

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. 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 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 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 1 Yes, other cover is primary 2 Yes, other coverage is secondary 9 Unknown	
9	Coverage Type	1	A		47	47		Patient's type of insurance coverage.	1 Medicare Supplemental (i.e., Individual, Group, WRAP) 2 Medicare Advantage Plan 3 Individual Market (not MHIP; not sold in MHBE) 4 Maryland Health Insurance Plan (MHIP) 5 Private Employer Sponsored or Other Group (i.e. union or association plans) 6 Public Employee – Federal (FEHBP) 7 Public Employee – Other (state, county, local/municipal government and public school systems) 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] 9 Health Insurance Partnership (HIP) A Student Health Plan B Individual Market sold in MHBE C Small Business Options Program (SHOP) sold in MHBE Z Unknown	Removed threshold, collected in eligibility file

	Field Name	Length	Type A=alphanumeric 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 2 Life & Health Insurance Company or Not-for-Profit Health Benefit Plan 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) 1 Work 2 Auto Accident 3 Other Accident 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 2 Non-Participating 3 Unknown/Not Coded 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 8 Capitated or Global Contract Services	Changed 1 from "Final bill" to "Fee-for-service"
15	Claim Control Number (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 (CCYMMDD)	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.	CCYMMDD	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 (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 (CCYMMDD)	8	N		166	173	100%	First date of service for a procedure in this line item.	CCYMMDD	
30	Service Thru Date* (CCYMMDD)	8	N		174	181	100%*	Last date of service for this line item.	CCYMMDD	
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 A=alphanumeric 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) 1 Transportation (ambulance air or ground) Miles 2 Anesthesia Time Units 3 Services 4 Oxygen Units 5 Units of Blood 6 Allergy Tests 7 Lab Tests 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. Nurse Anesthetist services are to be reported using the following Level II (HCPCS) modifiers: • QX – Nurse Anesthetist service; under supervision of a doctor • 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 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 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 A=alphanumeric 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) 2 Risk (under non-Maryland contract) 3 ASO (employer self-insured, under Maryland contract) 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 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 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...) 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 1 Yes, Assignment of Benefits Accepted and Practitioner Not in Network 2 N/A, Practitioner is In Network 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 2 ICD-10-CM 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 A=alphanumeric 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 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 4 Fourth Quarter = October 1 thru December 31	Added threshold of 100%
61	Claim Adjudication Date(CCYMMDD) New!	8	N		344	351	100%	The date that the claim was adjudicated.	CCYMMDD	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 V Void R Replacement B Back Out A Amendment	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. 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 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 (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) (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 # (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 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 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 A=alphanumeric 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.	<ul style="list-style-type: none"> 1 Processed Internally by Payor 2 Argus Health Systems, Inc. 3 Caremark, LLC 4 Catalyst Rx, Inc. 5 Envision Pharmaceutical Services, Inc. 6 Express Scripts, Inc. 7 Medco Health, LLC 8 National Employee Benefit Companies, Inc. 9 NextRx Services, Inc. A Atlantic Prescription Services, LLC B Benecard Services, Inc. C BioScrip PBM Services, LLC D Futurescripts, LLC E Health E Systems F HealthTran, LLC G Innoviant, Inc. H MaxorPlus I Medical Security Card Company J MedImpact Healthcare Systems, Inc. K MemberHealth, LLC L PharmaCare Management Services, LLC M Prime Therapeutics, LLC N Progressive Medical, Inc. O RxAmerica, LLC P RxSolutions, Inc. Q Scrip World, LLC R Tmesys, Inc. 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) <i>from which the data was obtained</i> by using an alphabet letter (A, B, C, D, etc...) 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	<ul style="list-style-type: none"> 1 First Quarter = January 1 thru March 31 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 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 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 prescribing practitioner.	Must link to the practitioner ID on the Provider Directory	Added field
33	Claim Adjudication Date(CCYMMDD) 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 A=alphanumeric 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 V Void R Replacement B Back Out A Amendment	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). Refer to the UUID summary description sheet in the data submission manual. A full description is available in the UUID Users' Manual.	
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.	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 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). (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
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). (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
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 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 2 Non-Participating 3 Unknown/Not Coded 9 No Network for this Plan	



	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Threshold	Description	Field Contents	Changes
13	Claim Control Number (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 (CCYMMDD)	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	CCYMMDD	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 11 Hospital Inpatient – Acute care 12 Hospital Inpatient – Children’s Hospital 13 Hospital Inpatient – Mental health or Substance abuse 14 Hospital Inpatient – Rehabilitation, Long term care, SNF stay 20 Hospital Outpatient – Undefined 21 Hospital Outpatient – Ambulatory Surgery 22 Hospital Outpatient – Emergency Room 23 Hospital Outpatient – Other 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 2 Urgent 3 Elective 4 Newborn 5 Trauma Center 6 Reserved for National Assignment 7 Reserved for National Assignment 8 Reserved for National Assignment 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”. (Note: Assign the code where the patient originated from before presenting to the health care facility.)	0 Not a hospital inpatient record For Newborns (Type of Admission = 4) 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Not used 5 Born inside this hospital 6 Born outside of this hospital 9 Information not available Admissions other than Newborn 1 Non-Health Facility Point of Origin 2 Clinic or Physician’s Office 3 Reserved for national assignment 4 Transfer from a Hospital (Different Facility) 5 Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) 6 Transfer from Another Health Care Facility 8 Court/Law Enforcement	

	Field Name	Length	Type A=alphanumeric 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. Applies only to hospital inpatient records. All other record types code "00".	01 Routine (home or self care) 02 Another Short-term Hospital 03 Skilled Nursing Facility (SNF) 04 Intermediate care facility (ICF) 05 Another type of facility (includes rehab facility, hospice, etc.) 06 Home Health Care (HHC) 07 Against medical advice 09 Admitted as an inpatient to this hospital 20 Expired (Religious) 21 Expired (Religious) 30 Still patient 40 Expired at home (Hospice claims) 41 Expired in a medical facility(Hospice claims only) 42 Expired - place unknown (Hospice claims only) 43 Federal hospital 50 Hospice - home 51 Hospice - medical facility 61 Hospital-based Medicare approved swing bed 62 IP Rehab facility (not hospital) 63 Discharged/transferred to long term care hospital 65 Psychiatric hospital 66 Transferred to a CAH 69 Designated disaster alternative care site 70 Another type of health care institution 81 Home or self-care(planned readmission) 82 Short term general hospital for IP care 83 Skilled nursing facility (SNF) 84 Facility providing custodial or supportive care 85 Designated cancer center or children's hospital 86 Home Health Care (HHC) 87 Court/Law Enforcement 88 Federal health care facility 89 Hospital-based Medicare approved swing bed	Added threshold of 95% 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 2 ICD-10-CM 3 Missing/Unknown	
22	Primary Diagnosis (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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting	

	Field Name	Length	Type A=alphanumeric 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 (Remove embedded decimal pt.)		
25	Other Diagnosis Code 1 present on Admission 1	1	A		156	156		Diagnosis Code 1 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 (Remove embedded decimal pt.)		
27	Other Diagnosis Code 2 present on Admission 2	1	A		164	164		Diagnosis Code 2 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 (Remove embedded decimal pt.)		
29	Other Diagnosis Code 3 present on Admission 3	1	A		172	172		Diagnosis Code 3 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 (Remove embedded decimal pt.)		
31	Other Diagnosis Code 4 present on Admission 4	1	A		180	180		Diagnosis Code 4 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 (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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting	

	Field Name	Length	Type A=alphanumeric 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 (Remove embedded decimal pt.)		
43	Other Diagnosis Code 10 present on Admission 10	1	A		228	228		Diagnosis Code 10 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 (Remove embedded decimal pt.)		
45	Other Diagnosis Code 11 present on Admission 11	1	A		236	236		Diagnosis Code 11 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 (Remove embedded decimal pt.)		
47	Other Diagnosis Code 12 present on Admission 12	1	A		244	244		Diagnosis Code 12 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 (Remove embedded decimal pt.)		
49	Other Diagnosis Code 13 present on Admission 13	1	A		252	252		Diagnosis Code 13 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 (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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not E – Unreported/Not used = Exempt from POA reporting	

	Field Name	Length	Type A=alphanumeric 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 (Remove embedded decimal pt.)		
61	Other Diagnosis Code 19 present on Admission 19	1	A		300	300		Diagnosis Code 19 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 (Remove embedded decimal pt.)		
63	Other Diagnosis Code 20 present on Admission 20	1	A		308	308		Diagnosis Code 20 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 (Remove embedded decimal pt.)		
65	Other Diagnosis Code 21 present on Admission 21	1	A		316	316		Diagnosis Code 21 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 (Remove embedded decimal pt.)		
67	Other Diagnosis Code 22 present on Admission 22	1	A		324	324		Diagnosis Code 22 present on Admission. (Applies only to hospital inpatient records. All other record types code "0".)	Y – Yes = Present at the time of inpatient admission N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 (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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 N – No = Not present at the time of inpatient admission U – Unknown = Documentation is insufficient to determine if condition is present on admission W – Clinically undetermined = Provider is unable to clinically determine whether condition was present on admission or not 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 2 ICD-10-PCS 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 A=alphanumeric 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.	<ul style="list-style-type: none"> 1 Inpatient DRGs (IP-DRGs) 2 All Patient Refined DRGs (APR-DRGs) 3 Centers for Medicare & Medicaid Services DRGs (CMS-DRGs) 4 Other Proprietary 	
132	DRG Grouper Version	2	A		556	557		Version of DRG Grouper used.		



	Field Name	Length	Type A=alphanumeric 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. DO NOT USE DECIMALS		Added 100% threshold to all financial fields
134	Allowed Amount	9	N		567	575	100%	Total patient and payor liability. 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. 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. 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. DO NOT USE DECIMALS		Added 100% threshold to all financial fields, added note to not use decimals

	Field Name	Length	Type A=alphanumeric 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 2 Skilled Nursing 3 Home Health 4 Christian Science Hospital 5 Christian Science Extended Care 6 Intermediate Care 7 Clinic 8 Special Facility Bill Classification – 2nd Digit if 1st Digit = 1-6 1 Inpatient (including Medicare Part A) 2 Inpatient (including Medicare Part B Only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Nursing Facility Level I 6 Nursing Facility Level II 7 Intermediate Care – Level III Nursing Facility 8 Swing Beds Bill Classification – 2nd Digit if 1st Digit = 7 1 Rural Health 2 Hospital-based or Independent Renal Dialysis Center 3 Freestanding Outpatient Rehabilitation Facility (ORF) 4 Comprehensive Outpatient Rehabilitation Facilities (CORFs) 5 Community Mental Health Center 9 Other Bill Classification – 2nd Digit if 1st Digit = 8 1 Hospice (Non-Hospital based) 2 Hospice (Hospital-based) 3 Ambulatory Surgery Center 4 Freestanding Birthing Center 9 Other Frequency – 3rd Digit 1 Admit through Discharge 2 Interim – First Claim Used 3 Interim – Continuing Claims 4 Interim – Last Claim 5 Late Charge Only 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 1 Yes, other coverage is primary 2 Yes, other coverage is secondary 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...) 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 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 4 Fourth Quarter = October 1 thru December 31	Added threshold of 100%
168	Claim Adjudication Date(CCYMMDD) New!	8	N		723	730	100%	The date that the claim was adjudicated.	CCYMMDD	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 V Void R Replacement B Back Out A Amendment	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 IdentifierU (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. 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 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.	1 Yes, other coverage is primary 2 Yes, other coverage is secondary 9 Unknown	
8	Coverage Type	1	A		46	46		Patient's type of insurance coverage.	1 Medicare Supplemental (i.e., Individual, Group, WRAP) 2 Medicare Advantage Plan 3 Individual Market (not MHIP; not sold in MHBE) 4 Maryland Health Insurance Plan (MHIP) 5 Private Employer Sponsored or Other Group (i.e. union or association plans) 6 Public Employee – Federal (FEHBP) 7 Public Employee – Other (state, county, local/municipal government and public school systems) 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] 9 Health Insurance Partnership (HIP) A Student Health Plan B Individual Market sold in MHBE C Small Business Options Program (SHOP) sold in MHBE Z Unknown	Removed threshold, collected in eligibility file



	Field Name	Length	Type A=alphanumeric 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 2 Life & Health Insurance Company or Not-for-Profit Health Benefit Plan 3 Third-Party Administrator (TPA) Unit 9 Non-Accident (Actuary)	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.	1 Work 2 Auto Accident 3 Other Accident 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 2 Non-Participating 3 Unknown/Not Coded 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 8 Capitated or Global Contract Services	
14	Claim Control Number (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 A=alphanumeric 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 12 Patient's Home 13 Assisted Living Facility 17 Walk-in Retail Health Clinic 18 Place of Employment - Worksite 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room – Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance – Land 42 Ambulance – Air or Water 51 Inpatient Psychiatric Facility 52 Psychiatric Facility – Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 57 Non-residential Substance Abuse Treatment Facility 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End-Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory & 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 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 A=alphanumeric 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 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 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 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). (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) 2 Health Maintenance Organization 3 Indemnity 4 Point of Service (POS) 5 Preferred Provider Organization (PPO) 6 Limited Benefit Plan (Mini-Meds) 7 Student Health Plan 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...) 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 A=alphanumeric 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 3 Child 4 Other Dependent 5 Other Adult 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 A=alphanumeric 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 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 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 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 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 V Void R Replacement B Back Out A Amendment	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 A=alphanumeric 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 IdentifierP (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 IdentifierU (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. 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 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 003 Anne Arundel 005 Baltimore County 009 Calvert 011 Caroline 013 Carroll 015 Cecil 017 Charles 019 Dorchester 021 Frederick 023 Garrett 025 Harford 027 Howard 029 Kent 031 Montgomery 033 Prince George's 035 Queen Anne's 037 St. Mary's 039 Somerset 041 Talbot 043 Washington 045 Wicomico 047 Worcester 510 Baltimore City 999 Unknown	Removed threshold, can be derived from zip code



	Field Name	Length	Type A=alphanumeric 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 2 Enrollee reported to another source 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 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 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 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 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 1 Yes	
14	Race Category Other – Direct	1	A		54	54		Enter whether the self-defined race of the enrollee is Other.	0 No 1 Yes	
15	Race Category Declined to Answer – Direct	1	A		55	55		Enter whether the enrollee declined to disclose their race.	0 No 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 1 Yes	
17	Imputed Race with Highest Probability	1	A		57	57	95%	Race of enrollee.	1 American Indian or Alaska Native 2 Asian 3 Black or African American 4 Native Hawaiian or Other Pacific Islander 5 White/Caucasian 6 Some Other Race 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 2 Enrollee reported to another source 9 Missing/Unknown/Not specified	

	Field Name	Length	Type A=alphanumeric 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 2 Not Hispanic or Latino or Not of Spanish origin 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 2 Not Hispanic or Latino or Not of Spanish origin 7 Declined to Answer 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 02 Albanian 03 Amharic 04 Arabic 05 Burmese 06 Cantonese 07 Chinese (simplified & traditional) 08 Creole (Haitian) 09 Farsi 10 French (European) 11 Greek 12 Gujarati 13 Hindi 14 Italian 15 Korean 16 Mandarin 17 Portuguese (Brazilian) 18 Russian 19 Serbian 20 Somali 21 Spanish (Latin America) 22 Tagalog (Pilipino) 23 Urdu 24 Vietnamese	
24	Coverage Type	1	A		69	69	99%	Enrollee's type of insurance coverage.	1 Medicare Supplemental (i.e., Individual, Group, WRAP) 2 Medicare Advantage Plan 3 Individual Market (not MHIP; not sold in MHBE) 4 Maryland Health Insurance Plan (MHIP) 5 Private Employer Sponsored or Other Group (i.e. union or association plans) 6 Public Employee – Federal (FEHBP) 7 Public Employee – Other (state, county, local/municipal government and public school systems) 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] 9 Health Insurance Partnership (HIP) A Student Health Plan B Individual Market (sold in MHBE) C Small Business Options Program (SHOP) sold in MHBE 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 2 Life & Health Insurance Company or Not-for-Profit Health Benefit Plan 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) 2 Health Maintenance Organization 3 Indemnity 4 Point of Service (POS) 5 Preferred Provider Organization (PPO) 6 Limited Benefit Plan (Mini-Meds) 7 Student Health Plan 8 Catastrophic	
27	Policy Type	1	A		72	72	95%	Type of policy.	1 Individual 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 <u>encryption algorithm generated by the payor</u> .	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 1 Yes	
31	Pharmacy Services Indicator	1	A		103	103	95%	Prescription Drug Coverage	0 No 1 Yes	
32	Behavioral Health Services Indicator	1	A		104	104	95%	Behavioral Health Services Coverage	0 No 1 Yes	
33	Dental Services Indicator	1	A		105	105	95%	Dental Coverage	0 No 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) 2 Risk (under non-Maryland contract) 3 ASO (employer self-insured, under Maryland contract) 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 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 <u>initially</u> 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). (see Source Company on page 72)	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.	Changed threshold to 100% from 99%

	Field Name	Length	Type A=alphanumeric 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 2 Spouse 3 Child 4 Other Dependent 5 Other Adult 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...) 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 2 Non-Grandfathered 3 Transitional 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: 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 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 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. 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.dhmd.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 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 A=alphanumeric 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 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) <i>from which the data was obtained</i> by using an alphabet letter (A, B, C, D, etc...) 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 2 Second Quarter = April 1 thru June 30 3 Third Quarter = July 1 thru September 30 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 Practitioner 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.dhmd.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.

