decimal point.
74	MC068	Patient account/control number	varchar	20	Number assigned by hospital.
75	MC069	Discharge date service provider	date	8	Date patient discharged. YYYYMMDD. Required for institutional claims.
76	MC070	Service provider country name	varchar	30	Code US for United States.
77	MC071	DRG	varchar	10	Insurers and healthcare 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).
78	MC072	DRG version	char	2	Version number of the grouper used
79	MC073	APC	char	4	Insurers and healthcare claims processors shall code using the CMS methodology when available. Precedence shall be given to APCs transmitted from the health care provider.
80	MC074	APC version	char	2	Version number of the grouper used

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
81	MC075	Drug code	varchar	11	An NDC code used only when a medication is paid for as part of a medical claim.
82	MC076	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. Must match MP001.
83	MC077	Billing provider NPI	varchar	20	National provider ID
84	MC078	Billing provider last name or organization name	varchar	60	Full name of provider billing organization or last name of individual billing provider.
85	MC101	Subscriber last name	varchar	128	Subscriber last name
86	MC102	Subscriber first name	varchar	128	Subscriber first name
87	MC103	Subscriber middle initial	char	1	Subscriber middle initial
88	MC104	Member last name	varchar	128	Last name of member
89	MC105	Member first name	varchar	128	First name of member
90	MC106	Member middle initial	char	1	Middle initial of member
91	MC201A	Present on admission—PDX	varchar	1	For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission. See lookup table B-1.I for valid values.
92	MC201B	Present on admission—DX1	varchar	1	For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
					indicates present on admission. See lookup table B-1.I for valid values.
93	MC201C	Present on admission—DX2	varchar	1	For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission. See lookup table B-1.I for valid values.
94	MC201D	Present on admission—DX3	varchar	1	For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission. See lookup table B-1.I for valid values.
95	MC201E	Present on admission—DX4	varchar	1	For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission. See lookup table B-1.I for valid values.
96	MC201F	Present on admission—DX5	varchar	1	For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission. See lookup table B-1.I for valid values.
97	MC201G	Present on admission—DX6	varchar	1	For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission. See lookup table B-1.I for valid values.
98	MC201H	Present on admission—DX7	varchar	1	For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
					indicates present on admission. See lookup table B-1.I for valid values.
99	MC201I	Present on admission—DX8	varchar	1	For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission. See lookup table B-1.I for valid values.
100	MC201J	Present on admission—DX9	varchar	1	For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission. See lookup table B-1.I for valid values.
101	MC201K	Present on admission—DX10	varchar	1	For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission. See lookup table B-1.I for valid values.
102	MC201L	Present on admission—DX11	varchar	1	For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission. See lookup table B-1.I for valid values.
103	MC201M	Present on admission—DX12	varchar	1	For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission. See lookup table B-1.I for valid values.
104	MC202	Tooth number	char	2	Tooth number or letter identification. Only include 1 tooth per claim line. If a procedure was performed on multiple teeth, such as a bridge, include only the

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
					first in the span. Required for dental claims.
105	MC203	Area of oral cavity	char	2	Area of oral cavity codes are maintained by the American Dental Association. Required for dental claims.
106	MC204	Tooth surface	char	10	Tooth surface identification. Required for dental claims.
107	MC205	ICD-10-PCS procedure date	date	8	Date MC058 was performed. YYYYDDMM. Required for institutional claims. Leave blank if not an institutional claim.
108	MC058A	ICD-10-PCS procedure code	char	7	Secondary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim.
109	MC205A	ICD-10-PCS procedure date	date	8	Date MC058A was performed. YYYYDDMM. Required for institutional claims. Leave blank if not an institutional claim.
110	MC058B	ICD-10-PCS procedure code	char	7	Secondary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim.
111	MC205B	ICD-10-PCS procedure date	date	8	Date MC058B was performed. YYYYDDMM. Required for institutional claims. Leave blank if not an institutional claim.
112	MC058C	ICD-10-PCS procedure code	char	7	Secondary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim.
113	MC205C	ICD-10-PCS procedure date	date	8	Date MC058C was performed. YYYYDDMM. Required for institutional claims. Leave blank if not an institutional claim.
114	MC058D	ICD-10-PCS procedure code	char	7	Secondary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim.
115	MC205D	ICD-10-PCS procedure date	date	8	Date MC058D was performed. YYYYDDMM. Required for institutional

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
					claims. Leave blank if not an institutional claim.
116	MC058E	ICD-10-PCS procedure code	char	7	Secondary procedure code for this line of service. Do not code decimal point. Leave blank if not an institutional claim.
117	MC205E	ICD-10-PCS procedure date	date	8	Date MC058E was performed. YYYYDDMM. Required for institutional claims. Leave blank if not an institutional claim.
118	MC206	Capitated service indicator	char	1	Y—services are paid under a capitated arrangement N—services are not paid under a capitated arrangement U—unknown
119	MC899	Record type	char	2	Value = MC
120	MC061A	Unit of measure	char	2	DA—days MJ—minutes UN—units Other standard ANSI values may be used with prior approval from HCS.
121	MC901	Procedure modifier – 3	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code (MC055).
122	MC902	Procedure modifier – 4	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code (MC055).
123	MC990	Unassigned			Reserved for future use.
124	MC991	Unassigned			Reserved for future use.
125	MC992	Unassigned			Reserved for future use.
126	MC993	Unassigned			Reserved for future use.
127	MC994	Unassigned			Reserved for future use.
128	MC999	42 CFR part 2 flag	char	1	0 no, this claim does not contain data protected under 42 CFR part 2

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
					1 yes, this claim does contain data protected under 42 CFR part 2 9 unknown

A-3 Pharmacy claims data

Frequency: monthly upload via FTP or web portal

Additional formatting requirements:

- Claims are paid claims. Non-covered or denied claims (duplicate or patient ineligible claims) are not included.
    - It is assumed that a complete snapshot of the claim is submitted at the time of final payment.
    - All claim lines submitted are processed as a unit.
    - Modifications to any previously submitted claim are submitted 1 of 2 ways:
        - Reversals—reverse the entire original claim (using PC025) and a new claim may be submitted as a replacement, or
        - Update with new version—replace the original claim with a new version (using PC201).
        - If a claim reversal is submitted in the same month as the original claim, submission of claims is unnecessary since neither were paid. However, if necessary in the payer system, the version (PC201) shall be incremented to indicate the reversal (MC025) regardless of method used to modify previously submitted claims.
- Financial amount data elements (PC035-PC042) assume the following:
    - The sum of all claim lines for a given data element will equal the total charge, paid, ingredient cost, postage, dispensing fee, co-pay, coinsurance, or deductible amounts for the entire claim.
    - The paid amount provided for each non-charge financial amount data element is mutually exclusive.
- A claim for a compound drug (PC031) should include a claim line for each ingredient in the drug.

- Payers submit data in a single consistent format for each data type.

A-3.1 Pharmacy claims file layout

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
1	PC001	Payer code	varchar	8	Distributed by HCS
2	PC002	Payer name	varchar	30	Distributed by HCS
3	PC003	Insurance type/product code	char	2	See lookup table B-1.A
4	PC004	Payer claim control number	varchar	35	Must apply to the entire claim and be unique within the payer's system.
5	PC005	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.
6	PC006	Insured group number	varchar	30	Group or policy number—not the number that uniquely identifies the subscriber
7	PC007	Subscriber social security number	varchar	9	Subscriber’s social security number; leave blank if unavailable
8	PC008	Plan specific contract number	varchar	128	Plan assigned subscriber’s contract number; leave blank 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 subscriber.
9	PC009	Member sequence number	varchar	128	Unique number of the member within the contract. Must be an identifier that is unique to the member. Must match ME010.
10	PC010	Member identification code	varchar	9	Member’s social security number; Leave blank if contract number = subscriber’s social security number or use an alternate unique identifier such as

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
					Medicaid ID. Must be an identifier that is unique to the member.
11	PC011	Individual relationship code	char	2	Member’s relationship to insured. Individual relationship codes maintained by ANSI ASC X12 (https://standard.x12.org/Home/Default/008030).
12	PC012	Member gender	char	1	M—male F—female U—unknown
13	PC013	Member date of birth	date	8	YYYYMMDD
14	PC014	Member city name of residence	varchar	50	City name of member
15	PC015	Member state or province	char	2	As defined by the US Postal Service
16	PC016	Member ZIP code	varchar	11	ZIP code of member—may include non-US codes; do not include dash. Plus 4 optional, but desired.
17	PC017	Date service approved (AP date)	date	8	YYYYMMDD—date claim paid if available, otherwise set to date prescription filled
18	PC018	Pharmacy number	varchar	30	Payer assigned pharmacy number. AHFS number is acceptable. Must match MP001.
19	PC019	Pharmacy tax ID number	varchar	10	Federal taxpayer's identification number coded with no punctuation (carriers that contract with outside PBMs will not have this)
20	PC915	In plan network indicator	char	1	Use this field to specify if services from the requested provider were provided within the health plan network. Valid values are: N = no Y = yes

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
					L = leased network
21	PC020	Pharmacy name	varchar	50	Name of pharmacy
22	PC021	Pharmacy NPI	varchar	20	Pharmacy's national provider ID. This data element pertains to the entity or individual directly providing the service.
23	PC048	Pharmacy location street address	varchar	30	Street address of pharmacy
24	PC022	Pharmacy location city	varchar	30	City name of pharmacy—preferably pharmacy location (if mail order leave blank)
25	PC023	Pharmacy location state	char	2	As defined by the US Postal Service (if mail order leave blank)
26	PC024	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 leave blank)
27	PC024d	Pharmacy country name	varchar	30	Code US for United States
28	PC025	Claim status	char	2	See lookup table B-1.H.
29	PC026	Drug code	varchar	11	NDC code
30	PC027	Drug name	varchar	80	Text name of drug
31	PC028	New prescription or refill	varchar	2	Provide '00' for new prescriptions; for refills, provide the refill number. 00 = new prescription; 01–99 = refill.
32	PC029	Generic drug indicator	char	2	01—branded drug 02—generic drug
33	PC030	Dispense as written code	char	1	Payers able to map available codes to those below. See lookup table B-1.J
34	PC031	Compound drug indicator	char	1	N—non-compound drug Y—compound drug U—non-specified drug compound

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
35	PC032	Date prescription filled	date	8	YYYYMMDD
36	PC033	Quantity dispensed	int	10	Number of metric units of medication dispensed
37	PC034	Days supply	int	5	Estimated number of days the prescription will last
38	PC035	Charge amount	int	10	Do not code decimal point or provide any punctuation. For example, $1,000.00 converted to 100000. Same format for all financial data that follows.
39	PC036	Paid amount	int	10	Includes all health plan payments and excludes all member payments. Do not code decimal point.
40	PC037	Ingredient cost/list price	int	10	Cost of the drug dispensed. Do not code decimal point.
41	PC038	Postage amount claimed	int	10	Do not code decimal point. Not typically captured.
42	PC039	Dispensing fee	int	10	Do not code decimal point.
43	PC040	Co-pay amount	int	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.
44	PC041	Coinsurance amount	int	10	The dollar amount an individual is responsible for—not the percentage. Do not code decimal point.
45	PC042	Deductible amount	int	10	Do not code decimal point.
46	PC907	Allowed amount	int	10	The maximum amount a plan will pay for a covered prescription. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.” Do not code decimal point.
47	PC043	Pharmaceutical company rebate	int	10	Do not code decimal point.

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
48	PC044	Prescribing physician first name	varchar	25	Physician first name
49	PC045	Prescribing physician middle name	varchar	25	Physician middle name or initial
50	PC046	Prescribing physician last name	varchar	60	Physician last name
51	PC047	Prescribing physician NPI	varchar	20	NPI number for prescribing physician
52	PC049	Member street address	varchar	50	Street address of member
53	PC101	Subscriber last name	varchar	128	Subscriber last name
54	PC102	Subscriber first name	varchar	128	Subscriber first name
55	PC103	Subscriber middle initial	char	1	Subscriber middle initial
56	PC104	Member last name	varchar	128	Member last name
57	PC105	Member first name	varchar	128	Member first name
58	PC106	Member middle initial	char	1	Member middle initial
59	PC201	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.
60	PC202	Prescription written date	date	8	Date prescription was written
61	PC047a	Prescribing physician provider ID	varchar	30	Provider ID for the prescribing physician. Must match MP001.

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
62	PC047b	Prescribing physician DEA	varchar	20	DEA number for prescribing physician
63	PC899	Record type	char	2	PC
64	PC905	Drug unit of measure	varchar	3	Report the code that defines the unit of measure for the drug dispensed in PC033. See lookup table B-1.K for valid values.
65	PC906	Prescription number	varchar	20	Unique prescription identifier
66	PC990	PBM client			For PBMs only, please specify the name of the client for this member's insurance plan
67	PC991	Unassigned			Reserved for future use.
68	PC992	Unassigned			Reserved for future use.
69	PC993	Unassigned			Reserved for future use.
70	PC994	Unassigned			Reserved for future use.
71	PC999	42 CFR part 2 flag	char	1	0—no, this claim does not contain data protected under 42 CFR Part 2 1—yes, this claim does contain data protected under 42 CFR Part 2 9—unknown

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 healthcare facility, healthcare practitioner, health product manufacturer, health product vendor or pharmacy.
- A billing provider means a provider or other entity that submits claims to healthcare claims processors for healthcare 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 healthcare service to a subscriber or member.
- One record submitted for each provider for each unique physical address.

A-4.1 Provider file layout

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
1	MP001	Provider ID	varchar	30	Unique identified for the provider as assigned by the reporting entity. Must match MC024, MC076, PC018, or PC047a.
2	MP002	Provider tax ID	varchar	10	Tax ID of the provider. Do not code punctuation.
3	MP003	Provider entity	char	1	F—facility G—provider group I—independent practice association P—practitioner
4	MP004	Provider first name	varchar	25	Individual first name. Leave blank if provider is a facility or organization.
5	MP005	Provider middle name or initial	varchar	25	Provider middle name or initial
6	MP006	Provider last name or organization name	varchar	60	Full name of provider organization or last name of individual provider
7	MP007	Provider suffix	varchar	10	Suffix to individual name. Leave blank if provider is a facility or organization. The service provider suffix shall be used to capture the generation of the individual clinician (Jr., Sr., III), if applicable, rather than the clinician's degree (MD, LCSW).
8	MP008	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 website at http://www.nucc.org/

DSG #	Data element #	Data element name	Type	Length	Description/codes/sources
9	MP009	Provider office street address	varchar	50	Physical address—address where provider delivers healthcare services
10	MP010	Provider office city	varchar	30	Physical address—city where provider delivers healthcare services
11	MP011	Provider office state	char	2	Physical address—state where provider delivers healthcare services. As defined by the US Postal Service.
12	MP012	Provider office ZIP	varchar	11	Physical address—ZIP code where provider delivers healthcare services. May include non-US codes; do not include dash. Plus 4 optional, but desired.
13	MP013	Provider DEA number	varchar	12	Provider DEA number
14	MP014	Provider NPI	varchar	20	Provider NPI
15	MP015	Provider state license number	varchar	20	Prefix with 2-character state of licensure with no punctuation. Example UTLL12345
16	MP899	Record type	char	2	MP
17	MP990	Unassigned			Reserved for future use.
18	MP991	Unassigned			Reserved for future use.
19	MP992	Unassigned			Reserved for future use.
20	MP993	Unassigned			Reserved for future use.
21	MP994	Unassigned			Reserved for future use.

B-1 Lookup tables

B-1.A Insurance type

Code	Description
17	Dental
20	Dental Medicaid plan
CI	Commercial insurance company
DM	Dental maintenance organization (DMO)
EP	Exclusive provider organization (EPO)
FH	Federal employees health benefits program (HMO)
FP	Federal employees health benefits program (PPO)
IN	Indemnity insurance
HM	Health maintenance organization (HMO)
HN	Health maintenance organization (HMO) Medicare Advantage / Medicare Part C
MA	Medicare Part A (not to be used for commercial plans)
MB	Medicare Part B (not to be used for commercial plans)
MC	Medicaid Fee For Service (FFS)
MD	Medicare Part D
MO	Medicaid Accountable Care Organization (ACO)
MP	Medicare primary (not to be used for commercial plans)
MT	Medicaid Children’s Health Insurance Program (CHIP)
OF	Other federal
PR	Preferred Provider Organization (PPO)
PS	Point of service (POS)
QM	Qualified Medicare beneficiary
SP	Medicare Supplemental (Medi-gap) plan
TV	Title V
ZZ	Mutually defined (Use code ZZ when type of insurance is unknown)

B-1.B Coverage level code

Code	Description
CHD	Children only
DEP	Dependents only
ECH	Subscriber and children/dependents
EMP	Subscriber only

ESP	Subscriber and spouse/life partner
FAM	Family
SPC	Spouse/life partner and children/dependents
SPO	Spouse/life partner only

B-1.C Market category code

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.D Race codes

Code	Description
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

B-1.E Ethnicity codes

Code	Description

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
RUSSIA	Russian
EASTEU	Eastern European
2047-9	Vietnamese
OTHER	Other ethnicity
UNKNOW	Unknown/not specified

B-1.F Discharge status

Discharge status codes are defined and maintained by the National Uniform Billing Committee (NUBC).

B-1.G Type of bill

Type of bill codes are defined and maintained by the National Uniform Billing Committee (NUBC).

B-1.H Claim status

Code	Description
01	Processed as primary
02	Processed as secondary
03	Processed as tertiary
04	Denied
19	Processed as primary, forwarded to additional payer(s)
20	Processed as secondary, forwarded to additional payer(s)
21	Processed as tertiary, forwarded to additional payer(s)
22	Reversal of previous payment
23	Not our claim, forward to additional payer(s)
25	Predetermination pricing only—no payment

B-1.I Present on admission codes

Code	Description
Y	Yes
N	No
U	Unknown
W	Not applicable

B-1.J Dispense as written codes

Code	Description
0	Not dispensed as written
1	Physician dispensed as written
2	Member dispensed as written
3	Pharmacy dispensed 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.K Drug unit of measure

Code	Description
EA	Each
F2	International units
GM	Grams
ML	Milliliters
MG	Milligrams
MEQ	Milliequivalent
MM	Millimeter
UG	Microgram
UU	Unit
OT	Other