

Virginia All-Payer Claims Database Data Submission Manual



DRAFT

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VA APCD Data Submission Manual

REVISION HISTORY

Date	Version	Description	Author
11/8/12	1.0	Initial Draft	VHI
8/5/13	1.1	Proposed changes accepted by Data Submitters	VHI
8/28/13	1.2	Language added to clarify data submission requirements.	VHI

Process for Revisions to the Virginia All-Payer Claims Database Data Submission Manual

1. A formal review of the Data Submission Manual by VHI will be conducted no more frequently than semi-annually to determine if any changes are warranted based on any number of factors including but not limited to changes in the health care environment, feedback from the data vendor based on data files received and analyzed, and feedback from data submitters.
2. Solicitation of input from data submitters whereby VHI contacts, via email or USPS, the data submitters to inform them of their periodic review of the Data Submission Manual, shares VHI's/the data vendor's suggested modifications and then request from the data submitters their suggested modifications to the Data Submission Manual.
3. VHI will seek verbal and written input from data submitters of its suggested modifications to the Manual, and then consider and make determinations regarding all suggested changes to the Data Submission Manual. After this open, consensus process is complete, VHI will send to data submitters via email or USPS a signed, letter outlining the changes for signature by the Data Submitters, and a copy of the final-revised Data Submission Manual (including both additions and deletions to the Manual) to the data submitters for their signature. The correspondence will include notice of the 180 days for the data submitters to implement the material changes.

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Attachment A VHI Data Submission Manual Revision History

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Data Submission Requirements – General

To facilitate data communications, data submissions and processing, data submitters will provide to the VHI APCD data subcontractor registration information with the following information:

- Company contacts
- Control totals for reconciliation
- Data files submitted and sources/platforms
- Special data considerations
- Member linkage information

The registration form should be completed within thirty days after the Data Submission Manual is finalized, whenever the data submitter's information is modified, and by June 30th of 2014 and every year thereafter.

Although data submitters may provide files on a quarterly basis, it is preferable that files be submitted on a monthly schedule due to the large volume of data contained in the files.

Pursuant to § 32.1-276.7:1.C.5, the APCD Advisory Committee has an exemption process for submitting entities that do not collect the specified data or pay on a per-claim basis.

It is expected that the data files, where applicable, be populated using the most current nationally adopted code sets. For those submitting entities that do not capture data in the manner set out below, best efforts must be used to complete all fields. A data key should be provided with the data submissions.

Data received from multiple data systems may be rolled up by member SSN# to report one line per member in the file or separate submitter codes can be provided, whichever is preferable for the submitting entity.

All medical or pharmacy claims processed by data submitters acting as Third Party Administrators (TPAs) or Pharmacy Benefits Managers (PBMs) under contract to a data submitter for carved-out services are to be submitted by the data submitter with unified member IDs in all files. If this is not possible due to contractual requirements, two fields are required for completion in both the Medical Claims (MC) and Pharmacy Claims (PC) files to link the individual claims to the specific carriers and to associate the members in the separate eligibility files. The fields, which are Carrier Associated with Claim (MC207/PC201) and Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number (MC208/PC202), are to be filled by the TPA or PBM submitting the files. If the data submitter does provide unified member IDs in all files, MC207/PC203 and MC208/PC204 are optional.

Data submissions detailed below will include eligibility, medical claims, pharmacy claims, and provider data. Dental claims are not currently being collected. Field definitions and other relevant data associated with these submissions are specified in Exhibit A. These datasets have been developed by the **APCD Council** in collaboration with stakeholders across the nation.

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Data Submission Requirements - SpecificMember Eligibility File (ME)

ME010 – Member Sequence Number is the unique identifier of the member within the plan. For plans that do not have a unique identifier within their dataset, please concatenate the subscriber contract number and the prefix number to create a unique ID. The member sequence number must be the same unique identifier across the member eligibility, medical claims and pharmacy claims file. A further explanation can be found on page 8 of the Data Submission Manual. Below is a table clarifying the referential integrity across the membership file and the claims files.

Member Eligibility = Claims File

ME009	MC008
ME009	PC008
ME010	MC009
ME010	PC009

ME011 – Member Identification Code is to be the *member's* social security number (SSN). If the member's SSN is not available, please leave null. This will enhance the integrity of the APCD Master Patient Index (MPI).

Medical Claim File (MC)

MC004 – Payer Claim Control Number (PCCN) is to be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (MC005A) will be used to determine which rows will carry forward into the final claim. It is also imperative a reversal (claim status – MC038 – set to '22') uses the same PCCN as the original paid claim.

MC005A – Version Number is to be coded as a '0' for the original claim. It is expected that every additional claim submitted corresponding to the original claim will have a version number incremented by '1' for the service line affected. Version number is required when reporting adjustments and reversals.

MC024 – Service Provider Number must match the Provider ID (MP001) found in the medical provider file.

MC032 – Service Provider Specialty Code in the medical claims file is preferred to be the CMS specialty code. This will provide consistency across all payers in the APCD. A crosswalk of Taxonomy and CMS Specialty codes can be found on the CMS website. If the CMS specialty code is not available a dictionary is required.

MC036 – Type of Bill – Institutional is to be populated for *institutional claims only*. It is expected that facility type (MC037) will be left null for institutional claims.

MC037 – Place of Service – Professional is to be populated for *professional claims only*. It is expected that type of bill (MC036) will be left null for professional claims.

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MC041 – MC053 – Principal and Other Diagnosis Codes - It is expected that ICD-9-CM or ICD-10-CM codes be used to populate these fields. However, if individual, non-bundled “home grown” codes are still in use, a table is required which lists the codes and definitions.

MC054 – Revenue Code is to be filled for *all institutional claims*.

MC055 – Procedure Code – It is expected that Health Care Common Procedure Coding System (HCPCS)/Common Procedural Terminology (CPT) codes be used to populate this field. However, if individual, non-bundled “home grown” codes are still in use, a table is required which lists the codes and definitions.

MC058 – An ICD-9-CM or ICD-10-CM Procedure Code is required for *all inpatient claims*. If multiple codes are submitted, line one will be considered the primary code.

MC059 – Date of Service - From is to be filled for all claim types.

MC060 – Date of Service - Thru is to be filled for all claim types. If the length of stay is 0, then code with the Date of Service – From (MC059).

Claim Selection Logic for Historical Files – paid claims with service dates at a minimum of 2 calendar years prior to the initial reporting year.

Claim Selection Logic for Incremental Files – any claim paid, adjusted or voided within the period with services dates beginning January 1 of the year and a minimum of 2 years prior to the initial reporting year.

Pharmacy Claim File (PC)

PC017 – Date Service Approved (AP Date) is required on the original claim. When reporting reversals, it must also be submitted.

PC025 – Claim status is required for original claim. When reporting reversals, the code ‘22 must be submitted.

Medical Provider File (MP)

MP001 – Provider ID is the unique identifier for *one* provider. The Provider ID should only occur *once* in the table. Provider ID is based on the billing and/or servicing provider.

MP003 – Provider Entity Type Code: - An additional utilization test will be implemented to verify the combination of NPI (MP014) and the Provider Entity Type Code (MP003) matching the NPPES NPI and NPPES entity type code.

MP014 – Provider NPI is currently a threshold column, but is anticipated to increase its requirement over time. It is important to work toward filling this field as the National Provider ID will assist healthcare plans in reporting accurate provider information including license numbers, taxonomy code and specialty codes. It will also enhance the integrity of the APCD by increasing match rates for the Master Provider Index (MPI). The NPPES database is available on the CMS website.

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1.1 DATA TO BE SUBMITTED

1.2.1 FILE HEADER AND TRAILER DATA

Separate Header and Trailer Record files must be submitted with each Eligibility, Medical Claims, Pharmacy Claims, and Provider File.

1.2.2 MEMBER ELIGIBILITY DATA

- a) Health Care Payers must provide a data set that contains information on every covered plan member whether or not the member utilized services during the reporting period. The file must include member identifiers, subscriber name and identifier, member relationship to subscriber, residence, age, race, ethnicity, and other required fields to allow retrieval of related information from pharmacy and medical claims data sets (Exhibit A-1).
- b) If dual coverage exists, send coverage of eligible members where payer insurance is primary, secondary, or tertiary. ME028 is a flag to indicate whether this insurance is primary, secondary, or tertiary coverage.
- c) Membership data received from multiple data systems may be rolled up by SSN# to report one line per member in the file, or separate submitter codes can be provided, whichever is preferable for the submitting entity.

1.2.3 MEDICAL CLAIMS DATA

- a) Payers shall report health care service paid claims and encounters for all resident members. Payers may be required to identify encounters corresponding to a capitation payment, Data Elements MC063 and MC064.
- b) Payers must provide information to identify the type of service and setting in which the service was provided. Each submitted data file shall have control totals and transmission control data (see File Header and Trailer Records in Exhibits for specifics).
- c) Claim data is required for submission for each month during which some action has been taken on that claim (i.e. payment, adjustment or other modification). Any claims that have been "soft" denied (denied for incompleteness, incorrect or other administrative reasons) which the data supplier expects to be resubmitted upon correction, do not have to be submitted until corrections have been completed and the claim paid. It is desirable that payers provide a reference that links the original claim to all subsequent actions associated with that claim (see Exhibit A-2 for specifics).
- d) ICD-9/ICD-10 Diagnosis and Procedure Codes are required to accurately report risk factors related to the Episode of Care. CPT/HCPCS codes are also required.
- e) For historical data submitted during the on boarding process, payers shall provide as a separate report monthly totals of covered members for the periods associated with the Historical Data.

1.2.4 PHARMACY CLAIMS

- a) Health Care Payers must provide data for all pharmacy paid claims for prescriptions that were actually dispensed to members and paid (Exhibit A-3).
- b) If your health plan allows for medical coverage without pharmacy (or vice versa), ME018 – ME020 in Exhibit A-1 provides data elements in which such options must be identified in order to effectively and accurately aggregate claims based on Episodes of Care.

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1.2.5 PROVIDER DATA

- a) Health Care Payers must provide a data set that contains information on every provider for whom claims were adjudicated during the reporting period.
- b) In the event the same provider delivered and was reimbursed for services rendered from two different physical locations, then the provider data file shall contain two separate records for that same provider reflecting each of those physical locations. One record shall be provided for each unique physical location for a provider.

2.0 FILE SUBMISSION METHODS

- 2.1. All files are to be submitted via Secure File Transport Protocol (SFTP), which will involve logging on to the appropriate FTP site and sending or receiving files using the SFTP client.
- 2.2 Web Upload – This method allows the sending and receiving of files and messages without the installation of additional software, but file size is limited to 2GB. This method requires internet access, a username and password.
- 2.3 Plan will have the option to choose one of the above file submission methods.
- 2.2 The naming convention for all submitted files and header and trailer records are as follows:

PayerCode	FileType_	PaidClaimsPeriod.txt
Monthly:		
VAXXXXX	ME, MC, PC, or MP	201***.txt
VAXXXXX	MEHD, METR, MCHD,_, MCTR, PCHD, PCTR, MPHR, MPTR	201***.txt
Quarterly:		
VAXXXXX	ME, MC, PC, or MP	201*Q*.txt
VAXXXXX	MEHD, METR, MCHD,_, MCTR, PCHR, PCTR, MPHD, MPTR	201*Q*.txt

- 2.3 Files that are compressed need to follow similar naming conventions to the files themselves and need to be compatible with WinZip. The naming convention needs to specify each file type and should conform to the following convention:

PayerCode	FileType_	PaidClaimsPeriod.zip
Monthly:		
VAXXXXX_	ME, MC, PC, or MP_	201***.zip and .zipx
Quarterly:		
VAXXXXX_	ME, MC, PC, or MP	201*Q*.zip and .zipx

3.0 DATA QUALITY REQUIREMENTS

- 3.1 The data elements in Exhibit A provide, in addition to field definitions, an indicator regarding data elements that are required. A data element that is required, indicated by "R", must contain a value unless an exemption, as described in Section 3.2 is put in

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place with a specific payer who is unable to provide that data element due to system limitations. A data element marked as “O” is an optional data element that should be provided when available, but otherwise may contain a null value. In some cases, a data element may be marked as optional for only institutional or professional claims. An overall record accuracy rate of 95% for fields completed is the goal in order to be considered processed and verified consistent with the Act. For example, for every 100 records submitted 95 must be free of error.

- 3.2 Data validation and quality audits will be developed in collaboration with each payer and refined as test data and production data are brought into the APCD. Data files missing required fields or that are formatted incorrectly may be rejected on submission and given a status of “Catastrophic Failure.” These files must be corrected and resubmitted. Other data elements will be validated against established ranges for both field and quality audits as the database is populated. If a data submission does not fall within an acceptable range for one or more field or quality audits, a file will be given a status of “Failed.” Exemption(s) may be granted for data variances in accordance with a process approved by the Virginia APCD Advisory Committee. Exemptions for data not collected and maintained in the normal course of business are granted. Exemption requests are to be submitted within 10 days of a file being processed. VHI and the data submitter must agree on all audit exemptions before a file can be given a status of “Pass” and retained for processing.

The objective is to populate the APCD with quality data and each payer will need to work interactively with VHI to develop data extracts that achieve validation and quality specifications.

4.0 FILE FORMAT

- 4.1 All files submitted to the APCD will be formatted as standard text file. Text files all comply with the following standards:

- a) Always one line item per row; no single line item of data may contain carriage return or line feed characters.
- b) All rows delimited by the carriage return + line feed character combination.
- c) All fields are variable field length, delimited using the pipe character (ASCII=124). It is imperative that no pipes (‘|’) appear in the data itself. If your data contains pipes, remove them prior to submission of the data.
- d) Text fields are *never* demarcated or enclosed in single or double quotes. Any quotes detected are regarded as a part of the actual data.
- e) The first row of the medical and pharmacy claims files *always* contains the data element names of data columns.
- f) Unless otherwise stipulated, numbers (ID numbers, account numbers, etc) do not contain spaces, hyphens or other punctuation marks.
- g) Text fields are never padded with leading or trailing spaces or tabs.
- h) Numeric fields are never padded with leading or trailing zeros.
- i) All fields must be filled where applicable. Text fields (varchar, char, date) must be left blank when not applicable or if the data are not available. “Blank” means do not supply

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any value at all between field delimiters (pipes). Numeric fields (int, dec) without a value are to be filled with a zero.

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5.0 DATA ELEMENT TYPES

date – date data type for dates from 1/1/0001 through 12/31/9999

int – integer (whole number)

tinyint – integer data from 0 through 255

decimal/numeric – fixed precision and scale numeric data

char – fixed length non-unicode data with a max of 8,000 characters

varchar – variable length non-unicode data with a maximum of 8,000 characters

text – variable length non-unicode data with a maximum of $2^{31} - 1$ characters

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EXHIBIT A - DATA ELEMENTS

A-1 ELIGIBILITY DATA

Frequency: Monthly or Quarterly Upload via FTP (due within 45 days of the end of the reporting period)

It is extremely important that the member ID (Member Suffix or Sequence Number) is unique to an individual and that this unique identifier in the eligibility file is consistent with the unique identifier in the medical claims/pharmacy file. This provides linkage between medical and pharmacy claims during established coverage periods and is critical for the implementation of Episode of Care reporting.

For Historic Data collected, eligibility data are to be reported for all Virginia residents who were covered members during that reporting month. In the event historical address data is not available, eligibility data for historical months shall be reported based on member's last known or current address. It is acknowledged that for some payers there may not be an eligibility record for each member identified in the medical claims file for that same period. In order to reconcile the total number of resident covered members for this 3 year period, each payer is to submit a summary report that totals the number of resident covered members for each month for Historic Data.

Additional formatting requirements:

- Eligibility files are formatted to provide one record per member per month. Member is either the Subscriber or the Subscriber's dependents.
- Payers submit data in a single, consistent format for each data type.

MEMBER ELIGIBILITY FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	ME
HD002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
HD003	Payer Name	varchar	75	
HD004	Beginning Month	date	6	CCYYMM
HD005	Ending Month	date	6	CCYYMM
HD006	Record count	int	10	Total number of records submitted in the medical eligibility file, excluding header and trailer records

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MEMBER ELIGIBILITY FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	ME
TR002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
TR003	Payer Name	varchar	75	
TR004	Beginning Month	date	6	CCYYMM
TR005	Ending Month	date	6	CCYYMM
TR006	Extraction Date	date	8	CCYYMMDD

A-1.1 MEMBER ELIGIBILITY FILE

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
ME001	N/A	Payer Name/Code	varchar	8	Payer submitting data file – Code assigned by system (may be multi-tiered to support different platforms).	R
ME002	271/2100A/N M1/XV/09	National Plan ID	varchar	30	CMS National Plan ID or NAIC code	R
ME003	271/2110C/E B/ /04, 271/2110D/E B/ /04	Insurance Type Code/Product	char	2	See Lookup Table B-1.A for codes.	R
ME004	N/A	Year	int	4	4 digit Year for which eligibility is reported in this submission	R
ME005	N/A	Month	char	2	Month for which eligibility is reported in this submission expressed numerical from 01 to 12.	R
Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required

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ME006	271/2100C/R EF/1L/02, 271/2100C/R EF/IG/02, 271/2100C/R EF/6P/02, 271/2100D/R EF/1L/02, 271/2100D/R EF/IG/02, 271/2100D/R EF/6P/02	Insured Group or Policy Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber	R
ME007	271/2110C/E B/ /02, 271/2110D/E B/ /02	Coverage Level Code	char	3	Benefit coverage level	R
					CHD Children Only	
					DEP Dependents Only	
					ECH Employee and Children	
					EPN Employee plus N where N equals the number of other covered dependents	
					ELF Employee and Life Partner	
					EMP Employee Only	
					ESP Employee and Spouse	
					FAM Family	
					IND Individual	
					SPC Spouse and Children	
					SPO Spouse Only	

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
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ME008	271/2100C/N M1/MI/09	Subscriber Social Security Number	varchar	9	Subscriber's social security number; Set as null if unavailable	R
ME009	271/2100C/N M1/MI/09	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber.	R
ME010	N/A	Member Suffix or Sequence Number	varchar	128	Unique number of the member within the contract. Must be an identifier that is unique to the member.	R
ME011	271/2100C/N M1/MI/09, 271/2100D/N M1/MI/09	Member Identification Code	varchar	9	Member's social security number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member.	R
ME012	271/2100C/I NS/Y/02, 271/2100D/I NS/N/02	Individual Relationship Code	char	2	Member's relationship to insured – see Lookup Table B-1.B for codes.	R
ME013	271/2100C/D MG/ /03, 271/2100D/D MG/ /03	Member Gender	char	1	M – Male F – Female U - UNKNOWN	R
ME014	271/2100C/D MG/D8/02, 271/2100D/D MG/D8/02	Member Date of Birth	char	8	CCYYMMDD	R
ME015	271/2100C/N 4/ /01, 271/2100D/N 4/ /01	Member City Name	varchar	30	City location of member	R
Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required

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ME016	271/2100C/N 4/ /02, 271/2100D/N 4/ /02	Member State or Province	char	2	As defined by the US Postal Service	R
ME017	271/2100C/N 4/ /03, 271/2100D/N 4/ /03	Member ZIP Code	varchar	11	ZIP Code of member - may include non-US codes. Do not include dash. Plus 4 optional but desired.	R
ME018	N/A	Medical Coverage	char	1	Y – YES N - NO	R
ME019	N/A	Prescription Drug Coverage	char	1	Y – YES N - NO	R
ME020	N/A	Dental Coverage	char	1	Y – YES N – NO 3 - UNKNOWN	R
ME021	N/A	Race 1	varchar	6	See Lookup Table B-1.C for codes.	O
ME022	N/A	Race 2	varchar	6	See code set for ME021.	O
ME023	N/A	Other Race	varchar	15	List race if MC021or MC022 are coded as R9.	O
ME024	N/A	Hispanic Indicator	char	1		O
					Y = Patient is Hispanic/Latino/Spanish	
					N = Patient is not Hispanic/Latino/Spanish	
					U = Unknown	
ME025	N/A	Ethnicity 1	varchar	6	See Lookup Table B-1.D for codes.	O
ME026	N/A	Ethnicity 2	varchar	6	See code set for ME025.	O
ME027	N/A	Other Ethnicity	varchar	20	List ethnicity if MC025 or MC026 are coded as OTHER.	O
Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required

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ME028	N/A	Primary Insurance Indicator	char	1	Y – Yes, primary insurance N – No, secondary or tertiary insurance	R
ME029	N/A	Coverage Type	char	3	ASO - self-funded plans STN – short-term, non-renewable health insurance (ie COBRA) UND – plans underwritten by the insurer OTH – any other plan. Insurers using this code shall obtain prior approval.	R
ME030	N/A	Market Category Code	varchar	4		O
					IND – policies sold and issued directly to individuals (non-group)	
					FCH – policies sold and issued directly to individuals on a franchise basis	
					GS3 – policies sold and issued directly to employers having 50 or more employees (100 or more employees after 1/1/2016)	
					GS4 – policies sold and issued directly to employers having fewer than 50 employees (fewer than 100 employees after 1/1/2016)	
					GSA – policies sold and issued directly to employers having fewer than 50 employees (fewer than 100 employees after 1/1/2016) through a qualified association trust	
					OTH – policies sold to other types of entities. Insurers using this market code shall obtain prior approval.	
ME031	N/A	Special Coverage	varchar	3	0 - not applicable 1 - XXX – reserved for VA special statewide health care coverage program(s)	O
ME032	N/A	Group Name	varchar	128	Group name or IND for individual policies	O
ME101	271/2100C/N M1/ /03	Subscriber Last Name	varchar	128	The subscriber last name	R
ME102	271/2100C/N M1/ /04	Subscriber First Name	varchar	128	The subscriber first name	R

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ME103	271/2100C/N M1/ /05	Subscriber Middle Initial	char	1	The subscriber middle initial	O
ME104	271/2100D/N M1/ /03	Member Last Name	varchar	128	The member last name	R
ME105	271/2100D/N M1/ /04	Member First Name	varchar	128	The member first name	R
ME201	N/A	Member Street Address	varchar	50	Street address of member	R
ME202	N/A	Employer Name	varchar	50	Name of the Employer, or if same as Group Name, null	O
ME897	N/A	Plan Effective Date	char	8	CCYYMMDD Date eligibility started for this member under this plan type. The purpose of this data element is to maintain eligibility span for each member.	R
ME106	271/2100D/N M1/ /05	Member Middle Initial	char	1	The member middle initial	O
ME899	N/A	Record Type	char	2	Value = ME	R

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A-2 MEDICAL CLAIMS DATA

Frequency: Monthly or Quarterly Upload via FTP (due within 45 days of the end of the reporting period)

Additional formatting requirements:

- Claims are paid claims. Non-covered or denied claims (e.g. duplicate or patient ineligible claims) are not included.
- Payers submit data in a single, consistent format for each data type.

MEDICAL CLAIMS FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	MC
HD002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
HD003	Payer Name	varchar	75	Example:
HD004	Beginning Month	date	6	CCYYMM
HD005	Ending Month	date	6	CCYYMM
HD006	Record count	int	10	Total number of records submitted in the medical claims file, excluding header and trailer records

MEDICAL CLAIMS FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	MC
TR002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
TR003	Payer Name	varchar	75	
TR004	Beginning Month	date	6	CCYYMM
TR005	Ending Month	date	6	CCYYMM
TR006	Extraction Date	date	8	CCYYMMDD

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A-2.1 MEDICAL CLAIMS FILE

Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC001	N/A	2330B NM109 where 2320 SR06 = 6	Payer	varchar	8	Payer submitting data file – Code assigned by system (may be multi-tiered to support different platforms).	R
MC002	837/2010BB/ NM1/XV/09	2330B NM109 where NM108 = XV and 2320 SR06 = 6	National Plan ID	varchar	30	CMS National Plan ID or NAIC code	R
MC003	837/2000B/S BR/ /09	2320 SBR09 where SBR06 = 6	Insurance Type/Product Code	char	2	See Lookup Table B-1.A	R
MC004	835/2100/CL P/ /07	2330B REF02 where REF01 = F8	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system.	R
MC005	837/2400/LX/ /01	2400 LX01	Line Counter	tinyint	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.	R
MC005A	N/A	N/A	Version Number	tinyint	4	The version number of this claim service line. The original claim will have a version number of 0, with the next version being assigned a 1, and each subsequent version being incremented by 1 for that service line.	R

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC006	837/2000B/S BR/ /03	2000B SBR03 (I); 2320 SBR03 where SBR06 = 6 (P)	Insured Group or Policy Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber.	R
MC007	835/2100/NM 1/34/09	2010BA REF02 where 2010BA REF01 = SY	Subscriber Social Security Number	varchar	9	Subscriber's social security number; Set as null if unavailable	R
MC008	835/2100/NM 1/HN/09	2010BA NM109	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber.	R
MC009	N/A	N/A	Member Suffix or Sequence Number	varchar	20	Unique number of the member within the contract. Must be an identifier that is unique to the member.	R
MC010	835/2100/NM 1/MI/089	2010CA NM109 or 2010BA NM109	Member Identification Code (patient)	varchar	128	Member's social security number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member.	R

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC011	837/2000B/S BR/ /02, 837/2000C/P AT/ /01, 837/2320/SBR/ /02	2000C PAT01 or 2000B SBR02	Individual Relationship Code	char	2	Member's relationship to insured – payers will map their available codes to those listed in Lookup Table B-1.B	R
MC012	837/2010CA/DMG/ /03	2010C DMG03 or 2010B DMG03	Member Gender	char	1	M - Male F – Female U - Unknown	R
MC013	837/2010CA/DMG/D8/02	2010C DMG02 or 2010B DMG02	Member Date of Birth	char	8	CCYYMMDD	R
MC014	837/2010CA/N4/ /01	2010CA N401 or 2010BA N401	Member City Name	varchar	30	City name of member	R
MC015	837/2010CA/N4/ /02	2010CA N402 or 2010BA N402	Member State or Province	char	2	As defined by the US Postal Service	R
MC016	837/2010CA/N4/ /03	2010CA N403 or 2010BA N403	Member ZIP Code	varchar	11	ZIP Code of member - may include non-US codes. Plus 4 optional but desired.	R
MC017	N/A	2330B DTP03 where 2320 SBR06 = 6 and DTP01 = 573	Date Service Approved/Accounts Payable Date/Actual Paid Date	char	8	CCYYMMDD	R

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC018	837/2300/DT P/435/03	2300 DTP03 (I); 2300 DTP03 where DTP02 = 435 (P)	Admission Date	char	8	Required for all inpatient claims. CCYYMMDD	O (inpatient claims only)
MC019	837/2300/DT P/435/03	2300 DTP03 N435	Admission Hour	char	4	Required for all inpatient claims. Time is expressed in military time - HHMM	O (inpatient claims only)
MC020	837/2300/CL1 / /01	2300 CL101 N413	Admission Type	tinyint	1	Required for all inpatient claims (SOURCE: National Uniform Billing Data Element Specifications)	O (inpatient claims only)
						1 Emergency	
						2 Urgent	
						3 Elective	
						4 Newborn	
						5 Trauma Center	
						9 Information not available	
MC021	837/2300/CL1 / /02	2300 CL102 N414	Admission Source	char	1	Required for all inpatient claims See Lookup Table B-1.I for codes.	O (inpatient claims only)
MC022	837/2300/DT P/096/03	2300 CL103 N392	Discharge Hour	tinyint	4	Time expressed in military time – HHMM	O (inpatient claims only)

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC023	837/2300/CL1 //03	2300 CL103 N415	Discharge Status	char	2	Required for all inpatient claims. See Lookup Table B-1.E for codes.	O (inpatient claims only)
MC024	835/2100/NM 1/BD/09, 835/2100/NM 1/BS/09, 835/2100/NM 1/MC/09, 835/2100/NM 1/PC/09	2310D REF02 where REF01 = 0B, G2, or LU (I) or 2310A REF02 where REF01 = 0B, G2, or LU (I); 2420A REF02 where REF01 = 0B, G2, or LU (P) or 2310B REF02 where REF01 = 0B, G2, or LU (P) or 2010AA REF02 where REF01 = 0B, G2, or LU (P)	Service Provider Number	varchar	30	Payer assigned service provider number, preferably for the individual provider but alternately for the clinic where the service occurred.	R
MC025	835/2100/NM 1/FI/09	N/A	Service Provider Tax ID Number	varchar	10	Federal taxpayer's identification number	R

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC026	professional: 837/2420A/N M1/XX/09; 837/2310B/N M1/XX/09; institutional: 837/2420A/N M1/XX/09; 837/2420C/N M1/XX/09; 837/2310A/N M1/XX/09	2310D NM109 (I) or 2310A NM109 (I); 2320A NM109 (P) or 2310B NM109 (P) or 2010AA NM109 (P)	Service National Provider ID	varchar	20	National Provider ID. This data element pertains to the entity or individual directly providing the service.	R
MC027	professional: 837/2420A/N M1/82/02; 837/2310B/N M1/82/02; institutional: 837/2420A/N M1/72/02; 837/2420C/N M1/82/02; 837/2310A/N M1/71/02	2310D NM102 (I) or 2310A NM102 (I); 2420A NM102 (P) or 2310B NM102 (P) or 2010AA NM102 (P)	Service Provider Entity Type Qualifier	char	1	HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a “person”, and these shall be coded as a person. Health care claims processors shall code according to:	R
						1 Person	
						2 Non-Person Entity	

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC028	professional: 837/2420A/N M1/82/04; 837/2310B/N M1/82/04; institutional: 837/2420A/N M1/72/04; 837/2420C/N M1/82/04; 837/2310A/N M1/71/04	2310D NM104 (I) or 2310A NM104 (I); 2420A NM104 (P) or 2310B NM104 (P) or 2010AA NM104 (P)	Service Provider First Name	varchar	25	Individual first name. Set to null if provider is a facility or organization.	O
MC029	professional: 837/2420A/N M1/82/05; 837/2310B/N M1/82/05; institutional: 837/2420A/N M1/72/05; 837/2420C/N M1/82/05; 837/2310A/N M1/71/05	2310D NM105 (I) or 2310A NM105 (I); 2420A NM105 (P) or 2310B NM105 (P) or 2010AA NM105 (P)	Service Provider Middle Name	varchar	25	Individual middle name or initial. Set to null if provider is a facility or organization.	O

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC030	professional: 837/2420A/N M1/82/03; 837/2310B/N M1/82/03; institutional: 837/2420A/N M1/72/03; 837/2420C/N M1/82/03; 837/2310A/N M1/71/03	2310D NM103 (I) or 2310A NM103 (I); 2420A NM103 (P) or 2310B NM103 (P) or 2010AA NM103 (P)	Service Provider Last Name or Organization Name	varchar	60	Full name of provider organization or last name of individual provider	R
MC031	professional: 837/2420A/N M1/82/07; 837/2310B/N M1/82/07; institutional: 837/2420A/N M1/72/07; 837/2420C/N M1/82/07; 837/2310A/N M1/71/07	2310D NM107 (I) or 2310A NM107 (I); 2420A NM107 (P) or 2310B NM107 (P) or 2010AA NM107 (P)	Service Provider Suffix	varchar	10	Suffix to individual name. Set to null if provider is a facility or organization. The service provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III), if applicable, rather than the clinician's degree (e.g., MD, LCSW).	O

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC032	professional: 837/2420A/P RV/PE/03; 837/2310B/P RV/PE/03; institutional: 837/2310A/P RV/AT/03	2310A PRV03 (I); 2420A PRV03 (P) or 2310B PRV03 (P) or 2000AA PRV03 (P)	Service Provider Specialty	varchar	10	As defined by payer. Dictionary for specialty code values must be supplied during testing.	R
MC033	professional: 837/2420C/N 4/ /01; 837/2310C/N 4/ /01; institutional: 837/2310E/N 4/ /01	2310E N401 (I); 2420C N401 (P) or 2310C N401 (P)	Service Provider City Name	varchar	30	City name of provider - preferably practice location	R
MC034	professional: 837/2420C/N 4/ /02; 837/2310C/N 4/ /02; institutional: 837/2310E/N 4/ /02	2310E N402 (I); 2420C N402 (P) or 2310C N402 (P)	Service Provider State or Province	char	2	As defined by the US Postal Service	R

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC035	professional: 837/2420C/N 4/ /03; 837/2310C/N 4/ /03; institutional: 837/2310E/N 4/ /03	2310E N403 (I); 2420C N403 (P) or 2310C N403 (P)	Service Provider ZIP Code	varchar	11	ZIP Code of provider - may include non-US codes; do not include dash. Plus 4 optional but desired.	R
MC036	837/2300/CLM/ /05-1	CLM 05-1 & CLM05-3	Type of Bill – Institutional	char	3	Required for institutional claims; Not to be used for professional claims. See Lookup Table B-1.F for codes.	O (institutional claims only)
MC037	837/2300/CLM/ /05-1	2300 CLM05-1	Place of Service - Professional	char	2	Required for professional claims. Not to be used for institutional claims. Map where you can and default to “99” for all others. See Lookup Table B-1.G for codes.	O (professional claims only)
MC038	835/2100/CLP/ /02	2300 CLM17	Claim Status	char	2	See Lookup Table B-1.H	R
MC039	837/2300/HI/BJ/021-2	2300 DTP03	Admitting Diagnosis	varchar	7	Required on all inpatient admission claims and encounters. ICD-9-CM or ICD-10-CM. Do not code decimal point.	O (inpatient claims and encounters only)
MC040	837/2300/HI/BN/031-2	2300 HI01-2 where HI01-1 = BN (ICD-9) or = ABN (ICD-10)	E-Code	varchar	7	Describes an injury, poisoning or adverse effect. ICD-9-CM or ICD-10-CM. Do not code decimal point.	O

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC041	837/2300/HI/BK/01-2	2300 HI01-2 where HI01-1 = BK (ICD-9) or = ABK (ICD-10)	Principal Diagnosis	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	R
MC042	837/2300/HI/BF/01-2	2300 HI01-2 where HI01-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 1	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC043	837/2300/HI/BF/02-2	2300 HI02-2 where HI02-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 2	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC044	837/2300/HI/BF/03-2	2300 HI03-2 where HI03-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 3	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC045	837/2300/HI/BF/04-2	2300 HI04-2 where HI04-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 4	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC046	837/2300/HI/BF/05-2	2300 HI05-2 where HI05-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 5	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC047	837/2300/HI/BF/06-2	2300 HI06-2 where HI06-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 6	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC048	837/2300/HI/BF/07-2	2300 HI07-2 where HI07-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 7	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC049	837/2300/HI/BF/08-2	2300 HI08-2 where HI08-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 8	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC050	837/2300/HI/BF/09-2	2300 HI09-2 where HI09-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 9	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC051	837/2300/HI/BF/10-2	2300 HI010-2 where HI010-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 10	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC052	837/2300/HI/BF/11-2	2300 HI011-2 where HI011-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 11	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC053	837/2300/HI/BF/12-2	2300 HI012-2 where HI012-1 = BF (ICD-9) or = ABF (ICD-10)	Other Diagnosis – 12	varchar	7	ICD-9-CM or ICD-10_CM. Do not code decimal point.	O
MC054	835/2110/SV C/NU/01-2	2430 SVD04	Revenue Code	char	10	National Uniform Billing Committee Codes. Code using leading zeroes, left justified, and four digits.	R
MC055	835/2110/SV C/HC/01-2	2430 SVD03-2	Procedure Code	varchar	10	Health Care Common Procedural Coding System (HCPCS); This includes the CPT codes of the American Medical Association.	R
MC056	835/2110/SV C/HC/01-3	2430 SVD03-3	Procedure Modifier – 1	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.	O
MC057	835/2110/SV C/HC/01-4	2430 SVD03-4	Procedure Modifier – 2	char	2	Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code.	O
MC058	835/2110/SV C/ID/01-2	2300 HI	ICD-9/10-CM Principal Procedure Code	char	7	Primary procedure code for this line of service. Do not code decimal point.	R

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC059	835/2110/DTM/150/02	2400 DTP03 where DTP01 = 472 or 2300 DTP03 where DTP01 = 434	Date of Service – From	date	8	First date of service for this service line. CCYYMMDD	R
MC060	835/2110/DTM/151/02	2400 DTP03 where DTP01 = 472 or 2300 DTP03 where DTP01 = 434	Date of Service – Thru	date	8	Last date of service for this service line. CCYYMMDD	R
MC061	835/2110/SVC/ /05	2400 SV205 (I); 2400 SV104 (P)	Quantity	dec (explicit)	12	Count of services performed. (For all observation bed service lines, set equal to one. For all other room and board service lines, regardless of the length of stay, set equal to zero.)	R
MC062	835/2110/SVC/ /02	2400 SV203 (I); 2400 SV102 (P)	Charge Amount	int	10	Do not code decimal point or provide any punctuation where \$1,000.00 converted to 100000 Same for all financial data that follows.	R
MC063	835/2110/SVC/ /03	2430 SVD02	Paid Amount	int	10	Includes any withhold amounts. Do not code decimal point. For capitated claims set to zero.	R
Data Element #	Reference	PACDR Reference Institutional (I) Professional	Data Element Name	Type	Length	Description/Codes/Sources	Required

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		(P)					
MC064	N/A	2320 and/or 2430 CASxx where the CARC code is 104.	Prepaid Amount	int	10	For capitated services, the fee for service equivalent amount. Do not code decimal point.	R
MC065	N/A	2320 and/or 2430 CASxx where the CARC code is 3.	Co-pay Amount	int	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.	R
MC066	N/A	2320 and/or 2430 CASxx where the CARC code is 2	Coinsurance Amount	int	10	The dollar amount an individual is responsible for – not the percentage. Do not code decimal point.	R
MC067	N/A	2320 and/or 2430 CASxx where the CARC code is 1.	Deductible Amount	int	10	Do not code decimal point.	R
MC068	837/2300/CLM/ /01	2300 CLM01	Patient Account/Control Number	varchar	20	Number assigned by hospital	O
MC069	N/A	2300 DTP02	Discharge Date	date	8	Date patient discharged. Required for all inpatient claims. CCYYMMDD	O (inpatient claims only)

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC070	N/A	2310 NA04	Service Provider Country Name	varchar	30	Code US for United States.	R
MC071	837/2300/HI/DR/01-2	2300 HI01-2 or 2330B REF-2 where 2320 SBR06 = 6 and REF01 = 1N	DRG	varchar	10	Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to DRGs transmitted from the hospital provider. When the CMS methodology for DRGs is not available, but the DRG system is used, the insurer shall format the DRG and the complexity level within the same field with an "A" prefix, and with a hyphen separating the DRG and the complexity level (e.g. AXXX-XX).	O
MC072	N/A	2330 B REF04-2 where 2320 SBR06 = 6 and REF01 = 1N and REF04-1 = V0	DRG Version	char	2	Version number of the grouper used	O

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC073	835/2110/RE F/APC/02	N/A	APC	char	4	Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to APCs transmitted from the health care provider.	O
MC074	N/A	N/A	APC Version	char	2	Version number of the grouper used	O
MC075	837/2410/LIN /N4/03	2410 HL04 (I); 2410 LIN03 (P)	Drug Code	varchar	11	An NDC code used only when a medication is paid for as part of a medical claim.	O
MC076	837/2010AA/ NM1/ID/09	2010AA REF02 where REF01 = G2 and/or LU	Billing Provider Number	varchar	30	Payer assigned billing provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change.	R
MC077	837/2010AA/ NM1/X X/09	2010AA NM109	National Billing Provider ID	varchar	20	National Provider ID	R
MC078	837/2010AA/ NM1//03	2010AA NM103	Billing Provider LastName or Organization Name	varchar	60	Full name of provider billing organization or last name of individual billing provider.	R
MC101	837/2010BA/ NM1//03	2010BA/NM1/ /03	Subscriber Last Name	varchar	128	Subscriber last name	R

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC102	837/2010BA/ NM1/	2010BA/NM1/ /04	Subscriber First Name	varchar	128	Subscriber first name	R
MC103	837/2010BA/ NM1/ /05	2010BA/NM1/ /05	Subscriber Middle Initial	char	1	Subscriber middle initial	O
MC104	837/2010CA/ NM1/ /03	2010CA NM103 or 2010BA NM103	Member Last Name	varchar	128	Member last name	R
MC105	837/2010CA/ NM1/ /04	2010CA NM104 or 2010BA NM104	Member First Name	varchar	128	Member first name	R
MC106	837/2010CA/ NM1/ /05	2010CA NM105 or 2010BA NM105	Member Middle Initial	char	1	Member middle intial	O
MC107		2010CA N301 & N302 or 2010BA N301 & N302	Member Street Address	varchar	50	Physical street address of the covered member	R
MC108		2310E N301 & N302 (I); 2420C N301 & N302 (P) or 2310C N301 & N302 (P)	Service Provider Street Address	varchar	50	Physical practice location street address of the provider administering the services	R

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC200	N/A	N/A	ICD-9 / ICD-10 Flag	char	1	0 - This claim contains ICD-9-CM codes 1 - This claim contains ICD-10-CM codes The purpose of this field is to identify which code set is being utilized.	R
MC201		2300 HI01-2 where HI01-1 = BQ (ICD-9) or = BBQ (ICD-10)	ICD-9/10-CM Other Procedure Code - 1	varchar	7	Secondary procedure code for this line of service. Do not code decimal point.	O
MC202		2300 HI02-2 where HI02-1 = BQ (ICD-9) or = BBQ (ICD-10)	ICD-9/10-CM Other Procedure Code – 2	varchar	7	Secondary procedure code for this line of service. Do not code decimal point.	O
MC203		2300 HI03-2 where HI03-1 = BQ (ICD-9) or = BBQ (ICD-10)	ICD-9/10-CM Other Procedure Code – 3	varchar	7	Secondary procedure code for this line of service. Do not code decimal point.	O
MC204		2300 HI04-2 where HI04-1 = BQ (ICD-9) or = BBQ (ICD-10)	ICD-9/10-CM Other Procedure Code – 4	varchar	7	Secondary procedure code for this line of service. Do not code decimal point.	O

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC205		2300 HI05-2 where HI05-1 = BQ (ICD-9) or = BBQ (ICD-10)	ICD-9/10-CM Other Procedure Code – 5	varchar	7	Secondary procedure code for this line of service. Do not code decimal point.	O
MC206		2300 HI06-2 where HI06-1 = BQ (ICD-9) or = BBQ (ICD-10)	ICD-9/10-CM Other Procedure Code - 6	varchar	7	Secondary procedure code for this line of service. Do not code decimal point.	O
MC207		N/A	Carrier Associated with Claim	varchar	8	For each claim, the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by data submitters acting as Third Party Administrators (TPAs) under contract to a data submitter for carved-out services are submitted by the data submitter with unified member IDs in all files.	R/O

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Data Element #	Reference	PACDR Reference Institutional (I) Professional (P)	Data Element Name	Type	Length	Description/Codes/Sources	Required
MC208		N/A	Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number	varchar	128	For each claim, the carrier specific contract number or subscriber/member social security number when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by data submitters acting as Third Party Administrators (TPAs) under contract to a data submitter for carved-out services are submitted by the data submitter with unified member IDs in all files.	R/O
MC209		N/A	Practitioner Group Practice	varchar	60	Name of group practice to which a practitioner is affiliated if different from MC078	O
MC899	N/A	N/A	Record Type	char	2	Value = MC	R

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A-3 PHARMACY CLAIMS DATA

Frequency: Monthly or Quarterly Upload via FTP (due within 45 days of the end of the reporting period)

Additional formatting requirements:

- Payers submit data in a single, consistent format for each data type.

PHARMACY CLAIMS FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	PC
HD002	Payer Code	char	8	NAIC code (example: 12345); leave blank if not applicable
HD003	Payer Name	char	75	Example:
HD004	Beginning Month	Date	6	CCYYMM
HD005	Ending Month	Date	6	CCYYMM
HD006	Record count	int	10	Total number of records submitted in the pharmacy claims file, excluding header and trailer records

PHARMACY CLAIMS FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	PC
TR002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
TR003	Payer Name	varchar	75	
TR004	Beginning Month	Date	6	CCYYMM
TR005	Ending Month	Date	6	CCYYMM
TR006	Extraction Date	Date	8	CCYYMMDD

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A-3.1 PHARMACY CLAIMS FILE

Data Element #	National Council for Prescription Drug Programs Field #	NCPDP Reporting Guide Reference #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC001	N/A	879	Payer	varchar	8	Payer submitting data file – Code assigned by system (may be multi-tiered to support different platforms).	R
PC002	N/A	879	Plan ID	varchar	30	CMS National Plan ID or NAIC	R
PC003	N/A	A90	Insurance Type/Product Code	char	2	See lookup table B-1.A	R
PC004	N/A	993-A7	Payer Claim Control Number	varchar	35	Must apply to the entire claim and be unique within the payer's system.	R
PC005	N/A	A91	Line Counter	tinyint	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.	R
PC006	301-C1	246	Insured Group Number	varchar	30	Group or policy number - not the number that uniquely identifies the subscriber	R
PC007	302-C2	302-C2	Subscriber Social Security Number	varchar	9	Subscriber's social security number; Set as null if unavailable	R
PC008	N/A	302-C2	Plan Specific Contract Number	varchar	128	Plan assigned subscriber's contract number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the subscriber.	R

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Data Element #	National Council for Prescription Drug Programs Field #	NCPDP Reporting Guide Reference #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC009	303-C3	303-C3	Member Suffix or Sequence Number	varchar	20	Unique number of the member within the contract. Must be an identifier that is unique to the member.	R
PC010	302-C2	332-CY	Member Identification Code	varchar	128	Member's social security number; Set as null if contract number = subscriber's social security number or use an alternate unique identifier such as Medicaid ID. Must be an identifier that is unique to the member.	R
PC011	306-C6	247	Individual Relationship Code	char	2	Member's relationship to insured See Lookup Table B-1.B	R
PC012	305-C5	305-C5	Member Gender	char	1	1 – Male 2 – Female 3 - Unknown	R
PC013	304-C4	304-C4	Member Date of Birth	date	8	CCYYMMDD	R
PC014	N/A	728-SU	Member City Name of Residence	varchar	50	City name of member	R
PC015	N/A	729-TA	Member State or Province	char	2	As defined by the US Postal Service	R
PC016	N/A	730-TC	Member ZIP Code	varchar	11	ZIP Code of member - may include non-US codes; Do not include dash. Plus 4 optional but desired.	R
PC017	N/A	578	Date Service Approved (AP Date)	date	8	CCYYMMDD – date claim paid if available, otherwise set to Date Prescription Filled	R
PC018	201-B1	201-B1	Pharmacy Number	varchar	30	Payer assigned pharmacy number. AHFS number is acceptable.	O

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Data Element #	National Council for Prescription Drug Programs Field #	NCPDP Reporting Guide Reference #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC019	N/A	N/A	Pharmacy Tax ID Number	varchar	10	Federal taxpayer's identification number coded with no punctuation (carriers that contract with outside PBMs will not have this)	R
PC020	833-5P	833-5P	Pharmacy Name	varchar	50	Name of pharmacy	R
PC021	N/A	201-B1	National Provider ID Number	varchar	20	National Provider ID. This data element pertains to the entity or individual directly providing the service.	O
PC022	831-5N	728-SU	Pharmacy Location City	varchar	30	City name of pharmacy - preferably pharmacy location (if mail order null)	R
PC023	832-5O	729-TA	Pharmacy Location State	char	2	As defined by the US Postal Service (if mail order null)	R
PC024	835-5R	730-TC	Pharmacy ZIP Code	varchar	10	ZIP Code of pharmacy - may include non-US codes. Do not include dash. Plus 4 optional but desired (if mail order null)	R
PC024A	N/A	A93	Pharmacy Country Name	varchar	30	Code US for United States	R
PC025	N/A	A88	Claim Status	char	2	See Lookup Table B-1.H.	R
PC026	407-D7	407-D7	Drug Code	varchar	11	NDC Code	R
PC027	516-FG	397	Drug Name	varchar	80	Text name of drug	R
PC028	403-D3	254	New Prescription or Refill	varchar	2	Provide '01' for new prescriptions; for refills, provide the refill number	R
						01 - New prescription	
						02 - XX - Refill Number	
PC029	425-DP	425-DP	Generic Drug Indicator	char	2	01 - branded drug	R
						02 - generic drug	

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Data Element #	National Council for Prescription Drug Programs Field #	NCPDP Reporting Guide Reference #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC030	408-D8	408-D8	Dispensed as Written Code	char	1	Payers able to map available codes to those listed below	R
						0 Not dispensed as written	
						1 Physician dispensed as written	
						2 Member dispensed as written	
						3 Pharmacy dispensed as written	
						4 No generic available	
						5 Brand 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	
PC031	406-D6	406-D6	Compound Drug Indicator	char	1		O
						N Non-compound drug	
						Y Compound drug	
						U Non-specified drug compound	
PC032	401-D1	401-D1	Date Prescription Filled	date	8	CCYYMMDD	R
PC033	404-D4	442-E7	Quantity Dispensed	dec (explicit)	10	Number of metric units of medication dispensed	O
PC034	405-D5	405-D5	Days Supply	int	3	Estimated number of days the prescription will last	O

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Data Element #	National Council for Prescription Drug Programs Field #	NCPDP Reporting Guide Reference #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC035	804-5B	430-DU	Charge Amount	int	10	Do not code decimal point or provide any punctuation where \$1,000.00 converted to 100000 Same for all financial data that follows.	R
PC036	876-4B	281	Paid Amount	int	10	Includes all health plan payments and excludes all member payments. Do not code decimal point.	R
PC037	506-F6	506-F6	Ingredient Cost/List Price	int	10	Cost of the drug dispensed. Do not code decimal point.	R
PC038	428-DS	N/A	Postage Amount Claimed	int	10	Do not code decimal point. Not typically captured.	O
PC039	412-DC	507-F7	Dispensing Fee	int	10	Do not code decimal point.	R
PC040	817-5E	518-FI	Co-pay Amount	int	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.	R
PC041	N/A	572-4U	Coinsurance Amount	int	10	The dollar amount an individual is responsible for – not the percentage. Do not code decimal point.	R
PC042	N/A	517-FH	Deductible Amount	int	10	Do not code decimal point.	R
PC043	N/A	N/A	Unassigned			Reserved for assignment	O
PC044	N/A	717	Prescribing Physician First Name	varchar	25	Physician first name.	O if PC047 is filled
PC045	N/A	A92	Prescribing Physician Middle Name	varchar	25	Physician middle name or initial.	O if PC047 is filled

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Data Element #	National Council for Prescription Drug Programs Field #	NCPDP Reporting Guide Reference #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC046	427-DR	716	Prescribing Physician Last Name	varchar	60	Physician last name.	O if PC047 is filled
PC047	421-DZ	411-DB	Prescribing Physician Number	varchar	20	NPI number for prescribing physician	O
PC101	313-CD	716	Subscriber Last Name	varchar	128		R
PC102	312-CC	717	Subscriber First Name	varchar	128		R
PC103	N/A	718	Subscriber Middle Initial	char	1		O
PC104	311-CB	716	Member Last Name	varchar	128		R
PC105	310-CA	717	Member First Name	varchar	128		R
PC106	N/A	718	Member Middle Initial	char	1		O
PC201	N/A	726	Pharmacy Location Street Address	varchar	30	Street address of pharmacy	R
PC202	N/A	726	Member Street Address	varchar	50	Street address of member	R
PC203	N/A	N/A	Carrier Associated with Claim	varchar	8	For each claim, the NAIC code of the carrier when a PBM processes claims on behalf of the carrier. Optional if all pharmacy claims processed by data submitters acting as Pharmacy Benefits Managers (PBMs) under contract to a data submitter for carved-out services are submitted by the data submitter with unified member IDs in all files.	R/O

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Data Element #	National Council for Prescription Drug Programs Field #	NCPDP Reporting Guide Reference #	Data Element Name	Type	Length	Description/Codes/Sources	Required
PC204	N/A	N/A	Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number	varchar	128	For each claim, the carrier specific contract number or subscriber/member social security number when a PBM processes claims on behalf of the carrier. Optional if all pharmacy claims processed by data submitters acting as Pharmacy Benefits Managers (PBMs) under contract to a data submitter for carved-out services are submitted by the data submitter with unified member IDs in all files.	R/O
PC899	N/A	N/A	Record Type	char	2	PC	R

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A-4 Provider File

Frequency: Monthly or Quarterly Upload via FTP (due within 45 days of the end of the reporting period)

Additional formatting requirements:

- Payers submit data in a single, consistent format for each data type.
- A provider means a health care facility, health care practitioner, health product manufacturer, health product vendor or pharmacy.
- A billing provider means a provider or other entity that submits claims to health care claims processors for health care services directly performed or provided to a subscriber or member by a service provider.
- A service provider means the provider who directly performed or provided a health care service to a subscriber or member.
- One record submitted for each provider for each unique physical address.

PROVIDER FILE HEADER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
HD001	Record Type	char	2	MP
HD002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
HD003	Payer Name	varchar	75	
HD004	Beginning Month	Date	6	CCYYMM (Example: 200801)
HD005	Ending Month	Date	6	CCYYMM (Example: 200812)
HD006	Record count	int	10	Total number of records submitted in the medical provider file, excluding header and trailer records

PROVIDER FILE TRAILER RECORD

Data Element #	Data Element Name	Type	Max Length	Description/valid values
TR001	Record Type	char	2	MP
TR002	Payer Code	varchar	8	NAIC code (example: 12345); leave blank if not applicable
TR003	Payer Name	varchar	75	
TR004	Beginning Month	Date	6	CCYYMM (Example: 200801)
TR005	Ending Month	Date	6	CCYYMM (Example: 200812)
TR006	Extraction Date	Date	8	CCYYMMDD

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A-4.1 PROVIDER FILE

Data Element #	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required
MP001	N/A	Provider ID	varchar	30	Unique identified for the provider as assigned by the reporting entity	R
MP002	N/A	Provider Tax ID	varchar	10	Tax ID of the provider. Do not code punctuation.	R
MP003	N/A	Provider Entity	char	1	F – Facility G –Group Practice I – IPA (Independent Practice Association) P – Practitioner (individuals filing a professional claim)	R
MP004	N/A	Provider First Name	varchar	25	Individual first name. Set to null if provider is a facility or organization.	R
MP005	N/A	Provider Middle Name or Initial	varchar	25		O
MP006	N/A	Provider Last Name or Organization Name	varchar	60	Full name of provider organization or last name of individual provider	R
MP007	N/A	Provider Suffix	varchar	10	Example: Jr.;null if provider is an organization. Do not use credentials such as MD or PhD	O
MP008	N/A	Provider Specialty	varchar	50	As defined by payer. Dictionary for specialty code values must be supplied during testing.	R
Data	Reference	Data Element Name	Type	Length	Description/Codes/Sources	Required

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Element #						
MP009	N/A	Provider Office Street Address	varchar	50	Physical address – address where provider delivers health care services	R
MP010	N/A	Provider Office City	varchar	30	Physical address – address where provider delivers health care services	R
MP011	N/A	Provider Office State	char	2	Physical address – address where provider delivers health care services. Use postal service standard 2 letter abbreviations.	R
MP012	N/A	Provider Office Zip	varchar	11	Physical address – address where provider delivers health care services. Minimum 5 digit code.	R
MP013	N/A	Provider DEA Number	varchar	12		R
MP014	N/A	Provider NPI	varchar	20		R
MP015	N/A	Provider State License Number	varchar	15	Prefix with two-character state of licensure with no punctuation. Example COLL12345	R
MP016	N/A	Payer	varchar	8	Payer submitting data file – Code assigned by system (may be multi-tiered to support different platforms).	R
MP017	271/2100A/ NM1/XV/09	National Plan ID	varchar	30	CMS National Plan ID or NAIC code.	R
MP899	N/A	Record Type	char	2	MP	R

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B-1 LOOKUP TABLES

B-1.A INSURANCE TYPE

12 Preferred Provider Organization (PPO)
13 Point of Service (POS)
14 Exclusive Provider Organization (EPO)
15 Indemnity Insurance
16 Health Maintenance Organization (HMO) Medicare Advantage
CI Commercial Insurance Company
FE Federal Employees Health Benefits Program
HM Health Maintenance Organization
HN HMO Medicare Risk/ Medicare Part C
MA Medicare Part A
MB Medicare Part B
MC Medicaid
MD Medicare Part D
MP Medicare Primary
QM Qualified Medicare Beneficiary
SP Supplemental Policy
TR Tricare
TV Title V
99 Other

B-1.B RELATIONSHIP CODES

01 Spouse
04 Grandfather or Grandmother
05 Grandson or Granddaughter
07 Nephew or Niece
10 Foster Child
15 Ward
17 Stepson or Stepdaughter
19 Child
20 Employee/Self
21 Unknown
22 Handicapped Dependent
23 Sponsored Dependent
24 Dependent of a Minor Dependent
29 Significant Other

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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
76 Dependent

B-1.C RACE 1/RACE 2

R1 American Indian/Alaska Native
R2 Asian
R3 Black/African American
R4 Native Hawaiian or other Pacific Islander
R5 White
R9 Other Race
UNKNOW Unknown/Not Specified

B-1.D Ethnicity 1/Ethnicity 2

2182-4 Cuban
2184-0 Dominican
2148-5 Mexican, Mexican American, Chicano
2180-8 Puerto Rican
2161-8 Salvadoran
2155-0 Central American (not otherwise specified)
2165-9 South American (not otherwise specified)
2060-2 African
2058-6 African American
AMERCN American
2028-9 Asian
2029-7 Asian Indian
BRAZIL Brazilian
2033-9 Cambodian
CVERDN Cape Verdean
CARIBI Caribbean Island
2034-7 Chinese
2169-1 Columbian
2108-9 European
2036-2 Filipino
2157-6 Guatemalan
2071-9 Haitian
2158-4 Honduran
2039-6 Japanese

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2040-4	Korean
2041-2	Laotian
2118-8	Middle Eastern
PORTUG	Portuguese
RUSSIA	Russian
EASTEU	Eastern European
2047-9	Vietnamese
OTHER	Other Ethnicity
UNKNOW	Unknown/Not Specified

B-1.E Discharge Status

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 a facility that provides custodial or supportive care
05	Discharged/transferred to a designated cancer center of 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	Reserved for assignment by the NUBC
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	Discharged/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)
69	Discharged/transferred to a designated disaster alternative care site (effective 10/1/13)
70	discharged/transferred to another type of health care institution not defined elsewhere in this code list
81	Discharged to home or self care with a planned acute care hospital inpatient readmission (effective 10/1/13)

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82 Discharged / transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission (effective 10/1/13)
83 Discharged / transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (effective 10/1/13)
84 Discharged / transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (effective 10/1/13)
85 Discharged / transferred to designated cancer center of children's hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
86 Discharged / transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission (effective 10/1/13)
87 Discharged / transferred to court / law enforcement with a planned acute care hospital inpatient readmission (effective 10/1/13)
88 Discharged / transferred to a federal health care facility with a planned acute care hospital inpatient readmission (effective 10/1/13)
89 Discharged / transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission (effective 10/1/13)
90 Discharged / transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
91 Discharged / transferred to a medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
92 Discharged / transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (effective 10/1/13)
93 Discharged / transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
94 Discharged / transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
95 Discharged / transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (effective 10/1/13)

B-1.F Type of Bill – Institutional

Type of Facility - First Digit
1 Hospital
2 Skilled Nursing
3 Home Health
4 Religious Non-Medical Health Care Institutions
5 Christian Science Extended Care
6 Intermediate Care
7 Clinic
8 Special Facility
Bill Classification - Second Digit if First Digit = 1-6
1 Inpatient (Including Medicare Part A)
2 Inpatient (Medicare Part B Only)
3 Outpatient

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4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment)
5 Nursing Facility Level I
6 Nursing Facility Level II
7 Intermediate Care - Level III Nursing Facility
8 Swing Beds
Bill Classification - Second Digit if First Digit = 7
1 Rural Health
2 Hospital Based or Independent Renal Dialysis Center
3 Clinic - Freestanding
4 Clinic - Outpatient Rehabilitation Facility (ORF)
5 Comprehensive Outpatient Rehabilitation Facilities (CORFs)
6 Community Mental Health Center
7 Clinic - Federally Qualified Health Center (FQHC) (Effective 4/1/10)
8 Licensed Freestanding Emergency Medical Facility (Effective 7/1/12)
9 Other
Bill Classification - Second Digit if First Digit = 8
1 Hospice (Non-Hospital Based)
2 Hospice (Hospital-Based)
3 Ambulatory Surgery Center
4 Free Standing Birthing Center
5 Critical Access Hospital
6 Residential Facility
9 Other
Frequency - third digit
0 Non-Payment/Zero
1 admit through discharge
2 interim - first claim used for the...
3 interim - continuing claims
4 interim - last claim
5 late charge only
7 replacement of prior claim
8 void/cancel of a prior claim
9 Admission/Election Notice

B-1.G Place of Service – Professional

01 Pharmacy
02 Unassigned
03 School
04 Homeless Shelter

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05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
09	Prison/Correctional Facility
10	Unassigned
11	Office
12	Home
13	Assisted Living Facility Congregate
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment-Worksite
19	Unassigned
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room - Hospital
24	Ambulatory Surgery Center
25	Birth Center
26	Military Treatment Facility
27-30	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35-40	Unassigned
41	Ambulance - Land
42	Ambulance - Air or Water
43-48	Unassigned
50	Federally Qualified Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
58-59	Unassigned
60	Mass Immunization Center

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61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63-64	Unassigned
65	End Stage Renal Disease Treatment Facility
66-70	Unassigned
71	State or Local Public Health Clinic
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-98	Unassigned
99	Other Unlisted Facility

B-1.H Claim Status

01	Processed as primary
02	Processed as secondary
03	Processed as tertiary
19	Processed as primary, forwarded to additional payer(s)
20	Processed as secondary, forwarded to additional payer(s)
21	Processed as tertiary, forwarded to additional payer(s)
22	Reversal of previous payment

B-1.I Admission Source

Code	Description
1	Non-Healthcare Facility Point of Origin (Physician Referral)
2	Clinic Referral
3	HMO Referral
4	Transfer from a Hospital (Different Facility)
5	Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available
A	Reserved for National Assignment
B	Transfer from Another Home Health Agency(Discontinued July 1,2010)
C	Readmission to Same Home Health Agency (Discontinued July 1,2010)
D	Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to

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	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 Structure for Newborn (to be used only when MC020/Type of Admission code = '4')

Code	Description
5	Born Inside the Hospital
6	Born Outside the Hospital

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Attachment A

VHI Data Submission Manual Revision History

8/5/2013 Revisions – v 1.1

Page 4

Data Submission Requirements – General

New Language

To facilitate data communications, data submissions and processing, data submitters will provide to VHI's APCD data subcontractor registration information with the following information:

- o Company contacts
- o Control totals for reconciliation
- o Data files submitted and sources/platforms
- o Special data considerations
- o Member linkage information

The registration form should be completed within thirty days after the Data Submission Manual is finalized, whenever the data submitter's information is modified, and by June 30th of 2014 and every year thereafter.

A registration process needed to be established to collect contact and data submission information from the commercial data supplying entities to ensure that the data submission sources and technical contacts are accurately identified and that there is a better understanding of the data being submitted.

New Language:

Although data submitters may provide files on a quarterly basis, it is preferable that files be submitted on a monthly schedule due to the large volume of data contained in the files.

This language was added because the files submitted by VA payers will be large. If data files are submitted monthly, the data processing vendor will be able to run the field level and quality audits as the files are submitted. If an entire quarter of files are submitted and problems are then found, it could cause delays in processing and could make it more difficult for the data submitters to address the issues due to the volume of data.

New Language:

It is expected that the data files, where applicable, be populated using the most current nationally adopted code sets.

This is a reminder to use national codes and to minimize any "home grown" codes.

New Language:

All medical or pharmacy claims processed by data submitters acting as Third Party Administrators (TPA's) or Pharmacy Benefits Managers (PBM's) under contract to a data submitter for carved-out services must be submitted by the data submitter with unified member ID's in all files.

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This modification was added to address the inability to accurately associate the members in the eligibility and medical claims file with those same members in the eligibility and claims files when data submitters that are carriers contract with a PBM or TPA to administer carve out coverage (pharmacy or mental health). If a data submitter cannot submit the files in this manner, two new fields were created in both the Medical Claims (MC) and Pharmacy Claims (PC) files to link the individual claims to the specific carriers and to associate the members in the separate eligibility files. The new fields are Carrier Associated with Claim (MC207/ PC203) and Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number (MC208/PC204).

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MC037 – **Place of Service** – Professional

The Data Element Name of MC037 was modified from “Facility Type – Professional” to “Place of Service – Professional” to conform to CMS naming conventions.

New Language:

MC041 – MC053 – **Principal and Other Diagnosis Codes** - It is expected that ICD-9-CM or ICD-10-CM codes be used to populate these fields. However, if individual, non-bundled “home grown” codes are still in use, a table is required which lists the codes and definitions.

Data submitters need to provide dictionaries (tables) specifying any “home grown” diagnosis codes, with definitions, still in use.

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New Language

MC055 – **Procedure Code** – It is expected that Health Care Common Procedure Coding System (HCPCS)/Common Procedural Terminology (CPT) codes be used to populate this field. However, if individual, non-bundled “home grown” codes are still in use, a table is required which lists the codes and definitions.

Data submitters need to provide dictionaries (tables) specifying any “home grown” procedure codes, with definitions, still in use.

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MC058 – An ICD-9-CM **or ICD-10-CM** Procedure Code

“ICD-10-CM” was added in anticipation of the implementation of the new codes.

Page 8

New Language (3.1):

In some cases, a data element may be marked as optional for professional claims, but it is noted in parenthesis to be required for inpatient claims.

This additional language clarifies the term “optional” when applied to facility claims vs. practitioner claims.

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Pages 11-17: Member Eligibility File

Page 11 - Language was added to clarify that data files may be submitted monthly and due within 45 days of the reporting period. Also, the word “Virginia” was added to clarify that the data reported relates to Virginia residents only.

Page 16 - Add “**Special Coverage**” field (ME031). This is a new 3 character field to be used if VA has, or develops, special statewide health care coverage programs. It would also retain a three character data element place holder that already exists in other state file formats, which will reduce the coding necessary to create extracts for those data submitters already providing data to other states.

Pages 18-39: Medical Claims File

Page 18 - Language was added to clarify that data files may be submitted monthly and due within 45 days of the reporting period

Pages 19 – 39 - A new column was created in order for the VHI data collection requirements to comply with national standards. The column, which is entitled “**PACDR Reference Institutional (I) Professional (P)**”, provides the mapping to the Post Adjudicated Claims Data Reporting (PACDR) guides (Institutional and Professional).

Page 32 - The Data Element Name of MC058 was modified to “ICD -9/10-CM Principal Procedure Code” and the Length was expanded to **7** to allow for the ICD-10 codes.

Page 37 & 38 – Six optional “**ICD-9/10-CM Other Procedure Code**” fields (**MC201 – MC206**) were added to enhance the accuracy of the data and to improve the utility of the hospital inpatient groupers.

Page 38 – **MC207**, entitled “**Carrier Associated with Claim**”, was added to link the individual claims to a specific carrier using the NAIC code when a data submitter acting as a TPA processes medical claims on behalf of the carrier.

Page 38 - **MC208**, entitled “**Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number**”, was added to associate identical members in separate eligibility files when a data submitter acting as a TPA. processes medical claims on behalf a carrier.

Page 39 – **MC209**, entitled “**Practitioner Group Practice**“, was added to capture the name of the group practice only when the MC078, Billing Provider Organization Name, field does not accurately identify the group practice to which the practitioner belongs.

Pages 40-47: Pharmacy Claims File

Page 40 - Language was added to clarify that data files may be submitted monthly and due within 45 days of the reporting period

Pages 41 – 47 - A new column has been created in order for the VHI data collection requirements to comply with national standards. The column, which is entitled “**NCPDP**”

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Reporting Guide Reference", provides the mapping to the National Council for Prescription Drug Programs (NCPDP) *Post Adjudication Standard Implementation Guide*.

Page 43 – The code for PC028 has been modified to account for the number of refills, rather than limiting the codes to either "1 - New Prescription" or "2 - Refill".

Page 46 – **PC201**, entitled "**Carrier Associated with Claim**", was added to link the individual claims to a specific carrier using the NAIC code when a PBM processes pharmacy claims on behalf of the carrier.

Page 47 – **MC202**, entitled "**Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number**", was added to associate identical members in separate eligibility files when a PBM processes claims on behalf a carrier.

Pages 48-49: Provider File

Page 47 - Language has been added to clarify that data files may be submitted monthly and due within 45 days of the reporting period

Page 48 – An error in the code list for MP003 has been corrected. "G-Provider" is now "**G-Group Practice**".

Pages 49-58: Lookup Tables

Code lists were updated to correspond to the most recent national code sets.

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Page 6

Medical Provider File (MP)

MP001 – The words "and one address" were removed from the first sentence because it is inaccurate. In the event the same provider delivered and was reimbursed for services rendered from two different physical locations, then the provider data file shall contain two separate records for that same provider reflecting each of those physical locations.

Page 8

New Language

1.2.5 FILE HEADER AND TRAILER DATA

Separate Header and Trailer Record files must be submitted with each Eligibility File, Medical Claims File, and Pharmacy Claims File.

This language was added to clarify that separate header and trailer files must be submitted with each eligibility and claims file.

Page 9

4.1 (e) was rewritten in the following manner to clarify the file structure: The first row **of the medical and pharmacy claims files** *always* contains the **data element** names of data columns.

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Page 16

ME030 – Market Category Code – In order to better categorize small group policies in VA a new code was added and two existing codes were modified in the following manner:

GS3 – policies sold and issued directly to employers having 50 or more employees (100 or more employees after 1/1/2016)

GS4 – policies sold and issued directly to employers having fewer than 50 employees (fewer than 100 employees after 1/1/2016)

GSA – policies sold and issued directly to small employers having fewer than 50 employees (fewer than 100 employees after 1/1/2016) through a qualified association trust

Pages 16 and 17

ME043 (Member Street Address) and ME044 (Employer Name) were renumbered to ME201 and ME202, respectively, and relocated after ME105 (Member First Name). The elements were moved and renumbered because it is easier to code data extracts when new data elements are located at the end of a file, rather than inserted in the middle of a file. Since at least three of the VHI data submitters have been sending data files to other states in the generally accepted APCD Council format, it will be easier for them to integrate these “new” elements if they fall at the end of the file.

Pages 46 and 47

PC048 (Pharmacy Location Street Address) and PC049 (Member Street Address) were renumbered to PC201 and PC202, respectively. Consequently, PC201 (Carrier Associated with Claim) and PC202 (Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number) now become PC203 and PC204, respectively. The location of the fields in the file have not changed, just the enumeration. This brings more consistency to the construction of the Manual.

Pages 50 and 51

Two new codes, FE Federal Employees Health Benefits Program and TR Tricare, were added to the Insurance Type code table because they had been inadvertently omitted in an earlier draft.