

## **DESCRIPTION/GENERAL INFORMATION**

This interface is designed to produce a Medical claims file for plan participants administered through **<Data Supplier>**.

The data will be provided in a fixed-record length, ASCII file format. The data request consists of two layouts/records; A Medical Detail Record and a Trailer Record.

## **METHOD OF SUBMISSION**

[To be determined] Truven Health Analytics supports a number of file submission options including: FTP, Web Submission, as well as physical media.

## **FREQUENCY OF SUBMISSION**

The data will be submitted to Truven Health Analytics on a **<monthly/quarterly>** basis.

## **TIMING OF SUBMISSION**

**<Monthly/Quarterly>** files should be submitted on or before the 15<sup>th</sup> of the month following the close of each **<month/quarter>**.

## Data Type: Medical Claims / Encounter Records

### Definitions:

- **Fee-for-service claims** – Claims records for services that result in direct payment to providers on a service-specific basis.
- **Encounter records** – Utilization records for services provided under capitation arrangements (i.e., plans in which a provider is paid based on the number of enrollees rather than the services rendered.) These records enable documentation of all services provided regardless of whether or not direct payment was made to the provider.
- **Facility Data** – Facility data includes all services rendered by an inpatient or outpatient facility. The basis for the requirements of facility data is the information found on the standard UB-04 claim form.
- **Professional Data** – Professional data includes all services rendered by a physician or other professional provider, including dental, vision and hearing. The basis for the requirements of professional data is the information found on the standard CMS-1500 claim form.
- **Fee-for-Service Equivalent** – Financial amounts for services rendered under a capitated arrangement found within encounter records.

### Items for discussion

#### General

- If both fee-for-service claims and encounter records are included on the data file, Truven Health will rely on the data supplier to explain how to differentiate them.
- Truven Health prefers to receive the facility, professional and capitation data (if applicable) in one file. We will rely on the data supplier to explain how to differentiate facility, professional and capitation services in their data.
- If encounter records contain fee-for-service equivalents, it is essential for Truven Health to understand which fields contain these amounts.
- Financial fields should be populated at the service line level, not at the claim level.
- Truven Health will need to understand the circumstances under which claims are not paid on a line item basis. For example, situations where claims are paid on a per diem basis or paid based on a DRG.

- If the managed care program includes a risk-sharing arrangement with providers such that a portion of the approved payment amount is withheld from the provider payment and placed in a risk-sharing pool for later distribution, then the withhold amount should be recorded as a separate field and also included in the Charge Submitted, Allowed Amount and Net Payment fields.

## Provider

Truven Health requires unique provider identifiers and associated names. Truven Health would like both the identifier and the name to be specific to each provider, rather than group level information. TAXID is preferred for the identifier.

- If providers within group practices use a single TAXID, Truven Health would prefer an additional qualifier that would make each identifier and name unique.
- If only the group name is available with the associated TIN, and a qualifier is not available, Truven Health prefers another identifier for professional claims and the TAXID for the facility claims. NPI is preferred for the alternate identifier. In this case the TAXID is still requested in addition to the NPI or alternate identifier.

## Example 1

When providers in group practices use the same TAXID, a qualifier is needed to insure unique provider names.

| Claim ID | TAXID     | Qualifier | Provider Name | Prov Type | Svc Cnt | Net Pay |
|----------|-----------|-----------|---------------|-----------|---------|---------|
| 11111    | 121212121 | 2222      | Dr. Brown     | 25        | 2       | 2000.00 |
| 22222    | 121212121 | 3333      | Dr. Smith     | 35        | 1       | 100.00  |

**Example 2**

The following is an example of what is **not** desired.

| Claim ID | TAXID     | Provider Name  | Prov Type | Svc Cnt | Net Pay |
|----------|-----------|----------------|-----------|---------|---------|
| 11111    | 121212121 | Dr. Brown      | 25        | 2       | 2000.00 |
| 22222    | 121212121 | Dr. Smith      | 35        | 1       | 100.00  |
| 33333    | 232323232 | XYZ Pediatrics | 25        | 1       | 125.00  |
| 44444    | 232323232 | XYZ Pediatrics | 35        | 1       | 110.00  |

**Example 3**

When only the groups name is available with TAXID, NPI is requested in addition to TAXID.

Professional

| Claim ID | TAXID     | Group Name     | NPI  | Provider Name | Prov Type | Svc Cnt | Net Pay |
|----------|-----------|----------------|------|---------------|-----------|---------|---------|
| 11111    | 121212121 | XYZ Pediatrics | 2222 | Dr. Brown     | 25        | 2       | 2000.00 |
| 22222    | 121212121 | XYZ Pediatrics | 3333 | Dr. Smith     | 35        | 1       | 100.00  |

Facility

| Claim ID | TAXID     | NPI  | Provider Name                  | Prov Type | Rev Code | Net Pay |
|----------|-----------|------|--------------------------------|-----------|----------|---------|
| 11111    | 343434343 | 2222 | University Hospital            | 25        | 110      | 2000.00 |
| 22222    | 454545454 | 3333 | University Children's Hospital | 35        | 120      | 100.00  |

## Financial Fields

Truven Health defines the relationship among financial fields as follows:

- Charge Submitted
- Not Covered Amount\*
- = Charge Covered\*
- Discount Amount
- = Allowed Amount
- Coinsurance
- Copayment
- Deductible
- Penalty/Sanction Amount\*
- Third Party Amount
- = **Net Payment**

\*not required in standard data extract (desirable if available)

## Corrections to paid claims

Data suppliers generally use either Void/Replacement or Adjustment records to make corrections to paid claims. Truven Health defines these as follows:

### Void/Replacement

A void is a claim that reverses or backs out a previously paid one. All financials and quantities are negated on the void record. A replacement record that contains the corrected information generally follows it.

The original, void and replacement need not appear in the same file.

**Example:** After adjudication, a paid claim with a \$25 Copay and \$50 Net Pay, a correction was necessary. The correction contains a \$10 Copay and \$65 Net Pay.

| Record Type | Service Count | Charge Submitted | Copay  | Deductible | Net Payment |
|-------------|---------------|------------------|--------|------------|-------------|
| Original    | 1             | 75.00            | 25.00  | 0.00       | 50.00       |
| Void        | -1            | -75.00           | -25.00 | 0.00       | -50.00      |
| Replacement | 1             | 75.00            | 10.00  | 0.00       | 65.00       |

## Adjustments

A financial adjustment is a claim line where one or more of the financial fields display the difference between the original amount and the final amount. Any financial not being adjusted should be zero. All quantities should be zero on the adjustment as well.

The original and adjustment need not appear in the same file.

**Example:** After a claim was adjudicated with a \$25 Copay and \$50 Net Pay, it was discovered that there should have been a \$10 Copay and \$65 Net Pay.

| Record Type | Service Count | Charge Submitted | Copay  | Deductible | Net Payment |
|-------------|---------------|------------------|--------|------------|-------------|
| Original    | 1             | 75.00            | 25.00  | 0.00       | 50.00       |
| Adjustment  | 0             | 0                | -15.00 | 0.00       | 15.00       |

**Facility Record Content**

- The standard UB-04 claim form contains both information that pertains to the entire claim and single service/procedure within the claim.
- Each record in the data file should represent one service (detail) line.
- All financials and quantities on each record should pertain to that service only (as opposed to the entire claim).
- The repeating of non-quantitative claim-level information (e.g., Claim ID, Provider ID, Provider Type, etc.) on each record is necessary.

**Example:** One facility claim with three service lines:

| Claim-Level Information |           |           | Service-Level Detail |        |         |         |
|-------------------------|-----------|-----------|----------------------|--------|---------|---------|
| Claim ID                | Prov ID   | Prov Type | Line Nbr             | Rev Cd | Svc Cnt | Net Pay |
| 11111                   | 121212121 | 25        | 1                    | 120    | 2       | 2000.00 |
| 11111                   | 121212121 | 25        | 2                    | 250    | 1       | 100.00  |
| 11111                   | 121212121 | 25        | 3                    | 720    | 10      | 1532.00 |

## Professional Record Content

- Truven Health does not store separate header/claim-level and detail/service-level information for professional claims. Truven Health requires the following:
- Each record in the data file should represent one service (detail) line.
- All financials and quantities on each record should pertain to that service only (as opposed to the entire claim.)
- The repeating of non-quantitative claim-level information (e.g., Claim ID, Provider ID, Provider Type, etc.) on each record is necessary.

**Example:** One professional claim with two service lines:

| Claim-Level Information |           |           | Service-Level Detail |         |         |         |
|-------------------------|-----------|-----------|----------------------|---------|---------|---------|
| Claim ID                | Prov ID   | Prov Type | Line Nbr             | Proc Cd | Svc Cnt | Net Pay |
| 13331                   | 621262121 | 51        | 1                    | 99201   | 1       | 100.00  |
| 13331                   | 621262121 | 51        | 2                    | 99175   | 1       | 150.00  |

## Denied Claims

Fully denied claims should be removed from the extract of claims prior to submission, while partially denied claims should be included. Truven Health defines denied claims as follows:

- Fully denied claim - The entire claim has been denied (typical reasons include an ineligible member, an ineligible provider, or a duplicate claims).
- Partially denied claim – The claim contains one or more service lines that are denied, but some that are paid. All service lines should be included on the file.

## **Data Type: Capitation Data**

### **Definition**

Capitation data contains information regarding payments made to a physician, facility or other provider for a pre-determined set of services, regardless if the services are rendered to the enrollee. When services are rendered, an encounter record will be found in the medical claims data.

### **Items for Discussion**

- Person-level information is preferred; such as, one record contains payment information per person per month
- Provider detail information is also preferred

### **DATA FORMATTING**

#### **Character Fields**

- Includes A - Z (lower or upper case), 0 – 9, and spaces
- Left justified, right blank/space filled
- Unrecorded or missing values in character fields are blank/spaces

#### **Numeric Fields**

- All numeric fields should be right-justified and left zero-filled.
- Unrecorded or missing values in numeric fields should be set to zero.

#### **Financial Fields**

- All financial fields should be right-justified and left zero-filled.
- Truven Health prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data. For example, the data string “1234567” would represent \$12,345.67. Please do not include an actual decimal point in the data.
- Negative signs should be the leading value in the first position. For example “-1234567” would represent -\$12,345.67.
- Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal) and left zero-filled.

## Invalid Characters

Please note that the following characters should not be included in the data or the descriptions in the data dictionary.

\*  
!  
?  
%  
\_ (under score)  
, (comma)

## Medical Record

| Field Number | Field Name                  | Start | End | Length | Type      | Data Element Description   | Data Supplier Instructions/Notes   |
|--------------|-----------------------------|-------|-----|--------|-----------|--|--|
| 1            | Adjustment Type Code        | 1     | 1   | 1      | Character | Client-specific code for the claim adjustment type   | Adjustment Type values will be identified in the <b>Data Dictionary</b> .  |
| 2            | Allowed Amount              | 2     | 11  | 10     | Numeric   | The maximum amount allowed by the plan for payment.  | Format 9(8)v99 (2 – digit, implied decimal)<br>On facility records, this field must be at the service/detail level as opposed to the header/claim level. |
| 3            | Bill Type Code UB           | 12    | 15  | 4      | Character | The UB-04 standard code for the billing type, indicating type of facility, bill classification, and frequency of bill. Length expanded from 3 to 4 for future use. | Bill Type values will be identified in the <b>Data Dictionary</b> .  |
| 4            | Capitated Service Indicator | 16    | 16  | 1      | Character | An indicator that this service (encounter record) was capitated  | Applicable field values are “Y” for Capitated services and “N” for non-cap services.   |
| 5            | Charge Submitted            | 17    | 26  | 10     | Numeric   | The submitted or billed charge amount  | Format 9(8)v99 (2 – digit, implied decimal)<br>On facility records, this field must be at the service/detail level as opposed to the header/claim level. |
| 6            | Claim ID                    | 27    | 41  | 15     | Character | The client-specific identifier of the claim.   |  |

| Field Number | Field Name                      | Start | End | Length | Type      | Data Element Description  | Data Supplier Instructions/Notes   |
|--------------|---------------------------------|-------|-----|--------|-----------|---|--|
| 7            | Claim Type Code                 | 42    | 43  | 2      | Numeric   | Client-specific code for the type of claim  | Claim Type Codes will be identified in the <b>Data Dictionary</b> .  |
| 8            | Co-Insurance                    | 44    | 53  | 10     | Numeric   | The coinsurance paid by the subscriber as specified in the plan provision.  | Format 9(8)v99 (2 – digit, implied decimal)<br>On facility records, this field must be at the service/detail level as opposed to the header/claim level.   |
| 9            | Copayment                       | 54    | 63  | 10     | Numeric   | The copayment paid by the subscriber as specified in the plan provision.  | Format 9(8)v99 (2 – digit, implied decimal)<br>On facility records, this field must be at the service/detail level as opposed to the header/claim level.   |
| 10           | Date of Birth                   | 64    | 73  | 10     | Date      | The birth date of the person.   | MM/DD/CCYY format<br>The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.<br>The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year. |
| 11           | Date of First Service           | 74    | 83  | 10     | Date      | The date of the first service reported on the claim or authorization record.  | MM/DD/CCYY format  |
| 12           | Date of Last Service            | 84    | 93  | 10     | Date      | The date of the last service reported on the claim or authorization record.   | MM/DD/CCYY format  |
| 13           | Date of Service Facility Detail | 94    | 103 | 10     | Date      | The date of service for the facility detail record.   | MM/DD/CCYY format  |
| 14           | Date Paid                       | 104   | 113 | 10     | Date      | The date the claim or data record was paid.   | MM/DD/CCYY format<br>This is the check date.   |
| 15           | Days                            | 114   | 119 | 6      | Numeric   | The number of inpatient days for the facility claim.  |  |
| 16           | Deductible                      | 120   | 129 | 10     | Numeric   | The amount paid by the subscriber through the deductible arrangement of the plan.                                     | Format 9(8)v99 (2 – digit, implied decimal)<br>On facility records, this field must be at the service/detail level as opposed to the header/claim level.   |
| 17           | Diagnosis Code Principal        | 130   | 137 | 8      | Character | The first or principal diagnosis code for a service, claim or lab result. Length expanded from 5 to 8 for future use. | No decimal point.  |

| Field Number | Field Name           | Start | End | Length | Type      | Data Element Description   | Data Supplier Instructions/Notes |
|--------------|----------------------|-------|-----|--------|-----------|--|----------------------------------|
| 18           | Diagnosis Code 2 UB  | 138   | 145 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 19           | Diagnosis Code 3 UB  | 146   | 153 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 20           | Diagnosis Code 4 UB  | 154   | 161 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 21           | Diagnosis Code 5 UB  | 162   | 169 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 22           | Diagnosis Code 6 UB  | 170   | 177 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 23           | Diagnosis Code 7 UB  | 178   | 185 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 24           | Diagnosis Code 8 UB  | 186   | 193 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 25           | Diagnosis Code 9 UB  | 194   | 201 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 26           | Diagnosis Code 10 UB | 202   | 209 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 27           | Diagnosis Code 11 UB | 210   | 217 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 28           | Diagnosis Code 12 UB | 218   | 225 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 29           | Diagnosis Code 13 UB | 226   | 233 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |

| Field Number | Field Name           | Start | End | Length | Type      | Data Element Description   | Data Supplier Instructions/Notes |
|--------------|----------------------|-------|-----|--------|-----------|--|----------------------------------|
| 30           | Diagnosis Code 14 UB | 234   | 241 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 31           | Diagnosis Code 15 UB | 242   | 249 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 32           | Diagnosis Code 16 UB | 250   | 257 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 33           | Diagnosis Code 17 UB | 258   | 265 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 34           | Diagnosis Code 18 UB | 266   | 273 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 35           | Diagnosis Code 19 UB | 274   | 281 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 36           | Diagnosis Code 20 UB | 282   | 289 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 37           | Diagnosis Code 21 UB | 290   | 297 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 38           | Diagnosis Code 22 UB | 298   | 305 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 39           | Diagnosis Code 23 UB | 306   | 313 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 40           | Diagnosis Code 24 UB | 314   | 321 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |
| 41           | Diagnosis Code 25 UB | 322   | 329 | 8      | Character | A secondary diagnosis code for the facility claim. Length expanded from 5 to 8 for future use. | No decimal point.                |

| Field Number | Field Name                 | Start | End | Length | Type      | Data Element Description   | Data Supplier Instructions/Notes   |
|--------------|----------------------------|-------|-----|--------|-----------|--|--|
| 42           | Discharge Status Code UB   | 330   | 331 | 2      | Numeric   | The UB-04 standard patient status code, indicating disposition at the time of billing.   |  |
| 43           | Discount                   | 332   | 341 | 10     | Numeric   | The discount amount of the claim, applied to charges for any plan pricing reductions.  | Format 9(8)v99 (2 – digit, implied decimal)<br>On facility records, this field must be at the service/detail level as opposed to the header/claim level. |
| 44           | Family ID/Employee SSN     | 342   | 350 | 9      | Character | The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents. | The subscriber's social security number is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.                       |
| 45           | Gender Code                | 351   | 351 | 1      | Character | The member's gender code.  | "M" or "F"<br>The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.                             |
| 46           | Line Number                | 352   | 353 | 2      | Numeric   | The detail line number for the service on the claim  |  |
| 47           | Net Payment                | 354   | 363 | 10     | Numeric   | The actual check amount for the record   | Format 9(8)v99 (2 – digit, implied decimal)<br>On facility records, this field must be at the service/detail level as opposed to the header/claim level. |
| 48           | Network Paid Indicator     | 364   | 364 | 1      | Character | An indicator of whether the claim was paid at in-network or out-of-network level   | "Y" or "N"   |
| 49           | Network Provider Indicator | 365   | 365 | 1      | Character | Indicates if the servicing provider participates in the network to which the patient belongs                                   | "Y" or "N"   |
| 50           | Ordering Provider ID       | 366   | 378 | 13     | Character | The ID number of the provider who referred the patient or ordered the test or procedure.                                       | The ID should be the physician's Federal Tax ID (TIN).   |
| 51           | Ordering Provider Name     | 379   | 408 | 30     | Character | The Name of the provider who referred the patient or ordered the test or procedure.  |  |

| Field Number | Field Name                   | Start | End | Length | Type      | Data Element Description  | Data Supplier Instructions/Notes   |
|--------------|------------------------------|-------|-----|--------|-----------|---|--|
| 52           | Ordering Provider Zip Code   | 409   | 413 | 5      | Character | The zip code of the provider who referred the patient or ordered the test or procedure.                     |  |
| 53           | PCP Responsibility Indicator | 414   | 414 | 1      | Character | An indicator signifying that the PCP is the physician considered responsible or accountable for this claim. |  |
| 54           | Place of Service Code        | 415   | 416 | 2      | Character | Client-specific code for the place of service.  | Place of Service values will be identified in the Data <b>Dictionary</b> . |
| 55           | Procedure Code               | 417   | 423 | 7      | Character | The procedure code for the service record. Length expanded from 5 to 7 for future use.                      | CPT/HCPCS codes.   |
| 56           | Procedure Code UB Surg 1     | 424   | 430 | 7      | Character | The primary surgical procedure code (1) on the facility claim. Length expanded from 5 to 7 for future use.  | ICD-9 or 10 Surgical procedure codes.                                      |
| 57           | Procedure Code UB Surg 2     | 431   | 437 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.    | ICD-9 or 10 Surgical procedure codes.                                      |
| 58           | Procedure Code UB Surg 3     | 438   | 444 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.    | ICD-9 or 10 Surgical procedure codes.                                      |
| 59           | Procedure Code UB Surg 4     | 445   | 451 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.    | ICD-9 or 10 Surgical procedure codes.                                      |
| 60           | Procedure Code UB Surg 5     | 452   | 458 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.    | ICD-9 or 10 Surgical procedure codes.                                      |
| 61           | Procedure Code UB Surg 6     | 459   | 465 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.    | ICD-9 or 10 Surgical procedure codes.                                      |
| 62           | Procedure Code UB Surg 7     | 466   | 472 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.    | ICD-9 or 10 Surgical procedure codes.                                      |
| 63           | Procedure Code UB Surg 8     | 473   | 479 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.    | ICD-9 or 10 Surgical procedure codes.                                      |

| Field Number | Field Name                | Start | End | Length | Type      | Data Element Description   | Data Supplier Instructions/Notes      |
|--------------|---------------------------|-------|-----|--------|-----------|--|---------------------------------------|
| 64           | Procedure Code UB Surg 9  | 480   | 486 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. | ICD-9 or 10 Surgical procedure codes. |
| 65           | Procedure Code UB Surg 10 | 487   | 493 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. | ICD-9 or 10 Surgical procedure codes. |
| 66           | Procedure Code UB Surg 11 | 494   | 500 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. | ICD-9 or 10 Surgical procedure codes. |
| 67           | Procedure Code UB Surg 12 | 501   | 507 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. | ICD-9 or 10 Surgical procedure codes. |
| 68           | Procedure Code UB Surg 13 | 508   | 514 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. | ICD-9 or 10 Surgical procedure codes. |
| 69           | Procedure Code UB Surg 14 | 515   | 521 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. | ICD-9 or 10 Surgical procedure codes. |
| 70           | Procedure Code UB Surg 15 | 522   | 528 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. | ICD-9 or 10 Surgical procedure codes. |
| 71           | Procedure Code UB Surg 16 | 529   | 535 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. | ICD-9 or 10 Surgical procedure codes. |
| 72           | Procedure Code UB Surg 17 | 536   | 542 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. | ICD-9 or 10 Surgical procedure codes. |
| 73           | Procedure Code UB Surg 18 | 543   | 549 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. | ICD-9 or 10 Surgical procedure codes. |
| 74           | Procedure Code UB Surg 19 | 550   | 556 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. | ICD-9 or 10 Surgical procedure codes. |
| 75           | Procedure Code UB Surg 20 | 557   | 563 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. | ICD-9 or 10 Surgical procedure codes. |

| Field Number | Field Name                | Start | End | Length | Type      | Data Element Description  | Data Supplier Instructions/Notes   |
|--------------|---------------------------|-------|-----|--------|-----------|---|--|
| 76           | Procedure Code UB Surg 21 | 564   | 570 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.                                | ICD-9 or 10 Surgical procedure codes.  |
| 77           | Procedure Code UB Surg 22 | 571   | 577 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.                                | ICD-9 or 10 Surgical procedure codes.  |
| 78           | Procedure Code UB Surg 23 | 578   | 584 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.                                | ICD-9 or 10 Surgical procedure codes.  |
| 79           | Procedure Code UB Surg 24 | 585   | 591 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.                                | ICD-9 or 10 Surgical procedure codes.  |
| 80           | Procedure Code UB Surg 25 | 592   | 598 | 7      | Character | The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.                                | ICD-9 or 10 Surgical procedure codes.  |
| 81           | Procedure Modifier Code 1 | 599   | 600 | 2      | Character | The 2-character code of the first procedure code modifier on the professional claim   |  |
| 82           | Provider ID               | 601   | 613 | 13     | Character | The unique identifier for the provider of service.  | This must be the federal tax ID in order to use the standard hospital identifier lookup (UNIHOOSP).  |
| 83           | TIN                       | 614   | 622 | 9      | Character | The federal tax ID of the provider.   | Only needed if Provider ID is not the federal tax ID.  |
| 84           | Provider Qualifier        | 623   | 632 | 10     | Character | A qualifier to make Provider ID unique.   | Only required if Provider ID is not unique.  |
| 85           | Provider Type Code Claim  | 633   | 635 | 3      | Numeric   | Client-specific code for the provider type on the claim record  | Provider Type codes are further defined in the <b>Data Dictionary</b>  |
| 86           | Provider Zip Code         | 636   | 640 | 5      | Numeric   | The 5-digit zip code corresponding to the Provider ID   | Provider Location zip code   |
| 87           | Revenue Code UB           | 641   | 644 | 4      | Numeric   | The CMS standard revenue code from the facility claim   | This field must be at the service/detail level.  |
| 88           | Third Party Amount        | 645   | 654 | 10     | Numeric   | The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare). | Format 9(8)v99 (2 – digit, implied decimal)<br>On facility records, this field must be at the service/detail level as opposed to the header/claim level. |

| Field Number | Field Name                     | Start | End | Length | Type      | Data Element Description   | Data Supplier Instructions/Notes   |
|--------------|--------------------------------|-------|-----|--------|-----------|--|--|
| 89           | Units of Service               | 655   | 658 | 4      | Numeric   | Client-specific quantity of services or units  |  |
| 90           | Provider Name                  | 659   | 688 | 30     | Character | The description or name corresponding to the Provider ID.  | The Provider Name should be specific to the provider and not a group name.                                 |
| 91           | Financial Cost Amount          | 689   | 698 | 10     | Numeric   | The amount of payments contributing to total cost of coverage, but received as a standard claim.   | Format 9(8)v99 (2 – digit, implied decimal)<br>Usually used for capitation payments.                       |
| 92           | Capitation Type Code           | 699   | 700 | 2      | Numeric   | Client-specific code for the type of capitation payment  |  |
| 93           | Funding Type Code              | 701   | 701 | 1      | Character | Specifies whether the claim was paid under a fully or self-funded arrangement  | “S” = Self-funded<br>“F” = Fully-funded  |
| 94           | Account Structure              | 702   | 709 | 8      | Character | Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.   | Additional fields may be added to the layout if there is more than one component of the account structure. |
| 95           | Provider NPI Number            | 710   | 719 | 10     | Character | The National Provider ID number for the provider.  |  |
| 96           | Provider Address 1             | 720   | 769 | 50     | Character | The current street address1 of the provider of service.  | If the provider has multiple addresses, the primary address is preferred.                                  |
| 97           | Provider Address 2             | 770   | 819 | 50     | Character | The current street address2 of the provider of service.  | If the provider has multiple addresses, the primary address is preferred.                                  |
| 98           | HRA Amount                     | 820   | 829 | 10     | Numeric   | The amount paid from the HRA as a result of this claim.  |  |
| 99           | HSA Amount                     | 830   | 839 | 10     | Numeric   | The amount paid from the HSA as a result of this claim.  |  |
| 100          | Present on Admission Principal | 840   | 840 | 1      | Character | The principal POA code for the facility claim. Indicates whether the principal diagnosis was present on admission.<br>Standard Values:<br>1 – Unreported/Not Used<br>N – No, not present at admission<br>U – Unknown<br>W – Clinically Undetermined<br>Y – Yes, present at admission | If standard values are not used, define in the <b>Data Dictionary</b> .                                    |

| Field Number | Field Name              | Start | End | Length | Type      | Data Element Description  | Data Supplier Instructions/Notes  |
|--------------|-------------------------|-------|-----|--------|-----------|---|---|
| 101          | Present on Admission 02 | 841   | 841 | 1      | Character | A secondary POA code for the facility claim. Indicates w hether the secondary diagnosis w as present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 102          | Present on Admission 03 | 842   | 842 | 1      | Character | A secondary POA code for the facility claim. Indicates w hether the secondary diagnosis w as present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 103          | Present on Admission 04 | 843   | 843 | 1      | Character | A secondary POA code for the facility claim. Indicates w hether the secondary diagnosis w as present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 104          | Present on Admission 05 | 844   | 844 | 1      | Character | A secondary POA code for the facility claim. Indicates w hether the secondary diagnosis w as present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 105          | Present on Admission 06 | 845   | 845 | 1      | Character | A secondary POA code for the facility claim. Indicates w hether the secondary diagnosis w as present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 106          | Present on Admission 07 | 846   | 846 | 1      | Character | A secondary POA code for the facility claim. Indicates w hether the secondary diagnosis w as present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 107          | Present on Admission 08 | 847   | 847 | 1      | Character | A secondary POA code for the facility claim. Indicates w hether the secondary diagnosis w as present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 108          | Present on Admission 09 | 848   | 848 | 1      | Character | A secondary POA code for the facility claim. Indicates w hether the secondary diagnosis w as present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 109          | Present on Admission 10 | 849   | 849 | 1      | Character | A secondary POA code for the facility claim. Indicates w hether the secondary diagnosis w as present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |

| Field Number | Field Name              | Start | End | Length | Type      | Data Element Description  | Data Supplier Instructions/Notes  |
|--------------|-------------------------|-------|-----|--------|-----------|---|---|
| 110          | Present on Admission 11 | 850   | 850 | 1      | Character | A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 111          | Present on Admission 12 | 851   | 851 | 1      | Character | A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 112          | Present on Admission 13 | 852   | 852 | 1      | Character | A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 113          | Present on Admission 14 | 853   | 853 | 1      | Character | A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 114          | Present on Admission 15 | 854   | 854 | 1      | Character | A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 115          | Present on Admission 16 | 855   | 855 | 1      | Character | A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 116          | Present on Admission 17 | 856   | 856 | 1      | Character | A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 117          | Present on Admission 18 | 857   | 857 | 1      | Character | A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 118          | Present on Admission 19 | 858   | 858 | 1      | Character | A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |

| Field Number | Field Name              | Start | End | Length | Type      | Data Element Description  | Data Supplier Instructions/Notes  |
|--------------|-------------------------|-------|-----|--------|-----------|---|---|
| 119          | Present on Admission 20 | 859   | 859 | 1      | Character | A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 120          | Present on Admission 21 | 860   | 860 | 1      | Character | A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 121          | Present on Admission 22 | 861   | 861 | 1      | Character | A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 122          | Present on Admission 23 | 862   | 862 | 1      | Character | A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 123          | Present on Admission 24 | 863   | 863 | 1      | Character | A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 124          | Present on Admission 25 | 864   | 864 | 1      | Character | A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. | If standard values are not used, define in the <b>Data Dictionary</b> . |
| 125          | DRG MS Payment Code     | 865   | 867 | 3      | Numeric   | The Diagnosis Related Group (MS-DRG) code under which the claim was paid.   |   |
| 126          | ICD Version             | 868   | 868 | 1      | Character | The ICD version or qualifier code that identifies either ICD-9 (9) or ICD-10 (0) diagnosis and procedure codes on the facility claim.                       | If 0 and 9 not used, values defined in the <b>Data Dictionary</b> .     |
| 127          | Tax Amount              | 869   | 878 | 10     | Numeric   | The amount charged by some states per medical claim.  | Format 9(8)v99 (2 – digit, implied decimal)                             |
| 128          | Tax Type Code           | 879   | 879 | 1      | Character | Data Supplier specific code identifying the state and/or type of tax.   | Tax Type Codes will be identified in the <b>Data Dictionary</b> .       |

| Field Number | Field Name  | Start | End  | Length | Type      | Data Element Description | Data Supplier Instructions/Notes |
|--------------|-------------|-------|------|--------|-----------|--------------------------|----------------------------------|
| 129          | Filler1     | 880   | 999  | 120    | Character | Reserved for future use  | Fill with blanks                 |
| 130          | Record Type | 1000  | 1000 | 1      | Character | Record Type Identifier   | Hard Code 'D'                    |

### Medical Detail – Trailer Record

| Field Number | Field Name         | Start | End  | Length | Type      | Data Element Description   | Data Supplier Instruction Notes   |
|--------------|--------------------|-------|------|--------|-----------|----------------------------|---|
| 1            | Data Start Date    | 1     | 10   | 10     | Date      | Data Start Date            | MM/DD/CCYY format – i.e. 09/01/2011. This will represent the 1 <sup>st</sup> day of the month for which data is provided. |
| 2            | Data End Date      | 11    | 20   | 10     | Date      | Data End Date              | MM/DD/CCYY format – i.e. 09/30/2011. This will represent the last day of the month for which data is provided.            |
| 3            | Record Count       | 21    | 30   | 10     | Numeric   | Number of Records on File  | The count of records provided in the data including the Trailer Record  |
| 4            | Total Net Payments | 31    | 44   | 14     | Numeric   | Total Net Payments on File | The sum of Net Payments provided on the file.   |
| 5            | Filler             | 45    | 999  | 955    | Character | Filler                     | Fill with Blanks  |
| 6            | Record Type        | 1000  | 1000 | 1      | Character | Record Type Identifier     | Hard Code 'T'   |