Minnesota Health Care Claims Reporting System:

Appendices to Minnesota Administrative Rules, Chapter 4653

Minnesota Department of Health

May 2009

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INTRODUCTION

Minnesota Statute 62U.04, Subd 4 requires the state to collect encounter data reported on a claim from all health plans and third-party administrators in a form and manner specified by the Commissioner of Health. In addition, Minnesota Statute 62U.04, Subd 5 requires the state to collect pricing data from all health plans and third-party administrators. The Department of Health has contracted with the Maine Health Information Center (MHIC) to collect these data. The proprietary data collection system operated by MHIC is known as the National Claims Data Management System, referred to in these appendices as "NCDMS." Data collected on behalf of Minnesota residents will be maintained in a separate, Minnesota-only database.

The data can only be used in the development of the provider peer grouping system, which will be based on a combined measure that incorporates both provider risk-adjusted cost of care and quality of care. To achieve an accurate measure, the state must collect not only de-identified data on patients who receive care, but also data on eligible patients who do not receive care during the same time period. The enrollment data detailed in this appendix, collected in conjunction with the institutional and professional claims data and pharmacy claims data detailed in appendices B and C, will ensure the analysis of the provider peer grouping system is based on the appropriate patient denominator.

Data Element Characteristics

1. **Element Number** - a number assigned to each data element, primarily for ease of reference. There are intentional gaps in the data element numbers. These gaps represent data elements from the larger NCDMS system, and which have been excluded from the recommendations in order to tailor the elements to Minnesota's needs.
2. **Element Name** – the English-like name of the data element.
3. **Encrypt** – identifies those data elements that will be encrypted by the data submitter through software supplied by the data processor. No live values of encrypted data elements will be supplied to the data processor.
4. **Type** – type of data element: text, integer or date.
5. **Max Len** – the maximum length allowed for this data element. Note that encrypted elements are 128 characters in length, regardless of the length of the unencrypted value.
6. **Description** – a brief description of the data element.
7. **Threshold** – the proposed completeness percentage for this element. Some elements have a threshold of 0% because the element is not yet available, voluntary, or a situational element that can be coded as null 100% of the time for certain data submitters.
8. **Reference Standard** - maps the proposed data elements to national standards where possible. Enrollment data elements in Appendix A are mapped to HIPAA 270/271 transaction data sets. Institutional and Professional data elements in Appendix B are mapped to HIPAA 835/837 transaction sets. The UB-04 and CMS-1500 columns in Appendix B are a reference to data submitters where an element appears on standard claim forms. Pharmacy data elements in Appendix C are mapped to the National Council for Prescription Drug Program transaction data set. Of the elements not mapped to a standard, this column will detail whether it is an administrative element or pricing data.

APPENDIX A
ENROLLMENT DATA

Element Number	Element Name	Encrypt	Type	Max Len	Description	Threshold	Reference Standard
ME001	Payer	N	Text	8	This field contains the NCDMS assigned submitter code for the data submitter. The first two characters of the submitter code indicate Minnesota and the third character designates the type of submitter. MNC Commercial carrier MNG Governmental agency MNT Third Party Administrator MNU Unlicensed entity A single data submitter may have multiple submitter codes because the data submitter is submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first 6 characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	100%	Administrative element
ME003	Insurance Type / Product Code	N	Text	6	This field contains the insurance type or product code that indicates the type of insurance coverage the individual has. Code all but MC and XX as 2 characters; MC and XX must include a valid subcode. 12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month Coordination Period with an Employer's Group Health Plan 14 Medicare Secondary, No-fault Insurance Including Auto is Primary 15 Medicare Secondary Worker's Compensation 16 Medicare Secondary Public Health Service or Other Federal Agency 41 Medicare Secondary Black Lung 42 Medicare Secondary Veteran's Administration 43 Medicare Secondary Disabled Beneficiary	99.9%	271/2110C/EB/ /04, 271/2110D/EB/ /04,

Element Number	Element Name	Encrypt	Type	Max Len	Description	Threshold	Reference Standard
					Under Age 65 with Large Group Health 47 Medicare Secondary, Other Liability Insurance is Primary CP Medicare Conditionally Primary D Disability DB Disability Benefits EP Exclusive Provider Organization HM Health Maintenance Organization (HMO) HN Health Maintenance Organization (HMO) Medicare Risk / Medicare Part C HS Special Low Income Medicare Beneficiary IN Indemnity MA Medicare Part A MB Medicare Part B MC Medical Assistance (must include sub-code) FFSM Fee-for-service Medical Assistance PMAP Prepaid Medical Assistance Program MDHO MN Disability Health Options MSHO MN Senior Health Options SNBC Special Needs Basic Care MISC Other managed care program within Medical Assistance MD Medicare Part D MH Medigap Part A MI Medigap Part B MP Medicare Primary PR Preferred Provider Organization (PPO) PS Point of Service (POS) QM Qualified Medicare Beneficiary SP Supplemental Policy XX Non-Medical-Assistance Public Program (must include sub-code) CDEP Chemical Dependency GAMC General Assistance Medical Care HIVA HIV/AIDS MCHA Minnesota Comprehensive Health Association MNCR MinnesotaCare		

Element Number	Element Name	Encrypt	Type	Max Len	Description	Threshold	Reference Standard
					MISC Other non-Medical Assitance public program		
ME004	Year	N	Integer	4	The year during which the member is eligible for services. This field is generally used in conjunction with the month (ME005) to determine a specific period of eligibility.	99.9%	Administrative element.
ME005	Month	N	Integer	2	Month indicates the month during which the member is eligible for services. This field is generally used with the year field (ME004) to determine a specific period of eligibility.	99.9%	Administrative element.
ME009	Plan Specific Contract Number	Y	Text	128	This field contains the data submitter assigned contract number for the subscriber. This field is encrypted using the same algorithm across all data submitters and is not available in the analytical data warehouse. When this field is populated, it forms the core of the unique member identification code. Set as null if unavailable.	99.9%	271/2100C/NM1/MI/09
ME012	Individual Relationship Code	N	Integer	2	This field contains the member's relationship to the subscriber or the insured. 01 Spouse 18 Self 19 Child 21 Unknown 34 Other Adult	99.9%	271/2100C/INS/ /02, 271/2100D/INS/ /02
ME013	Member Gender	N	Text	1	Member's gender M Male F Female U Unknown	99.9%	271/2100C/DMG/ /03, 271/2100D/DMG/ /03
ME014	Member Date of Birth	Y Transformed	Date	8	This field contains the member's data of birth with a format of CCYYMMDD. During the encryption process, this field is used to calculate age as of the first day of the membership month. The field is then encrypted. This data element will not be transmitted in unencrypted form.	99.5%	271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02

Element Number	Element Name	Encrypt	Type	Max Len	Description	Threshold	Reference Standard
ME015	Member City Name	N	Text	30	This field contains the member's city of residence.	90%	271/2100C/N4/ /01, 271/2100D/N4/ /01
ME016	Member State or Province	N	Text	2	The member state or province contains the 2 character abbreviation code used by the US Postal Service.	90%	271/2100C/N4/ /02, 271/2100D/N4/ /02
ME017	Member ZIP Code	N	Text	5	This field contains ZIP code of the member.	99.5%	271/2100C/N4/ /03, 271/2100D/N4/ /03
ME018	Medical Coverage	N	Text	1	The medical coverage flag indicates whether this member is covered for medical expenses. This is an administrative field required by NCDMS and derived from the enrollment data maintained by the data submitter. Y Yes N No	99.9%	Administrative element
ME019	Prescription Drug Coverage	N	Text	1	The prescription drug coverage flag indicates whether this member is covered for prescription drug expenses. This is an administrative field required by NCDMS and derived from the enrollment data maintained by the data submitter. Y Yes N No	99.9%	Administrative element
ME032	Health Care Home Assigned Flag	N	Text	1	This flags whether the member reported has an approved medical home for this coverage period 1 Yes 2 No 3 Unknown	0%	Administrative element reserved for assignment
ME033	Health Care Home Number	N	Text	30	Data submitter assigned medical home number. It is anticipated that this will be the same data submitter number used in reporting servicing provider. This field will be used to create a master provider index for Minnesota providers encompassing medical service providers, prescribing physicians and medical homes.	0%	Administrative element reserved for assignment
ME034	Health Care Home Tax ID Number	N	Text	10	Federal tax payer's identification number for medical home. This field will be used to create a master provider index for Minnesota providers encompassing medical service providers, prescribing physicians and medical homes	0%	Administrative element reserved for assignment

Element Number	Element Name	Encrypt	Type	Max Len	Description	Threshold	Reference Standard
ME035	Health Care Home National Provider ID	N	Text	20	Report the National Provider Identification (NPI) number for the entity or individual serving as the medical home. This field will be used to create a master provider index for Minnesota providers encompassing medical service providers, prescribing physicians and medical homes.	0%	Administrative element reserved for assignment
ME036	Health Care Home Name	N	Text	60	Report the full name of the provider – facility, organization or individual. If the medical home is an individual, report in the format of Last name, first name and middle initial with no punctuation.	0%	Administrative element reserved for assignment
ME101	Subscriber Last Name	Y	Text	128	Subscriber last name, used to create a unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	100%	271/2100C/NM1/ /03
ME102	Subscriber First Name	Y	Text	128	Subscriber first name, used to create a unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	90%	271/2100C/NM1/ /04
ME103	Subscriber Middle Initial	Y	Text	1	Subscriber middle initial, used to create a unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	0%	271/2100C/NM1/ /05
ME104	Member Last Name	Y	Text	128	Member last name, used to create a unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	100%	271/2100C/NM1/ /03, 271/2100D/NM1/ /03
ME105	Member First Name	Y	Text	128	Member first name, used to create a unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	90%	271/2100C/NM1/ /04, 271/2100D/NM1/ /04
ME106	Member Middle Initial	Y	Text	1	Member middle initial, used to create a unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	0%	271/2100C/NM1/ /05, 271/2100D/NM1/ /05
ME899	Record Type	N	Text	2	This field indicates the type of record. ME Eligibility This is an administrative field required by NCDMS and populated with a constant value.	100%	Administrative element.

APPENDIX B
INSTITUTIONAL AND PROFESSIONAL HEALTH CARE CLAIMS DATA

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
MC001	Payer	N	Text	8	This field contains the NCDMS assigned submitter code for the data submitter. The first two characters of the submitter code indicate Minnesota and the third character designates the type of submitter. MNC Commercial carrier MNG Governmental agency MNT Third Party Administrator MNU Unlicensed entity A single data submitter may have multiple submitter codes because the data submitter is submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first 6 characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	100%	N/A	N/A	Administrative element
MC003	Insurance Type / Product Code	N	Text	6	This field contains the insurance type or product code that indicates the type of insurance coverage the individual has. Code all but MC and XX as 2 characters; MC and XX must include a valid subcode. 12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month Coordination Period with an Employer's Group Health Plan 14 Medicare Secondary, No-fault	99.9%	N/A	N/A	835/2000/CLP/ /06

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
					Insurance Including Auto is Primary 15 Medicare Secondary Worker's Compensation 16 Medicare Secondary Public Health Service or Other Federal Agency 41 Medicare Secondary Black Lung 42 Medicare Secondary Veteran's Administration 43 Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health 47 Medicare Secondary, Other Liability Insurance is Primary CP Medicare Conditionally Primary D Disability DB Disability Benefits EP Exclusive Provider Organization HM Health Maintenance Organization (HMO) HN Health Maintenance Organization (HMO) Medicare Risk / Medicare Part C HS Special Low Income Medicare Beneficiary IN Indemnity MA Medicare Part A MB Medicare Part B MC Medical Assistance (must include sub-code) FFSM Fee-for-service Medical Assistance PMAP Prepaid Medical Assistance Program MDHO MN Disability Health Options MSHO MN Senior Health Options SNBC Special Needs Basic Care				

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
					MISC Other managed care program within Medical Assistance MD Medicare Part D MH Medigap Part A MI Medigap Part B MP Medicare Primary PR Preferred Provider Organization (PPO) PS Point of Service (POS) QM Qualified Medicare Beneficiary SP Supplemental Policy XX Non-Medical-Assistance Public Program (must include sub-code) CDEP Chemical Dependency GAMC General Assistance Medical Care HIVA HIV/AIDS MCHA Minnesota Comprehensive Health Association MNCR MinnesotaCare MISC Other non-Medical Assitance public program				
MC004	Payer Claim Control Number	N	Text	35	This field contains the claim number used by the data submitter to internally track the claim. In general the claim number is associated with all service lines of the bill. It must apply to the entire claim and be unique within the data submitter's system.	99.9%	N/A	N/A	835/2100/CLP/ /07
MC004A	Claim Submitter's Identifier	Y	Text	38	This field is used to track a claim from creation by the health care provider through the payment. This field is used in algorithms to determine the final payment for the service.	50%	3A	26	837/2300/CLM/ /01
MC005	Line Counter	N	Integer	4	This field contains the line number for this service. The line counter begins with 1 and is incremented by 1 for each additional	99.5%	N/A	N/A	837/2400/LX/ /01

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
					service line of a claim. This field is used in algorithms to determine the final payment for the service. If the data submitter's processing system assigns an internal line counter for the adjudication process, that number may be submitted in place of the line number submitted by the provider.				
MC005A	Version Number	N	Integer	4	This is a voluntary administrative field and is not required to be reported. This field contains the version number of the claim service line. It begins with 0 and is incremented by 1 for each subsequent version of that service line. This field is used in algorithms to determine the final payment for the service	0%	N/A	N/A	Administrative element
MC008	Plan Specific Contract Number	Y	Text	128	This field contains the data submitter assigned contract number for the subscriber. This field is encrypted using the same algorithm across all data submitters and is not available in the analytical data warehouse. When this field is populated, it forms the core of the unique member identification code. Set as null if unavailable.	99.9%	N/A	N/A	835/2100/NM1/MI/09,
MC011	Individual Relation-ship Code	N	Integer	2	This field contains the member's relationship to the subscriber or the insured. 01 Spouse 04 Grandfather or Grandmother 05 Grandson or Granddaughter 07 Nephew or Niece 10 Foster Child 15 Ward 17 Stepson or Stepdaughter 18 Self 19 Child 20 Employee 21 Unknown 22 Handicapped Dependent	99.9%	59 (A-C)	6	837/2000B/SBR/ /02, 837/2000C/PAT/ /01

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
					23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 34 Other Adult 36 Emancipated Minor 39 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Child Where Insured Has No Financial Responsibility 53 Life Partner				
MC012	Member Gender	N	Text	1	This field contains the gender of the patient. M Male F Female U Unknown	100%	11	3	837/2010CA/DMG/ /03
MC013	Member Date of Birth	Y Trans-formed	Date	8	This field contains the member's date of birth with a format of CCYYMMDD. During the encryption process, this field is used to calculate age as of the from date of service (MC059). The field is then encrypted. This data element will not be transmitted in unencrypted form.	99.5%	10	3	837/2010CA/DMG/D8/02
MC014	Member City Name	N	Text	30	This field contains the member's city of residence	90%	9B	5	837/2010CA/N4/ /01
MC015	Member State or Province	N	Text	2	The member state or province contains the 2 character abbreviation code used by the US Postal Service.	90%	9C	5	837/2010CA/N4/ /02
MC016	Member ZIP Code	N	Text	5	This field contains the ZIP code associated with the member's residence	90%	9D	5	837/2010CA/N4/ /03
MC017	Check Issue or EFT Effective Date	N	Date	8	This field contains the date the record was approved for payment. This is generally referred to as the paid date and reported with a CCYYMMDD format. When BPR04 is "NON" for non-payment, include remittance data	100%	N/A	N/A	835/Header Financial Information/BPR//16

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
MC018	Admission Date	N	Date	8	This field contains the date of the inpatient admission reported with a CCYYMMDD format.	90% of institutional inpatient claims	12	N/A	Professional 837/2300/DTP/435/D8/03 Institutional 837/2300/DTP/435/DT/03
MC020	Admission Type	N	Integer	1	This field is used to record the type of admission for all inpatient hospital claims. 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma Center 9 Information not Available	60% of institutional inpatient claims	14	N/A	837/2300/CL1/ /01
MC021	Admission Source	N	Text	1	This field is required for inpatient hospital claims. It records the source of admission. For newborns (Admission Type = 4) 1 - Normal delivery 2 - Premature delivery 3 - Sick baby 4 - Extramural birth 9 - Information not available Admissions other than newborn 1 - Physician referral 2 - Clinic referral 3 - HMO referral 4 - Transfer from a hospital 5 - Transfer from a skilled nursing facility 6 - Transfer from another health care facility 7 - Emergency room 8 - Court/Law enforcement 9 - Information not available	60% of institutional inpatient claims	15	N/A	837/2300/CL1/ /02
MC023	Discharge Status	N	Integer	2	This field contains the status for the patient discharged from the hospital. 01 Discharged to home or self care 02 Discharged/transferred to another short term general hospital for inpatient care	90% of institutional inpatient claims	17	N/A	837/2300/CL1/ /03

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
					03 Discharged/transferred to skilled nursing facility (SNF) 04 Discharged/transferred to nursing facility (NF) 05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution 06 Discharged/transferred to home under care of organized home health service organization 07 Left against medical advice or discontinued care 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital 20 Expired 30 Still patient or expected to return for outpatient services 40 Expired at home 41 Expired in a medical facility 42 Expired, place unknown 43 Discharged/transferred to a Federal hospital 50 Hospice – home 51 Hospice – medical facility 61 Discharged/transferred within this institution to a hospital based Medicare-approved swing bed 62 Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital 63 Discharge/transferred to a long-term care hospital 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare				

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
MC024	Service Provider Number	N	Text	30	Data submitter assigned or legacy rendering/attending provider number. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers. Required if MC026 is not filled. U – UMPI M – MHCP L – Legacy / pre-NPI O - Other	0%	76, 77, 78, 79	N/A	Professional 837/2310B/REF//02, 837/2420A/REF//02 Institutional 837/2310A/REF//02, 837/2420A/REF//02,
MC025	Service Provider Tax ID Number	N	Text	10	Federal tax payer's identification number for rendering/attending provider. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	90%	76, 77, 78, 79	25	Professional 837/2310B/NM1/24/09, 837/2310B/NM1/34/09, 837/2420A/NM1/24/09, 837/2420A/NM1/34/09 Institutional 837/2310A/NM1/24/09, 837/2310A/NM1/34/09, 837/2420A/NM1/24/09, 837/2420A/NM1/34/09
MC026	National Service Provider ID	N	Text	20	Record the National Provider Identification (NPI) number for the entity or individual directly providing the service. This field will be used to create a master provider index for Minnesota medical service and prescribing providers. Required if MC024 is not filled.	0%	76, 77, 78, 79	24J	Professional 837/2420A/NM1/XX/09, 837/2310B/NM1/XX/09 Institutional 837/2420A/NM1/XX/09, 837/2310A/NM1/XX/09
MC027	Service Provider Entity Type Qualifier	N	Text	1	The following codes are valid: 1 Person 2 Non-Person Entity	90%	N/A	N/A	Professional 837/2420A/NM1/82/02, 837/2310B/NM1/82/02 Institutional 837/2420A/NM1/71/02, 837/2310A/NM1/71/02

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
MC028	Service Provider First Name	N	Text	25	Report the individual's first name. Set to null if provider is a facility or an organization. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers	40%	76, 77, 78, 79	N/A	Professional 837/2420A/NM1/82/04, 837/2310B/NM1/82/04 Institutional 837/2420A/NM1/71/04, 837/2310A/NM1/71/04
MC029	Service Provider Middle Name	N	Text	25	Report the individual's middle name or initial. Set to null if provider is a facility or an organization. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	0%	N/A	N/A	Professional 837/2420A/NM1/82/05, 837/2310B/NM1/82/05 Institutional 837/2420A/NM1/71/05, 837/2310A/NM1/71/05
MC030	Service Provider Last Name or Organi-zation Name	N	Text	100	Report the last name of the individual practitioner or the full name if the provider is a facility or an organization. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	99.5%	76, 77, 78, 79	N/A	Professional 837/2420A/NM1/82/03, 837/2310B/NM1/82/03 Institutional 837/2420A/NM1/71/03, 837/2310A/NM1/71/03
MC031	Service Provider Suffix	N	Text	10	The service provider suffix is used to capture any generational identifiers associated with an individual clinician's name (e.g. Jr. Sr., III). Do not code the clinician's credentials (e.g. MD, LCSW) in this field. Set to null if the provider is a facility or an organization. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	0%	76, 77, 78, 79	N/A	Professional 837/2420A/NM1/82/07, 837/2310B/NM1/82/07 Institutional 837/2420A/NM1/71/07, 837/2310A/NM1/71/07
MC033	Service Provider City Name	N	Text	30	Report the city name of the provider address, preferably the practice location. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	90%	N/A	32	Professional 837/2420C/N4/ /01, 837/2310D/N4/ /01 Institutional 837/2310E/N4/ /01

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
MC034	Service Provider State or Province	N	Text	2	The provider's state or province contains the 2 character abbreviation code used by the US Postal Service. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	90%	N/A	32	Professional 837/2420C/N4/ /02, 837/2310D/N4/ /02 Institutional 837/2310E/N4/ /02
MC035	Service Provider ZIP Code	N	Text	15	Report the ZIP code of the servicing provider's address, preferably the practice location. This field will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	90%	N/A	32	Professional 837/2420C/N4/ /03, 837/2310D/N4/ /03 Institutional 837/2310E/N4/ /03
MC036	Type of Bill - Institutional	N	Integer	3	This field is required for institutional claims and must be set to null for professional claims. The following codes are valid: Type of Facility - First Digit 1 Hospital 2 Skilled Nursing 3 Home Health 4 Christian Science Hospital 5 Christian Science Extended Care 6 Intermediate Care 7 Clinic 8 Special Facility Bill Classification - Second Digit if First Digit = 1-6 1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B Only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Nursing Facility Level I 6 Nursing Facility Level II 7 Intermediate Care - Level III Nursing Facility 8 Swing Beds Bill Classification - Second Digit if First	99% of insitutional claims	4	N/A	Institutional 837/2300/CLM/ /05-1

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
					Digit = 7 1 Rural Health 2 Hospital Based or Independent Renal Dialysis Center 3 Free Standing Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (CORFs) 6 Community Mental Health Center 9 Other Bill Classification - Second Digit if First Digit = 8 1 Hospice (Non Hospital Based) 2 Hospice (Hospital-Based) 3 Ambulatory Surgery Center 4 Free Standing Birthing Center 9 Other Frequency – third digit 1 Admit Through Discharge 2 Interim-First Claim Used for the 3 Interim-Continuing Claims 4 Interim-Last Claim 5 Late Charge Only 7 Replacement of Prior Claim 8 Void/Cancel of a Prior Claim 9 Final Claim for a Home				
MC037	Site of Service - on NSF/CMS 1500 Claims	N	Text	2	For professional claims, this field records the type of facility where the service was performed. The field should be set to null for institutional claims. The valid codes are: 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room – Hospital 24 Ambulatory Surgery Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility	99% of professional claims	N/A	24B	Professional 837/2300/CLM/ /05-1

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
					32 Nursing Facility 33 Custodial Care Facility 34 Hospice 35 Boarding Home 41 Ambulance – Land 42 Ambulance - Air or Water 50 Federally Qualified Center 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 99 Other Unlisted Facility				
MC039	Admitting Diagnosis	N	Text	5	This field contains the ICD-9 diagnosis code indicating the reason for the inpatient admission. Decimal point is not coded.	60% of institutional inpatient claims	69	N/A	Institutional 837/2300/HI/BJ/02-2
MC040	E-Code	N	Text	5	This field describes an injury, poisoning or adverse effect using an ICD-9 E-code diagnosis. Decimal point is not coded. Additional E-Codes may be reported in other diagnosis fields MC041-MC053	5% of institutional claims	72 (A, B, C)	N/A	Institutional 837/2300/HI/BN/03-2

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
MC041	Principal Diagnosis	N	Text	5	This field contains the ICD-9 diagnosis code for the principal diagnosis. Decimal point is not coded.	90%	67	21.1	837/2300/HI/BK/01-2
MC042	Other Diagnosis - 1	N	Text	5	This field contains the ICD-9 diagnosis code for the first secondary diagnosis. Decimal point is not coded.	50%	67A	21.2	837/2300/HI/BF/01-2
MC043	Other Diagnosis - 2	N	Text	5	This field contains the ICD-9 diagnosis code for the second secondary diagnosis. Decimal point is not coded.	20%	67B	21.3	837/2300/HI/BF/02-2
MC044	Other Diagnosis - 3	N	Text	5	This field contains the ICD-9 diagnosis code for the third secondary diagnosis. Decimal point is not coded.	5%	67C	21.4	837/2300/HI/BF/03-2
MC045	Other Diagnosis - 4	N	Text	5	This field contains the ICD-9 diagnosis code for the fourth secondary diagnosis. Decimal point is not coded.	0%	67D	N/A	837/2300/HI/BF/04-2
MC046	Other Diagnosis - 5	N	Text	5	This field contains the ICD-9 diagnosis code for the fifth secondary diagnosis. Decimal point is not coded.	0%	67E	N/A	837/2300/HI/BF/05-2
MC047	Other Diagnosis - 6	N	Text	5	This field contains the ICD-9 diagnosis code for the sixth secondary diagnosis. Decimal point is not coded.	0%	67F	N/A	837/2300/HI/BF/06-2
MC048	Other Diagnosis - 7	N	Text	5	This field contains the ICD-9 diagnosis code for the seventh secondary diagnosis. Decimal point is not coded.	0%	67G	N/A	837/2300/HI/BF/07-2
MC049	Other Diagnosis - 8	N	Text	5	This field contains the ICD-9 diagnosis code for the eighth secondary diagnosis. Decimal point is not coded.	0%	67H	N/A	837/2300/HI/BF/08-2
MC050	Other Diagnosis - 9	N	Text	5	This field contains the ICD-9 diagnosis code for the ninth secondary diagnosis. Decimal point is not coded.	0%	67I	N/A	837/2300/HI/BF/09-2
MC051	Other Diagnosis - 10	N	Text	5	This field contains the ICD-9 diagnosis code for the tenth secondary diagnosis. Decimal point is not coded.	0%	67J	N/A	837/2300/HI/BF/10-2
MC052	Other Diagnosis - 11	N	Text	5	This field contains the ICD-9 diagnosis code for the eleventh secondary diagnosis. Decimal point is not coded.	0%	67K	N/A	837/2300/HI/BF/11-2
MC053	Other Diagnosis -	N	Text	5	This field contains the ICD-9 diagnosis code for the twelfth secondary diagnosis.	0%	67L	N/A	837/2300/HI/BF/12-2

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
	12				Decimal point is not coded.				
MC054	Revenue Code	N	Text	4	This field is used to report the revenue code for institutional claims. It is one of three fields used to report type of service. National Uniform Billing Committee Codes are accepted. Code using leading zeroes, left justified and four digits.	99.9% of institutional claims	42	N/A	835/2110/SVC/NU/01-2
MC055	Procedure Code	N	Text	5	This field contains the HCPC or CPT code for the procedure performed. It is one of three fields used to report the service. Health Care Common Procedural Coding System (HCPCS), including CPT codes of the American Medical Association, are accepted.	80%	44	24D	835/2110/SVC/HC/01-2
MC056	Procedure Modifier - 1	N	Text	2	A modifier is used to indicate that a service or procedure has been altered by some specific circumstance but not changed in definition or code. Modifiers may be used to indicate a service or procedure that has both a professional and a technical component, only part of a service was performed, a bilateral procedure was performed, or a service or procedure was provided more than once.	10%	44	24D	835/2110/SVC/HC/01-3
MC057A	Procedure Modifier - 2	N	Text	2	A modifier is used to indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code. Modifiers may be used to indicate a service or procedure that has both a professional and a technical component, only part of a service was performed, a bilateral procedure was performed, or a service or procedure was provided more than once.	2%	44	24D	835/2110/SVC/HC/01-4

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
MC057B	Procedure Modifier - 3	N	Text	2	A modifier is used to indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code. Modifiers may be used to indicate a service or procedure that has both a professional and a technical component, only part of a service was performed, a bilateral procedure was performed, or a service or procedure was provided more than once.	0%	44	24D	835/2110/SVC/HC/01-5
MC057C	Procedure Modifier - 4	N	Text	2	A modifier is used to indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code. Modifiers may be used to indicate a service or procedure that has both a professional and a technical component, only part of a service was performed, a bilateral procedure was performed, or a service or procedure was provided more than once.	0%	44	24D	835/2110/SVC/HC/01-6
MC058	Principal ICD-9-CM Procedure Code	N	Text	4	This is used to report the principal inpatient ICD-9 procedure code. The decimal point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary. This is one of three fields used to report type of service. Use fields MC058A-E to report other ICD-9-CM procedure codes.	55% of institutional inpatient claims	74	N/A	837/2300/HI/BR/02
MC058A	Other ICD-9-CM Procedure Code - 1	N	Text	4	This is used to report the second ICD-9 procedure code. The decimal point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary.	30% of institutional inpatient claims	74A	N/A	837/2300/HI/BQ/02-2
MC058B	Other ICD-9-CM Procedure Code - 2	N	Text	4	This is used to report the third ICD-9 procedure code. The decimal point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary.	15% of institutional inpatient claims	74A	N/A	837/2300/HI/BQ/03-2

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
MC058C	Other ICD-9-CM Procedure Code - 3	N	Text	4	This is used to report the fourth ICD-9 procedure code. The decimal point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary.	10% of institutional inpatient claims	74A	N/A	837/2300/HI/BQ/04-2
MC058D	Other ICD-9-CM Procedure Code - 4	N	Text	4	This is used to report the fifth ICD-9 procedure code. The decimal point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary.	5% of institutional inpatient claims	74A	N/A	837/2300/HI/BQ/05-2
MC058E	Other ICD-9-CM Procedure Code - 5	N	Text	4	This is used to report the sixth ICD-9 procedure code. The decimal point is not coded. The ICD-9 procedure must be repeated for all lines of the claim if necessary.	0%	74A	N/A	837/2300/HI/BQ/06-2
MC059	Date of Service - From	N	Date	8	This field contains the first date of service for this service line in a CCYYMMDD format.	99.5%	45	24A	835/2110/DTM/150/02
MC060	Date of Service - Thru	N	Date	8	This field contains the last date of service for this service line in a CCYYMMDD format. Future dates are acceptable.	99.5%	N/A	24A	835/2110/DTM/151/02
MC061	Quantity	N	Integer	5	This field contains a count of services performed. This field may be negative.	99.5%	46	24G	835/2110/SVC/ /05
MC062	Charge Amount	N	Decimal	10	This field contains the total charges for the service as reported by the provider. This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. 0$ is acceptable; code “data not available” as 9999999999. Only 1% of submissions can contain 9999999999.	99%	47	24F	835/2110/SVC/ /02

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
MC063	Paid Amount	N	Decimal	10	This field includes all health plan payments , and excludes all member payments and withholds from providers. This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. 0$ is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999.	99%	N/A	N/A	835/2110/SVC/ /03
MC063A	Header/ Line Payment Indicator	N	Text	1	This field is used to indicate whether the payment is reported on the header or line level. Code H for Header or L for Line. If H, populate each line after the first line with "H" and a paid amount of $0. If L, populate each line as necessary.	100%	N/A	N/A	Pricing data
MC063C	Managed Care Withhold	N	Decimal	10	This is an amount withheld from payment to a provider by a managed care organization, which may be paid at a later date. 0$ is acceptable; code "data not available" as 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.	99%	N/A	N/A	835/2110/CAS/CO/104
MC064	Prepaid Amount	N	Decimal	10	For capitated services, the fee for service equivalent amount. 0$ is acceptable; code "data not available" as 9999999999. Submissions containing 9999999999 will not factor into the calculation of the threshold.	99%	N/A	N/A	Pricing data
MC065	Copay / Co-insurance Amount	N	Decimal	10	This field contains the pre-set, fixed dollar amount of copay and/or ccoinsurance payable by a member, often on a per visit/service basis. This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. 0$ is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999.	99%	N/A	N/A	835/2110/CAS/PR/3 Plus 835/2110/CAS/PR/2

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
MC067	Deductible Amount	N	Decimal	10	This is an amount that is required to be paid by a member before health plan benefits will begin to reimburse for services. It is usually an annual amount of all health care costs that is not covered by the member's insurance plan. This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. 0$ is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999.	99%	N/A	N/A	835/2110/CAS/PR/1
MC076	Billing Provider Number	N	Text	30	Enter the data submitter assigned billing provider number. This should be the identifier used by the data submitter for internal reasons and does not routinely change. Required if MC077 is not filled. U – UMPI M – MHCP L – Legacy / pre-NPI O - Other	0%	57	33B	837/2010AA/REF//02
MC077	National Billing Provider ID	N	Text	10	National Provider Identification (NPI) number for the billing provider. Required if MC076 is not filled.	0%	56	33A	837/2010AA/NM1/XX/09
MC078	Billing Provider Last Name	N	Text	60	Report the full name of the billing organization or the last name of the individual billing provider.	99.5%	1	33	837/2010AA/NM1/ /03
MC079	Diagnosis Code Pointer -1	N	Integer	1	A pointer to the claim diagnosis code in the order of importance to this service. Use this pointer for the first diagnosis code pointer (primary diagnosis for this service line).	90%	N/A	24E	837/2400/SV1//07-1
MC080	Diagnosis Code Pointer -2	N	Integer	1	A pointer to the claim diagnosis code in the order of importance to this service. Use this pointer for the second diagnosis code pointer if applicable.	10%	N/A	24E	837/2400/SV1//07-2
MC081	Diagnosis Code Pointer -3	N	Integer	1	A pointer to the claim diagnosis code in the order of importance to this service. Use this pointer for the third diagnosis code pointer if applicable.	0%	N/A	24E	837/2400/SV1//07-3

Element Number	Element Name	En-crypt	Type	Max Len	Description	Threshold	UB-04	CMS 1500#	Reference Standard
MC082	Diagnosis Code Pointer -4	N	Integer	1	A pointer to the claim diagnosis code in the order of importance to this service. Use this pointer for the fourth diagnosis code pointer if applicable.	0%	N/A	24E	837/2400/SV1//07-4
MC101	Subscriber Last Name	Y	Text	128	The subscriber last name is used to create a unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	100%	58	4	837/2010BA/NM1/ /03
MC102	Subscriber First Name	Y	Text	128	Subscriber first name, used to create a unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	90%	58	4	837/2010BA/NM1/ /04
MC103	Subscriber Middle Initial	Y	Text	1	Subscriber middle initial, used to create a unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	0%	N/A	4	837/2010BA/NM1/ /05
MC104	Member Last Name	Y	Text	128	Member last name, used to create a unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	100%	8	2	837/2010CA/NM1/ /03
MC105	Member First Name	Y	Text	128	Member first name, used to create a unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	90%	8	2	837/2010CA/NM1/ /04
MC106	Member Middle Initial	Y	Text	1	Member middle initial, used to create unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	0%	8	2	837/2010CA/NM1/ /05
MC899	Record Type	N	Text	2	This field indicates the type of record. MC = Institutional & Professional Claims This is an administrative field required by NCDMS and populated with a constant value.	100%	N/A	N/A	Administrative element.

APPENDIX C
PHARMACY CLAIMS DATA

Element Number	Element Name	Encrypt	Type	Max Len	Description	Threshold	Reference Standard
PC001	Payer	N	Text	8	This field contains the NCDMS assigned submitter code for the data submitter. The first two characters of the submitter code indicate Minnesota and the third character designates the type of submitter. MNC Commercial carrier MNG Governmental agency MNT Third Party Administrator MNU Unlicensed entity A single data submitter may have multiple submitter codes because the data submitter is submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first 6 characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	100%	Administrative element.
PC003	Insurance Type/ Product Code	N	Text	6	This field contains the insurance type or product code that indicates the type of insurance coverage the individual has. 12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month Coordination Period with an Employer's Group Health Plan 14 Medicare Secondary, No-fault Insurance Including Auto is Primary 15 Medicare Secondary Worker's Compensation 16 Medicare Secondary Public Health Service or Other Federal Agency 41 Medicare Secondary Black Lung 42 Medicare Secondary Veteran's Administration 43 Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health 47 Medicare Secondary, Other Liability Insurance is Primary	0%	Administrative element.

Element Number	Element Name	Encrypt	Type	Max Len	Description	Threshold	Reference Standard
					CP Medicare Conditionally Primary D Disability DB Disability Benefits EP Exclusive Provider Organization HM Health Maintenance Organization (HMO) HN Health Maintenance Organization (HMO) Medicare Risk HS Special Low Income Medicare Beneficiary IN Indemnity MA Medicare Part A MB Medicare Part B MC Medical Assistance (must include sub-code) FFSM Fee-for-service Medical Assistance PMAP Prepaid Medical Assistance Program MDHO MN Disability Health Options MSHO MN Senior Health Options SNBC Special Needs Basic Care MISC Other managed care program within Medical Assistance MD Medicare Part D MH Medigap Part A MI Medigap Part B MP Medicare Primary PR Preferred Provider Organization (PPO) PS Point of Service (POS) QM Qualified Medicare Beneficiary SP Supplemental Policy XX Non-Medical-Assistance Public Program (must include sub-code) CDEP Chemical Dependency GAMC General Assistance Medical Care HIVA HIV/AIDS MCHA Minnesota Comprehensive Health Association MNCR MinnesotaCare MISC Other non-Medical Assitance public program		

Element Number	Element Name	Encrypt	Type	Max Len	Description	Threshold	Reference Standard
PC004	Payer Claim Control Number	N	Text	35	This field contains the claim number used by the data submitter to internally track the claim. In general the claim number is associated with all service lines of the bill. It must apply to the entire claim and be unique within the data submitter's system.	99.9%	Administrative element
PC005	Line Counter	N	Integer	4	This field contains the line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim. This field is used in algorithms to determine the final payment for the service. If the data submitter's processing system assigns an internal line counter for the adjudication process, that number may be submitted in place of the line number submitted by the provider. This should be discussed with NCDMS staff.	99.5%	Administrative element.
PC008	Plan Specific Contract Number	Y	Text	128	This field contains the data submitter assigned contract number for the subscriber. This field is encrypted using the same algorithm across all data submitters and is not available in the analytical data warehouse. When this field is populated, it forms the core of the unique member identification code. Set as null if unavailable.	99.9%	302-C2
PC011	Individual Relationship Code	N	Integer	2	This field contains the member's relationship to the subscriber or the insured. 01 Covered Individual is Policy holder 02 Spouse 03 Child 04 Other	100%	306-C6
PC012	Member Gender	N	Integer	1	This field contains the gender of the member. 1 Male 2 Female 3 Unknown	100%	305-C5
PC013	Member Date of Birth	Y Trans-formed	Date	8	This field contains the member's date of birth with a format of CCYYMMDD. During the encryption process, this field is used to calculate age as of the date the prescription was filled. The field is then encrypted. This data element will not be transmitted in unencrypted form..	99.5%	304-C4
PC014	Member City Name of Residence	N	Text	30	This field contains the member's city of residence.	90%	323-CN

Element Number	Element Name	Encrypt	Type	Max Len	Description	Threshold	Reference Standard
PC015	Member State or Province	N	Text	2	The member state or province contains the 2 character abbreviation code used by the US Postal Service.	90%	324-CO
PC016	Member ZIP Code	N	Text	5	This field contains ZIP Code of the member.	90%	325-CP
PC017	Date Service Approved (AP Date)	N	Date	8	This field contains the date the record was approved for payment. This is generally referred to as the paid date and reported with a CCYYMMDD format. May submit batch date.	100%	Pricing data
PC018	Pharmacy Number	N	Text	30	Payer assigned pharmacy number. Required if PC021 is not filled.	0%	201-B1
PC020	Pharmacy Name	N	Text	30	This field contains the name of the pharmacy.	99.5%	833-5P
PC021	National Pharmacy ID Number	N	Text	20	The field contains the National Provider Identification (NPI) number and pertains to the entity or individual directly providing the service. Required if PC018 is not filled.	0%	201-B1
PC025	Claim Status	N	Text	2	This field contains the status of the claim as reported by the data submitter. It will be used in the algorithms to determine the final payment for this service. Valid codes are as follows: 1 Processed as primary 2 Processed as secondary 3 Processed as tertiary 4 Denied 19 Processed as primary, forwarded to additional payer(s) 20 Processed as secondary, forwarded to additional payer(s) 21 Processed as tertiary, forwarded to additional payer(s) 22 Reversal of previous payment 25 Predetermination pricing only – no payment	99.5%	Administrative element

Element Number	Element Name	Encrypt	Type	Max Len	Description	Threshold	Reference Standard
PC026	Drug Code	N	Text	11	Each drug product listed under Section 510 of the Federal Food, Drug, and Cosmetic Act is assigned a unique 10-digit, 3-segment number. This number, known as the National Drug Code (NDC), identifies the labeler/vendor, product, and trade package size. The first segment, the labeler code, is assigned by the FDA. A labeler is any firm that manufactures, re-packs or distributes a drug product. The second segment, the product code, identifies a specific strength, dosage form, and formulation for a particular firm. The third segment, the package code, identifies package sizes. Both the product and package codes are assigned by the firm. The NDC will be in one of the following configurations: 4-4-2, 5-3-2, or 5-4-1.	99.5%	407-D7
PC027	Drug Name	N	Text	80	This field contains the text name of drug as supplied by the data submitter. *Voluntary – not required*	0%	516-FG
PC028	New Prescription or Refill	N	Integer	2	This field can be used to determine if this is a new prescription. It contains the prescription number. 00 New prescription 01-99 Refill prescription	99.5%	403-D3
PC029	Generic Drug Indicator	N	Text	1	This field indicates whether the drug is a branded drug or a generic drug. N No, branded drug Y Yes, branded drug *Voluntary – not required*	0%	425-DP
PC030	Dispense as Written Code	N	Integer	1	This field indicates the instructions given to the pharmacist for filling the prescription. For example, a prescription for a brand name drug that also has a generic equivalent may not have the generic equivalent substituted. In this case, the code is 1 – physician requires the script be filled as written. 0 Not dispensed as written 1 Physician dispense as written 2 Member dispense as written 3 Pharmacy dispense as written 4 No generic available 5 Brand dispensed as generic 6 Override 7 Substitution not allowed - brand drug mandated by law	95%	408-D8

Element Number	Element Name	Encrypt	Type	Max Len	Description	Threshold	Reference Standard
					8 Substitution allowed - generic drug not available in marketplace 9 Other		
PC031	Compound Drug Indicator	N	Text	1	This field indicates if this is a compound drug or not. 0 Not specified 1 No Compound 2 Compound	95%	406-D6
PC032	Date Prescription Filled	N	Text	8	This field contains the date the prescription was filled. Data is reported in a CCYYMMDD format.	99.5%	401-D1
PC033	Quantity Dispensed	N	Integer	5	This field contains the total unit dosage in metric units. This field may be negative.	85%	404-D4
PC034	Days Supply	N	Integer	3	This field contains the actual days supply for the prescription based on the metric quantity dispensed. This field may contain a negative value.	95%	405-D5
PC035	Gross Amount Due	N	Decimal	10	This field contains the total charges for the service as reported by the provider. This is a money field containing dollars and cents with an implied decimal point and may contain a negative value. 0$ is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999.	95%	430-DU
PC036	Total Amount Paid	N	Decimal	10	This field includes all health plan payments and excludes all member payments. This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. 0$ is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999.	99%	509-F9

Element Number	Element Name	Encrypt	Type	Max Len	Description	Threshold	Reference Standard
PC036A	Other Amount Paid	N	Decimal	10	This field contains the amount paid for additional costs claimed in "Other Amount Claimed Submitted (480-H9)." This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. 0$ is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999.	99%	565-J4
PC036B	Other Payer Amount Recognized	N	Decimal	10	This field contains the total dollar amount of any payment from another source, including coupons. This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. 0$ is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999.	99%	565-J5
PC037	Ingredient Cost/List Price	N	Decimal	10	This field contains the cost of the drug that was dispensed as reported by the data submitter. This is a money field containing dollars and cents with an implied decimal point. 0$ is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999.	99%	506-F6
PC039	Dispensing Fee Paid	N	Decimal	10	This field contains the amount charged for dispensing. This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. 0$ is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999.	99%	507-F7
PC040	Copay / Co-insurance Amount	N	Decimal	10	This field contains the pre-set, fixed dollar amount payable by a member, often on a per script basis. This is a money field containing dollars and cents with an implied decimal point. This field may contain a negative value. 0$ is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999.	99%	518-FI
PC042	Deductible Amount	N	Decimal	10	Do not code decimal point. 0$ is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999.	99%	Pricing data
PC043	Patient Pay Amount	N	Decimal	10	Amount that is calculated by the payer and returned to the pharmacy as the total amount to be paid by the patient to the pharmacy. 0$ is acceptable; code "data not available" as 9999999999. Only 1% of submissions can contain 9999999999.	99%	505-F5

Element Number	Element Name	Encrypt	Type	Max Len	Description	Threshold	Reference Standard
PC044	Prescribing Physician First Name	N	Text	25	This is the first name of the prescribing physician. This will be used to create a master provider index for Minnesota providers encompassing medical service providers, prescribing providers and medical homes. Since there is currently no HIPAA equivalent field for prescribing physician first name, this is a voluntary field.	0%	Administrative element.
PC045	Prescribing Physician Middle Name	N	Text	25	This is the middle name or initial of the prescribing physician. This will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers. Since there is currently no HIPAA equivalent field for prescribing physician middle initial, this is a voluntary field.	0%	Administrative element.
PC046	Prescribing Physician Last Name	N	Text	60	This is the last name of the prescribing physician. This will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers.	99%	427-DR
PC047	Prescribing Physician DEA / Legacy Number	N	Text	9	This field contains either the DEA number, the data submitter's legacy, pre-NPI number, or the Minnesota Health Care Program ID for the prescribing physician. This will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers. Required if PC048 is not filled. D DEA ID number L Legacy ID number M MHCP O Other	0%	411-DB
PC048	Prescribing Physician National Provider Identification Number	N	Text	20	This field contains the National Provider Identification (NPI) number for the prescribing physician. This will be used to create a master provider index for Minnesota providers encompassing both medical service providers and prescribing providers. Required if PC047 is not filled.	0%	411-DB
PC101	Subscriber Last Name	Y	Text	128	Subscriber last name, used to create a unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	100%	313-CD
PC102	Subscriber First Name	Y	Text	128	Subscriber first name, used to create unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	90%	312-CC

Element Number	Element Name	Encrypt	Type	Max Len	Description	Threshold	Reference Standard
PC103	Subscriber Middle Initial	Y	Text	1	Subscriber middle initial, used to create unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	0%	Administrative element.
PC104	Member Last Name	Y	Text	128	Member last name, used to create a unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	100%	311-CB
PC105	Member First Name	Y	Text	128	Member first name, used to create a unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	90%	310-CA
PC106	Member Middle Initial	Y	Text	1	Member middle initial, used to create unique de-identified member ID. It is encrypted at the data submitter's site. This data element will not be available in the data warehouse.	0%	Administrative element.
PC899	Record Type	N	Text	2	This field indicates the type of record. PC Pharmacy Claims This is an administrative field required by NCDMS and populated with a constant value.	100%	Administrative element.

APPENDIX D
SUBMISSION SPECIFICATIONS

I. Overview

The Maine Health Care Information Center (MHIC) has been selected by the commissioner as the private entity to collect and process health care claims data for the Minnesota Health Care Claims Reporting System. The National Claims Data Management System (NCDMS) (www.ncdms.org) is the data aggregation system used by MHIC to securely capture and validate claims and enrollment data. Data submitted on behalf of Minnesota residents by health plan companies and third-party administrators will be stored in a secure state-specific database.

Three data types will be submitted to MHIC's NCDMS data aggregation system:

- Enrollment – one record for each covered member during the eligibility month
- Institutional and professional claims – one record for each paid claim service line
- Pharmacy drug claims – one record for each paid claim service line

Each data file submission will be an ASCII file, variable field length and asterisk delimited. When asterisks are used in any field values, the entire value must be enclosed in double quotes.

With the exception of information regarding health care home, some pricing data and administrative data required by NCDMS, data submitters will be required to submit only enrollment and claims data elements as defined under HIPAA. There are several voluntary items that data submitters are encouraged to populate that are not defined under HIPAA. A number of the data elements included in the recommendations are situational. Situational data elements will not be populated for all records. Institutional, professional and pharmacy drug claims data will be collected on a paid basis.

Encryption software will be used to encrypt Personal Health Identifier (PHI) elements needed to create a de-identified member number before submission. The encryption software will be supplied by MHIC. A detailed description of each required data element appears in Appendices A, B and C.

In addition to content records, a header and trailer record for each submission is required for administrative purposes as described below. The information in the header and trailer records is compared against the content data between the two records to validate the data type, the eligibility or paid dates and the volume of records. The header and trailer information is primarily used in the encryption application and in the initial NCDMS load process.

II. National Claims Data Management System (NCDMS)

NCDMS has three main components – external, internal and tracking. The external portion of NCDMS includes the secure web portal used by the data submitter, by MDH staff and MHIC authorized users. There is also a non-secure portion of the NCDMS site with information that is publicly available. The internal NCDMS runs on an internal server and consists of a series of Oracle stored procedures for editing, processing, managing and storing the data. Tracker is the communication component that gathers information from each step in the process for system administration and determines the movement of the data through NCDMS.

1. External Components

   A. **WEB PORTAL.** The external component appears as a web portal with a secure SSL web upload interface for data submitters to submit and monitor data as well as a backend data management tool for tracking the status of each submission. After preparing the submission using the NCDMS encryption application, zipped files are uploaded through the secure web portal created for Minnesota data submitters. Using the web portal, the user (the data submitter or the MHIC staff person for submissions received via CD or DVD) indicates the type of submission (test, live data, replacement of live data) and the name of the file being submitted. Each uploaded submission is immediately acknowledged by NCDMS and the user is allowed to upload another file, check the status of submissions or log off.

   B. **ENCRYPTION SOFTWARE.** MHIC has developed a stand-alone one way data element encryption software that is run on the data submitter's desktop before data is submitted to NCDMS. The encryption algorithm is a one way hashing algorithm using the industry's highest standard protocol, currently SHA-512. SHA-512 is the computer security standard approved by the U.S. Department of Commerce, National Institute of Standards and Technology (NIST), Information Technology Laboratory (ITL). It is one of four secure hash algorithms described in the Federal Information Processing Standards (FIPS) Publication 180-2, Secure Hash Standard. The algorithms are distinguished by the length of the field to be encrypted. The four SHA algorithms specified in this standard are called secure because, for a given algorithm, it is computationally infeasible to break the encrypted message or alter the encrypted message.

   Providing encryption software that is run by every data submitter ensures that all patient identifiers are encrypted consistently across data submitters and eliminates the possibility that direct patient identifiers are submitted. Since the encryption is done at the data submitter's site, the data submitter can easily verify that the personal health identifiers passed through the encryption software.

2. Internal Components.

   A. **PRELIM.** The external component assigns a permanent unique file id that is used to track the stage and status of the submission as well as basic information regarding when it was submitted, the type of data, the submitter, the volume of records and the time span covered. During this PRELIM phase, the submission is unzipped and standard file level checking on the text file is performed. This includes validating date ranges, validating the submitter code, comparing the actual record count against the header record, and comparing the records against the file type indicated in the header. The PRELIM process will pass, fail or flag a submission for review. The process will fail a submission at the first occurrence of any PRELIM error and automatically email the data submitter that a failure has occurred, the reason for the failure, the record containing the failure and a request for resubmission. Any file that has not been run through the encryption tool prior to submission will be failed by PRELIM.

B. **LOAD.** In the LOAD phase the text file is loaded into Oracle and a text based Oracle view of the file is created. This step is necessary to accommodate data that fails to load due to incompatibility with the data type (e.g. alpha data in a numeric field). The LOAD process verifies the existence of critical data elements at a high level; all thresholds are evaluated. In the event a submission fails one or more LOAD conditions, the data submitter is emailed the list of failures and requires a resubmission.

C. **FREQUENCY REPORTS**: A frequency count is created for every data element to evaluate the percent of records with a null entry, a valid entry or an invalid entry. The completeness percent, based upon records with a valid entry, is evaluated against the state approved threshold of tolerance for that data element. Any submission with one or more data elements failing the threshold test will be rejected. An email to the data submitter containing a brief message indicating failure and a link to the web report for the entire submission will be automatically generated and sent by NCDMS. The statewide threshold is parameter driven and can be changed through NCDMS web pages available to the data managers. In the event that a payer cannot meet the statewide threshold for one or more data elements, the state may authorize a lower completeness threshold for a specified period of time. That payer's data will be evaluated against the lower threshold for the allotted time span.

D. **DATA QUALITY.** The Data Quality module includes data verification checks to evaluate the validity and distribution of the individual data elements and to cross check the appropriateness of values in conjunction with other data contained in the same record. There are over 100 eligibility checks, 300 medical checks and 200 pharmacy checks. The Data Quality checks include cross checking data against national coding systems including, but not limited to, ICD-9 diagnoses, ICD-9 procedures, CPT and HCPC procedures, and NDC codes. The DQ module also performs data quality checks to assess the inter-relationship of individual data elements and evaluate rates against parameter driven thresholds. For example, in institutional and professional claims "M" is a valid gender code for males. A submission with 100% of the records coded as "M" will pass LOAD but will fail the data quality check that flags a submission with less than 20% of the records or more than 80% of the records coded as male. A submission passing all data quality threshold checks is marked as DQ/PASS and an email is automatically sent to the data submitter indicating the submission is successful. Data submitters are notified a submission is at DQ/REVIEW if it has failed one or more data quality thresholds and the data quality report is flagged for manual review..

3. Tracking System

A. **DQ/REVIEW.** DQ/REVIEW submissions are manually reviewed within 3 business days. Hands-on data mining is generally required for problems identified in these submissions. MHIC's intake specialists send a detailed email to the data submitter regarding the problem and what research indicates may be causing the problem. The submission status is then set to DQ/FAIL. This initial email is often followed by conference calls to discuss data submitter system issues and limitations, rule clarification, or other contributing factors. MHIC's information systems staff is a major participant in researching data problems, discussing options with the data submitter and implementing customized system changes. These discussions may require MHIC to

make corrections to the submitted data and the data submitter to make changes in subsequent submissions or it may require the data submitter to resubmit the data.

B. **SUBMISSION STATUS TOOLS.** The current status of each submission is maintained in an Oracle table that is viewable to the data submitter from the data submitter's web portal and from the MHIC's staff screens. The data submitter may click on the "Report" button to see the detailed results. The frequency and data quality reports are accessible online to the data submitters as well. Through NCDMS, the commissioner's staff may monitor the submission and editing process for NCDMS in general, as well as for any individual payer. This includes the ability to identify overdue submissions by data type and time period. The commissioner's staff will have direct access to all reports available to data submitters, but will not have access to data submitters' submissions.

C. **AUXILIARY DATA QUALITY EVALUATION TOOLS.** In addition to the processing and verifying of individual submissions, it is necessary to review a submission in the context of all other submissions for that data period. Through NCDMS, MHIC staff has a series of software tools available to look at the Minnesota database in total. These tools are used to identify duplicate submissions, duplicate records, unusual trends in record volume, unusual trends in payments, and data gaps. Because the insurance industry is an active market and there are so many variables to consider, MHIC has found it inappropriate to program automatic responses to many of the data situations uncovered by these reports. It has sometimes been more effective to identify patterns for specific data submitters, make program adjustments for these patterns and continue to monitor the situation on a routine basis. These tools are used by the intake specialists.

D. **RESUBMISSIONS.** NCDMS also allows for the resubmission of the data and has a specific category of replacement data in the upload menu. A data submitter that is replacing accepted data must indicate the type of data and the start and end date for the data before uploading. Data submitted by a data submitter for a data type and time period that has already been accepted will be rejected as duplicate data unless the replacement submission procedures are followed. In those unusual situations where a subset of enrollment or claims records were omitted from the original filing, accommodations can be made with the MHIC staff to arrange for a supplemental submission to fill the gap of the missing data.

4. Summary

PRELIM, LOAD, FREQUENCY REPORTS, and DATA QUALITY are all NCDMS functions that are automatically performed within seconds or hours of the submission, depending upon the file size. DQ/REVIEW is a manual task completed by intake specialists within 3 business days of receipt. Intake specialists are also responsible for manually flagging replaced submissions for system deletion. This flagging occurs as a data warehouse preparation task.

III. Submission Requirements

1. **Registration Form.** All health plan companies and third-party administrators must submit to the data processor a registration form, as prescribed by MHIC, no later than June 15, 2009 and April 1 of each subsequent year certifying the dollar amount of paid institutional and professional health care claims and pharmacy drug claims for covered individuals during the previous calendar year, and including the following information:
    a. Type of submitter (health plan company, third-party administrator or pharmacy benefit manager);
    b. Company information: Name, mailing address;
    c. Estimated number of Minnesota resident lives for 1 month with coverage for institutional and professional health care claims and/or for pharmacy drug claims;
    d. Contact information for individual(s) responsible for submitting data, for compliance activity and general contact: Company, name, title, mailing address, telephone number, fax number, e-mail address;
    e. Description of consolidation process used to transform paid claims into a consolidated data set for incurred services. In order to more accurately calculate health care costs under Subd.2, it would be beneficial for data submitters to explain what claims consolidation method will be required to take the submitted paid claims datasets for a given time period and consolidate them into a detail claim line transaction set that represents the current claim payment status accurately. Typical methods are the use of the version number field, where the highest version number of any detail claim line or claim should be considered the latest payment status, or if all adjustment claim lines are present then a straight rollup method can be used and all quantity and dollar data elements summed.
2. **File Organization.** The data submitter must submit the member enrollment file, institutional and professional claims file and pharmacy drug claims file to the data processor as separate ASCII files. Each record must be terminated with a carriage return (ASCII 13) or a carriage return line feed (ASCII 13, ASCII 10).
3. **Filing Format.** Each data file submission must be an ASCII file, variable field length, and asterisk delimited. When asterisks are used in any field values, they must be enclosed in double quotes.
4. **Header and Trailer Records.** Each member enrollment file and each institutional, professional and pharmacy drug claims 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.

    The first record of each file submission must be a header record with the following contents:

Element #	Element Name	Type	Len	Description
HD001	Record Type	Text	2	HD = Header Record
HD002	Payer	Text	8	Payer Code

Element #	Element Name	Type	Len	Description
HD004	Type of File	Text	2	ME = Enrollment MC = Institutional & Prof'l Claims PC = Pharmacy Drug Claims
HD005	Period Beginning Date	Integer	6	CCYYMM
HD006	Period Ending Date	Integer	6	CCYYMM
HD007	Record Count	Integer	10	Total number of records submitted in the file
HD008	Comments	Text	80	Payer comments

The last record of each file submission must be a trailer record with the following contents:

Element #	Element Name	Type	Len	Description
TR001	Record Type	Text	2	Value TR
TR002	Payer	Text	8	Payer Code
TR004	Type of File	Text	2	ME = Enrollment MC = Institutional & Prof'l Claims PC = Pharmacy Drug Claims
TR005	Period Beginning Date	Integer	6	YYYYMM
TR006	Period Ending Date	Integer	6	YYYYMM
TR007	Date Processed	Date	8	CCYYMMDD; Date file was created

5. **Filing Media.** Data files may be submitted utilizing any of the following media: CD-ROM (650 MB), DVD, secure SSL web upload interface, or electronic transmission through a File Transfer Program. E-mail attachments will not be accepted. Space permitting, multiple data files may be submitted utilizing the same media. If this is the case, the external label must identify the multiple files.
6. **Transmittal Sheet.** All data file submissions on physical media must be accompanied by a hard copy transmittal sheet containing the following information: identification of the data submitter, file name, type of file, data period(s), date sent, record count(s) for the file(s), and a contact person with telephone number and e-mail address. The information on the transmittal sheet must match the information on the header and trailer records.
7. **Run-Out Period.** Data submitters must submit institutional and professional health care claims and pharmacy drug claims for a minimum of a six month period following the termination of coverage date for a member.

IV. NCDMS Setup and Testing

1. Register the Company via the web at www.ncdms.org, or
   Fax the form to (207) 622-7086, Attn: Data Manager, or
   Mail to: Data Manager
   Maine Health Information Center
   16 Association Drive
   P.O. Box 360
   Manchester, ME 04351
2. Provide Local/Homegrown CPT Codes with descriptions in Excel format
   a. Email to mninfo@ncdms.org
3. Provide Provider Specialty Codes in Excel format
   a. Email to mninfo@ncdms.org
4. Provide Local/Homegrown Diagnosis Codes with descriptions in Excel format
   a. Email to mninfo@ncdms.org
5. Payer registers in the NCDMS system
   a. Go to the web at www.ncdms.org;
   b. Select "Minnesota" in "Choose a State" then select "Register"
   c. Welcome letter is sent to payer which includes:
      1. Login name and password
      2. Submitter code
      3. Instructions on how to download the encryption software and upload their data files.
6. Encrypt data
   a. Go to the web at www.ncdms.org
   b. Select Member Services
   c. Enter logon name and password to NCDMS Secure Menu
   d. Select "Minnesota" in "Choose a State"
   e. Download "Encrypt Software"
   f. Launch Encryption software from desktop
7. Load data via web uploader
   a. Go to the web at www.ncdms.org
   b. Select Member Services
   c. Enter logon name and password to NCDMS Secure Menu
   d. Select "Minnesota" in "Choose a State"
   e. Select "Select Upload a Data File"

   OR Mail
   a. Go to the web at www.ncdms.org
   b. Select Member Services
   c. Enter logon name and password to NCDMS Secure Menu
   d. Select "Minnesota" in "Choose a State"
   e. Select "Encrypt Software"
   f. Select "Launch Encryption"

g. Copy encrypted Zip file to DVD
Mail to: Data Manager
Maine Health Information Center
16 Association Drive
P.O. Box 360
Manchester, ME 04351

8. View the status of your data submission via the web.
   a. Go to the web at www.ncdms.org
   b. Select Member Services
   c. Enter logon name and password to NCDMS Secure Menu
   d. Select "Minnesota" in "Choose a State"
   b. Select "Reports"

9. Testing Overview

   Testing is required by all data submitters who fall under the Minnesota data submission rule. Test submissions will be flagged by the submitter using the pull down menu on the upload page of the NCDMS web application.

   Initial submission for one month of data includes 2 files: a claim file and the corresponding eligibility file. These submissions then run through the full battery of data evaluation processes and edit checks to determine the quality of the data:

   a. Threshold levels for individual data elements are validated against the Minnesota rule.
   b. Quality edits defined for the file submissions are further applied. For example checks will be applied for average age of dependents. This average value is expected to be between 6 and 18. So while we may have no need to question the age fields in the eligibility file on submission we may reject it if this average age of dependent check is invalid.
   c. The MHIC staff also reviews the data at a variety of levels to look for suspicious trends that the system may not expose.
   d. Passing the system edits moves a submitter to the DQ/Pass status. With possession of additional longitudinal information (multiple file types for a given month and/or multiple months of multiple file types) our staff can review summarized data and determine if a data submitter should be moved to an approved for production status.
   e. Next submission is for 6 months of production data. Once these have been accepted and processed through the system; the MHIC staff runs standard Per Member Per Month paid reports and Healthcare and Pharmacy Profile reports to review overall trends and metrics for comparison to national, regional and industry standards.

   It is important to note that:

   a. Often in the test phase frequent re-submission of files is required.
   b. The system does not automatically move a data submitter from the testing to the production phase.
   c. During testing there is constant and close communication between the MHIC staff and the submitter.
   d. The test phase will likely take two to three months.

V. Detailed File Specifications

1. **Filled Fields.** All fields must be filled where applicable. Non-applicable text and date fields must be set to null. Non-applicable integer and decimal fields must be filled with one zero and must not include decimal points.
2. **Position.** All text fields are to be left justified. All integer and decimal fields are to be right justified.
3. **Signs.** All signs (+ or -) must appear in the left-most position of all integer and decimal fields. Over-punched signed integers or decimals are not to be utilized.
4. **Individual Elements, Statutory Authority, and Mapping.** Individual data elements, data types, field lengths, field description/code assignments, statutory authority, and/or mapping locators (UB-04, CMS 1500, ANSI X12N 270/271, 835, 837) for each file type are set forth in the following appendices:
    a. Enrollment files – Appendix A.
    b. Institutional and professional health care claim files – Appendix B.
    c. Pharmacy drug claim files – Appendix C.
5. **Local Codes.** When a data submitter utilizes a local code system, a reference table must be submitted. This requirement applies to data elements MC032, MC055, MC056, and MC057.

VI. Data Standards

The data processor must evaluate each member enrollment file, institutional and professional health care claim file and pharmacy drug claim file submission according to the following standards:

1. The applicable code for each data element identified in Appendices A, B and C must be included within eligible values, as described by type, length and description, for the element.
2. Coding values indicating "data not available," "data unknown," or the equivalent must not be used for individual data elements unless specified as an eligible value for the element.
3. Member sex, diagnosis and procedure codes, and date of birth and all other date fields must be consistent within an individual record.
4. Encrypted member identifiers must be consistent across files.

VII. Code Sources (with references to specific data elements by file type)

The following list identifies the organizations responsible for the development of standardized codes used in this document. For inquiries about specific codes or the processes of standardization, please contact the appropriate organization.

Admission Source Code
(Data Element: MC021)

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes explaining who recommended admission to a institutional and professional facility.

Admission Type Code
(Data Element: MC020)

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes explaining the priority of the admission to a institutional and professional facility.

Current Procedural Terminology (CPT) Codes
(Data Element: MC055)

SOURCE: Physicians' Current Procedural Terminology (CPT) Manual

AVAILABLE FROM:
Order Department
American Medical Association
515 North State Street
Chicago, IL 60610

ABSTRACT: A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

Health Care Common Procedural Coding System
(Data Element: MC055)
SOURCE: Health Care Common Procedural Coding System

AVAILABLE FROM:
www.cms.gov/medicare/hcpcs.htm
Centers for Medicare and Medicaid Services
Center for Health Plans and Providers
CCPP/DCPC
C5-08-27
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT: HCPCS is the Centers for Medicare and Medicaid Services (CMS) coding scheme to group procedures performed for payment to providers.

Centers for Medicare and Medicaid Services National Provider Identifier
(Data Elements: MC026, MC077, ME035, PC048)

SOURCE: National Provider System

AVAILABLE FROM:
Centers for Medicare and Medicaid Services
Office of Information Services
Security and Standards Group
Director, Division of Health Care Information Systems
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT: The Centers for Medicare and Medicaid Services is developing the National Provider Identifiers, which is proposed as the standard unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

International Classification of Diseases Clinical Mod (ICD-9-CM) and Procedures
(Minnesota Data Elements: MC040, MC041, MC042, MC043, MC044, MC045, MC046, MC047, MC048, MC049, MC050, MC051, MC052, MC053, MC058, MC058A, MC058B, MC058C, MC058D, MC058E)

SOURCE: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

AVAILABLE FROM:
U.S. National Center for Health Statistics
Commission of Professional and Hospital Activities
1968 Green Road
Ann Arbor, MI 48105

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 operations.

National Association of Boards of Pharmacy Number
(Data Element: PC021)

SOURCE: National Association of Boards of Pharmacy Database and Listings

AVAILABLE FROM:

National Council for Prescription Drug Programs
4201 North 24th Street
Suite 365
Phoenix, AZ 85016

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 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.

National Drug Code
(Data Element: PC026)

SOURCE: Blue Book, Price Alert, National Drug Data File

AVAILABLE FROM:

First Databank, The Hearst Corporation
1111 Bayhill Drive
San Bruno, CA 94066

ABSTRACT: The National Drug Code is a coding convention established by the Food and Drug Administration to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.

National Uniform Billing Committee (NUBC) Codes
(Data Element: MC054)

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:

National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: Revenue codes are a classification of hospital charges in a standard grouping that is controlled by the National Uniform Billing Committee. Place of service codes specify the type of location where a service is provided.

Member Status Code
(Data Element: MC023)

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes indicating Member status as of the date of service-thru field.

States and Outlying Areas of the U.S.
(Data Elements: DC015, DC028, MC015, MC034, ME016, PC015, PC023)

SOURCE: National Zip Code and Post Office Directory

AVAILABLE FROM:
U.S. Postal Service
National Information Data Center
P.O. Box 2977
Washington, DC 20013

ABSTRACT: Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The entities listed are considered to be the first order divisions of the U.S. Microfiche AVAILABLE FROM: NTIS (same as address above).

The Canadian Post Office lists the following as "official" codes for Canadian Provinces:

AB - Alberta
BC - British Columbia
MB - Manitoba
NB - New Brunswick
NF - Newfoundland
NS - Nova Scotia
NT - North West Territories
ON - Ontario
PE - Prince Edward Island
PQ - Quebec
SK - Saskatchewan
YT – Yukon

Uniform Billing Claim Form Bill Type
(Data Element: MC036)

SOURCE: National Uniform Billing Data Element Specifications Type of Bill Positions 1 and 2

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes describing the type of medical facility.

X12 Directories

SOURCE: X12.3 Data Element Dictionary

X12.22 Segment Directory

AVAILABLE FROM:
Data Interchange Standards Association, Inc. (DISA)
Suite 200
1800 Diagonal Road
Alexandria, VA 22314-2852

ABSTRACT: The data element dictionary contains the format and descriptions of data elements used to construct X12 segments. It also contains code lists associated with these data elements. The segment directory contains the format and definitions of the data segments used to construct X12 transaction sets.

ZIP Code
(Data Elements: MC016, MC035, ME017, PC016, PC024)

SOURCE: National ZIP Code and Post Office Directory, Publication 65
The USPS Domestic Mail Manual

AVAILABLE FROM:
U.S Postal Service
Washington, DC 20260

New Orders
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

ABSTRACT: 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 nine 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.

The USPS Domestics Mail Manual includes information on the use of the new 11-digit zip code.

MINNESOTA
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Division of Health Policy
Health Economics Program
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