## Appendix A: Eligibility File layout and dictionary

**Note:** All Mandatory Reporters other than CCO's must submit this file.

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error threshold |
|---|---|---|---|---|---|---|
| ME001 | Payer type | Text | 1 | Yes | See lookup table ME001 | 0% |
| ME003 | Product code | Text | 3 | Yes | See lookup table ME003 | 0% |
| ME004A | Eligibility date | Date | 8 | Yes | CCYYMMDD (example: 20100402). Dates before the submission date range are not valid. See Schedule A for submission data range. | 0% |
| ME005A | Termination date | Date | 8 | Yes | CCYYMMDD (example: 20100702). Use 99991231 if termination date is open-ended. | 0% |
| ME007 | Subscriber ID | Text | 30 | Yes | Plan-specific unique identifier for subscriber | 1.2% |
| ME009 | Plan specific contract number | Text | 30 | Yes | Plan-specific contract number (aka group number) | 1.2% |
| ME009A | PEBB flag | Numeric | 1 | Yes | Valid values: 1 (PEBB group), 0 (otherwise) | 0% |
| ME009B | OEBB flag | Numeric | 1 | Yes | Valid values: 1 (OEBB group), 0 (otherwise) | 0% |
| ME009C | Medical home flag | Numeric | 1 | Situational | Valid values: 1 (medical home plan), 0 (otherwise). Not required when ME001 = E | 0% |
| ME010 | Member ID | Text | 30 | Yes | Plan-specific unique identifier for member | 0% |
| ME012 | Relationship code | Numeric | 2 | Yes | See lookup table ME012 | 1.2% |
| ME013 | Member gender | Text | 1 | Yes | Valid values: M (male), F (female), and U (unknown) | 1.2% |
| ME014 | Member date of birth | Date | 8 | Yes | CCYYMMDD (example: 19570402). Do not populate if unavailable. | 1.2% |
| ME015A | Member's street address | Text | 50 | Yes | Member's primary street address. If member's address is missing, then default to subscriber's address. Example: 123 Main Street | 1.2% |
| ME015 | Member city | Text | 30 | Yes | Example: Grants Pass | 1.2% |
| ME016 | Member state | Text | 4 | Yes | Example: OR | 1.2% |
| ME017 | Member ZIP | Text | 10 | Yes | Example: 97209-1234 or 97209 | 1.2% |
| ME018 | Medical coverage flag | Text | 1 | Situational | Y or N. Not required when ME001 = E | 0% |

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error threshold |
|---|---|---|---|---|---|---|
| ME019 | Prescription drug coverage flag | Text | 1 | Situational | Y or N. Not required when ME001 = E | 0% |
| ME101 | Subscriber last name | Text | 35 | Yes | | 1.2% |
| ME102 | Subscriber first name | Text | 25 | Yes | | 1.2% |
| ME103 | Subscriber middle name | Text | 25 | Situational | Populate if available. | N/A |
| ME104 | Member last name | Text | 35 | Yes | | 1.2% |
| ME105 | Member first name | Text | 25 | Yes | | 1.2% |
| ME106 | Member middle name | Text | 25 | Situational | Populate if available. | N/A |
| QC013 | | | | | Do not populate as of 01/01/2018 | N/A |
| QC014 | | | | | Do not populate as of 01/01/2018 | N/A |
| QC015 | | | | | Do not populate as of 01/01/2018 | N/A |
| QC016 | | | | | Do not populate as of 01/01/2018 | N/A |
| QC017 | | | | | Do not populate as of 01/01/2018 | N/A |
| QC018 | | | | | Do not populate as of 01/01/2018 | N/A |
| QC019 | | | | | Do not populate as of 01/01/2018 | N/A |
| QC020 | | | | | Do not populate as of 01/01/2018 | N/A |
| RE1 | Member race | Text | 1 | Yes* | See lookup table RE1 | TBD |
| RE2 | Member ethnicity | Text | 1 | Yes* | See lookup table RE2 | TBD |
| RE3 | Primary spoken language | Text | 3 | Yes* | See lookup table RE3 | TBD |
| OHLC3 | | | | | Do not populate as of 01/01/2017 | N/A |
| OHLC4 | | | | | Do not populate as of 01/01/2017 | N/A |
| OHLC5 | | | | | Do not populate as of 01/01/2017 | N/A |
| OHLC6 | | | | | Do not populate as of 01/01/2017 | N/A |
| OHLC7 | | | | | Do not populate as of 01/01/2017 | N/A |
| ME009D | OMIP flag | Numeric | 1 | Yes | Valid values: 1 (OMIP member), 0 (otherwise) | 1.2% |
| ME009E | HKC flag | Numeric | 1 | Yes | Valid values: 1 (Healthy Kids Connect plan), 0 (otherwise) | 1.2% |

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error threshold |
|---|---|---|---|---|---|---|
| ME201 | Medicare coverage flag | Text | 2 | Situational | Type of Medicare coverage. Valid values: A (Part A), B (Part B), AB (Parts A and B), C (Part C only), D (Part D only), CD (Part C and Part D), X (other), Z (none). Not required when ME001 = E | 1.2% |
| ME202 | Market Segment | Text | 2 | Yes | See lookup table ME202 | 0% |
| ME203 | Metal Tier | Text | 1 | Situational | Health benefit plan metal tier for qualified health plans (QHPs) and catastrophic plans as defined in the Patient Protection and Affordable Care Act, Public Law 111-148, Section 1302: Essential Health Benefits Requirements. Valid values: 0 (Not a QHP or catastrophic plan), 1 (Catastrophic), 2 (Bronze), 3 (Silver), 4 (Gold), 5 (Platinum). Not required when ME001 = E | 0% |
| ME204 | HIOS Plan ID | Text | 14 | Situational | Health Insurance Oversight System ID. Required for qualified health plans (QHPs) as defined in the Patient Protection and Affordable Care Act (ACA). If plan is not a QHP under the ACA, enter 99999999999999.Not required when ME001 = E | 0% |
| ME205 | High Deductible Health Plan Flag | Text | 1 | Yes | Valid values: Y (policy meets IRS definition of HDHP), N (policy does not meet IRS definition of HDHP) | 1.2% |
| ME206 | Primary Insurance Indicator | Text | 1 | Yes | Valid Values: Y (primary insurance), N (secondary or tertiary insurance). If unknown, default to Y. | 0% |
| ME207 | Dental Coverage flag | Text | 1 | Yes | Valid values: Y (member had dental coverage in this period), N (member did not have dental coverage in this period). | 1.2% |
| ME208 | | | | | For future implementation | N/A |
| ME209 | | | | | For future implementation | N/A |
| ME210 | | | | | For future implementation | N/A |

*** - Implementation date TBD**

**Lookup Table ME001: Payer Type**
This field contains a single letter identifying the payer type.

| Code | Value |
|---|---|
| C | Carrier |
| D | Medicaid |
| G | Other government agency |
| P | Pharmacy benefits manager |
| T | Third party administrator |
| U | Unlicensed entity |
| E | Dental |

**Lookup Table ME003: Product Code**
This field contains the insurance type or product code that indicates the type of insurance coverage the individual has.

| Code | Value |
|---|---|
| MDE | Medicaid dual eligible HMO |
| MD | Medicaid disabled HMO |
| MLI | Medicaid low income HMO |
| MRB | Medicaid restricted benefit HMO |
| MR | Medicare Advantage HMO |
| MP | Medicare Advantage PPO |
| MPD | Medicare Part D only* |
| MC | Medicare Cost |
| PPO | Commercial PPO |
| POS | Commercial POS |
| HMO | Commercial HMO |
| SN1 | Special needs plan – chronic condition |
| SN2 | Special needs plan – institutionalized |
| SN3 | Special needs plan – dual eligible |
| CHP | Special Children's Health Insurance program (SCHIP) |
| MDF | Medicaid fee-for-service |
| SIP | Self insured PPO |
| SIF | Self insured POS |
| SIH | Self insured HMO |
| PH | Pharmacy benefits only* |
| IN | Commercial indemnity |
| EPO | Commercial EPO |
| SL | Commercial stop loss |
| DPPO | Dental PPO |
| DPOS | Dental POS |
| DHMO | Dental HMO |
| DSIP | Dental self insured PPO |
| DSIF | Dental self insured POS |
| DSIH | Dental self insured HMO |

- Please note that codes "PH" and "MPD" must be used in conjunction with the appropriate lines of business. "PH" should be used for Commercial lines of business only, while MPD should be used for Medicare membership only.

**Lookup Table ME012: Relationship code**
This field contains the member's relationship to the subscriber or the insured.

| Code | Value |
|---|---|
| 1 | Spouse |
| 4 | Grandfather or Grandmother |
| 5 | Grandson or Granddaughter |
| 7 | Nephew or Niece |
| 10 | Foster Child |
| 15 | Ward |
| 17 | Stepson or Stepdaughter |
| 18 | Self |
| 19 | Child |
| 20 | Employee |
| 21 | Unknown |
| 22 | Handicapped Dependent |
| 23 | Sponsored Dependent |
| 24 | Dependent of a Minor Dependent |
| 29 | Significant Other |
| 32 | Mother |
| 33 | Father |
| 36 | Emancipated Minor |
| 39 | Organ Donor |
| 40 | Cadaver Donor |
| 41 | Injured Plaintiff |
| 43 | Child Where Insured Has No Financial Responsibility |
| 53 | Life Partner |

**Lookup Table RE1**
This field contains a single letter identifying the member's race.

| Code | Value |
|---|---|
| A | Asian |
| B | Black or African American |
| I | American Indian or Alaska Native |
| P | Native Hawaiian or Pacific Islander |
| W | White |
| O | Other (or multiple races) |
| R | Refused |
| U | Unknown |

**Lookup Table RE2**
This field contains a single letter identifying the member's ethnicity.

| Code | Value |
|---|---|
| H | Hispanic |
| O | Not Hispanic |
| R | Refused |
| U | Unknown |

**Lookup Table RE3**
This field contains the ANSI/NISO three-character string identifying the member's primary spoken language. Please refer to most recent version of ANSI/NISO Z39.53 (Codes for the Representation of Languages for Information Interchange); the 2001 version is freely available here:
http://www.niso.org/apps/group_public/download.php/6541/Codes%20for%20the%20Representation%20of%20Languages%20for%20Information%20Interchange.pdf

**Lookup Table ME202**
This field contains an integer indicating the market segment.

| Code | Value |
|---|---|
| 1 | Policies sold and issued directly to individuals (non-group) inside exchange |
| 2 | Policies sold and issued directly to individuals (non-group) outside exchange |
| 3 | Policies sold and issued directly to employers having 50 or fewer employees inside exchange |
| 4 | Policies sold and issued directly to employers having 50 or fewer employees outside exchange |
| 5 | Policies sold and issued directly to employers having 51 to 100 employees inside exchange |
| 6 | Policies sold and issued directly to employers having 51 to 100 employees outside exchange |
| 7 | Policies sold and issued directly to employers having 100 or more employees |
| 8 | Self-funded plans administered by a TPA, or a carrier acting as a TPA, where the employer has purchased stop-loss or group excess insurance coverage |
| 9 | Self-funded plans administered by a TPA, or a carrier acting as a TPA, where the employer has not purchased stop-loss, or group excess insurance coverage |
| 10 | Associations/Trusts and Multiple Employer Welfare Arrangements (MEWAs) |
| 11 | Other |

## Appendix B: Medical Claims file layout and dictionary

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error threshold |
|---|---|---|---|---|---|---|
| MC001 | Payer type | Text | 1 | Yes | See lookup table ME001 (in Eligibility File) | 0% |
| MC003 | Product code | Text | 3 | Yes | See lookup table ME003 (in Eligibility File) | 0% |
| MC004 | Claim ID | Text | 80 | Yes | Payer's unique claim identifier | 0% |
| MC005 | Service line counter | Numeric | 4 | Yes | Increments of 1 for each claim line | 0% |
| MC010 | Member ID | Text | 30 | Yes | Plan-specific unique member identifier | 0% |
| MC017 | Payment date | Date | 8 | Yes | CCYYMMDD (example: 20090624). Blanks allowed for denied claims only. | 0% |
| MC018 | Admission date | Date | 8 | Yes | CCYYMMDD (example: 20090603). Required only for institutional claims. | 1.2% |
| MC023 | Discharge status | Text | 2 | Yes | See lookup table MC023. Required only for institutional claims. | 1.2% |
| MC024 | Rendering provider ID | Text | 30 | Yes | Identifier for the rendering provider as assigned by the reporting entity | 1.2% |
| MC036 | Type of bill | Numeric | 3 | Situational | See lookup table MC 036. Required only for institutional claims. | 1.2% |
| MC037 | Place of service | Text | 2 | Situational | See lookup table MC 037. Required only for professional claims. | 1.2% |
| MC038 | Claim status | Text | 1 | Yes | Was claim paid, denied, CCO encounter, or MCO encounter only? Valid values: P (paid), D (denied), C (CCO encounter), E (other managed care encounter) | 0% |
| MC038A | COB status | Text | 1 | Yes | Was claim a COB claim? Valid values: Y (yes), N (no) | 1.2% |
| MC041 | Principal diagnosis | Text | 8 | Yes | ICD-10 diagnosis code. Include all characters (example: E10.359). | 1.2% |
| MC041P | POA flag 1 | Text | 1 | Yes | Present on admission flag for principal diagnosis. See look-up table MC041P. Required only for inpatient claims. | 1.2% |
| MC042 | Diagnosis 2 | Text | 8 | Yes | ICD-10 diagnosis code. Include all characters (example: E10.359). | 1.2% |
| MC042P | POA flag 2 | Text | 1 | Situational | Present on admission flag for diagnosis 2. Required if MC042 is populated. See look-up table MC041P. Required only for inpatient claims. | 1.2% |

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error threshold |
|---|---|---|---|---|---|---|
| MC043 | Diagnosis 3 | Text | 8 | Yes | ICD-10 diagnosis code. Include all characters (example: E10.359). | 1.2% |
| MC043P | POA flag 3 | Text | 1 | Situational | Present on admission flag for diagnosis 3. Required if MC043 is populated. See look-up table MC041P. Required only for inpatient claims. | 1.2% |
| MC044 | Diagnosis 4 | Text | 8 | Yes | ICD-10 diagnosis code. Include all characters (example: E10.359). | 1.2% |
| MC044P | POA flag 4 | Text | 1 | Situational | Present on admission flag for diagnosis 4. Required if MC044 is populated. See look-up table MC041P. Required only for inpatient claims. | 1.2% |
| MC045 | Diagnosis 5 | Text | 8 | Yes | ICD-10 diagnosis code. Include all characters (example: E10.359). | 1.2% |
| MC045P | POA flag 5 | Text | 1 | Situational | Present on admission flag for diagnosis 5. Required if MC045 is populated. See look-up table MC041P. Required only for inpatient claims. | 1.2% |
| MC046 | Diagnosis 6 | Text | 8 | Yes | ICD-10 diagnosis code. Include all characters (example: E10.359). | 1.2% |
| MC046P | POA flag 6 | Text | 1 | Situational | Present on admission flag for diagnosis 6. Required if MC046 is populated. See look-up table MC041P. Required only for inpatient claims. | 1.2% |
| MC047 | Diagnosis 7 | Text | 8 | Yes | ICD-10 diagnosis code. Include all characters (example: E10.359). | 1.2% |
| MC047P | POA flag 7 | Text | 1 | Situational | Present on admission flag for diagnosis 7. Required if MC047 is populated. See look-up table MC041P. Required only for inpatient claims. | 1.2% |
| MC048 | Diagnosis 8 | Text | 8 | Yes | ICD-10 diagnosis code. Include all characters (example: E10.359). | 1.2% |
| MC048P | POA flag 8 | Text | 1 | Situational | Present on admission flag for diagnosis 8. Required if MC048 is populated. See look-up table MC041P. Required only for inpatient claims. | 1.2% |
| MC049 | Diagnosis 9 | Text | 8 | Yes | ICD-10 diagnosis code. Include all characters (example: E10.359). | 1.2% |
| MC049P | POA flag 9 | Text | 1 | Situational | Present on admission flag for diagnosis 9. Required if MC049 is populated. See look-up table MC041P. Required only for inpatient claims. | 1.2% |
| MC050 | Diagnosis 10 | Text | 8 | Yes | ICD-10 diagnosis code. Include all characters (example: E10.359). | 1.2% |

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error threshold |
|---|---|---|---|---|---|---|
| MC050P | POA flag 10 | Text | 1 | Situational | Present on admission flag for diagnosis 10. Required if MC050 is populated. See look-up table MC041P. Required only for inpatient claims. | 1.2% |
| MC051 | Diagnosis 11 | Text | 8 | Yes | ICD-10 diagnosis code. Include all characters (example: E10.359). | 1.2% |
| MC051P | POA flag 11 | Text | 1 | Situational | Present on admission flag for diagnosis 11 Required if MC051 is populated. See look-up table MC041P. Required only for inpatient claims. | 1.2% |
| MC052 | Diagnosis 12 | Text | 8 | Yes | ICD-10 diagnosis code. Include all characters (example: E10.359). | 1.2% |
| MC052P | POA flag 12 | Text | 1 | Situational | Present on admission flag for diagnosis 12 Required if MC052 is populated. See look-up table MC041P. Required only for inpatient claims. | 1.2% |
| MC053 | Diagnosis 13 | Text | 8 | Yes | ICD-10 diagnosis code. Include all characters (example: E10.359). | 1.2% |
| MC053P | POA flag 13 | Text | 1 | Situational | Present on admission flag for diagnosis 13 Required if MC053 is populated. See look-up table MC041P. Required only for inpatient claims. | 1.2% |
| MC054 | Revenue code | Text | 4 | Yes | Include all digits (example: 0320). Required only for institutional claims. | 1.2% |
| MC055 | CPT/CPT II/HCPCS procedure code | Text | 5 | Yes | CPT, CPT II or HCPCS code. Include all digits (examples: 29870 or G0289) | 1.2% |
| MC056 | Procedure modifier 1 | Text | 2 | Yes | CPT or HCPCS modifier. Include all digits (examples: 50 or AA) | 1.2% |
| MC057 | Procedure modifier 2 | Text | 2 | Yes | CPT or HCPCS modifier. Include all digits (examples: 50 or AA) | 1.2% |
| MC057A | Procedure modifier 3 | Text | 2 | Yes | CPT or HCPCS modifier. Include all digits (examples: 50 or AA) | 1.2% |
| MC057B | Procedure modifier 4 | Text | 2 | Yes | CPT or HCPCS modifier. Include all digits (examples: 50 or AA) | 1.2% |
| MC058 | Principal inpatient procedure code | Text | 8 | Situational | ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims. | 1.2% |
| MC058A | Inpatient procedure code 2 | Text | 8 | Situational | ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims. | 1.2% |

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error threshold |
|---|---|---|---|---|---|---|
| MC058B | Inpatient procedure code 3 | Text | 8 | Situational | ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims. | 1.2% |
| MC058C | Inpatient procedure code 4 | Text | 8 | Situational | ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims. | 1.2% |
| MC058D | Inpatient procedure code 5 | Text | 8 | Situational | ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims. | 1.2% |
| MC058E | Inpatient procedure code 6 | Text | 8 | Situational | ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims. | 1.2% |
| MC058F | Inpatient procedure code 7 | Text | 8 | Situational | ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims. | 1.2% |
| MC058G | Inpatient procedure code 8 | Text | 8 | Situational | ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims. | 1.2% |
| MC058H | Inpatient procedure code 9 | Text | 8 | Situational | ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims. | 1.2% |
| MC058J | Inpatient procedure code 10 | Text | 8 | Situational | ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims. | 1.2% |
| MC058K | Inpatient procedure code 11 | Text | 8 | Situational | ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims. | 1.2% |
| MC058L | Inpatient procedure code 12 | Text | 8 | Situational | ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims. | 1.2% |
| MC058M | Inpatient procedure code 13 | Text | 8 | Situational | ICD-10 procedure code. Include all characters, (example: B245ZZ3). Required only if populated on institutional claims. | 1.2% |
| MC059 | Date of service – From | Date | 8 | Yes | CCYYMMDD (example: 20090603) | 0% |
| MC060 | Date of service – Thru | Date | 8 | Yes | CCYYMMDD (example: 20090603) | 0% |

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error threshold |
|---|---|---|---|---|---|---|
| MC061 | Quantity | Numeric | 11 | Yes | Count of units sent on claim line. | 0% |
| MC062 | Charges | Numeric | 12 | Yes | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| MC062A | Allowed amount | Numeric | 12 | Yes | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| MC063 | Payment | Numeric | 12 | Yes | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| MC064 | Prepaid amount | Numeric | 12 | Yes | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| MC065 | Co-payment | Numeric | 12 | Yes | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| MC066 | Co-insurance | Numeric | 12 | Yes | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| MC067 | Deductible | Numeric | 12 | Yes | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| MC067A | Patient pay amount | Numeric | 12 | Situational | Required if any of MC065, MC066, or MC067 are missing. Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| MC070 | Discharge date | Date | 8 | Situational | Required only for institutional claims. Use 99991231 if patient has not discharged. CCYYMMDD (example: 20090605). Required only for institutional claims. | 1.2% |
| MC076 | Billing provider ID | Text | 30 | Yes | Identifier for the billing provider as assigned by the reporting entity | 1.2% |
| QC05 | | | | | Do not populate as of 01/01/2018 | N/A |
| QC06 | | | | | Do not populate as of 01/01/2018 | N/A |
| QC22 | | | | | Do not populate as of 01/01/2018 | N/A |
| QC23 | | | | | Do not populate as of 01/01/2018 | N/A |
| QC37 | | | | | Do not populate as of 01/01/2017 | N/A |
| QC38 | | | | | Do not populate as of 01/01/2017 | N/A |
| QC39 | | | | | Do not populate as of 01/01/2017 | N/A |
| OHLC1 | | | | | Do not populate as of 01/01/2017 | N/A |
| OHLC2 | | | | | Do not populate as of 01/01/2017 | N/A |

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error threshold |
|---|---|---|---|---|---|---|
| MC008 | Plan specific contract number | Text | 30 | Yes | Plan specific contract number (aka group number) | 0% |
| MC201 | ICD version code | Text | 2 | Yes | Specifies the claim's ICD version. Valid values: 9 (ICD-9) or 10 (ICD-10) | 0% |
| MC202 | Network | Text | 1 | Yes | See lookup table MC202 | 0% |
| MC203 | Admission Type | Text | 1 | Situational | Required for inpatient claims. Populate this field only if claim is inpatient. Valid values: 1 (Emergency), 2 (Urgent), 3 (Elective), 4 (Newborn), 5 (Trauma Center), 9 (Information Not Available) | 1.2% |
| MC204 | Admission Source | Text | 1 | Situational | Required for inpatient claims. Populate this field only if claim is inpatient. See lookup table MC204 | 1.2% |
| MC205 | Admitting Diagnosis | Text | 8 | Situational | Required for inpatient claims. ICD-10 diagnosis code for dates of service beginning 10/01/2015. Include all characters (example: E10.359). ICD-9 diagnosis code for dates of service before 10/01/2015. If ICD-9 include all digits and exclude decimal point (example: 01220). Required only for inpatient claims. | 1.2% |
| MC206 | Pay to Patient Flag | Text | 1 | Yes | Valid values: Y (patient was directly reimbursed), N (patient was not directly reimbursed). If unknown, default to N. | 0% |
| MC207 | Empty field | | | | For future implementation | N/A |
| MC208 | Empty field | | | | For future implementation | N/A |
| MC209 | Empty field | | | | For future implementation | N/A |
| MC210 | Empty field | | | | For future implementation | N/A |

**Lookup Table MC023: Discharge status**
This field contains the status for the patient discharged from the hospital.

| Code | Value |
|---|---|
| 01 | Discharged to home or self care |
| 02 | Discharged/transferred to another short term general hospital for inpatient care |
| 03 | Discharged/transferred to skilled nursing facility (SNF) |
| 04 | Discharged/transferred to nursing facility (NF) |
| 05 | Discharged/transferred to a designated cancer center or children's hospital |
| 06 | Discharged/transferred to home under care of organized home health service organization |
| 07 | Left against medical advice or discontinued care |
| 08 | Discharged/transferred to home under care of a Home IV provider |
| 09 | Admitted as an inpatient to this hospital |
| 20 | Expired |
| 21 | Discharged/transferred to court/law enforcement |
| 30 | Still patient or expected to return for outpatient services |
| 40 | Expired at home |
| 41 | Expired in a medical facility |
| 42 | Expired, place unknown |
| 43 | Discharged/transferred to a Federal hospital |
| 50 | Hospice – home |
| 51 | Hospice – medical facility |
| 61 | Discharged/transferred within this institution to a hospital based Medicare-approved swing bed |
| 62 | Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital |
| 63 | Discharge/transferred to a long-term care hospital |
| 64 | Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare |
| 65 | Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital |
| 66 | Discharged/transferred to a critical access hospital (CAH) |
| 70 | Discharged/transferred to another type of health care institution not defined elsewhere in this code list |

**Lookup Table MC036: Type of bill**

This field is required for institutional claims and must not be populated for professional claims. The values of the second digit are situational depending on the value of the first digit.

First digit: type of facility

| Code | Value |
|---|---|
| 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 |

Second Digit if First Digit = 1-6

| Code | Value |
|---|---|
| 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 |

Second Digit if First Digit =7

| Code | Value |
|---|---|
| 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 | Nursing Facility Level II |
| 7 | Community Mental Health Center |
| 9 | Other |

Second Digit if First Digit = 8

| Code | Value |
|---|---|
| 1 | Hospice (Non Hospital Based) |
| 2 | Hospice (Hospital-Based) |
| 3 | Ambulatory Surgery Center |
| 4 | Free Standing Birthing Center |
| 9 | Other |

Third digit: claim frequency

| Code | Value |
|---|---|
| 1 | Admit Through Discharge |
| 2 | Interim-First Claim |
| 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 Health Encounter |

**Lookup Table MC037: Site of service**
For professional claims, this field records the type of facility where the service was performed. This field should not be populated for institutional claims.

| Code | Value |
|---|---|
| 00 | Not supplied |
| 01 | Pharmacy |
| 03 | School |
| 04 | Homeless Shelter |
| 05 | Indian Health Service Freestanding Facility |
| 06 | Indian Health Service Provider-Based Facility |
| 07 | Tribal 638 Freestanding Facility |
| 08 | Tribal 638 Provider-Based Facility |
| 09 | Prison/Correctional Facility |
| 11 | Office |
| 12 | Home |
| 13 | Assisted Living Facility |
| 14 | Group Home |
| 15 | Mobile Unit |
| 16 | Temporary Lodging |
| 17 | Walk-in Retail Health Clinic |
| 20 | Urgent Care Facility |
| 21 | Inpatient Hospital |
| 22 | Outpatient Hospital |
| 23 | Emergency Room – Hospital |
| 24 | Ambulatory Surgical Center |
| 25 | Birthing Center |
| 26 | Military Treatment Facility |
| 31 | Skilled Nursing Facility |
| 32 | Nursing Facility |
| 33 | Custodial Care Facility |
| 34 | Hospice |
| 41 | Ambulance-Land |
| 42 | Ambulance-Air or Water |
| 49 | Independent Clinic |
| 50 | Federally Qualified Health 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 |
| 57 | Non-residential Substance Abuse Treatment Facility |
| 60 | Mass Immunization Center |
| 61 | Comprehensive Inpatient Rehabilitation Facility |

| Code | Value |
|---|---|
| 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 Place of Service |

**Lookup Table MC041P: POA flag**

This field contains the inpatient present on admission (POA) flag as reported by the provider. Do not populate if not reported by the provider.

| Code | Value |
|---|---|
| Y | Yes |
| N | No |
| W | Clinically undetermined |
| U | Information not in record |
| 1 | Diagnosis exempt from POA reporting |

**Lookup Table MC202: Network**

This field contains a single digit indicating whether the provider was paid under a network contract.

| Code | Value |
|---|---|
| 1 | In-network: The plan has a direct contract with the provider that made the claim. |
| 2 | National network: The plan does not have a direct contract with the provider that made the claim, but paid a contracted rate through participation in a national network or reciprocal agreement with a plan operating in another state. |
| 3 | Out-of-network: The plan did not pay the provider a contracted rate. |

**Lookup Table MC204: Admission Source**

This field contains a single character indicating source of referral for an inpatient admission. Populate this field only for institutional inpatient claims. Do not populate this field for professional claims. Use codes on the next page if MC203 = 4.

| Code | Value if MC203 <> 4 |
|---|---|
| 0 | ANOMALY: invalid value, if present, translate to '9' |
| 1 | Non-Health Care Facility Point of Origin (Physician Referral): The patient was admitted to this facility upon an order of a physician. |
| 2 | Clinic referral: The patient was admitted upon the recommendation of this facility's clinic physician. |
| 3 | HMO referral: Reserved for National Assignment. Prior to 3/08, HMO referral: The patient was admitted upon the recommendation of a health maintenance organization (HMO) physician. |
| 4 | Transfer from a hospital (different facility): The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient. |
| 5 | Transfer from a skilled nursing facility (SNF) or Intermediate Care Facility (ICF): The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident. |
| 6 | Transfer from another health care facility: The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list where he or she was an inpatient. |
| 7 | Emergency room: The patient was admitted to this facility after receiving services in this facility's emergency room. |
| 8 | Court/law enforcement: The patient was admitted upon the direction of a court of law or upon the request of a law enforcement agency's representative. |
| 9 | Information not available: The means by which the patient was admitted is not known. |
| A | Reserved for National Assignment. (eff. 3/08) Prior to 3/08 defined as: Transfer from a Critical Access Hospital: patient was admitted/referred to this facility as a transfer from a Critical Access Hospital. |
| B | Transfer from Another Home Health Agency: The patient was admitted to this home health agency as a transfer from another home health agency.(Discontinued July 1,2010- See Condition Code 47) |
| C | Readmission to Same Home Health Agency: The patient was readmitted to this home health agency within the same home health episode period. (Discontinued July 1,2010) |
| D | Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer: The patient was admitted to this facility as a transfer from hospital inpatient within this facility resulting in a separate claim to the payer. |
| E | Transfer from Ambulatory Surgical Center |
| F | Transfer from hospice and is under a hospice plan of care or enrolled in hospice program |

| Code | Value if MC203 = 4 |
|---|---|
| 1 | Normal delivery - A baby delivered without complications. ***Invalid for discharges after 12/31/2011.*** |
| 2 | Premature delivery - A baby delivered with time and/or weight factors qualifying it for premature status. ***Invalid for discharges after 12/31/2011.*** |
| 3 | Sick baby - A baby delivered with medical complications, other than those relating to premature status. ***Invalid for discharges after 12/31/2011.*** |
| 4 | Extramural birth - A baby delivered in a non-sterile environment. ***Invalid for discharges after 12/31/2011.*** |
| 5 | Born inside this hospital. |
| 6 | Born outside this hospital. |
| 7 - 8 | Reserved for national assignment. |
| 9 | Information not available. |

## Appendix C: Pharmacy Claims file layout and dictionary

**Note:** this layout intends to maintain consistency with Version 1.0 of the NCPDP Uniform Healthcare Payer Data Implementation Guide.

| Data element | Name | Max. Length | Type | Required? | NCPDP Field | NCPDP Source | Description | Error threshold |
|---|---|---|---|---|---|---|---|---|
| PC001 | Payer type | 1 | Text | Yes | N/A | N/A | See lookup table ME001 (in Eligibility file) | 0% |
| PC008 | Plan-specific contract number | 30 | Text | Yes | 246 | P | Plan-specific contract number (aka group number) | 1.2% |
| PC010 | Patient ID | 30 | Text | Yes | 332-CY | P | Unique identifier for member | 0% |
| PC003 | Insurance type/ product code | 3 | Text | Yes | New | P | See lookup table ME003 (in Eligibility File) | 1.2% |
| PC021 | Pharmacy NPI | 15 | Text | Yes | 201-B1 | C/P | The pharmacy's National Provider Identifier (NPI) | 1.2% |
| PC021A | Pharmacy alternate identifier | 15 | Text | Situational | 201-B1 | P | The pharmacy's alternate identifier as assigned by the payer; required if NPI is not available | N/A |
| PC020 | Pharmacy Name | 35 | Text | Yes | 833-5P | P | | 1.2% |
| PC022 | Pharmacy city | 30 | Text | Yes | 728 | P | | 1.2% |
| PC023 | Pharmacy state | 2 | Text | Yes | 729 | P | | 1.2% |
| PC024 | Pharmacy ZIP | 15 | Text | Yes | 730 | P | | 1.2% |
| PC048 | Prescribing provider NPI | 15 | Text | Yes | 411-DB | C | Identifier for the provider who prescribed the medication as assigned by the reporting entity | 1.2% |
| PC047 | | | | | | | Do not populate as of 01/01/2018 | N/A |
| PC025 | Claim status | 3 | Text | Yes | 399 | P | Was claim paid, denied, CCO, or encounter only? Valid values: P (paid), D (denied), C (CCO encounter), E (other managed care encounter) | 0% |
| PC026 | NDC | 11 | Text | Yes | 407-D7 | C | National Drug Code (NDC) | 1.2% |

| Data element | Name | Max. Length | Type | Required? | NCPDP Field | NCPDP Source | Description | Error threshold |
|---|---|---|---|---|---|---|---|---|
| PC032 | Date filled | 8 | Date | Yes | 401-D1 | C | Date the prescription was filled. CCYYMMDD (example: 20090624) | 0% |
| PC017 | Payment date | 8 | Date | No | 216 | P | CCYYMMDD (example: 20090624). Blanks allowed for denied claims only. | 0% |
| PC033 | Quantity dispensed | 10 | Numeric | Yes | 442-E7 | C | | 1.2% |
| PC028A | Alternate refill number | 2 | Numeric | Situational | 403-D3 | C | Required if PC028 (calculated refill number) is not available | N/A |
| PC034 | Days supply | 4 | Numeric | Yes | 405-D5 | C | Days supply of the prescription | 1.2% |
| PC030 | Dispense as written code | 1 | Text | Yes | 408-D8 | C | See look-up table PC030 | 1.2% |
| PC028 | Calculated refill number | 2 | Numeric | Yes | 254 | P | Processor's calculated refill number. If the processor is not able to calculate, the alternate refill number (PC028A) is to be used. | 1.2% |
| PC031 | Compound drug indicator | 1 | Numeric | Yes | 406-D6 | C | Indicates if this is a compound drug. Valid values: 1 (no), 2 (yes) | 1.2% |
| PC004 | Claim ID | 30 | Text | Yes | 993-A7 | P | Payer's unique claim control number | 0% |
| PC036 | Payment | 12 | Numeric | Yes | 281 | P | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| PC035 | Charges | 12 | Numeric | Yes | 430-DU | P | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| PC037 | Ingredient cost/list price | 12 | Numeric | Yes | 506-F6 | C | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |

| Data element | Name | Max. Length | Type | Required? | NCPDP Field | NCPDP Source | Description | Error threshold |
|---|---|---|---|---|---|---|---|---|
| PC039 | Dispensing fee paid | 12 | Numeric | Yes | 507-F7 | C | Two explicit decimal places.<br>Enter 0 if amount equals zero.<br>Leave blank if missing.<br>Example: 15102.00 | 0% |
| PC040 | Co-pay | 12 | Numeric | Yes | 518-FI | C | Two explicit decimal places.<br>Enter 0 if amount equals zero.<br>Leave blank if missing.<br>Example: 15102.00 | 0% |
| PC041 | Coinsurance | 12 | Numeric | Yes | 572-4U | C | Two explicit decimal places.<br>Enter 0 if amount equals zero.<br>Leave blank if missing.<br>Example: 15102.00 | 0% |
| PC042 | Deductible | 12 | Numeric | Yes | 517-FH | C | Two explicit decimal places.<br>Enter 0 if amount equals zero.<br>Leave blank if missing.<br>Example: 15102.00 | 0% |
| PC043 | Patient pay amount | 12 | Numeric | Situational | 505-F5 | C | Required if any of PC040, PC041, or PC042 are missing.<br>Two explicit decimal places.<br>Enter 0 if amount equals zero.<br>Leave blank if missing.<br>Example: 15102.00 | 0% |
| PC201 | | | | | | | For future implementation | N/A |
| PC202 | | | | | | | For future implementation | N/A |
| PC203 | | | | | | | For future implementation | N/A |
| PC204 | | | | | | | For future implementation | N/A |
| PC205 | | | | | | | For future implementation | N/A |
| PC206 | | | | | | | For future implementation | N/A |
| PC207 | | | | | | | For future implementation | N/A |
| PC208 | | | | | | | For future implementation | N/A |
| PC209 | | | | | | | For future implementation | N/A |
| PC210 | | | | | | | For future implementation | N/A |

**Look-up Table PC-030: Dispense as Written Code**
This field contains the NCPDP Dispense as Written Code.

| Code | Value |
|---|---|
| 0 | No product selection indicated |
| 1 | Substitution not allowed by provider |
| 2 | Substitution allowed- patient requested product dispensed |
| 3 | Substitution allowed- pharmacist selected product dispensed |
| 4 | Substitution allowed- generic drug not in stock |
| 5 | Substitution allowed- brand drug dispensed as generic |
| 6 | Override |
| 7 | Substitution not allowed- brand drug mandated by law |
| 8 | Substitution allowed- generic drug not available in marketplace |
| 9 | Other |

## Appendix D: Dental Claims file layout and dictionary

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error threshold |
|---|---|---|---|---|---|---|
| DC001 | Payer type | Text | 1 | Yes | See lookup table ME001 (in Eligibility File) | 0% |
| DC003 | Insurance Type/ Product code | Text | 3 | Yes | See lookup table ME003 (in Eligibility File) | 0% |
| DC004 | Claim ID | Text | 80 | Yes | Payer's unique claim identifier (i.e. claim control number) used to internally track the claim | 0% |
| DC005 | Service line counter | Numeric | 4 | Yes | Increments of 1 for each claim line | 0% |
| DC008 | Plan specific contract number | Text | 30 | Yes | Plan specific contract number (aka group number) | 0% |
| DC010 | Member ID | Text | 30 | Yes | Plan-specific unique member identifier | 0% |
| DC017 | Payment date | Date | 8 | Yes | CCYYMMDD (example: 20090624). Blanks allowed for denied claims only. | 0% |
| DC024 | Rendering provider ID | Text | 30 | Yes | Identifier for the rendering provider as assigned by the reporting entity | 1.2% |
| DC037 | Place of service | Text | 2 | Situational | See lookup table MC 037. Required only for professional claims. | 1.2% |
| DC038 | Claim status | Text | 1 | Yes | Was claim paid, denied, CCO encounter, or MCO encounter only? Valid values: P (paid), D (denied), C (CCO encounter), E (other managed care encounter) | 0% |
| DC038A | Denial Reason | Text | 5 | Situational | Report the code that defines the reason why the claim was denied. Required when DC038 = D. | 2% |
| DC039 | CDT Code | Text | 5 | Yes | Report the Common Dental Terminology Code for the dental procedure on the claim. CDT codes are maintained by the American Dental Association. | 0% |
| DC039A | Procedure Modifier - 1 | Text | 2 | Yes | Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated CDT code. Blanks allowed. | 0% |
| DC039B | Procedure Modifier - 2 | Text | 2 | Yes | Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated CDT code. Blanks allowed. | 0% |
| DC040 | Dental Quadrant | Text | 2 | Yes | Report the standard quadrant identifier when CDT code indicates procedure on 3 or more consecutive teeth. Up to four dental quadrant fields can be entered. See lookup table DC040. Blanks allowed. | 0% |

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error threshold |
|---|---|---|---|---|---|---|
| DC040A | Dental Quadrant - 2 | Text | 2 | Yes | Report the second standard quadrant identifier, if applicable. See lookup table DC040. Blanks allowed. | 0% |
| DC040B | Dental Quadrant - 3 | Text | 2 | Yes | Report the third standard quadrant identifier, if applicable. See lookup table DC040. Blanks allowed. | 0% |
| DC040C | Dental Quadrant - 4 | Text | 2 | Yes | Report the fourth standard quadrant identifier, if applicable. See lookup table DC040. Blanks allowed. | 0% |
| DC041 | Diagnosis | Text | 8 | Yes | ICD-10 Diagnosis code when applicable. Required when CDT code is within the ranges of D7000-D7999 or D9220-D9221 | 99% |
| DC059 | Date of Service – From | Date | 8 | Yes | CCYYMMDD (example: 20090603) | 0% |
| DC060 | Date of service – Thru | Date | 8 | Yes | CCYYMMDD (example: 20090603) | 0% |
| DC062 | Charges | Numeric | 12 | Yes | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| DC062A | Allowed amount | Numeric | 12 | Yes | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| DC063 | Payment | Numeric | 12 | Yes | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| DC064 | Prepaid amount | Numeric | 12 | Yes | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| DC065 | Co-payment | Numeric | 12 | Yes | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| DC066 | Co-insurance | Numeric | 12 | Yes | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| DC067 | Deductible | Numeric | 12 | Yes | Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| DC067A | Patient pay amount | Numeric | 12 | Situational | Required if any of DC065, DC066, or DC067 are missing. Two explicit decimal places. Enter 0 if amount equals zero. Leave blank if missing. Example: 15102.00 | 0% |
| DC076 | Billing provider ID | Text | 30 | Yes | Identifier for the billing provider as assigned by the reporting entity | 1.2% |
| DC202 | Network | Text | 1 | Yes | See lookup table MC202 (in medical claims file) | 0% |
| DC207 | Tooth Number/Letter (1) | Text | 2 | Situational | Report the tooth identifier. Required when CDT code is within the range of D2000 – D2999. Up to four tooth number/letter fields can be entered. Blanks allowed. | 0% |

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error threshold |
|---|---|---|---|---|---|---|
| DC208 | Tooth 1 – Surface 1 | Numeric | 1 | Situational | Report the tooth surface on which the service was performed. See lookup table DC208. Required when DC207 is populated and CDT code is within the range of DC2000 – D2709. Up to six tooth surface fields can be entered for each tooth number/letter. | 0% |
| DC208A | Tooth 1 – Surface 2 | Numeric | 1 | Situational | See comment under DC208. Blanks allowed. | 0% |
| DC208B | Tooth 1 – Surface 3 | Numeric | 1 | Situational | See comment under DC208. Blanks allowed. | 0% |
| DC208C | Tooth 1 – Surface 4 | Numeric | 1 | Situational | See comment under DC208. Blanks allowed. | 0% |
| DC208D | Tooth 1 – Surface 5 | Numeric | 1 | Situational | See comment under DC208. Blanks allowed. | 0% |
| DC208E | Tooth 1 – Surface 6 | Numeric | 1 | Situational | See comment under DC208. Blanks allowed. | 0% |
| DC209 | Tooth Number/Letter (2) | Text | 2 | Situational | Report the second tooth identifier, if applicable, on which the service was performed. See comment under DC207. Blanks allowed | 0% |
| DC210 | Tooth 2 – Surface 1 | Numeric | 1 | Situational | Report the tooth surface on which the service was performed. See lookup table DC208. Required when DC209 is populated and CDT code is within the range of DC2000 – D2709. Up to six tooth surface fields can be entered for each tooth number/letter. | 0% |
| DC210A | Tooth 2 – Surface 2 | Numeric | 1 | Situational | See comment under DC210. Blanks allowed. | 0% |
| DC210B | Tooth 2 – Surface 3 | Numeric | 1 | Situational | See comment under DC210. Blanks allowed. | 0% |
| DC210C | Tooth 2 – Surface 4 | Numeric | 1 | Situational | See comment under DC210. Blanks allowed. | 0% |
| DC210D | Tooth 2 – Surface 5 | Numeric | 1 | Situational | See comment under DC210. Blanks allowed. | 0% |
| DC210E | Tooth 2 – Surface 6 | Numeric | 1 | Situational | See comment under DC210. Blanks allowed. | 0% |
| DC211 | Tooth Number/Letter (3) | Text | 2 | Situational | Report the third tooth identifier, if applicable, on which the service was performed. See comment under DC207. Blanks allowed | 0% |
| DC212 | Tooth 3 – Surface 1 | Numeric | 1 | Situational | Report the tooth surface on which the service was performed. See lookup table DC208. Required when DC211 is populated and CDT code is within the range of DC2000 – D2709. Up to six tooth surface fields can be entered for each tooth number/letter. | 0% |
| DC212A | Tooth 3 – Surface 2 | Numeric | 1 | Situational | See comment under DC212. Blanks allowed. | 0% |
| DC212B | Tooth 3 – Surface 3 | Numeric | 1 | Situational | See comment under DC212. Blanks allowed. | 0% |
| DC212C | Tooth 3 – Surface 4 | Numeric | 1 | Situational | See comment under DC212. Blanks allowed. | 0% |

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error threshold |
|---|---|---|---|---|---|---|
| DC212D | Tooth 3 – Surface 5 | Numeric | 1 | Situational | See comment under DC212. Blanks allowed. | 0% |
| DC212E | Tooth 3 – Surface 6 | Numeric | 1 | Situational | See comment under DC212. Blanks allowed. | 0% |
| DC213 | Tooth Number/Letter (4) | Text | 2 | Situational | Report the fourth tooth identifier, if applicable, on which the service was performed. See comment under DC207. Blanks allowed | 0% |
| DC214 | Tooth 4 – Surface 1 | Numeric | 1 | Situational | Report the tooth surface on which the service was performed. See lookup table DC208. Required when DC213 is populated and CDT code is within the range of DC2000 – D2709. Up to six tooth surface fields can be entered for each tooth number/letter. | 0% |
| DC214A | Tooth 4 – Surface 2 | Numeric | 1 | Situational | See comment under DC214. Blanks allowed. | 0% |
| DC214B | Tooth 4 – Surface 3 | Numeric | 1 | Situational | See comment under DC214. Blanks allowed. | 0% |
| DC214C | Tooth 4 – Surface 4 | Numeric | 1 | Situational | See comment under DC214. Blanks allowed. | 0% |
| DC214D | Tooth 4 – Surface 5 | Numeric | 1 | Situational | See comment under DC214. Blanks allowed. | 0% |
| DC214E | Tooth 4 – Surface 6 | Numeric | 1 | Situational | See comment under DC214. Blanks allowed. | 0% |
| DC299 | CCO Identifier | Text | 15 | Situational | Populated by Medicaid only. Blank otherwise. | N/A |
| DC300 | | | | | For future implementation | N/A |
| DC301 | | | | | For future implementation | N/A |
| DC302 | | | | | For future implementation | N/A |
| DC303 | | | | | For future implementation | N/A |
| DC304 | | | | | For future implementation | N/A |

**Lookup Table DC040: Dental Quadrant**
This field contains the dental quadrant associated with the dental procedure.

| Code | Value |
|---|---|
| 00 | Entire Oral Cavity |
| 01 | Maxillary arch |
| 02 | Mandibular arch |
| 10 | Maxillary (upper) right |
| 20 | Maxillary (upper) left |
| 30 | Mandibular (lower) left |
| 40 | Mandibular (lower) left |
| UL | Upper left |
| UR | Upper right |
| LL | Lower left |
| LR | Lower right |

**Lookup Table DC208: Tooth Surface**
This field contains the tooth surface associated with the dental procedure.

| Code | Value |
|---|---|
| B | Buccal |
| D | Distal |
| F | Facial |
| I | Incisal |
| L | Lingual/Palatal |
| M | Mesial |
| O | Occlusal |

## Appendix E: Provider File layout and dictionary

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error Threshold |
|---|---|---|---|---|---|---|
| MP003 | Provider ID | Text | 30 | Yes | Identifier for the provider as assigned by the reporting entity | 1.2% |
| MP004 | Provider Tax ID | Text | 9 | Yes | Tax ID of the provider (example: 1234567890) | 1.2% |
| MP006 | Provider first name | Text | 25 | Yes | First name of the provider (example: John); null if provider is an organization entity | 1.2% |
| MP007 | Provider middle initial | Text | 1 | Yes | Middle initial of the provider (example: M); null if provider is an organization entity | 1.2% |
| MP008 | Provider last name | Text | 100 | Yes | Last name of the provider or organization entity name | 1.2% |
| MP010 | Provider specialty | Text | 10 | Yes | See lookup table MP010 | 1.2% |
| MP010A | Provider second specialty | Text | 10 | Situational | Required if available. See lookup table MP010 | 1.2% |
| MP010B | Provider third specialty | Text | 10 | Situational | Required if available. See lookup table MP010 | 1.2% |
| MP011A | Provider street address1 | Text | 50 | Yes | First line of physical address of practice. Example: 123 Main Street | 1.2% |
| MP011B | Provider street address2 | Text | 50 | Situational | Required if available. Second line of physical address of practice. Example: Bldg. A, Suite 100 | 1.2% |
| MP011 | Provider city | Text | 30 | Yes | Physical address of practice. Example: Grants Pass | 1.2% |
| MP012 | Provider state | Text | 2 | Yes | Physical address of practice. Example: OR | 1.2% |
| MP013 | Provider ZIP | Text | 10 | Yes | Physical address of practice. Examples: 97209-1234 or 97209 | 1.2% |
| MP017 | | | | | Do not populate as of 01/01/2018 | N/A |
| MP018 | Provider NPI | Text | 10 | Yes | NPI of the provider (example: 1234567890) | 1.2% |
| MP201 | | | | | For future implementation | N/A |
| MP202 | | | | | For future implementation | N/A |
| MP203 | | | | | For future implementation | N/A |
| MP204 | | | | | For future implementation | N/A |
| MP205 | | | | | For future implementation | N/A |
| MP206 | | | | | For future implementation | N/A |

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error Threshold |
|---|---|---|---|---|---|---|
| MP207 | | | | | For future implementation | N/A |
| MP208 | | | | | For future implementation | N/A |
| MP209 | | | | | For future implementation | N/A |
| MP210 | | | | | For future implementation | N/A |

**Lookup Table MP010: Provider specialty**

Report the HIPAA-compliant health care provider taxonomy code. The reference code set is extensive and is published semi-annually; version 12.0 (updated effective April 1, 2012) is freely available at the National Uniform Claims Committee's web site: http://www.nucc.org/. To access the taxonomy files, point to the Code Sets menu, then point to the Taxonomy menu, and then click on either PDF (if you want a PDF file) or CSV (if you want a comma-delimited text file).

## Appendix F: Subscriber Billed Premium File layout and dictionary

**Note:** All Mandatory reporters other than CCO's are required to file this report for subscribers in fully-insured commercial and Medicare Advantage plans. PBM's that offer stand-alone prescription drug plans are also required to submit this report. Mandatory reporters do not have to file a Form APAC-1 (waiver or exception of reporting requirements), for subscribers in plans which are not required to file this report.

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error threshold |
|---|---|---|---|---|---|---|
| PB001 | Payer type | Text | 1 | Yes | See lookup table MC001 (Appendix A) | 0% |
| PB003 | Product code | Text | 3 | Yes | See lookup table MC003 (Appendix A) | 0% |
| PB202 | Market segment | Text | 2 | Yes | See lookup table ME202 (Appendix B) | 0% |
| PB007 | Subscriber ID | Text | 30 | Yes | Plan-specific unique identifier for subscriber | 0% |
| PB008 | Premium billed month | Date | 6 | Yes | Month in which subscriber and related members had coverage for which subscriber was billed. CCYYMM | 0% |
| PB009 | Covered members in premium billed month | Numeric | 3 | Yes | Number of members with coverage for which subscriber was billed in the premium billed month. | 0% |
| PB010 | Total Premium Billed for Premium Billed Month | Numeric | 12 | Yes | Total premium amount subscriber was billed for coverage in premium billed month. Premium billed to subscriber for premium billed month may differ from premium paid by subscriber in premium billed month if, for example, subscriber pays for more than 1 month of coverage in premium billed month. Report premium billed, not premium paid or another amount. Enter 0 if amount equals zero. Example: 15102.00 | 0% |

## Appendix G: Control Totals

**Note:** The control totals file consists of two separate tab-delimited data files. All Mandatory Reporters other than CCO's must submit this file.

### 1. Claims file control totals layout and dictionary

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error threshold |
|---|---|---|---|---|---|---|
| CFCT1 | Payer | Text | 7 | Yes | Payer abbreviation. See lookup table CFCT1 | 0% |
| CFCT2 | File | Text | 10 | Yes | Valid values: medical, pharmacy, dental, enrollment, provider, and premium | 0% |
| CFCT3 | Data_Rows | Numeric | 8 | Yes | Count of data rows in the submitted file | 0% |
| CFCT4 | Amt_Billed | Numeric | 12 | Yes | Sum of MC062 (medical), PC035 (pharmacy), DC062 (dental), or PB010 (premium). Two explicit decimal places. Do not populate if File is enrollment or provider | 0% |
| CFCT5 | Amt_Paid | Numeric | 12 | Yes | Sum of MC063 (medical), PC036 (pharmacy), or DC063 (dental). Two explicit decimal places. Do not populate if File is enrollment or provider | 0% |

### 2. Claims file control totals example

| Payer | File | Data_Rows | Amt_Billed | Amt_Paid |
|---|---|---|---|---|
| OMIP | Medical | 12345678 | 123456789.12 | 123456789.12 |
| OMIP | Pharmacy | 12345678 | 123456789.12 | 123456789.12 |
| OMIP | Enrollment | 12345678 | | |
| OMIP | Provider | 123456 | | |
| OMIP | Premium | 12345 | 123456789.12 | |
| OMIP | Dental | 12345 | 123456789.12 | 123456789.12 |

### 3. File naming convention is <payer abbreviation>_<submitter abbreviation>_totals_<quarter>_<file created date>.dat

Example: OMIP_OMIP_totals_2015Q2_20150521_010101.dat

## 4. Member months control totals layout and dictionary

| Data element | Name | Type | Max. length | Required? | Description/valid values | Error threshold |
|---|---|---|---|---|---|---|
| MMCT1 | Payer | Text | 7 | Yes | Payer abbreviation. See lookup table CFCT1 | 0% |
| MMCT2 | Method | Text | 1 | No | Placeholder for future compatibility | N/A |
| MMCT3 | Month | Date | 6 | Yes | CCYYMM | 0% |
| MMCT4 | Medical_Members | Numeric | 8 | Yes | Count of members with medical coverage as of first of month. Do not populate if no medical members. | 0% |
| MMCT5 | Pharmacy_Members | Numeric | 8 | Yes | Count of members with pharmacy coverage as of first of month. Do not populate if no pharmacy members. | 0% |
| MMCT6 | Dental_Members | Numeric | 8 | Yes | Count of members with dental coverage as of first of month. Do not populate if no dental members | 0% |

## 5. Member months control totals example

| Payer | Method | Month | Medical_Members | Pharmacy_Members | Dental_Members |
|---|---|---|---|---|---|
| OMIP | | 201001 | 12345678 | 12345678 | 0 |
| OMIP | | 201002 | 12345678 | 12345678 | 0 |
| OMIP | | 201003 | 12345678 | 12345678 | 0 |
| OMIP | | 201004 | 12345678 | 12345678 | 0 |
| OMIP | | 201005 | 12345678 | 12345678 | 0 |
| OMIP | | 201006 | 12345678 | 12345678 | 0 |
| OMIP | | 201007 | 12345678 | 12345678 | 0 |
| OMIP | | 201008 | 12345678 | 12345678 | 0 |
| OMIP | | 201009 | 12345678 | 12345678 | 0 |
| OMIP | | 201010 | 12345678 | 12345678 | 0 |
| OMIP | | 201011 | 12345678 | 12345678 | 0 |
| OMIP | | 201012 | 12345678 | 12345678 | 0 |

## 6. File naming convention is <payer abbreviation>_<submitter abbreviation>_membership_<quarter>_<file created date>.dat

Example: OMIP_OMIP_membership_2015Q2_20150521_010101.dat

## Appendix 1: Payment Arrangement File

**Note:** PBM's that offer stand-alone prescription drug plans are not required to file this report, nor do they have to file a Form APAC-1 (waiver or exception of reporting requirements).

| Data Element | Name | Type | Max. length | Required? | Description/valid values | Error Threshold |
|---|---|---|---|---|---|---|
| PRAPM003 | Contract ID | Text | 30 | Yes | Internal ID of the entity receiving the payment or bearing the risk. Contract ID can be proprietary (i.e. specific to the payer reporting the data) but should be consistent throughout all reporting so that all payments/risk attributed to the same Contract ID can be summed up to capture the total payments/risk attributable to that contract entity by the payer.<br><br>If PRAPM103 = A, then leave this field null<br>If PRAPM103 = V, then leave this field null | 1% |
| PRAPM018 | Billing Provider or Organization NPI | Text | 10 | Yes | NPI for the billing provider or organization which received the payment from the mandatory reporter<br><br>If PRAPM103 = 2Ai, then report the PCPCH Practice ID in this field<br><br>If PRAPM103 = A, then leave this field null<br>If PRAPM103 = V, then leave this field null | 1% |
| PRAPM004 | Billing Provider or Organization Tax ID | Text | 9 | Yes | Federal taxpayer's ID of the billing provider or organization/facility which received the payment from the mandatory reporter. Include leading zeros and do not include dashes. Example: 012345678<br><br>If PRAPM103 = A, then leave this field null<br>If PRAPM103 = V, then leave this field null | 1% |

| Data Element | Name | Type | Max. length | Required? | Description/valid values | Error Threshold |
|---|---|---|---|---|---|---|
| PRAPM008 | Billing Provider Last Name or Organization | Text | 100 | Yes | Last name of the billing provider or the full name of the organization which received the payment from the mandatory reporter<br><br>If PRAPM103 = A, then leave this field null<br>If PRAPM103 = V, then leave this field null | 1% |
| PRAPM006 | Billing Provider First Name | Text | 25 | Situational | First name of the billing provider which received the payment from the mandatory reporter. Leave blank if the provider is an organization or facility.<br><br>If PRAPM103 = A, then leave this field null<br>If PRAPM103 = V, then leave this field null | 1% |
| PRAPM101 | Billing Provider or Organization Entity Type | Numeric | 2 | Yes | Valid Values:1 – Person, 2 – Facility, 3 – Professional Group, 4 – Retail Site, 5 – E-Site, 6 – Financial Parent, 7 – Transportation, 8 – Other<br>See Lookup Table PRAPM101 (Appendix G)<br><br>If PRAPM103 = A, then leave this field null<br>If PRAPM103 = V, then leave this field null | 1% |
| PRAPM102 | Line of Business | Text | 4 | Yes | Indicates insurance line of business. Only report the following lines of business using the codes below:<br><br>COMM = Commercial<br>MADV = Medicare Advantage<br>CCO = Medicaid CCOs<br>PEBB = Public Employees' Benefit Board<br>OEBB = Oregon Educators' Benefit Board | 2% |

| Data Element | Name | Type | Max. length | Required? | Description/valid values | Error Threshold |
|---|---|---|---|---|---|---|
| PRAPM103 | Payment Model | Text | 4 | Yes | Indicates the payment model type that is being reported. See Lookup Table PRAPM103 (Appendix 1)<br><br>If there is more than one payment type with a single Contract ID, then separately report each payment type. Note: All Payment Models are mutually exclusive with respect to payments and payments to the same Contract ID will be summed up to capture the total payments to that contract.<br><br>Valid value “A” and “V” must be reported once for every distinct line of business (PRAPM102) | 1% |
| PRAPM104 | Performance Period Start Date | Date | 8 | Yes | Effective date of performance period for reported Insurance Line of Business and Payment Arrangement Type. CCYYMMDD<br><br>If varying performance periods apply to a billing provider or organization (for a particular line of business and payment arrangement type), report results on separate lines.<br><br>If PRAPM103 = A, then leave this field null<br>If PRAPM103 = V, then leave this field null | 2% |
| PRAPM105 | Performance Period End Date | Date | 8 | Yes | End date of performance period for reported Insurance Line of Business and Payment Arrangement Type. CCYYMMDD<br><br>If varying performance periods apply to a billing provider or organization (for a particular line of business and payment arrangement type), report results on separate lines.<br><br>If PRAPM103 = A, then leave this field null<br>If PRAPM103 = V, then leave this field null | 2% |

| Data Element | Name | Type | Max. length | Required? | Description/valid values | Error Threshold |
|---|---|---|---|---|---|---|
| PRAPM106 | Member Months | Numeric | 7 | Situational | Total number of members in reported stratification that participate in the reported payment arrangement, expressed in months of membership<br><br>Membership should align with what is reported in annual NAIC/SERFF filings and should only be reported for those members for whom the mandatory reporter is the primary payer.<br><br>No decimal places; round to nearest integer. Example: 12345<br><br>Report this field only when PRAPM103 = 2Ai, 4A, 4B, 4C or 4N. | 2% |
| PRAPM107 | Total Primary Care Claims Payments | Numeric | 12 | Yes | Sum of all associated primary care claims payments (paid claims only), including patient cost-sharing amounts, that were made under policies that align with the inclusion criteria of annual NAIC/SERFF filings.<br><br>Reference the way OHA operationalizes OAR 836-053-1500 through 836-053-1510 and any supplemental documents referenced in those OARs for the definition of primary care.<br><br>Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no primary care claims payments made.<br><br>This value should never exceed the amount of Total Claims Payments (PRAPM109).<br><br>If PRAPM103 = A, then leave this field null<br>If PRAPM103 = V, then leave this field null | 1% |

| Data Element | Name | Type | Max. length | Required? | Description/valid values | Error Threshold |
|---|---|---|---|---|---|---|
| PRAPM108 | Total Primary Care Non-Claims Payments | Numeric | 12 | Yes | Sum of all associated non-claims payments that pertain to primary care, that were made under policies that align with the inclusion criteria of annual NAIC/SERFF filings.<br><br>Reference the way OHA operationalizes OAR 836-053-1500 through 836-053-1510 and any supplemental documents referenced in those OARs for the definition of primary care.<br><br>Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no primary care non-claims payments made.<br><br>This value should never exceed the amount of Total Non-Claims Payments (PRAPM110).<br><br>If PRAPM103 = A, then leave this field null<br>If PRAPM103 = V, then leave this field null | 1% |
| PRAPM109 | Total Claims Payments | Numeric | 12 | Yes | Sum of all associated claims payments (paid claims only), including patient cost-sharing amounts, that were made under policies that align with the inclusion criteria of annual NAIC/SERFF filings.<br><br>Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no claims payments made.<br><br>If PRAPM103 = A, then leave this field null<br>If PRAPM103 = V, then leave this field null | 1% |

| Data Element | Name | Type | Max. length | Required? | Description/valid values | Error Threshold |
|---|---|---|---|---|---|---|
| PRAPM110 | Total Non-Claims Payments | Numeric | 12 | Yes | Sum of all associated non-claims payments that were made under policies that align with the inclusion criteria of annual NAIC/SERFF filings.<br><br>Two explicit decimal places (e.g., 200.00). Enter negative number if the billing provider or organization has to pay the mandatory reporter. Enter 0 if no non-claims payments made<br><br>If PRAPM103 = A, then leave this field null<br>If PRAPM103 = V, then leave this field null | 1% |
| PRAPM201 | | | | | For future implementation. | N/A |
| PRAPM202 | | | | | For future implementation. | N/A |
| PRAPM203 | | | | | For future implementation. | N/A |
| PRAPM204 | | | | | For future implementation. | N/A |
| PRAPM205 | | | | | For future implementation. | N/A |
| PRAPM206 | | | | | For future implementation. | N/A |
| PRAPM207 | | | | | For future implementation. | N/A |
| PRAPM208 | | | | | For future implementation. | N/A |
| PRAPM209 | | | | | For future implementation. | N/A |
| PRAPM210 | | | | | For future implementation. | N/A |

## Lookup Table PRAPM101: Billing Provider or Organization Entity Type

This field contains all valid values for types of billing provider or organization entity types

| Code | Value | Definition/Example |
|---|---|---|
| 1 | Person | Physician, clinician, orthodontist, and any individual that is licensed/certified to perform healthcare services |
| 2 | Facility | Hospital, health center, long-term care, rehabilitation, and any building that is licensed to transact healthcare services |
| 3 | Professional Group | Collection of licensed/certified healthcare professionals that are practicing healthcare services under the same entity name and Federal Tax ID Number |
| 4 | Retail Site | Brick-and-mortar licensed/certified place of transaction that is not solely a healthcare entity (i.e., pharmacies, independent laboratories, vision services) |
| 5 | E-Site | Internet-based order/logistic system of healthcare services, typically in the form of durable medical equipment, pharmacy, or vision services. |
| 6 | Financial Parent | Financial governing body that does not perform healthcare services itself but directs and finances healthcare service entities, usually through a board of directors |
| 7 | Transportation | Any form of transport that conveys a patient to/from a healthcare provider |
| 8 | Other | Any type of entity not otherwise defined that performs health care services |

## Lookup Table PRAPM103: Payment Models

This field contains all valid values for types of payment models. These values are based on the HCP-LAN framework. For more information on HCP-LAN and some of the models below, see: https://hcp-lan.org.

| Code | Value | Definition/Example |
|---|---|---|
| 1A | Fee for Service With Link to APM | Payments based on the volume of services, for services that are subject to an APM, regardless of whether the billing provider or entity holds the APM contract (i.e. bears the risk) for the service. **Note: if a mandatory reporter cannot identify payments that qualify for this category, default to category 1 – Fee for Service Without Known Link to APM.** |
| 1 | Fee for Service Without Known Link to APM | Payments based on volume of services, on behalf of patients or enrollees, with no known link to an APM |
| 2Ai | Payments based on Patient Centered Primary Care Home (PCPCH) tier level | Payment for recognition as a PCPCH, or per-member per-month payment for members in a PCPCH. |
| 2Aii | Foundational payments for infrastructure and operations – that are not based on PCPCH tier level | Foundational payments to improve care delivery, such as care coordination fees and payments for investments in HIT. |
| 2B | Pay for Reporting | Bonus payments for reporting data on quality, or penalties for not reporting data. |
| 2C | Pay for Performance | Bonus payments for high performance on clinical quality measures, or penalties for poor performance. |
| 3A | Alternative Payment Models with Shared Savings | Payments made under arrangements that are based on cost (and occasionally utilization) performance, as long as quality targets are met. Examples include: Bundled payment with upside risk only; episode-based payments for procedure-based clinical episodes with shared savings only. |
| 3B | Alternative Payment Models with Shared Savings and Downside Risk | Payments or penalties made under arrangements that both reward and penalize cost (and occasionally utilization) performance, as long as quality targets are met. Examples include: Episode-based payments for procedures and comprehensive payments with upside and downside risk. |
| 3N | Risk Based Payments Not Linked to Quality | Payments that do not take quality into account |
| 4A | Condition-Specific Population-Based Payment | Prospective, population-based payment for a certain set of condition specific-services (e.g. oncology, mental health, diabetes) or for care delivered by particular types of clinicians (e.g. primary care, orthopedics). |

| Code | Value | Definition/Example |
|---|---|---|
| 4B | Comprehensive Population-Based Payment | Prospective, population-based payments for all of an individual's health care needs. |
| 4C | Integrated Finance and Delivery System | Payments for comprehensive care that integrate the financing arm with a delivery organization. In some cases, these integrated arrangements consist of insurance companies that own provider networks, and in others, they consist of delivery systems that offer their own insurance products. |
| 4N | Capitation Payments Not Linked to Quality | Payments that do not take quality into account. |
| A | All Member Months | Total enrollment during the previous calendar year.<br><br>Enrollment should be reported (in de-duplicated member months) for insurance policies that align with the inclusion criteria of annual NAIC/SERFF filings and should only be reported for those members for whom the mandatory reporter was the primary payer.<br><br>This value must be reported only once for every distinct line of business (PRAPM102) |
| V | Alternative Arrangement Member Months | Total enrollment in alternative payment arrangements during the previous calendar year.<br><br>Enrollment should only be reported for members in payment categories 2Ai, 4A, 4B, 4C and 4N.<br><br>Enrollment should be reported (in de-duplicated member months) for insurance policies that align with the inclusion criteria of annual NAIC/SERFF filings and should only be reported for those members for whom the mandatory reporter was the primary payer.<br><br>This value must be reported only once for every distinct line of business (PRAPM102).<br><br>Note: In many cases, the value reported for code "V" will be a subset of the value reported for code "A". |

***Note: Although they are valid values for PRAPM103, codes "A" and "V" are not payment arrangement categories. Instead, these values capture total enrollment, as specified, in policies that align with the inclusion criteria of annual NAIC/SERFF filings.

## Appendix 2: Payment Arrangement Control File (formerly Appendix H)

**Note:** PBM's that offer stand-alone prescription drug plans are not required to file this report, nor do they have to file a Form APAC-1 (waiver or exception of reporting requirements).

| Data Element | Name | Type | Max. length | Required? | Description/valid values | Error Threshold |
|---|---|---|---|---|---|---|
| PRAPMCT101 | Submitted File | Text | 60 | Yes | Data File Name<br>Example:<br>*ABCD_ABCD_SupplAPM_Provider_201609_20160918.dat.* | 0% |
| PRAPMCT102 | Data Rows | Numeric | 10 | Yes | Number of data rows in the submitted file | 0% |
| PRAPMCT103 | Member Months | Numeric | 10 | Yes | Sum of member months.<br>No decimal places; round to nearest integer. Example: 12345 | 0% |
| PRAPMCT104 | Total Primary Care Claims Payments | Numeric | 12 | Yes | Sum of Total Primary Care Claims Payments | 0% |
| PRAPMCT105 | Total Primary Care Non-Claims Payments | Numeric | 12 | Yes | Sum of Total Primary Care Non-Claims Payments | 0% |
| PRAPMCT106 | Total Claims Payments | Numeric | 12 | Yes | Sum of Total Claims Payments | 0% |
| PRAPMCT107 | Total Non-Claims Payments | Numeric | 12 | Yes | Sum of Total Non-Claims Payments | 0% |