

CENTER FOR HEALTH  
INFORMATION AND ANALYSIS (CHIA)

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**CY2009-2013 INCURRED  
ALL-PAYER CLAIMS DATABASE (MA APCD)  
RELEASE 3.0 DOCUMENTATION GUIDE**

**- Medical Claims -**

Issued: April 2015



Commonwealth of Massachusetts  
Center for Health Information and Analysis  
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# INTRODUCTION

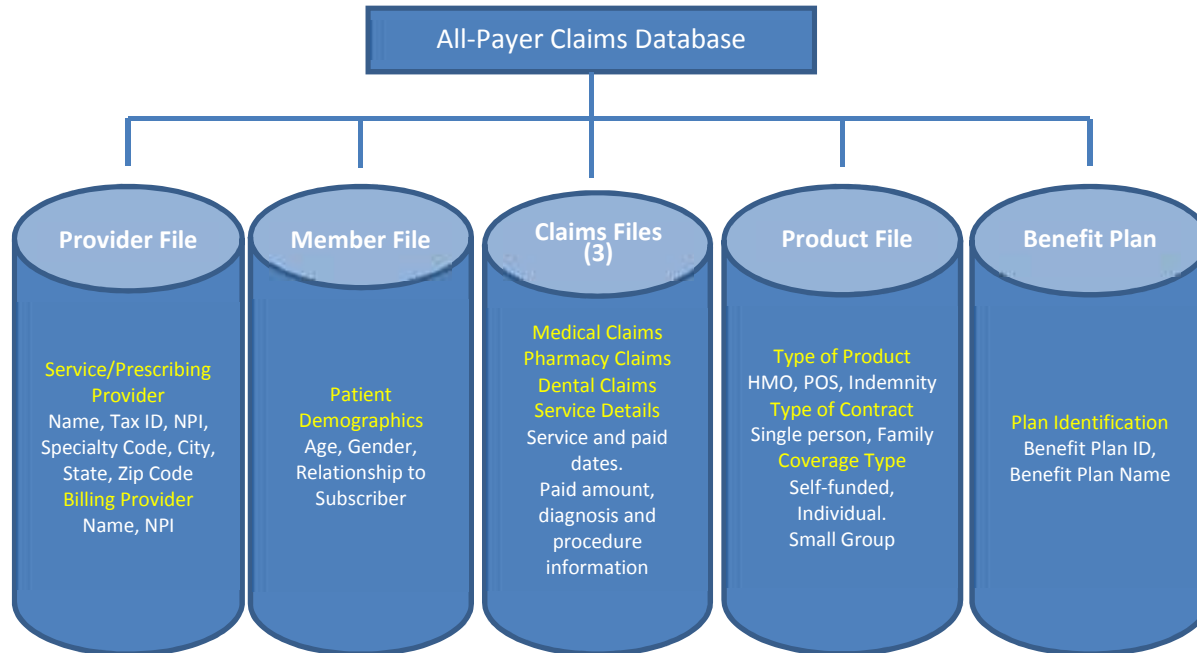
The Center for Health Information and Analysis (CHIA) was created to be the hub for high quality data and analysis for the systematic improvement of health care access and delivery in Massachusetts. Acting as the repository of health care data in Massachusetts, CHIA works to provide meaningful data and analysis for those seeking to improve health care quality, affordability, access, and outcomes.

To this end, the **All-Payer Claims Database (APCD)** contributes to a deeper understanding of the Massachusetts health care delivery system by providing access to accurate and detailed claims-level data essential to improving quality, reducing costs, and promoting transparency. This document is provided as a manual to accompany the release of data from the APCD.

The APCD is comprised of **medical, pharmacy, and dental claims**, and information from the **member eligibility, provider, and product** files, that is collected from health insurance payers operating in the Commonwealth of Massachusetts. This information encompasses public and private payers as well as insured and self-insured plans.

**APCD data collection and data release** are governed by **regulations** which are available on the APCD website (see <http://chiamass.gov/regulations/>)

For ease of use, the Center for Health Information and Analysis (CHIA) has created separate documents for **each** APCD file type and one for the appendices—for a total of eight separate documents. All are available on the CHIA website.



## Section 1.0: History

### 1.1: Establishment of the Massachusetts APCD (MA APCD)

The first efforts to collect claim-level detail from payers in Massachusetts began in 2006 when the Massachusetts Health Care Quality and Cost Council (HCQCC) was established, pursuant to legislation in 2006, to monitor the Commonwealth's health care system and disseminate cost and quality information to consumers. Initially, data was collected by a third party under contract to the HCQCC. On July 1, 2009, the Division of Health Care Finance and Policy (DHCFP) assumed responsibility for receiving secure file transmissions, creating, maintaining and applying edit criteria, storing the edited data, and creating analytical public use files for the HCQCC. By July 2010, Regulations 114.5 CMR 21.00 and 114.5 CMR 22.00 became effective, establishing the APCD in Massachusetts.

Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation," created the Center for Health Information and Analysis (CHIA) which assumed many of the functions – including management of the MA APCD – that were previously performed by the Division of Health Care Finance and Policy (DHCFP).

According to Chapter 224, the purpose of the Massachusetts APCD is **Administrative Simplification**:

“The center shall collect, store and maintain such data in a payer and provider claims database. The center shall acquire, retain and oversee all information technology, infrastructure, hardware, components, servers and employees necessary to carry out this section. All other agencies, authorities, councils, boards and commissions of the commonwealth seeking health care data that is collected under this section shall, whenever feasible, utilize the data before requesting data directly from health care providers and payers. In order to ensure patient data confidentiality, the center shall not contract or transfer the operation of the database or its functions to a third-party entity, nonprofit organization or governmental entity; provided, however, that the center may enter into interagency services agreements for transfer and use of the data. ”

A Preliminary Release of the MA APCD – covering dates of service CY 2008-2010 and paid through February 28, 2011 – was first released in 2012. Release 3.0, to be available in early 2015, covers dates of service CY 2009-2013 (paid through June 30, 2014).

## 1.2: MA APCD Release 3.0 Overview

The MA APCD is comprised of data elements collected from **all Private and Public Payers** of eligible **Health Care Claims for Massachusetts Residents**. Data is collected in seven file types: **Product (PR)**, **Member Eligibility (ME)**, **Medical Claims (MC)**, **Dental Claims (DC)**, **Pharmacy Claims (PC)**, **Provider (PV)**, and **Benefit Plan (BP) Control**. Each is described separately in this user manual.

Highlights of the release include:

- Data is available for dates of service from January 1, 2009 to December 31, 2013 as paid through June 2014. Data submitted to CHIA after June 2014 is **NOT** included in the files.
- Release 3.0 contains more comprehensive and recently updated data, including resubmissions from several large carriers.
- Data elements are classified as either Level 2 or Level 3 data elements. Level 2 include data elements that pose a risk of re-identification of an individual patient. Level 3 data elements are generally either Direct Personal information, such as name, social security number, and date of birth, that uniquely identifies an individual or are among the 18 identifiers specified by HIPAA. Refer to the **File Layout** sections for listings of Level 2 and Level 3 data elements for each file.
- Public Use Files (PUFs), which are de-identified extracts of the Medical Claims (MC) and Pharmacy Claims (PC) files, will be release separately. The PUFs incorporate certain levels of aggregation and a much more limited list of elements to help ensure data privacy protection.
- Certain identifying or sensitive data elements are **Masked** in the release in order to protect personally identifiable information and allow for the linkage of data elements within the same file.
- Some data elements have been derived by CHIA from submission data elements or have been added to the database to aid in versioning and identifying claims (e.g. Unique Record IDs and status flags). Refer to the **File Layout** sections for detail

## Section 2.0: MA APCD Data Collection Process

The data collected from the payers for the MA APCD is processed by the **Data Compliance and Support** team. Data Compliance works with the payers to collect the data on a regular, predetermined, basis and ensure that the data is as complete and accurate as possible. The **Data Quality Assurance** and **Data Standardization and Enhancement** teams work to clean and standardize the data to the fullest extent possible. Data Standardization relies on **external source codes** (see Appendix 8) from outside government agencies, medical and dental associations, and other vendors to ensure that the data collectors properly utilized codes and lookup tables to make data uniform.

### 2.1: Edits

When payers submit their data to CHIA for the MA APCD, an **Edits process** is run on each file to check that the data complies with requirements for the file and for each data element in the file.

The automated edits perform an important data quality check on incoming submissions from payers. They identify whether or not the information is in the expected format (i.e. alpha vs. numeric), contains invalid characters (i.e. negative values, decimals, future dates) or is missing values (i.e. nulls). If these edits detect any issues with a file, they are identified on a report that is sent to the payer.

Data elements are grouped into four categories (A, B, C, and Z) which indicate their relative analytic value to CHIA and MA APCD users. Refer to the **File Layout** sections of each document to view the Edit Level for each Data Element:

- ‘A’ level fields must meet their **MA APCD threshold percentage** in order for a file to pass. There is an allowance for up to a 2% variance within the error margin percentage (depending on the data element). If any ‘A’ level field falls below this percentage it will result in a failed file submission for the payer and a discussion with their liaison regarding corrective action.
- The other categories (**B, C, and Z**) are also **monitored**, but the thresholds are not presently enforced.

More detailed APCD Version 3.0 File Edit documentation can be found at: <http://chiamass.gov/apcd-data-submission-guides>

## 2.2: Variances

The **Variance process** is a collaborative effort between the payer and CHIA to reach a mutually agreed upon **threshold percentage** for any data element which may not meet the MA APCD standard. Payers are allowed to request a lower threshold for specific fields, but they must provide a business reason (rationale) and, in some cases, a remediation plan for those elements. CHIA staff carefully reviews each request and follows up with a discussion with the payers about how to improve data quality, suggest alternative threshold rates or creating plans to reach threshold over time to improve reporting quality.

Once this process is complete, the variance template is loaded into production so that any submissions from the payer are held to the CHIA standard thresholds and any approved variances. The payer receives a report after each submission is processed which compares their data against the required threshold percentages. 'Failed' files are reviewed by CHIA liaisons and discussed with the payer for corrective action. (see Appendix 4)

## 2.3: Broad Caveats

Researchers using the MA APCD Release 3.0 data should be aware of the following:

- Due to the variance process, data quality may vary from one payer to another. (see Appendix 4)
- Claim Files submitted through June 2014 were accepted with relaxed edits. (Refer to the MA APCD Submission Guide for Edit information)
- The release files contain the data submitted to CHIA including valid and invalid values.
- Certain data elements were cleaned when necessary. Detail on the cleaning logic applied is described at the end of each file layout.
- Certain data elements were redacted to protect against disclosure of sensitive information.
- Some Release Data was manipulated to protect patient privacy:
  - Assignment of linkage IDs to replace reported linkage identifiers (see Appendix 3).
  - Member Birth Year is reported as 999 for all records where the member age was reported as older than 89 years on the date of service.
  - Member Birth Year is reported as Null for all records where the member was reported as older than 115 years on the date of service.



## Section 3.0: Medical Claims File

As part of the All Payer Claims Database (APCD), payers are required to submit a Medical Claims File. The Medical Claims File consists of all **final paid claims** from all reporting payers segregated by **Date of Service** in 2009, 2010, 2011, 2012, and 2013 as reported through June 2014 (this represents a twelve month plus run-out period from 2013 data).

The Medical Claim File will be released for each requested year based on **Date of Service To** for the **claim line**. In the event that Date of Service To is unavailable, the following will be utilized:

- 1) Discharge Date
- 2) Date of Service From or Admit Date
- 3) Submission Month Period

Below are details on business rules, data definitions, and the potential uses of this data. For a full list of elements refer to the File Layout section.

### 3.1: Types of Data Collected in the Medical Claims File

#### 3.1.1: Payer-assigned Identifiers

CHIA requires various **Payer-assigned identifiers** for matching-logic to the other files, i.e., Product File and Member Eligibility. Examples of this field include MC003, MC006, MC137 and MC141, which will all be used by CHIA to aid with the matching algorithm to those other files.

#### 3.1.2: Claims Data

CHIA requires the line-level detail of all Medical Claims for analysis, which aids with understanding utilization within products across Payers. The specific medical data reported in MC039 through MC062, MC071, MC072, MC075, MC083 through MC088, MC090, MC108, MC109, MC111, MC126, MC127, MC129, MC130, and MC136 would be the same elements that are reported to a Payer on the UB04, HCFA 1500, the HIPAA 837I and 837P or a Payer specific direct data entry system.

Subscriber and Member (Patient) Payer unique identifiers are requested to aid with the matching algorithm, see MC137 and MC141.

### 3.1.3: Fields MC024-MC035 - Servicing provider data

The set of fields MC024-MC035 are all related to the servicing provider **entity**. CHIA wishes to collect entity level rendering provider information here, and at the lowest level achievable by the payer. A physician's office is also appropriate here, but not the physician. The physician or other person providing the service is expected in MC134.

If the payer only knows the billing entity, and the billing entity is not a **service rendering** provider, then the billing provider data (MC076-MC078) is **not** appropriate. In this case the payer would need a variance request for the service provider fields.

If the payer only has the data for a main **service rendering** site but not the specific satellite information where services are rendered, then the main service site **is** acceptable for the service provider fields.

For example – XYZ Orthopedic Group is acceptable, if XYZ Orthopedic Group Westside is not available. However, XYZ Orthopedic Group Westside is preferable, and ultimately the goal.

### 3.1.4: Fields MC134 (Plan Rendering Provider) and MC135 (Provider Location)

The intent of these fields is to capture servicing or rendering provider at the physician or other licensed person rendering level. These fields should describe precisely who and where the service was rendered. If the payer does not know who actually performed the service or the specific site where the service was actually performed, the payer will need a variance request for one or both of these fields. It is not appropriate to report facility or billing information here

### 3.1.5: Non-Massachusetts Residents

CHIA does not require payers submitting claims and encounter data on behalf of an employer group to submit claims data for employees who reside outside of Massachusetts, unless the payer is required by contract with the Group Insurance Commission (GIC).

### 3.1.6: Adjudication Data

CHIA requires adjudication-centric data on the file for analysis of Member Eligibility to Product. The elements typically used in an adjudication process are MC017 through MC023, MC036 through MC038, MC063 through MC069, MC071 through MC075, MC080, MC081, MC089, MC092 through MC099, MC113 through MC119, MC122 through MC124, MC128, and MC138 and are variations of paper remittances or the HIPAA 835 4010.

CHIA has made a conscious decision to collect numerous identifiers that may be associated with a provider. The provider identifiers will be used to help link providers across payers in the event that the primary linking data elements are not a complete match. The existence of these extra identifying elements in claims is part of our quality assurance process, and will be analyzed in conjunction with the provider file. We expect this will improve the quality of our matching algorithms within and across payers.

### 3.1.7: Denied Claims

Payers are not required to submit wholly denied claims.

### 3.1.8: The Provider ID

Element MC024 (Service Provider ID), MC134 (Plan Rendering Provider) and MC135 (Provider Location) are some of the most critical fields in the APCD process as it links the Provider identified on the Medical Claims file with the corresponding Provider ID (PV002) in the Provider File. The definition of PV002, Provider ID, is:

*the unique number for every service provider (persons, facilities or other entities involved in claims transactions) that a payer has in its system. This field is used to uniquely identify a provider and that provider's affiliation and a provider and a provider's practice location within this provider file.*

The goal of PV002 is to help identify provider data elements associated with provider data that was submitted in the claim line detail, and to identify the details of the Provider Affiliation. However, due to the fact that PV002 frequently contains sensitive personal information, the element PV002 has received a **substitution linkage element** (with the added suffix “\_Linkage\_ID”) for this release by CHIA which allows linking to the Provider File. Refer to the Linkage Section of the Appendices for greater detail on this process.

### 3.2: Medical Claims Release File Structure:

The following is general information about the **Medical Claims File and the Release Data**:

Topic	Clarification																		
Claims that are paid under a <b>'global payment', or 'capitated payment'</b> , thus zero paid	Payers are instructed by CHIA to submit any medical claim that is considered 'paid'. Paid amount should be reported as 0 and the corresponding Allowed, Contractual, Deductible Amounts should be calculated accordingly.																		
Previously paid but now <b>Voided</b> claims	The reporting of Voided Claims maintains logic integrity between services utilized and deductibles applied.																		
<b>Release ID</b>	<p>A unique id for each <b>claim line</b> in the data release will assigned by CHIA.</p> <p>All Level 1 and Level 2 file records will contain <b>Release IDs</b> to enable linking between the records in the public use file and the records in the restricted use files.</p>																		
<b>Redundancy:</b>	Certain data elements of claim level data will be repeated in every row in order to report unique line item processing. Claim-line level data is required to capture accurate details of claims and encounters.																		
<b>Changes to Claim Lines</b>	<p>Claim line versioning is triggered by the <b>Claim Line Type</b> field:</p> <table border="1" data-bbox="478 873 1598 1101"> <thead> <tr> <th data-bbox="478 873 751 914">Claim Type Code</th> <th data-bbox="751 873 1146 914">Claim Line Type Description</th> <th data-bbox="1146 873 1598 914">Action/Source</th> </tr> </thead> <tbody> <tr> <td data-bbox="478 914 751 946">O</td> <td data-bbox="751 914 1146 946">Original</td> <td data-bbox="1146 914 1598 946"></td> </tr> <tr> <td data-bbox="478 946 751 987">V</td> <td data-bbox="751 946 1146 987">Void</td> <td data-bbox="1146 946 1598 987">Delete Line Referenced / Provider</td> </tr> <tr> <td data-bbox="478 987 751 1027">R</td> <td data-bbox="751 987 1146 1027">Replacement</td> <td data-bbox="1146 987 1598 1027">Replace line Referenced /Provider</td> </tr> <tr> <td data-bbox="478 1027 751 1068">B</td> <td data-bbox="751 1027 1146 1068">Back Out</td> <td data-bbox="1146 1027 1598 1068">Delete Line Referenced / Payer</td> </tr> <tr> <td data-bbox="478 1068 751 1101">A</td> <td data-bbox="751 1068 1146 1101">Amendment</td> <td data-bbox="1146 1068 1598 1101">Replace Line Referenced / Payer</td> </tr> </tbody> </table>	Claim Type Code	Claim Line Type Description	Action/Source	O	Original		V	Void	Delete Line Referenced / Provider	R	Replacement	Replace line Referenced /Provider	B	Back Out	Delete Line Referenced / Payer	A	Amendment	Replace Line Referenced / Payer
Claim Type Code	Claim Line Type Description	Action/Source																	
O	Original																		
V	Void	Delete Line Referenced / Provider																	
R	Replacement	Replace line Referenced /Provider																	
B	Back Out	Delete Line Referenced / Payer																	
A	Amendment	Replace Line Referenced / Payer																	

<b>Versioning Claim Lines</b>	<p>Highest Version Flag created for Medical Claim Files:</p> <ul style="list-style-type: none"> <li>• Data Element Name: Highest Version Flag (Derived-MC10)</li> <li>• Domain Values: <ul style="list-style-type: none"> <li>○ 0-Not Highest Version</li> <li>○ 1-Highest Version</li> <li>○ 9-Undetermined</li> </ul> </li> <li>• CHIA’s standard versioning process includes applying cleaning logic, identifying duplicates, voids/back-outs, and replacements/amendments, and setting the highest version flag. Versioning logic has been reviewed with each carrier.</li> <li>• A highest versioning flag is used in version 3.0 release. A value of 0 or 1 has been assigned to each medical claim line from the following carriers: 290, 293, 295, 296, 300, 301, 3156, 3505, 3735, 4962, 7041, 7422, 7655, 8026, 8647, 10353, 10441, 10442, 10647, 10920, 10929, 11215, 11474, 11701, 11726, partial on 10632. Claim lines from all other carriers should have a value of 9. Future releases will include versioning for additional carriers.</li> <li>• Data Caveats: OrgID 10632 has only been versioned from May 2013 forward. Any data prior has not been versioned.</li> </ul> <p>* For services rendered on or after 3/1/2010 only. Claim lines for services rendered before 3/1/2010 should have a value of 9.</p>
<b>Claim ID</b>	<p><b>Claims may be isolated by grouping claim lines by the following elements:</b>  Payer Claim Control Number (MC004)/Payer Org ID (MC001)</p>
<b>Denied claim lines</b>	<p>Wholly denied claims are not submitted to CHIA. However, if a <b>single procedure</b> is denied within a paid claim that denied line is reported. Denied line items of an adjudicated claim may aid with analysis in the APCD in terms of covered benefits and/or eligibility.</p>

## 3.3: Medical Claims File Layout

### Restricted Release Elements:

- Each **row** in the release file contains one record of the indicated file type. There is an **asterisk-delimited field** in each row for every data element listed in the Restricted Release sections for each file type.
- Data Elements will be delimited in the order displayed in the File Layout sections of this document.
- **Empty** or **null** data elements will have no spaces or characters between the asterisks.
- **Lookup Tables:** Have been moved within the structure of the Element description, similar to the APCD Submission Guide documentation.
- A **Carrier-Specific Master Lookup** table is included with each data extract. Refer to the **Carrier-Specific Reference** and **Linking** sections in this document for more information.
- **External Code Sources** are listed in Appendix 8.
- **Masked Elements:** For the Data Release, some of the data elements have been Masked to provide confidentiality for Payers and Providers, and individuals, while allowing for linkage between claims, files, and lookup tables. Refer to the Data Protection/Confidentiality and Linkage sections of the Appendices for more information.

### 3.3.1: Release Text File Column Titles

**Release File Column Names** included in this document lists the column name for each data element in the Level 2 and Level 3 release files. The text files exported from the APCD SQL Database include these SQL column names in the first row. (see Appendix 6)

### 3.3.2: File Layout Section Columns

- **Data Element:** The code name of the element, with reference to the Regulation and the Submission files received by CHIA from Payers. The first two digits refer to the File Type and the following numbers to the ordering in the Submission Files.
- **Data Element Name:** Name of the element.
- **Format/Length:** Maximum Length of the data column in the APCD's SQL Server database at CHIA.
- **Description:** Description of the element; **additionally** the lookup table is included where applicable.
- **Additional Element Description:** Additional information about the element in the release.
- **Edit Level:** Level of enforcement of the data element's requirements by CHIA on Payer Submissions. Refer to the **Edits** section of this document.
- **%:** The expected percentage of validity for instances of the element in each submission file by the Payer.

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
Derived-MC1	Submission Month	Int[2]	Submission Month	Month of the file submission—derived by CHIA.		N/A	N/A
Derived-MC2	Submission Year	Int[4]	Submission Year	Year of the file submission—derived by CHIA.		N/A	N/A
Derived-MC3	County of Member	Varchar[3]	County of Member	County of the Member/Patient—derived by CHIA		N/A	N/A
Derived-MC4	County of Service Provider	Varchar[3]	County of Service Provider	County of the Service Provider—derived by CHIA		N/A	N/A
Derived-MC5	Medical Claim ID	Int- NULL	Medical Claim ID	Unique record ID per submission control ID	With each submission control ID this number is reset to 1 and sequentially incremented by one for every record submitted	N/A	N/A
Derived-MC6	Member ZIP code (first 3 digits)	Varbinary[256]	Member ZIP code (first 3 digits)	Zip Code of Member/Patient (first 3 digits)—derived by CHIA	Zip Code of Member/Patient (first 3 digits)—derived by CHIA	N/A	N/A
Derived-MC7	Release ID	Int-NULL	Release ID	Unique record ID derived specifically for this release file type	With each release file type table this number is reset to 1 and sequentially incremented by one for every record released	N/A	N/A

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
Derived-MC8	Submission Control ID	Int-NULL	Submission Control ID	Unique sequential number assigned to any new file type submitted to CHIA across all carriers	With each file submission this number is incremented by one	N/A	N/A
Derived-MC9	CHIA Incurred Date (Year and Month Only)	Int[6]	CHIA Incurred Date (Year and Month Only)	This is a derived YYYYMM value as best determined by CHIA. Determination was based on availability of valid date data – typically “Date of Service To” or “Discharge date”.	This is a derived YYYYMM value.	N/A	N/A
Derived-MC10	Highest Version Paid Flag	Int[1]	Indicates highest version of claim received by CHIA, including paid claim lines. (Method developed in partnership with submitters)			N/A	N/A
Derived-MC11	Highest Version Denied	Int-NULL				N/A	N/A
Derived-MC12	Highest Version Indicator	Int-NULL	Indicates highest version of claim received by CHIA, including <b>both</b> paid and denied claim lines			N/A	N/A
Derived-MC13	Substance Abuse Indicator	bit-NULL				N/A	N/A



**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
Derived-MC14	Medicaid/HSN Indicator	bit-NULL				N/A	N/A
Derived-MC15	Member Link EID	Int-NULL				N/A	N/A
Derived-MC16	Member Age At Service	Smallint-NULL				N/A	N/A
MC001	Submitter	varchar[6]	CHIA defined and maintained unique identifier	Report the Unique Submitter ID as defined by CHIA here. This must match the Submitter ID reported in HD002.	A CHIA-assigned identifier for any APCD Data Submitter; Insurance, Benefit Manager/Administrator, TPA, Vendor	A0	100%
MC002	National Plan ID	int[10]	CMS National Plan Identification Number (PlanID)	Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans.	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.	Z	0%
MC003	Insurance Type Code/ Product	char[2]	Type / Product Identification Code 09 - Self-pay 10 - Central Certification 11 - Other Non-Federal Programs 12 - Preferred Provider Organization (PPO) 13 - Point of Service	Report the code that defines the type of insurance under which this patient's claim line was processed. EXAMPLE: HM = HMO	A code that defines the type of insurance applied to the claim line. This value can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	C	92%

**Medical Claims – APCD Level 2 Data Elements**

Data Element	Data Element Name	Format / Length	Description	Element Submission Guideline	Additional Element Description	Edit Level	%
			(POS) 14 - Exclusive Provider Organization (EPO) 15 - Indemnity Insurance 16 - Health Maintenance Organization (HMO) Medicare Risk AM - Automobile Medical BL - Blue Cross / Blue Shield CC - Commonwealth CareCE - Commonwealth Choice CH – Champus CI - Commercial Insurance Co. DS – Disability HM - Health Maintenance Organization LI – Liability LM - Liability Medical MA - Medicare Part AMB - Medicare Part BMC – Medicaid OF - Other Federal Program TV - Title				

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
			VVA – Veterans Administration Plan WC - Workers' Compensation				
MC004	Payer Claim Control Number	varchar[35]	Payer Claim Control Identification	Report the Unique identifier within the payer's system that applies to the entire claim.	Unique identifier within the payer's system that applies to the entire claim.	A0	100%
MC005	Line Counter	varchar[4]	Incremental Line Counter	Report the line number for this service within the claim. Start with 1 and increment by 1 for each additional line. Do not start with 0, include alphas or special characters.	The line number for this service on the claim. First line should start with 1 and each additional line incremented by 1.	A0	100%
MC005A	Version Number	varchar[4]	Claim Service Line Version Number	Report the version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line. No alpha or special characters.	Incrementing counter for a claim line that is reprocessed for any reason over the course of time. Highest value should indicate latest reprocessing of line by the carrier/submitter.	A0	100%
MC011	Individual Relationship Code	char[2]	Patient to Subscriber Relationship Code - 1 Spouse 4 Grandfather or Grandmother	Report the value that defines the Patient's relationship to the Subscriber. EXAMPLE: 20 = Self / Employee	Numeric indicator to define the Patient's relationship to the Subscriber. This value can be derived from the claim as submitted by the provider or	B	98%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
			5 Grandson or Granddaughter 7 Nephew or Niece 10 Foster Child 15 Ward 17 Stepson or Stepdaughter 19 Child 20 Self/Employee 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 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		reassigned by the carrier or its designee.		

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC012	Member Gender	char[1]	Patient's Gender F Female M Male O Other U Unknown	Report patient gender as found on the claim in alpha format. Used to validate clinical services when applicable and Unique Member ID. EXAMPLE: F = Female	A code that defines the Patient's gender. This can be derived from the claim as submitted by the provider or reassigned by the carrier or its designee.	B	98%
MC013	Member Birth (Month Only)	Int-NULL					
MC013	Member Birth (Year Only)	Int-NULL					
DC013	Member Birth Year	Int-NULL				B	99%
MC015	Member State	char[2]	State / Province of the Patient	Report the state of the patient as defined by the US Postal Service. Report Province when Country Code does not = USA.	State of the Member/Patient	B	98
MC016	Member ZIP Code	varchar[9]	Zip Code of the Member / Patient	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	Zip Code of the Patient.	B	98

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC017	Date Service Approved (AP Date)	int[8]	Date Service Approved by Payer	Report the date that the payer approved this claim line for payment in CCYYMMDD Format. This element was designed to capture date other than the Paid date. If Approved Date and Paid Date are the same, then the date here should match Paid Date.	The date that the Patient was admitted into an inpatient setting at the facility. (YYYY-MM-DD 00:00:00.000)	C	93%
MC018	Admission Date	int[8]	Inpatient Admit Date	Report the date of admit to a facility in CCYYMMDD Format. Only applies to facility claims where Type of Bill = an inpatient setting.	The date that the Patient was admitted into an inpatient setting at the facility. (YYYY-MM-DD 00:00:00.000)	A1	98%
MC019	Admission Hour	char[4]	Admission Time	Report the Admit Time in HHMM Format. Only applies to facility claims where Type of Bill = an inpatient setting. Time is expressed in military time. If only the hour is known, code the minutes as 00. 4 AM would be reported as 0400; 4 PM would be reported as 1600.	The admission time of the Patient into an inpatient setting/facility and reported in military time.	C	5%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC020	Admission Type	int[1]	Admission Type Code	Report Admit Type as it applies to facility claims where Type of Bill = an inpatient setting. This code indicates the type of admission into an inpatient setting. Also known as Admission Priority.	A standardized, numeric code that reports the type of admission into an inpatient setting. Also known as Admission Priority.	A1	98%
MC021	Admission Source	char[1]	Admission Source Code	Report the code that applies to facility claims where Type of Bill = an inpatient setting. This code indicates how the patient was referred into an inpatient setting at the facility.	A standardized code that reports the admission source of the Patient into an inpatient setting/facility and indicates how the Patient was referred into the inpatient setting.	A1	98%
MC022	Discharge Hour	char[4]	Discharge Time	Report the Discharge Time in HHMM Format. Only applies to facility claims where Type of Bill = an inpatient setting. Time is expressed in military time. If only the hour is known, code the minutes as 00. 4 AM would be reported as 0400; 4 PM would be reported as 1600.	The discharge/transfer time of the Patient from the inpatient setting/facility and reported in military time.	C	5%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC023	Discharge Status	char[2]	Inpatient Discharge Status Code	Report the appropriate Discharge Status Code of the patient as defined by External Code Source	A standardized, numeric code that reports the discharge status of the Patient.	A1	98%
MC024	Service Provider Number	varchar[30]	Service Provider Identification Number	Report the carrier / submitter assigned service provider number. This number should be the identifier used for internal identification purposes, and does not routinely change. The value in this field must match a record in the provider file in PV002.	Link to PV002 on Provider File to obtain detailed attributes of the Service Provider.	A1	99%
MC026	National Provider ID - Service	int[10]	National Provider Identification (NPI) of the Service Provider	Report the Primary National Provider ID (NPI) of the Service Provider in MC024. This ID should be found on the Provider File in the NPI Field (PV039)	The National Provider ID (NPI) of the Service Provider.	C	98%
MC027	Service Provider Entity Type Qualifier	int[1]	Service Provider Entity Identifier Code 1 Person 2 Non-person entity	Report the value that defines the Service Provider entity type. Only individuals should be identified with a 1. Facilities, professional groups and clinic sites should all be identified with a 2. EXAMPLE: 1 = Person	Numeric indicator to define the Service Provider as a Person or Non-person. This value drives various 'person' -type requirements; First Name, Date of Birth, Gender, etc.	A0	98%



**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC028	Service Provider First Name	varchar[25]	First name of Service Provider	Report the individual's first name here. If provider is a facility or organization , do not report any value here	First name of the Service Provider, when appropriate.	C	92%
MC029	Service Provider Middle Initial	varchar[25]	Middle initial of Service Provider	Report the individual's middle initial here. If provider is a facility or organization , do not report any value here	Middle name / initial of the Service Provider when appropriate.	C	2%
MC030	Servicing Provider Last Name or Organization Name	varchar[60]	Last name or Organization Name of Service Provider	Report the name of the organization or last name of the individual provider. MC027 determines if this is an Organization or Individual Name reported here.	Last name, or Organization name, of the Servicing Provider.	A2	94%
MC031	Service Provider Suffix	int[1]	Provider Name Suffix 0 Unknown / Not Applicable 1 I. 2 II. 3 III. 4 Jr. 5 Sr.	Report the individuals name-suffix when applicable here. Used to capture the generation of the individual clinician (e.g., Jr. Sr., III). Do not report degree acronyms here. EXAMPLE: 0 = Unknown / Not Applicable	The generational title of the provider when the Service Provider Entity Type = 1 (Person)	Z	2%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC032	Service Provider Taxonomy	varchar[10]	Taxonomy Code	Report the standard code that defines this provider for this line of service. Taxonomy values allow for the reporting of nurses, assistants and laboratory technicians, where applicable, as well as Physicians, Medical Groups, Facilities, etc.	A standardized taxonomy code (External Code Source 13) OR a carrier-defined specialty code of the Servicing Provider (APCD Master Lookup Table). Value is required to be in carrier-defined table if provided.	B	98%
MC033	Service Provider City Name	varchar[30]	City Name of the Provider	Report the city name of provider - preferably practice location. Do not report any value if not available.	City of the Service Provider.	A2	98%
MC034	Service Provider State	char[2]	State of the Service Provider	Report the state of the service providers as defined by the US Postal Service. Do not report any value if not available.	State of the Service Provider.	B	98%
MC035	Service Provider ZIP Code	varchar[9]	Zip Code of the Service Provider	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	Zip Code of the Service Provider.	B	98%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC036	Type of Bill - on Facility Claims	int[2]	Type of Bill	Report the two-digit value that defines the Type of Bill on an institutional claim. Do not report leading zero	For Institutional Claims: a standardized code that reports the type of facility where the claim line service occurred.	B	98%
MC037	Site of Service - on NSF/CMS 1500 Claims	char[2]	Place of Service Code	Report the two-digit value that defines the Place of Service on professional claim	For Professional Claims, a standardized code that reports the type of facility where the claim line service occurred.	A0	100%
MC038	Claim Status	varchar[2]	Claim Line 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	Report the value that defines the payment status of this claim line	Numeric indicator that reports if the claim line was paid by the carrier or its designee, and the COB order of the payment.	A0	98%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC039	Admitting Diagnosis	varchar[7]	Admitting Diagnosis Code	Report the diagnostic code assigned by provider that supported admission into the inpatient setting.	Diagnostic code assigned by the provider to support admission into an inpatient setting at the facility reported in Plan Rendering Provider ID and Provider Location.	A0	98%
MC040	E-Code	varchar[7]	ICD Diagnostic External Injury Code	Report the external injury code for patient when appropriate to the claim.	The ICD9 External Injury code for Patients with trauma or accidents.	A1	3%
MC041	Principal Diagnosis	varchar[7]	ICD Primary Diagnosis Code	Report the Primary ICD Diagnosis Code here.	Primary ICD9 Diagnosis Code.	A0	99%
MC042	Other Diagnosis - 1	varchar[7]	ICD Secondary Diagnosis Code	Report the Secondary ICD Diagnosis Code here. If not applicable do not report any value here.	Secondary ICD9 Diagnosis Code.	B	70%
MC043	Other Diagnosis - 2	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 2. If not applicable do not report any value here.	Other ICD9 Diagnosis Code 2.	B	24%
MC044	Other Diagnosis - 3	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 3. If not applicable do not report any value here.	Other ICD9 Diagnosis Code 3.	C	13%

**Medical Claims – APCD Level 2 Data Elements**

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MC045	Other Diagnosis - 4	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 4. If not applicable do not report any value here.	Other ICD9 Diagnosis Code 4.	C	7%
MC046	Other Diagnosis - 5	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 5. If not applicable do not report any value here.	Other ICD9 Diagnosis Code 5.	C	4%
MC047	Other Diagnosis - 6	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 6. If not applicable do not report any value here.	Other ICD9 Diagnosis Code 6.	C	3%
MC048	Other Diagnosis - 7	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 7. If not applicable do not report any value here.	Other ICD9 Diagnosis Code 7.	C	3%
MC049	Other Diagnosis - 8	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 8. If not applicable do not report any value here.	Other ICD9 Diagnosis Code 8.	C	2%
MC050	Other Diagnosis - 9	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 9. If not applicable do not report any value here.	Other ICD9 Diagnosis Code 9.	C	1%
MC051	Other Diagnosis - 10	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 10. If not applicable do not report any value here.	Other ICD9 Diagnosis Code 10.	C	1%

**Medical Claims – APCD Level 2 Data Elements**

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MC052	Other Diagnosis - 11	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 11. If not applicable do not report any value here.	Other ICD9 Diagnosis Code 11.	C	1%
MC053	Other Diagnosis - 12	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 12. If not applicable do not report any value here.	Other ICD9 Diagnosis Code 12.	C	1%
MC054	Revenue Code	char[4]	Revenue Code	Report the valid National Uniform Billing Committee Revenue Code here. Code using leading zeroes, left-justified, and four digits.	A standardized code that reports the revenue center of a facility where the claim line service occurred.	A0	98%
MC055	Procedure Code	varchar[10]	HCPCS / CPT Code	Report a valid Procedure code for the claim line as defined by MC130.	The procedure code reported for this claim line.	A1	98%
MC056	Procedure Modifier - 1	char[2]	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055).	The first modifier for the procedure code reported on this claim line.	B	20%

**Medical Claims – APCD Level 2 Data Elements**

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MC057	Procedure Modifier - 2	char[2]	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055).	The second modifier for the procedure code reported on this claim line.	B	3%
MC058	ICD-CM Primary Procedure Code	varchar[7]	ICD Primary Procedure Code	Report the primary ICD CM procedure code when appropriate. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	Primary ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	A2	98%
MC059	Date of Service - From	int[8]	Date of Service	Report the date of service for the claim line in CCYYMMDD Format.	The first date of service for the claim line. Inpatient claims may or may not repeat this date on all lines.	A0	98%
MC060	Date of Service - To	int[8]	Date of Service	Report the end service date for the claim line in CCYYMMDD Format. For inpatient claims, the room and board line may or may not be equal to the discharge date. Procedures delivered during a visit should indicate which date they occurred.	Year of the last date of Service for the claim line. Inpatient claims may or may not repeat this date on all lines.	A0	98%

**Medical Claims – APCD Level 2 Data Elements**

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MC061	Quantity	±varchar[15]	Claim line units of service	Report the count of services / units performed.	Count of services/units performed.	A0	98%
MC062	Charge Amount	±varchar[10]	Amount of provider charges for the claim line	Report the charge amount for this claim line. 0 dollar charges allowed only when the procedure code indicates a Category II procedure code vs. a service code. When reporting Total Charges for facilities for the entire claim use 001 (the generally accepted Total Charge Revenue Code) in MC054 (Revenue Code). Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	The amount the provider charged for the claim line service.	A0	99%
MC063	Paid Amount	±varchar[10]	Amount paid by the carrier for the claim line	Report the amount paid for the claim line. Report 0 if line is paid as part of another procedure / claim line. Do not report any value if the line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	The amount paid to the provider for this claim line.	A1	99%



**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC064	Prepaid Amount	±varchar[10]	Amount carrier has prepaid towards the claim line	Report the prepaid amount for this claim line. Report the Fee for Service equivalent amount for Capitated services. Report 0 when there is no Prepaid amount. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	The amount the carrier or its designee has pre-paid towards a claim line.	A2	100%
MC065	Copay Amount	±varchar[10]	Amount of Copay member/patient is responsible to pay	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Copay applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	The copay amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99%

**Medical Claims – APCD Level 2 Data Elements**

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MC066	Coinsurance Amount	±varchar[10]	Amount of coinsurance member/patient is responsible to pay	Report the amount that defines a calculated percentage amount for this claim line service that the patient is responsible to pay. Report 0 if no Coinsurance applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	The coinsurance amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99%
MC067	Deductible Amount	±varchar[10]	Amount of deductible member/patient is responsible to pay on the claim line	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Deductible applies to service. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	The deductible amount applied to a claim line or full claim as calculated by the carrier or its designee.	A1	99%
MC069	Discharge Date	int[8]	Discharge Date	Report the date the member was discharged from the facility in CCYYMMDD Format. If patient is still in-house and claim represents interim billing for interim payment, report the interim through date.	Report the date the member was discharged from the facility in CCYYMMDD Format. If patient is still in-house and claim represents interim billing for interim payment, report the interim through date.	A2	98%

**Medical Claims – APCD Level 2 Data Elements**

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MC070	Service Provider Country Code	char[3]	Country name of the Service Provider	Report the three-character country code as defined by ISO 3166-1, Alpha 3	Country of the Service Provider.	C	98%
MC071	DRG	varchar[7]	Diagnostic Related Group Code	Report the DRG number applied to this claim on every line to which it's applicable. Insurers and health care claims processors shall code using the CMS methodology when available. When the CMS methodology for DRGs is not available, but the All Payer DRG system is used, the insurer shall format the DRG and the complexity level within the same element with the prefix of "A" and with a hyphen separating the AP DRG from the complexity level (e.g. AXXX-XX)	CMS methodology when available. When the CMS methodology for DRGs is not available, but the All Payer 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).	B	98%
MC072	DRG Version	char[2]	Diagnostic Related Group Version Number	Report the version of the grouper used.	Version identifier of the DRG Grouper used.	B	20%
MC073	APC	char[4]	Ambulatory Payment Classification Number	Report the APC number applied to this claim line, with the leading zero(s) when applicable. Code using the CMS methodology.	CMS APC methodology expected.	C	20%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC074	APC Version	char[2]	Ambulatory Payment Classification Version	Report the version of the grouper used.	Version identifier of the APC Grouper used	C	20%
MC075	Drug Code	char[11]	National Drug Code (NDC)	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'. Drug Code as defined by the FDA in 11 digit format (5-4-2) without hyphenation.	A standard NDC Code as defined by the FDA in 5-4-2 format without hyphenation.	B	1%
MC076	Billing Provider Number	varchar[30]	Billing Provider Number	Report the carrier / submitter assigned billing provider number. This number should be the identifier used for internal identification purposes, and does not routinely change. The value in this field must match a record in the provider file in PV002.	Link to PV002 on the Provider File to obtain detailed attributes of the Billing Provider.	B	99%
MC077	National Provider ID - Billing	int[10]	National Provider Identification (NPI) of the Billing Provider	Report the Primary National Provider ID (NPI) here. This ID should be found on the Provider File in the NPI field (PV039).	The National Provider ID (NPI) of the Billing Provider.	B	99%

**Medical Claims – APCD Level 2 Data Elements**

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MC078	Billing Provider Last Name or Organization Name	varchar[60]	Last name or Organization Name of Billing Provider	Report the name of the organization or last name of the individual provider.	Last name, or Organization name, of the Billing Provider.	B	99%
MC079	Product ID Number	varchar[30]	Product Identification	Report the submitter-assigned identifier as it appears in PR001 in the Product File. This element is used to understand Product and Eligibility attributes of the member / subscriber as applied to this record.	Link to PR001 on the Product File to obtain detailed attributes of the Product to which this claim line's member eligibility is associated.	A0	100%
MC080	Payment Reason	varchar[10]	Payment Reason Code	Report the value that describes how the claim line was paid, either using a standard code set or a proprietary list pre-sent by submitter.		A0	100%
MC081	Capitated Encounter Flag	int[1]	Indicator - Capitation Payment 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	Report the value that defines the element. EXAMPLE: 1 = Yes payment for this service is covered under a capitated arrangement.		A0	100%

**Medical Claims – APCD Level 2 Data Elements**

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MC083	Other ICD-CM Procedure Code - 1	varchar[7]	ICD Secondary Procedure Code	Report the subsequent ICD CM procedure code when applicable. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	Second ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1%
MC084	Other ICD-CM Procedure Code - 2	varchar[7]	ICD Other Procedure Code	Report the third ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Third ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1%
MC085	Other ICD-CM Procedure Code - 3	varchar[7]	ICD Other Procedure Code	Report the fourth ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Fourth ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1%
MC086	Other ICD-CM Procedure Code - 4	varchar[7]	ICD Other Procedure Code	Report the fifth ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Fifth ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1%

**Medical Claims – APCD Level 2 Data Elements**

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MC087	Other ICD-CM Procedure Code - 5	varchar[7]	ICD Other Procedure Code	Report the sixth ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Sixth ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1%
MC088	Other ICD-CM Procedure Code - 6	varchar[7]	ICD Other Procedure Code	Report the seventh ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Seventh ICD-9 procedure code. The Integer point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. Required for inpatient institutional claims.	C	1%
MC089	Paid Date	int[8]	Paid date of the claim line	Report the date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment in CCYYMMDD Format. This can be the same date as Processed Date. EXAMPLE: Claims paid in full, partial or zero paid must have a date reported here.	The date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment for this claim line (Claims paid in full, partial or zero paid). This can be the same date as Processed Date.	A0	98%
MC091	Coinsurance Days	±varchar[4]	Covered Coinsurance Days	Report the number of partially covered days the patient incurred during this admission. Report 0 if all days were covered and/or Non-covered days.	This element is used to determine a type of covered benefit days as defined by Medicare. Submitters that use a similar methodology are encouraged to report the appropriate number of days that correspond with the Medicare definition.	B	98%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC092	Covered Days	±varchar[4]	Covered Inpatient Days	Report the number of covered days the patient incurred during this admission. Report 0 if days were Non-covered or partially covered under Coinsurance Days.	Amount of inpatient days paid for by the carrier. If not available, the number of days authorized by the carrier for the admission.	B	98%
MC093	Non Covered Days	±varchar[4]	Non-covered Inpatient Days	Report the number of Non-covered days the patient incurred during this admission. Report 0 if all days were covered.	Amount of inpatient days that were not paid for by the plan for the inpatient event. Enter 0 when not applicable.	B	87%
MC094	Type of Claim	char[3]	Type of Claim Indicator 001 Professional 002 Hospital 003 Reimbursement Form	Report the value that defines the type of claim submitted for payment. EXAMPLE: 001 = Professional Claim Line	Numeric indicator of the type of claim received and processed by the carrier or its designee (Professional, Hospital, or Reimbursement Form).	A0	100%



**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC095	Coordination of Benefits/TPL Liability Amount	±varchar[10]	Amount due from a Secondary Carrier when known	Report the amount that another carrier / insurer is liable for after submitting payer has processed this claim line. Report 0 if there is no COB / TPL amount. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	The amount that another carrier/insurer is liable for, as determined by the carrier or its designee after their adjudication.	A2	98%
MC096	Other Insurance Paid Amount	±varchar[10]	Amount paid by a Primary Carrier	Report the amount that a prior payer has paid for this claim line. Indicates the submitting Payer is 'secondary' to the prior payer. Only report 0 if the Prior Payer paid 0 towards this claim line, else do not report any value here. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	The amount that another carrier paid for this claim line.	A2	98%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC097	Medicare Paid Amount	±varchar[10]	Amount Medicare paid on claim	Report the amount Medicare paid towards this claim line. Only report 0 here if Medicare paid 0. If Medicare did not pay towards this claim line do not report any value here. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	The amount that Medicare paid towards this claim line prior to carrier adjudication.	A2	98%
MC098	Allowed amount	±varchar[10]	Allowed Amount	Report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider contract and most often it is less than or equal to the fee charged by the provider. Report 0 when the claim line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	The maximum amount contractually allowed and payable for this claim line as defined by the carrier or its designee.	A2	99%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC099	Non-Covered Amount	±varchar[10]	Amount of claim line charge not covered	Report the amount that was charged on a claim that is not reimbursable due to eligibility limitations or provider requirements. Report 0 if all charges are covered or fall into other categories. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	The amount that the carrier or its designee has determined to be above the plan limitations on this claim line.	A2	98%
MC100	Delegated Benefit Administrator Organization ID	varchar[6]	CHIA defined and maintained Org ID for linking across submitters	Risk holders report the OrgID of the DBA here. DBAs report the OrgID of the insurance carrier here. This element contains the CHIA assigned organization ID for the DBA. Contact the APCD for the appropriate value. If no DBA is affiliated with this claim line do not report any value here: i.e., do not repeat the OrgID from MC001	Linking ID used by carriers to identify their Benefit Administrators / Managers, Vendors, etc. This value is a CHIA-assigned identifier.	A2	98%
MC107	ICD Indicator	int[1]	International Classification of Diseases version (did not formally implement for Intake Submission V3.0, therefore will not present an impact in MA APCD R3.0)	Report the value that defines whether the diagnoses on claim are ICD9 or ICD10. EXAMPLE: 9 = ICD9	This element is required and becomes invoked when any Diagnosis Element is populated. It is required to insure that clinical editing and categorization occurs correctly and is assumed to report ICD9 until ICD10 implementation.	B	100%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
					The values present on the MA APCD table align to those used by CHIA for Medicare and Medicaid Services to provide continuity across submitters.		
MC108	Procedure Modifier - 3	char[2]	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055).	The third modifier for the procedure code reported on this claim line.	C	0%
MC109	Procedure Modifier - 4	char[2]	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055).	The fourth modifier for the procedure code reported on this claim line.	C	0%
MC110	Claim Processed Date	int[8]	Claim Processed Date	Report the date the claim was processed by the carrier / submitter in CCYYMMDD Format. This date can be equal to Paid Date, but cannot be after Paid Date.	The date the claim was processed by the carrier or its designee for adjudication.	A2	98%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC111	Diagnostic Pointer	varchar[4]	Diagnostic Pointer Number	Report the placement number of the diagnosis(es) a procedure is related to for a professional claim. Can report up to four diagnostic positions within the first nine diagnoses that can be reported. Do not separate multiple mappings with spaces, zeros or special characters. Do not zero fill. EXAMPLE: Procedure related to diagnoses 1, 4 and 5 = 145	A numeric indicator that aligns each claim line service to a diagnosis: 1 for Principal Diagnosis; 2 for Other Diagnosis-1; 3 for Other Diagnosis-2, etc.	B	98%
MC112	Referring Provider ID	varchar[30]	Referring Provider ID	Report the identifier of the provider that submitted the referral for the service or ordered the test that is on the claim (if applicable). The value in this field must have a corresponding Provider ID (PV002) on the provider file.	Link to PV002 on the Provider File to obtain detailed attributes of the Referring Provider.	A2	98%
MC113	Payment Arrangement Type	char[2]	Payment Arrangement Type Value 01 Capitation 02 Fee for Service 03 Percent of Charges 04 DRG 05 Pay for Performance 06 Global Payment 07 Other	Report the value that defines the contracted payment methodology for this claim line. EXAMPLE: 02 = Fee for Service	Numeric indicator that reports how the payment was derived for the claim line by the carrier or its designee.	A0	98%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC114	Excluded Expenses	±varchar[10]	Amount not covered at the claim line due to benefit/plan limitation	Report the amount that the patient has incurred towards covered but over-utilized services. Scenario: Physical Therapy units that are authorized for 15 visits at \$50 a visit but utilized 20. The amount reported here would be 25000 to state over-utilization by \$250.00. Report 0 if there are no Excluded Expenses. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	The amount that a carrier or its designee has determined to be over the plan limitations for Patient utilization.	A2	98%
MC115	Medicare Indicator	int[1]	Indicator - Medicare Payment Applied 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	Report the value that defines the element. EXAMPLE: 1 = Yes, Medicare paid for part or all of services.	Numeric indicator that reports if the claim line has any Medicare payments applied towards it as a Prior Payer on the claim.	A0	100%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC116	Withhold Amount	±varchar[10]	Amount to be paid to the provider upon guarantee of performance	Report the amount paid to the provider for this claim line if the provider qualified / met performance guarantees. Report 0 if the provider has the agreement but did not satisfy the measure, else do not report any value here. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	The amount paid to the provider for this service if the provider qualifies / meets performance guarantees.	A2	98%
MC117	Authorization Needed	int[1]	Indicator - Authorization Needed 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	Report the value that defines the element. EXAMPLE: 1 = Yes service required a pre-authorization.	Numeric indicator that reports if a claim line requires an authorization by the carrier or its designee.	A2	100%
MC118	Referral Indicator	int[1]	Indicator - Referral Needed 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	Report the value that defines the element. EXAMPLE: 1 = Yes service was preceded by a referral.	Numeric indicator that reports if a claim line requires a referral by the carrier or its designee.	A0	100%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC119	PCP Indicator	int[1]	Indicator - PCP Rendered Service 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	Report the value that defines the element. EXAMPLE: 1 = Yes service was performed by members PCP.	Numeric indicator that reports if a claim line was performed by the Patient's assigned Primary Care Provider.	A2	100%
MC120	DRG Level	int[1]	Diagnostic Related Group Code Severity Level	Report the level used for severity adjustment when applicable.	Severity adjustment level when applicable.	B	80%
MC121	Patient Total Out of Pocket Amount	±varchar[10]	Total amount patient/member must pay	Report the total amount patient / member is responsible to pay to the provider as part of their costs for services. Report 0 if there are no Out of Pocket expenses. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	This element is required to measure patient / member out of pocket expenses in correlation to the benefits assigned on the eligibility file. Submitters should report 0 when there is no out of pocket expense for a claim line.	A2	100%
MC122	Global Payment Flag	int[1]	Indicator - Global Payment 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	Report the value that defines the element. EXAMPLE: 1 = Yes the claim line was paid under a global payment arrangement.	Numeric indicator that reports if a claim line was processed / paid under a global payment arrangement.	A0	100%



**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC123	Denied Flag	int[1]	Denied Claim Line Indicator 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	Report the value that defines the element. EXAMPLE: 1 = Yes, Claim Line was denied.	Numeric indicator that reports if the claim line was denied by the claims processor.	A0	100%
MC124	Denial Reason	varchar[15]	Denial Reason Code	Report the code that defines the reason for denial of the claim line. Carrier must submit denial reason codes in separate table to the APCD.	The Claim Line denial reason as assigned by the carrier or its designee.	A2	98%
MC125	Attending Provider	varchar[30]	Attending Provider ID	Report the ID that reflects the provider that provided general oversight of the patient's care. This individual may or may not be the Servicing or Rendering provider. This value needs to be found in field PV002 on the Provider File. This field may or may not be NPI based on the carrier's identifier system.	Link to PV002 on the Provider File to obtain detailed attributes of the Attending Provider as defined at a facility.	A1	98%
MC126	Accident Indicator	int[1]	Indicator - Accident Related 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	Report the value that defines the element. EXAMPLE: 1 = Yes, Claim Line is Accident related.	Numeric indicator that reports if the claim line procedure was performed due to an accident (not employment based).	A2	100%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC127	Family Planning Indicator	int[1]	Service is related to Family Planning 0 Unknown / Not Applicable / Not Avail 1 Family planning services provided 2 Abortion services provided 3 Sterilization services provided 4 No family planning services provided	Report the value that defines if family planning services were provided. EXAMPLE: 0 = Unknown / Not Applicable	Numeric indicator that reports the claim line service's relation to family planning.	A2	98%
MC128	Employment Related Indicator	int[1]	Indicator - Accident Related 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	Report the value that defines the element. EXAMPLE: 1 = Yes, Claim Line was related to employment accident.	Numeric indicator that reports if the claim line procedure was performed due to an employment related accident.	A2	100%
MC129	EPSDT Indicator	int[1]	Service related to Early Periodic Screening, Diagnosis and Treatment (EPSDT) 0 Unknown / Not Applicable / Not Avail 1 EPSDT Screen 2 EPSDT Treatment 3 EPSDT Referral	Report the value that defines if service was related to EPSDT and the type of EPSDT service, such as 'screening', 'treatment' or 'referral'. EXAMPLE: 0 = Unknown / Not Applicable	Numeric indicator that reports the claim line service's relation to EPSDT services.	B	98%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC130	Procedure Code Type	int[1]	Claim line Procedure Code Type Identifier 0 Carrier Custom Code 1 CPT or HCPCS Level 1 Code 2 HCPCS Level II Code 3 HCPCS Level III Code (State Medicare code) 4 American Dental Association (ADA) Procedure Code (Also referred to as CDT code.) 5 State defined Procedure Code	Report the value that defines the type of Procedure Code expected in MC055.	Numeric indicator that reports the type of procedure code expected on this claim line.	A1	98%
MC131	InNetwork Indicator	int[1]	Indicator - Network Rate Applied 1 Yes 2 No 3 Unknown 4 Other 5 Not Applicable	Report the value that defines the element. EXAMPLE: 1 = Yes claim line was paid at an InNetwork rate.	Numeric indicator that reports if a claim line was processed / paid at In-Network rates.	A2	100%
MC132	Service Class	char[2]	Service Class Code	Report the code that defines the service class for Medicaid PCC members receiving behavioral health services (values based on MassHealth encounter table).	A code used to define Behavioral Health services to MassHealth and MassHealth Managed Care Organization patients.	C	10%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC133	Bill Frequency Code	char[1]	Bill Frequency	Report the valid frequency code of the claim to indicate version, credit/debit activity and/or settling of claim.	This element file is required to identify aspects of claim line activity for versioning lines to the highest value. The allowable values are those that are generally accepted.	A2	100%
MC134	Plan Rendering Provider Identifier	varchar[30]	Plan Rendering Number	Report the unique code which identifies for the carrier / submitter who or which individual provider cared for the patient for the claim line in question. This code must be able to link to the Provider File. Any value in this field must also show up as a value in field PV002 (Provider ID) on the Provider File.	Link to PV002 on the Provider File to obtain detailed attributes of the Rendering Provider. This code identifies the actual individual that performed the service at the location reported via Provider Location.	A0	100%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC135	Provider Location	varchar[30]	Location of Provider	Report the unique code which identifies the location / site of the service provided by the plan rendering provider identified in MC134. The code should link to a provider record in field PV002 (Provider ID) and indicate that the service was performed at a specific location; e.g.: Dr. Jones Pediatrics, 123 Main St, Boston, MA, or Pediatric Associates, or Mass General Hospital, etc. Only the code is needed in this field, and the link to the Provider ID in the field PV002 (Provider ID) will allow the physical address and other identifying information about the service location to be captured. Type of location is an incorrect value.	Link to PV002 on the Provider File to obtain detailed attributes of the Provider Location. This code identifies the location/site where the service was performed by the Provider ID reported in Plan Rendering Provider Identifier.	A2	98%
MC136	Discharge Diagnosis	varchar[7]	ICD Discharge Diagnosis Code	Report the ICD diagnosis code as applied to the patient upon discharge. This may or may not be the same as the primary diagnosis or admitting diagnosis.	The ICD9 diagnosis code assigned to the Patient upon discharge.	B	80%
MC137	Carrier Specific Unique Member ID	varbinary[256]	Member's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to validate Unique Member ID and link back to Member Eligibility (ME107).	Unique, internal identification assigned by the carrier or its designee to the Member. This can be used to link Claim Lines to eligibility segments.	A0	100%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC138	Claim Line Type	char[1]	Claim Line Activity Type Code O Original V Void R Replacement B Back Out A Amendment	Report the code that defines the claim line status in terms of adjudication. EXAMPLE: O = Original	A code that reports the final outcome of the claim line during the submission period of the carrier or its designee. Example: Original, Void, Replacement, Back Out, Amendment	A2	98%
MC139	Former Claim Number	varchar[35]	Previous Claim Number	Report the Claim Control Number (MC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own MC004. Use of “Former Claim Number” to version claims can only be used if approved by the APCD. Contact the APCD for conditions of use.	The Payer Claim Control Number previously assigned to this claim line in a prior reporting period.	B	0%
MC141	Carrier Specific Unique Subscriber ID	varbinary[256]	Subscriber's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to validate Unique Member ID and link back to Member Eligibility (ME117).	Unique, internal identification assigned by the carrier or its designee to the Subscriber. This can be used to link Claim Lines to eligibility segments.	A0	100%
MC142	Other Diagnosis - 13	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 13. If not applicable do not report any value here.		C	1%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC143	Other Diagnosis - 14	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 14. If not applicable do not report any value here.		C	1%
MC144	Other Diagnosis - 15	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 15. If not applicable do not report any value here.		C	1%
MC145	Other Diagnosis - 16	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 16. If not applicable do not report any value here.		C	1%
MC146	Other Diagnosis - 17	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 17. If not applicable do not report any value here.		C	1%
MC147	Other Diagnosis - 18	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 18. If not applicable do not report any value here.		C	1%
MC148	Other Diagnosis - 19	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 19. If not applicable do not report any value here.		C	1%
MC149	Other Diagnosis - 20	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 20. If not applicable do not report any value here.		C	1%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC150	Other Diagnosis - 21	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 21. If not applicable do not report any value here.		C	1%
MC151	Other Diagnosis - 22	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 22. If not applicable do not report any value here.		C	1%
MC152	Other Diagnosis - 23	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 23. If not applicable do not report any value here.		C	1%
MC153	Other Diagnosis - 24	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 24. If not applicable do not report any value here.		C	1%
MC154	Present on Admission Code (POA) - 01	char[1]	POA code for Principal Diagnosis	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC155	Present on Admission Code (POA) - 02	char[1]	POA code for Other Diagnosis - 1	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%



**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC156	Present on Admission Code (POA) - 03	char[1]	POA code for Other Diagnosis - 2	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC157	Present on Admission Code (POA) - 04	char[1]	POA code for Other Diagnosis - 3	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC158	Present on Admission Code (POA) - 05	char[1]	POA code for Other Diagnosis - 4	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC159	Present on Admission Code (POA) - 06	char[1]	POA code for Other Diagnosis - 5	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC160	Present on Admission Code (POA) - 07	char[1]	POA code for Other Diagnosis - 6	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC161	Present on Admission Code (POA) - 08	char[1]	POA code for Other Diagnosis - 7	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC162	Present on Admission Code (POA) - 09	char[1]	POA code for Other Diagnosis - 8	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC163	Present on Admission Code (POA) - 10	char[1]	POA code for Other Diagnosis - 9	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC164	Present on Admission Code (POA) - 11	char[1]	POA code for Other Diagnosis - 10	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC165	Present on Admission Code (POA) - 12	char[1]	POA code for Other Diagnosis - 11	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC166	Present on Admission Code (POA) - 13	char[1]	POA code for Other Diagnosis - 12	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC167	Present on Admission Code (POA) - 14	char[1]	POA code for Other Diagnosis - 13	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC168	Present on Admission Code (POA) - 15	char[1]	POA code for Other Diagnosis - 14	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC169	Present on Admission Code (POA) - 16	char[1]	POA code for Other Diagnosis - 15	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC170	Present on Admission Code (POA) - 17	char[1]	POA code for Other Diagnosis - 16	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC171	Present on Admission Code (POA) - 18	char[1]	POA code for Other Diagnosis - 17	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC172	Present on Admission Code (POA) - 19	char[1]	POA code for Other Diagnosis - 18	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC173	Present on Admission Code (POA) - 20	char[1]	POA code for Other Diagnosis - 19	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC174	Present on Admission Code (POA) - 21	char[1]	POA code for Other Diagnosis - 20	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC175	Present on Admission Code (POA) - 22	char[1]	POA code for Other Diagnosis - 21	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC176	Present on Admission Code (POA) - 23	char[1]	POA code for Other Diagnosis - 22	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC177	Present on Admission Code (POA) - 24	char[1]	POA code for Other Diagnosis - 23	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC178	Present on Admission Code (POA) - 25	char[1]	POA code for Other Diagnosis - 24	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.		A2	100%
MC179	Condition Code - 1	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here.		B	1%
MC180	Condition Code - 2	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here.		B	1%
MC181	Condition Code - 3	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here.		B	1%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC182	Condition Code - 4	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here.		B	1%
MC183	Condition Code - 5	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here.		B	1%
MC184	Condition Code - 6	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here.		B	1%
MC185	Condition Code - 7	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here.		B	1%
MC186	Condition Code - 8	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here.		B	1%
MC187	Condition Code - 9	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here.		B	1%
MC188	Condition Code - 10	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here.		B	1%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC189	Condition Code - 11	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here..		B	1%
MC190	Condition Code - 12	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here.		B	1%
MC191	Value Code - 1	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here.		B	1%
MC192	Value Amount - 1	±varchar[10]	Amount that corresponds to Value Code - 1	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070		B	100%
MC193	Value Code - 2	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here.		B	1%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC194	Value Amount - 2	±varchar[10]	Amount that corresponds to Value Code - 2	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070		B	100%
MC195	Value Code - 3	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here.		B	1%
MC196	Value Amount - 3	±varchar[10]	Amount that corresponds to Value Code - 3	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070		B	100%
MC197	Value Code - 4	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here.		B	1%



**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC198	Value Amount - 4	±varchar[10]	Amount that corresponds to Value Code - 4	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070		B	100%
MC199	Value Code - 5	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here.		B	1%
MC200	Value Amount - 5	±varchar[10]	Amount that corresponds to Value Code - 5	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070		B	100%
MC201	Value Code - 6	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here.		B	1%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC202	Value Amount - 6	±varchar[10]	Amount that corresponds to Value Code - 6	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070		B	100%
MC203	Value Code - 7	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here.		B	1%
MC204	Value Amount - 7	±varchar[10]	Amount that corresponds to Value Code - 7	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070		B	100%
MC205	Value Code - 8	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here.		B	1%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC206	Value Amount - 8	±varchar[10]	Amount that corresponds to Value Code - 8	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070		B	100%
MC207	Value Code - 9	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here.		B	1%
MC208	Value Amount - 9	±varchar[10]	Amount that corresponds to Value Code - 9	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070		B	100%
MC209	Value Code - 10	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here.		B	1%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC210	Value Amount - 10	±varchar[10]	Amount that corresponds to Value Code - 10	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070		B	100%
MC211	Value Code - 11	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here.		B	1%
MC212	Value Amount - 11	±varchar[10]	Amount that corresponds to Value Code - 11	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070		B	100%
MC213	Value Code - 12	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here.		B	1%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC214	Value Amount - 12	±varchar[10]	Amount that corresponds to Value Code - 12	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070		B	100%
MC215	Occurrence Code - 1	char[2]	Occurrence Code	Report the appropriate value that defines an occurrence category for the claim or patient. If not applicable do not report any value here.		B	1%
MC216	Occurrence Date - 1	int[8]	Date that corresponds to Occurrence Code - 1	Report the appropriate date that corresponds to the occurrence code in CCYYMMDD Format.		B	100%
MC217	Occurrence Code - 2	char[2]	Occurrence Code	Report the appropriate value that defines an occurrence category for the claim or patient. If not applicable do not report any value here.		B	1%
MC218	Occurrence Date - 2	int[8]	Date that corresponds to Occurrence Code - 2	Report the appropriate date that corresponds to the occurrence code in CCYYMMDD Format.		B	100%
MC219	Occurrence Code - 3	char[2]	Occurrence Code	Report the appropriate value that defines an occurrence category for the claim or patient. If not applicable do not report any value here.		B	1%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC220	Occurrence Date - 3	int[8]	Date that corresponds to Occurrence Code - 3	Report the appropriate date that corresponds to the occurrence code in CCYYMMDD Format.		B	100%
MC221	Occurrence Code - 4	char[2]	Occurrence Code	Report the appropriate value that defines an occurrence category for the claim or patient. If not applicable do not report any value here.		B	1%
MC222	Occurrence Date - 4	int[8]	Date that corresponds to Occurrence Code - 4	Report the appropriate date that corresponds to the occurrence code in CCYYMMDD Format.		B	100%
MC223	Occurrence Code - 5	char[2]	Occurrence Code	Report the appropriate value that defines an occurrence category for the claim or patient. If not applicable do not report any value here.		B	1%
MC224	Occurrence Date - 5	int[8]	Date that corresponds to Occurrence Code - 5	Report the appropriate date that corresponds to the occurrence code in CCYYMMDD Format.		B	100%
MC225	Occurrence Span Code - 1	char[2]	Occurrence Span Code	Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here.		B	1%
MC226	Occurrence Span Start Date - 1	int[8]	Start Date that corresponds to Occurrence Span Code - 1	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.		B	100%
MC227	Occurrence Span End Date - 1	int[8]	End Date that corresponds to Occurrence Span Code - 1	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.		B	100%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC228	Occurrence Span Code - 2	char[2]	Occurrence Span Code	Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here.		B	1%
MC229	Occurrence Span Start Date - 2	int[8]	Start Date that corresponds to Occurrence Span Code - 2	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.		B	100%
MC230	Occurrence Span End Date - 2	int[8]	End Date that corresponds to Occurrence Span Code - 2	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.		B	100%
MC231	Occurrence Span Code - 3	char[2]	Occurrence Span Code	Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here..		B	1%
MC232	Occurrence Span Start Date - 3	int[8]	Start Date that corresponds to Occurrence Span Code - 3	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.		B	100%
MC233	Occurrence Span End Date - 3	int[8]	End Date that corresponds to Occurrence Span Code - 3	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.		B	100%
MC234	Occurrence Span Code - 4	char[2]	Occurrence Span Code	Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here.		B	1%

**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC235	Occurrence Span Start Date - 4	int[8]	Start Date that corresponds to Occurrence Span Code - 4	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.		B	100%
MC236	Occurrence Span End Date - 4	int[8]	End Date that corresponds to Occurrence Span Code - 4	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.		B	100%
MC237	Occurrence Span Code - 5	char[2]	Occurrence Span Code	Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here.		B	1%
MC238	Occurrence Span Start Date - 5	int[8]	Start Date that corresponds to Occurrence Span Code - 5	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.		B	100%
MC239	Occurrence Span End Date - 5	int[8]	End Date that corresponds to Occurrence Span Code - 5	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.		B	100%
MC241	APCD ID Code	int[1]	Member Enrollment Type 1 FIG - Fully-Insured Commercial Group Enrollee 2 SIG - Self-Insured Group Enrollee 3 GIC - Group Insurance Commission Enrollee 4 MCO - MassHealth Managed Care	Report the value that describes the member's / subscriber's enrollment into one of the predefined categories; aligns enrollment to appropriate editing and thresholds. EXAMPLE: 1 = FIG - Fully Insured Commercial Group Enrollee.	This element utilizes a MA APCD pre-defined lookup table with values that identify a categorized line of eligibility. The value selected here will invoke various edits that apply to that enrollee category in tandem with the CHIA assigned OrgID.	A2	100%



**Medical Claims – APCD Level 2 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
			Organization Enrollee 5 Supplemental Policy Enrollee 6 ICO - Integrated Care Organization 0 Unknown / Not Applicable				

**Medical Claims – APCD Level 3 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
Derived-MC1	Submission Month	Int[2]	Submission Month	N/A	N/A	N/A	N/A
Derived-MC15	Member Link MCL	Int-NULL	Member Matching Confidence Level	N/A	N/A	N/A	N/A
MC006	Insured Group or Policy Number	Varbinary[256]	Group / Policy Number	Report the number that defines the insured group or policy. Do not report the number that uniquely identifies the subscriber or member.	The carrier assigned group / policy number for this claim line. This information is often filed as reported by the provider.	C	95%
MC007	Subscriber SSN	Varbinary[256]	Subscriber's Social Security Number	Report the Subscriber's SSN here; used to validate Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here	Tax ID of the Subscriber.	B	79%
MC008	Plan Specific Contract Number	Varbinary[256]	Contract Number	Report the Plan assigned contract number. Do not include values in this field that will distinguish one member of the family from another. This should be the contract or certificate number for the subscriber and all of the dependents.	Plan assigned contract/certificate number for the Subscriber and all of the corresponding dependents. This identifier must not disclose individuals.	C	98%
MC009	Member Suffix or Sequence Number	Varbinary[256]	Member/Patient's Contract Sequence Number	Report the unique number / identifier of the member / patient within the contract.	A unique identifier that is assigned to each beneficiary under a contract.	B	98%
MC010	Member SSN	Varbinary[256]	Member/Patient's Social Security Number	Report the patient's social security number here; used to validate Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any	Tax ID of the Patient.	B	73%

**Medical Claims – APCD Level 3 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
				value here.			
MC013	Member Date of Birth	Varbinary[256]	Member/Patient's date of birth	Report the date the member / patient was born in CCYYMMDD Format. Used to validate Unique Member ID.		B	98%
MC025	Service Provider Tax ID Number	Varchar[10]	Service Provider's Tax ID number	Report the Federal Tax ID of the Service Provider here. Do not use hyphen or alpha prefix.		C	97%
MC068	Patient Control Number	varchar[20]	Patient Control Number	Report the provider assigned Encounter / Visit number to identify patient treatment. Also known as the Patient Account Number.	The encounter/visit number assigned by the provider to identify Patient treatment at a facility.	A2	98%
MC082	Member Street Address	Varchar[250]	Street address of the Member/Patient	Report the patient / member's address. Used to validate Unique Member ID.		A0	100%
MC090	LOINC Code	Varchar[7]	Logical Observation Identifiers, Names and Codes (LOINC) Code	The Logical Observation Identifiers, Names and Code for laboratory test / results for the claim line.		B	0%
MC101	Subscriber Last Name	Varbinary[256]	Last name of Subscriber	Report the last name of the subscriber. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. <b>EXAMPLE:</b> O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE		B	98%

**Medical Claims – APCD Level 3 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
MC102	Subscriber First Name	Varbinary[256]	First name of Subscriber	Report the first name of the subscriber here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. <b>EXAMPLE:</b> Anne-Marie becomes ANNEMARIE		B	98%
MC103	Subscriber Middle Initial	Varchar[1]	Middle initial of Subscriber	Report the Subscriber's middle initial here. Used to validate Unique Member ID.		C	2%
MC104	Member Last Name	Varbinary[256]	Last name of Member/Patient	Report the last name of the patient / member here. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. <b>EXAMPLE:</b> O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE		B	98%
MC105	Member First Name	Varbinary[256]	First name of Member/Patient	Report the first name of the patient / member here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report		B	98%

**Medical Claims – APCD Level 3 Data Elements**

<b>Data Element</b>	<b>Data Element Name</b>	<b>Format / Length</b>	<b>Description</b>	<b>Element Submission Guideline</b>	<b>Additional Element Description</b>	<b>Edit Level</b>	<b>%</b>
				spaces. <b>EXAMPLE:</b> Anne-Marie becomes ANNEMARIE			
MC106	Member Middle Initial	Varchar[1]	Middle initial of Member/Patient	Report the middle initial of the patient / member when available. Used to validate Unique Member ID.		C	2%
MC140	Member Address 2	Varchar[250]	Secondary Street Address of the Member/Patient	Report the address of member which may include apartment number or suite, or other secondary information besides the street. Used to validate Unique Member ID.		B	1%
MC240	GIC ID	Varchar[9]	GIC Member ID	Report the GIC Member Identification number as provided to GIC Plan Submitters. If not applicable do not report any value here.	This element reports the GIC assigned identifier from the member. The presence of this identifier is dependent upon the value reported in MC241. Non-GIC reporters SHOULD NOT report a value here as this will invoke other data elements that may not be applicable to a line of business.	N/A	N/A

### 3.3.3: Medical Claims File Standardization, , SSN Redaction and Reidentification

*APCD Medical Claims File Cleaning Logic, by Element*

Element	Data Element Name	Format/Length	Description	Cleaning Logic
Derived from MC013	MemberAgeAtService	N/A	Member's age	Set MemberAgeAtService = 999 if >89 Nullify MemberAgeAtService if >= 115.
MC142	OtherDiagnosis13	Varchar[7]	ICD Other Diagnosis Code	Remove decimal point
MC143	OtherDiagnosis14	Varchar[7]	ICD Other Diagnosis Code	Remove decimal point
MC144	OtherDiagnosis15	Varchar[7]	ICD Other Diagnosis Code	Remove decimal point
MC145	OtherDiagnosis16	Varchar[7]	ICD Other Diagnosis Code	Remove decimal point
MC146	OtherDiagnosis17	Varchar[7]	ICD Other Diagnosis Code	Remove decimal point
MC147	OtherDiagnosis18	Varchar[7]	ICD Other Diagnosis Code	Remove decimal point
MC148	OtherDiagnosis19	Varchar[7]	ICD Other Diagnosis Code	Remove decimal point
MC149	OtherDiagnosis20	Varchar[7]	ICD Other Diagnosis Code	Remove decimal point
MC150	OtherDiagnosis21	Varchar[7]	ICD Other Diagnosis Code	Remove decimal point
MC151	OtherDiagnosis22	Varchar[7]	ICD Other Diagnosis Code	Remove decimal point
MC152	OtherDiagnosis23	Varchar[7]	ICD Other Diagnosis Code	Remove decimal point
MC153	OtherDiagnosis24	Varchar[7]	ICD Other Diagnosis Code	Remove decimal point

*APCD Medical Claims File SSN Redaction, by Element*

<b>Element</b>	<b>Data Element Name</b>	<b>Format/Length</b>	<b>Description</b>
MC014	Member City Name	Varchar[30]	Member City Name
MC016	Member ZIP Code	Varchar[9]	Member ZIP Code
MC028	Service Provider First Name	Varchar[25]	Service Provider First Name
MC029	Service Provider Middle Initial	Varchar[25]	Service Provider Middle Initial
MC030	Servicing Provider Last Name or Organization Name	Varchar[60]	Servicing Provider Last Name or Organization Name
MC032	Service Provider Taxonomy	Varchar[10]	Service Provider Taxonomy
MC033	Service Provider City Name	Varchar[30]	Service Provider City Name
MC035	Service Provider ZIP Code	Varchar[9]	Service Provider ZIP Code
MC055	Procedure Code	Varchar[10]	Procedure Code
MC068	Patient Control Number	Varchar[20]	Patient Control Number
MC075	Drug Code	Char[11]	Drug Code
MC078	Billing Provider Last Name or Organization Name	Varchar[60]	Billing Provider Last Name or Organization Name
MC080	Payment Reason	Varchar[10]	Payment Reason
MC124	Denial Reason	Varchar[15]	Denial Reason

*APCD Medical Claims File Reidentification, by Element*

<b>Element</b>	<b>Data Element Name</b>	<b>Format/Length</b>	<b>Description</b>
MC024	Service Provider Number	varchar[30]	Service Provider Identification Number
MC076	Billing Provider Number	varchar[30]	Billing Provider Number
MC079	Product ID Number	varchar[30]	Product Identification
MC112	Referring Provider ID	varchar[30]	Referring Provider ID
MC125	Attending Provider	varchar[30]	Attending Provider ID
MC134	Plan Rendering Provider Identifier	varchar[30]	Plan Rendering Number
MC135	Provider Location	varchar[30]	Location of Provider



**Center for Health Information and Analysis**

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