APCD-CDL™

APCD COMMON DATA LAYOUT

Maintained by APCD Council

VERSION 1.1 WITH ERRATA| RELEASED FEBRUARY 11, 2020

APCD-CDL™

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Acknowledgements

Development of the Common Data Layout (CDL) for All-Payer Claims Databases (APCD-CDL™) was a collaborative effort of the APCD council Leadership Team, individuals representing states APCDs including their vendors and APCD data submitters. This group would like to thank the Center for Healthcare Transparency (CHT) for giving us permission to utilize its CHT Model Data Submission Manual as part of the development process for the APCD-CDL™.

Introduction

Overview

All-Payer Claims Databases (APCDs) are large-scale databases that systematically collect healthcare claim data from the existing transaction systems created to pay healthcare claims. They are typically created by a state mandate, that generally include data derived from medical claims, pharmacy claims, eligibility files, provider (physician and facility) files, and dental claims from private and public payers. APCDs can exist as a statewide, comprehensive database managed by an agency of state government or its designee. APCDs can also be created at a regional or sub-state level, usually by nonprofit organizations such as healthcare-related employer business groups or community coalition organizations.

APCDs collect claims data for each patient encounter that is used to better understand health care payments, quality, and utilization.

APCDs are used by state agencies, employers, provider, consumers, health plans and other researchers for many purposes including, but not limited to:

- Examining healthcare cost, utilization, quality, and outcomes;
- Promoting transparency of healthcare costs;
- Evaluating value-based purchasing;
- Designing wellness programs;
- Trending and benchmarking.

APCDs are designed with these use cases in mind. Most are structured to create a single de-identified person identifier across payers to describe services rendered and their associated costs, without duplication.

Purpose

The purpose of the Common Data Layout (CDL) for All-Payer Claims Databases (APCD-CDL™) is to harmonize the claims collection effort across states and reduce the burden of data submission. The overall goals of this effort are to improve efficiency, reduce administrative costs and improve accuracy in claims data collection.

Technical Specifications

Data Submission Requirements

File Content

Individual data elements, data types, field lengths, field description/code assignments, and industry standards can be found in the file layout in Appendices A-H. The submission of the medical, pharmacy, and dental claim is based upon the adjudication date within a given reporting period. The member eligibility file, medical claims file, pharmacy claims file, dental claims file, and provider file shall be submitted as separate ASCII files with variable field lengths, and pipe delimited. Variations from this format can cause data processing delays and errors and additional resources to be expended in order to bring non-compliant submissions into the APCD. Therefore, exceptions to these requirements should only be granted in exceptional circumstances where compliance by the data submitter is not a practical option. Any exception should only be granted for the shortest time possible.

Consistent Inter-file Identifier

The member file, claims files, and provider file are intended to be used as parts of a multi-relational database. Therefore, it is critical to provide a consistent person identifier across all files for any members, providers, and plans. A health care claims processor and any contracted entity acting on behalf of a carrier shall ensure that member and subscriber identifiers for the same individuals are unique and consistent across medical claims, pharmacy claims, dental claims and member eligibility files.

Header and Trailer Records

Each member eligibility, medical claims, pharmacy claims, dental claims, and provider file submission must contain a header record and a trailer record. The header record is the first record of each separate file submission and the trailer record is the last.

Member Eligibility File (ME)

A member eligibility file is a data file composed of demographic information for each individual member eligible for medical, pharmacy, and dental benefits for one or more days of coverage at any time during the reporting time period. A reporting period will be no greater than six months. Dates of coverage are also included in the member eligibility file. Data suppliers must provide a data set that contains information on every covered plan member, regardless of whether the member utilized services during the reporting period. One record, per member, per month, per plan, is required. For example, if a member is covered as both a

subscriber and a dependent on two different policies during the same month, two records must be submitted. If a member has two contract numbers for two different coverage types, two member eligibility records must be submitted. References to the ASC X12 270/271 implementation guides are provided in the tables below.

Consideration for Specific Data Files

The following consideration potentially apply to all claims types:

Adjustment Records

Subsequent incremental claims submissions should include all reversal and adjustment/restated versions of previously submitted claim service lines. They should also include all new, fully-processed service lines associated with the claim, provided that they have paid dates in the reporting period. Claim status code should be used to indicate reversals of previously submitted claims. Data suppliers that assign a completely new Payer Claim Control Number for adjusted claims must submit the original claim number on each record. The data supplier will use the designated field in the standard layout for inclusion of the original Claim Control Number.

Financial Amounts

Financial amount data elements assume the following:

- The sum of all claim lines for a given data element will equal the total charge, paid, prepaid, co-pay, coinsurance, or deductible amounts for the entire claim (variables may differ among the medical, pharmacy and dental claims files).
- The paid amount provided for each non-charge financial amount data element is mutually exclusive.

Medical Claims File (MC)

A medical claims file is a data file composed of service level remittance information, including, but not limited to: member demographics, provider information, charge/payment/allowed information, clinical diagnosis codes, and procedure codes from all non-denied adjudicated claims for each billed service. Data suppliers must report medical service paid claims and encounters data for all applicable/covered members. For the purposes of the descriptions in the tables below, the term “claims” means “claims and encounters”. Many descriptions in the tables below refer to “inpatient” claims; please refer to the National Uniform Billing Committee for the definition of “inpatient”. References to the ASC X12 Post Adjudicated Claims Data Reporting Guides (Institutional and Professional) are provided in the tables below.

Pharmacy Claims File (PC)

A pharmacy claims file is a data file composed of service-level remittance information including, but not limited to: member demographics, provider information, charge/payment/allowed information, and national drug codes from all non-denied adjudicated prescription drug claims. Data suppliers must provide data for all pharmacy claims for prescriptions that were dispensed and paid for the reporting period. References to the NCPDP Uniform Healthcare Payer Data Standard Implementation Guide Version 27 are provided in the tables below.

Dental Claims File (DC)

A dental claims file is a data file composed of service level remittance information including, but not limited to, member demographics, provider information, charge/payment/allowed information, clinical diagnosis codes, and procedure codes from all non-denied adjudicated claims for each billed service. Data suppliers must report dental service paid claims and encounters data for all applicable members. References to the ASC X12 Post Adjudicated Claims Data Reporting Guide (Dental) are provided in the tables below.

Provider File (PV)

A provider file is a data file composed of information including but not limited to: provider IDs, provider names, National Provider Identifiers (NPI), specialty codes, and practice location(s) for all providers as indicated by the payer on the eligibility file and on the claim. Data suppliers must provide a data set that contains information for all providers as indicated by the payer on the eligibility file and on every provider that a claim (Medical, Dental, and Pharmacy) was adjudicated for in the targeted reporting period. Third party administrators (including pharmacy benefit managers, etc.) who may not contract directly with providers, are expected to include providers who are on the claims file for the time period of the corresponding reporting period.

A-1 Header					
NEW CDL Data Element #	**Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Valid Values**
CDLHD001	HD001	Record Type	char	2	HD.
CDLHD002	HD003	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.
CDLHD003	HD002	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLHD004	HD004	Data Submitter Name	varchar	75	Name of data submitter.
CDLHD005	HD005	File Type	char	2	ME = Member Eligibility; MC = Medical Claims; PC = Pharmacy Claims; DC = Dental Claims; PV = Provider File.
CDLHD006	HD006	Period Beginning Date	date	6	CCYYMM. Beginning of period covered for Eligibility. Beginning of paid/adjudicated period for Claims. Beginning of period for Provider file updates.
CDLHD007	HD007	Period Ending Date	date	6	CCYYMM. End of period covered for Eligibility. End of paid/adjudicated period for Claims. End of period for Provider file updates.

A-1 Header					
NEW CDL Data Element #	**Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Valid Values**
CDLHD008	HD008	Test File Flag	char	1	T=File submitted is a test file; P= File submitted is a production file.
CDLHD009	HD009	Comments	varchar	50	Comments.

A-2 Trailer					
NEW CDL Data Element #	**Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Valid Values**
CDLTR001	TR001	Record Type	char	2	TR.
CDLTR002	TR003	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payer.

A-2 Trailer					
NEW CDL Data Element #	**Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Valid Values**
CDLTR003	TR002	Payer Code	varchar	8	APCD-assigned identifier of insurer/underwriter in the case of premiums- based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLTR004	TR004	Data Submitter Name	varchar	75	Name of data submitter.
CDLTR005	TR005	File Type	char	2	ME = Member Eligibility; MC = Medical Claims; PC = Pharmacy Claims; DC = Dental Claims; PV = Provider File.
CDLTR006	TR006	Extraction Date	date	8	CCYYMMDD; Date file was created.
CDLTR007	TR007	Control Total of Paid Amount	int	12	Medical (MC) Pharmacy (PC) and Dental (DC) Claims files only. Provide total paid dollars submitted in the file. Control total for each file (MC063, PC036, DC038). Eligibility and provider file blank. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).
CDLTR008	TR008	Record Count	int	10	Total number of records submitted in the file, excluding header and trailer records.

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME001	ME900	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code used in the Payer Code field.	N/A
CDLME002	ME001	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).	N/A
CDLME003	ME002	Plan ID	varchar	30	CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER)	271/2100A/ NM1/ XV/09
CDLME004	ME003	Member Insurance/ Product Category code	char	2	See Appendix G-1: Insurance/Product Category for codes. Use the most granular choice available.	271/2110D/ EB/ /04
CDLME005	ME004	Start Year of Submission	int	4	The year for which eligibility is reported in this submission file. CCYY.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME006	ME005	Start Month of Submission	char	2	The month for which eligibility is reported in this submission file expressed numerical from 01 to 12.	N/A
CDLME007	ME006	Insured Group or Policy Number	varchar	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. ME006 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, leave blank. If a policy is sold to an individual as a non-group policy, then report with a value of "IND".	271/2100C/ REF/1L/02, 271/2100C/R EF/ IG/02, 271/2100C/ REF/6P/02, 271/2100D/ REF/1L/02, 271/2100D/ REF/ IG/02, 271/2100D/ REF/6P/02
CDLME008	ME007	Coverage Level Code	char	3	Benefit coverage level selected: CHD = Children Only; DEP = Dependents Only; ECH =Subscriber and Children/dependents; EMP = Subscriber only; ESP = Subscriber and Spouse/Life Partner; FAM = Family; SPC = Spouse/Life Partner and Children/ dependents; SPO = Spouse/Life Partner Only.	271/2110C/E B/ /02, 271/2110D/ EB/ /02

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLMC009	MCXXX	Medicaid AID Category	char	4	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank.	N/A
CDLME010	ME008	Subscriber Social Security Number	char	9	Subscriber's Social Security Number - do not include dashes. Required if collected. If not available, leave blank.	271/2100C/REF/ SY/02
CDLME011	ME009	Plan Specific Contract Number	varchar	80	Plan assigned contract number. If Plan Specific Contract Number is the subscriber's Social Security Number, leave blank. If this is a Medicaid claim, provide Medicaid ID.	271/2100C/ NM1 09
CDLME012	ME101	Subscriber Last Name	varchar	60	The subscriber's last name.	271/2100C/ NM103
CDLME013	ME102	Subscriber First Name	varchar	35	The subscriber's first name.	271/2100C/ NM104
CDLME014	ME103	Subscriber Middle Initial	char	1	The subscriber's middle initial.	271/2100C/ NM105

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME015	ME010	Sequence Number	varchar	20	Unique number of the member within the contract. When the member is the subscriber use subscriber sequence number.	N/A
CDLME016	ME011	Member Social Security Number	char	9	Member's Social Security Number - do not include dashes. Required if collected. If not available, leave blank.	271/2100C/ NM1/ MI/09

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME017	ME012	Individual Relationship Code	char	2	Member's relationship to insured. Individual Relationship Code is maintained by ANSI ASC X12. See Appendix H: External Code Source, Accredited Standards Committee.	271/2100C/INS/Y/02, 271/2100D/INS/N/02 If subscriber is patient, then use 2010BA, otherwise, use 2010CA for all related references for "member" (2010CA is patient; 2010BA is subscriber)
CDLME018	ME013	Member Gender	char	1	Gender of the member. M = Male; F = Female; U = UNKNOWN.	271/2100C/DMG//03, 271/2100D/DMG//03

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME019	ME014	Member Date of Birth	date	8	Date of birth of the member. CCYYMMDD.	271/2100C/ DMG/ D8/02, 271/2100D/ DMG/D8/02
CDLME020	ME104	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.	271/2100D/ NM103
CDLME021	ME105	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name.	271/2100D/ NM104
CDLME022	ME106	Member Middle Initial	char	1	The member's middle initial. If the member is the subscriber, report the subscriber's middle initial.	271/2100D/ NM105
CDLME023	ME901	Member Street Address	varchar	55	Street address of member's residence.	271/2100C/ N3/ /01, 02 271/2100D/ N3/ /01, 02
CDLME024	ME015	Member City Name	varchar	30	City location of member's residence.	271/2100C/ N4/ /01, 271/2100D/ N4/ /01

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME025	ME016	Member State or Province	char	2	State or province of member's residence. State or Province codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service.	271/2100C/ N4/ /02, 271/2100D/ N4/ /02
CDLME026	ME017	Member ZIP Code	varchar	9	Report the 5 or 9 digit Zip Code of the member's residence. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.	271/2100C/ N4/ /03, 271/2100D/ N4/ /03
CDLME027	ME924	Member FIPs County Code	char	5	Report the FIPS county code based on the members residential address. The FIPS county code is a five-digit Federal Information Processing Standard (FIPS) code (FIPS 6-4) which uniquely identifies counties and county equivalents in the United States, certain U.S. possessions, and certain freely associated states. If member lives outside US, leave blank. See Appendix H: External Code Source, United States Census Bureau.	N/A
CDLME028	MEXXX	Member Country Code	char	2	Country code of member's residence. Code US for United States. See Appendix H: External Code Source, United States Postal Service.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME029	ME021	Race 1	varchar	2	Report the Member-identified race. The code value "UN" (Unknown/not specified), should be used ONLY when Member answers unknown, or refuses to answer. Report only collected data. If not available leave blank. See Appendix G-2: Race 1/Race 2 for codes.	N/A
CDLME030	ME022	Race 2	varchar	2	Report the Member-identified race. The code value "UN" (Unknown/not specified), should be used ONLY when Member answers unknown, or refuses to answer. Report only collected data. If not available leave blank. See Appendix G-2: Race 1/Race 2 for codes.	N/A
CDLME031	ME023	Race 3	varchar	2	Report the Member-identified race. The code value "UN" (Unknown/not specified), should be used ONLY when Member answers unknown, or refuses to answer. Report only collected data. If not available leave blank. See Appendix G-2: Race 1/Race 2 for codes.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME032	ME024	Hispanic Indicator	char	1	Report the value that defines the element. The code value “U” for unknown, should be used ONLY when member answers unknown, or refuses to answer. Report only collected data. If not available leave blank. Y = Member is Hispanic/Latino/Spanish; N = Member is not Hispanic/Latino/Spanish; U = Unknown/not specified.	N/A
CDLME033	ME025	Ethnicity 1	varchar	6	Report the Member-identified ethnicity from the External Code Source that best describes the information obtained from the Member / Subscriber. The value “UNKNOW” should be used ONLY when the Member answers unknown or refuses to answer. Report only collected data. If not available leave blank. Ethnicity codes are maintained by the Centers for Disease Control and Prevention. See Appendix H: External Code Sources, Centers for Disease Control and Prevention.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME034	ME026	Ethnicity 2	varchar	6	Report the Member-identified ethnicity from either the External Code Source that best describes the information obtained from the Member / Subscriber. The value “UNKNOW” should be used ONLY when the Member answers unknown or refuses to answer. Report only collected data. If not available leave blank. See Appendix H: External Code Sources, Centers for Disease Control and Prevention.	N/A
CDLME035	ME027	Other Ethnicity	varchar	6	Report the Member-identified ethnicity from either the External Code Source that best describes the information obtained from the Member / Subscriber. The value “UNKNOW” should be used ONLY when the Member answers unknown or refuses to answer. Report only collected data. If not available leave blank. Ethnicity codes are maintained by the Centers for Disease Control and Prevention. See Appendix H: External Code Sources, Centers for Disease Control and Prevention.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME036	ME018	Medical Coverage Under This Plan	char	1	Use this field to indicate whether medical coverage is part of this member's plan (Note: medical coverage may be bundled with other types of coverage) Medical coverage includes any type of coverage besides prescription drug. Y = Yes; N = No.	N/A
CDLME037	ME019	Pharmacy Coverage Under This Plan	char	1	Use this field to indicate whether pharmacy coverage is part of this member's plan (Note: pharmacy coverage may include prescription drugs, supplies and DME; and may be bundled with other types of coverage) Y = Yes; N = No.	N/A
CDLME038	ME020	Dental Coverage Under This Plan	char	1	Use this field to indicate whether dental coverage is part of this member's plan (Note: dental coverage may be bundled with other types of coverage) Y = Yes; N = No.	N/A
CDLME039	ME909	Behavioral Health Coverage Under this Plan	char	1	Use this field to indicate whether behavioral health coverage is part of this member's plan (Note: behavioral health coverage may be bundled with other types of coverage). Valid codes include: Y = Yes; N = No.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME040	ME028	Primary Insurance Indicator	char	1	Use this field to report whether the policy for this eligibility record is the primary insurance for the member. Y = Yes, primary insurance; N = No, this is not the member's primary insurance.	N/A
CDLME041	ME029	Coverage Type	char	3	This field identifies which entity holds the risk: ASW = Self-funded plans administered by a TPA, where the employer has purchased stop-loss, or group excess insurance coverage; ASO = Self- funded plans administered by a TPA, where the employer has not purchased stop-loss, or group excess insurance coverage; STN = Short-term, non-renewable health insurance (e.g., COBRA); UND = Plans underwritten by the insurer(fully insured group and individual policies); MEW = Associations/Trusts and Multiple Employer Welfare Arrangements; OTH = Any other plan (for example-student health plan). Insurers using this code shall obtain prior approval.	N/A
CDLME042	MEXXX	Plan State	char	2	State in which the plan is sold/sitused. State or Province codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME043	ME030	Market Category Code	varchar	4	Code for identifying market category. See Appendix G-3: Market Category Codes which defines the market category by size and or association to which the policy is directly sold and issued. Report subscribers (not employees).	N/A
CDLME044	ME031	Special Coverage	varchar	6	Reserved for specific state coverage. 0 = Not applicable; XXXXXX = Specific state coverage.	N/A
CDLME045	ME032	Group Name	varchar	60	Name of the group which is covering the member (the name established in the payer's system and not the full legal name). If the member is part of a group of one, or non-group, then use IND.	N/A
CDLME046	MEXXX	Member PCP ID	Varchar	35	Unique code identified for the Primary Care Provider (PCP) This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File. If not applicable, leave blank.	N/A
CDLME047	ME903	NPI of Member's PCP	char	10	NPI of the member's Primary Care Provider. If not applicable, leave blank.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME048	MEXXX	PCP Assignment	char	1	1 = PCP in CDLME046 was selected by the member; 2 = PCP in CDLME046 was attributed by the health plan; 3 = PCP is not selected, and no services rendered; 4 = PCP is not-assigned/ unknown.	N/A
CDLME049	ME934	Member PCP Effective Date	date	8	Primary Care Provider Effective Date with member if CDLME048=1 or 2 (PCP Assignment). Report the date in CCYYMMDD format. If not applicable, leave blank.	N/A
CDLME050	ME904	Plan Effective Date	date	8	CCYYMMDD. Effective date of coverage; Date eligibility started for this member under this plan type. The purpose of this data element is to maintain an eligibility span for each member.	N/A
CDLME051	ME905	Plan Term Date	date	8	CCYYMMDD. Last continuous day of coverage (date eligibility ended) for this member under this plan. The purpose of this data element is to maintain an eligibility span for each member. For open contracts, leave blank.	N/A
CDLME052	MEXXX	HIOS Plan indicator	varchar	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Is the member enrolled in a Health Insurance Oversight System plan? 1=Yes; 2=No; 3=Unknown/not applicable.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME053	ME906	HIOS Plan ID	varchar	16	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Health Insurance Oversight System ID. Required for qualified health plans (QHPs) as defined in the Patient Protection and Affordable Care Act (ACA). If CDLME051 is NOT=1 or 2, leave blank. The HIOS Plan ID (Standard Component) includes a five-digit issuer ID, two-character state ID, three digit product number, four digit standard component number and two digit variant component ID. This field may not be available for all market segments. If not applicable, leave blank.	N/A
CDLME054	ME907	Metal Tier	char	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Health benefit plan metal tier for qualified health plans (QHPs) and catastrophic plans as defined in the Patient Protection and Affordable Care Act, Public Law 111-148, Section 1302: Essential Health Benefits Requirements: 0=Not a QHP or catastrophic plan; 1=Catastrophic; 2=Bronze; 3=Silver; 4=Gold; 5 =Platinum. If not applicable, leave blank.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME055	ME910	Medical Home Indicator	char	1	Use this field to report whether the member had a medical home on record for this coverage period. If not stored in payer system, use code '3'. Valid codes include: 1=Yes; 2=No; 3=Unknown/not applicable.	N/A
CDLME056	ME911	Payer assigned ID for Medical Home	varchar	30	"Unique code identified for the Medical Home (as assigned by the reporting entity). Payer assigned ID for the Medical Home is for the Medical Home to which the member belongs. Payer assigned ID for the Medical Home is the identifier used by the payer for internal identification purposes and does not routinely change. Must correspond to a Payer Assigned Provider ID (CDLPV004) in the Provider File. If not applicable, leave blank."	N/A
CDLME057	ME912	Enrolled Through a Public Health Insurance Exchange	char	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Use this field to report whether the policy for this eligibility record was enrolled through a Public Health Insurance Exchange. Valid codes include: 1=Yes; 2=No; 3=Unknown/ not applicable.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME058	ME919	Employer Tax ID	varchar	15	Subscriber's employer EIN or SSN. If coverage not purchased through or enrolled by an employer, leave blank. If not received leave blank.	N/A
CDLME059	ME921	Employment Status	char	1	Report the code that defines the employment status of the member/subscriber: A=Active; I=Involuntary Leave; P=Pending; R=Retiree; Z=Unemployed; U=Unknown.	N/A
CDLME060	ME916	Employer Zip Code	varchar	9	Report the 5 or 9 digit Zip Code of the employer (as reported in CDLME058) When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. If coverage not purchased through or enrolled by an employer, leave blank. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Source.	N/A
CDLME061	ME917	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME062	ME918	Carrier Specific Unique Subscriber ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLME063	ME920	NAIC ID	char	5	Report the NAIC Code associated with the entity that maintains this product. Leave blank if entity does not have a NAIC Code. See Appendix H: External Code Source; NAIC codes are maintained by the National Association of Insurance Commissioners.	N/A
CDLME064	ME922	High Deductible Plan Indicator	char	1	High deductible plan as defined by the IRS at start of plan year. Valid codes include: Y=Yes; N=No. If not applicable, leave blank.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME065	ME923	Total Monthly Premium Amount	int	12	For fully-insured premiums, report the average monthly fee paid by a subscriber and/or employer for health insurance coverage for a given number of members (e.g. individual, individual plus one, family), prior to any medical loss ratio rebate payments, but inclusive of any fees paid to a third party (e.g., exchange fees, reinsurance). Report the total monthly premium at the Subscriber level only. Do not report on member lines. Report 0 if no premium is charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A
CDLME066	ME925	Actuarial Value	dec	64	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Report value as calculated in the most recent version of the HHS Actuarial Value Calculator. Include decimal point with reported value. Format to be used is 0.0000. For example, an AV of 88.27689% should be reported as 0.8828. Required as of January 1, 2014, for small group and non-group (individual) plans sold inside or outside the Exchange. If not applicable, leave blank. See Appendix H: External Code Source, Centers for Medicaid and Medicare Services.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME067	ME926	Grand-fathered Plan Indicator	char	1	Indicates if a plan qualifies as a “Grandfathered” or “Transitional Plan” under the Affordable Care Act (ACA). Please see definition for “grandfathered” and “transitional” in HHS rules 45-CFR-147.140: https://www.federalregister.gov/select-citation/2013/06/03/45-CFR-147. The values of the indicator are as follows: 1= Grandfathered; 2 = Non-Grandfathered; 3 =Transitional; 4 = Not Applicable.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME068	ME928	Cost-Sharing Reduction Indicator	char	1	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Indicates cost-sharing reduction under the Affordable Care Act (ACA). This is a person- level indicator in which enrollees who qualify for cost-sharing reduction are assigned cost- sharing indicator values of 1-8. Non-Cost-Sharing recipients are assigned a cost-sharing indicator value of zero. Valid codes include: 1 = Enrollees in 94% Actuarial Value (AV) Silver Plan Variation; 2 = Enrollees in 87% AV Silver Plan Variation; 3 = Enrollees in 73% AV Silver Plan Variation; 4 = Enrollees in Zero Cost Sharing Plan Variation of Platinum Level QHP (Qualified Health Plan); 5 = Enrollee in Zero Cost Sharing Plan Variation of Gold Level QHP; 6 = Enrollee in Zero Cost Sharing Plan Variation of Silver Level QHP; 7 = Enrollee in Zero Cost Sharing Plan Variation of Bronze Level QHP; 8 = Enrollee in Limited Cost Sharing Plan Variation; 0 = Non-CSR recipient, and enrollees with unknown CSR.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME069	ME929	Admin-istrative Service Fees	int	12	Administrative Service Fees (ASFs): Average monthly fee paid by an employer to cover its self-insured health plan administration, excluding any stop-loss premiums, and divided by the number of members under administration. Administrator services for these fees may vary, including plan design and network access, claims adjudication and administration, and/or population health management. Primary reporting goal will be to monitor self-insured coverage costs over time, using ASFs as one component of a "premium-equivalent." Report 0 if no fee is charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Required when CDLME041 =ASW or ASO.	N/A

B- Eligibility						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**ASC X12 271 References**
CDLME070	ME932	Tiered Network	char	1	Tiered Network: Plans that segment their provider networks into tiers, with tiers typically based on differences in the quality and/or the cost of care provided. Tiers are not considered separate networks, but rather sub-segments of a payer's HMO or PPO network. A tiered network is different than a plan only splitting benefits by in- network vs. out-of-network; a tiered network will have varying degrees of payments of in-network providers. Report the code that defines the tier network of the member/subscriber' plan: 0 = Limited Network; 1 = Single Tier-Not tiered; 2 = Two Tier; 3 = Three Tier; 4 = Four Tier; 5 = Other.	N/A
CDLME071	MEXXX-MEXXX (20 fields)	Un-assigned	char	1	Reserved for future use. Elements will only be added with review from states and payers.	N/A
CDLME072	ME899	Record Type	char	2	Value = ME.	N/A

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC001	MC900	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLMC002).	N/A
CDLMC002	MC001	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).	N/A
CDLMC003	MC002	Plan ID	varchar	30	CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER).	2330B NM109
CDLMC004	MC003	Member Insurance/ Product Category Code	char	2	See Appendix G-1: Insurance Type/Product Category for codes. Use the most granular choice available.	2320 SBR09 when SBR06=6

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC005	MC004	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system. Payer Claim Control Number (PCCN) must be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (CDLMC007) will be used to determine which rows will carry forward into the final claim. It is also imperative that a reversal uses the same PCCN as the original paid claim.	2300 REF02 where REF01 = F8
CDLMC006	MC005	Line Counter	int	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.	2400 LX01
CDLMC007	MC005A	Version Number	int	4	The version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, Cross Reference Claims ID (CDLMC008) is to be utilized.	N/A
CDLMC008	MC915	Cross Reference Claims ID	varchar	35	The original Payer Claim Control Number (CDLMC005). Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Version Number (CDLMC007) is not used.	N/A

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC009	MC006	Insured Group or Policy Number	varchar	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. CDLME007 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, leave blank. If a policy is sold to an individual as a non-group policy, then report with a value of "IND".	2320 SBR03 (I); 2320 SBR03 (P)
CDLMC010	MCXXX	Medicaid AID Category	char	4	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank.	N/A
CDLMC011	MC007	Subscriber Social Security Number	char	9	Subscriber's Social Security Number - do not include dashes. Required if collected. If not available, leave blank.	2010BA REF02
CDLMC012	MC008	Plan Specific Contract Number	varchar	80	Plan assigned contract number. Leave blank if Plan Specific Contract Number is the subscriber's Social Security Number. If this is a Medicaid claim, provide Medicaid ID.	2010BA NM109

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC013	MC101	Subscriber Last Name	varchar	60	The subscriber's last name.	2010BA/NM 1//03
CDLMC014	MC102	Subscriber First Name	varchar	35	The subscriber's first name.	2010BA/NM 1//04
CDLMC015	MC009	Sequence Number	varchar	20	Unique number of the member within the contract. When the member is the subscriber, use subscriber sequence number.	N/A
CDLMC016	MC010	Member Social Security Number	char	9	Member's Social Security Number - do not include dashes; Required if collected. If not available, leave blank.	2010CA REF109 or 2010BA REF109
CDLMC017	MC011	Individual Relationship Code	char	2	Member's relationship to insured. Individual Relationship codes are maintained by ANSI ASC X12. See Appendix H: External Code Source, see Accredited Standards Committee.	2000C PAT01 or 2000B SBR02
CDLMC018	MC012	Member Gender	char	1	Gender of Member M = Male; F = Female; U = Unknown.	2010CA DMG03 or 2010BA DMG03

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC019	MC013	Member Date of Birth	date	8	CCYYMMDD; Date of birth of member.	2010CA DMG02 or 2010BA DMG02
CDLMC020	MC104	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.	2010CA NM103 or 2010BA NM103
CDLMC021	MC105	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name.	2010CA NM104 or 2010BA NM104
CDLMC022	MC016	Member ZIP Code	varchar	9	Report the 5 or 9 digit Zip Code of the member's residence. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.	2010CA N403 or 2010BA N403
CDLMC023	MC068	Patient Control Number	varchar	20	Patient's unique (alphanumeric) number assigned by the provider to facilitate retrieval of the individual's account of services.	2300 CLM 01

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC024	MC017	Paid Date	date	8	CCYYMMDD. 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. If paid/adjudicated date is not available use Processed Date. Claims paid in full, partial, or zero paid, must have a date reported here.	2330B DTP03 where DTP01 = 57
CDLMC025	MC018	Admission Date	date	8	CCYYMMDD. Required for all inpatient claims, this is the date of admission. For professional claims leave blank.	2300 DTP03 where DTP01 = 435 (I)
CDLMC026	MC019	Admission Hour	char	4	HHMM. (Military time) The hour during which the patient was admitted for inpatient care. For professional claims leave blank.	2300 DTP03 where DTP01 = 435 and DTP02 = DT (I)

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC027	MC020	Admission Type	char	1	Required for all inpatient claims. Valid codes are: 1 = Emergency; 2 = Urgent; 3 = Elective; 4 = Newborn; 5 = Trauma Center; 9 = Information not available. For professional claims, leave blank. Admission Type codes are maintained by NUBC. See Appendix H: External Code Source, National Uniform Billing Committee.	2300 CL101 (I)
CDLMC028	MC021	Point of Origin	char	1	A code indicating the point of patient origin for this admission or visit. Required for all institutional claims. Admission Type codes are maintained by NUBC. See Appendix H: External Code Source, National Uniform Billing Committee.	2300 CL102 (I)
CDLMC029	MC069	Discharge Date	date	8	CCYYMMDD. Date patient discharged. Required for all inpatient claims.	2300 DTP 03 where DTP01=096 (I)
CDLMC030	MC022	Discharge Hour	char	4	HHMM (Military time). The hour during which the patient was discharged from inpatient care. For professional claims, leave blank.	2300 DTP02 where DTP01=096 and DTP02=TM (I)

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC031	MC023	Discharge Status	char	2	Required for all institutional claims. Discharge Status codes are maintained by NUBC. For professional claims, leave blank. See Appendix H: External Code Source, National Uniform Billing Committee.	2300 CL103 (I)
CDLMC032	MC036	Type of Bill – Institutional	char	3	Required for institutional claims. Not to be used for professional claims. As defined by the National Uniform Billing Committee. Do not include the leading zero. Type of Bill codes are maintained by NUBC. See Appendix H: External Code Source, National Uniform Billing Committee.	2300 CLM 05-2 & CLM05-3 (I)
CDLMC033	MC037	Place of Service – Professional	char	2	Required for professional claims. Not to be used for institutional claims. Place of Service codes are maintained by CMS. See Appendix H: External Code Source, Center for Medicaid and Medicare Services.	2300 CLM05-01 (P)
CDLMC034	MC039	Admitting Diagnosis	varchar	7	The ICD code describing the patient's diagnosis at the time of admission. Required on all inpatient admission claims and encounters. Codes found in ICD-9-CM or ICD -10-CM. Do not code decimal point. See Appendix H: External Code Source, World Health Organization.	2300 HI01-2 (I)

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC035	MC040	First External Cause Code	varchar	7	The ICD diagnosis codes pertaining to environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. As submitted by provider in the first external cause field- if not submitted by the provider or captured by the carrier leave blank. Codes found in ICD-9-CM or ICD -10-CM. Do not code decimal point. See Appendix H: External Code Source, World Health Organization.	2300 HI01-2 where HI01-1 = BN (ICD-9) or = ABN (ICD- 10)
CDLMC036	MC904	ICD-9/ICD-10 Flag	char	1	The purpose of this field is to identify which code set is being utilized. 9 = This claim contains ICD-9-CM codes. 0= This claim contains ICD-10-CM codes.	N/A
CDLMC037	MC041	Principal Diagnosis	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. Cannot include codes V00-Y99. See Appendix H: External Code Source.	2300 HI01-2 where HI01-1 = BK (ICD-9) or = ABK (ICD- 10)

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC038	MC042	Other Diagnosis – 1	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI01-2 where HI01-1 = BF (ICD-9) or = ABF (ICD- 10)
CDLMC039	MC043	Other Diagnosis – 2	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI02-2 where HI02-1= BF (ICD-9) or = ABF (ICD- 10)
CDLMC040	MC044	Other Diagnosis – 3	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI03-2 where HI03-1= BF (ICD-9) or = ABF (ICD- 10)
CDLMC041	MC045	Other Diagnosis – 4	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI04-2 where HI04-1= BF (ICD-9) or = ABF (ICD- 10)

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC042	MC046	Other Diagnosis – 5	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI05-2 where HI05-1= BF (ICD-9) or = ABF (ICD- 10)
CDLMC043	MC047	Other Diagnosis – 6	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI06-2 where HI06-1= BF (ICD-9) or = ABF (ICD- 10)
CDLMC044	MC048	Other Diagnosis – 7	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI07-2 where HI07-1= BF (ICD-9) or = ABF (ICD- 10)
CDLMC045	MC049	Other Diagnosis – 8	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI08-2 where HI08-1= BF (ICD-9) or = ABF (ICD- 10)

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC046	MC050	Other Diagnosis – 9	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI09-2 where HI09-1= BF (ICD-9) or = ABF (ICD- 10)
CDLMC047	MC051	Other Diagnosis – 10	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI10-02 where HI10-01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC048	MC052	Other Diagnosis – 11	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI11-02 where HI11- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC049	MC053	Other Diagnosis – 12	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI12-02 where HI12- 01 = BF (ICD-9) or = ABF (ICD-10)

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC050	MC917	Other Diagnosis – 13	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI13-02 where HI13- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC051	MC918	Other Diagnosis – 14	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI14-02 where HI14- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC052	MC919	Other Diagnosis – 15	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI15-02 where HI15- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC053	MC920	Other Diagnosis – 16	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI16-02 where HI16- 01 = BF (ICD-9) or = ABF (ICD-10)

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC054	MC921	Other Diagnosis – 17	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI17-02 where HI17- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC055	MC922	Other Diagnosis – 18	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI18-02 where HI18- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC056	MC923	Other Diagnosis – 19	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI19-02 where HI19- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC057	MC924	Other Diagnosis – 20	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI20-02 where HI20- 01 = BF (ICD-9) or = ABF (ICD-10)

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC058	MC925	Other Diagnosis – 21	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI21-02 where HI21- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC059	MC926	Other Diagnosis – 22	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI22-02 where HI22- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC060	MC927	Other Diagnosis – 23	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI23-02 where HI23- 01 = BF (ICD-9) or = ABF (ICD-10)
CDLMC061	MC928	Other Diagnosis – 24	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI24-02 where HI24- 01 = BF (ICD-9) or = ABF (ICD-10)

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC062	MC929	Present on Admission Code -01	char	1	Present on Admission Indicator Principal Diagnosis For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI01-09 where 2300 HI01-2 where HI01-1 = BK (ICD-9) or = ABK (ICD-10) and HI01-01 is populated
CDLMC063	MC930	Present on Admission Code -02	char	1	POA Indicator for Other Diagnosis – 1. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI01-09 where HI01- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC064	MC931	Present on Admission Code -03	char	1	POA Indicator for Other Diagnosis – 2. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI02-09 where HI02- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC065	MC932	Present on Admission Code -04	char	1	POA Indicator for Other Diagnosis – 3. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI03-09 where HI03- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC066	MC933	Present on Admission Code -05	char	1	POA Indicator for Other Diagnosis – 4. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI04-09 where HI04- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC067	MC934	Present on Admission Code -06	char	1	POA Indicator for Other Diagnosis – 5. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI05-09 where HI05- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC068	MC935	Present on Admission Code -07	char	1	POA Indicator for Other Diagnosis – 6. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI06-09 where HI06- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC069	MC936	Present on Admission Code -08	char	1	POA Indicator for Other Diagnosis – 7. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI07-09 where HI07- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC070	MC937	Present on Admission Code -09	char	1	POA Indicator for Other Diagnosis – 8. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI08-09 where HI08- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC071	MC938	Present on Admission Code -10	char	1	POA Indicator for Other Diagnosis – 9. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI09-09 where HI09- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC072	MC939	Present on Admission Code -11	char	1	POA Indicator for Other Diagnosis – 10. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI10-09 where HI10- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC073	MC940	Present on Admission Code -12	char	1	POA Indicator for Other Diagnosis – 11. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI11-09 where HI11- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC074	MC941	Present on Admission Code -13	char	1	POA Indicator for Other Diagnosis – 12 For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI12-09 where HI12- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC075	MC942	Present on Admission Code - 14	char	1	POA Indicator for Other Diagnosis – 13. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI13-09 where HI13- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC076	MC943	Present on Admission Code - 15	char	1	POA Indicator for Other Diagnosis – 14. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI14-09 where HI14- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC077	MC944	Present on Admission Code - 16	char	1	POA Indicator for Other Diagnosis – 15. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI15-09 where HI15- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC078	MC945	Present on Admission Code - 17	char	1	POA Indicator for Other Diagnosis – 16. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI16-09 where HI16- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC079	MC946	Present on Admission Code- 18	char	1	POA Indicator for Other Diagnosis – 17. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI17-09 where HI17- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC080	MC947	Present on Admission Code - 19	char	1	POA Indicator for Other Diagnosis – 18. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI18-09 where HI18- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC081	MC948	Present on Admission Code - 20	char	1	POA Indicator for Other Diagnosis – 19. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI19-09 where HI19- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC082	MC949	Present on Admission Code - 21	char	1	POA Indicator for Other Diagnosis – 20. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI20-09 where HI20- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC083	MC950	Present on Admission Code - 22	char	1	POA Indicator for Other Diagnosis – 21. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI21-09 where HI21- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC084	MC951	Present on Admission Code - 23	char	1	POA Indicator for Other Diagnosis – 22. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI22-09 where HI22- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC085	MC952	Present on Admission Code - 24	char	1	POA Indicator for Other Diagnosis – 23. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI23-09 where HI23- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC086	MC952	Present on Admission Code - 25	char	1	POA Indicator for Other Diagnosis – 24. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y=Yes; N = No; U=Unknown; W = Not Applicable.	2300 HI24-09 where HI24- 01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated
CDLMC087	MC054	Revenue Code	char	4	Codes that identify specific accommodations, ancillary service or unique billing calculations or arrangements. NUBC Code using leading zeroes, left justified, and four digits. For institutional claims only. Not for professional claims. Revenue codes are maintained by NUBC. See Appendix H: External Code Source, National Uniform Billing Committee.	2400 SV201 (I)
CDLMC088	MC055	Procedure Code	varchar	5	Healthcare Common Procedural Coding System (HCPCS). This includes the CPT codes maintained by the American Medical Association. This field should not include modifiers. Modifiers are submitted in different fields. See Appendix H: External Code Source, American Medical Association.	2400 SV202-02 where SV202-01 = HC (I); 2400 SV101-02 where SV101-01=HC (P)

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NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC089	MC056	Procedure Modifier – 1	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association.	2400 SV202-03; 2400 SV101-03 where SV101-01=HC (P)
CDLMC090	MC057	Procedure Modifier – 2	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association.	2400 SV2 02-4

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NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC091	MC963	Procedure Modifier – 3	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association.	2400 SV2 02-5
CDLMC092	MC964	Procedure Modifier – 4	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association.	2400 SV2 02-6
CDLMC093	MC058	ICD-9 CM/10- PCS Principal Procedure Code	char	7	Primary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI01-2 where 2300 HI01-01 = BR (ICD-9-CM) or BBR (ICD10PCS)

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NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC094	MC905	ICD-9 CM/10- CM-PCS Other Procedure Code – 1	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI01-2 where HI01-1= BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC095	MC906	ICD-9 CM/10-CM-PCS Other Procedure Code – 2	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI02-2 where HI02-1= BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC096	MC907	ICD-9 CM/10-CM-PCS Other Procedure Code – 3	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI03-2 where HI03-1= BQ (ICD-9) or = BBQ (ICD- 10)

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NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC097	MC908	ICD-9 CM/10-CM-PCS Other Procedure Code – 4	varchar	7	Secondary procedure code for this line of service. Do not code decimal point For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI04-2 where HI04-1= BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC098	MC909	ICD-9 CM/10-CM-PCS Other Procedure Code – 5	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI05-2 where HI05-1= BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC099	MC910	ICD-9 CM/10-CM-PCS Other Procedure Code – 6	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI06-2 where HI06-1= BQ (ICD-9) or = BBQ (ICD- 10)

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NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC100	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 7	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI07-2 where HI07-1= BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC101	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 8	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI08-2 where HI08-1= BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC102	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code –9	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI09-2 where HI09-1= BQ (ICD-9) or = BBQ (ICD- 10)

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NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC103	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 10	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI10-2 where HI10-1= BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC104	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 11	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI11-2 where HI11-1= BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC105	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 12	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI12-2 where HI12-1 = BQ (ICD-9) or = BBQ (ICD- 10)

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NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC106	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 13	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI13-2 where HI13-1 = BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC107	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 14	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI14-2 where HI14-1= BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC108	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 15	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI15-2 where HI15-1= BQ (ICD-9) or = BBQ (ICD- 10)

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NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC109	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code –1 6	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI16-2 where HI16-1= BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC110	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 17	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI17-2 where HI17-1= BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC111	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 18	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI18-2 where HI18-1= BQ (ICD-9) or = BBQ (ICD- 10)

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NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC112	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 19	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI19-2 where HI19-1= BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC113	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 20	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI20-2 where HI20-1= BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC114	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 21	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI21-2 where HI21-1= BQ (ICD-9) or = BBQ (ICD- 10)

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NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC115	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 22	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI22-2 where HI22-1= BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC116	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 23	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI23-2 where HI23-1= BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC117	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 24	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI24-2 where HI24-1= BQ (ICD-9) or = BBQ (ICD- 10)

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NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC118	MCXXX	ICD-9 CM/10-CM-PCS Other Procedure Code – 25	varchar	7	Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	2300 HI25-2 where HI25-1= BQ (ICD-9) or = BBQ (ICD- 10)
CDLMC119	MC059	Date of Service – From	date	8	CCYYMMDD. First date of service for this service line. Filled for all claim types. (This date should be within the coverage period on the Eligibility file i.e. between the Plan Effective Date and the Plan Term Date on the Eligibility file all inclusive).	2300 DTP 03 where DTP 02 = RD8 (I); 2400 DTP03 where DTP01 = 472 or 2300 DTP03 where DTP01 = 434 (P)

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NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC120	MC060	Date of Service – Thru	date	8	CCYYMMDD Last date of service for this service line. Filled for all claim types.	2300 DTP 03 where DTP 02 = RD8 (I); 2400 DTP03 where DTP01 = 472 or 2300 DTP03 where DTP01 = 434 (P)
CDLMC121	MC061	Service Units/ Quantity	dec	12,2	Count of service units performed. Count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay.	2400 SV205 where SV204 = (I); 2400 SV104 (P)
CDLMC122	MC965	Unit of Measure	varchar	2	Type of units reported in CDLMC121.Example codes: DA=Days; MJ= Minutes; UN=Units. If CDLMC121 is blank (not reported), leave CDLMC122 blank.	N/A

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NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC123	MC062	Charge Amount	int	12	The amount charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2400 SV203 (I); 2400 SV102 (P)
CDLMC124	MCXXX	Withhold Amount	int	12	A claim-based payment that is included in total medical expense. Report the amount paid to the provider for this claim line if the provider qualified / met performance guarantees. Report 0 if there is no withhold amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A
CDLMC125	MC063	Plan Paid Amount	int	12	This is the amount paid by the plan to cover the services, to the provider or member. This excludes the patient liability. For capitated claims, set to 0. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2430 SVD02
CDLMC126	MC065	Co-Pay Amount	int	12	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. If only collected on the header record, report the co-pay amount on the first claim line. Report 0 if there is no co-pay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2320 and/or 2430 CAS03 where the CARC is 3

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NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC127	MC066	Coinsurance Amount	int	12	The dollar amount for which the member is responsible attributed to the coinsurance amount. This is the dollar amount, not the percentage from which the dollar amount was calculated. If only collected on the header record, report the coinsurance amount on the first claim line. Report 0 if there is no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2320 and/or 2430 CAS03 where the CARC is 2
CDLMC128	MC067	Deductible Amount	int	12	Report the amount of the deductible applied to the claim. If only collected on the header record, report the deductible amount on the first claim line. Report 0 if there is no deductible amount applied to the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2320 and/or 2430 CAS03 where the CARC is 1.

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC129	MC966	Other Insurance Paid Amount	int	12	Amount already paid by another carrier. Report the amount that a prior payer has paid for this claim line. Indicates the submitting payer is not the primary payer. Only Report “0” if the prior payer paid 0 toward this claim line; or if there is no prior payer. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). May be reported as a negative.	N/A
CDLMC130	MC914	COB/TPL Amount	int	12	Amount due from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2320 AMT02

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC131	MC955	Allowed Amount	int	12	When payment arrangement type in CDLMC132 is equal to 01 for capitated services, report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. When payment arrangement type in CDLMC132 is equal to 02 for fee for service, report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. Report 0 if there is no allowed amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2300 HCP02
CDLMC132	MC959	Payment Arrangement Type Flag	char	2	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 03=Percent of Charges; 04=DRG; 05=Pay For Performance; 06=Global Payment; 07=Other; 08=Bundled Payment.	N/A
CDLMC133	MC075	Drug Code	char	11	Report the NDC code only when a medication is paid for as part of a medical claim. Do not include dashes. NDC codes are maintained by the Federal Drug Administration. If not available, leave blank. See Appendix H: External Code Source, United States Food and Drug Administration.	2410 LIN03 where LIN02 = N4 (I)

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC134	MC024	Rendering Provider ID	varchar	35	Unique code identified for the provider as assigned by the reporting entity. Payer assigned provider ID for the provider that provided the services on the claims. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	2310D REF02 where REF01 = G2 (I) or 2310A REF02 where REF01 =G2 (I); 2420A REF02 where REF01 =G2 (P) or 2310B REF02 where REF01 = G2 (P)
CDLMC135	MC026	Rendering Provider NPI	char	10	Rendering Provider NPI is the NPI of the entity or individual directly providing the service, as enumerated in the Center for Medicaid and Medicare Services NPPES.	2310D NM109 (I) or 2310A NM109 (I); 2420A NM109 (P) or 2310B NM109 (P)

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC136	MC027	Rendering Provider Entity Type Qualifier	char	1	Use this field to indicate whether the rendering provider is a person or "non-person entity. HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "Person." Valid codes are: 1 = Person; 2 = Non-Person Entity.	2310D NM102 (I) or 2310A NM102 (I); 2420A NM102 (P) or 2310B NM102 (P)
CDLMC137	MC916	In Plan Network Indicator	char	1	A yes/no indicator that specifies if the provider (not the benefit) is within the health plan network. Valid codes are: N=No; Y=Yes.	N/A
CDLMC138	MC028	Rendering Provider First Name	varchar	35	Individual first name. If CDLMC136=2, leave blank.	2310D NM104 (I) or 2310A NM104 (I); 2420A NM104 (P) or 2310B NM104 (P)

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC139	MC029	Rendering Provider Middle Name	varchar	25	Individual middle name or initial. If CDLMC136=2, leave blank.	2310D NM105 (I) or 2310A NM105 (I); 2420A NM105 (P) or 2310B NM105 (P) or 2010AA NM105 (P)
CDLMC140	MC030	Rendering Provider Last Name or Organization Name	varchar	60	Full name of provider organization (“non-person entity”) or last name of individual (“person”) provider. CDLMC136 determines if the Rendering Provider is a “person” or a “non-person entity”.	2310D NM103 (I) or 2310A NM103 (I); 2420A NM103 (P) or 2310B NM103 (P) or 2010AA NM103 (P)

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC141	MC031	Rendering Provider Suffix	varchar	10	Suffix of Rendering Provider. Leave blank if provider is a facility or organization. The rendering provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III). Do not use credentials such as MD or PhD.	2310D NM107 (I) or 2310A NM107 (I); 2420A NM107(P) or 2310B NM107 (P) or 2010AA NM107 (P)
CDLMC142	MC032	Rendering Provider Specialty	varchar	10	Standard code that identifies the provider specialty for this line of service. Report the HIPAA-compliant healthcare provider national taxonomy code. Provider taxonomy codes are maintained by the National Uniform Claims Committee (NUCC). See Appendix H: External Code Source, National Uniform Claims Committee.	2310A PRV03 (I); 2420A PRV03 (P) or 2310B PRV03 (P) or 2000AA PRV03 (P)
CDLMC143	MC033	Rendering Provider City Name	varchar	30	City name of provider or service facility location.	2310E N401 (I); 2420C N401 (P) or 2310C N401 (P)

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC144	MC034	Rendering Provider State or Province	char	2	State or Province codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service.	2310E N402 (I); 2420C N402 (P) or 2310C N402 (P)
CDLMC145	MC035	Rendering Provider ZIP Code	varchar	9	Report the 5 or 9 digit Zip Code of the Rendering Provider. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources	2310E N403 (I); 2420C N403 (P) or 2310C N403 (P)
CDLMC146	MC913	Rendering Provider Group Practice NPI	varchar	10	NPI of group practice to which a rendering provider is affiliated if different from CDLMC135.	N/A
CDLMC147	MC076	Billing Provider ID	varchar	30	Unique code assigned to the provider by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	2010AA REF02 where REF01 = G2 and/or LU

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC148	MC077	Billing Provider NPI	char	10	NPI for billing provider as enumerated in the Center for Medicaid and Medicare Services NPPES.	2010AA NM109 where 2010AA NM108 = XX
CDLMC149	MC078	Billing Provider Last Name or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.	2010AA NM103
CDLMC150	MC079	Billing Provider Tax ID	varchar	10	Tax ID of the billing provider. Do not code punctuation.	2010AA REF02

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC151	MCXXX	Referring Provider ID	varchar	30	Payer assigned provider ID for the referring provider. The Referring Provider is the provider who directed the patient for care to the provider that rendered the services being submitted on the claim form. The Referring Provider Number is the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File. If not available, leave blank.	N/A
CDLMC152	MC956	Referring Provider NPI	char	10	NPI of the referring provider. The referring provider is the entity or individual that submitted the referral of the service or procedure. The Referring Provider is the individual who directed the patient for care to the provider that rendered the services being submitted on the claim form. If not available, leave blank.	2310F NM109 (I) where NM108 = XX

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC153	MCXXX	Attending Provider ID	varchar	30	Payer assigned provider ID for the attending provider. On the institutional claim, the Attending Provider is the individual that has primary responsibility for the patient's medical care and treatment reported in the claim. The Attending Provider Number is the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File. If not available, leave blank.	2310A REF02 where REF01 = G2 (I)
CDLMC154	MC958	Attending Provider NPI	char	10	NPI of the attending provider. The Attending Provider on an 837I claim represents the individual that has primary responsibility for the patient's medical care and treatment reported in the claim. The Attending and Rendering provider can be the same individual. If not available, leave blank.	2310A NM109 where NM108 = XX

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC155	MC911	Carrier Associated with Claim	varchar	8	For each claim, use the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved- out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. If not available, leave blank. See Appendix H: External Code Source, National Association of Insurance Commissioners.	N/A
CDLMC156	MC954	Type of Claim	char	1	Indicates the type of claim that was submitted. Valid codes are: 1=Professional; 2=Institutional/ Facility; 3=Reimbursement Form (Member).	N/A
CDLMC157	MC038	Claim Status	char	2	Claim status codes maintained by ANSI ASC X12 is the code identifying type of claim. See Appendix H: External Code Source, Accredited Standards Committee.	2320 SBR01
CDLMC158	MC960	Denied Claim Line Indicator	char	1	Use this field to indicate whether the payer denied this specific line on this specific claim. Valid codes are: 1=Yes (denied); 2= No (not denied).	N/A

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC159	MC968	Claim adjustment reason code	varchar	3	Report the claim adjustment reason code for the denial. If CDLMC158=1, report the code that defines the reason for denial of the claim line. If not available, leave blank. Reason codes are maintained by ANSI ASC X12. See Appendix H: External Code Source, Accredited Standards Committee.	N/A
CDLMC160	MCXXX	Claim Line Type	char	1	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment.	N/A
CDLMC161	MC961	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLMC162	MC962	Carrier Specific Unique Subscriber ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's / submitter's files for reporting and aggregation.	N/A

C- Medical						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLMC163	MCXXX-MCXXX (20 fields)	Un-assigned	char	1	Reserved for future use. Elements will only be added with review from states and payers.	N/A
CDLMC164	MC899	Record Type	char	2	Value = MC.	N/A

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC001	PC900	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi- tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLPC002).	N/A
CDLPC002	PC001	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi- tiered to support different platforms).	879-N2

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC003	PC002	Plan ID	varchar	30	CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER).	569-J8
CDLPC004	PC003	Member Insurance/ Product Category code	char	2	See Appendix G-1: Insurance Type/Product Category for codes. Use the most granular choice available.	A90
CDLPC005	PC004	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system. Payer Claim Control Number (PCCN) must be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (CDLPC007) will be used to determine which rows will carry forward into the final claim. It is also imperative that a reversal uses the same PCCN as the original paid claim.	993-A7 Carrier Plan Specific Contract Number or Subscriber/ Member Social Security Number
CDLPC006	PC005	Line Counter	int	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.	A91

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC007	PC005A	Version Number	int	4	The version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, Cross Reference Claims ID (CDLPC008) is to be utilized.	102-A2 (version/release number of the claim)
CDLPC008	PC902	Cross Reference Claims ID	varchar	35	The original Payer Claim Control Number (CDLPC005). Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Version Number (CDLPC007) is not used.	N/A
CDLPC009	PC006	Insured Group or Policy Number	varchar	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. CDLPC009 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, leave blank. If a policy is sold to an individual as a non-group policy, then report with a value of "IND".	246
CDLPC010	PCXXX	Medicaid AID Category	char	4	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank.	N/A

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC011	PC007	Subscriber Social Security Number	char	9	Subscriber's Social Security Number - do not include dashes. Required if collected. If not available, leave blank.	A89
CDLPC012	PC008	Plan Specific Contract Number	varchar	80	Plan assigned subscriber's contract number (NCPDP refers to this as the Cardholder ID). If Plan Specific Contract Number is the subscriber's Social Security Number, leave blank. If this is a Medicaid claim, provide Medicaid ID.	302-C2
CDLPC013	PC101	Subscriber Last Name	varchar	60	The subscriber's last name.	716
CDLPC014	PC102	Subscriber First Name	varchar	35	The subscriber's first name.	717
CDLPC015	PC009	Sequence Number	varchar	20	Unique number of the member within the contract. When the member is the subscriber, use subscriber sequence number.	303-C3
CDLPC016	PC010	Member Social Security Number	char	9	Member's Social Security Number - do not include dashes. Required if collected. If not available, leave blank.	332-CY

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC017	PC011	Individual Relationship Code	char	2	Member's relationship to insured. Individual Relationship codes maintained by ANSI ASC X12. See Appendix H: External Code Source.	247
CDLPC018	PC012	Member Gender	char	1	1 = Male; 2 = Female; 0 = Unspecified.	305-C5
CDLPC019	PC013	Member Date of Birth	varchar	8	CCYYMMDD; Date of birth of member.	304-C4
CDLPC020	PC104	Member Last Name	varchar	60	Member last name.	716
CDLPC021	PC105	Member First Name	varchar	35	Member first name.	717
CDLPC022	PC016	Member ZIP Code	varchar	9	Report the 5 or 9 digit Zip Code of the member's residence. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.	730-TC
CDLPC023	PC032	Date Prescription Filled	date	8	CCYYMMDD. Date the prescription was filled.	401-D1

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC024	PC017	Paid Date	date	8	CCYYMMDD. 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. If paid/adjudicated date is not available use Processed Date. Claims paid in full, partial, or zero paid, must have a date reported here.	216 (check date) or 578 (adjudication date)
CDLPC025	PC026	Drug Code	char	11	NDC Code for the drug on the claim. Do not include dashes. NDC codes are maintained by the Federal Drug Administration. See Appendix H: External Code Source, United States Federal Drug Administration.	407-D7
CDLPC026	PC028	New Prescription or Refill	char	2	Provide '00' for new prescriptions; for refills, provide the refill number. 00 = New prescription; 01–99 = Refill.	254
CDLPC027	PC029	Generic Drug Indicator	char	2	Indicates whether the drug itself is generic, not how the payer pays it. Valid codes are: 01 = Branded drug; 02 = Generic drug.	425-DP

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC028	PC030	Dispensed as Written Code	char	1	Use this field to indicate how the drug was dispensed: 0 = No Product Selection Indicated (may also have missing values) 1 = Substitution Not Allowed by Prescriber 2 = Substitution Allowed - Patient Requested That Brand Product Be Dispensed 3 = Substitution Allowed - Pharmacist Selected Product Dispensed 4 = Substitution Allowed - Generic Drug Not in Stock 5 = Substitution Allowed - Brand Drug Dispensed as Generic 6 = Override 7 = Substitution Not Allowed - Brand Drug Mandated by Law 8 = Substitution Allowed - Generic Drug Not Available in Marketplace 9 = Other	408-D8
CDLPC029	PC031	Compound Drug Indicator	char	1	Use this field to indicate whether the drug is a compound drug or non-compound drug. Valid codes are: N = Non-compound drug; Y = Compound drug; U = Unknown.	406-D6

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC030	PCXXX	Compound Drug Name or Compound Drug Ingredient List	char	80	If CDLPC029 = Y, then provide the name of the compound drug. If no compound drug name is identified, include the names of the compound drug ingredients. Use spaces between multiple drugs.	N/A
CDLPC031	PC914	Formulary Indicator	char	1	Use this field to report if the prescribed drug was on the carrier's formulary list. Valid codes include: 1=Yes; 2= No; 3= Unknown; 4= Other; 5= Not applicable.	N/A
CDLPC032	PC033	Quantity Dispensed	dec	10,2	Number of metric units of medication dispensed.	442-E7
CDLPC033	PC034	Days' Supply	int	3	Estimated number of days the prescription will last.	405-D5
CDLPC034	PC905	Drug Unit of Measure	varchar	3	Report the code that defines the unit of measure for the drug dispensed in PC033. Valid codes are EA= Each; F2= International Units; GM= Grams; ML=Milliliters; MG= Milligrams; MEQ-Milliequivalent; MM= Millimeter; UG= Microgram; UU= Unit; OT=Other.	N/A

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC035	PC906	Prescription Number	varchar	20	Report the unique prescription identifier.	254 (fill number calculated)
CDLPC036	PC035	Charge Amount	int	10	NCPDP refers to this as Gross Amount Due. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	430-DU
CDLPC037	PC036	Plan Paid Amount	int	10	NCPDP refers to this as Net Amount Due. Includes all health plan payments and excludes all member payments. For capitated claims, set to 0. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	281
CDLPC038	PC907	Allowed Amount	int	12	When payment arrangement type in CDLPC049 is equal to 01 for capitated services, report the maximum amount that would have been paid under fee for service for a prescription. When payment arrangement type in CDLPC049 is equal to 02 for fee for service, report the maximum amount contractually allowed. Report 0 if there is no allowed amount Do not code decimal point or provide any punctuation (e.g. $1,000.25 converted to 100025).	N/A

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC039	PC908	Sales Tax Amount	int	12	Report the amount of state sales tax applied to this claim line. Report 0 if there is no state tax amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Do not round up / down to whole dollars, code zero cents (00) when applicable.	558-AW
CDLPC040	PC037	Ingredient Cost/List Price	int	10	Cost of the drug dispensed. Report 0 if there is no Ingredient Cost/List Price Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	506-F6
CDLPC041	PC038	Postage Amount Claimed	int	10	Postage amount associated with the claim. Report 0 if there is no Postage Amount Claimed Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A
CDLPC042	PC039	Dispensing Fee	int	10	Dispensing fee associated with the claim Report 0 if there is no Dispensing Fee. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	507-F7

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC043	PC040	Co-Pay Amount	int	10	Actual co-payment dollar amount paid for which the individual is responsible. (e.g., If the fixed amount is $25 but the cost to the member is $4 report, 400.) Report 0 if there is no co-pay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	518-FI
CDLPC044	PC041	Coinsurance Amount	int	10	The dollar amount of coinsurance for this claim line for which an individual is responsible, not the percentage. Report 0 if no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	572-4U
CDLPC045	PC042	Deductible Amount	int	10	The dollar amount for this claim line applied to the deductible. Report 0 if there is no deductible amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	517-FH

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC046	PC205	COB/TPL Amount	int	12	Amount due from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/ TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	N/A
CDLPC047	PC912	Other Insurance Paid Amount	int	10	Amount already paid by another carrier. Report the amount that a prior payer has paid for this claim line. Indicates the submitting payer is not the primary payer. Only Report “0” if the prior payer paid 0 toward this claim line; or if there is no prior payer. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). May be reported as a negative.	565-J4

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC048	PC913	Member Self- Pay Amount	int	12	Report the amount that the member has paid beyond the other patient obligations (e.g., gap on Medicare Part D, or difference between generic and brand) that are not otherwise listed in the file in CDLPC043, CDLPC044, CDLPC045. Report "0" if there is no member Self-Pay Amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Do not round up / down to whole dollars, code zero cents (00) when applicable.	505-F5
CDLPC049	PC917	Payment Arrangement Type Flag	char	2	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 03=Percent of Charges; 07=Other.	N/A
CDLPC050	PC043	Prescribing Physician ID	varchar	30	Payer assigned provider ID for the prescribing physician. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	N/A
CDLPC051	PC047	Prescribing Physician NPI	char	10	NPI number for prescribing physician.	411-DB

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC052	PC044	Prescribing Physician First Name	varchar	25	Prescribing Physician's first name or initial.	A92
CDLPC053	PC046	Prescribing Physician Last Name	varchar	60	Prescribing Physician's last name.	716
CDLPC054	PCXXX	Pharmacy NCPDP Number	varchar	7	Unique 7-digit number assigned by the National Council for Prescription Drug Program (NCPDP).	N/A
CDLPC055	PC018	Pharmacy ID	varchar	30	Payer assigned pharmacy ID. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	201-B1
CDLPC056	PC019	Pharmacy Tax ID Number	varchar	10	Dispensing pharmacy federal taxpayer's identification number coded with no punctuation (carriers that contract with outside PBMs may not have this data).	N/A
CDLPC057	PC021	Pharmacy NPI	char	10	NPI of the entity or individual (pharmacy) directly providing the service.	201-B1

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC058	PC201	Pharmacy Location Street Address	varchar	55	Street address of pharmacy that dispensed the prescription, including street number, name. Include suite number if applicable. Relates to CDLPC059-CDLPC062.	728-SU
CDLPC059	PC023	Pharmacy Location State	char	2	State or Province where dispensing pharmacy located. State or Province codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service.	729-TA
CDLPC060	PC024	Pharmacy ZIP Code	varchar	9	Report the 5 or 9 digit Zip Code of the Pharmacy. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.	730-TC
CDLPC061	PC024A	Pharmacy Country Code	char	2	Country where dispensing pharmacy located. Code US for United States. See Appendix H: External Code Sources, United States Postal Service	A93-1T
CDLPC062	PC911	Mail-Order Pharmacy Indicator	char	1	Use this field to report if the pharmacy was a mail-order pharmacy. Valid codes include: 1=Yes mail order pharmacy; 2=No-not a mail order pharmacy; 3=Unknown; 4=Other; 5=Not applicable.	N/A

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC063	PC203	Carrier Associated with Claim	varchar	8	For each claim, use the NAIC code of the carrier when a PBM processes claims on behalf of the carrier. Optional if all pharmacy claims processed by a PBM under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. See Appendix H: External Code Source, National Association of Insurance Commissioners.	N/A
CDLPC064	PC915	In Plan Network Indicator	char	1	Use this field to specify if services from the requested provider were provided within the health plan network. Valid values are: N=No; Y=Yes.	N/A
CDLPC065	PC025	Record Status Code	char	1	Record status codes maintained by NCPDP is the code identifying type of claim. See Appendix H: External Code Source, NCPDP.	A88
CDLPC066	PCXXX	Claim Line Type	char	1	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment.	N/A

D- Pharmacy						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**NCPDP References**
CDLPC067	PC916	Reject Code	varchar	3	Report the reason code for the denial. Report the code that defines the reason for denial of the claim line. If not available, leave blank. Reason codes are maintained by NCPDP. See Appendix H: External Code Source, NCPDP.	511-FB
CDLPC068	PC909	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLPC069	PC910	Carrier Specific Unique Subscriber ID	char	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLPC070		Un-assigned	char	1	Reserved for future use. Elements will only be added with review from states and payers.	N/A
CDLPC071	PC899	Record Type	char	2	Value = PC.	N/A

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC001	DC900	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLDC002).	N/A
CDLDC002	DC001	Payer Code	varchar	8	APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).	N/A
CDLDC003	DC002	Plan ID	varchar	30	CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER).	2330B NM109
CDLDC004	DC003	Member Insurance/ Product Category code	char	2	See Appendix G-1: Insurance Type/Product Category for codes. Use the most granular choice available.	2320 SBR09

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC005	DC004	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system. Payer Claim Control Number (PCCN) must be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (CDLDC007) will be used to determine which rows will carry forward into the final claim. It is also imperative that a reversal uses the same PCCN as the original paid claim.	2330B REF02 where REF01 = F8
CDLDC006	DC005	Line Counter	int	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.	2400 LX01
CDLDC007	DC005A	Version Number	int	4	The version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, use Cross Reference Claims ID (CDLDC008).	N/A
CDLDC008	DC901	Cross Reference Claims ID	varchar	35	The original Payer Claim Control Number (CDLDC005) Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Version Number (CDLDC007) is not used.	N/A

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC009	DC006	Insured Group or Policy Number	varchar	50	The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. CDLDC009 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, leave blank. If a policy is sold to an individual as a non-group policy, then report with a value of "IND".	2320 SBR03
CDLDC010	DCXXX	Medicaid AID Category	char	4	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank.	N/A
CDLDC011	DC007	Subscriber Social Security Number	char	9	Subscriber's Social Security Number - do not include dashes. Required if collected. If not available, leave blank.	2010BA REF02
CDLDC012	DC008	Plan Specific Contract Number	varchar	80	Plan assigned contract number. If Plan Specific Contract Number is the subscriber's Social Security Number, leave blank. If this is a Medicaid claim, provide the Medicaid ID.	2010BA NM109

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC013	DC101	Subscriber Last Name	varchar	60	The subscriber's last name.	2010BA/NM 1//03
CDLDC014	DC102	Subscriber First Name	varchar	35	The subscriber's first name.	2010BA/NM 1//03
CDLDC015	DC009	Sequence Number	varchar	20	Unique number of the member within the contract. When the member is the subscriber, use subscriber sequence number.	N/A
CDLDC016	DC010	Member Social Security Number	char	9	Member's Social Security Number - do not include dashes. Required if collected. If not available, leave blank.	2010CA REF109 or 2010BA REF109
CDLDC017	DC011	Individual Relationship Code	char	2	Member's relationship to insured. Individual Relationship codes maintained by ANSI ASC X12. See Appendix H: External Code Source, Accredited Standards Committee.	2000C PAT01 or 2000B SBR02
CDLDC018	DC012	Member Gender	char	1	Gender of Member M = Male; F = Female; U = Unknown.	2010CA DMG03
CDLDC019	DC013	Member Date of Birth	date	8	CCYYMMDD. Date of birth of member.	2010CA DMG02

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC020	DC104	Member Last Name	varchar	60	The member's last name. If the member is the subscriber, report the subscriber's last name.	2010CA NM103
CDLDC021	DC105	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name.	2010CA NM104
CDLDC022	DC016	Member ZIP Code	varchar	9	Report the 5 or 9 digit Zip Code of the member's residence. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.	2010CA N403 or 2010BA N403
CDLDC023	DC017	Paid Date	date	8	CCYYMMDD. 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. If paid/adjudicated date is not available use Processed Date. Claims paid in full, partial, or zero paid must have a date reported.	2330B DTP03 where DTP01 = 57
CDLDC024	DC030	Place of Service– Professional	char	2	Required for professional claims. Not to be used for institutional claims. Place of Service codes are maintained by CMS. See Appendix H: External Code Source, Center for Medicaid and Medicare Services.	2300 CLM05-01

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC025	DC911	ICD 10-CM Diagnosis Code	varchar	7	ICD 10-CM Diagnosis Code when applicable. See Appendix H: External Code Source.	2300 HI01-2
CDLDC026	DCXXX	ICD-9/ICD-10 Flag	char	1	The purpose of this field is to identify which code set is being utilized. 9 = This claim contains ICD-9-CM codes. 0= This claim contains ICD-10-CM codes.	N/A
CDLDC027	DC032	CDT Code	varchar	5	Common Dental Terminology code for the dental procedure on the claim. CDT codes are maintained by American Dental Association. See Appendix H: External Code Source, American Dental Association.	2400 SV301-02

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC028	DCXXX	Oral Cavity 1	char	2	Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00=entire oral cavity, 01=maxillary arch, 02=mandibular arch, 10=upper right quadrant, 20=upper left quadrant, 30=lower left quadrant, 40=lower right quadrant	2400 SV304-01
CDLDC029	DCXXX	Oral Cavity 2	char	2	Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00=entire oral cavity, 01=maxillary arch, 02=mandibular arch, 10=upper right quadrant, 20=upper left quadrant, 30=lower left quadrant, 40=lower right quadrant	2400 SV304-02

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC030	DCXXX	Oral Cavity 3	char	2	Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00=entire oral cavity, 01=maxillary arch, 02=mandibular arch, 10=upper right quadrant, 20=upper left quadrant, 30=lower left quadrant, 40=lower right quadrant	2400 SV304-03
CDLDC031	DCXXX	Oral Cavity 4	char	2	Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00=entire oral cavity, 01=maxillary arch, 02=mandibular arch, 10=upper right quadrant, 20=upper left quadrant, 30=lower left quadrant, 40=lower right quadrant	2400 SV304-04

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC032	DCXXX	Oral Cavity 5	char	2	Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00=entire oral cavity, 01=maxillary arch, 02=mandibular arch, 10=upper right quadrant, 20=upper left quadrant, 30=lower left quadrant, 40=lower right quadrant	2400 SV304-05
CDLDC033	DC204	Tooth Number or Letter (1)	varchar	2	Required when CDLDC027 = D2000 thru D2999. Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. If not available, leave blank. Tooth Number codes are maintained by the American Dental Association. See Appendix H: External Code Source, American Dental Association.	2400 TOO 02
CDLDC034	DCXXX	Tooth – 1 Surface – 1	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC033 is populated.	2400 TOO02-01

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC035	DCXXX	Tooth – 1 Surface – 2	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC033 is populated.	2400 TOO02-02
CDLDC036	DCXXX	Tooth – 1 Surface – 3	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC033 is populated.	2400 TOO02-03
CDLDC037	DCXXX	Tooth – 1 Surface – 4	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC033 is populated.	2400 TOO02-04
CDLDC038	DCXXX	Tooth – 1 Surface – 5	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC033 is populated.	2400 TOO02-05
CDLDC039	DCXXX	Tooth Number or Letter (2)	varchar	2	Report the tooth identifier(s) when CDLDC027 is within the given range if a second tooth is involved in the procedure. Required when CDLDC027 = D2000 thru D2999. See Appendix H: External Code Source, American Dental Association.	2400 TOO 03

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC040	DCXXX	Tooth – 2 Surface – 1	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC039 is populated.	2400 TOO03-01
CDLDC041	DCXXX	Tooth – 2 Surface – 2	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC039 is populated.	2400 TOO03-02
CDLDC042	DCXXX	Tooth – 2 Surface – 3	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC039 is populated.	2400 TOO03-03
CDLDC043	DCXXX	Tooth – 2 Surface – 4	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC039 is populated.	2400 TOO03-04
CDLDC044	DCXXX	Tooth – 2 Surface – 5	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC039 is populated.	2400 TOO03-05

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC045	DCXXX	Tooth Number or Letter (3)	varchar	2	Report the tooth identifier(s) when CDLDC027 is within the given range if a third tooth is involved in the procedure. Required when CDLDC027 = D2000 thru D2999. See Appendix H: External Code Source, American Dental Association.	2400 TOO 04
CDLDC046	DCXXX	Tooth – 3 Surface – 1	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC045 is populated.	2400 TOO04-01
CDLDC047	DCXXX	Tooth – 3 Surface – 2	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC045 is populated.	2400 TOO04-02
CDLDC048	DCXXX	Tooth – 3 Surface – 3	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC045 is populated.	2400 TOO04-03
CDLDC049	DCXXX	Tooth – 3 Surface – 4	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC045 is populated.	2400 TOO04-04

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC050	DCXXX	Tooth – 3 Surface – 5	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC045 is populated.	2400 TOO04-05
CDLDC051	DCXXX	Tooth Number or Letter (4)	varchar	2	Report the tooth identifier(s) when CDLDC027 is within the given range if a fourth tooth is involved in the procedure. Required when CDLDC027 = D2000 thru D2999. See Appendix H: External Code Source, American Dental Association.	2400 TOO 05
CDLDC052	DCXXX	Tooth – 4 Surface – 1	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC051 is populated.	2400 TOO05-01
CDLDC053	DCXXX	Tooth – 4 Surface – 2	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC051 is populated.	2400 TOO05-02
CDLDC054	DCXXX	Tooth – 4 Surface – 3	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC051 is populated.	2400 TOO05-03

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC055	DCXXX	Tooth – 4 Surface – 4	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC051 is populated.	2400 TOO05-04
CDLDC056	DCXXX	Tooth – 4 Surface – 5	varchar	1	Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC051 is populated.	2400 TOO05-05
CDLDC057	DC035	Date of Service – From	date	8	CCYYMMDD. First date of service for this service line. Filled for all claim types. (This date should be within the coverage period on the Eligibility file i.e. between the Plan Effective Date and the Plan Term Date on the Eligibility file all inclusive).	2400 DTP03 where DTP01 = 472 or 2300 DTP03 where DTP01 = 434
CDLDC058	DC036	Date of Service – Thru	date	8	CCYYMMDD Last date of service for this service line. Filled for all claim types.	2400 DTP03 where DTP01 = 472 or 2300 DTP03 where DTP01 = 434

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC059	DC037	Charge Amount	int	12	The amount charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2400 SV102 (P)
CDLDC060	DC038	Plan Paid Amount	int	12	This is the amount paid by the plan to cover the services, to the provider or member. This excludes the patient liability. For capitated claims, set to 0. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2430 SVD02
CDLDC061	DC039	Co-pay Amount	int	12	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. If only collected on the header record, report the co-pay amount on the first claim line. Report 0 if there is no co-pay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2320 and/or 2430 CAS03 where the CARC is 3

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC062	DC040	Coinsurance Amount	int	12	The dollar amount for which the member is responsible attributed to the coinsurance amount. This is the dollar amount, not the percentage from which the dollar amount was calculated. If only collected on the header record, report the coinsurance amount on the first claim line. Report 0 if there is no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2320 and/or 2430 CAS03 where the CARC is 2
CDLDC063	DC041	Deductible Amount	int	12	Report the amount of the deductible applied to the claim. If only collected on the header record, report the deductible amount on the first claim line. Report 0 if there is no deductible amount applied to the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	2320 and/or 2430 CAS03 where the CARC is 1.

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC064	DC906	Allowed Amount	Int	12	When payment arrangement type in CDLDC065 is equal to 01 for capitated services, report the maximum amount that would have been paid under fee for service for a particular procedure or service. When payment arrangement type in CDLDC065 is equal to 02 for fee for service, report the maximum amount contractually allowed, and that a carrier will pay for a particular procedure or service. Report 0 if there is no allowed amount. Do not code decimal point or provide any punctuation (e.g. $1,000.25 converted to 100025).	2300 HCP02
CDLDC065	DC912	Payment Arrangement Type Flag	char	2	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 03=Percent of Charges; 07=Other.	N/A
CDLDC066	DC018	Rendering Provider ID	varchar	30	Unique code identified for the provider as assigned by the reporting entity. Payer assigned provider ID for the provider that provided the services on the claims. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	2420A REF02 where REF01 =G2 (P) or 2310B REF02 where REF01 = G2 (P)

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC067	DC020	Rendering Provider NPI	char	10	Rendering Provider NPI is the NPI of the entity or individual directly providing the service, as enumerated in the Center for Medicaid and Medicare Services NPPES.	2420A NM109
CDLDC068	DC021	Rendering Provider Entity Type Qualifier	char	1	Use this field to indicate whether the rendering provider is a person or "non-person entity. HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "Person." Valid codes are: 1=Person; 2=Non- Person Entity.	2420A NM102 or 2310B NM102
CDLDC069	DC022	Rendering Provider First Name	varchar	35	Individual first name. If CDLDC068=2, leave blank.	2420A NM104 or 2310B NM104
CDLDC070	DC023	Rendering Provider Middle Name	varchar	25	Individual middle name or initial. If CDLDC068=2, leave blank.	2420A NM105 or 2310B NM105 or 2010AA NM105

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC071	DC024	Rendering Provider Last Name or Organization Name	varchar	60	Full name of provider organization (“non- person entity”) or last name of individual (“person”) provider. CDLDC068 determines if the rendering provider is a “person” or a “non- person entity”.	2420A NM103 or 2310B NM103 or 2010AA NM103
CDLDC072	DC025	Rendering Provider Suffix	varchar	10	Suffix to individual name. Set to null if provider is a facility or organization. The service provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III).	2420A NM107 or 2310B NM107 or 2010AA NM107
CDLDC073	DC026	Rendering Provider Specialty	varchar	10	Standard code that identifies the provider specialty for this line of service. Report the HIPAA-compliant healthcare provider national taxonomy code. Provider taxonomy codes are maintained by the National Uniform Claims Committee (NUCC). See Appendix H: External Code Source, National Uniform Claims Committee.	2420A PRV03 or 2310B PRV03 or 2000AA PRV03
CDLDC074	DC027	Rendering Provider City Name	varchar	30	City name of provider or practice location.	2420C N401 or 2310C N401

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC075	DC028	Rendering Provider State or Province	char	2	State of provider or practice location. State or Province codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service.	2420C N402 or 2310C N402
CDLDC076	DC029	Rendering Provider ZIP Code	varchar	9	Report the 5 or 9 digit Zip Code of the Rendering Provider. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.	2420C N403 or 2310C N403
CDLDC077	DC203	Rendering Provider Group Practice NPI	varchar	10	NPI of rendering provider group practice to which a practitioner is affiliated if different from CDLDC067.	N/A
CDLDC078	DC042	Billing Provider ID	varchar	30	Unique code identified for the provider as assigned by the reporting entity. Payer assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payer for internal identification purposes and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File.	2010AA REF02 where REF01 = G2 and/or LU

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC079	DC043	Billing Provider NPI	char	10	NPI for billing provider as enumerated in the Center for Medicaid and Medicare Services NPPES.	2010AA NM109 where 2010AA NM108 = XX
CDLDC080	DC044	Billing Provider Last Name or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.	2010AA NM103
CDLDC081	DC079	Billing Provider Tax ID	varchar	10	Tax ID of the billing provider. Do not code punctuation.	N/A

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC082	DC201	Carrier Associated with Claim	varchar	8	For each claim, use the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved- out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. If not available, leave blank. See Appendix H: External Code Source, National Association of Insurance Commissioners.	N/A
CDLDC083	DC031	Claim Status	char	2	Claim status codes maintained by ANSI ASC X12 is the code identifying type of claim. See Appendix H: External Code Source, Accredited Standards Committee.	2320 SBR01
CDLDC084	DCXXX	Claim Line Type	char	1	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment.	N/A

E- Dental						
NEW CDL Data Element #	**Original Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/ Codes/ Sources**	**PACDR References**
CDLDC085	DC907	Carrier Specific Unique Member ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLDC086	DC908	Carrier Specific Unique Subscriber ID	varchar	50	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's / submitter's files for reporting and aggregation.	N/A
CDLDC087	DCXXX-DCXXX (20 fields)	Un-assigned	char	1	Reserved for future use. Elements will only be added with review from states and payers.	N/A
CDLDC088	DC899	Record Type	char	2	Value = DC	N/A

F- Provider					
NEW CDL Data Element #	**Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/Codes/Sources**
CDLPV001	PV900	Data Submitter Code	varchar	8	APCD-assigned identifier of payer submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the Payer Code (CDLPV002).
CDLPV002	PV001	Payer Code	varchar	8	APCD-assigned identifier of insurer/underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms).
CDLPV003	PV002	Plan ID	varchar	30	CMS National Plan ID. The national plan ID is a code assigned by CMS. (PLACEHOLDER).
CDLPV004	PV003	Payer Assigned Provider ID	varchar	30	Unique code identified for the provider as assigned by the reporting entity. For every provider included in the Eligibility, Medical, Pharmacy and Dental claims the payer assigned provider IDs shall be included.
CDLPV005	PV004	Provider Tax ID	varchar	10	Tax ID of the provider. Do not code punctuation.

F- Provider					
NEW CDL Data Element #	**Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/Codes/Sources**
CDLPV006	PV901	Entity Type Qualifier	char	1	Use this field to indicate whether the rendering provider is a person or non-person entity. HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "Person." Valid codes are: 1=Person; 2=Non-Person Entity.
CDLPV007	PV016	Provider NPI	char	10	NPI for provider as enumerated in the Center for Medicaid and Medicare Services NPPES.
CDLPV008	PV015	Provider DEA Number	varchar	12	Provider Drug Enforcement Agency number. For all prescribing providers (CDLPC050) that have a DEA number.
CDLPV009	PV017	Provider State License Number	varchar	15	Prefix with two-character state of licensure with no punctuation. Example: COLL12345. Do not leave a blank space in between state and license number.
CDLPV010	PV006	Provider First Name	varchar	35	Individual first name. If provider is a facility or organization, leave blank.
CDLPV011	PV007	Provider Middle Name or Initial	varchar	25	Individual middle name or initial. If provider is a facility or organization, leave blank.

F- Provider					
NEW CDL Data Element #	**Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/Codes/Sources**
CDLPV012	PV008	Provider Last Name or Organization Name	varchar	60	Full name of provider organization or last name of individual provider.
CDLPV013	PV009	Provider Suffix	varchar	10	Suffix to individual name. If provider is a facility or organization, leave blank. The provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III). Do not use credentials such as MD or PhD.
CDLPV014	PV011	Provider Office Street Address	varchar	55	Physical address – address where the provider delivers healthcare services (street number and street name). Include suite number if applicable. Multiple addresses will require multiple provider records.
CDLPV015	PV012	Provider Office City	varchar	30	The city of the physical address where the provider delivers healthcare services. Multiple addresses will require multiple provider records.
CDLPV016	PV013	Provider Office State	char	2	The state of the physical address where the provider delivers healthcare services. Use postal service standard 2 letter abbreviations. Multiple addresses will require multiple provider records. See Appendix H: External Code Source, United States Postal Service.

F- Provider					
NEW CDL Data Element #	**Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/Codes/Sources**
CDLPV017	PV014	Provider Office Zip Code	varchar	9	Report the 5-9 digit Zip Code of the Rendering Provider. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Multiple addresses will require multiple provider records. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Source.
CDLPV018	PV904	Provider FIPS County Code	char	5	Report the FIPS county code based on the providers address. The FIPS county code is a five-digit Federal Information Processing Standard (FIPS) code (FIPS 6-4) which uniquely identifies counties and county equivalents in the United States, certain U.S. possessions, and certain freely associated states. If member lives outside US, leave blank. See Appendix H: External Code Source, United States Census Bureau. See Appendix H: External Code Source, United States Postal Service.
CDLPV019	PV903	Provider Country Code	char	2	Country code of provider's practice location. Code US for United States. See Appendix H: External Code Source, United States Postal Service.
CDLPV020	PV905	Provider Phone	char	10	Phone number of provider.
CDLPV021	PV010	Provider Specialty	varchar	10	Report the NUCC healthcare provider taxonomy code. See Appendix H: External Code Source, National Uniform Claim Committee.

F- Provider					
NEW CDL Data Element #	**Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/Codes/Sources**
CDLPV022	PV902	Atypical Provider Taxonomy Code	varchar	10	Non-medical or atypical providers not defined as covered entities by CMS. Non-medical providers who supply non-healthcare services, such as non-emergency transportation, will continue to submit claims and other transactions using their current provider ID and taxonomy. Use Code set for Atypical Provider Taxonomy Codes (maintained by NUCC). If not applicable, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee.
CDLPV023	PV906	Provider Medicare Provider ID	varchar	30	Provider ID as assigned by Medicare If not available, leave blank.
CDLPV024	PV907	Provider Medicaid Provider ID	varchar	30	Provider ID as assigned by Medicaid. If not available, leave blank.
CDLPV025	PV908	Provider Specialty 2	varchar	10	Report additional NUCC healthcare provider taxonomy code for second specialty. In addition to the taxonomy code listed in CDLPV021. If not available, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee.

F- Provider					
NEW CDL Data Element #	**Data Element #**	**Data Element Name**	**Type**	**Max Length**	**Description/Codes/Sources**
CDLPV026	PV909	Provider Specialty 3	varchar	10	Report third NUCC healthcare provider taxonomy code. If not available, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee.
CDLPV027	PV910	Provider Specialty 4	varchar	10	Report fourth NUCC healthcare provider taxonomy code. If not available, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee.
CDLPV028	PV911	Provider Specialty-5	varchar	10	Report fifth NUCC healthcare provider taxonomy code. If not available, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee.
CDLPV029	PVXXX–PVXXX (20 fields)	Un-assigned			Reserved for future use. Elements will only be added with review from states and payers.
CDLPV030	PV899	Record Type	char	2	Value = PV.

Appendix G-1: Insurance Type/Product Code	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
14	Medicare Secondary, No-Fault Insurance including Insurance in which Auto Is Primary
15	Medicare Secondary Workers' Compensation
16	Medicare Secondary Public Health Service (PHS) or Other Federal Agency
17	Dental
18	Vision
19	Prescription Drugs (Commercial Coverage)
41	Medicare Secondary Black Lung
42	Medicare Secondary Veterans' Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
47	Medicare Secondary, Other Liability Is Primary
AP	Auto Insurance Policy

Appendix G-1: Insurance Type/Product Code	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
C1	Other Commercial (Not Specified Elsewhere)
CO	Consolidated Omnibus Reconciliation Act (COBRA)
CP	Medicare Conditionally Primary
D	Disability
DB	Disability Benefits
E	Medicare – Point of Service (POS)
EP	Exclusive Provider Organization
FH	Federal Employees Health Benefits Program (HMO)
FP	Federal Employees Health Benefits Program (PPO)
FF	Family or Friends
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) Medicare Advantage/Risk
HS	Special Low Income Medicare Beneficiary
IN	Indemnity

Appendix G-1: Insurance Type/Product Code	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
IP	Individual Policy
LC	Long Term Care
LD	Long Term Policy
LI	Life Insurance
LT	Litigation
MA	Medicare Part A (not to be used for commercial plans)
MB	Medicare Part B (not to be used for commercial plans)
MC	Medicaid
MD	Medicare Part D
MH	Medigap Part A
MI	Medigap Part B
MO	Medicare Advantage PPO
MP	Medicare Primary (not to be used for commercial plans)
MT	Medicaid CHIP

Appendix G-1: Insurance Type/Product Code	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
OT	Other
PE	Property Insurance – Personal
PL	Personal
PP	Personal Payment (Cash – No Insurance)
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
RP	Property Insurance – Real
SP	Supplemental Policy
S1	Medicare Special Needs Plan – Chronic Condition
S2	Medicare Special Needs Plan - Institutionalized
S3	Medicare Special Needs Plan – Dual Eligible
TF	Tax Equity Fiscal Responsibility Act (TEFRA)
TR	Tricare

Appendix G-1: Insurance Type/Product Code	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
U	Multiple Options Health Plan
VA	Veterans Administration Plan
WC	Workers' Compensation
WU	Wrap Up Policy
11	Other Non-Federal Programs
DM	Dental Maintenance Organization
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	Champus
CI	Commercial Insurance Company
LB	Liability
LM	Liability Medical
OF	Other Federal Program
TV	Title V

Appendix G-1: Insurance Type/Product Code	
This is a list of codes used by state APCDs. To be used for claims and eligibility.	
Code	**Description**
SL	Standalone limited (for example, vision only, hearing only)
ZZ	Mutually Defined (Use code ZZ when Type of Insurance is Unknown)

Appendix G-2: Race 1/Race 2/Race 3	
These codes are a limited subset from http://www.cdc.gov/nchs/data/dvs/Race_Ethnicity_CodeSet.pdf	
Code	**Description**
R1	American Indian/Alaska Native
R2	Asian
R3	Black/African American
R4	Native Hawaiian or Other Pacific Islander
R5	White
R9	Other Race
UN	Unknown/Not Specified
R1	American Indian/Alaska Native

Appendix G-3: Market Category Codes	
Code	**Description**
IND	Individuals (non-group)
FCH	Individuals on a franchise basis
GCV	Individuals as group conversion Policies
GS1	Employers having exactly 1 employee
GS2	Employers having 2 thru 9 employees
GS3	Employers having 10 thru 25 employees
GS4	Employers having 26 thru 50 employees
GLG1	Employers having 51 thru 100 employees
GLG2	Employers having 101 thru 250 employees
GLG3	Employers having 251 thru 500 employees
GLG4	Employers having more than 500 employees
GSA	Small employers through a qualified association trust
OTH	Other types of entities. Insurers using this market code shall obtain prior approval.

Appendix H: External Code Sources
American Dental Association Current Dental Terminology (CDT) Codes SOURCE: Current Dental Terminology (CDT) Manual AVAILABLE FROM: American Dental Association 211 East Chicago Avenue Chicago, IL 60611-2678 ABSTRACT: The CDT contains the American Dental Association's codes for dental procedures and nomenclature and is the nationally accepted set of numeric codes and descriptive terms for reporting dental treatments.
American Medical Association Current Procedural Terminology (CPT) Codes SOURCE: Physicians' Current Procedural Terminology (CPT) Manual AVAILABLE FROM: American Medical Association 515 North State Street Chicago, IL 60654 ABSTRACT: A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.
Accredited Standards Committee (ASC) ASC X12 Directories SOURCE: PACDR Implementation Guides, ASC X12 005010 Standard AVAILABLE FROM: Data Interchange Standards Association, Inc. (DISA) 7600 Leesburg Pike Ste 430 Falls Church, VA 22043 http://store.x12.org/store Washington Publishing Company http://www.wpc-edi.com/reference/ ABSTRACT: The PACDR Implementation Guides contain the descriptions of data elements used to construct X12 segments. The PACDR Guides also contain code lists associated with these data elements.

Appendix H: External Code Sources
Centers for Disease Control and Prevention HL7/CDC Race and Ethnicity Code Set SOURCE: Race and Ethnicity Code Set AVAILABLE FROM: Centers for Disease Control and Prevention 1600 Clifton Road Atlanta, GA 30329-4027 http://www.cdc.gov/nchs/data/dvs/Race_Ethnicity_CodeSet.pdf ABSTRACT: The race and ethnicity code set is to be used for coding the race and ethnicity of the member.
Centers for Medicare and Medicaid Services Health Care Common Procedural Coding System SOURCE: Health Care Common Procedural Coding System AVAILABLE FROM: Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244-1850 www.cms.gov/HCPCSReleaseCodeSets/ ABSTRACT: HCPCS is the Centers for Medicare and Medicaid Services (CMS) coding scheme to group procedures performed for payment to providers.

Appendix H: External Code Sources

Centers for Medicare and Medicaid Services
Health Insurance Prospective Payment System (HIPPS)
SOURCE: Center for Medicare & Medicaid Services
AVAILABLE FROM:
Center for Medicare and Medicaid Services 7500 Security Boulevard
Baltimore, MD 21244
http://www.cms.gov/Medicare/Medicare-fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html
ABSTRACT: Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Case-mix groups are developed based on research into utilization patterns among various provider types. For the payment systems that use HIPPS codes, clinical assessment data is the basic input used to determine which case-mix group applies to a particular patient. A standard patient assessment instrument is interpreted by case-mix grouping software algorithms, which assign the case mix group. For payment purposes, at least one HIPPS code is defined to represent each case-mix group. These HIPPS codes are reported on claims to insurers.

Centers for Medicare and Medicaid Services
HHS Actuarial Value Calculator
SOURCE: Center for Consumer Information & Insurance Oversight
AVAILABLE FROM:
Centers for Medicare and Medicaid Services 7500 Security Boulevard
Baltimore, MD 21244-1850 https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html ABSTRACT: CCIIO publishes an AV calculator on an annual basis.

Appendix H: External Code Sources

Centers for Medicare and Medicaid Services
National Provider Identifier
SOURCE: National Plan and Provider Enumeration System
AVAILABLE FROM:
Centers for Medicare and Medicaid Services 7500 Security Boulevard
Baltimore, MD 21244-1850 https://nppes.cms.hhs.gov/NPPES/Welcome.do
ABSTRACT: The Centers for Medicare and Medicaid Services developed the National Provider Identifier as the standard, unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

Centers for Medicare and Medicaid Services
Place of Service Codes for Professional Claims
SOURCE: Place of Service Codes for Professional Claims
AVAILABLE FROM:
Centers for Medicare and Medicaid Services 7500 Security Boulevard
Baltimore, MD 21244-1850 www.cms.gov/physicianfeesched/downloads/Website_POS_database.pdf
ABSTRACT: The place of service code identifies the location where the healthcare service was rendered.

ISO 3166 Maintenance Agency
Country Codes
SOURCE: ISO 3166 Maintenance Agency
AVAILABLE FROM:
ISO 3166 Maintenance Agency
c/o International Organization for Standardization Chemin de Blandonnet 8
CP 401
1214 Vernier, Geneva Switzerland
Telephone: +41 22 749 01 11
e-mail: customerservice@iso.org www.iso.org/iso/country_codes

Appendix H: External Code Sources

National Association of Insurance Commissioners
NAIC Codes
SOURCE: National Association of Insurance Commissioners
AVAILABLE FROM:
NAIC Central Office
1100 Walnut Street Suite 1500 Kansas City, MO 64106 816.842.3600
http://www.naic.org/prod_serv/LOC-ZU-15-01.pdf https://eapps.naic.org/cis/companySearch.do
ABSTRACT: NAIC maintains an identification code for each payer that is a 5-digit unique number assigned to an insurance entity by the NAIC. NAIC has developed a tool to look up the code and find the company, or look up the company to find the code:

National Council for Prescription Drug Programs (NCPDP)
National Association of Boards of Pharmacy Number
SOURCE: National Association of Boards of Pharmacy Database and Listings
AVAILABLE FROM:
www.ncpdp.org
National Council for Prescription Drug Programs 9240 East Raintree Drive
Scottsdale, AZ 85260-7518
ABSTRACT: A unique number assigned in the U.S. and its territories to individual clinic, hospital, chain, and independent pharmacy locations that conduct business at retail by billing third-party drug benefit payers. The National Council for Prescription Drug Programs (NCPDP) maintains this database under contract from the National Association of Boards of Pharmacy. The National Association of Boards of Pharmacy Number is a seven-digit numeric number with the following format SSNNNNC, where SS=NCPDP assigned state code number, NNNN=NCPDP assigned pharmacy location number, and C=check digit calculated by algorithm from previous six digits.

Appendix H: External Code Sources
National Council for Prescription Drug Programs (NCPDP) Uniform Healthcare Payer Data SOURCE: NCPDP Uniform Healthcare Payer Data Standard Implementation Guide AVAILABLE FROM: National Council for Prescription Drug Programs 9240 East Raintree Drive Scottsdale, AZ 85260 www.ncpdp.org ABSTRACT: The Implementation Guide is intended to meet an industry need to supply detailed drug or utilization claim information from adjudicated claims that processors/payers or their clients report to States or their Agents.
National Uniform Billing Committee (NUBC) NUBC Codes SOURCE: National Uniform Billing Committee Official Data Specifications Manual AVAILABLE FROM: National Uniform Billing Committee American Hospital Association 155 N Wacker Drive Chicago, IL 60606 www.nubc.org
National Uniform Claim Committee (NUCC) Healthcare Provider Taxonomy Code Set SOURCE: Washington Publishing Company AVAILABLE FROM: National Uniform Claim Committee nuccinfo@nucc.org http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40

Appendix H: External Code Sources
United States Food and Drug Administration (FDA) National Drug Codes SOURCE: National Drug Data File AVAILABLE FROM: U.S. Food and Drug Administration Center for Drug Evaluation and Research Division of Data Management and Services 10903 New Hampshire Avenue Silver Spring, MD 20993 www.fda.gov or http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm
United States Census Bureau 2010 FIPS Codes for Counties and County Equivalent Entities SOURCE: United States Census Bureau, Geography https://www.census.gov/geo/reference/codes/cou.html AVAILABLE FROM: United States Census Bureau, Geography https://www.census.gov/geo/reference/codes/cou.html

Appendix H: External Code Sources

United States Postal Service (USPS)
States and Outlying Areas of the U.S. ZIP Code
SOURCE: United States Postal Service
AVAILABLE FROM:
U.S. Postal Service
National Information Data Center
P.O. Box 9408
Gaithersburg, MD 20898-9408 https://www.usps.com
ABSTRACT: Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies
one of these groups. The next two digits identify a smaller geographic area within the large group. The two right-most digits identify a local delivery area. In the 9-digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery area. The two leftmost digits identify a sector which may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes.

World Health Organization (WHO)
International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure and Diagnosis
SOURCE: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
AVAILABLE FROM:
WHO Publications Center AUS 49 Sheridan Avenue
Albany, NY 12210 http://www.cdc.gov/nchs/icd/icd9cm.htm
ABSTRACT: The International Classification of Diseases, 9th Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and procedures.

Appendix H: External Code Sources

World Health Organization (WHO)
International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS)
SOURCE: International Classification of Diseases, 10th Revision, (ICD-10-CM/PCS)
AVAILABLE FROM:
WHO Publications Center AUS 49 Sheridan Avenue
Albany, NY 12210 www.cdc.gov/nchs/icd/icd10cm.htm#9update
ABSTRACT: The International Classification of Diseases, 10th Revision, is used to report medical diagnosis in all U.S. health care settings after October 1, 2015.