

VERSION NUMBER: ~~16~~17

Date: MARCH 202~~6~~5

SUPERCEDES

VERSION NUMBER: 1~~6~~5

DATE: MARCH 202~~5~~4

CENTER FOR IMPROVING VALUE IN HEALTH CARE (CIVHC)

Colorado All-Payer Claims Database DATA SUBMISSION GUIDETR

REVISION HISTORY

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

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

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

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

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

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| | | <u>3N and 4N to B.1.J Alternative Payment Model (APM) Payment Category.</u> | |
| <u>9/5/2025</u> | <u>17 draft</u> | <u>Revisions include the addition of annual test file requirements and associated timelines, clarification of CSV file submission standards, inclusion of a "Methodology" field in the PDAB table, a requirement for annual registration, and defined offboarding procedures. CDT requirements have been added to the HCPCS list and to MC055 Outpatient Procedure Codes. Additional changes include a prohibition on submitting header names in files and updated naming conventions for both monthly and annual file submissions.</u> | <u>D. Velez</u> |
| <u>9/5/2025</u> | <u>17 draft</u> | <u>Therapeutic Class DR007 reporting requirement updated from required to optional in the Drug Rebate file.</u> | <u>A. Aguirre</u> |
| <u>9/15/2025</u> | <u>17 draft</u> | <u>Adding APM, DR, PB, VB, PB, and CT to annual file naming convention and requiring PC017 to be reported for all claims.</u> | <u>D. Velez</u> |
| <u>9/18/2025</u> | <u>17 draft</u> | <u>added IPT 20 to include prescription drug coverage through Medicare Advantage line of business</u> | <u>D. Velez</u> |
| <u>10/21/2025</u> | <u>17 draft</u> | <p><u>Noting previously made changes to DSGv17 for Onpoint transition:</u></p> <ul style="list-style-type: none"> - <u>Requirement of all files previously submitted as Excel files to be submitted as CSV files</u> - <u>Requirement to not include names of data element in files</u> - <u>Requirement to not include extended ASCII or non-printable characters</u> - <u>Changes to monthly file naming convention</u> - <u>Changes to annual file naming convention</u> - <u>Changes to payer code naming convention</u> - <u>Adding "File Type" and "Test File Flag" fields in all header records</u> - <u>Adding "Test File Flag" field in all trailer records</u> - <u>MC017 - Added "Denial Processed Date" to Data Element Name. Now required for all claims, including fully denied claims.</u> - <u>PC017 - Added "Denial Processed Date" to Data Element Name. Now required for all claims, including fully denied claims.</u> | <u>D. Velez</u> |
| <u>11/11/2025</u> | <u>17 draft</u> | <u>Adding that RowCount is required in the naming file convention for AC, VB, PD, and PB files.</u> | <u>D. Velez</u> |

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1.0 DATA SUBMISSION REQUIREMENTS - GENERAL

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

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

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

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

1.1 DATA TO BE SUBMITTED

1.1.1 MEDICAL CLAIMS DATA

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

file. (See Exhibit A for specifics).

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

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

1.1.2 PHARMACY CLAIMS DATA

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

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

1.1.3 MEMBER ELIGIBILITY DATA

- a) Health Care Payers must provide a dataset that contains information on every covered plan member who is a Colorado resident (see paragraph ~~1.2.1.b~~ 1.1.1.b and 1.1.2.b above) whether or not the member utilized services during the reporting period. The file must include member identifiers, subscriber name and identifier, member relationship to subscriber, residence, age, race, ethnicity and language, and other required fields to allow retrieval of related information from pharmacy and medical claims data sets (Exhibit A).
- b) If dual coverage exists, send coverage of eligible members where payer insurance is primary or tertiary. ME028 is a flag to indicate whether this insurance is primary coverage.
- c) Information, such as patient address, should be submitted accurately based on the time of eligibility identified in ME004 and ME005. For example, if a payer submits historical data back to 2017 and a given member changed addresses in 2018, the 2017 eligibility data should contain the 2017 address and the 2018-forward data should reflect the updated address information.

1.1.4 PROVIDER DATA

- a) Health Care Payers must provide a dataset that contains information on every provider for whom claims were adjudicated during the targeted reporting period or for whom were reported on the eligibility file during the targeted reporting period.
- b) A provider file is a data file composed of information including but not limited to: provider IDs, provider names, National Provider Identifiers (NPI), specialty codes, and practice location(s) for all providers as indicated by the payer on the eligibility and on the claim.
- c) Data suppliers must provide a dataset that contains information for all providers as indicated on the eligibility file and on every provider that a claim (Medical, Dental, and Pharmacy) was adjudicated for in the targeted reporting period. Third party administrators (including pharmacy benefit managers, etc.) who may not contract directly with providers, are expected to include providers who are on the claims file for the time period of the corresponding reporting period.
- d) In the event the same provider delivered and was reimbursed for services rendered from two different physical locations, then the provider data file shall contain two separate records for that same provider reflecting each of those physical locations. One record shall be provided for each unique physical location for a provider who was reported during the period.

1.1.5 ALTERNATIVE PAYMENT MODEL DATA (APM)

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

1.1.6 ALTERNATIVE PAYMENT MODEL CONTROL TOTAL DATA

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

1.1.7 ALTERNATIVE PAYMENT MODEL CONTRACT SUPPLEMENT DATA

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

1.1.8 DRUG REBATE (DR) DATA

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

1.1.9 PHARMACY BENEFIT MANAGERS (PBM) CONTRACT INFORMATION DATA

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

1.1.10 DATA COLLECTION FOR THE PRESCRIPTION DRUG AFFORDABILITY BOARD (PDAB)

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

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1.1.11 PHARMACY VALUE BASED PURCHASING CONTRACT DATA (VBPC)

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

1.1.12 Member Capitation File (CF)

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

1.2 COORDINATION OF SUBMISSIONS

- a) In the event that the health plan contracts with a pharmacy benefits manager or other service entity that manages claims for Colorado residents, the health plan shall be responsible for ensuring that complete and accurate files are submitted to the CO APCD by the subcontractor. The health plan shall ensure that the member identification information on the subcontractor's file(s) is consistent with the member identification information on the health plan's eligibility, medical claims and dental claims files. The health plan shall include utilization and cost information for all services provided to members under any financial arrangement, including sub-capitated, bundled and global payment arrangements.

1.3 TEST, HISTORICAL AND PARTIAL YEAR INITIAL SUBMISSION

For payers required to begin submitting files to the CO APCD, the [CO APCD Administrator](#) will identify:

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

2.0 FILE SUBMISSION METHODS

- 2.1 SFTP - Secure File Transport Protocol involves logging on to the appropriate FTP site and sending or receiving files using the SFTP client.
- 2.2 Web Upload - This method allows the sending and receiving of files and messages without the installation of additional software. This method requires internet access, a username and password.
- [2.3](#) All files submitted through SFTP or Web Upload must use PGP encryption, as required by the CO APCD's data administrator.

3.0 DATA QUALITY REQUIREMENTS

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

A data element marked as “O” is an optional data element that should be provided when available, but otherwise may contain a null value.

- 3.2 Data validation and quality edits will be developed in collaboration with payers and refined as test data and production data ~~is~~are brought into the CO APCD. Data files missing required fields, or when claim line/record line totals don’t match, may be rejected on submission. Other data elements will be validated against established ranges as the database is populated and may require manual intervention in order to ensure the data is correct.

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

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

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

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

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

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

- 3.4 The system includes all denied claims including fully denied claims and partially denied claims, claims denied when first received (with version number=0) and denied after some back and forth (with version number>0). These claims or claim lines are expected to have claim status equals 04 or 23, Denied Claim Line Indicator is ~~1~~Y or Claim Line Type is D. The payment fields (copay, deductible, paid amount, coinsurance, etc.) on denied claim lines must be 0 and they will be excluded from the valid sets.

~~3.5 The following ruling from the APCD Final Rule outlines the potential penalties related to data not submitted to the APCD or data that remains uncorrected after submissions:~~

1.200.6 Penalties

~~1.200.6.A. If any payer fails to submit required data to the APCD in a timely manner, or fails to correct submissions rejected because of errors, the administrator shall provide written notice to the payer. The administrator may grant an extension of time for just cause. If the payer fails to provide the required information within thirty days following receipt of said written notice, the administrator shall provide the payer with notice of the failure to report and will notify the director of the payer's failure to report. The director shall assess a penalty of up to \$1,000 per week for each week that a payer fails to provide the required data to the APCD, up to a maximum penalty of \$50,000. In determining whether to impose a penalty, the director may consider mitigating factors such as the size and sophistication of a payer, the reasons for the failure to report, and the detrimental impact upon the public purpose served by the APCD.~~

- ~~3.56 CIVHC conducts data quality reviews on all submitted files to ensure compliance with the DSG and to identify any structural, format, or content-level issues. Once a file is reviewed, CIVHC will notify the payer of any required corrections or clarifications.~~

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

4.0 FILE FORMAT

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

Text files all comply with the following standards:

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

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

All file names will follow the template:

• PayerCode FileType PeriodStartDate PeriodEndDate RowCount ProdFlag Fixe
dWidthInd Create Date
TESTorPROD_PayerID_PeriodEndingDateFileTypeVersionNumber.txt

Examples:

COCXXDPCXX ME 202201 2022013 45000 T DL 20250422

i.e

COCXXDPCXX ME 202201 2022013 45000 P DL 20250422

i.TEST_0000_201606MEv01.txt

• PROD_0000_201606MEv02.txt

- Payer Code = Unique identifier assigned to each submitterpayer by the CO APCD's data administrator

- FileType = A two-character code that indicates which file is being submitted:

i. 'ME' = Eligibility

ii. 'MC' = Medical Claims

iii. 'PC' = Pharmacy Claims

iv. 'MP' = Provider

- PeriodStartDate (YYYYMM format)

i. For claims data, this will be the very first Paid Date year-month reported in the file

ii. For eligibility data, this will be the very first year-month of enrollment reported in the file, based on the first field in the eligibility file that dictates year-months of coverage ~~(eff dt)~~

- PeriodEndDate (YYYYMM format)

i. For claims data, this will be the very last Paid Date year-month reported in the file

ii. For eligibility data, this will be the very last year-month of enrollment reported in the file, based on the first field in the eligibility file that dictates year-months of coverage ~~(eff dt)~~

- RowCount (no commas)

i. Total number of records submitted in the file, excluding header and trailer records

ii. For all monthly files files, if payer cannot fill in the "RowCount" section of the file naming convention, then a "0" can be used instead. For example:

COCXXXX_ME_202201_202201_0_T_DL_202504

- ProdFlag = A one-character code that indicates whether a file is a 'Test' file or a 'Production' file:
 - i. 'T' = Test
 - ii. 'P' = Production
- DelimitedFileInd = A two-character code that indicates whether a file is reported with delimiters:
 - i. 'DL' = Delimiters included
- CreateDate (YYYYMMDD)
- ~~TEST or PROD – TEST for test files; PROD for production files~~
- ~~PayerID – The payer ID assigned to each submitter~~
- ~~Period ending date, expressed as CCYYMM (four digit calendar year and two digit month; for example, 201403 indicates a March 2014 end date).~~
- ~~File Type – Member Eligibility (ME), Medical Claims (MC), Pharmacy Claims (PC), Provider (MP), Specialty Crosswalk (SC), Alternative Payment Model (AM), Control Total (CT), Member Capitation (CF), and Drug Rebate (DR) files..~~
- ~~Version number: Used to differentiate multiple submissions of the same file. This is important when a file must be resubmitted to resolve an issue, such as a validation failure. The letter v should be used, followed by two digits, starting with v01. Please include the leading zero. Original submissions of all files should be labeled v01. The Portal will not accept files that have the same name as an existing file.~~
- ~~File extension (.txt)~~

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

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

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

All file names will follow the template:

PayerCode FileType PeriodStartDate PeriodEndDate RowCount ProdFlag FixedWidthInd Create Date

- Examples
 - i. COCBXXPCXX AMME 202201 202421203 45000 T DL 20250422
 - ii. COCBXXPCXX AMME 202201 202421203 45000 P DL 20250422
- Payer Code = Unique identifier assigned to each payersubmitter by the CO APCD's data administrator
- FileType = A two-character code that indicates which file is being submitted:
 - i. 'AM' = Alternative Payment Model
 - ii. 'CT' = Control Total
 - iii. 'CF' = Member Capitation
 - iv. 'DR' = Drug Rebate
 - v. 'PB' = PBM Contract Supplement
 - vi. 'PD' = PDAB
 - vii. 'VB' = Value Based Purchasing Contract
- PeriodStartDate (YYYYMM format)
 - i. For claims data, this will be the very first Paid Date year-month reported in the file
 - ii. For eligibility data, this will be the very first year-month of enrollment reported in the file, based on the first field in the eligibility file that dictates year-months of coverage (eff dt)
- PeriodEndDate (YYYYMM format)
 - i. For claims data, this will be the very last Paid Date year-month reported in the file
 - ii. For eligibility data, this will be the very last year-month of enrollment reported in the file, based on the first field in the eligibility file that dictates year-months of coverage (eff dt)
- RowCount (no commas)
 - i. Total number of records submitted in the file, excluding header and trailer records
 - ii. For AM, CT, DR, and CF files if payer cannot fill in the "RowCount" section of the file naming convention, then a "0" can be used instead. For example:
COCXXXX_AM_202201_202401_0_T_DL_20250422
 - iii. For AC, PB, PD, and VB files, a nonzero integer is required
- ProdFlag = A one-character code that indicates whether a file is a 'Test' file or a 'Production' file:

i. 'T' = Test

ii. 'P' = Production

- DelimitedFileInd = A two-character code that indicates whether a file is reported with delimiters:

i. 'DL' = Delimiters included

~~TESTorPROD_PayerID_SubmissionYearDueFileTypeVersionNumber.txt~~

d. ~~Examples~~

~~iv. TEST_0000_2019AMv01.txt~~

~~iv. PROD_0000_2019DRv02.txt~~

- ~~TEST or PROD TEST for test files; PROD for production files~~
- ~~PayerID The payer ID assigned to each submitter~~
- ~~Submission year due, expressed as CCYY (four digit calendar year).~~
- ~~File Type APM File (AM), Control Total (CT), APM Contract Supplement (AC), Member Capitation (CF), Drug Rebate (DR), PBM Contract Supplement (PB), PDAB (PD), Value Based Purchasing Contract (VB)~~
- ~~Version number: Used to differentiate multiple submissions of the same file. This is important when a file must be resubmitted to resolve an issue, such as a validation failure. The letter v should be used, followed by two digits, starting with v01. Please include the leading zero. Original submissions of all files should be labeled v01. The Portal will not accept files that have the same name as an existing file.~~
- ~~File extension (.xlsx for PD, PB, AC and VB files, .txt for AM, CT, CF, and DR files)~~

5.0 DATA ELEMENT TYPES

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

int - integer (whole number)

decimal/numeric - fixed precision and scale numeric data

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

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

text - variable length non-unicode data with a maximum of 2³¹ -1 characters

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

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

time - time expressed in military time = HHMM

6.0 DATES FOR MONTHLY CLAIMS DATA SUBMISSION

30 days after the end of the reporting month.

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

EXHIBIT A - DATA ELEMENTS

A-1 ELIGIBILITY FOR MEDICAL CLAIMS DATA

Frequency: Monthly Upload via FTP or Web Portal

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

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

Additional formatting requirements:

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

MEDICAL ELIGIBILITY FILE HEADER RECORD

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|----------------|-------------------|---------|------------|---|
| HD001 | Record Type | char | 2 | HDME |
| HD002 | File Type | char | 2 | ME |
| HD003 | Payer Code | varchar | 74 | Distributed by CIVHC's data administrator |
| HD004 | Payer Name | varchar | 75 | Distributed by CIVHC |
| HD005 | Beginning Month | date | 6 | CCYYMMYYYYMM |
| HD006 | Ending Month | date | 6 | CCYYMMYYYYMM |
| HD007 | Record count | int | 10 | Total number of records submitted in the medical eligibility file, excluding header and trailer records |
| HD008 | Med_BH PMPM | int | 7 | Place holder. Leave field value blank. |
| HD009 | Pharmacy PMPM | int | 7 | Place holder. Leave field value blank. |
| HD010 | Dental PMPM | int | 7 | Place holder. Leave field value blank. |
| HD011 | Vision PMPM | int | 7 | Place holder. Leave field value blank. |
| HD012 | Test File Flag | char | 1 | T=File submitted is a test file; P=File submitted is a production file. |

MEDICAL ELIGIBILITY FILE TRAILER RECORD

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|----------------|-------------------|---------|------------|---|
| TR001 | Record Type | char | 2 | TRME |
| TR002 | File Type | char | 2 | ME |
| TR003 | Payer Code | varchar | 78 | Distributed by CIVHC's data administrator |
| TR004 | Payer Name | varchar | 75 | Distributed by CIVHC |
| TR005 | Beginning Month | date | 6 | CCYYMMYYYYMM |
| TR006 | Ending Month | date | 6 | CCYYMMYYYYMM |
| TR007 | Extraction Date | date | 8 | CCYYMMDDYYYYMMDD |

A-1.1 MEDICAL ELIGIBILITY FILE

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---|-----------------------------------|---------|--------|--|----------|
| ME001 | N/A | Payer Code | varchar | 74 | Distributed by CIVHC's data administrator | R |
| ME002 | N/A | Payer Name | varchar | 30 | Distributed by CIVHC | R |
| ME003 | 271/2110C/EB/ /04, 271/2110D/EB/ /04 | Insurance Type Code/Product | Char | 2 | See Lookup Table B.1.A | R |
| ME004 | N/A | Year | Year | 4 | 4-digit Year for which eligibility is reported in this submission | R |
| ME005 | N/A | Month | Month | 2 | Month for which eligibility is reported in this submission expressed numerical from 01 to 12. One record, per member, per month, per plan, is required. | R |
| ME006 | 271/2100C/REF/1L/02, 271/2100C/REF/IG/02, 271/2100C/REF/6P/02, 271/2100D/REF/1L/02, 271/2100D/REF/IG/02, 271/2100D/REF/6P/02 | Insured Group or Policy Number | varchar | 30 | Group or policy number - not the number that uniquely identifies the subscriber Ensure continuity across file types. Note that ME006 = MC006; PC006. | R |
| ME007 | 271/2110C/EB/ /02, 271/2110D/EB/ /02 | Coverage Level Code | Char | 3 | See Lookup Table B.1.I | R |
| ME008 | 271/2100C/NM1/MI/09 | Subscriber Social Security Number | varchar | 9 | Subscriber's social security number; Set as null if unavailable Ensure continuity across file types. Note that ME008 = MC007; PC007. | O |
| ME009 | 271/2100C/NM1/MI/09 | Plan Specific Contract Number | varchar | 128 | Plan assigned subscriber's contract number; may use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber. Ensure continuity across file types. Note that ME009 = MC008; PC008 | R |
| ME010 | N/A | Member Number | varchar | 128 | Unique number of the member within the contract. Must be an identifier that is unique to the member. May include a combination of contract number and suffix number in order to be unique. This column is the unique identifying column for membership and related medical and pharmacy claims. Only one record per eligibility month. Ensure continuity across file types. Note that ME010 = MC009; PC009 | R |
| ME011 | 271/2100C/NM1/MI/09, 271/2100D/NM1/MI/09 | Member Identification Code | varchar | 9 | Member's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member. Ensure continuity across file types. Note that ME011 = MC010; PC010 | O |
| ME012 | 271/2100C/INS/Y/02, 271/2100D/INS/N/02 | Individual Relationship Code | Char | 2 | Member's relationship to insured - see Lookup Table B.1.B Ensure continuity across file types. Note that ME012 = MC011; PC011 | R |
| ME013 | 271/2100C/DMG/ /03, 271/2100D/DMG/ /03 | Member Gender | Char | 1 | M = Male F = Female X = Non-binary U = UNKNOWN | R |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---|-------------------------------|---------|--------|--|----------|
| ME014 | 271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02 | Member Date of Birth | Date | 8 | CCYYYYMMDD | R |
| ME015 | 271/2100C/N4/ /01, 271/2100D/N4/ /01 | Member City Name of Residence | varchar | 30 | City name of member residence | R |
| ME016 | 271/2100C/N4/ /02, 271/2100D/N4/ /02 | Member State or Province | Char | 2 | As defined by the US Postal Service | R |
| ME017 | 271/2100C/N4/ /03, 271/2100D/N4/ /03 | Member ZIP Code | varchar | 11 | ZIP Code of member - may include non-US codes. Do not include dash. Plus 4 optional but desired. | R |
| ME018 | N/A | Medical Coverage | Char | 1 | Y = YES N = NO 3 = UNKNOWN Corresponds to coverage provided by payer code associated with record. If member has coverage type through separate entity (TPA, ASO, PBM, stand-alone coverage, etc.), then submit "N." Only submit "Y" if carrier provides coverage. | R |
| ME019 | N/A | Prescription Drug Coverage | Char | 1 | Y = YES N = NO 3 = UNKNOWN Corresponds to coverage provided by payer code associated with record. If member has coverage type through separate entity (TPA, ASO, PBM, stand-alone coverage, etc.), then submit "N." Only submit "Y" if carrier provides coverage. | R |
| ME020 | N/A | Dental Coverage | Char | 1 | Y = YES N = NO 3 = UNKNOWN Corresponds to coverage provided by payer code associated with record. If member has coverage type through separate entity (TPA, ASO, PBM, stand-alone coverage, etc.), then submit "N." Only submit "Y" if carrier provides coverage. | R |
| ME123 | N/A | Behavioral Health | Char | 1 | Y = YES N = NO 3 = UNKNOWN Corresponds to coverage provided by payer code associated with record. If member has coverage type through separate entity (TPA, ASO, PBM, stand-alone coverage, etc.), then submit "N." Only submit "Y" if carrier provides coverage. | R |
| ME021 | N/A | Race 1 | varchar | 6 | R1 American Indian/Alaska Native R2 Asian R3 Black/African American R4 Native Hawaiian or other Pacific Islander R5 White R9 Other Race UNKNOW Unknown/Not Specified The code value 'UNKNOW' (unknown/not specified) should be used ONLY when member answers unknown, or refuses to answer. If not available or not collected from members, leave this field blank. | R |
| ME022 | N/A | Race 2 | varchar | 6 | See code set for ME021. | O |
| ME023 | N/A | Other Race | varchar | 15 | List race if ME021 or ME022 are coded as R9. | O |

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

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

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

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

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

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|----------------------------------|-------------------------|--------|---|---|
| ME151 | N/A | HIOS Plan ID | varchar | 14 | Health Insurance Oversight System (HIOS) Plan ID is a 14-digit alphanumeric value that has a health insurer and product component included. This ID is required for all DOI/CMS rate filings. Example: 21032CO1040003 or 76680CO220020 where the first five digits identify the carrier, and the last 9 digits identify the product/plan. Leave <u>this field</u> blank if not applicable | R when: ME007 = 'IND' AND ME045 = 'Y' OR 'N'; ME149 = 'Y'; O if ME149 = 'N' |
| ME152 | N/A | Vision Coverage | char | 1 | Y = YES N = NO 3 = UNKNOWN Corresponds to coverage provided by payer code associated with record. If member has coverage type through separate entity (TPA, ASO, PBM, stand-alone coverage, etc.), then submit "N." Only submit "Y" if carrier provides coverage. | R |
| ME153 | N/A | Colorado PBM Registration Number | char varchar | 10 | The identifier assigned by the Colorado Division of Insurance (DOI) for registered Pharmacy Benefit Managers (PBM). | R for PBMs |
| ME899 | N/A | Record Type | char | 2 | Value = ME | R |

A-2 MEDICAL CLAIMS DATA

Frequency: Monthly Upload via FTP or Web Portal

Additional formatting requirements:

- Include paid, partially paid, Claims are paid and fully denied claims. ~~Non-covered or denied claims (e.g. duplicate or patient ineligible claims) are not included.~~
- Payers submit data in a single, consistent format for each data type.

MEDICAL CLAIMS FILE HEADER RECORD

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|------------------|----------------------|-----------------|--------------|---|
| HD001 | Record Type | char | 2 | HD MC |
| HD002 | File Type | char | 2 | MC |
| HD003 | Payer Code | varchar | 74 | Distributed by CIVHC's <u>data administrator</u> |
| HD004 | Payer Name | varchar | 75 | Distributed by CIVHC |
| HD005 | Beginning Month | date | 6 | CCYYMM YYYYMM |
| HD006 | Ending Month | date | 6 | CCYYMM YYYYMM |
| HD007 | Record count | int | 10 | Total number of records submitted in the medical claims file, excluding header and trailer records |
| HD008 | Med_BH PMPM | int | 7 | Sum of MC063(Paid Amount) + MC064(Prepaid Amount) + MC065(Co-pay Amount) + MC066(Coinsurance Amount) + MC067(Deductible Amount) (as applicable) in medical claims divided by the total distinct member IDs in the member eligibility, where medical coverage (ME018) = 'Y' or behavioral health (ME123) = 'Y' <u>when MC209 or MC220 does not = 'Y'</u> . Do not code decimal point or provide any punctuation where \$1,000.00 converted to 100000 Two decimal places implied. <u>Leave blank if above condition does not apply.</u> |
| HD009 | Pharmacy PMPM | int | 7 | Place holder. Leave <u>this field</u> value blank. |
| HD010 | Dental PMPM | int | 7 | Sum of MC063(Paid Amount) + MC064(Prepaid Amount) + MC065(Co-pay Amount) + MC066(Coinsurance Amount) + MC067(Deductible Amount) (as applicable) in dental claims divided by the total distinct member IDs in the member eligibility where dental coverage (ME020) = 'Y' when MC209 = 'Y'. Do not code decimal point or provide any punctuation where \$1,000.00 converted to 100000 Two decimal places implied. <u>Leave blank if above condition does not apply.</u> |

| | | | | |
|--------|----------------|------|---|--|
| HD0110 | Vision PMPM | int | 7 | Sum of MC063(Paid Amount) + MC064(Prepaid Amount) + MC065(Co-pay Amount) + MC066(Coinsurance Amount) + MC067(Deductible Amount) (as applicable) in vision claims divided by the total distinct member IDs in the member eligibility where vision coverage (ME152) = 'Y' when MC220 = 'Y'. Do not code decimal point or provide any punctuation where \$1,000.00 converted to 100000 Two decimal places implied. <u>Leave blank if above condition does not apply.</u> |
| HD012 | Test File Flag | char | 1 | T=File submitted is a test file; P=File submitted is a production file. |

MEDICAL CLAIMS FILE TRAILER RECORD

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|----------------|-------------------|---------|------------|---|
| TR001 | Record Type | char | 2 | TRMC |
| TR002 | File Type | char | 2 | MC |
| TR0032 | Payer Code | varchar | 74 | Distributed by CIVHC's data administrator |
| TR0043 | Payer Name | varchar | 75 | Distributed by CIVHC |
| TR0054 | Beginning Month | date | 6 | CCYYMMYYYYMM |
| TR0065 | Ending Month | date | 6 | CCYYMMYYYYMM |
| TR0076 | Extraction Date | date | 8 | CCYYMMDDYYYYMMDD |

A-2.1 MEDICAL CLAIMS FILE

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---------------------|-----------------------------------|---------|--------|---|----------|
| MC001 | N/A | Payer Code | varchar | 74 | Distributed by CIVHC's data administrator | R |
| MC002 | N/A | Payer Name | varchar | 30 | Distributed by CIVHC | R |
| MC003 | 837/2000B/SBR/ /09 | Insurance Type/Product Code | char | 2 | See Lookup Table B.1.A | R |
| MC004 | 835/2100/CLP/ /07 | Payer Claim Control Number | varchar | 35 | Must apply to the entire claim and be unique within the payer's system. No partial claims. Include all claim lines whether paid or denied. | R |
| MC004A | N/A | Cross Reference Claims ID | varchar | 35 | The original Payer Claim Control Number (MC004). Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Version Number (MC005A) is not used. MC004A and MC004 should be identical when MC038C = O. | R |
| MC005 | 837/2400/LX/ /01 | Line Counter | int | 4 | Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim. All claims must contain a line 1. | R |
| MC005A | N/A | Version Number | int | 4 | The version number of this claim service line. The original claim will have a version number of 0, with the next version being assigned a 1, and each subsequent version being incremented by 1 for that service line. | R |
| MC006 | 837/2000B/SBR/ /03 | Insured Group or Policy Number | varchar | 30 | Group or policy number - not the number that uniquely identifies the subscriber. Ensure continuity across file types. Note that ME006 = MC006; PC006. | R |
| MC007 | 835/2100/NM1/34/ 09 | Subscriber Social Security Number | varchar | 9 | Subscriber's social security number; set as null if unavailable Ensure continuity across file types. Note that ME008 = MC007; PC007. | O |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|--|--|---------|--------|---|--|
| MC008 | 835/2100/NM1/HN/09 | Plan Specific Contract Number | varchar | 128 | Plan assigned subscriber's contract number; may use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber. Ensure continuity across file types. Note that ME009 = MC008; PC008 | R |
| MC009 | N/A | Member Number | varchar | 128 | Unique number of the member within the contract. Must be an identifier that is unique to the member. May include a combination of contract number and suffix number in order to be unique. This column is the unique identifying column for membership and related medical and pharmacy claims. Only one record per eligibility month per eligibility year. Ensure continuity across file types. Note that MC009 = ME010; PC009 | R |
| MC010 | 835/2100/NM1/MI/089 | Member Identification Code (patient) | varchar | 9 | Member's social security number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member. Ensure continuity across file types. Note that ME011 = MC010; PC010 | O |
| MC011 | 837/2000B/SBR/02, 837/2000C/PAT/01, 837/2320/SBR/02 | Individual Relationship Code | char | 2 | Member's relationship to insured - payers will map their available codes to those listed in Lookup Table B.1.B Ensure continuity across file types. Note that ME012 = MC011; PC011 | R |
| MC012 | 837/2010CA/DMG/03 | Member Gender | char | 1 | M = Male F = Female X = Non-binary U = Unknown | R |
| MC013 | 837/2010CA/DMG/D8/02 | Member Date of Birth | date | 8 | YYYYMMDD | R |
| MC014 | 837/2010CA/N4/01 | Member City Name of Residence | varchar | 30 | City name of member's residence | R |
| MC107 | 271/2100C/N3/01, 02 271/2100D/N3/01, 02 | Member Street Address | varchar | 50 | Physical street address of the covered member | R |
| MC015 | 837/2010CA/N4/02 | Member State or Province | char | 2 | As defined by the US Postal Service | R |
| MC016 | 837/2010CA/N4/03 | Member ZIP Code | varchar | 11 | ZIP Code of member - may include non-US codes. Do not include dash. Plus 4 optional but desired. | R |
| MC017 | N/A | Date Service Approved/Accounts Payable Date/Actual Paid Date/ <u>Denial Processed Date</u> | date | 8 | YYYYMMDD Leave blank if claim fully denied when MC038 = 04 or 23. | R for paid and partially paid claims |
| MC018 | 837/2300/DTP/435/03 | Admission Date | date | 8 | Required for all inpatient claims. YYYYMMDD | R for all inpatient claims O for outpatient |

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

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

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

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

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---------------------|------------------------|---------|--------|---|----------|
| MC060 | 835/2110/DTM/151/02 | Date of Service - Thru | date | 8 | Last date of service for this service line. GGYYMMDD | R |
| MC061 | 835/2110/SVC/ /05 | Quantity | dec | 12 | Count of services performed. The Unit of Measure is typically based on the relevant reporting code (e.g., CPT, revenue, HCPCS) For example: Anesthesiology = minutes Ambulance = Miles Room and board = Days Do code decimal point when applicable. For denied claims/claim lines, enter quantity as a positive value. | R |
| MC061A | N/A | Unit of Measure | varchar | 2 | Types of units for quantity reported in MC061. For drugs, report the code that defines the unit of measure for the drug dispensed in MC075. See Lookup Table B.1.N | R |
| MC062 | 835/2110/SVC/ /02 | Charge Amount | int | 11 | Do not code decimal point or provide any punctuation where \$1,000.00 converted to 100000. Do not code decimal point. Two decimal places implied. Same for all financial data that follows. For denied claims/claim lines, enter charge amount as a positive value. | R |
| MC063 | 835/2110/SVC/ /03 | Paid Amount | int | 10 | Includes any withhold amounts. Do not code decimal point. Two decimals implied. For capitated claims set to zero. For denied claims/claim lines, paid amount should be \$0. | R |
| MC064 | N/A | Prepaid Amount | int | 10 | For capitated services, the fee for service equivalent amount. Do not code decimal point. Two decimals implied. For denied claims/claim lines, prepaid amount can be a positive amount or \$0. | R |
| MC065 | N/A | Co-pay Amount | int | 10 | The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point. Two decimals implied. For denied claims/claim lines, co-pay amount should be \$0. | R |
| MC066 | N/A | Coinsurance Amount | int | 10 | The dollar amount an individual is responsible for - not the percentage. Do not code decimal point. Two decimals implied. For denied claims/claims lines, coinsurance amount should be \$0. | R |
| MC067 | N/A | Deductible Amount | int | 10 | Do not code decimal point. Two decimals implied. For denied claims/claims lines, deductible amount should be \$0. | R |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|----------------------|---|---------|--------|---|--|
| MC213 | N/A | Payment Arrangement Type Flag | char | 2 | Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 03=Percent of Charges; 04=DRG; 05=Pay for Performance; 06=Global Payment; 07=Other; 08=Bundled Payment. | R |
| MC068 | 837/2300/CLM/ /01 | Patient Account/Control Number | varchar | 20 | Number assigned by hospital | O |
| MC069 | N/A | Discharge Date | date | 8 | Date patient discharged. Required for all inpatient claims. CC YYMMDD | R for all Inpatient Claims O for Outpatient |
| MC070 | N/A | Service Provider Country Name | varchar | 30 | Code US for United States. | R |
| MC071 | 837/2300/HI/DR/01-2 | DRG | varchar | 10 | Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to DRGs transmitted from the hospital provider. When the CMS methodology for DRGs is not available, but the DRG system is used, the insurer shall format the DRG and the complexity level within the same field with an “A” prefix, and with a hyphen separating the DRG and the complexity level (e.g. AXXX-XX). | O |
| MC072 | N/A | DRG Version | char | 2 | Version number of the grouper used | O |
| MC073 | 835/2110/REF/APC/02 | APC | char | 4 | Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to APCs transmitted from the health care provider. | O |
| MC074 | N/A | APC Version | char | 2 | Version number of the grouper used | O |
| MC075 | 837/2410/LIN/N4/03 | NDC Drug Code | varchar | 11 | Report the NDC code used only when a medication is paid for as part of a medical claim or when a DME device has an NDC code. J codes should be submitted under procedure code (MC055), and have a procedure code type of ‘HCPCS. | R; set as null if unavailable |
| MC076 | 837/2010AA/NM1/ID/09 | Billing Provider Number | varchar | 30 | Payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. | R |
| MC077 | 837/2010AA/NM1/XX/09 | National Billing Provider ID | varchar | 20 | National Provider ID | R |
| MC078 | 837/2010AA/NM1/ /03 | Billing Provider Last Name or Organization Name | varchar | 60 | Full name of provider billing organization or last name of individual billing provider. | R |
| MC101 | 837/2010BA/NM1/ /03 | Subscriber Last Name | varchar | 128 | Subscriber last name | R |
| MC102 | 837/2010BA/NM1/ /04 | Subscriber First Name | varchar | 128 | Subscriber first name | R |
| MC103 | 837/2010BA/NM1/ /05 | Subscriber Middle Initial | char | 1 | Subscriber middle initial | O |
| MC104 | 837/2010CA/NM1/ /03 | Member Last Name | varchar | 128 | Member last name | R |
| MC105 | 837/2010CA/NM1/ /04 | Member First Name | varchar | 128 | Member first name | R |

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

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

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

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

A-3 PHARMACY CLAIMS DATA

Frequency: Monthly Upload via FTP or Web Portal

Additional formatting requirements:

- [Include paid and denied claims.](#)
- Payers submit data in a single, consistent format for each data type.

PHARMACY CLAIMS FILE HEADER RECORD

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|------------------|---------------------------|-----------------|---------------|---|
| HD001 | Record Type | char | 2 | HD PC |
| HD002 | File Type | char | 2 | PC |
| HD003 | Payer Code | char | 74 | Distributed by CIVHC's data administrator |
| HD004 | Payer Name | char | 75 | Distributed by CIVHC |
| HD005 | Beginning Month | date | 6 | CCYYMM YYYYMM |
| HD006 | Ending Month | date | 6 | CCYYMM YYYYMM |
| HD007 | Record count | int | 10 | Total number of records submitted in the Pharmacy Claims file, excluding header and trailer records |
| HD008 | Med_BH PMPM | int | 7 | Place holder. Leave this field-value blank. |
| HD009 | Pharmacy PMPM | int | 7 | Sum of PC036(Paid Amount) + PC040(Co-pay Amount) + PC041(Coinsurance Amount) + PC042(Deductible Amount) in pharmacy claims divided by the total distinct member IDs in the member eligibility, where prescription drug coverage flag (ME019) = 'Y'. Do not code decimal point or provide any punctuation where \$1,000.00 converted to 100000 Two decimal places implied. Leave blank if above condition does not apply. |
| HD010 | Dental PMPM | int | 7 | Place holder. Leave this field-value blank. |
| HD011 | Vision PMPM | int | 7 | Place holder. Leave this field-value blank. |
| HD012 | Test File Flag | char | 1 | T=File submitted is a test file; P=File submitted is a production file. |

PHARMACY CLAIMS FILE TRAILER RECORD

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|------------------|-------------------------|--------------------|---------------|---|
| TR001 | Record Type | char | 2 | TR PC |
| TR002 | File Type | char | 2 | PC |
| TR003 | Payer Code | varchar | 74 | Distributed by CIVHC's data administrator |
| TR004 | Payer Name | varchar | 75 | Distributed by CIVHC |
| TR005 | Beginning Month | date | 6 | CCYYMM YYYYMM |
| TR006 | Ending Month | date | 6 | CCYYMM YYYYMM |
| TR007 | Extraction Date | date | 8 | CCYYMMDD YYYYMMDD |

A-3.1 PHARMACY CLAIMS FILE

| Data Element # | National Council for Prescription Drug Programs Field # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---|-----------------------------|---------|--------|--|----------|
| PC001 | N/A | Payer Code | varchar | 74 | Distributed by CIVHC's data administrator | R |
| PC002 | N/A | Payer Name | varchar | 30 | Distributed by CIVHC | R |
| PC003 | N/A | Insurance Type/Product Code | char | 2 | See lookup table B.1.A | R |
| PC004 | N/A | Payer Claim Control Number | varchar | 35 | Must apply to the entire claim and be unique within the payer's system. Required for all paid, partially paid and fully denied claims. | R |
| PC204 | N/A | Script number | int | 18 | Script number of prescription | R |
| PC005 | N/A | Line Counter | int | 4 | Line number for this service. The line counter begins with 1 and is incremented | R |

| Data Element # | National Council for Prescription Drug Programs Field # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---|--|---------|--------|---|---|
| | | | | | by 1 for each additional service line of a claim. | |
| PC006 | 301-C1 | Insured Group or Policy Number | varchar | 30 | Group or policy number – not the number that uniquely identifies the subscriber Ensure continuity across file types. Note that ME006 = MC006; PC006. | R |
| PC007 | 302-C2 | Subscriber Social Security Number | varchar | 9 | Subscriber's social security number; Set as null if unavailable Ensure continuity across file types. Note that ME008 = MC007; PC007. | O |
| PC008 | N/A | Plan Specific Contract Number | varchar | 128 | Plan assigned subscriber's contract number; may use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber. Ensure continuity across file types. Note that ME009 = MC008; PC008 | R |
| PC009 | 303-C3 | Member Number | varchar | 128 | Unique number of the member within the contract. Must be an identifier that is unique to the member. May include a combination of contract number and suffix number in order to be unique. This column is the unique identifying column for membership and related medical and pharmacy claims. Only one record per eligibility month per eligibility year. Ensure continuity across file types. Note that ME010 = MC009; PC009 | R |
| PC010 | 302-C2 | Member Identification Code | varchar | 128 | Member's social security number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member. Ensure continuity across file types. Note that ME011 = MC010; PC010 | O |
| PC011 | N/A | Individual Relationship Code | char | 2 | Member's relationship to insured Use Lookup Table B.1.B Ensure continuity across file types. Note that ME012 = MC011; PC011 | R |
| PC012 | 305-C5 | Member Gender | char | 1 | M = Male F = Female X = Non-binary U = UNKNOWN | R |
| PC013 | 304-C4 | Member Date of Birth | date | 8 | YYCCYYMMDD | R |
| PC014 | N/A | Member City Name of Residence | varchar | 50 | City name of member's residence | R |
| PC015 | N/A | Member State or Province | char | 2 | As defined by the US Postal Service | R |
| PC016 | N/A | Member ZIP Code | varchar | 11 | ZIP Code of member – may include non-US codes. Do not include dash. Plus 4 optional but desired. | R |
| PC017 | N/A | Paid date/ Denial processed date | date | 8 | CCYYMMDD – date claim paid or denial processed if available, otherwise set to date prescription filled Leave blank if claim fully denied when PC025 = 04 or 23 | R for paid and partially paid claims |

| Data Element # | National Council for Prescription Drug Programs Field # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---|--------------------------------------|---------|--------|---|-------------------------|
| PC018 | 201-B1 | Pharmacy Number | varchar | 30 | Payer assigned pharmacy number. AHFS number is acceptable. | R |
| PC019 | N/A | Pharmacy Tax ID Number | int | 9 | Federal taxpayer's identification number coded with no punctuation (carriers that contract with outside PBM's will not have this) | R |
| PC020 | 833-5P | Pharmacy Name | varchar | 50 | Name of pharmacy | R |
| PC021 | N/A | Pharmacy National Provider ID Number | varchar | 20 | National Provider ID of pharmacy. This data element pertains to the entity or individual directly providing the service. | R |
| PC048 | N/A | Pharmacy Location Street Address | varchar | 50 | Street address of pharmacy | O |
| PC022 | 831-5N | Pharmacy Location City | varchar | 30 | City name of pharmacy - preferably pharmacy location (if mail order null) | R |
| PC023 | 832-5O | Pharmacy Location State | char | 2 | As defined by the US Postal Service (if mail order null) | R |
| PC024 | 835-5R | Pharmacy ZIP Code | varchar | 10 | ZIP Code of pharmacy - may include non-US codes. Do not include dash. Plus 4 optional but desired (if mail order null) | R |
| PC024d | N/A | Pharmacy Country Name | varchar | 30 | Code US for United States | R |
| PC025 | N/A | Claim Status | char | 2 | See Lookup Table B.1.F | R |
| PC025A | N/A | COB/TPL Amount | int | 12 | Amount due from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/TPL amount. Do not code decimal point or provide any punctuation (e.g., \$1,000.25 converted to 100025). | R if PC025 = 19, 20, 21 |
| PC025B | N/A | Claim Line Type | char | 1 | Report the code that defines the claim line status in terms of adjudication. Valid codes are: O = original (original claim with no amendments or reversals) V = void (claim is voided and no amendment or replacement is expected) R = replacement (replaced claim) B = back out (claim is backed out and an amendment or replacement is expected) A = amendment (amended claim after original claim was backed out) D = denied | R |
| PC026 | 407-D7 | NDC Drug Code | varchar | 11 | NDC Code | R |
| PC027 | 516-FG | Drug Name | varchar | 80 | Text name of drug | R |
| PC053 | N/A | Formulary Indicator | char | 1 | Use this field to report if the prescribed drug was on the carrier's formulary list. Valid codes include: 1 = Yes; 2 = No; 3 = Unknown; 4 = Other; 5 = Not applicable. | R |
| PC028 | 403-D3 | New Prescription or Refill | varchar | 2 | Older systems provide only an "N" for new or an "R" for refill, otherwise provide refill # 01 = New prescription 02 = Refill | R |
| PC028A | N/A | Refill Number | varchar | 2 | 01-99 = Number of refill | R |
| PC029 | 425-DP | Generic Drug Indicator | char | 2 | 00 01 = Branded drug 02 = Generic drug Should represent the generic/brand status at the time of adjudication. | R |

| Data Element # | National Council for Prescription Drug Programs Field # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---|---|------|--------|--|----------|
| PC029A | N/A | Specialty Drug Indicator | char | 1 | Y = Drug is a specialty drug based on payer formulary N = Drug is not a specialty drug based on payer formulary | R |
| PC030 | 408-D8 | Dispense as Written Code | char | 1 | Please use Table B.1.H | R |
| PC031 | 406-D6 | Compound Drug Indicator | char | 1 | N = Non-compound drug Y = Compound drug U = Non-specified drug compound | R |
| PC031A | N/A | Compound Drug Name or Compound Drug Ingredient List | char | 255 | If PC031 = Y, then provide the name of the compound drug. If no compound drug name is identified, include the names of the compound drug ingredients. Do not include drug NDCs. Use spaces between multiple drugs. | O |
| PC032 | 401-D1 | Date Prescription Filled | date | 8 | YY GG YYMMDD | R |
| PC033 | 404-D4 | Quantity Dispensed | dec | 10 | Number of metric units of medication dispensed. Code decimal point. For denied claims/claim lines, enter quantity dispensed as 0. | R |
| PC034 | 405-D5 | Days Supply | int | 4 | Estimated number of days the prescription will last. For denied claims/claim lines, enter days supply as 0. | R |
| PC035 | 804-5B | Charge Amount | int | 10 | Do not code decimal point or provide any punctuation where \$1,000.00 converted to 100000. Two decimal places implied. Same for all financial data that follows. For denied claims/claim lines, enter charge amount as a positive value. | R |
| PC036 | 876-4B | Paid Amount | int | 10 | Includes all health plan payments and excludes all member payments. Do not code decimal point. Two decimal places implied. Do not deduct POS rebate amount, if applicable. For denied claims/claim lines, paid amount should be \$0. | R |
| PC037 | 506-F6 | Ingredient Cost/List Price | int | 10 | Cost of the drug dispensed. Do not code decimal point. Two decimal places implied. | R |
| PC038 | 428-DS | Postage Amount Claimed | int | 10 | Do not code decimal point. Two decimal places implied. Not typically captured. For denied claims/claim lines, postage amount claimed should be \$0. | O |
| PC039 | 412-DC | Dispensing Fee | int | 10 | Do not code decimal point. Two decimal places implied. For denied claims/claim lines, dispensing fee should be \$0. | R |
| PC040 | 817-5E | Co-pay Amount | int | 10 | The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point. Two decimal places implied. Do not deduct POS rebate amount, if applicable. For denied claims/claim lines, co-pay amount should be \$0. | R |
| PC041 | N/A | Coinsurance Amount | int | 10 | The dollar amount an individual is responsible for - not the percentage. Do not code decimal point. Two decimal places | R |

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

| Data Element # | National Council for Prescription Drug Programs Field # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---|--|---------|--------|--|--------------------------------------|
| PC051 | N/A | NAIC ID | char | 5 | Report the NAIC Code associated with the entity that maintains this product. For each claim, use the NAIC code of the carrier when a PBM processes claims on behalf of the carrier. Leave this field blank if entity does not have a NAIC Code. | R |
| PC052 | N/A | Medicaid AID category | char | 4 | For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. Contact CIVHC for acceptable codes. If not applicable, leave this field blank. | R for HCPF |
| PC203 | N/A | Managed Care Coordination Flag | char | 1 | Y = claim is associated with managed care coordination, HCPF-defined "encounter claim" N = claim is not associated with managed care coordination Leave this field blank if submitterpayer is not HCPF | R for HCPF |
| PC205 | N/A | Mail Order Pharmacy Indicator | char | 1 | Y = prescription was filled using a mail order pharmacy N = prescription was not filled using a mail order pharmacy | R |
| PC206 | N/A | Value-Based Payment (VBP) Indicator | char | 1 | Y = claim was adjudicated under a value-based payment (VBP) N = claim was not adjudicated under a value-based payment (VBP) | O for six months (R in January 2022) |
| PC207 | N/A | Denied Claim Line Indicator | char | 1 | Use this field to indicate whether the payer denied this specific line on this specific claim. Valid codes are: Y=Yes (denied). N= No (not denied). 1=Yes (denied); 2= No (not denied). | R |
| PC208 | N/A | Denial Reason | char | 5 | Report the National Council for Prescription Drug Programs, (NCPDP) reject code- that defines the reason why the claim was denied. | R when PC025 = 04 |
| PC209 | N/A | Formulary Tier | int | 1 | The level of coverage based on the type or usage of the medication. For drugs on the carrier's formulary list only. 1 = Tier 1 Preferred generic drugs (Lower-cost, commonly used generic drugs) 2 = Tier 2 Generic drugs (High-cost, commonly used generic drugs) 3 = Tier 3 Preferred brand drugs (Brand-name drugs without a lower-cost generic therapeutic equivalent) 4 = Tier 4 Non-preferred generic and brand drugs (Higher-cost generic and brand-name drugs with a lower-cost generic therapeutic equivalent) 5 = Tier 5 Specialty drugs (Unique and/or high-cost generic and brand-name drugs) | R when PC053 = 1 |
| PC210 | N/A | Benefit Plan Code (HCPF -specific) | varchar | 6 | For HCPF only. Provide the Benefit Plan Code for which the member is eligible and applies to this claim. Codes are determined by the state's Medicaid agency. Leave this field blank if non-HCPF submitterpayer | R for HCPF |
| PC211 | N/A | Benefit Plan Code Description (HCPF -specific) | varchar | 100 | -HCPF-defined Benefit Plan Code description Leave this field blank if non-HCPF submitterpayer | R for HCPF |

| Data Element # | National Council for Prescription Drug Programs Field # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---|-------------------|------|--------|---------------------------|----------|
| PC899 | N/A | Record Type | char | 2 | PC | R |

A-4 PROVIDER DATA

Frequency: Monthly Upload via FTP or Web Portal

Additional formatting requirements:

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

PROVIDER FILE HEADER RECORD

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|------------------|-----------------------|-------------|---------------|--|
| HD001 | Record Type | char | 2 | <u>HDMP</u> |
| <u>HD002</u> | <u>File Type</u> | <u>char</u> | <u>2</u> | <u>MP</u> |
| HD003 | Payer Code | varchar | 74 | Distributed by CIVHC's <u>data administrator</u> |
| HD004 | Payer Name | varchar | 75 | Distributed by CIVHC |
| HD005 | Beginning Month | date | 6 | CCYYMM <u>YYYYMM</u> (Example: 200801) |
| HD006 | Ending Month | date | 6 | CCYYMM <u>YYYYMM</u> (Example: 200812) |
| HD007 | Record count | int | 10 | Total number of records submitted in the Provider file, excluding header and trailer records |
| HD008 | Med_BH PMPM | int | 7 | Place holder. Leave <u>this</u> field value blank. |
| HD009 | Pharmacy PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD010 | Dental PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD011 | Vision PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| <u>HD012</u> | <u>Test File Flag</u> | <u>char</u> | <u>1</u> | <u>T=File submitted is a test file;</u> <u>P=File submitted is a production file.</u> |

PROVIDER FILE TRAILER RECORD

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|--------------------|-------------------|-------------|------------|---|
| TR001 | Record Type | char | 2 | <u>HD</u> MP |
| <u>TR002</u> | <u>File Type</u> | <u>char</u> | <u>2</u> | <u>MP</u> |
| TR003 2 | Payer Code | varchar | <u>74</u> | Distributed by CIVHC's <u>data administrator</u> |
| TR004 3 | Payer Name | varchar | 75 | Distributed by CIVHC |
| TR005 4 | Beginning Month | date | 6 | CCYYMM - <u>YYYYMM</u> (Example: 200801) |
| TR006 5 | Ending Month | date | 6 | CCYYMM - <u>YYYYMM</u> (Example: 200812) |
| TR007 6 | Extraction Date | date | 8 | CCYYMMDD <u>YYYYMMDD</u> |

A-4.1 PROVIDER FILE

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|---|---------|-----------|--|----------|
| MP001A | N/A | Payer Code | varchar | <u>74</u> | Distributed by CIVHC's <u>data administrator</u> | R |
| MP001B | N/A | Year | year | 4 | 4-digit Year for which the provider is reported in this submission | R |
| MP001C | N/A | Month | month | 2 | Month for which the provider is reported in this submission expressed numerical from 01 to 12. | R |
| MP001 | N/A | Provider ID | varchar | 30 | A unique identifier for the provider as assigned by the reporting entity. Needs to be unique within the MP file. One unique ID Per Provider. May include a unique combination of NPI and tax ID. MP001= MC024, PC047A | R |
| MP002 | N/A | Provider Tax ID | int | 9 | Tax ID of the provider. Do not code punctuation. Report employer TIN when entity is a practitioner. | R |
| MP003 | N/A | Provider Entity | char | 1 | F = Facility G = Provider group I = IPA P = Practitioner | R |
| MP004 | N/A | Provider First Name | varchar | 25 | Individual first name. Set to null if provider is a facility or organization. | R |
| MP005 | N/A | Provider Middle Name or Initial | varchar | 25 | Provider middle name or initial | O |
| MP006 | N/A | Provider Last Name or Organization Name | varchar | 60 | Full name of provider organization or last name of individual provider | R |
| MP007 | N/A | Provider Suffix | varchar | 10 | Example: Jr.; <u>leave this field blank-NULL</u> if provider is an organization. Do not use credentials such as MD or PhD | O |
| MP008 | N/A | Provider Specialty | varchar | 50 | Report the HIPAA-compliant health care provider taxonomy code. Code set is freely available at the National Uniform Claims Committee's web site https://taxonomy.nucc.org/ | R |
| MP009 | N/A | Provider Office Street Address | varchar | 50 | Physical address line 1- street address where provider delivers health care services: street name and number | R |

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

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

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

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

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

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

On a yearly basis, payers will transmit complete and accurate APM data for the most recent and complete three calendar year periods by no later than September 1st of the following year. Please see an example of the timeline below. Payers are required to submit test files by July 1 containing the same three calendar year periods as the production files. Please note that the administrator may choose to require test files to be submitted prior to the annual due date of September 1st. The administrator requires test files containing the same three calendar year periods reported in the production file to be submitted by July 1.

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

~~Submitters requesting to opt out of one or more annual file(s) are required to submit a waiver by July April 1st to submissions@civhc.org.
Waivers are required to be sent separately by each payer code.~~

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

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

All definitions for APM types are included in [look up table B.1.J](#)

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

APM FILE HEADER RECORD

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|--------------------|----------------------|-----------------|---------------|---|
| HD001 | Record Type | char | 2 | AM-HD |
| HD002 | File Type | char | 2 | AM |
| HD003 2 | Payer Code | varchar | 74 | Distributed by CIVHC's data administrator |
| HD004 3 | Payer Name | varchar | 75 | Distributed by CIVHC |
| HD005 4 | Beginning Month | date | 6 | CCYYMM -YYYYMM (Example: 200801) |
| HD006 5 | Ending Month | date | 6 | CCYYMM -YYYYMM (Example: 200812) |
| HD007 6 | Record Count | int | 10 | Total number of records submitted in the APM file, excluding header and trailer records |
| HD008 7 | Med_BH PMPM | int | 7 | Place holder. Leave this field blank. Leave field value blank. |

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|----------------|-------------------|------|------------|--|
| HD0098 | Pharmacy PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD01009 | Dental PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD0110 | Vision PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD012 | Test File Flag | char | 1 | T=File submitted is a test file; P=File submitted is a production file. |

APM FILE TRAILER RECORD

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|----------------|-------------------|---------|------------|---|
| TR001 | Record Type | char | 2 | TRAM |
| TR002 | File Type | char | 2 | AM |
| TR0032 | Payer Code | varchar | 74 | Distributed by CIVHC's data administrator |
| TR0043 | Payer Name | varchar | 75 | Distributed by CIVHC |
| TR0054 | Beginning Month | date | 6 | CCYYMM-YYYYMM (Example: 200801) |
| TR0065 | Ending Month | date | 6 | CCYYMM-YYYYMM (Example: 200812) |
| TR0076 | Extraction Date | date | 8 | CCYYMMDD-YYYYMMDD |

A-5.1 -APM FILE

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|---|---------|--------|--|----------|
| AM001 | N/A | Payer Code | varchar | 74 | Distributed by CIVHC's data administrator | R |
| AM002 | N/A | Billing Provider Number | varchar | 30 | Payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. This number should align with billing provider numbers in the MC file. | R |
| AM003 | N/A | National Billing Provider ID | varchar | 20 | National Provider ID | R |
| AM004 | N/A | Billing Provider Tax ID | varchar | 9 | Tax ID of billing provider. Do not code punctuation. | R |
| AM005 | N/A | Billing Provider Last Name or Organization Name | varchar | 128 | Full name of provider billing organization or last name of individual billing provider. | R |
| AM006 | N/A | Billing Provider Entity | char | 1 | F = Facility G = Provider group I = IPA P = Practitioner | R |
| AM007 | CDLAP012 | Payment Arrangement Category | char | 1 | See look up table B.1.J Payment arrangement type reported. If there is more than one payment arrangement type with a billing provider/organization, then separately report each payment arrangement type. | R |
| AM008 | N/A | Prospective Payment Flag | char | 1 | Y = Payment to provider for services was made prospectively; populate field with 'Y' even when retrospective reconciliation is part of contract N = Payment to provider for services was not made prospectively | R |
| AM009 | N/A | Performance Year | year | 4 | Effective year of performance period for reported Insurance Product Type Code and Payment Arrangement Type. YY YY format | R |
| AM010 | N/A | Insurance Product Type Code | char | 2 | See lookup table B.1.A | R |
| AM011 | N/A | Member Months | int | 12 | Total number of members in reported stratification attributed to given billing provider that participate in the reported payment | R |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|---|---------|--------|---|----------|
| | | | | | <p>arrangement in given year, expressed in months of membership</p> <p>No decimal places; round to nearest integer. Example: 12345</p> | |
| AM012 | N/A | Total Primary Care Claims Payments | numeric | 15 | <p>Sum of all associated payments tied to a claim, including patient cost-sharing amounts that pertain to primary care. Primary care services are to be identified based on the definition provided in table B.1.K.</p> <p>Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no primary care claims payments made.</p> <p>This value should never exceed the amount of Total Claims Payments (AM016).</p> | R |
| AM013 | N/A | Payer Portion: Total Primary Care Claims Payments | numeric | 15 | <p>Payer portion of total primary care payments tied to a claim reported in AM012. Exclude member portion (copay, coinsurance, deductible). Should be a sub-set of AM012.</p> <p>Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no primary care claims payments made by payer.</p> | R |
| AM014 | N/A | Total Primary Care Non-Claims Payments | numeric | 15 | <p>Sum of all associated non-claims payments that pertain to primary care. Primary care services are to be identified based on the definition provided in table B.1.K.</p> <p>Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no primary care non-claims payments made. Amount reported should be net of any provider recoupments.</p> <p>This value should never exceed the amount of Total Non-Claims Payments (AM018).</p> | R |
| AM015 | N/A | Payer portion: Total Primary Care Non-Claims Payments | numeric | 15 | <p>Payer portion of Total Primary Care Non-Claims Payments reported in AM014. Exclude member portion (copay, coinsurance, deductible). Should be a sub-set of AM014.</p> <p>Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Amount reported should be net of any provider recoupments.</p> <p>Enter 0 if no primary care non-claims payments made by payer.</p> | R |
| AM016 | N/A | Total Claims Payments | numeric | 15 | <p>Sum of all associated payments tied to a claim, including patient cost-sharing amounts.</p> <p>Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no claims payments made.</p> | R |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|--|---------|--------|--|--------------------|
| AM017 | N/A | Payer Portion: Total Claims Payments | numeric | 15 | Payer portion of total payments tied to a claim reported in AM016. Exclude member portion (copay, coinsurance, deductible). Should be a sub-set of AM016. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no claims payments made by payer. | R |
| AM018 | N/A | Total Non-Claims Payments | numeric | 15 | Sum of all associated non-claims payments. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Amount reported should be net of any provider recoupments. Enter 0 if no non- claims payments made. | R |
| AM019 | N/A | Payer Portion: Total Non-Claims Payments | numeric | 15 | Payer portion of Total Non-Claims Payments reported in AM018. Exclude member portion (copay, coinsurance, deductible). Should be a sub-set of AM018. Amount reported should be net of any provider recoupments. Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no non-claims payments made by payer. | R |
| AM020 | N/A | Recoupments from Provider | numeric | 15 | Any funds that were refunded to carrier from provider as a result of missed quality metrics, missed spending targets, or APM reconciliation payments. Do not report claim reversals or any other recoupments that occurred as a result of accounting errors. | R |
| AM021 | N/A | Billing Provider Office City | varchar | 30 | Physical address – name of city | R |
| AM022 | N/A | Billing Provider Office State | char | 2 | Physical address – name of state. Use postal service standard 2 letter abbreviations. | R |
| AM023 | N/A | Billing Provider Office Zip | varchar | 11 | Physical address - Minimum 5-digit zip code. | R |
| AM024 | N/A | RAE Indicator | char | 2 | Identify which Medicaid Regional Accountable Entity the provider is associated with 1 = RAE Region 1 2 = RAE Region 2 3 = RAE Region 3 4 = RAE Region 4 5 = RAE Region 5 6 = RAE Region 6 7 = RAE Region 7 8 = RAE Region 8 Leave this field blank if non-MCO/RAE submitter/payer | R for RAE and MCOs |
| AM025 | CDLAP005 | Contract Number | varchar | 80 | The unique number identifying a contract between the submitter/payer and the billing provider for the reported payment model. | R |
| AM026 | CDLAP011 | Billing Provider First Name | varchar | 35 | Individual first name. If provider is a facility or organization, leave this field blank. | R |
| AM027 | CDLAP012 | Payment Subcategory | char | 2 | Report a Payment Subcategory corresponding to the initial character in the Payment Arrangement Category in AM007. See table B.1.J.A | R |
| AM028 | CDLAP014 | Member Count | int | 12 | The total number of members enrolled during the reporting period. Report when Payment Category (AM007) = 'B', 'D', or 'Z': | R |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|---|---------|--------|---|----------|
| | | | | | 1. Category = 'B': Total number of members associated with the incentive payments. 2. Category = 'D': Total number of members associated with the capitated payments reported. 3. Category = 'Z': Total number of months enrolled for members reported in Member Count (members for submitterpayer's entire book of business for the year). This record is not expected to have any associated dollar amounts reported. | |
| AM029 | CDLAP017 | Total Member Responsibility Amount | numeric | 15 | Total of all member responsibility amounts (copay, coinsurance, and deductibles). Two explicit decimal places (e.g., 200.00). If the value for this field is zero, report as "0.00", not as null. This field may contain a negative value. | R |
| AM030 | CDLAP019 | Total Amount Paid for Behavioral Health | numeric | 15 | Total of all payments made to a billing provider for behavioral health services during the Reporting/Performance Period. For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member responsibility amounts (copay, coinsurance, and deductibles). Two explicit decimal places (e.g., 200.00). If the value for this field is zero, report as "0.00", not as null. This field may contain a negative value. | R |
| AM999 | N/A | Record Type | char | 2 | AM | R |

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

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

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

~~On a yearly basis, payers will transmit complete and accurate APM data for the most recent and complete three calendar year periods by no later than September 1st of the following year. Please see an example of the timeline below. Please note that the administrator may choose to require test files to be submitted prior to the annual due date of September 1st. To request a one-year waiver from the annual submission requirement, submitters must send the waiver to **submissions@civhc.org** by April 1st. Waivers apply to production files due September 1st of the same calendar year and must be submitted separately for each payer code. Payers are also required to submit test files by July 1 containing the same three calendar year periods as the production files. Test files are intended to help the administrator identify and address issues in advance of the final production submission, ensuring alignment with the strict reporting timelines. Submitters are expected to communicate with CIVHC throughout the testing process and during production submission for clarification, feedback, and resubmission guidance, as applicable. Payers are also expected to use test file validation findings to preemptively correct issues identified by the CO APCD administrator in preparation for production file submissions. See the tables below for detailed submission timeline requirements for both test and production files.~~

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

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

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

| Date That Supplier Must Submit Control Total file to CO APCD | Period Begin date | Period End date |
|---|-------------------|-----------------|
| | | |

| | | |
|---|-----------------------|--------------------------|
| 120 days after the effective date of the rule | N/A | N/A |
| July 1, 2019 | January 1, 2016 | December 31, 2016 |
| September 30, 2019 | January 1, 2016 | December 31, 2018 |
| September 30, 2020 | January 1, 2017 | December 31, 2019 |
| September 30, 2021 | January 1, 2018 | December 1 2020 |
| September 1, 2022 | January 1, 2019 | December 31, 2021 |
| September 1, 2023 | January 1, 2020 | December 31, 2022 |
| September 1, 2024 | January 1 2021 | December 31, 2023 |
| September 1, 2025 | January 1 2022 | December 31, 2024 |
| <u>September 1, 2026</u> | <u>January 1 2023</u> | <u>December 31, 2025</u> |

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

CONTROL TOTAL FILE HEADER RECORD

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|------------------|-----------------------|-----------------|--------------|---|
| HD001 | Record Type | char | 2 | HDCT |
| HD002 | File Type | char | 2 | CT |
| HD0032 | Payer Code | varchar | 74 | Distributed by CIVHC's data administrator |
| HD0043 | Payer Name | varchar | 75 | Distributed by CIVHC |
| HD0054 | Beginning Month | date | 6 | CCYYMM - YYYYMM (Example: 200801) |
| HD0065 | Ending Month | date | 6 | CCYYMM - YYYYMM (Example: 200812) |
| HD0076 | Record count | Int | 10 | Total number of records submitted in the Drug Rebate file, excluding header and trailer records |
| HD0087 | Med_BH PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD0098 | Pharmacy PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD01009 | Dental PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD0110 | Vision PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD012 | <u>Test File Flag</u> | <u>char</u> | <u>1</u> | <u>T=File submitted is a test file;</u> <u>P=File submitted is a production file.</u> |

CONTROL TOTAL FILE TRAILER RECORD

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|------------------|----------------------|-----------------|--------------|---|
| TR001 | Record Type | char | 2 | TRCT |
| TR002 | File Type | char | 2 | CT |
| TR0032 | Payer Code | varchar | 74 | Distributed by CIVHC's data administrator |
| TR0043 | Payer Name | varchar | 75 | Distributed by CIVHC |
| TR0054 | Beginning Month | date | 6 | CCYYMM - YYYYMM (Example: 200801) |
| TR0065 | Ending Month | date | 6 | CCYYMM - YYYYMM (Example: 200812) |
| TR0076 | Extraction Date | date | 8 | CCYYMMDD - YYYYMMDD |

A 6.1 - APM FILE CONTROL RECORD

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|---|---------|--------|---|----------|
| CT001 | N/A | Payer Code | varchar | 24 | Distributed by CIVHC's data administrator | R |
| CT002 | N/A | Payer Name | varchar | 75 | Distributed by CIVHC | R |
| CT003 | N/A | Submitted File | varchar | 25 | <p>File name of the APM file. Note, please do not include file extension in the corresponding APM file name, i.e., '.txt'. If your organization resubmits AM under v02, the reference in CT003 should also reflect v02.</p> <p>The value should be case sensitive. For example, if the AM file name is <i>PROD_0000_2024AMv02</i>, CT003 should be <i>PROD_0000_2024AMv02</i> and not <i>PROD_0000_2024AMV02</i>.</p> | R |
| CT004 | N/A | Performance Year | year | 4 | Year of reporting, submit in YYYY format | R |
| CT005 | N/A | Insurance Product Type Code | char | 2 | See lookup table B.1.A | R |
| CT006 | N/A | Payment Arrangement Category | varchar | 2 | See look up table B.1.J Payment arrangement type reported. | R |
| CT007 | N/A | Payment Arrangement Category Member Months | int | 12 | <p>Total, de-duplicated member months associated with payment arrangement category identified in CT006 & CT020 and Medicaid Regional Accountable Entity (RAE) identified in CT018, if applicable .</p> <p>No decimal places; round to nearest integer Example: 12345</p> <p>Enrollment should be reported as de-duplicated member months and should only be reported for those members for whom the mandatory reporter was the primary payer</p> | R |
| CT008 | N/A | All Member Months | int | 12 | <p>Total enrollment during the previous calendar year, regardless of payment arrangement type.</p> <p>No decimal places; round to nearest integer. Example: 12345</p> <p>Enrollment should be reported as de-duplicated member months and should only be reported for those members for whom the mandatory reporter was the primary payer.</p> <p>The value in this field will repeat in the Control Total file for each reported year/insurance product type code/RAE (if applicable) combination.</p> | R |
| CT009 | N/A | Total Alternative Arrangement Member Months | int | 12 | <p>Total enrollment in alternative payment arrangements during the previous calendar year.</p> <p>No decimal places; round to nearest integer Example: 12345</p> <p>Enrollment should be reported as de-duplicated member months and should only be reported for those members for whom the mandatory reporter was the primary payer.</p> <p>The value in this field will repeat in the Control Total file for each reported year/insurance product type code/RAE (if applicable) combination.</p> | R |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|--|---------|--------|--|----------|
| CT010 | N/A | Sum of Primary Care Claims Payments | numeric | 15 | Sum of Total Primary Care Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00). | R |
| CT011 | N/A | Sum of Payer Portion of Primary Care Claims Payments | numeric | 15 | Sum of Payer Portion of Total Primary Care Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00). | R |
| CT012 | N/A | Sum of Primary Care Non-Claims Payments | numeric | 15 | Sum of Total Primary Care Non-Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00). | R |
| CT013 | N/A | Sum of Payer Portion of Primary Care Non-Claims Payments | numeric | 15 | Sum of Payer Portion of Total Primary Care Non-Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00). | R |
| CT014 | N/A | Sum of Claims Payments | numeric | 15 | Sum of Total Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00). | R |
| CT015 | N/A | Sum of Payer Portion of Claims Payments | numeric | 15 | Sum of Payer Portion of Total Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00). | R |
| CT016 | N/A | Sum of Non-Claims Payments | numeric | 15 | Sum of Total Non-Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. Two explicit decimal places (e.g., 200.00). | R |
| CT017 | N/A | Sum of Payer Portion of Non-Claims Payments | numeric | 15 | Sum of Payer Portion of Total Non-Claims Payments, as reported in AM file. Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable. | R |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|--|---------|--------|--|--------------------|
| | | | | | Two explicit decimal places (e.g., 200.00). | |
| CT018 | N/A | RAE Indicator | char | 2 | Identify which Medicaid Regional Accountable Entity the provider is associated with 1 = RAE Region 1 2 = RAE Region 2 3 = RAE Region 3 4 = RAE Region 4 5 = RAE Region 5 6 = RAE Region 6 7 = RAE Region 7 8 = RAE Region 8 Leave this field blank if non-MCO/RAE submitterpayer | R for RAE and MCOs |
| CT019 | N/A | Percent of Providers Participating in at Least One APM | numeric | 3 | Percent of providers under at least one APM contract with the payer. Report the percentage for the Performance Year (CT004) CT019 = (Count of providers that participate in at least one APM contract) / (Count of providers that have at least one claim adjudicated or at least one APM payment during the performance year (CT004)) Two explicit decimal places (e.g., 78.05) | R |
| CT020 | CDLAP012 | Payment Subcategory | char | 2 | Report a Payment Subcategory corresponding to the initial character in the Payment Category in CT006. See table B.1.J.A | R |
| CT021 | | Payment Arrangement Category Member Count | int | 12 | Total, de-duplicated member count associated with payment arrangement category identified in CT006 & CT020 and Medicaid Regional Accountable Entity (RAE) identified in CT018, if applicable. No decimal places; round to nearest integer Example: 12345 Count should be reported as de-duplicated member counts and should only be reported for those members for whom the mandatory reporter was the primary payer | |
| CT022 | | All Member Count | int | 12 | Total member count during the previous calendar year, regardless of payment arrangement type. No decimal places; round to nearest integer. Example: 12345 Count should be reported as de-duplicated member counts and should only be reported for those members for whom the mandatory reporter was the primary payer. The value in this field will repeat in the Control Total file for each reported year/insurance product type code/RAE (if applicable) combination. | R |
| CT023 | | Total Alternative | int | 12 | Total enrollment in alternative payment arrangements during the previous calendar year. | R |

| Data Element # | Reference | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------|---|---------|--------|--|----------|
| | | Arrangement Member Count | | | <p>No decimal places; round to nearest integer Example: 12345</p> <p>Count should be reported as de-duplicated member counts and should only be reported for those members for whom the mandatory reporter was the primary payer.</p> <p>The value in this field will repeat in the Control Total file for each reported year/insurance product type code/RAE (if applicable) combination.</p> | |
| CT024 | CDLAP017 | Total Member Responsibility Amount | numeric | 15 | <p>Total of all member responsibility amounts (copay, coinsurance, and deductibles).</p> <p>Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable.</p> <p>Two explicit decimal places (e.g., 200.00). If the value for this field is zero, report as "0.00", not as null. This field may contain a negative value.</p> | R |
| CT025 | CDLAP019 | Total Amount Paid for Behavioral Health | numeric | 15 | <p>Total of all payments made to a billing provider for behavioral health services during the Reporting/Performance Period. For fee for service claims, this is the total allowable to include amounts paid by the insurer and the member responsibility amounts (copay, coinsurance, and deductibles).</p> <p>Value should be rolled up at Year (CT004), Insurance Product Type (CT005), Payment Arrangement Category (CT006 & CT020) and RAE (CT018) level, if applicable.</p> <p>Two explicit decimal places (e.g., 200.00). If the value for this field is zero, report as "0.00", not as null. This field may contain a negative value.</p> | R |
| CT999 | N/A | Record Type | char | 2 | CT | R |

A-7 ANNUAL APM CONTRACT INFORMATION

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

~~Beginning in 2022, production files with complete three calendar year periods will be submitted no later than September 1st. Please note that the administrator may choose to require test files to be submitted prior to the annual due date of September 1st. Test files covering the same three most recent and complete calendar-year periods are required by July 1 to identify and resolve issues prior to final production submission. Annual submissions must include accurate and complete data for the three most recent calendar years. During both testing and production, submitters are expected to communicate with CIVHC for clarification, feedback, and resubmission guidance, and to take timely corrective action to ensure submissions meet reporting requirements. Payers must also provide explanations for discrepancies, including but not limited to those between files covering the same reporting years, between CO APCD monthly and annual file data, or within reporting years contained in the same submission file. Detailed timelines for both test and production submissions are provided in the tables below.~~

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

AM, CT, and AC Annual Data File Submission Requirements Timeline

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

A 7.1 Annual APM Contract Information

| Data Element # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|--|---------|----------------------------------|--|----------|
| AC001 | Payer Code | varchar | 7N/A Excel file | Distributed by CIVHC's data administrator | R |
| AC002 | Payer Name | varchar | 75N/A Excel file | Distributed by CIVHC | R |
| AC003 | Contract Type Name | varchar | 75N/A Excel file | The unique name of the alternative payment contract type between the payer and providers. | R |
| AC004 | Contract Description | varchar | 500N/A Excel file | Description of the alternative payment model contract 3-5 sentences describing the nature of the contract including a summary of services provided, provider reimbursement method, and any other important details related to the purpose and structure of the contract. If AC007 = "Y," then describe quality metrics associated with arrangement | R |
| AC005 | Involves both claims and non-claims payments | char | 1N/A Excel file | C = Claims only N = Non-Claims only B = Both claims and non-claims | R |
| AC006 | Services Covered | char | 1N/A Excel file | N = Non-medical activities only S = Specific set of medical services M = Comprehensive medical services | R |
| AC007 | Involves Measurement of Quality | char | 1N/A Excel file | Y = Quality measurement N = No quality measurement | R |
| AC008 | Involves Measurement of Spending Targets | char | 1N/A Excel file | Y = Spending targets N = No spending targets | R |
| AC009 | Payments are Prospective or Retrospective | char | 3N/A Excel file | PR = Prospective with retrospective reconciliation PN = Prospective with no retrospective reconciliation RT = Retrospective N/A = Not Applicable | R |
| AC010 | Payment is Population-based | char | 1N/A Excel file | Y = Population-Based N = Not Population-Based | R |
| AC011 | Risk to Provider | char | 3N/A Excel file | U = Upside Only D = Downside Only B = Both Upside and Downside N/A = Not Applicable | R |
| AC012 | Payment Model Involves Quality Measurement of Drug Utilization or Spending | char | 1N/A Excel file | Y = Drug spending/utilization targets N = No drug spending/utilization targets | R |
| AC013 | Provider Type | char | 2N/A Excel file | PC = Primary care provider BH = Behavioral health provider OT = Other provider | R |
| AC014 | Assigned Payment Subc Category | char | 2N/A Excel file | See look up table B.1.J.A↓ Payment arrangement type reported. | R |
| AC015 | Comments | varchar | 1000N/A Excel file | Use this field to provide additional information or describe any caveats | O |
| AC016 | Contract Number | varchar | 80 | The unique number identifying a contract between the submitter payer and the billing | |

| Data Element # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-------------------|------|--------|--|----------|
| | | | | provider for the- <u>reported payment model as reported in AM025.</u> reported payment model as reported in AM025. | |
| AC017 | Contract Type | char | 1 | Use this field to indicate whether the payments reported were administered as part of a medical benefits contract or a dental benefits contract. The only valid codes for this field are: M = Medical: Payments made under a medical benefits contract, including all payments made to providers for medical, pharmacy, and dental services incurred under medical stand-alone coverage. D = Dental: Payments made under a dental benefits contract; this should include only payments made to providers for members on dental stand-alone coverage. | R |

A-8 ANNUAL PRESCRIPTION DRUG REBATE DATA FILE

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

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

Additional formatting requirements:

- Payers submit aggregate level data in a single, consistent format for each data type.
- Include the total amount of any prescription drug rebates, discounts and other pharmaceutical manufacturer compensation or price concessions paid by pharmaceutical manufacturers to a payer or their pharmacy benefit manager(s) during the previous three calendar years. Data elements to be included in the prescription drug rebate file are listed in Table A7.1 Annual Prescription Drug Rebate Data.
- The definition of prescription drug rebates, discounts and all other pharmaceutical manufacturer compensation or price concessions to be used for implementation of the Annual Prescription Drug Rebate Data File requirement is as follows:
 - Rebates: "Rebates" will include price concessions, price discounts, or discounts of any sort that reduce payments, a partial refund of payments or any reductions to the ultimate amount paid; a performance based financial reward; a financial reward for inclusion of a drug in a preferred drug list or formulary or preferred formulary position; market share incentive payments and rewards; credits; remuneration or payments for the provision of utilization or claim data to manufacturers for rebating, marketing, outcomes insights, or any other purpose; rebates, regardless of how categorized, and all Other Compensation to carriers, their PBMs, rebate aggregators, subsidiaries, any affiliated holding and/or parent company or within the parent organization, and all other organizational affiliates. The rebate terms of the reduction must be fixed and disclosed in writing to the payer.
 - All Other Compensation: "All Other Compensation" includes, but is not limited to, all remuneration from the manufacturer to pay for services, actions, activities or trade or fees for an item or service as part of an arms-length transaction; educational grants or other commissions; manufacturer administrative fees; and administrative management fees.

On a yearly basis, payers will transmit complete and accurate drug rebate data for the most recent and complete three calendar year periods by no later than September 1st of the following year. Please note that the administrator may choose to require test files to be submitted prior to the annual due date of September 1st. Test files covering the same three most recent and complete calendar-year periods are required by July 1 to identify and resolve issues prior to final production submission. Annual submissions must include accurate and complete data for the three most recent calendar years. During both testing and production, submitters are expected to communicate with CIVHC for clarification, feedback, and resubmission guidance, and to take timely corrective action to ensure submissions meet reporting requirements. Payers must also provide explanations for discrepancies, including but not limited to those between files covering the same reporting years, between CO APCD monthly and annual file data, or within reporting years contained in the same submission file. Detailed timelines for both test and production submissions are provided in the tables below.

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

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

| Date That Supplier Must Submit Drug Rebate file to CO APCD | Period Begin date | Period End date |
|---|-------------------|-----------------|
| 120 days after the effective date of the rule | N/A | N/A |

| | | |
|--------------------------|-----------------------|--------------------------|
| July 1, 2019 | January 1, 2016 | December 31, 2016 |
| September 30, 2019 | January 1, 2016 | December 31, 2018 |
| September 30, 2020 | January 1, 2017 | December 31, 2019 |
| September 30, 2021 | January 1, 2018 | December 1 2020 |
| September 1, 2022 | January 1, 2019 | December 31, 2021 |
| September 1, 2023 | January 1, 2020 | December 31, 2022 |
| September 1, 2024 | January 1 2021 | December 31, 2023 |
| September 1, 2025 | January 1 2022 | December 31, 2024 |
| <u>September 1, 2026</u> | <u>January 1 2023</u> | <u>December 31, 2025</u> |

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

DRUG REBATE FILE HEADER RECORD

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|------------------|-----------------------|-----------------|--------------|---|
| HD001 | Record Type | char | 2 | HD0R |
| HD002 | File Type | char | 2 | DR |
| HD0032 | Payer Code | varchar | 74 | Distributed by CIVHC's data administrator |
| HD0043 | Payer Name | varchar | 75 | Distributed by CIVHC |
| HD0054 | Beginning Month | date | 6 | CCYYMM - YYYYMM (Example: 200801) |
| HD0065 | Ending Month | date | 6 | CCYYMM - YYYYMM (Example: 200812) |
| HD0076 | Record Count | int | 10 | Total number of records submitted in the Drug Rebate file, excluding header and trailer records |
| HD0087 | Med_BH PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD0098 | Pharmacy PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD0109 | Dental PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD0110 | Vision PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD012 | <u>Test File Flag</u> | <u>char</u> | <u>1</u> | <u>T=File submitted is a test file;</u> <u>P=File submitted is a production file.</u> |

DRUG REBATE FILE TRAILER RECORD

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|------------------|----------------------|-----------------|--------------|---|
| TR001 | Record Type | char | 2 | TR0R |
| TR002 | File Type | char | 2 | DR |
| TR0032 | Payer Code | varchar | 74 | Distributed by CIVHC's data administrator |
| TR0043 | Payer Name | varchar | 75 | Distributed by CIVHC |
| TR0054 | Beginning Month | date | 6 | CCYYMM - YYYYMM (Example: 200801) |
| TR0065 | Ending Month | date | 6 | CCYYMM - YYYYMM (Example: 200812) |
| TR0076 | Extraction Date | date | 8 | CCYYMMDD - YYYYMMDD |

A 8.1 ANNUAL PRESCRIPTION DRUG REBATE DATA

| Data Element # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-------------------|---------|--------|---|----------|
| DR001 | Payer Code | varchar | 74 | Distributed by CIVHC's data administrator | R |
| DR002 | Payer Name | varchar | 75 | Distributed by CIVHC | R |

| Data Element # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|--|---------|--------|---|-------------------|
| DR003 | Insurance Type Code/Product | char | 2 | See Lookup Table B ₂ -1.A | R |
| DR004 | Calendar Year | year | 4 | 4-digit year for the most recent calendar year time period reported in this submission | R |
| DR005 | Drug Manufacturer NDC/NHRIC Labeler Code | varchar | 5 | The first four or five digits in the 11-digit national drug code (NDC) format that is assigned to the manufacturer by the Food & Drug Administration (FDA). Include leading zeros Labeler code can be found on the FDA website. https://www.fda.gov/industry/structured-product-labeling-resources/ndcnhric-labeler-codes | R |
| DR006 | Labeler Code Firm Name | varchar | 200 | Firm name associated with NDC/NHRIC labeler code | R |
| DR007 | Therapeutic Class | varchar | 70 | Therapeutic class of drug, e.g., 28:00. Leave the field blank if there is no available drug class for a reported NDC. | R O |
| DR008 | Total Pharmacy Expenditure Amount | numeric | 15 | The sum of all incurred claim allowed payment amounts to pharmacies for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit in a given calendar year. This amount shall include member cost sharing amounts. This shall also include all incurred claims for individuals included in the member population regardless of where the prescription drugs are dispensed (i.e., includes claims from in-state and out-of-state providers). Claims should be attributed to a calendar year based on the date of fill. (Allowed amount should include direct drug costs and exclude non-claim costs. This amount will not reflect prescription drug rebates in any way) Two explicit decimal places (e.g., 200.00). | R |
| DR009 | Pharmacy Expenditure Amount: Specialty Drugs | numeric | 15 | The total expenditure for a specialty drug. Specialty drug expenditure and rebate amounts should be mutually exclusive from non-specialty brand drug and non-specialty generic drug expenditure and rebate amounts. Drug defined as a specialty drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00). | R |
| DR010 | Pharmacy Expenditure Amount: Non-Specialty Brand Drugs | numeric | 15 | The total expenditure for Non-Specialty Brand Drugs. Non-specialty brand drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty generic drug expenditure and rebate amounts. A drug defined as a non-specialty brand drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00). | R |
| DR011 | Pharmacy Expenditure Amount: Non-Specialty Generic Drugs | numeric | 15 | The total expenditure for Non-Specialty Generic Drugs. Non-specialty generic drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty brand drug expenditure and rebate amounts. A drug defined as a non-specialty generic drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00). | R |

| Data Element # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---|---------|--------|--|----------|
| DR012 | Total Prescription Drug Rebate/Other Compensation Amount | numeric | 15 | Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts (including concessions from price protection and hold harmless contract clauses) provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, excluding manufacturer-provided, fair market value, bona fide service fees. Two explicit decimal places (e.g., 200.00). | R |
| DR013 | Prescription Drug Rebate/Other Compensation Amount: Specialty Drugs | numeric | 15 | Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts for all specialty drugs. Specialty drug expenditure and rebate amounts should be mutually exclusive from non-specialty brand drug and non-specialty generic drug expenditure and rebate amounts. Drug defined as a specialty drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00). | R |
| DR014 | Prescription Drug Rebate/Other Compensation Amount: Non-Specialty Brand Drugs | numeric | 15 | Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts for all Non-Specialty Brand Drugs. Non-specialty brand drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty generic drug expenditure and rebate amounts. A drug defined as a non-specialty brand drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00). | R |
| DR015 | Prescription Drug Rebate/Other Compensation Amount: Non-Specialty Generic Drugs | numeric | 15 | Total drug rebates, discounts and other pharmaceutical manufacturer compensation or price concession amounts for all Non-Specialty Generic Drugs. Non-specialty generic drug expenditure and rebate amounts should be mutually exclusive from specialty drug and non-specialty brand drug expenditure and rebate amounts. A drug defined as a non-specialty generic drug under the terms of a payer's contract with its PBM. Two explicit decimal places (e.g., 200.00). | R |
| DR016 | Total Count of Prescriptions Filled | int | 15 | Total count of all prescriptions filled by members. | R |
| DR017 | Count of Prescriptions Filled: Specialty Drugs | int | 15 | Total count of all specialty prescriptions filled by members. A drug defined as a specialty drug under the terms of a payer's contract with its PBM. | R |
| DR018 | Count of Prescriptions Filled: Non-Specialty Brand Drugs | int | 15 | Total count of all non-specialty brand prescriptions filled by members. A drug defined as a non-specialty brand drug under the terms of a payer's contract with its PBM. | R |
| DR019 | Count of Prescriptions Filled: Non-Specialty Generic Drugs | int | 15 | Total count of all non-specialty generic prescriptions filled by members. | R |

| Data Element # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-------------------|---------|--------|--|----------|
| | | | | A drug defined as a non-specialty generic drug under the terms of a payer's contract with its PBM. | |
| DR020 | Comments | varchar | 1000 | Use this field to provide additional information or describe any caveats regarding data in the Drug Rebate submission. | O |
| DR999 | Record Type | char | 2 | DR | R |

A-9 ANNUAL PBM CONTRACT INFORMATION

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

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

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

Beginning in 2022, production files with complete three calendar-year periods will be submitted no later than September 1st. Please note that the administrator may choose to require test files to be submitted prior to the annual due date of September 1st.

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

A 9.1 Annual PBM Contract Information

| Data Element # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|---------------------------------------|---------|--|---|----------|
| PB001 | Payer Code | varchar | 7N/A— Excel file | Distributed by CIVHC's data administrator | R |
| PB002 | Payer Name | varchar | 75N/A— Excel file | Distributed by CIVHC | R |
| PB003 | Pharmacy Benefit Manager Name | varchar | 75N/A— Excel file | The name of a pharmacy benefit manager (PBM) that provided any of the following services in a given insurance category and calendar year: claims processing, drug formulary management, or manufacturer drug rebate contracting. | R |
| PB004 | Insurance Product Type code | char | 2N/A— Excel file | See lookup table B.1.A Payers shall report for all insurance categories for which they have business. | R |
| PB005 | Calendar Year | year | 4N/A— Excel file | 4-digit year for the calendar year time period reported in this submission | R |
| PB006 | Drug Formulary Management? | varchar | 4N/A— Excel file | Identify whether an individual PBM organization performed all, some, or none of the drug formulary management for its pharmacy benefit within a given insurance category and year. Three possible responses: All, Some, None | R |
| PB007 | Manufacturer Drug Rebate Contracting? | varchar | 4N/A— Excel file | Identify whether an individual PBM organization performed all, some, or none of the | R |

| Data Element # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|----------------------------------|---------|----------------------------------|---|----------|
| | | | | manufacturer drug rebate contracting for its pharmacy benefit within a given insurance category and year. Three possible responses: All, Some, None | |
| PB008 | Percent Rebate Passed to Carrier | decimal | 4N/A Excel file | Identify the proportion of total rebates and other compensation that is passed through to the carrier from the PBM. If the percent passed to carrier is 90%, submit as .9. | R |
| PB009 | Comments | varchar | 1000N/A Excel file | Use this field to provide additional information or describe any caveats regarding data in the PBM Contract submission | O |

A-10 ANNUAL COLLECTION FOR THE PRESCRIPTION DRUG AFFORDABILITY BOARD (PDAB)

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

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

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

~~Beginning in 2022, production files containing a 1-year look-back period will be submitted no later than September 1st. Please note that the administrator may choose to require test files to be submitted prior to the annual due date of September 1st.~~

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

A 10.1 Annual PDAB Collection Information

| Data Element # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------------------|-------------------------|--------------------------------|--|----------|
| PD001 | Payer Code | varchar | 7N/A Excel file | Distributed by CIVHC's data administrator | R |
| PD002 | Payer Name | varchar | 75N/A Excel file | Distributed by CIVHC | R |
| PD003 | Year | Year varchar | 4N/A Excel file | Immediately preceding year (Paid_Date_Year) | R |
| PD004 | Legislative Reference | varchar | 4N/A Excel file | See table B.1.P | R |
| PD005 | Rank | int varchar | 3N/A Excel file | Populate field with rank of 1-15 | R |
| PD006 | NDC | varchar | 11N/A Excel file | 11-digit NDC of associated drug | R |
| PD007 | Drug Name | varchar | 80N/A Excel file | Name of associated NDC | R |
| <u>PD008</u> | <u>Methodology</u> | <u>varchar</u> | <u>1000</u> | <u>Detailed methodological description for each legislative requirement.</u> | <u>R</u> |

A-11 ANNUAL PHARMACY VALUE BASED PURCHASING CONTRACTS (VBPC) COLLECTION

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

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

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

~~Beginning in 2022, production files with complete four calendar-year periods will be submitted no later than September 1st. Please note that the administrator may choose to require test files to be submitted prior to the annual due date of September 1st.~~

Submitter Payers should submit data based on Fill Date.

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

A 11.1 ANNUAL VBPC COLLECTION INFORMATION

| Data Element # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-------------------|------------------------|------------------------------|---|----------|
| VB001 | Payer Code | varchar | 7N/A—Excel file | Distributed by CIVHC's <u>data administrator</u> | R |
| VB002 | Payer Name | varchar | 75N/A—Excel file | Distributed by CIVHC | R |
| VB003 | Drug Name | varchar | 80N/A—Excel file | Name of drug associated with pharmacy VBPC | R |
| VB004 | NDC | varchar | 200N/A—Excel file | NDC(s) for associated drug If multiple NDCs are associated with a given contract for a drug name, list each NDC <u>separated by a semicolon (;).</u> on separate records in a separate tab in the Excel file. If carrier is unable to break out VB008-VB012 fields by NDC, then report VB008-VB012 on the first line associated with Drug Name (VB003). | R |
| VB005 | Manufacturer | varchar | 75N/A—Excel file | Name of associated drug's manufacturer | R |
| VB006 | Start Date | varchar | 8N/A—Excel file | Date when outcomes of treatment begin to be measured. CCYYMMDD | R |
| VB007 | End Date | varchar | 8N/A—Excel file | Date when outcomes of treatment are no longer measured. CCYYMMDD | R |
| VB008 | Metric measured | int varchar | 2N/A—Excel | Metrics measured under contract: 1 = Reduced hospitalization 2 = Reduced relapse rate 3 = Qualifying event 4 = Discontinuation 5 = Disease prevalence | R |

| Data Element # | Data Element Name | Type | Length | Description/Codes/Sources | Required |
|----------------|-----------------------------------|--|---|--|----------|
| | | | | 99 = Other | |
| VB009 | Total Count of Members on Drug | int varchar | 12N/A Excel file | Distinct number of members who have taken drug in specified time period, whether under the VBPC or not | R |
| VB010 | Count of Measured Members on Drug | int varchar | 12N/A Excel file | Distinct number of members who have taken drug in specified time period and whose outcomes are measured by contract | R |
| VB011 | Total Spend | numeric va rchar | 15N/A Excel file | Total spend on claims associated with drug in specified time period, whether under the VBPC or not Do not deduct any VBPC rebates <u>Two explicit decimal places (e.g., 200.00)</u> | R |
| VB012 | Total Measured Spend | numeric va rchar | 15N/A Excel file | Total spend on claims associated with drug in specified time period for members whose outcomes are measured by contract Do not deduct any VBPC rebates <u>Two explicit decimal places (e.g., 200.00)</u> | R |
| VB013 | Total VBPC Rebate | numeric va rchar | 15N/A Excel file | Total dollars received as a result of the VBPC contracts <u>Two explicit decimal places (e.g., 200.00)</u> | R |
| VB014 | Comments | varchar | 1000N/A Excel file | Any additional information regarding a particular contract | O |

A-12 ANNUAL MEMBER CAPITATION FILE (CF)

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

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

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

~~Beginning in 2025, production files with complete three calendar-year periods will be submitted no later than September 1st. Please note that the administrator may choose to require test files to be submitted prior to the annual due date of September 1st.~~

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

CF File Header Record

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|----------------|-------------------|-------------|------------|--------------------------|
| HD001 | Record Type | char | 2 | HD CF |
| <u>HD002</u> | <u>File Type</u> | <u>char</u> | <u>2</u> | <u>CF</u> |

| | | | | |
|--------|-----------------|---------|----|---|
| HD0032 | Payer Code | varchar | 74 | Distributed by CIVHC's data administrator |
| HD0043 | Payer Name | varchar | 75 | Distributed by CIVHC |
| HD0054 | Beginning Month | date | 6 | CCYYMM-YYYYMM (Example: 200801) |
| HD0065 | Ending Month | date | 6 | CCYYMM-YYYYMM (Example: 200812) |
| HD0076 | Record Count | int | 10 | Total number of records submitted in the Drug Rebate file, excluding header and trailer records |
| HD0087 | Med_BH PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD0098 | Pharmacy PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD0109 | Dental PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD0110 | Vision PMPM | int | 7 | Place holder. <u>Leave this field blank.</u> Leave field value blank. |
| HD012 | Test File Flag | char | 1 | T=File submitted is a test file; P=File submitted is a production file. |

CF File TRAILER RECORD

| Data Element # | Data Element Name | Type | Max Length | Description/valid values |
|----------------|-------------------|---------|------------|---|
| TR001 | Record Type | char | 2 | TRCF |
| TR002 | File Type | char | 2 | CF |
| TR0032 | Payer Code | varchar | 74 | Distributed by CIVHC's data administrator |
| TR0043 | Payer Name | varchar | 75 | Distributed by CIVHC |
| TR0054 | Beginning Month | date | 6 | CCYYMM-YYYYMM (Example: 200801) |
| TR0065 | Ending Month | date | 6 | CCYYMM-YYYYMM (Example: 200812) |
| TR0076 | Extraction Date | date | 8 | CCYYMMDD-YYYYMMDD |

A 12.1 ANNUAL MEMBER CAPITATION COLLECTION INFORMATION

| Data Element | Name | Type | Max Length | Description/Valid Values |
|--------------|---|---------|------------|--|
| CF001 | Payer Code | varchar | 78 | Distributed by CIVHC's data administrator |
| CF002 | Reporting Period Start Date | integer | 6 | YYYYMM. Beginning of reporting period covered for contract performance. |
| CF003 | Reporting Period End Date | integer | 6 | YYYYMM. End of reporting period covered for contract performance. |
| CF004 | Carrier Specific Unique Member ID | varchar | 50 | Report the identifier the carrier/payersubmitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's/submitterpayer's files for reporting and aggregation. |
| CF005 | Member Last Name | varchar | 60 | The member's last name. If the member is the subscriber, report the subscriber's last name. |
| CF006 | Member First Name | varchar | 35 | The member's first name. If the member is the subscriber, report the subscriber's first name |
| CF007 | Member Middle Initial | varchar | 1 | The member's middle initial. If the member is the subscriber, report the subscriber's middle initial. |
| CF008 | Member Sex | char | 1 | Sex of the member. M=Male F=Female U=UNKNOWN Member sex represents biological or administrative sex. Where available, submitterpayers should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, submitterspayers may provide the values they have access to regarding physical or legal sex (e.g., administrative sex as categorized by X12 values) |
| CF009 | Member Date of Birth | date | 8 | Date of birth of the member. If the member is the subscriber, report the subscriber's date of birth. YYYYMMDD. |
| CF010 | Member Social Security Number Identification Code | char | 9 | Member's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member. |

| | | | | |
|------------------------|--|---------|----|--|
| | | | | The member's Social Security Number. If the member is the subscriber, report the subscriber's Social Security Number. Do not include dashes. Leave this field blank if not collected. |
| CF011 | Billing Provider ID | varchar | 35 | Unique code assigned to the provider by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes and does not routinely change. |
| CF012 | Billing Provider NPI | char | 10 | National Provider Identifier (NPI) for the billing provider as enumerated in the Center for Medicaid and Medicare Services National Plan & Provider Enumeration System (NPPES). |
| CF013 | Billing Provider Tax ID | char | 9 | Tax ID of the billing provider. Do not code punctuation. |
| CF014 | Billing Provider Last Name or Organization | varchar | 60 | Full name of provider billing organization or last name of individual billing provider. |
| CF015 | Billing Provider First Name | varchar | 35 | Individual first name. If provider is a facility or organization, leave <u>this field</u> blank. |
| CF016 | Insurance/Product Category Code | char | 2 | See B.1.A Insurance Type for codes. Use the most granular choice available. |
| CF017 | Payment Subcategory | char | 2 | D1 = Primary care capitation D2 = Professional capitation D3 = Facility Capitation D4 = Behavioral health capitation D5 = Global capitation D6 = Payment to integrated, comprehensive payment and delivery systems D7 = Laboratory capitation D8 = Radiology capitation |
| CF018 | Total Paid Amount | numeric | 15 | Total of all payments made to a contractor during the Reporting/Performance Period. Two explicit decimal places (e.g., 200.00). This field may contain a negative value. |
| CF999 CF019 | Record Type | char | 2 | Value = CF |

EXHIBIT B – LOOKUP TABLES

B.1.A INSURANCE TYPE

| |
|--|
| 12 Preferred Provider Organization (PPO) – Commercial |
| 13 Point of Service (POS) – Commercial |
| 15 Indemnity Insurance – Commercial |
| 16 Health Maintenance Organization (HMO) Medicare Advantage |
| 17 Dental Maintenance Organization (DMO) |
| HM Health Maintenance Organization – Commercial |
| 19 Prescription Drug Only Insurance – Commercial |
| EP Exclusive Provider Organization (EPO) – Commercial |
| MA Medicare Part A |
| MB Medicare Part B |
| MC Medicaid |
| MD Medicare Part D |
| MP Medicare Primary |
| QM Qualified Medicare Beneficiary |
| TV Title V |
| 99 Other |
| SP Medicare Supplemental (Medi-gap) plan |
| CP Medicaid CHIP |
| MS Medicaid Fee for service |
| MM Medicaid Managed care |
| CS Commercial Supplemental plan |
| ME Medicare Advantage Preferred Provider Organization (PPO) |
| ML Medicare Advantage Indemnity Plan |
| MO Medicare Advantage Point of Service (POS) Plan |
| <u>S1 Medicare Special Needs Plan – Chronic Condition</u> |
| <u>S2 Medicare Special Needs Plan – Institutionalized</u> |
| <u>S3 Medicare Special Needs Plan – Dual Eligible</u> |
| 20 Prescription Drug Coverage Only – Medicare Advantage |

B.1.B RELATIONSHIP CODES

| |
|--|
| 01 Spouse |
| 04 Grandfather or Grandmother |
| 05 Grandson or Granddaughter |
| 07 Nephew or Niece |
| 10 Foster Child |
| 14 Brother or Sister |
| 15 Ward |
| 17 Stepson or Stepdaughter |
| 19 Child |
| 20 Employee/Self |
| 21 Unknown |
| 22 Handicapped Dependent |
| 23 Sponsored Dependent |
| 24 Dependent of a Minor Dependent |
| 25 Ex-Spouse |
| 29 Significant Other |
| 32 Mother |
| 33 Father |
| 36 Emancipated Minor |
| 39 Organ Donor |
| 40 Cadaver Donor |
| 41 Injured Plaintiff |
| 43 Child Where Insured Has No Financial Responsibility |
| 53 Life Partner |
| 76 Dependent |

B.1.C DISCHARGE STATUS

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

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

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

B.1.F CLAIM STATUS

| | |
|----|--|
| 01 | Processed as primary |
| 02 | Processed as secondary |
| 03 | Processed as tertiary |
| 04 | Denied |
| 19 | Processed as primary, forwarded to additional payer(s) |
| 20 | Processed as secondary, forwarded to additional payer(s) |
| 21 | Processed as tertiary, forwarded to additional payer(s) |
| 22 | Reversal of previous payment |
| 23 | Not our claim, forwarded to additional payer(s) |

B.1.G PRESENT ON ADMISSION CODES

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

B.1.H DISPENSE AS WRITTEN CODE

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

B.1.I BENEFIT COVERAGE LEVEL

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

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

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

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

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

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

B.1.K PRIMARY CARE PROVIDER DEFINITION

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

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

B.1.K.A: PRIMARY CARE PROVIDER TAXONOMIES

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

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

B.1.K.B: OTHER PRIMARY CARE PROVIDER TAXONOMIES: BEHAVIORAL HEALTH. NURSE PRACTITIONERS, AND PHYSICIAN ASSISTANTS

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

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

B.1.K.C: PRIMARY CARE PROCEDURE CODES

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

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

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

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

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

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

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

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

B.1.L: MARKET CATEGORY CODES

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

B.1.M ADMISSION SOURCE CODES

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

B.1.N UNIT OF MEASURE

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

B.1.O MARKET OPTIONS

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

B.1.P PDAB LEGISLATIVE REFERENCE

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