**PROFESSIONAL SERVICES DATA REPORT SUBMISSION**

This report details all fee-for-service and capitated encounters provided by health care practitioners and office facilities for the quarterly reporting period designated – First Quarter: Claims paid from January 1, 2015 through March 31, 2015; Second Quarter: Claims paid from April 1, 2015 through June 30, 2015; Third Quarter: Claims paid from July 1, 2015 through September 30, 2015; and Fourth Quarter: Claims paid from October 1, 2015 through December 31, 2015. Please provide information on all health care services provided to applicable insureds whether those services were provided by a practitioner or office facility located in-State or out-of-State.

*(Reminder: **Patient Liability** is calculated using these three financial fields: **Patient Deductible, Patient Coinsurance/Co-payment,** and **Other Patient Obligations.** Total Patient Liability **should equal the sum** of Patient Deductible + Patient Coinsurance/Co-payment + Other Patient Obligations.)*

Please note that the layout below is for formatting a flat file. The MCDB Portal will accept files delimited by a pipe (|) or a comma (,).

| | Field Name | Length | Type A=alphanumeric N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Record Identifier | 1 | A | | 1 | 1 | 100% | The value is 1 | **1 Professional Services** | |
| 2 | Patient Identifier**P** (payor encrypted) | 12 | A | | 2 | 13 | 100% | Patient's unique identification number assigned by payor and encrypted. | The unique ID for each person on this file should correspond to the same unique Patient ID used for all other files (Eligibility, Pharmacy Claims, Institutional Services, and Dental Services Files) | |
| 3 | Patient Identifier**U** (UUID encrypted) | 12 | A | | 14 | 25 | 100% | Patient's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC. | Refer to the UUID summary description sheet in the data submission manual. A full description is available in the UUID Users' Manual.<br><br>Leave UUID blank if it is not generated by the UUID software | Added threshold of 100%, added note to leave blank if not generated by UUID software |
| 4 | Patient Year and Month of Birth (CCYYMM00) | 8 | N | | 26 | 33 | 100% | Date of patient's birth using 00 instead of day. | CCYYMM00 | Changed to one threshold of 100% from three thresholds of 99%/99%/100% |
| 5 | Patient Sex | 1 | A | | 34 | 34 | 99% | Sex of the patient. | 1 Male<br>2 Female | Removed option 3, "Unknown" |
| 6 | Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator | 1 | A | | 35 | 35 | | Consumer Directed Health Plan (CDHP) with Health Savings Account (HSA) or Health Resources Account(HRA) | 0 No<br>1 Yes | Removed threshold, collected in eligibility file |
| 7 | Patient Zip Code+4digit add-on code (include hyphen) | 10 | A | | 36 | 45 | 99% | Zip code of patient's residence. | 5-digit US Postal Service code plus 4-digit add-on code. Report '0000' if +4-digit is missing | Added note for reporting missing 4-digit add-on code |
| 8 | Patient Covered by Other Insurance Indicator | 1 | A | | 46 | 46 | 95% | Indicates whether patient has additional insurance coverage. | 0 No<br>1 Yes, other cover is primary<br>2 Yes, other coverage is secondary<br>9 Unknown | |
| 9 | Coverage Type | 1 | A | | 47 | 47 | | Patient's type of insurance coverage. | 1 Medicare Supplemental (i.e., Individual, Group, WRAP)<br>2 Medicare Advantage Plan<br>3 Individual Market (not MHIP; not sold in MHBE)<br>4 Maryland Health Insurance Plan (MHIP)<br>5 Private Employer Sponsored or Other Group (i.e. union or association plans)<br>6 Public Employee – Federal (FEHBP)<br>7 Public Employee – Other (state, county, local/municipal government and public school systems)<br>8 Comprehensive Standard Health Benefit Plan (not sold in MHBE) [a self employed individual or small businesses (public or private employers) with 2-50 eligible employees]<br>9 Health Insurance Partnership (HIP)<br>A Student Health Plan<br>B Individual Market sold in MHBE<br>C Small Business Options Program (SHOP) sold in MHBE<br>Z Unknown | Removed threshold, collected in eligibility file |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 10 | Source Company | 1 | A | | 48 | 48 | | Defines the payor company that holds the beneficiary's contract; for use in characterizing contract requirements under Maryland law. | 1 Health Maintenance Organization<br>2 Life & Health Insurance Company or Not-for-Profit Health Benefit Plan<br>3 Third-Party Administrator (TPA) Unit | Removed threshold, collected in eligibility file |
| 11 | Claim Related Condition | 1 | A | | 49 | 49 | | Describes connection, if any, between patient's condition and employment, automobile accident, or other accident. | 0 Non-accident (default)<br>1 Work<br>2 Auto Accident<br>3 Other Accident<br>9 Unknown | |
| 12 | Practitioner Federal Tax ID | 9 | A | | 50 | 58 | 100% | Employer Tax ID of the practitioner, practice or office facility receiving payment for services. | | |
| 13 | Participating Provider Status | 1 | A | | 59 | 59 | 95% | Indicates if the service was provided by a provider that participates in the payor's network. | 1 Participating<br>2 Non-Participating<br>3 Unknown/Not Coded<br>9 No Network for this Plan | |
| 14 | Record Status | 1 | A | | 60 | 60 | 95% | Describes payment and adjustment status of a claim. Adjustments include paying a claim more than once, paying additional services that may have been denied, or crediting a provider due to overpayment or paying the wrong provider. | 1 Fee-for-service<br>8 Capitated or Global Contract Services | Changed 1 from "Final bill" to "Fee-for-service" |
| 15 | Claim Control Number<br>(Include on each record as this is the key to summarizing service detail to claim level) | 23 | A | | 61 | 83 | 100% | Internal payor claim number used for tracking. | | Changed threshold to 100% from 95%, credit no longer needs to have the same claim number as the original debit record |
| 16 | Claim Paid Date (CCYYMMDD) | 8 | N | | 84 | 91 | 100% | The date that the claim was paid. This date should agree with the paid date the Finance and Actuarial department is using in your organization | CCYYMMDD | Changed description to include instructions on determining claim paid date. |
| 17 | Filler | 2 | N | | 92 | 93 | | Filler | Used to be Number of Diagnosis Codes | Removed threshold, renamed to "Filler," left blank |
| 18 | Filler | 2 | N | | 94 | 95 | | Filler | Used to be Number of Line Items | Removed threshold, renamed to "Filler," left blank |
| 19 | Diagnosis Code 1<br>(Remove imbedded decimal points) | 7 | A | | 96 | 102 | 99% | The primary ICD-9-CM or ICD-10-CM Diagnosis Code followed by a secondary diagnosis (up to 9 codes), if applicable at time of service. **Remove embedded decimal point.** | | |
| 20 | Diagnosis Code 2 | 7 | A | | 103 | 109 | | | | |
| 21 | Diagnosis Code 3 | 7 | A | | 110 | 116 | | | | |
| 22 | Diagnosis Code 4 | 7 | A | | 117 | 123 | | | | |
| 23 | Diagnosis Code 5 | 7 | A | | 124 | 130 | | | | |
| 24 | Diagnosis Code 6 | 7 | A | | 131 | 137 | | | | |
| 25 | Diagnosis Code 7 | 7 | A | | 138 | 144 | | | | |
| 26 | Diagnosis Code 8 | 7 | A | | 145 | 151 | | | | |
| 27 | Diagnosis Code 9 | 7 | A | | 152 | 158 | | | | |
| 28 | Diagnosis Code 10 | 7 | A | | 159 | 165 | | | | |
| 29 | Service From Date (CCYYMMDD) | 8 | N | | 166 | 173 | 100% | First date of service for a procedure in this line item. | CCYYMMDD | |
| 30 | Service Thru Date* (CCYYMMDD) | 8 | N | | 174 | 181 | 100%* | Last date of service for this line item. | CCYYMMDD | |
| 31 | Place of Service | 2 | A | | 182 | 183 | 99% | Two-digit numeric code that describes where a service was rendered. | See link for available codes: http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html | Replaced list of codes with hyperlink to CMS website |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 32 | Service Location Zip Code +4digit add-on code (include hyphen) | 10 | A | | 184 | 193 | 95% | Zip code for location where service described was provided. | 5-digit US Postal Service code plus 4-digit add-on code. Report '0000' if +4-digit is missing | Added note for reporting missing 4-digit add-on code |
| 33 | Service Unit Indicator | 1 | A | | 194 | 194 | 95% | Category of service as it corresponds to Units data element. | 0 Values reported as zero (no allowed services)<br>1 Transportation (ambulance air or ground) Miles<br>2 Anesthesia Time Units<br>3 Services<br>4 Oxygen Units<br>5 Units of Blood<br>6 Allergy Tests<br>7 Lab Tests<br>8 Minutes of Anesthesia (waiver required) | |
| 34 | Units of Service | 3 | A | 1 implied** | 195 | 197 | 95% | Quantity of services or number of units for a service or minutes of anesthesia. | One (1) implied decimal for anesthesia time units; all other units submit as integers. | |
| 35 | Procedure Code | 6 | A | | 198 | 203 | 95% | Describes the health care service provided (i.e., CPT-4, HCPCS, ICD-9-CM, ICD-10-CM) | | |
| 36 | Modifier I | 2 | A | | 204 | 205 | | Discriminate code used by practitioners to distinguish that a health care service has been altered [by a specific condition] but not changed in definition or code. A modifier is added as a suffix to a procedure code field. | MHCC accepts national standard modifiers approved by the American Medical Association as published in the 2008 Current Procedure Terminology. Modifiers approved for Hospital Outpatient use: Level I (CPT) and Level II (HCPCS/National) modifiers.<br><br>Nurse Anesthetist services are to be reported using the following Level II (HCPCS) modifiers:<br>· **QX** – Nurse Anesthetist service; under supervision of a doctor<br>· **QZ** – Nurse Anesthetist service; w/o the supervision of a doctor | |
| 37 | Modifier II (specific to Modifier I) | 2 | A | | 206 | 207 | | Specific to Modifier I. | | |
| 38 | Servicing Practitioner ID | 11 | A | | 208 | 218 | 100% | Payor-specific identifier for the practitioner rendering health care service(s). | | |
| 39 | Billed Charge | 9 | N | | 219 | 227 | 100% | A practitioner's billed charges rounded to whole dollars. **DO NOT USE DECIMALS** | | Added 100% threshold to all financial fields |
| 40 | Allowed Amount | 9 | N | | 228 | 236 | 100% | Total patient and payor liability. **DO NOT USE DECIMALS** | | Added 100% threshold to all financial fields |
| 41 | Reimbursement Amount | 9 | N | | 237 | 245 | 100% | Amount paid to Employer Tax ID # of rendering physician as listed on claim. **DO NOT USE DECIMALS** | | Added 100% threshold to all financial fields |
| 42 | Date of Enrollment | 8 | N | | 246 | 253 | | The first day of the reporting period the patient is in this delivery system (in this data submission time period). (see Source Company on page 26) | CCYYMMDD<br>Date is the first day of the reporting period if patient is enrolled at that time. Enter other date if patient **not enrolled** at start of reporting period, but enrolled during reporting period. | Removed threshold, collected in eligibility file |
| 43 | Date of Disenrollment | 8 | N | | 254 | 261 | | The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 26) | CCYYMMDD<br>If patient is still enrolled on the last day of the reporting period, enter 20991231. If patient disenrolled before end of reporting period enter date disenrolled. | Removed threshold, collected in eligibility file |
| 44 | Patient Deductible | 9 | N | | 262 | 270 | 100% | The fixed amount that the patient must pay for covered medical services before benefits are payable. **DO NOT USE DECIMALS** | | Added 100% threshold to all financial fields |
| 45 | Patient Coinsurance or Patient Co-payment | 9 | N | | 271 | 279 | 100% | The specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible. **DO NOT USE DECIMALS** | | Added 100% threshold to all financial fields |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 46 | Other Patient Obligations | 9 | N | | 280 | 288 | 100% | Any patient obligations other than the deductible or coinsurance/co-payment. This could include obligations for out-of-network care (balance billing net of patient deductible, patient coinsurance/co-payment and payor reimbursement), non-covered services, or penalties. **DO NOT USE DECIMALS** | | Added 100% threshold to all financial fields |
| 47 | Plan Liability | 1 | N | | 289 | 289 | | Indicates if insurer is at risk for the patient's service use or the insurer is simply paying claims as Administrative Services Only (ASO) | 1 Risk (under Maryland contract)<br>2 Risk (under non-Maryland contract)<br>3 ASO (employer self-insured, under Maryland contract)<br>4 ASO (employer self-insured, under non-Maryland contract | Added options for ASO under Maryland and non-Maryland contracts. Removed threshold, collected in eligibility file. |
| 48 | Servicing Practitioner Individual National Provider Identifier (NPI) number | 10 | A | | 290 | 299 | 100% | Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner. | Ten (10) digits<br>www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf | Changed threshold to 100% from 95% |
| 49 | Practitioner National Provider Identifier (NPI) number used for Billing | 10 | A | | 300 | 309 | 100% | Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner or an organization for billing purposes. | Ten (10) digits<br>www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf | Changed threshold to 100% from 95% |
| 50 | Product Type | 1 | A | | 310 | 310 | | Classifies the benefit plan by key product characteristics (scope of coverage, size of network, coverage for out-of-network benefits). | SSS will populate this field through the eligibility file. Payors are not required to fill it. | Removed threshold, collected in eligibility file, added instruction to leave field blank, as SSS will populate with eligibility file |
| 51 | Payor ID Number | 4 | A | | 311 | 314 | 100% | Payor assigned submission identification number. | | |
| 52 | Source System | 1 | A | | 315 | 315 | 100% | Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…)<br><br>Please ensure that the source system letter used is consistent from year to year, as well as with the source system letter indicated on the MCDB Portal. | A – Z. If only submitted for one source system, default is A. | Added threshold of 100%, added note on reporting source system |
| 53 | Assignment of Benefits | 1 | A | | 316 | 316 | 100% | For out-of-network services please provide information on whether or not the patient assigned benefits to the servicing physician for an out-of-network service. | 0 No, Assignment of Benefits not accepted and Practitioner Not in Network<br>1 Yes, Assignment of Benefits Accepted and Practitioner Not in Network<br>2 N/A, Practitioner is In Network<br>9 Unknown | |
| 54 | Diagnosis Code Indicator | 1 | A | | 317 | 317 | | Indicates the volume of the International Classification of Diseases, Clinical Modification system used in assigning codes to diagnoses. | 1 ICD-9-CM<br>2 ICD-10-CM<br>3 Missing/Unknown | Removed threshold |
| 55 | CPT Category II Code 1 | 5 | A | | 318 | 322 | | Provide any applicable CPT Category II codes. | | |
| 56 | CPT Category II Code 2 | 5 | A | | 323 | 327 | | | | |
| 57 | CPT Category II Code 3 | 5 | A | | 328 | 332 | | | | |
| 58 | CPT Category II Code 4 | 5 | A | | 333 | 337 | | | | |
| 59 | CPT Category II Code 5 | 5 | A | | 338 | 342 | | | | |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 60 | Reporting Quarter | 1 | N | | 343 | 343 | 100% | Indicate the quarter number for which the data is being submitted. | 1 First Quarter = January 1 thru March 31<br>2 Second Quarter = April 1 thru June 30<br>3 Third Quarter = July 1 thru September 30<br>4 Fourth Quarter = October 1 thru December 31 | Added threshold of 100% |
| 61 | Claim Adjudication Date(CCYYMMDD) New! | 8 | N | | 344 | 351 | 100% | The date that the claim was adjudicated. | CCYYMMDD | Added field |
| 62 | Claim Line Number New! | 4 | A | | 352 | 355 | 100% | Line number for the service within a claim. | The first line is 1 and subsequent lines are incremented by 1 | Added field |
| 63 | Version Number New! | 4 | A | | 356 | 359 | 100% | Version number of this claim service line. The version number begins with 1 and is incremented by 1 for each subsequent version of that service line. | | Added field |
| 64 | Claim Line Type New! | 1 | A | | 360 | 360 | 100% | Code Indicating Type of Record. Example: Original, Void, Replacement, Back Out, Amendment | O Original<br>V Void<br>R Replacement<br>B Back Out<br>A Amendement | Added field |
| 65 | Former Claim Number New! | 23 | A | | 361 | 383 | 100% | Former claims control number or claims control number used in the original claim that corresponds to this claim line. | Must be different to the claims control number reported under field # 15 | Added field |

** If the Service thru Date is not reported, then assume that the Service from Date (data element #29) and the Service*
*** Implied decimal should only be used for anesthesia time units; all other units should be submitted as integers.*

**PHARMACY DATA REPORT SUBMISSION**

This report details all prescription drug encounters for your enrollees for the quarterly reporting period designated – First Quarter: Claims paid from January 1, 2015 through March 31, 2015; Second Quarter: Claims paid from April 1, 2015 through June 30, 2015; Third Quarter: Claims paid from July 1, 2015 through September 30, 2015; and Fourth Quarter: Claims paid from October 1, 2015 through December 31, 2015. Please provide information on all pharmacy services provided to applicable insureds whether the services were provided by a pharmacy located in-State or out-of-State. **Do not include pharmacy supplies or prosthetics.**

COMAR 10.25.06 specifies the Pharmacy Data Report be submitted separately from the Professional Services Data Report.

*(Reminder: **Patient Liability** is calculated using these three financial fields: **Patient Deductible, Patient Coinsurance/Co-payment,** and **Other Patient Obligations**. Total Patient Liability **should equal the sum** of Patient Deductible + Patient Coinsurance/Co-payment + Other Patient Obligations.)*

Please note that the layout below is for formatting a flat file. The MCDB Portal will accept files delimited by a pipe (|) or a comma (,).

| | Field Name | Length | Type A=alphanumeric N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Record Identifier | 1 | A | | 1 | 1 | 100% | The value is 2 | **2 Pharmacy Services** | |
| 2 | Patient Identifier**P** (payor encrypted) | 12 | A | | 2 | 13 | 100% | Patient's unique identification number assigned by payor and encrypted. | The unique ID for each person on this file should correspond to the same unique Patient ID used for all other files (Eligibility, Professional Services, Institutional Services, and Dental Services Files) | |
| 3 | Patient Identifier**U** (UUID encrypted) | 12 | A | | 14 | 25 | 100% | Patient's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC. | Refer to the UUID summary description sheet in the data submission manual. A full description is available in the UUID Users' Manual.<br><br>Leave UUID blank if it is not generated by the UUID software | Added threshold of 100%, added note to leave blank if not generated by UUID software |
| 4 | Patient Sex | 1 | A | | 26 | 26 | 99% | Sex of Patient. | 1 Male<br>2 Female | Removed option 3, "Unknown" |
| 5 | Patient Zip Code +4digit add-on code (include hyphen) | 10 | A | | 27 | 36 | 99% | Zip code of patient's residence. | 5-digit US Postal Service code plus 4-digit add-on code. Report '0000' if +4-digit is missing | Added note for reporting missing 4-digit add-on code |
| 6 | Patient Year and Month of Birth (CCYYMM00) | 8 | N | | 37 | 44 | 100% | Date of patient's birth using 00 instead of day. | CCYYMM00 | Changed to one threshold of 100% from three thresholds of 99%/99%/100% |
| 7 | Pharmacy NCPDP Number<br>**(left justified)** | 7 | A | | 45 | 51 | 100% | Unique 7 digit number assigned by the National Council for Prescription Drug Program (NCPDP). | Use Pharmacy NPI Number if Pharmacy NCPDP Number is unavailable. | |
| 8 | Pharmacy Zip Code +4digit add-on code (include hyphen)<br>(location where prescription was filled and dispensed) | 10 | A | | 52 | 61 | 95% | Zip code of pharmacy where prescription was filled and dispensed. | 5-digit US Postal Service code plus 4-digit add-on code. Report '0000' if +4-digit is missing | Added note for reporting missing 4-digit add-on code |
| 9 | Practitioner DEA #<br>(left justified; for many payors the last 2 positions on the right will be blank)* | 11 | A | | 62 | 72 | 100% | Drug Enforcement Agency number assigned to an individual registered under the Controlled Substance Act. | Same as DEA # in Provider File. Only required if NPI has not been reported. | Changed threshold to 100% from 99%, added note that this applies unless NPI Number has been reported |
| 10 | Fill Number | 2 | A | | 73 | 74 | 100% | The code used to indicate if the prescription is an original prescription or a refill. Use '01' for all refills if the specific number of the prescription refill is not available. | 00 New prescription/Original<br>01 – 99 Refill number | Added threshold of 100% |
| 11 | NDC Number | 11 | A | | 75 | 85 | 100% | National Drug Code 11 digit number. | | |
| 12 | Drug Compound | 1 | A | | 86 | 86 | | Indicates a mix of drugs to form a compound medication. | 1 Non-compound<br>2 Compound | |
| 13 | Drug Quantity | 5 | N | | 87 | 91 | 99% | Number of units of medication dispensed. | | |
| 14 | Drug Supply | 3 | N | | 92 | 94 | 99% | Estimated number of days of dispensed supply. | | |
| 15 | Date Filled (CCYYMMDD) | 8 | N | | 95 | 102 | 100% | Date prescription was filled. | CCYYMMDD | Changed to one threshold of 100% from three thresholds of 99%/99%/100% |

| | Field Name | Length | Type A=alphanumeric N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 16 | Date Prescription Written (CCYYMMDD) | 8 | N | | 103 | 110 | | Date prescription was written. | CCYYMMDD | |
| 17 | Billed Charge | 9 | N | 2 | 111 | 119 | 100% | Retail amount for drug including dispensing fees and administrative costs. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.** | | Added 100% threshold to all financial fields |
| 18 | Reimbursement Amount | 9 | N | 2 | 120 | 128 | 100% | Amount paid to the pharmacy by payor. Do not include patient copayment or sales tax. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.** | | Added 100% threshold to all financial fields |
| 19 | Prescription Claim Control Number | 15 | A | | 129 | 143 | 100% | Internal payor claim number used for tracking. | | Changed threshold to 100% from 95%, credit no longer needs to have the same claim number as the original debit record, changed name from "Prescription Claim Number" |
| 20 | Prescription Claim Paid Date (CCYYMMDD) | 8 | N | | 144 | 151 | 100% | The date that the claim was paid. This date should agree with the paid date the Finance and Actuarial department is using in your organization | CCYYMMDD | Changed description to include instructions on determining claim paid date. |
| 21 | Prescribing Practitioner Individual National Provider Identifier (NPI)# | 10 | A | | 152 | 161 | 100% | Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner. | Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf | Changed threshold to 100% from 95% |
| 22 | Patient Deductible | 9 | N | 2 | 162 | 170 | 100% | The fixed amount that the patient must pay for covered pharmacy services before benefits are payable. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.** | | Added 100% threshold to all financial fields |
| 23 | Patient Coinsurance or Patient Co-payment | 9 | A | 2 | 171 | 179 | 100% | The specified amount or percentage the patient is required to contribute towards covered pharmacy services after any applicable deductible. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.** | | Added 100% threshold to all financial fields |
| 24 | Other Patient Obligations | 9 | N | 2 | 180 | 188 | 100% | Any patient obligations other than the deductible or coinsurance/co-payment. This could include obligations for non-formulary drugs, non-covered pharmacy services, or penalties. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.** | | Added 100% threshold to all financial fields |
| 25 | Date of Enrollment | 8 | N | | 189 | 196 | | The first day of the reporting period the patient is in this delivery system (in this data submission time period). (see Source Company on page 26) | CCYYMMDD Date is the first day of the reporting period if patient is enrolled at that time. Enter other date if patient **not enrolled** at start of reporting period, but enrolled during reporting period. | Removed threshold, collected in eligibility file |
| 26 | Date of Disenrollment | 8 | N | | 197 | 204 | | The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 26) | CCYYMMDD If patient is still enrolled on the last day of the reporting period, enter 20991231. If patient disenrolled before end of reporting period enter date disenrolled. | Removed threshold, collected in eligibility file |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 27 | Source of Processing | 1 | A | | 205 | 205 | 100% | The source processing the pharmacy claim. | 1 Processed Internally by Payor<br>2 Argus Health Systems, Inc.<br>3 Caremark, LLC<br>4 Catalyst Rx, Inc.<br>5 Envision Pharmaceutical Services, Inc.<br>6 Express Scripts, Inc.<br>7 Medco Health, LLC<br>8 National Employee Benefit Companies, Inc.<br>9 NextRx Services, Inc.<br>A Atlantic Prescription Services, LLC<br>B Benecard Services, Inc.<br>C BioScrip PBM Services, LLC<br>D Futurescripts, LLC<br>E Health E Systems<br>F HealthTran, LLC<br>G Innoviant, Inc.<br>H MaxorPlus<br>I Medical Security Card Company<br>J MedImpact Healthcare Systems, Inc.<br>K MemberHealth, LLC<br>L PharmaCare Management Services, LLC<br>M Prime Therapeutics, LLC<br>N Progressive Medical, Inc.<br>O RxAmerica, LLC<br>P RxSolutions, Inc.<br>Q Scrip World, LLC<br>R Tmesys, Inc.<br>S WellDynerx, Inc. | |
| 28 | Payor ID Number | 4 | A | | 206 | 209 | 100% | Payor assigned submission identification number. | | |
| 29 | Source System | 1 | A | | 210 | 210 | 100% | Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…)<br><br>Please ensure that the source system letter used is consistent from year to year, as well as with the source system letter indicated on the MCDB Portal. | A – Z. If only submitted for one source system, default is A. | Added threshold of 100%, added note on reporting source system |
| 30 | Reporting Quarter | 1 | A | | 211 | 211 | 100% | Indicate the quarter number for which the data is being submitted | 1 First Quarter = January 1 thru March 31<br>2 Second Quarter = April 1 thru June 30<br>3 Third Quarter = July 1 thru September 30<br>4 Fourth Quarter = October 1 thru December 31 | Added threshold of 100% |
| 31 | Pharmacy NPI Number New! | 10 | A | | 212 | 221 | 100% | Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner. This is the NPI of the dispensing pharmacy | Ten (10) digits<br>www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf | Added field |
| 32 | Prescribing Provider ID New! | 11 | A | | 222 | 232 | 100% | Payor-specific identifier (internal ID) for the prescibing practitioner. | Must link to the practitioner ID on the Provider Directory | Added field |
| 33 | Claim Adjudication Date(CCYYMMDD) New! | 8 | N | | 233 | 240 | 100% | The date that the claim was adjudicated. | CCYYMMDD | Added field |
| 34 | Claim Line Number New! | 4 | A | | 241 | 244 | 100% | Line number for the service within a claim. | The first line is 1 and subsequent lines are incremented by 1 | Added field |
| 35 | Version Number New! | 4 | A | | 245 | 248 | 100% | Version number of this claim service line. The version number begins with 1 and is incremented by 1 for each subsequent version of that service line. | | Added field |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 36 | Claim Line Type New! | 1 | A | | 249 | 249 | 100% | Code Indicating Type of Record. Example: Original, Void, Replacement, Back Out, Amendment | O Original<br>V Void<br>R Replacement<br>B Back Out<br>A Amendement | Added field |
| 37 | Former Prescription Claim Number New! | 23 | A | | 250 | 272 | 100% | Former claims control number or claims control number used in the original claim that corresponds to this claim line. | Must be different to the claims control number reported under field # 19 | Added field |

**INSTITUTIONAL SERVICES DATA REPORT SUBMISSION**

This report details all institutional health care services *(including hospital inpatient, outpatient, and emergency department services)* provided to your enrollees quarterly reporting period designated – First Quarter: Claims paid from January 1, 2015 through March 31, 2015; Second Quarter: Claims paid from April 1, 2015 through June 30, 2015; Third Quarter: Claims paid from July 1, 2015 through September 30, 2015; and Fourth Quarter: Claims paid from October 1, 2015 through December 31, 2015. Please provide information on all institutional services provided to applicable insureds whether by a health care facility located in-State or out-of-State.

*(Reminder: **Patient Liability** is calculated using these three financial fields: **Patient Deductible, Patient Coinsurance/Co-payment,** and **Other Patient Obligations**. Total Patient Liability **should equal the sum** of Patient Deductible + Patient Coinsurance/Co-payment + Other Patient Obligations.)*

This summary record should reflect all charges and payments from an interim or final claim. To avoid sending duplicate charges and payments, submit summaries from interim claims only when a final claim does not exist for a visit or stay.

Please note that the layout below is for formatting a flat file. The MCDB Portal will accept files delimited by a pipe (|) or a comma (,).

| | Field Name | Length | Type A=alphanumeric N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Record Identifier | 1 | A | | 1 | 1 | 100% | The value is 4 | **4 Institutional Services** | |
| 2 | Patient Identifier**P** (payor encrypted) | 12 | A | | 2 | 13 | 100% | Patient's unique identification number assigned by payor and encrypted. | The unique ID for each person on this file should correspond to the same unique Patient ID used for all other files (Eligibility, Professional Services, Pharmacy Claims, and Dental Services Files). | |
| 3 | Patient Identifier**U** (UUID encrypted) | 12 | A | | 14 | 25 | 100% | Patient's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC. | Refer to the UUID summary description sheet in the data submission manual. A full description is available in the UUID Users' Manual.<br><br>Leave UUID blank if it is not generated by the UUID software. | Added threshold of 100%, added note to leave blank if not generated by UUID software |
| 4 | Patient Year and Month of Birth (CCYYMM00) | 8 | N | | 26 | 33 | 100% | Date of patient's birth using 00 instead of day. | CCYYMM00 | Changed to one threshold of 100% from three thresholds of 99%/99%/100% |
| 5 | Patient Sex | 1 | A | | 34 | 34 | 99% | Sex of the patient. | 1 Male<br>2 Female | Removed option 3, "Unknown" |
| 6 | Patient Zip Code +4digit add-on code (include hyphen) | 10 | A | | 35 | 44 | 99% | Zip code of patient's residence. | 5-digit US Postal Service code plus 4-digit add-on code. Report '0000' if +4-digit is missing | Added note for reporting missing 4-digit add-on code |
| 7 | Date of Enrollment | 8 | N | | 45 | 52 | | The start date of enrollment for the patient in this delivery system (in this data submission time period).<br>(see Source Company on page 26) | CCYYMMDD<br>Date is the first day of the reporting period if patient is enrolled at that time. Enter other date if patient **not enrolled** at start of reporting period, but enrolled during reporting period. | Removed threshold, collected in eligibility file |
| 8 | Date of Disenrollment | 8 | N | | 53 | 60 | | The end date of enrollment for the patient in this delivery system (in this data submission time period).<br>(see Source Company on page 26) | CCYYMMDD<br>If patient is still enrolled on the last day of the reporting period, enter 20991231. If patient disenrolled before end of reporting period enter date disenrolled. | Removed threshold, collected in eligibility file |
| 9 | Hospital/Facility Federal Tax ID | 9 | A | | 61 | 69 | 100% | Federal Employer Tax ID of the facility receiving payment for care. | | |
| 10 | Hospital/Facility National Provider Identifier (NPI) Number | 10 | A | | 70 | 79 | 100% | Federal identifier assigned by the federal government for use in all HIPAA transactions to an organization for billing purposes. | Ten (10) digits<br>www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf | Changed threshold to 100% |
| 11 | Hospital/Facility Medicare Provider Number | 6 | A | | 80 | 85 | | Federal identifier assigned by the federal government for use in all Medicare transactions to an organization for billing purposes. | Six (6) digits | |
| 12 | Hospital/Facility Participating Provider Flag | 1 | A | | 86 | 86 | 95% | Indicates if the service was provided at a hospital/facility that participates in the payor's network. | 1 Participating<br>2 Non-Participating<br>3 Unknown/Not Coded<br>9 No Network for this Plan | |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 13 | Claim Control Number<br>(This is the key to summarizing service detail to claim level & must be included on each record.) | 23 | A | | 87 | 109 | 100% | Internal payor claim number used for tracking. | | Changed threshold to 100% from 95%, credit no longer needs to have the same claim number as the original debit record |
| 14 | Claim Paid Date (CCYYMMDD) | 8 | N | | 110 | 117 | 100% | The date that the claim was paid. This date should agree with the paid date the Finance and Actuarial department is using in your organization | CCYYMMDD | Changed description to include instructions on determining claim paid date. |
| 15 | Record Type | 2 | A | | 118 | 119 | | Identifies the type of facility or department in a facility where the service was provided. This date correspond to the | 10 Hospital Inpatient – Undefined<br>11 Hospital Inpatient – Acute care<br>12 Hospital Inpatient – Children's Hospital<br>13 Hospital Inpatient – Mental health or Substance abuse<br>14 Hospital Inpatient – Rehabilitation, Long term care, SNF stay<br>20 Hospital Outpatient – Undefined<br>21 Hospital Outpatient – Ambulatory Surgery<br>22 Hospital Outpatient – Emergency Room<br>23 Hospital Outpatient – Other<br>30 Non-Hospital Facility | |
| 16 | Type of Admission | 1 | A | | 120 | 120 | 95% | Applies **only** to hospital inpatient records. All other record types code "0". | 1 Emergency<br>2 Urgent<br>3 Elective<br>4 Newborn<br>5 Trauma Center<br>6 Reserved for National Assignment<br>7 Reserved for National Assignment<br>8 Reserved for National Assignment<br>9 Information Not Available | |
| 17 | Point of Origin for Admission or Visit | 1 | A | | 121 | 121 | 95% | Applies **only** to hospital inpatient records. All other record types code "0".<br><br>(Note: Assign the code where the patient originated from before presenting to the health care facility.) | 0 Not a hospital inpatient record<br><br>For Newborns (Type of Admission = 4)<br>1 Normal delivery<br>2 Premature delivery<br>3 Sick baby<br>4 Not used<br>5 Born inside this hospital<br>6 Born outside of this hospital<br>9 Information not available<br><br>Admissions other than Newborn<br>1 Non-Health Facility Point of Origin<br>2 Clinic or Physician's Office<br>3 Reserved for national assignment<br>4 Transfer from a Hospital (Different Facility)<br>5 Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)<br>6 Transfer from Another Health Care Facility<br>8 Court/Law Enforcement | |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 18 | Patient Discharge Status | 2 | A | | 122 | 123 | 95% | Indicates the disposition of the patient at discharge.<br><br>Applies **only** to hospital inpatient records. All other record types code "00". | 01 Routine (home or self care)<br>02 Another Short-term Hospital<br>03 Skilled Nursing Facility (SNF)<br>04 Intermediate care facility (ICF)<br>05 Another type of facility (includes rehab facility, hospice, etc.)'06<br>06 Home Health Care (HHC)<br>07 Against medical advice<br>09 Admitted as an inpatient to this hospital<br>20 Expired ( Religious)<br>21 Expired ( Religious)<br>30 Still patient<br>40 Expired at home (Hospice claims)<br>41 Expired in a medical facility(Hospice claims only)<br>42 Expired - place unknown (Hospice claims only)<br>43 Federal hospital<br>50 Hospice - home<br>51 Hospice - medical facility<br>61 Hospital-based Medicare approved swing bed<br>62 IP Rehab facility (not hospital)<br>63 Discharged/transferred to long term care hospital<br>65 Psychiatric hospital<br>66 Transferred to a CAH<br>69 Designated disaster alternative care site<br>70 Another type of health care institution<br>81 Home or self-care(planned readmission)<br>82 Short term general hospital for IP care<br>83 Skilled nursing facility (SNF)<br>84 Facility providing custodial or supportive care<br>85 Designated cancer center or children's hospital<br>86 Home Health Care (HHC)<br>87 Court/Law Enforcement<br>88 Federal health care facility<br>89 Hospital-based Medicare approved swing bed | Added threshold of 95%<br>Changed accepted values. |
| 19 | Date of Admission or Start of Service | 8 | N | | 124 | 131 | 99% | First date of service for a procedure in this line item. | CCYYMMDD | |
| 20 | Date of Discharge or End of Service* | 8 | A | | 132 | 139 | 99%* | Last date of service for a procedure in this line item. | CCYYMMDD | |
| 21 | Diagnosis Code Indicator | 1 | A | | 140 | 140 | | Indicates the volume of the International Classification of Diseases, Clinical Modification system used in assigning codes to diagnoses. | 1 ICD-9-CM<br>2 ICD-10-CM<br>3 Missing/Unknown | |
| 22 | Primary Diagnosis<br>(**Remove embedded decimal points)** | 7 | A | | 141 | 147 | 99% | The primary ICD-9-CM or ICD-10-CM Diagnosis Code followed by a secondary diagnosis (up to 29 codes), if applicable at the time of service. (Remove embedded decimal pt.) | | |
| 23 | Primary Diagnosis present on Admission | 1 | A | | 148 | 148 | | Primary Diagnosis present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 24 | Other Diagnosis Code 1 | 7 | A | | 149 | 155 | | ICD-9-CM/ICD-10-CM Diagnosis Code 1<br>(Remove embedded decimal pt.) | | |
| 25 | Other Diagnosis Code 1 present on Admission 1 | 1 | A | | 156 | 156 | | Diagnosis Code 1 present on Admission.<br>(Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 26 | Other Diagnosis Code 2 | 7 | A | | 157 | 163 | | ICD-9-CM/ICD-10-CM Diagnosis Code 2<br>(Remove embedded decimal pt.) | | |
| 27 | Other Diagnosis Code 2 present on Admission 2 | 1 | A | | 164 | 164 | | Diagnosis Code 2 present on Admission.<br>(Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 28 | Other Diagnosis Code 3 | 7 | A | | 165 | 171 | | ICD-9-CM/ICD-10-CM Diagnosis Code 3<br>(Remove embedded decimal pt.) | | |
| 29 | Other Diagnosis Code 3 present on Admission 3 | 1 | A | | 172 | 172 | | Diagnosis Code 3 present on Admission.<br>(Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 30 | Other Diagnosis Code 4 | 7 | A | | 173 | 179 | | ICD-9-CM/ICD-10-CM Diagnosis Code 4<br>(Remove embedded decimal pt.) | | |
| 31 | Other Diagnosis Code 4 present on Admission 4 | 1 | A | | 180 | 180 | | Diagnosis Code 4 present on Admission.<br>(Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 32 | Other Diagnosis Code 5 | 7 | A | | 181 | 187 | | ICD-9-CM/ICD-10-CM Diagnosis Code 5<br>(Remove embedded decimal pt.) | | |

| | Field Name | Length | Type A=alphanumeric N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 33 | Other Diagnosis Code 5 present on Admission 5 | 1 | A | | 188 | 188 | | Diagnosis Code 5 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 34 | Other Diagnosis Code 6 | 7 | A | | 189 | 195 | | ICD-9-CM/ICD-10-CM Diagnosis Code 6 (Remove embedded decimal pt.) | | |
| 35 | Other Diagnosis Code 6 present on Admission 6 | 1 | A | | 196 | 196 | | Diagnosis Code 6 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 36 | Other Diagnosis Code 7 | 7 | A | | 197 | 203 | | ICD-9-CM/ICD-10-CM Diagnosis Code 7 (Remove embedded decimal pt.) | | |
| 37 | Other Diagnosis Code 7 present on Admission 7 | 1 | A | | 204 | 204 | | Diagnosis Code 7 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 38 | Other Diagnosis Code 8 | 7 | A | | 205 | 211 | | ICD-9-CM/ICD-10-CM Diagnosis Code 8 (Remove embedded decimal pt.) | | |
| 39 | Other Diagnosis Code 8 present on Admission 8 | 1 | A | | 212 | 212 | | Diagnosis Code 8 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 40 | Other Diagnosis Code 9 | 7 | A | | 213 | 219 | | ICD-9-CM/ICD-10-CM Diagnosis Code 9 (Remove embedded decimal pt.) | | |
| 41 | Other Diagnosis Code 9 present on Admission 9 | 1 | A | | 220 | 220 | | Diagnosis Code 9 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 42 | Other Diagnosis Code 10 | 7 | A | | 221 | 227 | | ICD-9-CM/ICD-10-CM Diagnosis Code 10<br>(Remove embedded decimal pt.) | | |
| 43 | Other Diagnosis Code 10 present on Admission 10 | 1 | A | | 228 | 228 | | Diagnosis Code 10 present on Admission.<br>(Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 44 | Other Diagnosis Code 11 | 7 | A | | 229 | 235 | | ICD-9-CM/ICD-10-CM Diagnosis Code 11<br>(Remove embedded decimal pt.) | | |
| 45 | Other Diagnosis Code 11 present on Admission 11 | 1 | A | | 236 | 236 | | Diagnosis Code 11 present on Admission.<br>(Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 46 | Other Diagnosis Code 12 | 7 | A | | 237 | 243 | | ICD-9-CM/ICD-10-CM Diagnosis Code 12<br>(Remove embedded decimal pt.) | | |
| 47 | Other Diagnosis Code 12 present on Admission 12 | 1 | A | | 244 | 244 | | Diagnosis Code 12 present on Admission.<br>(Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 48 | Other Diagnosis Code 13 | 7 | A | | 245 | 251 | | ICD-9-CM/ICD-10-CM Diagnosis Code 13<br>(Remove embedded decimal pt.) | | |
| 49 | Other Diagnosis Code 13 present on Admission 13 | 1 | A | | 252 | 252 | | Diagnosis Code 13 present on Admission.<br>(Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 50 | Other Diagnosis Code 14 | 7 | A | | 253 | 259 | | ICD-9-CM/ICD-10-CM Diagnosis Code 14<br>(Remove embedded decimal pt.) | | |

| | Field Name | Length | Type A=alphanumeric N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 51 | Other Diagnosis Code 14 present on Admission 14 | 1 | A | | 260 | 260 | | Diagnosis Code 14 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 52 | Other Diagnosis Code 15 | 7 | A | | 261 | 267 | | ICD-9-CM/ICD-10-CM Diagnosis Code 15 (Remove embedded decimal pt.) | | |
| 53 | Other Diagnosis Code 15 present on Admission 15 | 1 | A | | 268 | 268 | | Diagnosis Code 15 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 54 | Other Diagnosis Code 16 | 7 | A | | 269 | 275 | | ICD-9-CM/ICD-10-CM Diagnosis Code 16 (Remove embedded decimal pt.) | | |
| 55 | Other Diagnosis Code 16 present on Admission 16 | 1 | A | | 276 | 276 | | Diagnosis Code 16 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 56 | Other Diagnosis Code 17 | 7 | A | | 277 | 283 | | ICD-9-CM/ICD-10-CM Diagnosis Code 17 (Remove embedded decimal pt.) | | |
| 57 | Other Diagnosis Code 17 present on Admission 17 | 1 | A | | 284 | 284 | | Diagnosis Code 17 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 58 | Other Diagnosis Code 18 | 7 | A | | 285 | 291 | | ICD-9-CM/ICD-10-CM Diagnosis Code 18 (Remove embedded decimal pt.) | | |
| 59 | Other Diagnosis Code 18 present on Admission 18 | 1 | A | | 292 | 292 | | Diagnosis Code 18 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 60 | Other Diagnosis Code 19 | 7 | A | | 293 | 299 | | ICD-9-CM/ICD-10-CM Diagnosis Code 19<br>(Remove embedded decimal pt.) | | |
| 61 | Other Diagnosis Code 19 present on Admission 19 | 1 | A | | 300 | 300 | | Diagnosis Code 19 present on Admission.<br>(Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 62 | Other Diagnosis Code 20 | 7 | A | | 301 | 307 | | ICD-9-CM/ICD-10-CM Diagnosis Code 20<br>(Remove embedded decimal pt.) | | |
| 63 | Other Diagnosis Code 20 present on Admission 20 | 1 | A | | 308 | 308 | | Diagnosis Code 20 present on Admission.<br>(Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 64 | Other Diagnosis Code 21 | 7 | A | | 309 | 315 | | ICD-9-CM/ICD-10-CM Diagnosis Code 21<br>(Remove embedded decimal pt.) | | |
| 65 | Other Diagnosis Code 21 present on Admission 21 | 1 | A | | 316 | 316 | | Diagnosis Code 21 present on Admission.<br>(Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 66 | Other Diagnosis Code 22 | 7 | A | | 317 | 323 | | ICD-9-CM/ICD-10-CM Diagnosis Code 22<br>(Remove embedded decimal pt.) | | |
| 67 | Other Diagnosis Code 22 present on Admission 22 | 1 | A | | 324 | 324 | | Diagnosis Code 22 present on Admission.<br>(Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 68 | Other Diagnosis Code 23 | 7 | A | | 325 | 331 | | ICD-9-CM/ICD-10-CM Diagnosis Code 23<br>(Remove embedded decimal pt.) | | |

| | Field Name | Length | Type A=alphanumeric N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 69 | Other Diagnosis Code 23 present on Admission 23 | 1 | A | | 332 | 332 | | Diagnosis Code 23 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 70 | Other Diagnosis Code 24 | 7 | A | | 333 | 339 | | ICD-9-CM/ICD-10-CM Diagnosis Code 24 (Remove embedded decimal pt.) | | |
| 71 | Other Diagnosis Code 24 present on Admission 24 | 1 | A | | 340 | 340 | | Diagnosis Code 24 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 72 | Other Diagnosis Code 25 | 7 | A | | 341 | 347 | | ICD-9-CM/ICD-10-CM Diagnosis Code 25 (Remove embedded decimal pt.) | | |
| 73 | Other Diagnosis Code 25 present on Admission 25 | 1 | A | | 348 | 348 | | Diagnosis Code 25 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 74 | Other Diagnosis Code 26 | 7 | A | | 349 | 355 | | ICD-9-CM/ICD-10-CM Diagnosis Code 26 (Remove embedded decimal pt.) | | |
| 75 | Other Diagnosis Code 26 present on Admission 26 | 1 | A | | 356 | 356 | | Diagnosis Code 26 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 76 | Other Diagnosis Code 27 | 7 | A | | 357 | 363 | | ICD-9-CM/ICD-10-CM Diagnosis Code 27 (Remove embedded decimal pt.) | | |
| 77 | Other Diagnosis Code 27 present on Admission 27 | 1 | A | | 364 | 364 | | Diagnosis Code 27 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |

| | Field Name | Length | Type A=alphanumeric N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 78 | Other Diagnosis Code 28 | 7 | A | | 365 | 371 | | ICD-9-CM/ICD-10-CM Diagnosis Code 28 (Remove embedded decimal pt.) | | |
| 79 | Other Diagnosis Code 28 present on Admission 28 | 1 | A | | 372 | 372 | | Diagnosis Code 28 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 80 | Other Diagnosis Code 29 | 7 | A | | 373 | 379 | | ICD-9-CM/ICD-10-CM Diagnosis Code 29 (Remove embedded decimal pt.) | | |
| 81 | Other Diagnosis Code 29 present on Admission 29 | 1 | A | | 380 | 380 | | Diagnosis Code 29 present on Admission. (Applies **only** to hospital inpatient records. All other record types code "0".) | Y – Yes = Present at the time of inpatient admission<br>N – No = Not present at the time of inpatient admission<br>U – Unknown = Documentation is insufficient to determine if condition is present on admission<br>W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not<br>E – Unreported/Not used = Exempt from POA reporting | |
| 82 | Attending Practitioner Individual National Provider Identifier (NPI) # | 10 | A | | 381 | 390 | 95% | Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner. | The physician responsible for the patient's medical care and treatment. If outpatient or emergency room, this data element refers to the Practitioner treating patient at time of service. | |
| 83 | Operating Practitioner Individual National Provider Identifier (NPI) # | 10 | A | | 391 | 400 | | Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner. | This element identifies the operating physician who performed the surgical procedure. | |
| 84 | Procedure Code Indicator | 1 | A | | 401 | 401 | | Indicates the classification used in assigning codes to procedures. | 1 ICD-9-CM<br>2 ICD-10-PCS<br>3 CPT Code/HCPCS | Changed ICD-10-CM to ICD-10-PCS |
| 85 | Principal Procedure Code 1 | 6 | A | | 402 | 407 | | The principal health care service provided, followed by a secondary procedure (up to 15 codes), if applicable at the time of service. **Remove embedded decimal pt.** | CPT Codes are required on all non-inpatient claims (ER, clinic, outpatient), but will allow ICD-9-CM or ICD-10-CM Codes for inpatient claims. | |
| 86 | Procedure Code 1 Modifier I | 2 | A | | 408 | 409 | | Discriminate code used by practitioners to distinguish that a health care service has been altered [by a specific condition] but not changed in definition or code. A modifier is added as a suffix to a procedure code field. | Modifier applies only to CPT Codes. | |
| 87 | Procedure Code 1 Modifier II | 2 | A | | 410 | 411 | | Specific to Modifier I. | | |
| 88 | Other Procedure Code 2 | 6 | A | | 412 | 417 | | Remove embedded decimal pt. | | |
| 89 | Procedure Code 2 Modifier I | 2 | A | | 418 | 419 | | | Modifier applies only to CPT Codes. | |
| 90 | Procedure Code 2 Modifier II | 2 | A | | 420 | 421 | | | | |
| 91 | Other Procedure Code 3 | 6 | A | | 422 | 427 | | Remove embedded decimal pt. | | |
| 92 | Procedure Code 3 Modifier I | 2 | A | | 428 | 429 | | | Modifier applies only to CPT Codes. | |
| 93 | Procedure Code 3 Modifier II | 2 | A | | 430 | 431 | | | | |
| 94 | Other Procedure Code 4 | 6 | A | | 432 | 437 | | Remove embedded decimal pt. | | |
| 95 | Procedure Code 4 Modifier I | 2 | A | | 438 | 439 | | | Modifier applies only to CPT Codes. | |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 96 | Procedure Code 4 Modifier II | 2 | A | | 440 | 441 | | | | |
| 97 | Other Procedure Code 5 | 6 | A | | 442 | 447 | | Remove embedded decimal pt. | | |
| 98 | Procedure Code 5 Modifier I | 2 | A | | 448 | 449 | | | Modifier applies only to CPT Codes. | |
| 99 | Procedure Code 5 Modifier II | 2 | A | | 450 | 451 | | | | |
| 100 | Other Procedure Code 6 | 6 | A | | 452 | 457 | | Remove embedded decimal pt. | | |
| 101 | Procedure Code 6 Modifier I | 2 | A | | 458 | 459 | | | Modifier applies only to CPT Codes. | |
| 102 | Procedure Code 6 Modifier II | 2 | A | | 460 | 461 | | | | |
| 103 | Other Procedure Code 7 | 6 | A | | 462 | 467 | | Remove embedded decimal pt. | | |
| 104 | Procedure Code 7 Modifier I | 2 | A | | 468 | 469 | | | Modifier applies only to CPT Codes. | |
| 105 | Procedure Code 7 Modifier II | 2 | A | | 470 | 471 | | | | |
| 106 | Other Procedure Code 8 | 6 | A | | 472 | 477 | | Remove embedded decimal pt. | | |
| 107 | Procedure Code 8 Modifier I | 2 | A | | 478 | 479 | | | Modifier applies only to CPT Codes. | |
| 108 | Procedure Code 8 Modifier II | 2 | A | | 480 | 481 | | | | |
| 109 | Other Procedure Code 9 | 6 | A | | 482 | 487 | | Remove embedded decimal pt. | | |
| 110 | Procedure Code 9 Modifier I | 2 | A | | 488 | 489 | | | Modifier applies only to CPT Codes. | |
| 111 | Procedure Code 9 Modifier II | 2 | A | | 490 | 491 | | | | |
| 112 | Other Procedure Code 10 | 6 | A | | 492 | 497 | | Remove embedded decimal pt. | | |
| 113 | Procedure Code 10 Modifier I | 2 | A | | 498 | 499 | | | Modifier applies only to CPT Codes. | |
| 114 | Procedure Code 10 Modifier II | 2 | A | | 500 | 501 | | | | |
| 115 | Other Procedure Code 11 | 6 | A | | 502 | 507 | | Remove embedded decimal pt. | | |
| 116 | Procedure Code 11 Modifier I | 2 | A | | 508 | 509 | | | Modifier applies only to CPT Codes. | |
| 117 | Procedure Code 11 Modifier II | 2 | A | | 510 | 511 | | | | |
| 118 | Other Procedure Code 12 | 6 | A | | 512 | 517 | | Remove embedded decimal pt. | | |
| 119 | Procedure Code 12 Modifier I | 2 | A | | 518 | 519 | | | Modifier applies only to CPT Codes. | |
| 120 | Procedure Code 12 Modifier II | 2 | A | | 520 | 521 | | | | |
| 121 | Other Procedure Code 13 | 6 | A | | 522 | 527 | | Remove embedded decimal pt. | | |
| 122 | Procedure Code 13 Modifier I | 2 | A | | 528 | 529 | | | Modifier applies only to CPT Codes. | |
| 123 | Procedure Code 13 Modifier II | 2 | A | | 530 | 531 | | | | |
| 124 | Other Procedure Code 14 | 6 | A | | 532 | 537 | | Remove embedded decimal pt. | | |
| 125 | Procedure Code 14 Modifier I | 2 | A | | 538 | 539 | | | Modifier applies only to CPT Codes. | |
| 126 | Procedure Code 14 Modifier II | 2 | A | | 540 | 541 | | | | |
| 127 | Other Procedure Code 15 | 6 | A | | 542 | 547 | | Remove embedded decimal pt. | | |
| 128 | Procedure Code 15 Modifier I | 2 | A | | 548 | 549 | | | Modifier applies only to CPT Codes. | |
| 129 | Procedure Code 15 Modifier II | 2 | A | | 550 | 551 | | | | |
| 130 | Diagnosis Related Groups (DRGs) Number | 3 | A | | 552 | 554 | | The inpatient classifications based on diagnosis, procedure, age, gender and discharge disposition. | | |
| 131 | DRG Grouper Name | 1 | A | | 555 | 555 | | The actual DRG Grouper used to produce the DRGs. | 1 All Patient DRGs (AP-DRGs)<br>2 All Patient Refined DRGs (APR-DRGs)<br>3 Centers for Medicare & Medicaid Services DRGs (CMS-DRGs)<br>4 Other Proprietary | |
| 132 | DRG Grouper Version | 2 | A | | 556 | 557 | | Version of DRG Grouper used. | | |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 133 | Billed Charge | 9 | N | | 558 | 566 | 100% | A provider's billed charges rounded to whole dollars.<br>**DO NOT USE DECIMALS** | | Added 100% threshold to all financial fields |
| 134 | Allowed Amount | 9 | N | | 567 | 575 | 100% | Total patient and payor liability.<br>**DO NOT USE DECIMALS** | | Added 100% threshold to all financial fields |
| 135 | Reimbursement Amount | 9 | N | | 576 | 584 | 100% | Amount paid by carrier to Tax ID # of provider as listed on claim.<br>**DO NOT USE DECIMALS** | | Added 100% threshold to all financial fields |
| 136 | Total Patient Deductible | 9 | N | | 585 | 593 | 100% | The fixed amount that the patient must pay for covered medical services/hospital stay before benefits are payable. | | Added 100% threshold to all financial fields |
| 137 | Total Patient Coinsurance or Patient Co-payment | 9 | N | | 594 | 602 | 100% | The specified amount or percentage the patient is required to contribute towards covered medical services/hospital stay after any applicable deductible. | | Added 100% threshold to all financial fields |
| 138 | Total Other Patient Obligations | 9 | N | | 603 | 611 | 100% | Any patient liability other than the deductible or coinsurance/co-payment. This could include obligations for out-of-network care (balance billing net of patient deductible, patient coinsurance/co-payment and payor reimbursement), non-covered services, or penalties.<br>**DO NOT USE DECIMALS** | | Added 100% threshold to all financial fields |
| 139 | Coordination of Benefit Savings or Other Payor Payments | 9 | N | | 612 | 620 | 100% | If you are not the primary insurer, report the amount paid by the primary payor.<br>**DO NOT USE DECIMALS** | | Added 100% threshold to all financial fields, added note to not use decimals |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 140 | Type of Bill | 3 | A | | 621 | 623 | 99% | UB 04 or UB 92 form 3-digit code = Type of Facility + Bill Classification + Frequency | 1 Hospital<br>2 Skilled Nursing<br>3 Home Health<br>4 Christian Science Hospital<br>5 Christian Science Extended Care<br>6 Intermediate Care<br>7 Clinic<br>8 Special Facility<br>**Bill Classification – 2nd Digit if 1st Digit = 1-6**<br>1 Inpatient (including Medicare Part A)<br>2 Inpatient (including Medicare Part B Only)<br>3 Outpatient<br>4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)<br>5 Nursing Facility Level I<br>6 Nursing Facility Level II<br>7 Intermediate Care – Level III Nursing Facility<br>8 Swing Beds<br>**Bill Classification – 2nd Digit if 1st Digit = 7**<br>1 Rural Health<br>2 Hospital-based or Independent Renal Dialysis Center<br>3 Freestanding Outpatient Rehabilitation Facility (ORF)<br>4 Comprehensive Outpatient Rehabilitation Facilities (CORFs)<br>5 Community Mental Health Center<br>9 Other<br>**Bill Classification – 2nd Digit if 1st Digit = 8**<br>1 Hospice (Non-Hospital based)<br>2 Hospice (Hospital-based)<br>3 Ambulatory Surgery Center<br>4 Freestanding Birthing Center<br>9 Other<br>**Frequency – 3rd Digit**<br>1 Admit through Discharge<br>2 Interim – First Claim Used<br>3 Interim – Continuing Claims<br>4 Interim – Last Claim<br>5 Late Charge Only<br>6 Adjustment of Prior Claim | List of options needs to be updated |
| 141 | Patient Covered by Other Insurance Indicator | 1 | A | | 624 | 624 | | Indicates whether patient has additional insurance coverage. | 0 No<br>1 Yes, other coverage is primary<br>2 Yes, other coverage is secondary<br>9 Unknown | |
| 142 | Payor ID Number | 4 | A | | 625 | 628 | 100% | Payor assigned submission identification number. | | |
| 143 | Source System | 1 | A | | 629 | 629 | 100% | Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…)<br><br>Please ensure that the source system letter used is consistent from year to year, as well as with the source system letter indicated on the MCDB Portal. | A – Z. If only submitted for one source system, default is A. | Added threshold of 100%, added note on reporting source system |
| 144 | Revenue Code 1 | 4 | A | | 630 | 633 | 100% | Provide the codes used to identify specific accommodation and/or ancillary charges. | | Changed threshold to 100% from 95% |
| 145 | Other Revenue Code 2 | 4 | A | | 634 | 637 | | | | |
| 146 | Other Revenue Code 3 | 4 | A | | 638 | 641 | | | | |
| 147 | Other Revenue Code 4 | 4 | A | | 642 | 645 | | | | |
| 148 | Other Revenue Code 5 | 4 | A | | 646 | 649 | | | | |

| | Field Name | Length | Type A=alphanumeric N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 149 | Other Revenue Code 6 | 4 | A | | 650 | 653 | | | | |
| 150 | Other Revenue Code 7 | 4 | A | | 654 | 657 | | | | |
| 151 | Other Revenue Code 8 | 4 | A | | 658 | 661 | | | | |
| 152 | Other Revenue Code 9 | 4 | A | | 662 | 665 | | | | |
| 153 | Other Revenue Code 10 | 4 | A | | 666 | 669 | | | | |
| 154 | Other Revenue Code 11 | 4 | A | | 670 | 673 | | | | |
| 155 | Other Revenue Code 12 | 4 | A | | 674 | 677 | | | | |
| 156 | Other Revenue Code 13 | 4 | A | | 678 | 681 | | | | |
| 157 | Other Revenue Code 14 | 4 | A | | 682 | 685 | | | | |
| 158 | Other Revenue Code 15 | 4 | A | | 686 | 689 | | | | |
| 159 | Other Revenue Code 16 | 4 | A | | 690 | 693 | | | | |
| 160 | Other Revenue Code 17 | 4 | A | | 694 | 697 | | | | |
| 161 | Other Revenue Code 18 | 4 | A | | 698 | 701 | | | | |
| 162 | Other Revenue Code 19 | 4 | A | | 702 | 705 | | | | |
| 163 | Other Revenue Code 20 | 4 | A | | 706 | 709 | | | | |
| 164 | Other Revenue Code 21 | 4 | A | | 710 | 713 | | | | |
| 165 | Other Revenue Code 22 | 4 | A | | 714 | 717 | | | | |
| 166 | Other Revenue Code 23 | 4 | A | | 718 | 721 | | | | Changed character type from numeric to alphanumeric |
| 167 | Reporting Quarter | 1 | A | | 722 | 722 | 100% | Indicate the quarter number for which the data is being submitted. | 1 First Quarter = January 1 thru March 31<br>2 Second Quarter = April 1 thru June 30<br>3 Third Quarter = July 1 thru September 30<br>4 Fourth Quarter = October 1 thru December 31 | Added threshold of 100% |
| 168 | Claim Adjudication Date(CCYYMMDD) New! | 8 | N | | 723 | 730 | 100% | The date that the claim was adjudicated. | CCYYMMDD | Added field |
| 169 | Claim Line Number New! | 4 | A | | 731 | 734 | 100% | Line number for the service within a claim. | The first line is 1 and subsequent lines are incremented by 1 | Added field |
| 170 | Version Number New! | 4 | A | | 735 | 738 | 100% | Version number of this claim service line. The version number begins with 1 and is incremented by 1 for each subsequent version of that service line | | Added field |
| 171 | Claim Line Type New! | 1 | A | | 739 | 739 | 100% | Code Indicating Type of Record. Example: Original, Void, Replacement, Back Out, Amendment | O Original<br>V Void<br>R Replacement<br>B Back Out<br>A Amendement | Added field |
| 172 | Former Claim Number New! | 23 | A | | 740 | 762 | 100% | Former claims control number or claims control number used in the original claim that corresponds to this claim line. | Must be different to the claims control number reported under field # 13 | Added field |

** If the Date of Discharge or End of Service (data element #20) is not reported, then assume that the Date of*

**DENTAL SERVICES DATA REPORT SUBMISSION**

This report details all dental health care services provided to your enrollees for the reporting period designated – First Quarter: Claims paid from January 1, 2015 through March 31, 2015; Second Quarter: Claims paid from April 1, 2015 through June 30, 2015; Third Quarter: Claims paid from July 1, 2015 through September 30, 2015; Fourth Quarter: Claims paid from October 1, 2015 through December 31, 2015.

Please provide information on all dental services provided to Maryland residents whether those services were provided by a practitioner or office facility located in-State or out-of-State.

*(Reminder: **Patient Liability** is calculated using these three financial fields: **Patient Deductible, Patient Coinsurance/Co-payment,** and **Other Patient Obligations**. Total Patient Liability **should equal the sum** of Patient Deductible + Patient Coinsurance/Co-payment + Other Patient Obligations.)*

Please note that the layout below is for formatting a flat file. The MCDB Portal will accept files delimited by a pipe (|) or a comma (,).

| | Field Name | Length | Type A=alphanumeric N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Record Identifier | 1 | A | | 1 | 1 | 100% | The value is 6 | **6 Dental Services** | |
| 2 | Patient IdentifierP (payor encrypted) | 12 | A | | 2 | 13 | 100% | Patient's unique identification number assigned by payor and encrypted. | The unique ID for each person on this file should correspond to the same unique Patient ID used for all other files (Eligibility, Professional Services, Pharmacy Claims, and Institutional Services Files) | |
| 3 | Patient Identifier**U** (UUID encrypted) | 12 | A | | 14 | 25 | 100% | Patient's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC. | Refer to the UUID summary description sheet in the data submission manual. A full description is available in the UUID Users' Manual.<br><br>Leave UUID blank if it is not generated by the UUID software | Added threshold of 100%, added note to leave blank if not generated by UUID software |
| 4 | Patient Year and Month of Birth (CCYYMM00) | 8 | N | | 26 | 33 | 100% | Date of patient's birth using 00 instead of day. | CCYYMM00 | Changed to one threshold of 100% from three thresholds of 99%/99%/100% |
| 5 | Patient Sex | 1 | A | | 34 | 34 | 99% | Sex of the patient. | 1 Male<br>2 Female | Removed option 3, "Unknown" |
| 6 | Patient Zip Code+4digit add-on code (include hyphen) | 10 | A | | 35 | 44 | 99% | Zip code of patient's residence. | 5-digit US Postal Service code plus 4-digit add-on code. Report '0000' if +4-digit is missing | Added note for reporting missing 4-digit add-on code |
| 7 | Patient Covered by Other Insurance Indicator | 1 | A | | 45 | 45 | 95% | Indicates whether patient has additional insurance coverage. | 0 No<br>1 Yes, other coverage is primary<br>2 Yes, other coverage is secondary<br>9 Unknown | |
| 8 | Coverage Type | 1 | A | | 46 | 46 | | Patient's type of insurance coverage. | 1 Medicare Supplemental (i.e., Individual, Group, WRAP)<br>2 Medicare Advantage Plan<br>3 Individual Market (not MHIP; not sold in MHBE)<br>4 Maryland Health Insurance Plan (MHIP)<br>5 Private Employer Sponsored or Other Group (i.e. union or association plans)<br>6 Public Employee – Federal (FEHBP)<br>7 Public Employee – Other (state, county, local/municipal government and public school systems)<br>8 Comprehensive Standard Health Benefit Plan (not sold in MHBE) [a self-employed individual or small businesses (public or private employers) with 2-50 eligible employees]<br>9 Health Insurance Partnership (HIP)<br>A Student Health Plan<br>B Individual Market sold in MHBE<br>C Small Business Options Program (SHOP) sold in MHBE<br>Z Unknown | Removed threshold, collected in eligibility file |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 9 | Source Company | 1 | A | | 47 | 47 | | Defines the payor company that holds the beneficiary's contract; for use in characterizing contract requirements under Maryland law. | 1 Health Maintenance Organization<br>2 Life & Health Insurance Company or Not-for-Profit Health Benefit Plan<br>3 Third-Party Administrator (TPA) Unit | Removed threshold, collected in eligibility file |
| 10 | Claim Related Condition | 1 | A | | 48 | 48 | | Describes connection, if any, between patient's condition and employment, automobile accident, or other accident. | 0 Non-accident (default)<br>1 Work<br>2 Auto Accident<br>3 Other Accident<br>9 Unknown | |
| 11 | Practitioner Federal Tax ID (TIN) | 9 | A | | 49 | 57 | 100% | Employer Tax ID of the practitioner, practice or office facility receiving payment for services. | | |
| 12 | Participating Provider Flag | 1 | N | | 58 | 58 | 95% | Indicates if the service was provided by a provider that participates in the payor's network. | 1 Participating<br>2 Non-Participating<br>3 Unknown/Not Coded<br>9 No Network for this Plan | |
| 13 | Record Status | 1 | A | | 59 | 59 | 95% | Describes payment and adjustment status of a claim. Adjustments include paying a claim more than once, paying additional services that may have been denied, or crediting a provider due to overpayment or paying the wrong provider. | 1 Final Bill<br>8 Capitated or Global Contract Services | |
| 14 | Claim Control Number<br>(Include on each record as this is the key to summarizing service detail to claim level) | 23 | A | | 60 | 82 | 100% | Internal payor claim number used for tracking. | | Changed threshold to 100% from 95%, credit no longer needs to have the same claim number as the original debit record |
| 15 | Claim Paid Date (CCYYMMDD) | 8 | N | | 83 | 90 | 100% | The date that the claim was paid. This date should agree with the paid date the Finance and Actuarial department is using in your organization | CCYYMMDD | Changed description to include instructions on determining claim paid date. |
| 16 | Filler | 2 | | | 91 | 92 | | Filler | Used to be Number of Line Items | |
| 17 | Service From Date (CCYYMMDD) | 8 | N | | 93 | 100 | 100% | First date of service for a procedure in this line item. | CCYYMMDD | |
| 18 | Service Thru Date* (CCYYMMDD) | 8 | N | | 101 | 108 | 100%* | Last date of service for this line item. | CCYYMMDD | |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 19 | Place of Service | 2 | A | | 109 | 110 | 99% | Two-digit numeric code that describes where a service was rendered. | 11 Provider's Office<br>12 Patient's Home<br>13 Assisted Living Facility<br>17 Walk-in Retail Health Clinic<br>18 Place of Employment - Worksite<br>20 Urgent Care Facility<br>21 Inpatient Hospital<br>22 Outpatient Hospital<br>23 Emergency Room – Hospital<br>24 Ambulatory Surgical Center<br>25 Birthing Center<br>26 Military Treatment Facility<br>31 Skilled Nursing Facility<br>32 Nursing Facility<br>33 Custodial Care Facility<br>34 Hospice<br>41 Ambulance – Land<br>42 Ambulance – Air or Water<br>51 Inpatient Psychiatric Facility<br>52 Psychiatric Facility – Partial Hospitalization<br>53 Community Mental Health Center<br>54 Intermediate Care Facility/Mentally Retarded<br>55 Residential Substance Abuse Treatment Facility<br>56 Psychiatric Residential Treatment Center<br>57 Non-residential Substance Abuse Treatment Facility<br>60 Mass Immunization Center<br>61 Comprehensive Inpatient Rehabilitation Facility<br>62 Comprehensive Outpatient Rehabilitation Facility<br>65 End-Stage Renal Disease Treatment Facility<br>71 State or Local Public Health Clinic<br>72 Rural Health Clinic<br>81 Independent Laboratory & Imaging | |
| 20 | Service Location Zip Code +4digit add-on code (include hyphen) | 10 | A | | 111 | 120 | 95% | Zip code for location where service described was provided. | 5-digit US Postal Service code plus 4-digit add-on code. Report '0000' if +4-digit is missing | Added note for reporting missing 4-digit add-on code |
| 21 | Procedure Code (CDT) (Current Dental Terminology) | 5 | A | | 121 | 125 | 95% | Describes the health care service provided (i.e., CDT). | | |
| 22 | Servicing Practitioner ID | 11 | A | | 126 | 136 | 100% | Payor-specific identifier for the practitioner rendering health care service(s). | | |
| 23 | Billed Charge | 9 | N | | 137 | 145 | 100% | A practitioner's billed charges rounded to whole dollars. **DO NOT USE DECIMALS** | | Added 100% threshold to all financial fields |
| 24 | Allowed Amount | 9 | N | | 146 | 154 | 100% | Total patient and payor liability. DO NOT USE DECIMALS | | Added 100% threshold to all financial fields |
| 25 | Reimbursement Amount | 9 | N | | 155 | 163 | 100% | Amount paid to Employer Tax ID # of rendering physician as listed on claim. **DO NOT USE DECIMALS** | | Added 100% threshold to all financial fields |
| 26 | Date of Enrollment | 8 | N | | 164 | 171 | | The start date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 81) | CCYYMMDD<br>Date is the first day of the reporting period if patient is enrolled at that time. Enter other date if patient **not enrolled** at start of reporting period, but enrolled during reporting period. | Removed threshold, collected in eligibility file |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 27 | Date of Disenrollment | 8 | N | | 172 | 179 | | The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 81) | CCYYMMDD<br>If patient is still enrolled on the last day of the reporting period, enter 20991231. If patient disenrolled before end of reporting period enter date disenrolled. | Removed threshold, collected in eligibility file |
| 28 | Patient Deductible | 9 | N | | 180 | 188 | 100% | The fixed amount that the patient must pay for covered medical services before benefits are payable. **DO NOT USE DECIMALS** | | Added 100% threshold to all financial fields |
| 29 | Patient Coinsurance or Patient Co-payment | 9 | N | | 189 | 197 | 100% | The specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible. **DO NOT USE DECIMALS** | | Added 100% threshold to all financial fields |
| 30 | Other Patient Obligations | 9 | N | | 198 | 206 | 100% | Any patient obligations other than the deductible or coinsurance/co-payment. This could include obligations for out-of-network care (balance billing net of patient deductible, patient coinsurance/co-payment and payor reimbursement), non-covered services, or penalties. DO NOT USE DECIMALS | | Added 100% threshold to all financial fields |
| 31 | Servicing Practitioner Individual National Provider Identifier (NPI) number | 10 | A | | 207 | 216 | 100% | Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner. | Ten (10) digits<br>www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf | Changed threshold to 100% from 95% |
| 32 | Practitioner National Provider Identifier (NPI) number used for Billing | 10 | A | | 217 | 226 | 100% | Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner or an organization for billing purposes. | Ten (10) digits<br>www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf | Changed threshold to 100% from 95% |
| 33 | Product Type | 1 | A | | 227 | 227 | | Classifies the benefit plan by key product characteristics (scope of coverage, size of network, coverage for out-of-network benefits).<br><br>(Please code based on how the product is primarily marketed, and most importantly be consistent from year to year. If not sure, send an e-mail describing the product to Larry Monroe at larry.monroe@maryland.gov.) | 1 Exclusive Provider Organization (in any form)<br>2 Health Maintenance Organization<br>3 Indemnity<br>4 Point of Service (POS)<br>5 Preferred Provider Organization (PPO)<br>6 Limited Benefit Plan (Mini-Meds)<br>7 Student Health Plan<br>8 Catastrophic | Removed threshold, collected in eligibility file. Added note that SSS will populate with eligibility, payors do not need to submit it. |
| 34 | Payor ID Number | 4 | A | | 228 | 231 | 100% | Payor assigned submission identification number. | | |
| 35 | Source System | 1 | A | | 232 | 232 | 100% | Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…)<br><br>Please ensure that the source system letter used is consistent from year to year, as well as with the source system letter indicated on the MCDB Portal. | A – Z. If only submitted for one source system, default is A. | Added threshold of 100%, added note on reporting source system |
| 36 | Encrypted Contract or Group Number (payor encrypted) | 20 | A | | 233 | 252 | | Payor assigned contract or group number for the plan sponsor using an encryption algorithm generated by the payor. | This number should be the same for all family members on the same plan. | Removed threshold |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 37 | Relationship to Policyholder | 1 | A | | 253 | 253 | | Member's relationship to subscriber/insured. | 2 Spouse<br>3 Child<br>4 Other Dependent<br>5 Other Adult<br>9 Unknown | Removed threshold |
| 38 | Tooth Number/Letter – 1 | 2 | A | | 254 | 255 | | Report the tooth identifier(s) when Current Dental Terminology Code is within given range. | Up to four (4) Tooth Number/Letter fields can be entered. | |
| 39 | Tooth – 1 Surface – 1 | 5 | A | | 256 | 260 | | Report the tooth surface(s) that this service relates to. Provides further detail on procedure(s). Required when Tooth Number/Letter is populated. | Up to six (6) Tooth Surface fields can be entered for each Tooth Number/Letter entry. | |
| 40 | Tooth – 1 Surface – 2 | 5 | A | | 261 | 265 | | | | |
| 41 | Tooth – 1 Surface – 3 | 5 | A | | 266 | 270 | | | | |
| 42 | Tooth – 1 Surface – 4 | 5 | A | | 271 | 275 | | | | |
| 43 | Tooth – 1 Surface – 5 | 5 | A | | 276 | 280 | | | | |
| 44 | Tooth – 1 Surface – 6 | 5 | A | | 281 | 285 | | | | |
| 45 | Tooth Number/Letter – 2 | 2 | A | | 286 | 287 | | Report the tooth identifier(s) when Current Dental Terminology Code is within given range. | Up to four (4) Tooth Number/Letter fields can be entered. | |
| 46 | Tooth – 2 Surface – 1 | 5 | A | | 288 | 292 | | Report the tooth surface(s) that this service relates to. Provides further detail on procedure(s). Required when Tooth Number/Letter is populated. | Up to six (6) Tooth Surface fields can be entered for each Tooth Number/Letter entry. | |
| 47 | Tooth – 2 Surface – 2 | 5 | A | | 293 | 297 | | | | |
| 48 | Tooth – 2 Surface – 3 | 5 | A | | 298 | 302 | | | | |
| 49 | Tooth – 2 Surface – 4 | 5 | A | | 303 | 307 | | | | |
| 50 | Tooth – 2 Surface – 5 | 5 | A | | 308 | 312 | | | | |
| 51 | Tooth – 2 Surface – 6 | 5 | A | | 313 | 317 | | | | |
| 52 | Tooth Number/Letter – 3 | 2 | A | | 318 | 319 | | Report the tooth identifier(s) when Current Dental Terminology Code is within given range. | Up to four (4) Tooth Number/Letter fields can be entered. | |
| 53 | Tooth – 3 Surface – 1 | 5 | A | | 320 | 324 | | Report the tooth surface(s) that this service relates to. Provides further detail on procedure(s). Required when Tooth Number/Letter is populated. | Up to six (6) Tooth Surface fields can be entered for each Tooth Number/Letter entry. | |
| 54 | Tooth – 3 Surface – 2 | 5 | A | | 325 | 329 | | | | |
| 55 | Tooth – 3 Surface – 3 | 5 | A | | 330 | 334 | | | | |
| 56 | Tooth – 3 Surface – 4 | 5 | A | | 335 | 339 | | | | |
| 57 | Tooth – 3 Surface – 5 | 5 | A | | 340 | 344 | | | | |
| 58 | Tooth – 3 Surface – 6 | 5 | A | | 345 | 349 | | | | |
| 59 | Tooth Number/Letter – 4 | 2 | A | | 350 | 351 | | Report the tooth identifier(s) when Current Dental Terminology Code is within given range. | Up to four (4) Tooth Number/Letter fields can be entered. | |
| 60 | Tooth – 4 Surface – 1 | 5 | A | | 352 | 356 | | Report the tooth surface(s) that this service relates to. Provides further detail on procedure(s). Required when Tooth Number/Letter is populated. | Up to six (6) Tooth Surface fields can be entered for each Tooth Number/Letter entry. | |
| 61 | Tooth – 4 Surface – 2 | 5 | A | | 357 | 361 | | | | |
| 62 | Tooth – 4 Surface – 3 | 5 | A | | 362 | 366 | | | | |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 63 | Tooth – 4 Surface – 4 | 5 | A | | 367 | 371 | | | | |
| 64 | Tooth – 4 Surface – 5 | 5 | A | | 372 | 376 | | | | |
| 65 | Tooth – 4 Surface – 6 | 5 | A | | 377 | 381 | | | | |
| 66 | Dental Quadrant – 1 | 2 | A | | 382 | 383 | | Report the standard quadrant identifier when CDT indicates procedures of 3 or more consecutive teeth. Provides further detail on procedure(s). | Up to four (4) Dental Quadrant fields can be entered. | |
| 67 | Dental Quadrant – 2 | 2 | A | | 384 | 385 | | | | |
| 68 | Dental Quadrant – 3 | 2 | A | | 386 | 387 | | | | |
| 69 | Dental Quadrant – 4 | 2 | A | | 388 | 389 | | | | |
| 70 | Orthodontics Treatment | 1 | A | | 390 | 390 | | Indicate if the treatment is for Orthodontics. | 0 No<br>1 Yes | |
| 71 | Date Appliance Placed (CCYYMMDD) | 8 | N | | 391 | 398 | | If treatment is for Orthodontics, then provide the date the appliance was placed. | CCYYMMDD | |
| 72 | Months of Treatment Remaining | 2 | N | | 399 | 400 | | If treatment is for Orthodontics, then provide the number of months of treatment remaining. | Number of months remaining for treatment. | |
| 73 | Prosthesis Replacement | 1 | A | | 401 | 401 | | Indicate if the treatment is for the replacement of Prosthesis. | 0 No<br>1 Yes | Changed character type from numeric to alphanumeric |
| 74 | Date of Prior Placement (CCYYMMDD) | 8 | N | | 402 | 409 | | If treatment is for replacement of Prosthesis, then provide the prior date of Prosthesis placement. | CCYYMMDD | |
| 75 | Reporting Quarter | 1 | A | | 410 | 410 | 100% | Indicate the quarter number for which the data is being submitted. | 1 First Quarter = January 1 thru March 31<br>2 Second Quarter = April 1 thru June 30<br>3 Third Quarter = July 1 thru September 30<br>4 Fourth Quarter = October 1 thru December 31 | Added threshold of 100% |
| 76 | Claim Adjudication Date(CCYYMMDD) New! | 8 | N | | 411 | 418 | 100% | The date that the claim was adjudicated. | CCYYMMDD | Added field |
| 77 | Claim Line Number New! | 4 | A | | 419 | 422 | 100% | Line number for the service within a claim. | The first line is 1 and subsequent lines are incremented by 1 | Added field |
| 78 | Version Number New! | 4 | A | | 423 | 426 | 100% | Version number of this claim service line. The version number begins with 1 and is incremented by 1 for each subsequent version of that service line | | Added field |
| 79 | Claim Line Type New! | 1 | A | | 427 | 427 | 100% | Code Indicating Type of Record. Example: Original, Void, Replacement, Back Out, Amendment | O Original<br>V Void<br>R Replacement<br>B Back Out<br>A Amendement | Added field |
| 80 | Former Claim Number New! | 23 | A | | 428 | 450 | 100% | Former claims control number or claims control number used in the original claim that corresponds to this claim line. | Must be different to the claims control number reported under field # 14 | Added field |

**ELIGIBILITY DATA REPORT SUBMISSION**

This report details information on the characteristics of all enrollees covered for medical services under the plan for the quarterly reporting period designated – First Quarter: Claims paid from January 1, 2015 through March 31, 2015; Second Quarter: Claims paid from April 1, 2015 through June 30, 2015; Third Quarter: Claims paid from July 1, 2015 through September 30, 2015; and Fourth Quarter: Claims paid from October 1, 2015 through December 31, 2015. Please provide an entry for each month that the enrollee was covered by a general health benefit plan regardless of whether or not the enrollee received any covered services during the reporting year.

*(For example, an enrollee with 3 months of coverage will have 3 eligibility records; an enrollee with 2 months of coverage will only have 2 records.)*

Please note that the layout below is for formatting a flat file. The MCDB Portal will accept files delimited by a pipe (|) or a comma (,).

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Record Identifier | 1 | A | | 1 | 1 | 100% | The value is 5 | **5 Eligibility** | |
| 2 | Encrypted Enrollee's Identifier**P**<br>(payor encrypted) | 12 | A | | 2 | 13 | 100% | Enrollee's unique identification number assigned by payor and encrypted. | The unique ID for each person on this file would correspond to the same unique Patient/Enrollee ID used for all other files (Professional Services, Pharmacy Claims, Institutional Services, and Dental Services Files). | |
| 3 | Encrypted Enrollee's Identifier**U**<br>(UUID encrypted) | 12 | A | | 14 | 25 | 100%* | Enrollee's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC. | Refer to the UUID summary description sheet in the data submission manual. A full description is available in the UUID Users' Manual.<br><br>Leave UUID blank if it is not generated by the UUID software | Added threshold of 100%, added note to leave blank if not generated by UUID software |
| 4 | Enrollee Year and Month of Birth (CCYYMM00) | 8 | N | | 26 | 33 | 100% | Date of enrollee's birth using 00 instead of day. | CCYYMM00 | Changed to one threshold of 100% from three thresholds of 99%/99%/100% |
| 5 | Enrollee Sex | 1 | A | | 34 | 34 | 99% | Sex of the enrollee. | 1 Male<br>2 Female | Removed option 3, "Unknown" |
| 6 | Enrollee Zip Code of Residence +4digit add-on code (include hyphen) | 10 | A | | 35 | 44 | 99% | Zip code of enrollee's residence. | 5-digit US Postal Service code plus 4-digit add-on code. Report '0000' if +4-digit is missing | Added note for reporting missing 4-digit add-on code |
| 7 | Enrollee County of Residence | 3 | A | | 45 | 47 | | County of enrollee's residence. If known, please provide. If not known, MHCC will arbitrarily assign using Zip code of residence. | 001 Allegany<br>003 Anne Arundel<br>005 Baltimore County<br>009 Calvert<br>011 Caroline<br>013 Carroll<br>015 Cecil<br>017 Charles<br>019 Dorchester<br>021 Frederick<br>023 Garrett<br>025 Harford<br>027 Howard<br>029 Kent<br>031 Montgomery<br>033 Prince George's<br>035 Queen Anne's<br>037 St. Mary's<br>039 Somerset<br>041 Talbot<br>043 Washington<br>045 Wicomico<br>047 Worcester<br>510 Baltimore City<br>999 Unknown | Removed threshold, can be derived from zip code |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 8 | Source of Direct Reporting of Enrollee Race | 1 | A | | 48 | 48 | 95% | Indicate the source of direct reporting of enrollee race. | 1 Enrollee reported to payor<br>2 Enrollee reported to another source<br>9 Missing/Unknown/Not specified | |
| 9 | Race Category White – Direct | 1 | A | | 49 | 49 | | Enter whether the self-defined race of the enrollee is White or Caucasian. White is defined as a person having lineage in any of the original peoples of Europe, the Middle East, or North Africa. | 0 No<br>1 Yes | |
| 10 | Race Category Black or African American – Direct | 1 | A | | 50 | 50 | | Enter whether the self-defined race of the enrollee is Black or African American. Black or African American is defined as a person having lineage in any of the Black racial groups of Africa. | 0 No<br>1 Yes | |
| 11 | Race Category American Indian or Alaska Native – Direct | 1 | A | | 51 | 51 | | Enter whether the self-defined race of the enrollee is American Indian or Alaska Native. American Indian or Alaska Native is defined as a person having lineage in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment. | 0 No<br>1 Yes | |
| 12 | Race Category Asian – Direct | 1 | A | | 52 | 52 | | Enter whether the self-defined race of the enrollee is Asian. Asian is defined as a person having lineage in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. | 0 No<br>1 Yes | |
| 13 | Race Category Native Hawaiian or Pacific Islander – Direct | 1 | A | | 53 | 53 | | Enter whether the self-defined race of the enrollee is Native Hawaiian or Other Pacific Islander. Native Hawaiian or Other Pacific Islander is defined as a person having lineage in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. | 0 No<br>1 Yes | |
| 14 | Race Category Other – Direct | 1 | A | | 54 | 54 | | Enter whether the self-defined race of the enrollee is Other. | 0 No<br>1 Yes | |
| 15 | Race Category Declined to Answer – Direct | 1 | A | | 55 | 55 | | Enter whether the enrollee declined to disclose their race. | 0 No<br>1 Yes | |
| 16 | Race Category Unknown or Cannot be Determined – Direct | 1 | A | | 56 | 56 | | Enter whether the race of the enrollee is unknown or cannot be determined. | 0 No<br>1 Yes | |
| 17 | Imputed Race with Highest Probability | 1 | A | | 57 | 57 | 95% | Race of enrollee. | 1 American Indian or Alaska Native<br>2 Asian<br>3 Black or African American<br>4 Native Hawaiian or Other Pacific Islander<br>5 White/Caucasian<br>6 Some Other Race<br>9 Missing/Unknown/Not specified | |
| 18 | Probability of Imputed Race Assignment | 3 | A | | 58 | 60 | 95% | Specify the probability of race assignment; probability used in race determination. | Percentage | |
| 19 | Source of Direct Reporting of Enrollee Ethnicity | 1 | A | | 61 | 61 | 95% | Indicate source of reporting enrollee ethnicity. | 1 Enrollee reported to payor<br>2 Enrollee reported to another source<br>9 Missing/Unknown/Not specified | |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 20 | Enrollee OMB Hispanic Ethnicity | 1 | A | | 62 | 62 | | Ethnicity of enrollee. | 1 Hispanic or Latino or Spanish origin<br>2 Not Hispanic or Latino or Not of Spanish origin<br>9 Missing/Unknown/Not specified | |
| 21 | Imputed Ethnicity with Highest Probability | 1 | A | | 63 | 63 | 95% | Enter the Ethnicity of the enrollee. | 1 Hispanic or Latino or Spanish origin<br>2 Not Hispanic or Latino or Not of Spanish origin<br>7 Declined to Answer<br>9 Missing/Unknown/Not specified | |
| 22 | Probability of Imputed Ethnicity Assignment | 3 | A | | 64 | 66 | 95% | Specify the probability of ethnicity assignment; probability used in ethnicity determination. | Percentage | |
| 23 | Enrollee Preferred Spoken Language for a Healthcare Encounter | 2 | A | | 67 | 68 | | A locally relevant list of languages has been developed by the Commission. | 01 English<br>02 Albanian<br>03 Amharic<br>04 Arabic<br>05 Burmese<br>06 Cantonese<br>07 Chinese (simplified & traditional)<br>08 Creole (Haitian)<br>09 Farsi<br>10 French (European)<br>11 Greek<br>12 Gujarati<br>13 Hindi<br>14 Italian<br>15 Korean<br>16 Mandarin<br>17 Portuguese (Brazilian)<br>18 Russian<br>19 Serbian<br>20 Somali<br>21 Spanish (Latin America)<br>22 Tagalog (Pilipino)<br>23 Urdu<br>24 Vietnamese<br>99 Other and unspecified | |
| 24 | Coverage Type | 1 | A | | 69 | 69 | 99% | Enrollee's type of insurance coverage. | 1 Medicare Supplemental (i.e., Individual, Group, WRAP)<br>2 Medicare Advantage Plan<br>3 Individual Market (not MHIP; not sold in MHBE)<br>4 Maryland Health Insurance Plan (MHIP)<br>5 Private Employer Sponsored or Other Group (i.e. union or association plans)<br>6 Public Employee – Federal (FEHBP)<br>7 Public Employee – Other (state, county, local/municipal government and public school systems)<br>8 Comprehensive Standard Health Benefit Plan (not sold in MHBE) [a self employed individual or small businesses (public or private employers) with 2-50 eligible employees]<br>9 Health Insurance Partnership (HIP)<br>A Student Health Plan<br>B Individual Market (sold in MHBE)<br>C Small Business Options Program (SHOP) sold in MHBE<br>Z Unknown | |

| | Field Name | Length | Type A=alphanumeric N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 25 | Source Company | 1 | A | | 70 | 70 | 99% | Defines the payor company that holds the beneficiary's contract; for use in characterizing contract requirements under Maryland law. | 1 Health Maintenance Organization<br>2 Life & Health Insurance Company or Not-for-Profit Health Benefit Plan<br>3 Third-Party Administrator (TPA) Unit | |
| 26 | Product Type | 1 | A | | 71 | 71 | 95% | Classifies the benefit plan by key product characteristics (scope of coverage, size of network, coverage for out-of-network benefits). | 1 Exclusive Provider Organization (in any form)<br>2 Health Maintenance Organization<br>3 Indemnity<br>4 Point of Service (POS)<br>5 Preferred Provider Organization (PPO)<br>6 Limited Benefit Plan (Mini-Meds)<br>7 Student Health Plan<br>8 Catastrophic | |
| 27 | Policy Type | 1 | A | | 72 | 72 | 95% | Type of policy. | 1 Individual<br>2 Any combination of two or more persons | |
| 28 | Encrypted Contract or Group Number (payor encrypted) | 20 | A | | 73 | 92 | 95% | Payor assigned contract or group number for the plan sponsor using an encryption algorithm generated by the payor. | This number should be the same for all family members on the same plan. | |
| 29 | Employer Federal Tax ID Number | 9 | A | | 93 | 101 | 100% | Employer Federal Tax ID number will be encrypted by the database contractor in such a way that an employer will have the same encrypted ID across all payor records and the same employer has the same encrypted number from year to year. | Threshold does not apply to individual market plans. | Changed threshold to 100% from 95%, added note: Threshold doesn't apply for individual market plans |
| 30 | Medical Services Indicator | 1 | A | | 102 | 102 | 95% | Medical Coverage | 0 No<br>1 Yes | |
| 31 | Pharmacy Services Indicator | 1 | A | | 103 | 103 | 95% | Prescription Drug Coverage | 0 No<br>1 Yes | |
| 32 | Behavioral Health Services Indicator | 1 | A | | 104 | 104 | 95% | Behavioral Health Services Coverage | 0 No<br>1 Yes | |
| 33 | Dental Services Indicator | 1 | A | | 105 | 105 | 95% | Dental Coverage | 0 No<br>1 Yes | |
| 34 | Plan Liability | 1 | A | | 106 | 106 | 100% | Indicates if insurer is at risk for the patient's service use or the insurer is simply paying claims as an ASO. | 1 Risk (under Maryland contract)<br>2 Risk (under non-Maryland contract)<br>3 ASO (employer self-insured, under Maryland contract)<br>4 ASO (employer self-insured, under non-Maryland Contract | Changed threshold to 100% from 95%, added Maryland and Non-Maryland options to ASO |
| 35 | Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator | 1 | A | | 107 | 107 | 100% | Consumer Directed Health Plan (CDHP) with Health Savings Account (HSA) or Health Resources Account (HRA). | 0 No<br>1 Yes | Changed threshold to 100% from 95% |
| 36 | Start Date of Coverage (in the month CCYYMMDD) | 8 | N | | 108 | 115 | 100% | The start date for benefits in the month (for example, if the enrollee was insured at the start of the month of January in 2014, the start date is 20140101) | CCYYMMDD | Changed threshold to 100% from 95% |
| 37 | End Date of Coverage (in the month CCYYMMDD) | 8 | N | | 116 | 123 | 100% | The end date for benefits in the month (for example, if the enrollee was insured for the entire month of January in 2014, the end date is 20140131) | CCYYMMDD | Changed threshold to 100% from 95% |
| 38 | Date of FIRST Enrollment ** | 8 | N | | 124 | 131 | 100% | The date of that the patient was initially enrolled in the plan. | CCYYMMDD | Changed threshold to 100% from 99% |
| 39 | Date of Disenrollment | 8 | N | | 132 | 139 | 100% | The end date of enrollment for the patient in this delivery system (in this data submission time period).<br>(see Source Company on page 72) | CCYYMMDD<br>If patient is still enrolled on the last day of the reporting period, enter 20991231. If patient disenrolled before end of reporting period enter date disenrolled. | Changed threshold to 100% from 99% |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 40 | Coverage Period End Date | 8 | N | | 140 | 147 | 100% | Contract renewal date, after which benefits, such as deductibles and out of pocket maximums reset. | CCYYMMDD | Added threshold of 100% |
| 41 | Relationship to Policyholder | 1 | A | | 148 | 148 | 100% | Member's relationship to subscriber/insured. | 1 Self/employee<br>2 Spouse<br>3 Child<br>4 Other Dependent<br>5 Other Adult<br>9 Unknown | Changed threshold to 100% from 95% |
| 42 | Payor ID Number | 4 | A | | 149 | 152 | 100% | Payor assigned submission identification number. | | |
| 43 | Source System | 1 | A | | 153 | 153 | 100% | Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…)<br><br>Please ensure that the source system letter used is consistent from year to year, as well as with the source system letter indicated on the MCDB Portal | A – Z. If only submitted for one source system, default is A. | Added threshold of 100%, added note on reporting source system |
| 44 | Grandfathered Plan Indicator | 1 | A | | 154 | 154 | 100% | **Indicate if the plan qualifies as a "Grandfathered or Transitional Plan" under the Affordable Care Act (ACA).** | 1 Grandfathered<br>2 Non-Grandfathered<br>3 Transitional<br>4 Not Applicable | Added threshold of 100% |
| 45 | Plan or Product ID Number | 20 | A | | 155 | 174 | 100% | Payor ID number associated with an enrollee's coverage and benefits in the claim adjudication system. | | Added threshold of 100% |
| 46 | Subscriber ID Number | 20 | A | | 175 | 194 | 100% | Subscriber ID number associated with individual or family enrollment. | Encrypt the same as PatientIDP, consistently with PatientIDP:<br><br>The unique ID for each person on this file would correspond to the same unique Patient/Enrollee ID used for all other files (Professional Services, Pharmacy Claims, and Institutional Services Files) | Added threshold of 100%, added explanation for encrypting Subscriber ID |
| 47 | Health Insurance Oversight System (HIOS) Number | 20 | A | | 195 | 214 | 100%* | HIOS ID number supplied by the federal government. | Only required for individual and small group market payors. | Added threshold of 100%, only applicable to individual and small group market payors |
| 48 | Master Patient Index (MPI) | 40 | A | | 215 | 254 | 100% | **Indicates the unique patient identifier assigned by Maryland's Health Information Exchange, Chesapeake Regional Information System for our Patients (CRISP).** | Leave this field blank. However, MHCC expects payors to provide patient characteristics needed by CRISP to generate the MPI. | Added threshold of 100%, added note for payors to leave field blank |
| 49 | Reporting Quarter | 1 | A | | 255 | 255 | 100% | Indicate the quarter number for which the data is being submitted. | 1 First Quarter = January 1 thru March 31<br>2 Second Quarter = April 1 thru June 30<br>3 Third Quarter = July 1 thru September 30<br>4 Fourth Quarter = October 1 thru December 31 | Added threshold of 100% |

** Note: The Commission expects the algorithm to be applied to every eligibility record.*

*** Unlike the Date of Enrollment listed on the other files, which refers to the start date of enrollment in this data submission period, this Date of FIRST Enrollment should reflect*

**PROVIDER DIRECTORY REPORT SUBMISSION**

This report details all health care Practitioners *(including other health care professionals, dental/vision services covered under a general health benefit plan, and office facilities)* and Suppliers that provided services to your enrollees for the reporting period designated – First Quarter: Claims paid from January 1, 2015 through March 31, 2015; Second Quarter: Claims paid from April 1, 2015 through June 30, 2015; Third Quarter: Claims paid from July 1, 2015 through September 30, 2015; Fourth Quarter: Claims paid from October 1, 2015 through December 31, 2015. Please provide information for all in-State Maryland practitioners/suppliers and all out-of-State practitioners/suppliers serving applicable insureds.

Please note that the layout below is for formatting a flat file. The MCDB Portal will accept files delimited by a pipe (|) or a comma (,).

| | Field Name | Length | Type A=alphanumeric N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Record Identifier | 1 | A | | 1 | 1 | 100% | The value is 3 | **3 Provider Services** | |
| 2 | Practitioner/Supplier ID (payor encrypted) | 11 | A | | 2 | 12 | 100% | Payor-specific identifier for a practitioner, practice, or office facility rendering health care service(s). | | |
| 3 | Practitioner/Supplier Federal Tax ID (without embedded dashes) | 9 | A | | 13 | 21 | 100% | Employer Tax ID # of the practitioner, practice or office facility receiving payment for services. | Same as Federal Tax ID # in Professional Services and Dental Services File. | |
| 4 | Practitioner/Supplier Last Name or Multi-practitioner Health Care Organization (Truncate if over 31 characters) | 31 | A | | 22 | 52 | 100% | Last name of practitioner or complete name of multi-practitioner health care organization. | **Please truncate if name of practitioner or medical organization exceeds 31 characters.** | Changed threshold to 100% from 99% |
| 5 | Practitioner/Supplier First Name | 19 | A | | 53 | 71 | 100% | Practitioner's first name. | Individual provider's first name.<br><br>Leave blank if organization (threshold does not apply). | Changed threshold to 100% from 99%, instructions added for organizations to leave blank |
| 6 | Practitioner Middle Initial | 1 | A | | 72 | 72 | | | First letter of individual provider's middle name. | |
| 7 | Practitioner Name Suffix | 4 | A | | 73 | 76 | | | Individual provider's name suffix, such as Jr., Sr., II, III, IV, or V. | |
| 8 | Practitioner Credential | 5 | A | | 77 | 81 | | | Abbreviations for professional degrees or credentials used or held by an individual provider, such as MD, DDS, CSW, CNA, AA, NP, PSY. | |
| 9 | Practitioner/Supplier Specialty – 1* | 10 | A | | 82 | 91 | 100%* | The health care field in which a practitioner is licensed, certified, or otherwise authorized under Health Occupations Article, Annotated Code of Maryland, to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program. Up to 3 codes may be listed. | Please reference the National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy, Version 13.0, January 2013 Code Book available on the MHCC website at: http://mhcc.dhmh.maryland.gov/payercompliance/Documents/Taxonomy_13_0.pdf | Updated note that if Practitioner Individual NPI# (14) is filled, this field is not required |
| 10 | Practitioner/Supplier Specialty – 2* | 10 | A | | 92 | 101 | | | | |
| 11 | Practitioner/Supplier Specialty – 3* | 10 | A | | 102 | 111 | | | | |
| 12 | Practitioner DEA # | 11 | A | | 112 | 122 | 100% | Drug Enforcement Agency number assigned to an individual registered under the Controlled Substance Act. | Same as DEA# in Pharmacy File. | Changed threshold to 100% from 99% |
| 13 | Indicator for Multi-Practitioner Health Care Organization | 1 | A | | 123 | 123 | 99% | | 0 Solo Practitioner<br>1 Multiple Practitioners | |
| 14 | Practitioner Individual National Provider Identifier (NPI) number | 10 | A | | 124 | 133 | 100% | Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner. | Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf | Added threshold of 100% |

| | Field Name | Length | Type<br>A=alphanumeric<br>N=numeric | Dec | Start | End | Threshold | Description | Field Contents | Changes |
|---|---|---|---|---|---|---|---|---|---|---|
| 15 | Practitioner Organizational National Provider Identifier (NPI) number | 10 | A | | 134 | 143 | 100% | Federal identifier assigned by the federal government for use in all HIPAA transactions to an organization for billing purposes. | Ten (10) digits<br>www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf | Added threshold of 100% |
| 16 | Payor ID Number | 4 | A | | 144 | 147 | 100% | Payor assigned submission identification number. | | |
| 17 | Source System | 1 | A | | 148 | 148 | 100% | Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…)<br><br>Please ensure that the source system letter used is consistent from year to year, as well as with the source system letter indicated on the MCDB Portal | A – Z. If only submitted for one source system, default is A. | Added threshold of 100%, added note on reporting source system |
| 18 | Reporting Quarter | 1 | A | | 149 | 149 | 100% | Indicate the quarter number for which the data is being submitted. | 1 First Quarter = January 1 thru March 31<br>2 Second Quarter = April 1 thru June 30<br>3 Third Quarter = July 1 thru September 30<br>4 Fourth Quarter = October 1 thru December 31 | Added threshold of 100% |

**Reminders**

• Use specific (separate) fields for practitioner First Name and Last Name.

• Confirm **Practitioner/Supplier ID #** matches **Servicing Practitioner ID #** in the Professional Services and Dental Services, and Prescriber Practioner ID in the Pharmacy file layouts. Confirm **Practitioner DEA #** matches **Practitioner DEA #** in the Pharmacy file layout.
If the practice is a Multi-Practitioner Health Care Organization, then **Practitioner Organizational NPI #** (data element #15) should be filled.

• * Note: If the Practitioner Individual NPI (field #14) or the Practitioner Organizational NPI numbers (field #15) are not provided, then the Practitioner Specialty code (field #9) must be filled using the NUCC Health Care Provider Taxonomy codes available at: http://mhcc.dhmh.maryland.gov/payorcompliance/Documents/Taxonomy_13_0.pdf. If Practitioner Individual NPI (field #14) is filled, this field can be left blank.

• If a payor requests to provide internal practitioner specialty coding, then a crosswalk of the internal practitioner specialty codes to the appropriate taxonomy specialty codes must be provided.