

DESCRIPTION/GENERAL INFORMATION

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

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

METHOD OF SUBMISSION

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

FREQUENCY OF SUBMISSION

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

TIMING OF SUBMISSION

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

Data Type: Medical Claims / Encounter Records

Definitions:

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

Items for discussion

General

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

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

Provider

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

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

Example 1

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

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

Example 2

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

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

Example 3

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

Professional

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

Facility

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

Financial Fields

Truven Health defines the relationship among financial fields as follows:

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

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

Corrections to paid claims

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

Void/Replacement

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

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

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

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

Adjustments

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

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

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

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

Facility Record Content

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

Example: One facility claim with three service lines:

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

Professional Record Content

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

Example: One professional claim with two service lines:

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

Denied Claims

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

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

Data Type: Capitation Data

Definition

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

Items for Discussion

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

DATA FORMATTING

Character Fields

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

Numeric Fields

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

Financial Fields

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

Invalid Characters

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

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

Medical Record

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical Detail – Trailer Record

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