ONPOINT Health Data

Data Submission Guide

Vermont Health Care Uniform Reporting & Evaluation System (VHCURES)

VERSION: 2.2

UPDATED: April 2018

Table of Contents

1. Welcome 1

2. Introductions & Contact Information 2
   - About the Green Mountain Care Board 2
   - How to Reach the GMCB 2
   - About Onpoint Health Data 3
   - How to Reach Onpoint 3

3. General Submission Requirements 4
   - Who Must Register? 4
   - Who Must Actually Submit Data … & When? 5

4. Getting Oriented at Onpoint CDM 8
   - Options at the Public Level 8
   - Options at the Secure Level 9
   - Supporting Submitters 10
   - Submission & Status Tracking 11
   - Requesting a Variance from the State's Standards 12

5. Sending & Receiving Data 13
   - Setting Up for Secure Transfers 13
   - Step 1: Verifying the Presence of Java Runtime Environment (JRE) 15
   - Step 2: Choosing Your Upload Option 16
   - Upload Option 1: AutoUploader 17
   - Upload Option 2: Manual Hashing & Uploading 18

6. General File Specifications 31

7. Eligibility File 33
   - The Basics 33
   - Columns Included in the Eligibility File 33
   - File Layout & Specifications 34

8. Medical Claims 42
   - The Basics 42
   - Columns Included in the Medical Claims File 42
   - File Layout & Specifications 43

9. Pharmacy Claims 58
   - The Basics 58
   - Columns Included in the Pharmacy Claims File 58
   - File Layout & Specifications 59

10. Announcements & Additional Information 67
   - GMCB Announces Reporting Change for Medicare Supplement Insurers 67

11. Change Log 68

1. Welcome

On behalf of Vermont's Green Mountain Care Board (GMCB), welcome to the Vermont Health Care Uniform Reporting & Evaluation System (VHCURES), the state's all-payer claims database (APCD). VHCURES is a comprehensive, longitudinal, multi-payer data set providing unprecedented research and policy opportunities for improving the state's health care delivery system.

Vermont law (Act 79 of 2013, Section 40, Regulation H-2008-01) requires the GMCB to collect data on Vermont residents from commercial health insurers and Vermont's Medicaid program. (The VHCURES program previously was managed by the Vermont Department of Banking, Insurance, Securities & Health Care Administration (BISHCA), which subsequently became the Department of Financial Regulation (DFR).

For the purposes of VHCURES data collection, the definition of "health insurers" includes third-party administrators (TPAs), pharmacy benefit managers (PBMs), hospitals and health systems, administrators of self-insured or publicly insured health benefits plans, and any other similar entity with claims data, eligibility data, provider files and other information relating to health care provided to Vermont residents.

How can you help? By providing accurate and complete data that helps paint the picture of the current state of healthcare delivery and utilization. How can we help? By safely and securely integrating and enriching this data and supplying it to the state for follow-on analytics and research.

Your organization will play a critical part in creating this important resource, providing the foundational data needed to enhance understanding of the use, cost, quality, and delivery of healthcare across Vermont. We're glad you're part of this exciting initiative — and we're here to help.

We're Onpoint Health Data, the State's contracted vendor for data intake, cleansing, consolidation, and extract. We've been doing this work for more than 15 years, helping launch multiple statewide APCDs from Maine to Minnesota. We're a nonprofit company committed to a singular mission: advancing informed decision making by providing independent and reliable health data services.

We'll work closely with you to help understand Vermont's submission requirements and how to meet them as efficiently as possible. This manual is the place to start. On the following pages, we'll outline the process from start to finish, walking you through each step of working with Onpoint CDM (Claims Data Manager), our data integration solution for commercial, Medicaid, and Medicare files alike.

For new submitters, this is the place to familiarize yourself with the ins and outs of data submissions, including information on how data fields should be prepared, how to protect and transmit data for VHCURES, and who to contact when questions arise. For submitters already familiar with Onpoint, these pages may provide a helpful refresher on coding specifications and program milestones. Whether new or veteran, welcome! We're glad to have you on board.

2. Introductions & Contact Information

About the Green Mountain Care Board

The GMCB was created by the Vermont Legislature in 2011. It is an independent group of five Vermonters who, with their staff, are charged with ensuring that changes in the health system improve quality while stabilizing costs. All five members of the GMCB have been nominated by a broad-based committee and appointed by Governor Peter Shumlin.

The Legislature assigned the GMCB three main responsibilities: regulation, innovation, and evaluation. The GMCB regulates not only health insurance rates, but also hospital budgets and major hospital expenditures. The Board also innovates, testing new ways to pay for and deliver health care as part of its role in building a new system. Finally, the board evaluates innovation projects, proposals for what benefits should be included in Vermont's new health system, proposals for funding the new system, and the effect of the new system on Vermont's economy. The Green Mountain Care Board wants to hear from Vermonters and continues to travel around the state to listen to residents' questions, ideas, and concerns.

Learn more by visiting the GMCB online: gmcboard.vermont.gov

How to Reach the GMCB

The Green Mountain Care Board serves as the primary state agency responsible for VHCURES administration. For questions about relevant statutory regulations and other issues under the State's purview, including submission compliance, please use the contact information below.

gmcb.data@vermont.gov

http://gmcboard.vermont.gov/hit/vhcures

Green Mountain Care Board
Attn: VHCURES Program
144 State Street
Montpelier, Vermont 05602

About Onpoint Health Data

Onpoint Health Data is Vermont's contracted vendor for data collection, cleansing, validation, integration, consolidation, and analytic extract construction. We are a Maine-based independent, nonprofit organization formed in 1976 by key stakeholders from the state's healthcare community. We are a full-service health data organization with two primary divisions: data management and analytic services. Our data management team — data intake specialists, data architects, and systems and data analysts — collect and integrate data from commercial and public payers, helping them meet our clients' quality thresholds. Onpoint's analytics team — additional systems analysts, quality assurance staff, health data analysts, health services researchers, and senior consultants — put the data to use through customized analysis and reporting, non-claims data linkage, and Business Intelligence tools.

Learn more by visiting us online: www.onpointhealthdata.org

Meeting the requirements of APCD reporting can seem sometimes like a complicated process. Onpoint is here to help. Our intake staff are trained, experienced, and ready to work with you. If you have a question, we'll help find the answer.

How to Reach Onpoint

Onpoint's data intake specialists are available to answer your questions regarding the mechanics of APCD collection, use of Onpoint's hashing and submission tools, and technical issues regarding the population, intent, or contents of submitted fields. We can be reached using the information below.

207-623-2555, 8:00am – 4:30pm (Eastern)

vt-support@onpointhealthdata.org

www.onpointhealthdata.org

Onpoint Health Data
Attn: VHCURES Operations Team
75 Washington Avenue, Suite 1E
Portland, ME 04101

3. General Submission Requirements

Who Must Register?

Vermont State Regulation H-2008-01 requires all covered health insurers and related parties to register with the state in support of the Vermont Health Care Uniform Reporting & Evaluation System (VHCURES). Onpoint facilitates this registration (and annual re-registration) process on behalf of the Green Mountain Care Board, which assumed control of VHCURES from the Vermont Department of Financial Regulation (known formerly as the Department of Banking, Insurance, Securities and Health Care Administration, or BISHCA).

Regulation H-2008-01 requires covered parties to submit healthcare eligibility and claims data for aggregation, analysis, and reporting using VHCURES, which was established as a "resource for measuring and improving health care system performance" in the State. This mandate covers not only insurers, but also third-party administrators (TPAs) and pharmacy benefit managers (PBMs) that cover Vermont residents or services rendered within the State. As noted in Regulation H-2008-01:

> Mandated Reporters shall submit to BISHCA or its designee health care claims data for all members who are Vermont residents . . . who received covered services provided by Vermont health care providers or facilities in accordance with the requirements of this section. Each Mandated Reporter is also responsible for the submission of all health care claims processed by any sub-contractor on its behalf unless such subcontractor is already submitting the identical data as a Mandated Reporter in its own right. The health care claims data submitted shall include, where applicable, a member eligibility file containing records associated with each of the claims files reported: a medical claims file and a pharmacy claims file. The data submitted shall also include supporting definition files for payer specific provider specialty taxonomy codes and procedure and/or diagnosis codes.

Mandatory registration — and re-registration — is due each year by December 31 to ensure that the State's records are kept current. Note that there are additional triggers that require you to file an updated registration throughout the year, including any changes to your currently filed contact information.

Who Must Actually Submit Data … & When?

As noted above, all health plan companies, TPAs, and PBMs covered by Vermont's Regulation H-2008-01 must register with Onpoint each year. However, not all parties must actually submit data for VHCURES. Those plans with fewer than 200 members must register, but are not required to submit data. Those with 200 or more members must both register and submit data according to the following schedules: Plans with 2,000 or more members must submit monthly (Table 1), while those with 500–1,999 members must submit quarterly (Table 2), and those with 200–499 members must submit annually (Table 3). Note that plans with 200–1,999 members may also submit on a more-frequent monthly/quarterly schedule if preferred. (For full rules and requirements, please review Regulation H-2008-01.)

Table 1. Monthly Reporting Schedule (≥2,000 Members)

Calendar Month	Submission by . . .
January	February 28 (February 29 on leap years)
February	March 31
March	April 30
April	May 31
May	June 30
June	July 31
July	August 31
August	September 30
September	October 31
October	November 30
November	December 31
December	January 31 of the next calendar year

Table 2. Quarterly Reporting Schedule (500–1,999 Members)

Calendar Quarter	Submission by . . .
Q1: January 1 – March 31	April 30
Q2: April 1 – June 30	July 31
Q3: July 1 – September 30	October 31
Q4: October 1 – December 31	January 31 of the next calendar year

Table 3. Annual Reporting Schedule (200–499 Members)

Eligibility & Paid Claims Dates	Submission by . . .
April 1 (of the preceding year) – March 31 (of the current year)	April 30

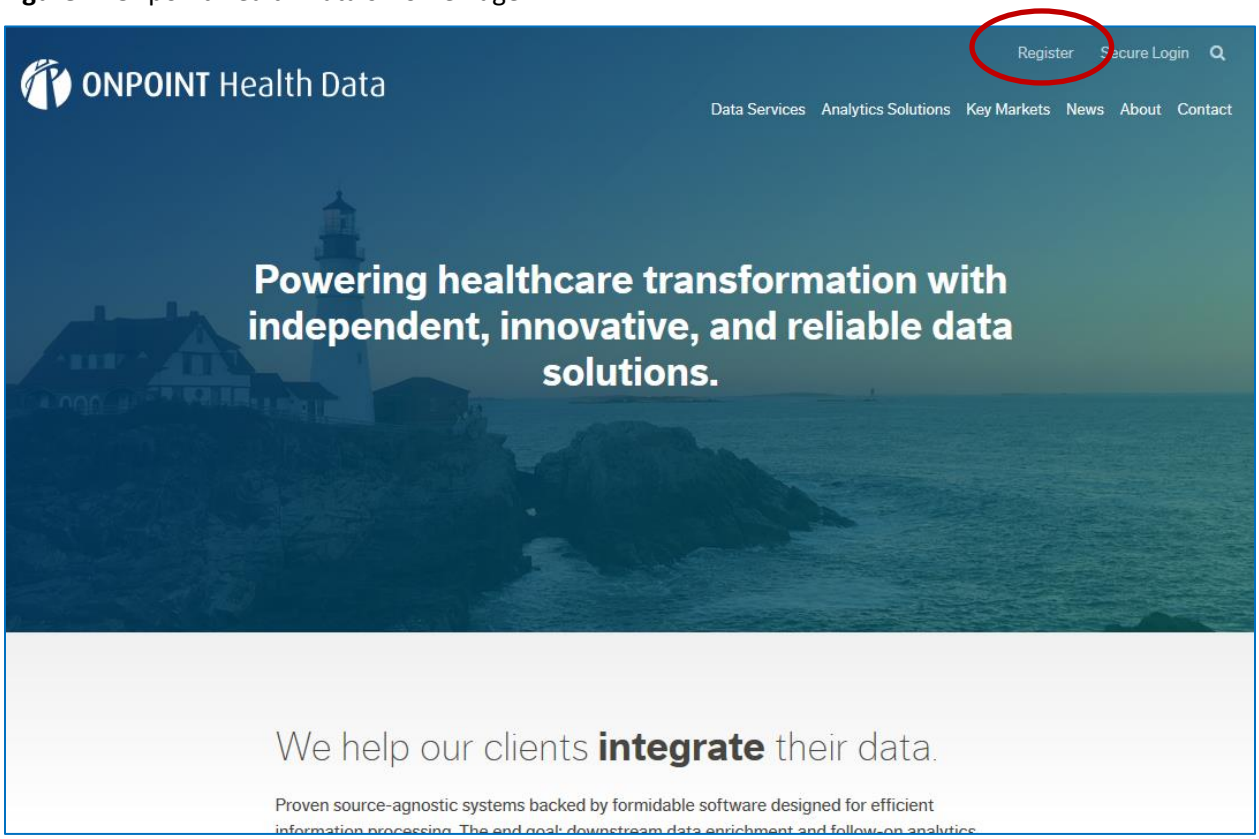
To satisfy the first step of Vermont State's Regulation H-2008-01, submitters first must register with Onpoint, supplying all required information. (Note that if you already submit data to Onpoint for another client, you still need to register for Vermont submissions. To keep things simple, though, we'll extend your authorizations appropriately, enabling you to use your existing logon for VHCURES services.)

Information included on the standard registration form includes:

- Company address(es)
- Number of covered lives
- Adjustment-reporting methodology
- Contacts for questions regarding eligibility, medical claims, pharmacy claims, and compliance

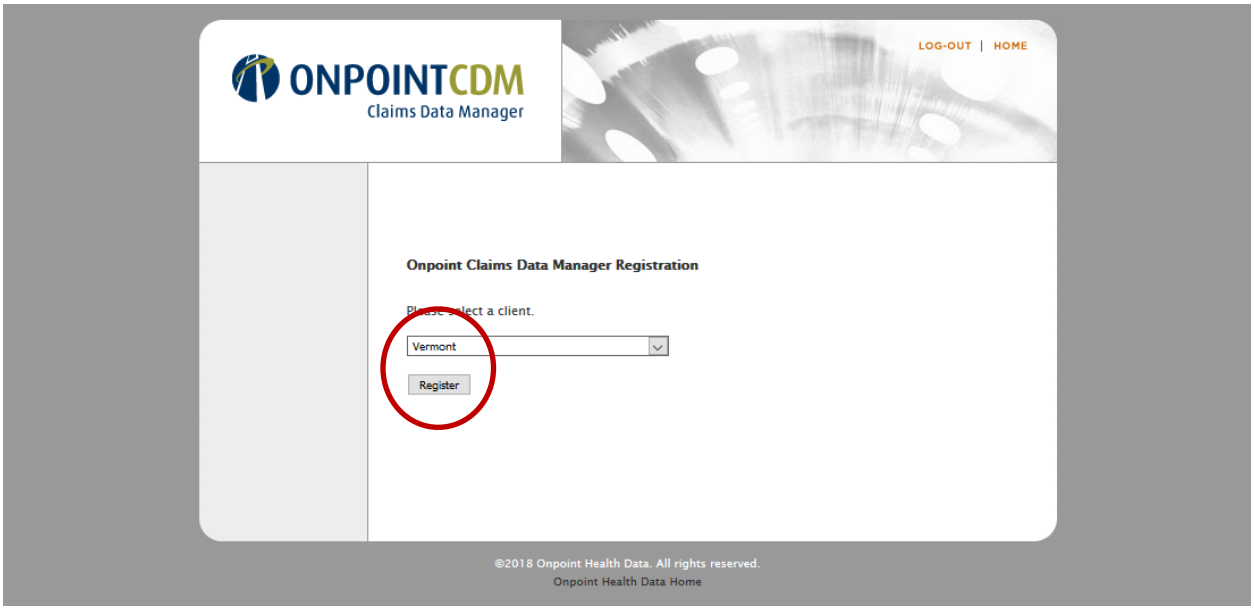
To get started, please visit www.onpointhealthdata.org, and click the "Register" link in the home page's upper-right menu (see Figure 1).

Figure 1. Onpoint Health Data's Home Page



On the resulting Onpoint CDM registration page, simply select “Vermont” from the list of clients and click the “Register” button (Figure 2), which will direct you to the online registration form.

Figure 2. Onpoint CDM’s Registration Launch Page



After registration, each of your organization’s identified contacts will receive an email with their assigned login and password. Each contact will receive a copy of all Onpoint CDM emails. Contacts who wish to receive email regarding only a subset of topics (e.g., compliance, newsletters, etc.) must send an email specifying their preferences to vt-support@onpointhealthdata.org to restrict their email distribution.

Please remember that mandatory re-registration is due each year prior to December 31 to ensure that the State’s records are kept current. Please contact the Green Mountain Care Board or Onpoint’s intake specialists for further details or clarification regarding registration requirements.

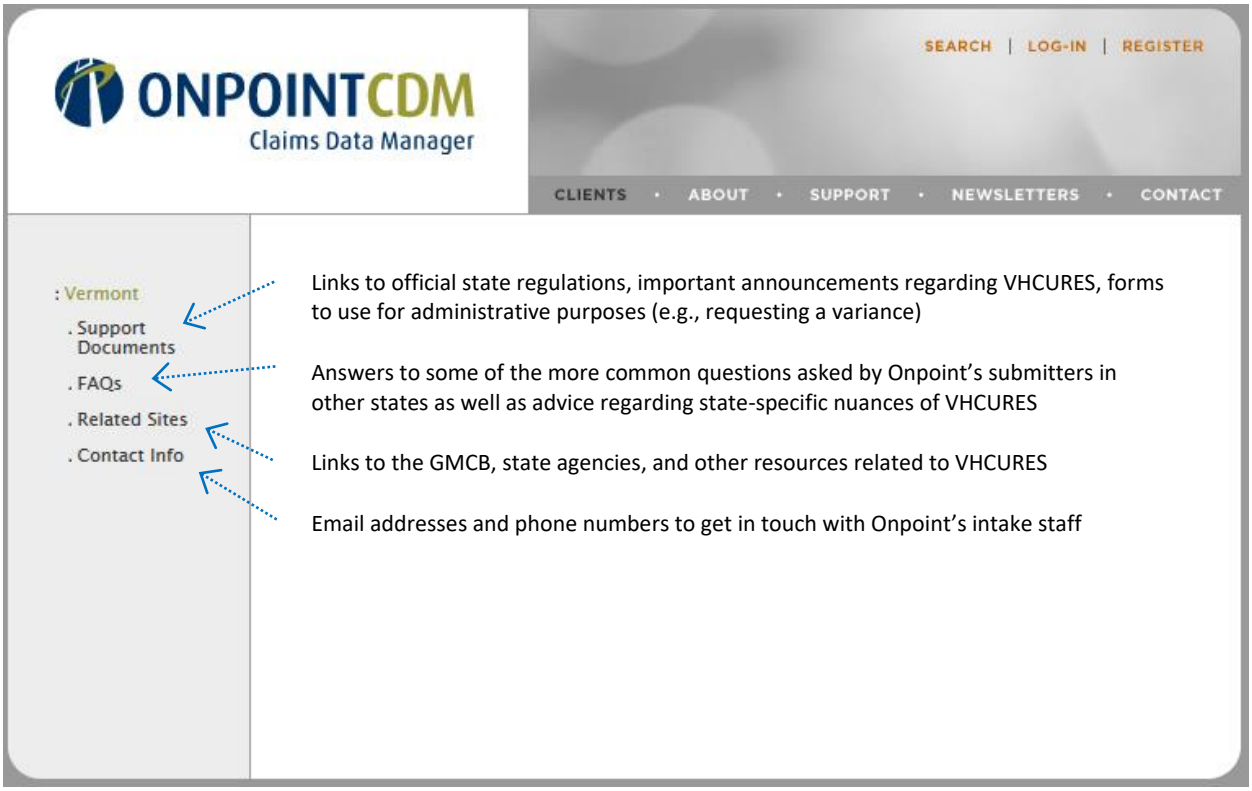
4. Getting Oriented at Onpoint CDM

Data collection and validation for VHCURES submissions is performed by Onpoint's suite of data integration and processing services, Onpoint CDM (Claims Data Manager). Onpoint CDM begins with submitter registration and ends with processed, standardized data. In between, it spans a series of complicated steps that include mapping submitters' data, benchmarking data, vetting data against an extensive library of data quality validations, tuning acceptance thresholds, validating intake, verifying quality, mapping identifiers, compiling records, and consolidating the resulting data into an accurate resource for follow-on research and online reporting. Throughout the process, Onpoint CDM's online interface — www.onpointcdm.org — serves as a resource for data reporters and clients alike. Onpoint CDM begins with payer registration and ends with processed, standardized data.

Options at the Public Level

Onpoint CDM's public zone offers quick access to publicly available reference materials, maintenance announcements, answers to frequently asked questions, and links to relevant state agencies and resources (see Figure 3). Onpoint CDM's section for VHCURES can be found here.

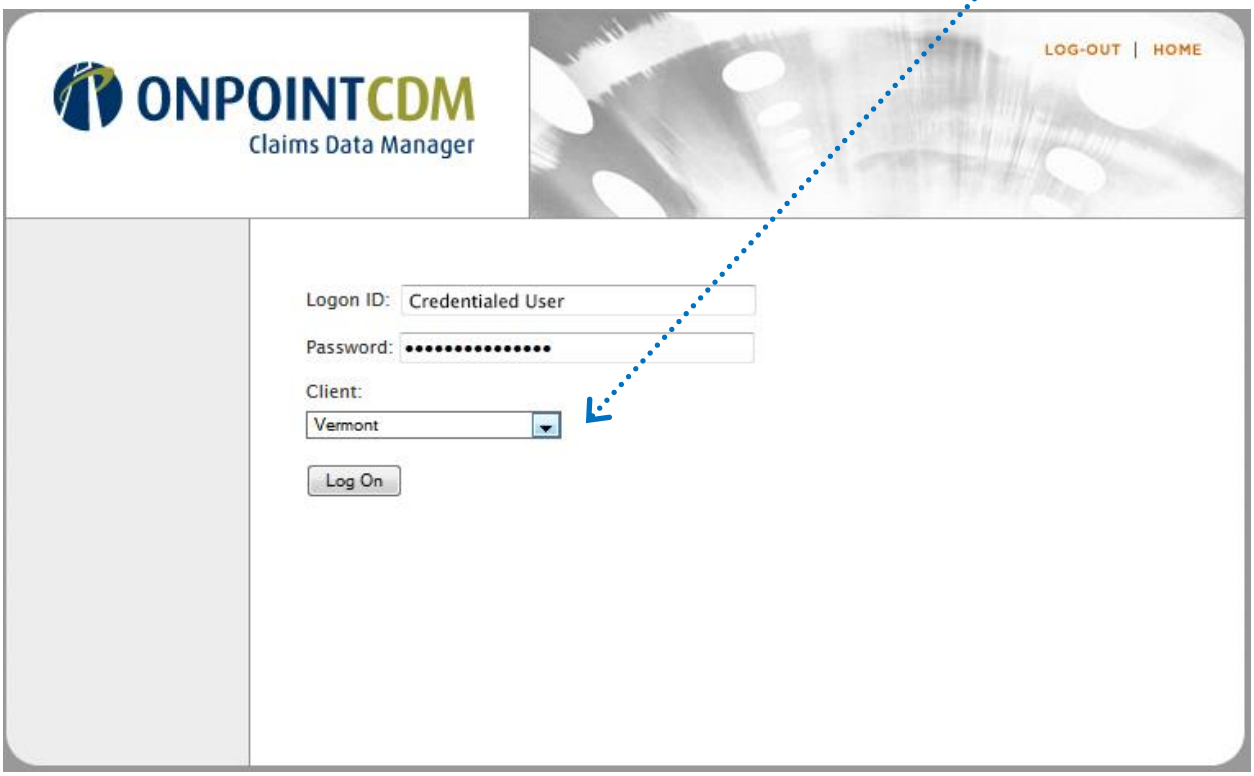
Figure 3. Onpoint CDM Options — Public Zone



Options at the Secure Level

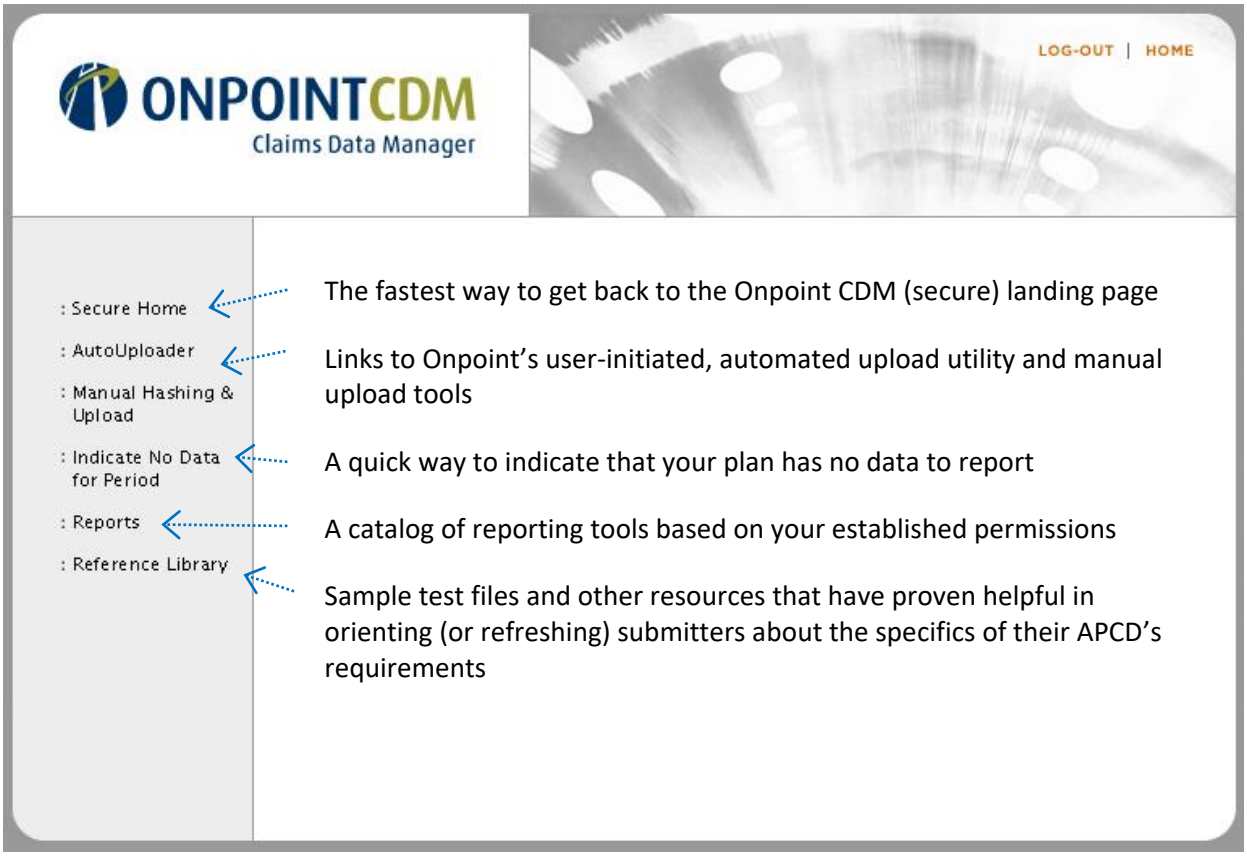
Credentialed users can log in to Onpoint CDM anytime to monitor the status of their submissions, including up-to-date reporting on stage, status, reasons for file failure, and resubmission deadlines. Gaining access begins at the Onpoint CDM home page. Simply click the LOG-IN option from the page's upper-right corner. Next, enter your Onpoint-assigned Logon ID and Password, select VERMONT from the drop-down list of clients, and click the LOG ON button (Figure 4).

Figure 4. Onpoint CDM Options — Logging in to the Secure Zone



Within Onpoint CDM's secure portal, the left-hand menu provides a range of options to help you monitor submissions and access reports that help explain issues that we're seeing in your submitted data (see Figure 5).

Figure 5. Onpoint CDM Options — Secure Zone



Supporting Submitters

Onpoint's data intake staff will work hand in hand with your technical staff to understand and meet Vermont's established data layouts, quality and completeness thresholds, and data quality validation process. We don't simply fail a submission and abandon submitters to resolve issues on their own; instead, we will help you find the solutions that both you and the GMCB need to obtain high-quality data. Our ultimate goal is to arrive at a solution that is efficient and programmable for participating plans while not compromising the timeliness and high quality of VHCURES and its important follow-on analytics.

Onpoint CDM includes automated alerts and hands-on support — on the phone, by email, via webinar tools, etc. — to help resolve any issues as soon as they arise. We tackle these issues through two key tools: submission tracking and status updates.

Submission & Status Tracking

Throughout the entire data flow, Onpoint CDM monitors each submission from start to finish — and enables submitters to do the same. Onpoint CDM provides authorized data reporters with a series of tracking tools, including an updated log of each submission's status, frequency reports, and validation reports.

When your submission passes all phases — or at any failure prior to final review — Onpoint CDM will send you an email alert. Submissions that fail any threshold check trigger an auto-generated failure notice, which is created instantly at the time of failure and refers submitters to an online report documenting the failure. Submissions that fail a data quality check trigger a review by Onpoint's data intake team, who notify the submitter, identify the data problem, provide examples of the records failing the check, and enumerate the necessary next steps. For more complex problems, intake staff also work with plans to suggest the probable cause and identify possible fixes. This process generally takes less than 48 hours following file processing. See Table 4 below for a summary of common stage and status categories.

All failure notices alert submitters to any required resubmission and include details regarding the data type, data period, and due date. Resubmission due dates are tracked by Onpoint CDM, which captures sufficient information to identify the submitter, the submission, the date due, the date received, the date entered, the submission stage, the submission status, and any additional comments, allowing our intake staff to track and report on any needed resubmissions.

Table 4. Data Stage & Status Categories

Stage	Status	Description	Typical Follow-Up Action Required
PRELIM	REJECTED	File has been rejected in the preliminary stage since a preceding version has been extracted	Reason for resubmission required
PRELIM	FAIL	File has failed the preliminary stage for not meeting field requirements	Resubmission required
LOAD	FAIL	File has failed the load stage for not meeting the default threshold on particular fields	Resubmission or request for a waiver to the threshold required
DELETE	DONE	File has been replaced and deleted	None
DQ	FAIL	File has failed the data quality validations	Resubmission required
DQ	HOLD	File has some questionable data quality validations that are failing	Resubmission or explanation required
DQ	REVIEW	File has entered data quality review	Manual review by Onpoint's staff
DQ	PASS	File has passed the data quality validations	None
REPLACED	FAIL	Failed file has been replaced	None
REPLACED	PASS	Passed file has been replaced	None
TRANSMIT	INHOUSE	File has been received in house and is in the queue for processing	None

Requesting a Variance from the State's Standards

Throughout the course of capturing VHCURES data, it may be necessary to make exceptions to the State's mandated data thresholds — most commonly when a payer's system does not collect a required element or has special considerations based on the population that they serve. When these situations arise, Onpoint CDM enables the state to authorize payer-specific overrides and variances. Approved variances have a built-in expiration date, requiring payers to reapply and justify any continuing exception on a regular basis.

5. Sending & Receiving Data

Setting Up for Secure Transfers

Onpoint's data collection system ensures that direct member identifiers remain secure — both at rest and in motion — through the use of a federally recommended hashing algorithm. This hashing is not performed by Onpoint; instead, it is performed locally by health plans. Using Onpoint's system, all fields specified as "encrypted" in Vermont's Regulation H-2008-01 are hashed upon preparation for submission, remain solely within the health plan's platform, and are neither transmitted nor received by Onpoint.

For VHCURES, Table 5 identifies the fields that will be rendered de-identified through non-reversible hashing prior to transmission to Onpoint.

Table 5. VHCURES Elements to be Hashed Prior to Submission to Onpoint

File	Number	Common Name
Eligibility	ME008	Subscriber Unique Identification Number (Social Security Number)
Eligibility	ME009	Plan-Specific Contract Number
Eligibility	ME011	Member Identification Code (Social Security Number)
Eligibility	ME101	Subscriber Last Name
Eligibility	ME102	Subscriber First Name
Eligibility	ME103	Subscriber Middle Initial
Eligibility	ME104	Member Last Name
Eligibility	ME105	Member First Name
Eligibility	ME106	Member Middle Initial
Medical Claims	MC007	Subscriber Unique Identification Number (Social Security Number)
Medical Claims	MC008	Plan-Specific Contract Number
Medical Claims	MC010	Member Identification Code (Social Security Number)
Medical Claims	MC101	Subscriber Last Name
Medical Claims	MC102	Subscriber First Name
Medical Claims	MC103	Subscriber Middle Initial
Medical Claims	MC104	Member Last Name
Medical Claims	MC105	Member First Name
Medical Claims	MC106	Member Middle Initial
Pharmacy Claims	PC007	Subscriber Unique Identification Number (Social Security Number)
Pharmacy Claims	PC008	Plan-Specific Contract Number
Pharmacy Claims	PC010	Member Identification Code (Social Security Number)
Pharmacy Claims	PC101	Subscriber Last Name
Pharmacy Claims	PC102	Subscriber First Name

File	Number	Common Name
Pharmacy Claims	PC103	Subscriber Middle Initial
Pharmacy Claims	PC104	Member Last Name
Pharmacy Claims	PC105	Member First Name
Pharmacy Claims	PC106	Member Middle Initial

All data submitted to Onpoint CDM are processed first by our hashing and upload applications, which safeguard electronic PII both at rest (within applications at the point of capture) and in motion (during transmission from payers to Onpoint using HTTPS and SSL protocols). These applications also provide preliminary validation of the data being submitted, zip the file for more efficient transmission, and rename the file according to normalizing conventions.

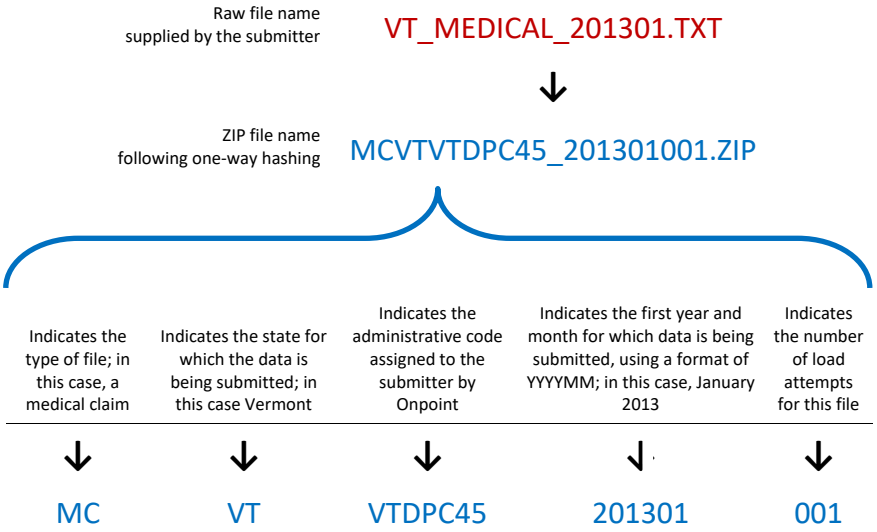
Onpoint CDM also features success verification and viewable logs to provide reassurance to carriers and clients alike. Our software additionally validates the contents of submissions at a very high level, providing a preliminary safeguard against critical flaws.

Files that fail any of the following checks are rejected prior to completing the hashing process:

1. The file contains one header record and one trailer record, both of which are formatted correctly
2. The correct number of fields appears in each record
3. The number of data records matches the count in the header record
4. The data type is valid
5. The length and format of submitted Social Security numbers are valid
6. Each file's last record element (i.e., **899 — Record Type) is populated correctly (i.e., ME for eligibility, MC for medical claims, PC for pharmacy claims)
7. For eligibility data, the year and month of eligibility are within the period beginning and period ending values cited in the header record
8. For claims data, the date approved for payment is within the period beginning and period ending values cited in the header record

After hashing, a ZIP file is created following Onpoint CDM's naming conventions. If the user renames the ZIP file before submission, the submission will be rejected. An example of Onpoint CDM's hashing name convention is included below in Figure 6:

Figure 6. Naming Convention for Zipped, Hashed Files



Providing hashing software that is run by all submitters ensures that all identifiers are hashed consistently and without exception. Since this hashing is done at the carrier's site, the carrier can verify easily that all PII processed by the hashing software have been removed and replaced with an unrecognizable, hashed 128-character field.

The time from receipt of the data by Onpoint CDM to notification of success or failure (due to quality checks) depends on a number of variables, including system load, file size, data type. Submissions of fewer than one million records generally will be processed within one to two hours. The average processing time for a six-million record medical file is six hours. In general, submitters should expect an email regarding their submission within 24 hours of receipt.

Upon receipt, data submissions are unzipped and inspected for quality and compliance with submission requirements. Onpoint CDM includes complex and customizable programming that fine-tunes data quality edits and thresholds to ensure that collected data meets Vermont's research needs. Onpoint staff will continue to work with the Green Mountain Care Board to set these thresholds and then with reporters to make sure that they can meet them. Onpoint CDM currently employs a library of more than 500 distinct data quality edits that vet submissions for anomalies and errors before they can make their way into the data warehouse.

Step 1: Verifying the Presence of Java Runtime Environment (JRE)

All of Onpoint CDM's hashing and upload utilities employ a Java Web Start application that assists in the execution of the SHA-512 hashing algorithm necessary to de-identify any personally identifiable information (PII) on incoming submissions. Before you can use any of our submission tools, you will need to verify that your system has Oracle's Java Runtime Environment (JRE) properly installed.

Perhaps the easiest way to do this is to install the AutoUploader (see below) and try to submit a test file. If you have JRE installed, the application will first prepare the Java environment on your computer and then install. Two notes about this process:

1. If you have Java installed, but are questioning whether it is JRE, Oracle notes that Java Runtime Environment goes by many names, including Java Runtime, Runtime, Java Virtual Machine, Virtual Machine, Java VM, Java plug-in, Java add-on, and Java download.
2. It may appear that the installer is done, but nothing happens; do not be alarmed. This step sometimes takes a few minutes. If this happens, check your computer's task bar to see if a Web Start button has appeared and if a Java warning message is there. Clicking YES at this point will allow you to proceed with hashing, but you will receive the same prompt each time you run the hashing software. Clicking NO will not install the hashing software. By clicking ALWAYS, you will be able to proceed with hashing and will not be prompted again.

If you are prompted to choose an application to launch the hashing application, you most likely do not have JRE installed. In that case, please visit Oracle's website to download the latest version here: http://java.com/en/download/index.jsp.

Step 2: Choosing Your Upload Option

Onpoint offers carriers two options for securely submitting their data — AutoUploader and a web-based utility that requires manual operation. Both options utilize our one-way hashing algorithms to eliminate the possibility of ePII re-identification or recovery.

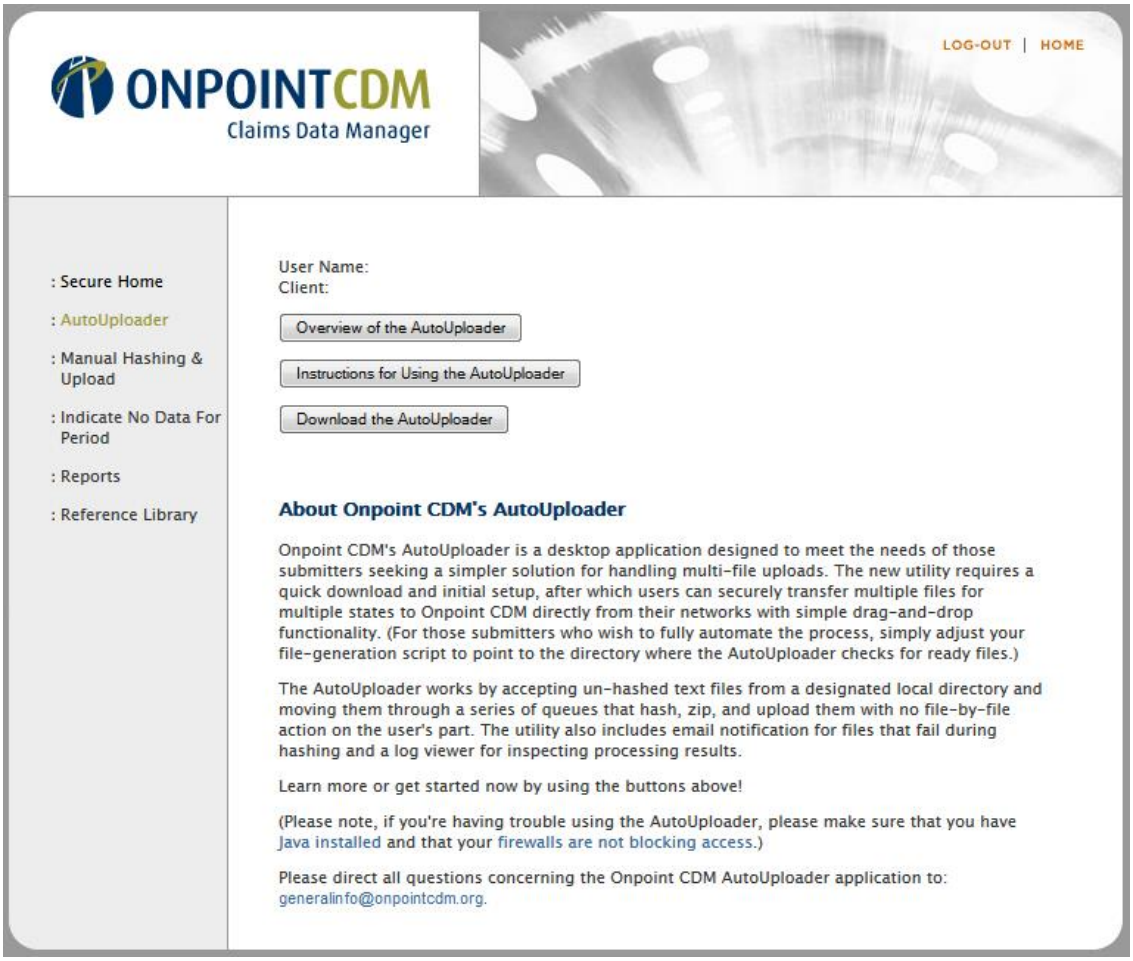
The tool most preferred by our submitters is Onpoint CDM's AutoUploader. The AutoUploader works by accepting unencrypted text files from a designated local directory and moving them through a series of queues that hash, zip, and upload them. Key features include:

- **Easy installation.** The utility, which is compatible with Windows, Linux, and UNIX, is distributed as an executable file that runs as a self-contained console/desktop application.
- **Robust scope.** Any number of files for any number of clients may be queued as long as the data requires hashing prior to submission.
- **Customizable configuration.** The AutoUploader allows each user to tailor their alerts for efficient usage.
- **Durable sessions.** Since the utility runs entirely on the user's network, there is no login and no session expiration to disrupt uploads midstream.
- **Viewable logs.** The application provides a log viewer, allowing users to see key details and track the status of their submissions.
- **Secure uploads.** Users' original files are never seen by Onpoint; only hashed contents are viewable after being uploaded to Onpoint CDM.

Upload Option 1: AutoUploader

To get started with AutoUploader, log in to Onpoint CDM and select the AutoUploader link from the page's left menu (see Figure 7). Also be sure to download the latest instructions using the on-page link.

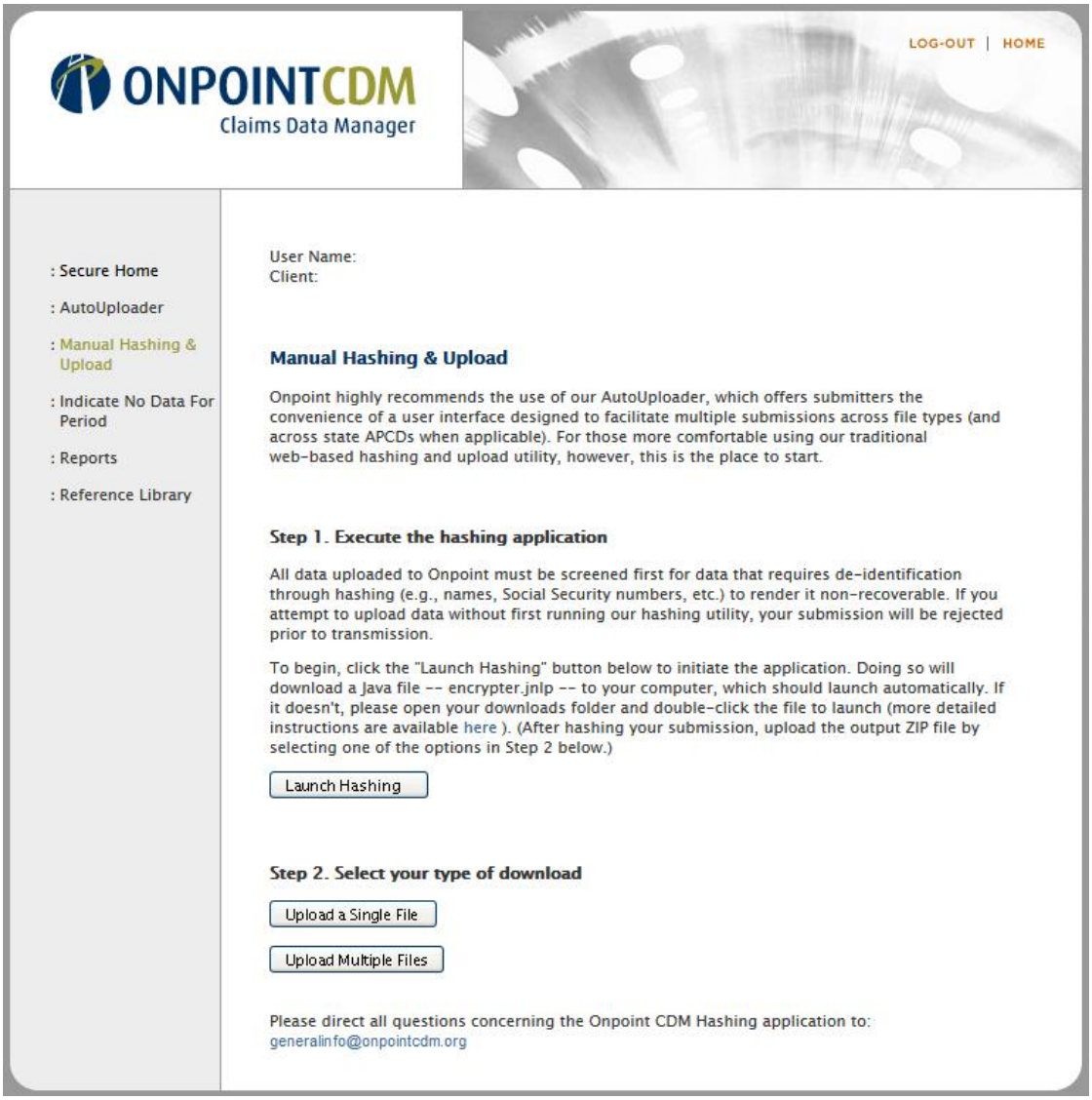
Figure 7. Onpoint CDM (Secure) — AutoUploader Page



Upload Option 2: Manual Hashing & Uploading

Onpoint highly recommends the use of our AutoUploader, but for those more comfortable using our manual web-based hashing and upload utility, this is the place to start. Start by selecting the Manual Hashing & Upload option from the screen's left menu (see Figure 8).

Figure 8. Onpoint CDM (Secure) — Manual Hashing & Upload Page

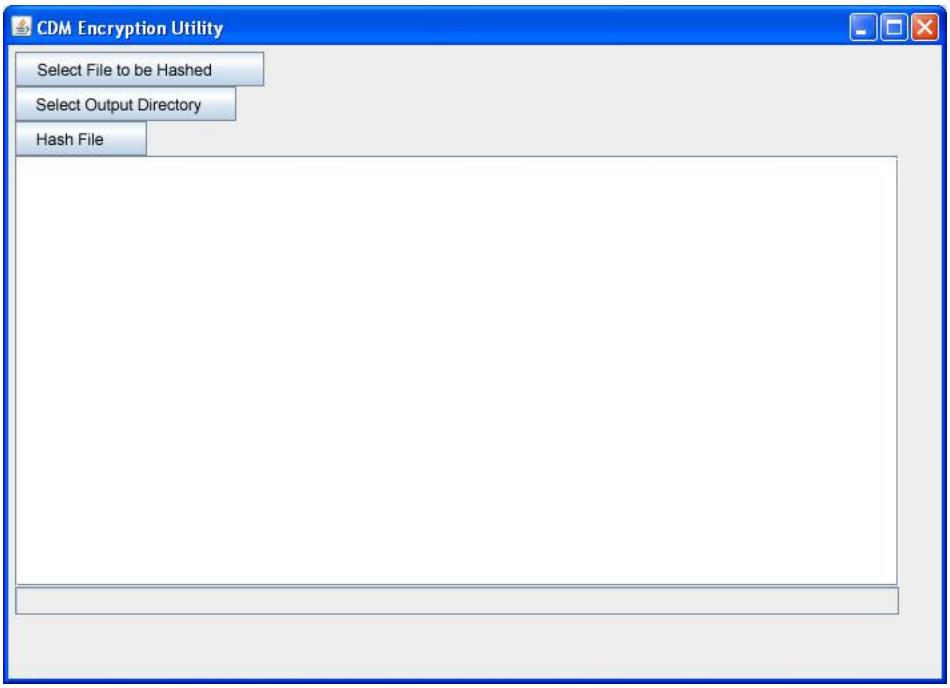


Upload Option 2 (Part 1): Manually Hash Your Data

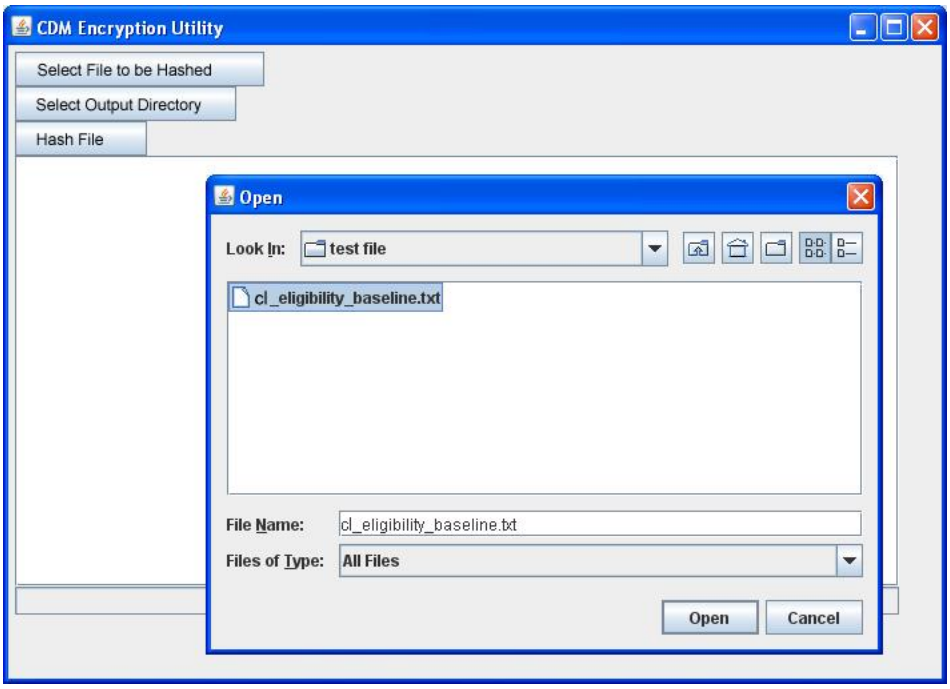
1. All data uploaded to Onpoint must undergo screening and hashing to prevent PII from being transmitted to the APCD. To begin, click the LAUNCH HASHING button under the page's Step 1 narrative.

2. Doing so will download a file — ENCRYPTER.JNLP — to your computer, which is designed to launch automatically. (If it does not launch due to local settings, please open your downloads folder and double-click the file to launch.)

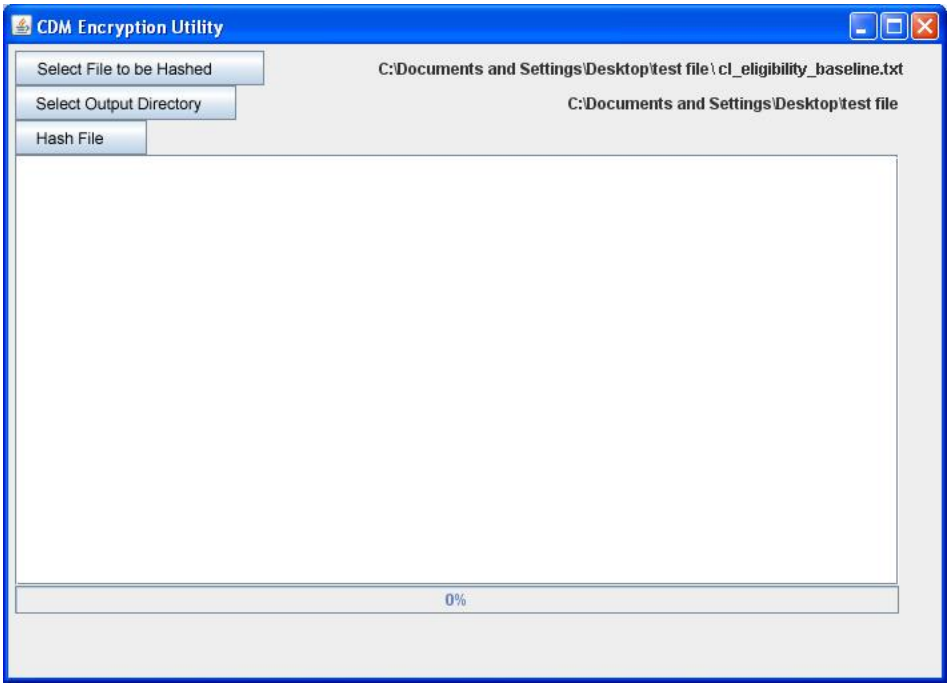
3. In the hashing application, you will be required to select a target file to be screened and hashed. To do so, click the SELECT FILE TO BE HASHED button. (Note that the manual upload utility allows the selection of only a single file at a time; for expedited and batch processing, please use the AutoUploader.)



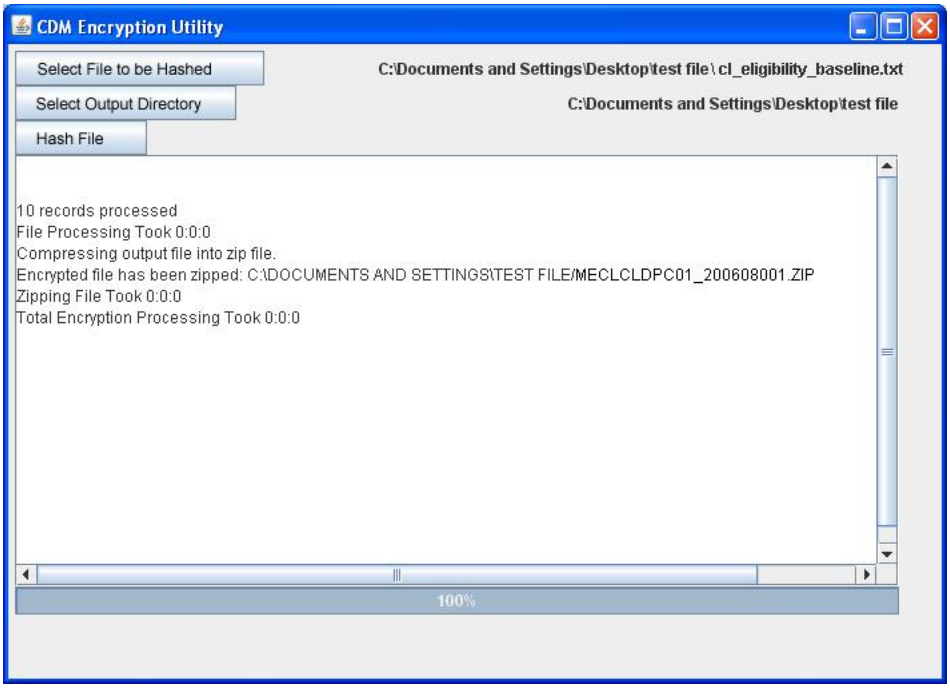
4. In the pop-up dialog box, locate the file within your local system, then click OPEN. You can verify the selected file by checking the path name to the right of the button.

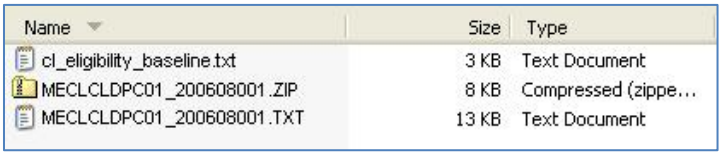


5. Next, identify the desired location for the output file by clicking the SELECT OUTPUT DIRECTORY and designating the desired location on your local system. This selection also can be verified by checking the path to the right of the button.



6. After verifying both the target file and the output location, click the HASH FILE button. The application will process the file, display its progress, and output two files: (1) a compressed ZIP file that contains your hashed data for submission and (2) a non-zipped copy of the TXT file for rapid verification of successful hashing.

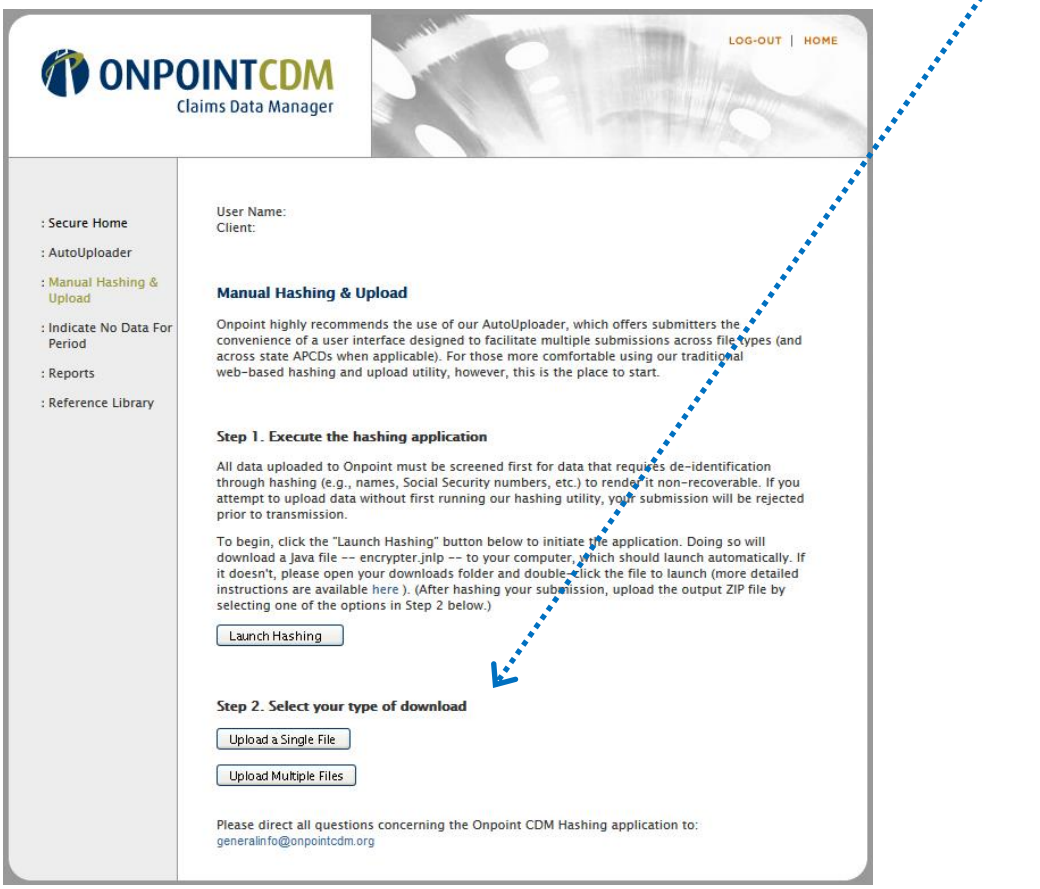




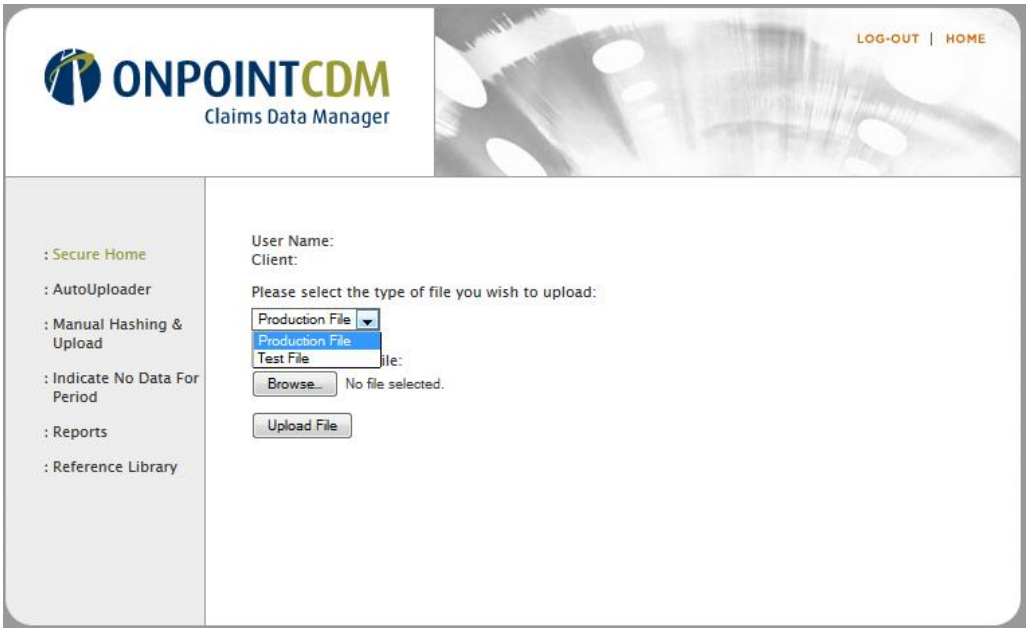
7. After this step, return to your web browser to begin the upload process.

Upload Option 2 (Part 2): Manually Uploading Your File

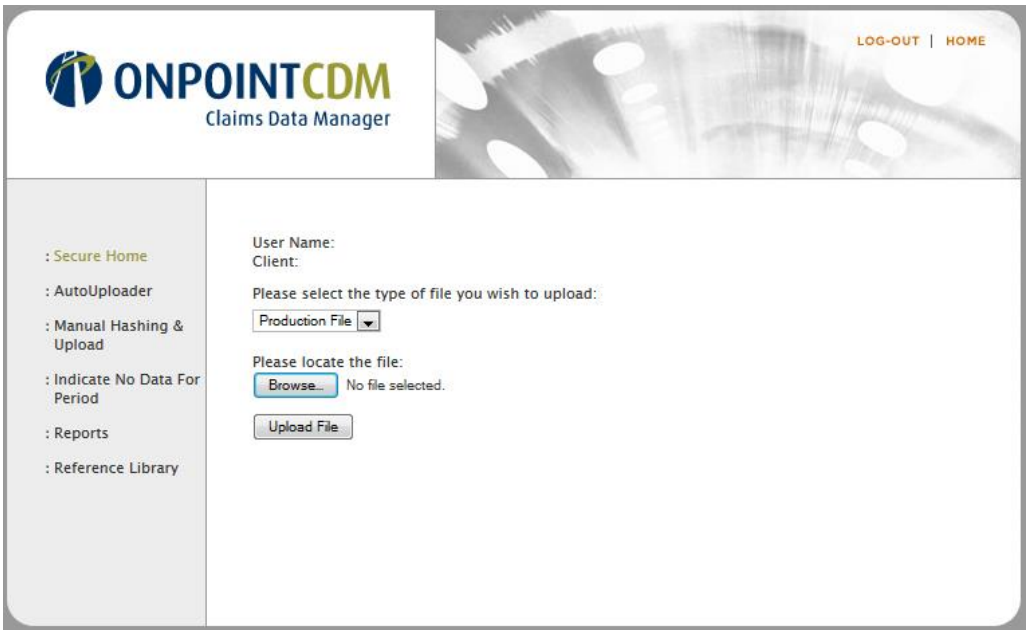
1. The next step of the manual process requires you to designate whether you plan to upload a single file or multiple files instead. Do so by clicking the appropriate button under Step 2. (The following directions will discuss uploading a single file; skip to the next section if uploading multiple files.)

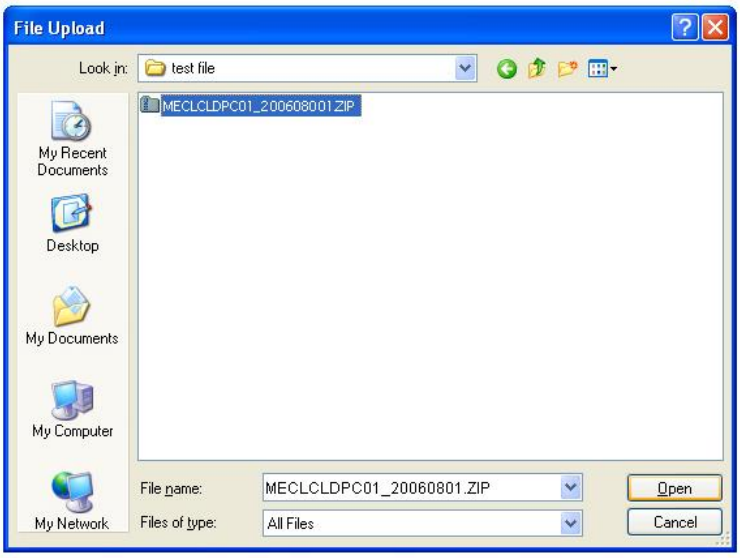


2. After clicking the UPLOAD A SINGLE FILE button, designate the type of file — production or test — that you plan to upload. (Since most payers have entered production with Onpoint's system, the default selection is a production file. If in the testing phase, simply use the drop-down option to change the file type.)

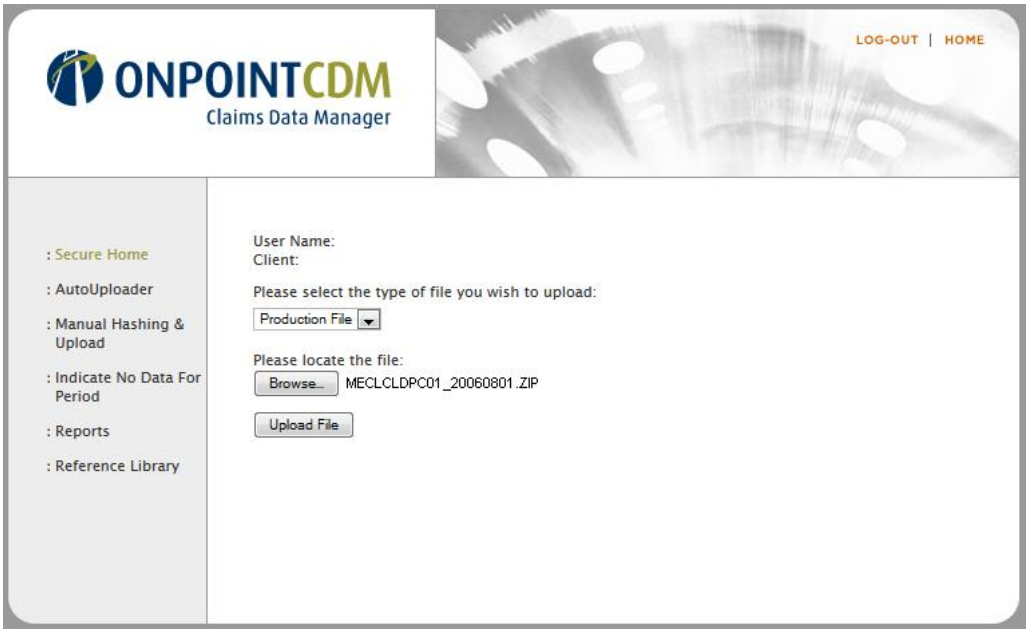


3. Next, click the BROWSE button to locate the file within your local system that you plan to upload. Do so by using the FILE UPLOAD pop-up dialog box and clicking OPEN.

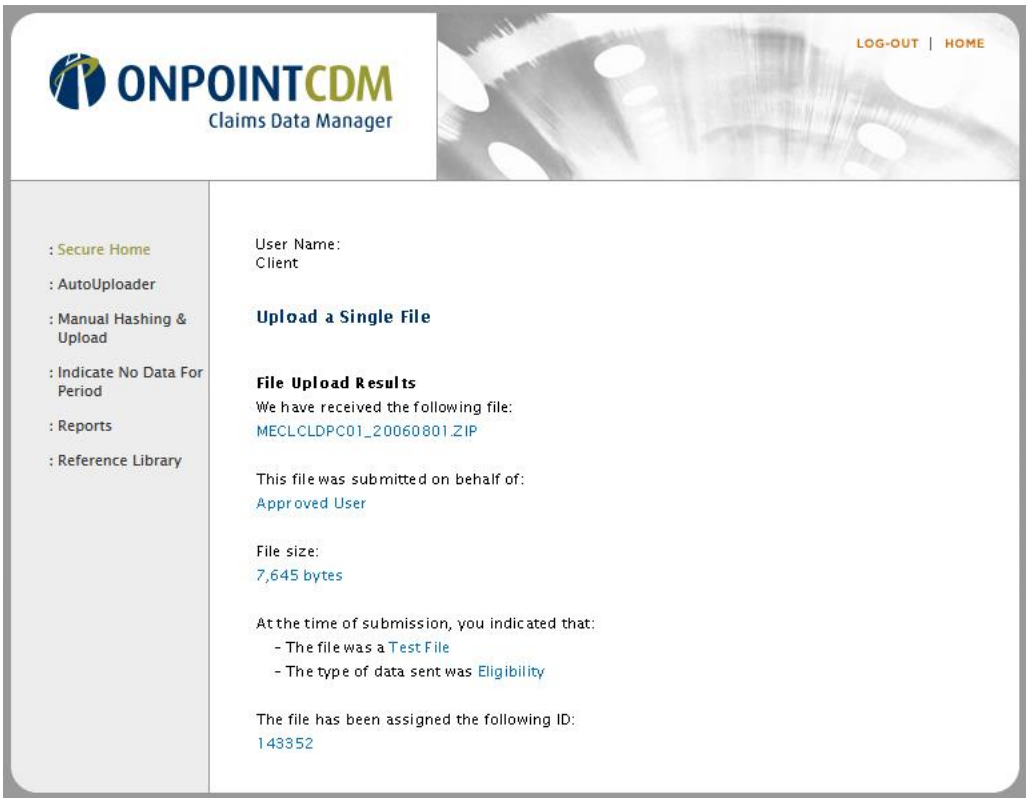




4. After verifying the correct file selection by examining the displayed file name to the right of the BROWSE button, click the UPLOAD FILE button to begin transmission to Onpoint.



5. Once your file has been submitted to Onpoint CDM, a response file will notify you of the upload results, providing documentation that can be used to track your submission.

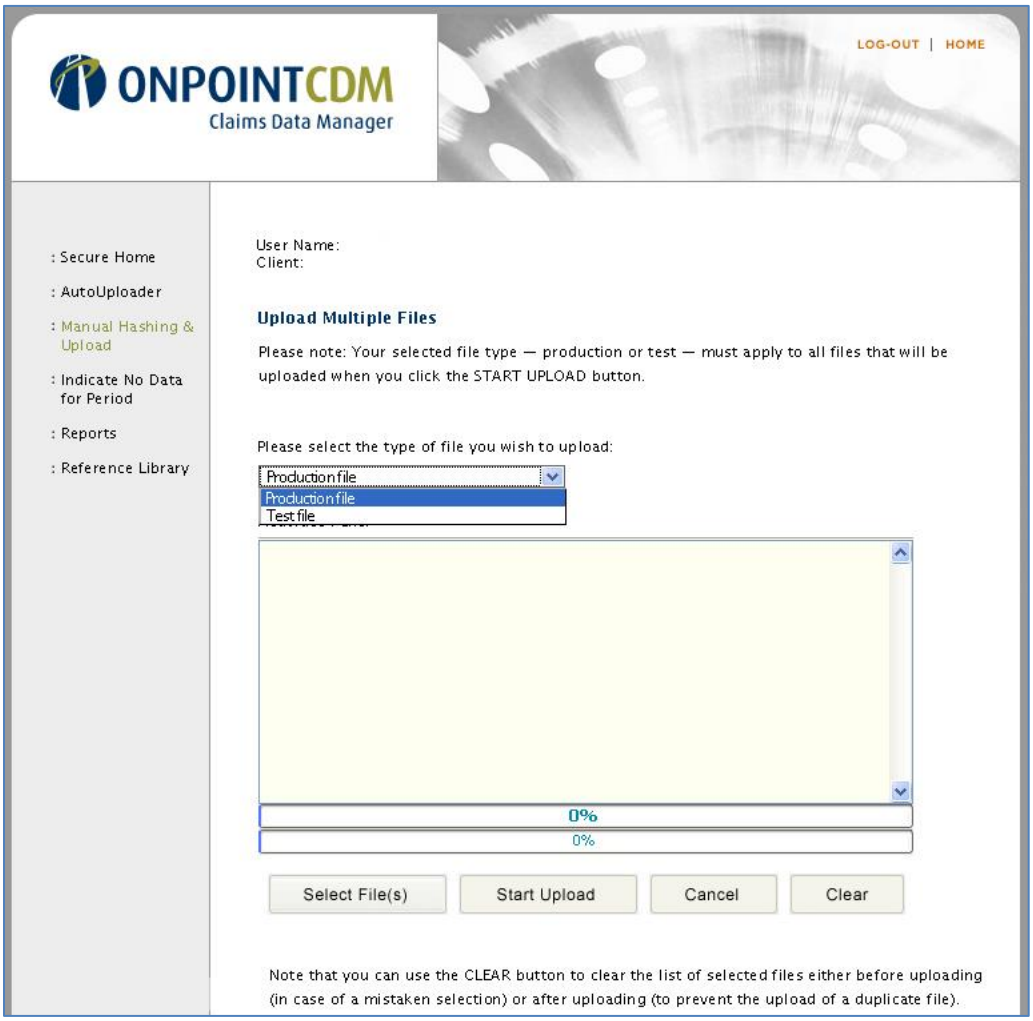


Uploading Multiple Files

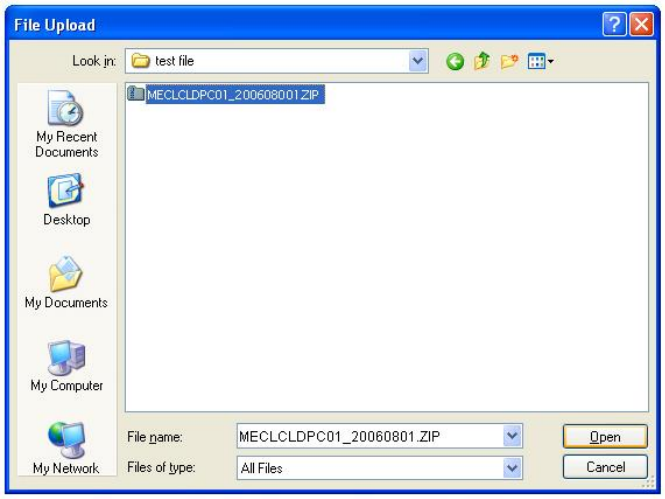
1. Manually uploading multiple files follows a similar path. After manually hashing your data, click instead on the UPLOAD MULTIPLE FILES button.

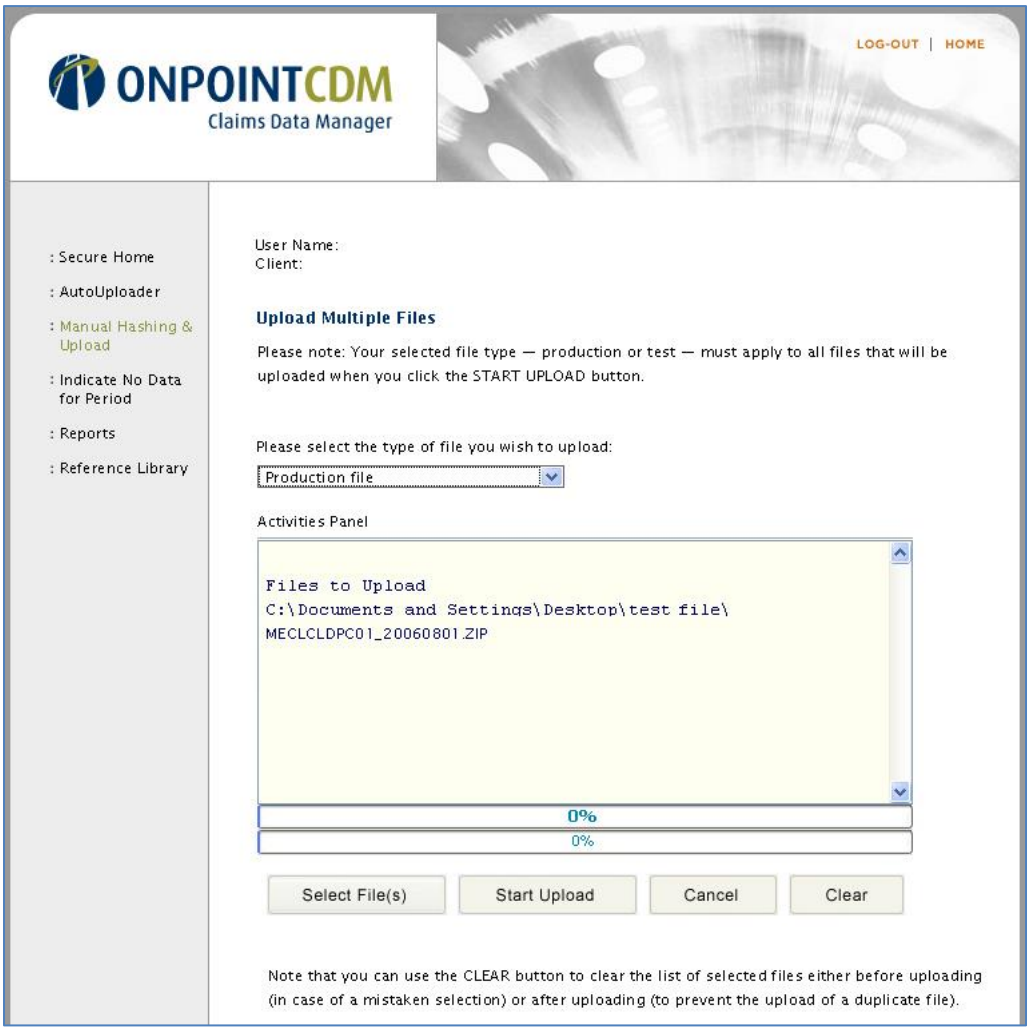
2. Depending on your browser's cache file and session storage, Java may need to reload. If so, you will see the animated Java icon with a progress bar (below).

3. Once the Java applet has loaded, use the drop-down menu to identify whether your files are production or test files. (Note that all files submitted during a manual upload must be of the same type.) You may use the multiple file uploader to submit files for more than one state at the same time, and you may select as many files as you wish to upload at one time.



4. Click on the SELECT FILES(S) button at the bottom of the screen and browse to find the hashed files to be uploaded. Verify your file selection by checking the session's Activity Panel in the center of the screen.





5. After selecting the files that you wish to upload, click the START UPLOAD button. Note that you can use the CLEAR button to clear the list of selected files either before uploading (in case of a mistaken selection) or after uploading (to prevent the upload of a duplicate file).

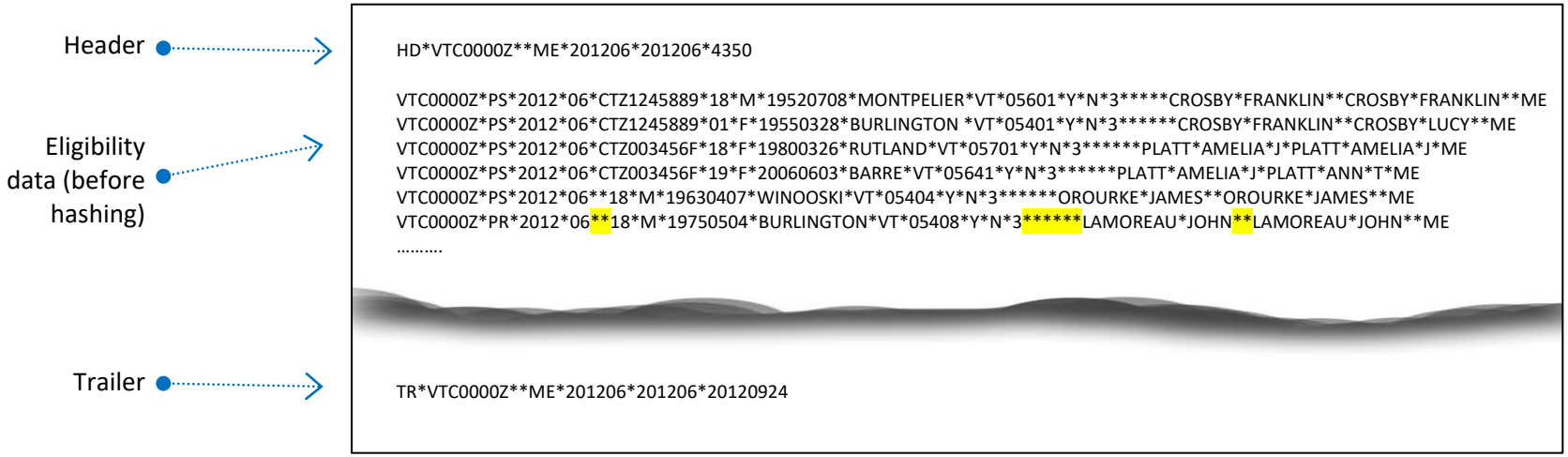
6. While your files are uploading, the upper progress bar shows the percentage complete for the file currently being uploaded. The lower progress bar shows the percentage of files that have completed the upload process. You can click CANCEL if you wish to stop the upload. When all of your files have finished uploading, your screen will show a status message for each one.

7. Additionally, when your files have finished uploading, a window or tab will open with a report on all of the files that you have uploaded today.

6. General File Specifications

Basic Rules

- **Header and trailer records.** Each submission regardless of type — eligibility, medical claims, and pharmacy claims — must begin with a header record and end with a trailer record (example header and trailer records for a test eligibility submission of 4,350 records for June 2012 are included below).
- **Submitting multiple months at once.** You may submit multiple complete months of data with one pair of header and trailer records by indicating the earliest year and month in HD005 and TR005 and the latest year and month in HD006 and TR006. Note that each month of data will be evaluated for completeness in its own right and will pass or fail as if it were submitted as a single month of data. If a submitter provides a single file with six months of data for January through June and all months except May pass all checks, May will be rejected and the submitter will be asked to correct and resend only May data. No partially complete months are allowed.
- **Indicating missing data.** When two or more asterisks appear together, there is no data for the field. For example, in the Eligibility File example below, the lack of data between the asterisks highlighted in yellow indicate fields that are unavailable for reporting.



- **No punctuation.** Punctuation should not be included in the reporting of any names, including the names of drugs. For example, a last name of O'Rourke should be reported as "OROURKE".
- **No decimal points.** Decimal points should not be included in the reporting of financial fields. For example, a dollar amount of $120.56 should be reported as "12056".
- **Date formats.** Dates, unless otherwise specified, should be reported using the 8-digit format of CCYYMMDD. For example, January 18, 1972, should be reported as "19720118".
- **Review the online FAQs.** Please refer to the FAQs section at Onpoint CDM's website — www.onpointcdm.org — for additional information and updates regarding the population of data fields.

7. Eligibility File

The Basics

Key References Regulation H-2008-01, §6.I

Covered Parties All

Required Frequency Monthly, quarterly, or annually based on number of covered members

Important Notes

- One record must be submitted for each member who had coverage during the period reported in the header and trailer records.
- Submissions must cover full months of data; partial months must not be reported.

Columns Included in the Eligibility File

#	ID	Name	Hash?	Type	Length	Description	X12 Ref.	Threshold	Denominator
Indicates the element's required position within the submission file	Indicates the element's reference number	Indicates the element's name	Indicates whether or not the element's true value has been rendered permanently non-recoverable by one-way hashing prior to submission to Onpoint	Indicates whether the type of data for the element is a date, decimal, integer, or text	Indicates the maximum length allowed for this element	Provides a general description of the data element, including valid codes for elements whose acceptable codes vary from industry standards and for elements that lack a national standard altogether.	Indicates the element's X12 reference standard	Indicates the percent of submitted records for which this element must have a valid code	Indicates the type of records to be used to calculate the threshold percent for submission.

File Layout & Specifications

ELIGIBILITY FILE									
#	ID	Name	Hash?	Type	Length	Description	X12 Ref.	Threshold	Denominator
1	HD001	Record Type	N	Text	2	This field must be coded "HD" to indicate the start of the header record.	N/A	100%	All
2	HD002	Submitter Code	N	Text	8	This field must contain the submitter code assigned to you by Onpoint Health Data.	N/A	100%	All
3	HD003	National Plan ID	N	Text	30	Use this field to report the CMS National Plan ID when implemented by the U.S. Centers for Medicaid & Medicare Services (CMS). Until CMS issues a National Plan ID, report this field as null.	N/A	0%	All
4	HD004	Type of File	N	Text	2	This field must be coded "ME" to indicate submission of eligibility data.	N/A	100%	All
5	HD005	Period Beginning Date	N	Integer	6	Use this field to report the earliest eligibility year/month included in the submission in CCYYMM format. Submissions with records containing an eligibility period (ME004, ME005) before this date will fail.	N/A	100%	All
6	HD006	Period Ending Date	N	Integer	6	Use this field to report the latest eligibility year/month included in the submission in CCYYMM format. Submissions with records containing an eligibility period (ME004, ME005) after this date will fail.	N/A	100%	All
7	HD007	Record Count	N	Integer	10	Use this field to report the total number of records in the submission, excluding the header and trailer records. If the number of records within the submission does not equal the number reported in this field, the submission will fail.	N/A	100%	All
8	HD008	Comments	N	Text	80	This field may be used by the submitter to document a file name, system source, or other administrative device to assist with their internal tracking of the submission.	N/A	0%	All
1	ME001	Submitter Code	N	Text	8	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the client and the third character designates the type of submitter. For Vermont's APCD collection, valid prefixes include: VTC .....Commercial carrier VTG .....Governmental agency VTT .....Third-party administrator **Notes:** A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	N/A	100%	All
2	ME002	National Plan ID	N	Text	30	Use this field to report the CMS National Plan ID when implemented by the U.S. Centers for Medicaid & Medicare Services (CMS). Until CMS issues a National Plan ID, report this field as null.	N/A	0%	All

ELIGIBILITY FILE									
#	ID	Name	Hash?	Type	Length	Description	X12 Ref.	Threshold	Denominator
3	ME003	Insurance Type / Product Code	N	Text	2	Use this field to report the member's type of insurance or insurance product. Valid codes include: 12.....Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13.....Medicare Secondary End-Stage Renal Disease Beneficiary in the 12-Month Coordination Period with an Employer's Group Health Plan 14.....Medicare Secondary, No-fault Insurance Including Auto is Primary 15.....Medicare Secondary Workers' Compensation 16.....Medicare Secondary Public Health Service or Other Federal Agency 41.....Medicare Secondary Black Lung 42.....Medicare Secondary Veterans Administration 43.....Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) 47.....Medicare Secondary, Other Liability Insurance is Primary CP.....Medicare Conditionally Primary D .....Disability DB .....Disability Benefits EP.....Exclusive Provider Organization HM.....Health Maintenance Organization (HMO) HN.....Health Maintenance Organization (HMO) Medicare Advantage / Medicare Part C HS .....Special Low-Income Medicare Beneficiary IN .....Indemnity MA.....Medicare Part A (Fee for Service only) MB .....Medicare Part B (Fee for Service only) MC .....Medicaid MD.....Medicare Part D MH.....Medigap Part A MI .....Medigap Part B MP .....Medicare Primary PC.....Personal Care PE.....Property Insurance – Personal PR .....Preferred Provider Organization (PPO) PS.....Point of Service (POS) QM.....Qualified Medicare Beneficiary ~~SP.....Supplemental Policy~~ (no longer valid for reporting to VHCURES) **Notes:** To ensure reporting consistency between submitters' eligibility data, all Medicare Advantage plans should use the code "HN" to denote a Health Maintenance Organization (HMO) – Medicare Risk. Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	271/2110C/EB/ /04, 271/2110D/EB/ /04	100%	All
4	ME004	Year	N	Integer	4	Use this field to report the year of eligibility using a 4-digit format of CCYY (e.g., January 2014, would be coded as "2014").	N/A	100%	All
5	ME005	Month	N	Text	2	Use this field to report the month of eligibility using a 2-digit format of MM (e.g., January would be coded as "01").	N/A	100%	All

ELIGIBILITY FILE									
#	ID	Name	Hash?	Type	Length	Description	X12 Ref.	Threshold	Denominator
6	ME006	Insured Group or Policy Number	N	Text	30	Use this field to report the group or policy number. **Notes:** This is not the number that uniquely identifies the subscriber. If a policy is sold to an individual as a non-group policy, then both the Insured Group or Policy Number (ME006) and Group Name (ME032) should be reported with a value of "IND". This principle pertains to all claim types: commercial, Medicaid, and Medicare. The value reported for this field should be reported consistently across file types in the "Insured Group or Policy Number" fields (ME006, MC006, PC006).	271/2100C/REF/1L/02, 271/2100C/REF/IG/02, 271/2100C/REF/6P/02, 271/2100D/REF/1L/02, 271/2100D/REF/IG/02, 271/2100D/REF/6P/02	99.5%	All
7	ME007	Coverage Level Code	N	Text	3	Use this field to report the benefit level of coverage. **Notes:** Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	271/2110C/EB/ /02, 271/2110D/EB/ /02	99.50%	All
8	ME008	Subscriber Social Security Number	Y	Text	9	Use this field to report the subscriber's 9-digit Social Security number. **It is important to note that if this field is not reported, the "Plan-Specific Contract Number" field (ME009) must be populated.** **Notes:** The value reported for this field should be reported consistently across file types in the "Subscriber Social Security Number" fields (ME008, MC007, and PC007). This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/REF/SY/02	0% (please see the description's **bolded note**)	All
9	ME009	Plan-Specific Contract Number	Y	Text	80	Use this field to report the submitter-assigned contract number for the subscriber. **It is important to note that if this field is not reported, the "Subscriber Social Security Number" field (ME008) must be populated.** **Notes:** The value reported for this field should be reported consistently in the "Plan-Specific Contract Number" field in both the medical claims (MC008) and pharmacy claims (PC008) data. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/NM1/MI/09	0% (please see the description's **bolded note**)	All
10	ME010	Member Suffix or Sequence Number	N	Text	20	Use this field to report the unique number of the member within the contract	N/A	90%	All
11	ME011	Member Social Security Number	Y	Text	9	Use this field to report the member's 9-digit Social Security number. **Notes:** The value reported for this field should be consistently reported in the "Member Social Security Number" field in both the medical claims (MC010) and pharmacy claims (PC010) data. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/REF/SY/02, 271/2100D/REF/SY/02	0%	All

ELIGIBILITY FILE									
#	ID	Name	Hash?	Type	Length	Description	X12 Ref.	Threshold	Denominator
12	ME012	Member Relationship	N	Text	2	Use this field to report the member's relationship to the subscriber or the insured. Valid codes include: 01.....Spouse 18.....Self 19.....Child 20.....Employee + 01/01/2012 21.....Unknown ~~34.....Other Adult~~ x 12/31/2011 39.....Organ donor + 01/01/2012 40.....Cadaver donor + 01/01/2012 53.....Life partner + 01/01/2012 G8.....Other relationship + 01/01/2012 **Notes:** The value reported for this field should be consistently reported in the "Member Relationship" field in both the medical claims (MC011) and pharmacy claims (PC011) data. Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	271/2100C/INS/Y/02, 271/2100D/INS/N/02	100%	All
13	ME013	Member Gender	N	Text	1	Use this field to report the member's gender. The only valid codes for this field are: F.....Female M.....Male U.....Unknown **Notes:** The value reported for this field should be consistently reported across file types in the "Member Gender" fields (ME013, MC012, PC012). Note that while the code used in pharmacy claims to report this field differs from the code used in eligibility and medical claims (e.g., male =1 in PC, but M in both ME and MC), the value (i.e., the gender) reported for this field should be consistently reported across all file types for the same member.	271/2100C/DMG/ /03, 271/2100D/DMG/ /03	100%	All
14	ME014	Member Date of Birth	N	Date	8	Use this field to report the member's date of birth using an 8-digit format of CCYYMMDD (e.g., February 17, 1972, would be coded as "19720217"). **Notes:** The value reported for this field should be consistently reported across file types in the "Member Date of Birth" fields (ME014, MC013, PC013).	271/2100C/DMG/D8/02 , 271/2100D/DMG/D8/02	99.50%	All
15	ME015	Member City	N	Text	30	Use this field to report the name of the member's city of residence.	271/2100C/N4/ /01, 271/2100D/N4/ /01	99.5%	All
16	ME016	Member State or Province	N	Text	2	Use this field to report the member's state or province using the two-character abbreviation code defined by the U.S. Postal Service (for U.S. states) and Canada Post (for Canadian provinces).	271/2100C/N4/ /02, 271/2100D/N4/ /02	99.5%	All
17	ME017	Member ZIP/Postal Code	N	Text	11	Use this field to report the ZIP/postal code of the member's residence. **Notes:** For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code). Do not code dashes or spaces within ZIP/postal codes.	271/2100C/N4/ /03, 271/2100D/N4/ /03	99.50%	All

ELIGIBILITY FILE									
#	ID	Name	Hash?	Type	Length	Description	X12 Ref.	Threshold	Denominator
18	ME018	Medical Coverage	N	Text	1	Use this field to report whether or not the member had medical coverage during the reported period. The only valid codes for this field are: Y.....Yes N.....No	N/A	100%	All
19	ME019	Prescription Drug Coverage	N	Text	1	Use this field to report whether or not the member had prescription drug coverage during the reported period. The only valid codes for this field are: Y.....Yes N.....No	N/A	100%	All
20	ME020	Placeholder	N	Text	1	Placeholder used to report Dental Coverage	N/A	N/A	N/A
21	ME021	Placeholder	N	Text	6	Placeholder used to report Race (1)	N/A	N/A	N/A
22	ME022	Placeholder	N	Text	6	Placeholder used to report Race (2)	N/A	N/A	N/A
23	ME023	Placeholder	N	Text	15	Placeholder used to report Race (Other)	N/A	N/A	N/A
24	ME024	Placeholder	N	Text	1	Placeholder used to report Hispanic Indicator	N/A	N/A	N/A
25	ME025	Placeholder	N	Text	6	Placeholder used to report Ethnicity (1)	N/A	N/A	N/A
26	ME026	Placeholder	N	Text	6	Placeholder used to report Ethnicity (2)	N/A	N/A	N/A
27	ME027	Placeholder	N	Text	20	Placeholder used to report Ethnicity (Other)	N/A	N/A	N/A
28	ME028	Primary Insurance Indicator	N	Text	1	Use this field to report whether or not this coverage is primary. The only valid codes for this field are: 1 .....Yes 2 .....No	N/A	99.9%	All
29	ME029	Coverage Type	N	Text	3	Use this field to report the type of coverage, distinguishing self-funded plans from commercially insured plans. The only valid codes for this field are: ASW.....Self-funded plans that are administered by a third-party administrator, where the employer has purchased stop-loss or group excess insurance coverage ASO.....Self-funded plans that are administered by a third-party administrator, where the employer has not purchased stop-loss or group excess insurance coverage STN .....Short-term, non-renewable health insurance UND.....Plans underwritten by the insurer OTH.....Any other plan	N/A	99.9%	All

ELIGIBILITY FILE									
#	ID	Name	Hash?	Type	Length	Description	X12 Ref.	Threshold	Denominator
30	ME030	Market Category Code	N	Text	4	Use this field to report the type of policy sold by the insurer. The only valid codes for this field are: IND.....Policies sold and issued directly to individuals (i.e., a non-group policy) FCH .....Policies sold and issued directly to individuals on a franchise basis GCV.....Policies sold and issued directly to individuals as group conversion policies GS1 .....Policies sold and issued directly to employers having exactly one employee GS2 .....Policies sold and issued directly to employers having between two and nine employees GS3 .....Policies sold and issued directly to employers having 10–25 employees GS4 .....Policies sold and issued directly to employers having 26–50 employees GLG1.....Policies sold and issued directly to employers having 51–99 employees GLG2.....Policies sold and issued directly to employers having 100 or more employees GSA.....Policies sold and issued directly to small employers through a qualified association trust OTH.....Policies sold to other types of entities	N/A	99.9%	All
31	ME031	Blueprint Medical Home (BPMH) Indicator and Vermont ACO Participation Indicator	N	Text	2	Use this field to report both the Vermont Blueprint Medical Home (BPMH) Indicator and the Vermont ACO Participation Indicator. Use the first character in the field to report whether or not the member was a participant in the Vermont Blueprint for Health's medical home initiative. Use the second character in the field to report whether or not the member was a participant in a Vermont accountable care organization (ACO). Submitters participating in the Blueprint medical home initiative should use the following codes for the first character in the field: 2 .....Member attributed to a Blueprint medical home 1 .....Member not attributed to a Blueprint medical home Non-participating submitters should use: 0 .....Information not available due to non-participation in the Blueprint medical home initiative Only those submitters reporting participation in a Vermont ACO should use the following codes for the second character in the field: A.....Not attributed to an ACO B.....Attributed to the OneCare ACO C.....Attributed to the CHAC ACO	N/A	99.9%	All
32	ME032	Group Name	N	Text	100	Use this field to report the name of the group that covers the member. **Notes:** If a policy is sold to an individual as a non-group policy, then both the "Insured Group or Policy Number" field (ME006) and this "Group Name" field (ME032) should be reported with a value of "IND".	834/2100D/NM1/36/03	99.5%	All
33	ME101	Subscriber Last Name	Y	Text	60	Use this field to report the subscriber's last name. **Notes:** The value reported for this field should be consistently reported across file types in the "Subscriber Last Name" fields (ME101, MC101, PC101). This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/NM1/ /03	100%	All

ELIGIBILITY FILE									
#	ID	Name	Hash?	Type	Length	Description	X12 Ref.	Threshold	Denominator
34	ME102	Subscriber First Name	Y	Text	35	Use this field to report the subscriber's first name. **Notes:** The value reported for this field should be consistently reported across file types in the "Subscriber First Name" fields (ME013, MC102, PC102). This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/NM1/ /04	100%	All
35	ME103	Subscriber Middle Initial	Y	Text	1	Use this field to report the subscriber's middle initial. **Notes:** The value reported for this field should be consistently reported across file types in the "Subscriber Middle Initial" fields (ME013, MC103, PC103). This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/NM1/ / 05	50%	All
36	ME104	Member Last Name	Y	Text	60	Use this field to report the member's last name. **Notes:** The value reported for this field should be consistently reported across file types in the "Member Last Name" fields (ME104, MC104, PC104). This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/NM1/ /03, 271/2100D/NM1/ /03	100%	All
37	ME105	Member First Name	Y	Text	35	Use this field to report the member's first name. **Notes:** The value reported for this field should be consistently reported across file types in the "Member First Name" fields (ME105, MC105, PC105). This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/NM1/ /04, 271/2100D/NM1/ /04	100%	All
38	ME106	Member Middle Initial	Y	Text	1	Use this field to report the member's middle initial. **Notes:** The value reported for this field should be consistently reported across file types in the "Member Middle Initial" fields (ME106, MC106, PC106). This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	271/2100C/NM1/ /05, 271/2100D/NM1/ /05	50%	All
39	ME899	Record Type	N	Text	2	Use this field to report the constant value of "ME" to denote a member eligibility record.	N/A	100%	All
1	TR001	Record Type	N	Text	2	This field must be coded "TR" to indicate the start of the trailer record.	N/A	100%	All
2	TR002	Submitter Code	N	Text	8	This field must contain the submitter code assigned to you by Onpoint Health Data.	N/A	100%	All
3	TR003	National Plan ID	N	Text	30	Use this field to report the CMS National Plan ID when implemented by the U.S. Centers for Medicaid & Medicare Services (CMS). Until CMS issues a National Plan ID, report this field as null.	N/A	0%	All
4	TR004	Type of File	N	Text	2	This field must be coded "ME" to indicate submission of eligibility data.	N/A	100%	All

ELIGIBILITY FILE									
#	ID	Name	Hash?	Type	Length	Description	X12 Ref.	Threshold	Denominator
5	TR005	Period Beginning Date	N	Integer	6	Use this field to report the earliest eligibility year/month included in the submission in CCYYMM format. Submissions with records containing an eligibility period (ME004, ME005) before this date will fail.	N/A	100%	All
6	TR006	Period Ending Date	N	Integer	6	Use this field to report the latest eligibility year/month included in the submission in CCYYMM format. Submissions with records containing an eligibility period (ME004, ME005) after this date will fail.	N/A	100%	All
7	TR007	Date Processed	N	Date	8	Use this field to report the date on which the file was created in CCYYMMDD format.	N/A	0%	All

8. Medical Claims

The Basics

Key References Regulation H-2008-01, §6.I

Covered Parties All

Required Frequency Monthly, quarterly, or annually based on number of covered members

Important Notes

- Medical claims submissions must include all claims adjudicated during the reported time period.
- All lines of partially denied claims are to be reported. Only fully denied claims are to be excluded.
- One record must be submitted for each service adjudicated during the period reported in the header and trailer records.
- Submissions must cover full months of data; partial months must not be reported.

Columns Included in the Medical Claims File

#	ID	Name	Hash?	Type	Length	Description	Mappings			Threshold	Denominator
							UB-04 Ref.	CMS 1500 Ref.	X12 Ref.		
Indicates the element's required position within the submission file	Indicates the element's reference number	Indicates the element's name	Indicates whether or not the element's true value has been rendered permanently non-recoverable by one-way hashing prior to submission to Onpoint	Indicates whether the type of data for the element is a date, decimal, integer, or text	Indicates the maximum length allowed for this element	Provides a general description of the data element, including valid codes vary from industry standards and for elements that lack a national standard altogether. Values appended with superscript text in blue (e.g., + 01/01/2012) note the effective date of newly valid values; those with strikethrough text (i.e., ~~strikethrough~~) are no longer valid and have their expiration dates appended in red superscript text (e.g., x 12/31/2011).	Indicates the element's relevant reference standard across national coding systems			Indicates the percent of submitted records for which this element must have a valid code	Indicates the type of records to be used to calculate the threshold percent for submission.

File Layout & Specifications

MEDICAL CLAIMS											
#	ID	Element Name	Hash?	Type	Length	Description	UB-04 Ref.	CMS 1500 Ref.	X12 Ref.	Threshold	Denom.
1	HD001	Record Type	N	Text	2	This field must be coded "HD" to indicate the start of the header record.	N/A	N/A	N/A	100%	All
2	HD002	Submitter Code	N	Text	8	This field must contain the submitter code assigned to you by Onpoint Health Data.	N/A	N/A	N/A	100%	All
3	HD003	National Plan ID	N	Text	30	Use this field to report the CMS National Plan ID when implemented by the U.S. Centers for Medicaid & Medicare Services (CMS). Until CMS issues a National Plan ID, report this field as null.	N/A	N/A	N/A	0%	All
4	HD004	Type of File	N	Text	2	This field must be coded "MC" to indicate submission of eligibility data.	N/A	N/A	N/A	100%	All
5	HD005	Period Beginning Date	N	Integer	6	Use this field to report the earliest payment year/month included in the submission in CCYYMM format. Submissions with records containing a Payment Date / Settlement Date (MC017) outside of the date range indicated in this file's header and trailer records will fail.	N/A	N/A	N/A	100%	All
6	HD006	Period Ending Date	N	Integer	6	Use this field to report the latest payment year/month included in the submission in CCYYMM format. Submissions with records containing a Payment Date / Settlement Date (MC017) outside of the date range indicated in this file's header and trailer records will fail.	N/A	N/A	N/A	100%	All
7	HD007	Record Count	N	Integer	10	Use this field to report the total number of records in the submission, excluding the header and trailer records. If the number of records within the submission does not equal the number reported in this field, the submission will fail.	N/A	N/A	N/A	100%	All
8	HD008	Comments	N	Text	80	This field may be used by the submitter to document a file name, system source, or other administrative device to assist with their internal tracking of the submission.	N/A	N/A	N/A	0%	All
1	MC001	Submitter Code	N	Text	8	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the client and the third character designates the type of submitter. For Vermont's APCD collection, valid prefixes include: VTC .....Commercial carrier VTG.....Governmental agency VTT .....Third-party administrator **Notes:** A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	N/A	N/A	N/A	100%	All

MEDICAL CLAIMS											
#	ID	Element Name	Hash?	Type	Length	Description	UB-04 Ref.	CMS 1500 Ref.	X12 Ref.	Threshold	Denom.
2	MC002	National Plan ID	N	Text	30	Use this field to report the CMS National Plan ID when implemented by the U.S. Centers for Medicaid & Medicare Services (CMS). Until CMS issues a National Plan ID, report this field as null.	N/A	N/A	835/1000A/N1/XV/04	0%	All
3	MC003	Insurance Type / Product Code	N	Text	2	Use this field to report the member's type of insurance or insurance product. Valid codes include: 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 / Medicare Part C HM ..... Health Maintenance Organization MA ..... Medicare Part A (Fee for Service only) MB ..... Medicare Part B (Fee for Service only) MC..... Medicaid OF..... Other Federal Program PC..... Personal care ~~SP ..... Supplemental Policy~~ (no longer valid for reporting to VHCURES) TV..... Title V VA ..... Veterans Administration Plan **Notes:** Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	N/A	N/A	835/2100/CLP/ /06	100%	All
4	MC004	Payer Claim Control Number	N	Text	35	Use this field to report the claim number used by the data submitter to internally track the claim. **Notes:** In general, the claim number is associated with all service lines of the claim. It must apply to the entire claim and be unique within the data submitter's system. The value reported in this field should remain consistent over time. If reporting multiple versions of the same claim, this number should remain the same; use MC005A (Version Number) to report multiple versions of the same claim subject to subsequent changes/adjustments.	N/A	N/A	835/2100/CLP/ /07	100%	All
5	MC005	Line Counter	N	Integer	4	Use this field to report the line number for this service. **Notes:** The line counter should begin with 1 and be incremented by 1 for each additional service line of a claim.	N/A	N/A	837/2400/LX/ /01	99.50%	All

MEDICAL CLAIMS											
#	ID	Element Name	Hash?	Type	Length	Description	UB-04 Ref.	CMS 1500 Ref.	X12 Ref.	Threshold	Denom.
6	MC005A	Version Number	N	Integer	4	Use this field to report the version number of the claim service record. **Notes:** The version number should begin with 0 and be incremented by 1 for each subsequent version of that service line. If versioning is not used to report adjusted claims, report claims with a Version Number of zero (0).	N/A	N/A	N/A	99.5%	All
7	MC006	Insured Group or Policy Number	N	Text	30	Use this field to report the group or policy number. **Notes:** This is not the number that uniquely identifies the subscriber. The value reported for this field should be consistent with the value reported in the "Insured Group or Policy Number" field (ME006) in the eligibility file. If a policy is sold to an individual as a non-group policy, then this field should be reported with a value of "IND". This principle pertains to all claim types: commercial, Medicaid, and Medicare.	62 (A-C)	11C	837/2000B/SBR/ /03	99.5%	All
8	MC007	Subscriber Social Security Number	Y	Text	9	Use this field to report the subscriber's 9-digit Social Security number. **It is important to note that if this field is not reported, MC008 (Plan-Specific Contract Number) must be populated.** **Notes:** The value reported for this field should be consistent with the value reported in the "Subscriber Social Security Number" field (ME008) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	N/A	N/A	835/2100/NM1/FI/09	0% (please see the description's **bolded note**)	All
9	MC008	Plan-Specific Contract Number	Y	Text	80	Use this field to report the submitter-assigned contract number for the subscriber. **It is important to note that if this field is not reported, the "Subscriber Social Security Number" field (MC007) must be populated.** **Notes:** The value reported for this field should be consistent with the value reported in the "Plan-Specific Contract Number" field (ME009) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	60 (A-C)	1a	835/2100/NM1/MI/09	0% (please see the description's **bolded note**)	All
10	MC009	Member Suffix or Sequence Number	N	Integer	20	Use this field to report the unique number of the member within the contract.	N/A	N/A	N/A	90%	All

MEDICAL CLAIMS

#	ID	Element Name	Hash?	Type	Length	Description	UB-04 Ref.	CMS 1500 Ref.	X12 Ref.	Threshold	Denom.
11	MC010	Member Social Security Number	Y	Text	9	Use this field to report the member's 9-digit Social Security number. **Notes:** The value reported for this field should be consistent with the value reported in the "Member Social Security Number" field (ME011) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	N/A	N/A	835/2100/NM1/34/09	0%	All
12	MC011	Member Relationship	N	Text	2	Use this field to report the member's relationship to the subscriber or the insured. Valid codes include: 01 .....Spouse ~~04 .....Grandfather or Grandmother~~ x 12/31/2011 ~~05 .....Grandson or Granddaughter~~ x 12/31/2011 ~~07 .....Nephew or Niece~~ x 12/31/2011 ~~10 .....Foster Child~~ x 12/31/2011 ~~15 .....Ward~~ x 12/31/2011 ~~17 .....Stepson or Stepdaughter~~ x 12/31/2011 18 .....Self 19 .....Child 20 .....Employee 21 .....Unknown ~~22 .....Handicapped Dependent~~ x 12/31/2011 ~~23 .....Sponsored Dependent~~ x 12/31/2011 ~~24 .....Dependent of a Minor Dependent~~ x 12/31/2011 ~~29 .....Significant Other~~ x 12/31/2011 ~~32 .....Mother~~ x 12/31/2011 ~~33 .....Father~~ x 12/31/2011 ~~34 .....Other Adult~~ x 12/31/2011 ~~36 .....Emancipated Minor~~ x 12/31/2011 39 .....Organ Donor 40 .....Cadaver Donor ~~41 .....Injured Plaintiff~~ x 12/31/2011 ~~43 .....Child Where Insured Has No Financial Responsibility~~ x 12/31/2011 53 .....Life Partner G8.....Other relationship + 01/01/2012 **Notes:** The value reported for this field should be consistent with the value reported in the "Member Relationship" field (ME012) in the eligibility file. Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	59 (A-C)	6	837/2000B/SBR/ /02, 837/2000C/PAT/ /01	100%	All

MEDICAL CLAIMS

#	ID	Element Name	Hash?	Type	Length	Description	UB-04 Ref.	CMS 1500 Ref.	X12 Ref.	Threshold	Denom.
13	MC012	Member Gender	N	Text	1	Use this field to report the member's gender. The only valid codes for this field are: F.....Female M.....Male U.....Unknown **Notes:** The value reported for this field should be consistent with the value reported in the "Member Gender" field (ME013) in the eligibility file. Note that while the code used in pharmacy claims to report this field differs from the code used in eligibility and medical claims (e.g., male =1 in PC, but M in both ME and MC), the value (i.e., the gender) reported for this field should be consistently reported across all file types for the same member.	11	3	837/2010BA/DMG/ /03, 837/2010CA/DMG/ /03	100%	All
14	MC013	Member Date of Birth	N	Date	8	Use this field to report the member's date of birth using an 8-digit format of CCYYMMDD (e.g., February 17, 1972, would be coded as "19720217"). **Notes:** The value reported for this field should be consistent with the value reported in the "Member Date of Birth" field (ME014) in the eligibility file.	10	3	837/2010BA/DMG/D8/02 , 837/2010CA/DMG/D8/02	99.5%	All
15	MC014	Member City	N	Text	30	Use this field to report the name of the member's city of residence.	09 (b)	5	837/2010BA/N4/ /01, 837/2010CA/N4/ /01,	99.5%	All
16	MC015	Member State or Province	N	Text	2	Use this field to report the member's state or province using the two-character abbreviation code defined by the U.S. Postal Service(for U.S. states) and Canada Post (for Canadian provinces).	09 (c)	5	837/2010BA/N4/ /02 837/2010CA/N4/ /02	99.5%	All
17	MC016	Member ZIP/Postal Code	N	Text	11	Use this field to report the ZIP/postal code associated with the member's residence. **Notes:** For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code). Do not code dashes or spaces within ZIP/postal codes.	09 (d)	5	837/2010BA/N4/ /03, 837/2010CA/N4/ /03	99.5%	All
18	MC017	Payment Date / Settlement Date	N	Date	8	Use this field to report the date on which the record was approved for payment using an 8-digit format of CCYYMMDD (e.g., January 18, 2014, would be coded as "20140118"). **Notes:** This date generally is referred to as the paid date. When BPR04 is "NON" for nonpayment, report the remittance date instead.	N/A	N/A	835/Header Financial Information/BPR/ /16	100%	All
19	MC018	Admission Date	N	Date	8	Use this field to report the date of the inpatient admission using an 8-digit format of CCYYMMDD (e.g., January 18, 2014, would be coded as "20140118").	12	18	837/2300/DTP/435/DT/03	95%	Institutional inpatient
20	MC019	Admission Hour	N	Text	4	Use this field to report the hour — in the format of HHMM, with hours reported using military time (i.e., 00 through 23) — during which the member was admitted for inpatient care.	13	N/A	*Institutional* 837/2300/DTP/435/03	50%	Institutional inpatient

MEDICAL CLAIMS											
#	ID	Element Name	Hash?	Type	Length	Description	UB-04 Ref.	CMS 1500 Ref.	X12 Ref.	Threshold	Denom.
21	MC020	Admission Type	N	Text	1	Use this field to report the type of admission for the inpatient hospital claim. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	14	N/A	*Institutional* 837/2300/CL1/ /01	85%	Institutional inpatient
22	MC021	Admission Source	N	Text	1	Use this field to report the source of admission. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	15	N/A	*Institutional* 837/2300/CL1/ /02	85%	Inpatient
23	MC022	Discharge Hour	N	Text	4	Use this field to report the hour — in the format of HHMM, with hours reported using military time (i.e., 00 through 23) — during which the member was discharged from inpatient care.	16	N/A	*Institutional* 837/2300/DTP/096/03	50%	Institutional inpatient
24	MC023	Discharge Status	N	Text	2	Use this field to report the status for the patient discharged from an inpatient stay. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual.	17	N/A	*Institutional* 837/2300/CL1/ /03	90%	Institutional inpatient
25	MC024	Rendering Provider Plan ID	N	Text	30	Use this field to report the submitter-assigned or legacy provider plan ID for the rendering provider.	57	24J	835/2100/REF/1A/02, 835/2100/REF/1B/02, 835/2100/REF/1C/02, 835/2100/REF/1D/02, 835/2100/REF/G2/02, 835/2100/NM1/BD/09, 835/2100/NM1/BS/09, 835/2100/NM1/MC/09, 835/2100/NM1/PC/09	90%	All
26	MC025	Rendering Provider Tax ID Number	N	Text	9	Use this field to report the federal taxpayer identification number for the rendering provider.	5	N/A	835/2100/NM1/FI/09	90%	All
27	MC026	Rendering Provider NPI	N	Text	10	Use this field to report the National Provider Identifier (NPI) for the rendering provider or entity.	56	24J	835/2100/NM1/XX/09	65%	All
28	MC027	Entity Type Qualifier	N	Text	1	Use this field to report whether the rendering provider was an individual practitioner or a business entity. **Notes:** Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	N/A	N/A	835/2100/NM1/82/02	90%	All
29	MC028	Rendering Provider First Name	N	Text	25	Use this field to report the rendering provider's first name. **Notes:** Set to null if the provider is a facility or an organization.	N/A	31	835/2100/NM1/82/04	40%	Professional
30	MC029	Rendering Provider Middle Name or Initial	N	Text	25	Use this field to report the rendering provider's middle name or initial. **Notes:** Set to null if the provider is a facility or an organization.	N/A	31	835/2100/NM1/82/05	0.5%	Professional

MEDICAL CLAIMS											
#	ID	Element Name	Hash?	Type	Length	Description	UB-04 Ref.	CMS 1500 Ref.	X12 Ref.	Threshold	Denom.
31	MC030	Rendering Provider Last Name or Organization Name	N	Text	60	Use this field to report the last name of the rendering provider if an individual or the full name if the provider is a facility or an organization.	1	31	835/2100/NM1/82/03	99.5%	All
32	MC031	Rendering Provider Suffix	N	Text	10	Use this field to report any generational identifiers associated with the rendering provider's name (e.g., JR, SR, III). **Notes:** Do not code punctuation and do not code the rendering provider's credentials (e.g., MD, LCSW) in this field. Set to null if the provider is a facility or an organization.	N/A	31	*Professional* 837/2420A/NM1/82/07, 837/2310B/NM1/82/07, 835/2100/NM1/82/03	0.5%	Professional
33	MC032	Rendering Provider Specialty	N	Text	50	Use this field to report the rendering provider's taxonomy or payer-assigned specialty code.	N/A	24J Qualifier ZZ	*Institutional* 837/2000A/PRV/PXC/03 *Professional* 837/2310B/PRV/PXC/03	99.50%	All
34	MC033	Rendering Provider City Name	N	Text	30	Use this field to report the city where the service was rendered. **Notes:** When not available (e.g., ambulance services), report the organization or provider's location city.	1	32	*Institutional* 837/2010AA/N4/ /01 *Professional* 837/2420C/N4/ /01, 837/2310C/N4/ /01	90%	All
35	MC034	Rendering Provider State or Province	N	Text	2	Use this field to report the state or province where the service was rendered using the two-character abbreviation defined by the U.S. Postal Service (for U.S. states) and Canada Post (for Canadian provinces). **Notes:** When not available (e.g., ambulance services), report the organization or provider's location state or province.	1	32	*Institutional* 837/2010AA/N4/ /02 *Professional* 837/2420C/N4//02, 837/2310C/N4/ /02	90%	All
36	MC035	Rendering Provider ZIP/Postal Code	N	Text	11	Use this field to report the ZIP/postal code where the service was rendered. **Notes:** For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code). Do not code dashes or spaces within ZIP/postal codes. When not available (e.g., ambulance services), report the organization or provider's location ZIP/postal code.	1	32	*Institutional* 837/2010AA/N4/ /03 *Professional* 837/e2420C/N4/ /03, 837/2310C/N4/ /03	90%	All
37	MC036	Type of Bill	N	Text	2	Use this field to report the code for the type of bill. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual. This field is required for institutional claims and must be set to null for professional claims.	4	N/A	*Institutional* 837/2300/CLM/ /05-1	95%	Institutional
38	MC037	Place of Service	N	Text	2	Use this field to report the place of service code as reported on a professional claim. **Notes:** This field is required for professional claims and must be set to null for institutional claims.	N/A	24B	*Professional* 837/2300/CLM/ /05-1	95%	Non-Facility

MEDICAL CLAIMS											
#	ID	Element Name	Hash?	Type	Length	Description	UB-04 Ref.	CMS 1500 Ref.	X12 Ref.	Threshold	Denom.
39	MC038	Claim Status	N	Text	2	Use this field to report the status of the claim line — whether paid as primary, paid as secondary, denied, etc. **Notes:** Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	N/A	N/A	835/2100/CLP/ /02	99.5%	All
40	MC039	Admitting Diagnosis	N	Text	7	Use this field to report the ICD diagnosis code indicating the reason for the inpatient admission. **Notes:** Do not include the decimal point when coding this field.	69	N/A	*Institutional* 837/2300/HI/BJ/01-2, 837/2300/HI/ABJ/01-2	90%	Institutional inpatient
41	MC040	External Cause of Injury (ECI) Code - 1	N	Text	7	Use this field to report the first injury, poisoning, or adverse effect using an ICD diagnosis code. **Notes:** Do not include the decimal point when coding this field.	72a	N/A	*Institutional* 837/2300/HI/BN/01-2, 837/2300/HI/ABN/01-2	1%	All
42	MC041	Principal Diagnosis | ICD Version Indicator	N	Text	9	Use this field to report both the ICD diagnosis for the Principal Diagnosis and the ICD Version Indicator separated by the pipe character. For example, ICD diagnosis code V30.00 (i.e., single liveborn, born in hospital, delivered without mention of cesarean section) would be reported in the asterisk-delimited file as *V3000|9*. Note that the ICD Version Indicator should declare the version of ICD reported on this service line. The only valid codes for this field are: 9 .....ICD-9 0 .....ICD-10 **Notes:** Do not include the decimal point when coding the diagnosis field. **The ICD Version Indicator reported here should pertain to the entire claim and to all of its ICD diagnosis and procedure codes.** It is not to be reported redundantly with the other diagnosis and procedure codes.	67/66	21.1	*Principal Diagnosis:* 837/2300/HI/BK/01-2, 837/2300/HI/ABK/01-2	Principal Diagnosis: 95% ICD Version Indicator: 100%	All
43	MC042	Other Diagnosis - 1	N	Text	7	Use this field to report the ICD diagnosis code for the first secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67A	CMS 1500 Version 08/05 21.2, CMS 1500 Version 02/12 21.B	*Institutional* 837/2300/HI/BF/01-2, 837/2300/HI/ABF/01-2 *Professional* 837/2300/HI/BF/02-2, 837/2300/HI/ABF/02-2	10%	All
44	MC043	Other Diagnosis - 2	N	Text	7	Use this field to report the ICD diagnosis code for the second secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67B	CMS 1500 Version 08/05 21.3, CMS 1500 Version 02/12 21.C	*Institutional* 837/2300/HI/BF/02-2, 837/2300/HI/ABF/02-2 *Professional* 837/2300/HI/BF/03-2, 837/2300/HI/ABF/03-2	5%	All

MEDICAL CLAIMS											
#	ID	Element Name	Hash?	Type	Length	Description	UB-04 Ref.	CMS 1500 Ref.	X12 Ref.	Threshold	Denom.
45	MC044	Other Diagnosis - 3	N	Text	7	Use this field to report the ICD diagnosis code for the third secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67C	CMS 1500 Version 08/05, 21.4 CMS D500 Version 02/12 21.D	*Institutional* 837/2300/HI/BF/03-2, 837/2300/HI/ABF/03-2 *Professional* 837/2300/HI/BF/04-2, 837/2300/HI/ABF/04-2	0.5%	All
46	MC045	Other Diagnosis - 4	N	Text	7	Use this field to report the ICD diagnosis code for the fourth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67D	CMS 1500 Version 02/12 21.E	*Institutional* 837/2300/HI/BF/04-2, 837/2300/HI/ABF/04-2 *Professional* 837/2300/HI/BF/05-2, 837/2300/HI/ABF/05-2	0%	All
47	MC046	Other Diagnosis - 5	N	Text	7	Use this field to report the ICD diagnosis code for the fifth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67E	CMS 1500 Version 02/12 21.F	*Institutional* 837/2300/HI/BF/05-2, 837/2300/HI/ABF/05-2 *Professional* 837/2300/HI/BF/06-2, 837/2300/HI/ABF/06-2	0%	All
48	MC047	Other Diagnosis - 6	N	Text	7	Use this field to report the ICD diagnosis code for the sixth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67F	CMS 1500 Version 02/12 21.G	*Institutional* 837/2300/HI/BF/06-2, 837/2300/HI/ABF/06-2 *Professional* 837/2300/HI/BF/07-2, 837/2300/HI/ABF/07-2	0%	All
49	MC048	Other Diagnosis - 7	N	Text	7	Use this field to report the ICD diagnosis code for the seventh secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67G	CMS 1500 Version 02/12 21.H	*Institutional* 837/2300/HI/BF/07-2, 837/2300/HI/ABF/07-2 *Professional* 837/2300/HI/BF/08-2, 837/2300/HI/ABF/08-2	0%	All
50	MC049	Other Diagnosis - 8	N	Text	7	Use this field to report the ICD diagnosis code for the eighth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67H	CMS 1500 Version 02/12 21.I	*Institutional* 837/2300/HI/BF/08-2, 837/2300/HI/ABF/08-2 *Professional* 837/2300/HI/BF/09-2, 837/2300/HI/ABF/09-2	0%	All
51	MC050	Other Diagnosis - 9	N	Text	7	Use this field to report the ICD diagnosis code for the ninth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67I	CMS 1500 Version 02/12 21.J	*Institutional* 837/2300/HI/BF/09-2, 837/2300/HI/ABF/09-2 *Professional* 837/2300/HI/BF/10-2, 837/2300/HI/ABF/10-2	0%	All

MEDICAL CLAIMS											
#	ID	Element Name	Hash?	Type	Length	Description	UB-04 Ref.	CMS 1500 Ref.	X12 Ref.	Threshold	Denom.
52	MC051	Other Diagnosis - 10	N	Text	7	Use this field to report the ICD diagnosis code for the tenth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67J	CMS 1500 Version 02/12 21.K	*Institutional* 837/2300/HI/BF/10-2, 837/2300/HI/ABF/10-2 *Professional* 837/2300/HI/BF/11-2, 837/2300/HI/ABF/11-2	0%	All
53	MC052	Other Diagnosis - 11	N	Text	7	Use this field to report the ICD diagnosis code for the eleventh secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67K	CMS 1500 Version 02/12 21.L	*Institutional* 837/2300/HI/BF/11-2, 837/2300/HI/ABF/11-2 *Professional* 837/2300/HI/BF/12-2, 837/2300/HI/ABF/12-2	0%	All
54	MC053	Other Diagnosis - 12	N	Text	7	Use this field to report the ICD diagnosis code for the twelfth secondary diagnosis. **Notes:** Do not include the decimal point when coding this field.	67L	N/A	*Institutional* 837/2300/HI/BF/12-2, 837/2300/HI/ABF/12-2	0%	All
55	MC054	Revenue Code	N	Text	4	Use this field to report the revenue code for institutional claims. **Notes:** Valid codes are maintained by the National Uniform Billing Committee (NUBC) and are available in the UB-04 Data Specifications Manual. Code using leading zeroes to ensure a full complement of four digits. Leave this field null for professional claims.	42	N/A	835/2110/SVC/NU/01-2 835/2110/SVC/ /04	30%	All
56	MC055	Procedure Code | Vermont ACO Payment Arrangement Indicator	N	Text	7	Use this field to report both the HCPCS, CPT, or HIPPS code for the service rendered and the ACO Payment Arrangement Indicator, if applicable. Only those submitters requested to report participation in a Vermont ACO should use the following codes for the ACO Payment Arrangement Indicator component of this field: 0……Not paid under ACO capitation 1……Paid under ACO capitation Examples of combined Procedure Code and ACO Payment Arrangement Indicator separated by pipe character reported in an asterisk-delimited file: *99211|1*…….Procedure Code and paid under ACO capitation *|0* ……..No Procedure Code and Not paid under ACO capitation **Notes:** there are no spaces between the Procedure Code and the pipe character and between the pipe character and the ACO Payment Arrangement Indicator.	44	24.D	835/2110/SVC/HC/01-2, 835/2110/SVC/HP/01-2	80%	All
57	MC056	Procedure 1 Modifier - 1	N	Text	2	Use this field to report the first modifier indicating that a service or procedure has been altered by some specific circumstance but has not been changed in its definition or code.	44	24.D	835/2110/SVC/HC/01-3	0.5%	All

MEDICAL CLAIMS											
#	ID	Element Name	Hash?	Type	Length	Description	UB-04 Ref.	CMS 1500 Ref.	X12 Ref.	Threshold	Denom.
58	MC057	Procedure 1 Modifier - 2	N	Text	2	Use this field to report the second modifier indicating that a service or procedure has been altered by some specific circumstance but has not been changed in its definition or code.	44	24.D	835/2110/SVC/HC/01-4	0.5%	All
59	MC058	Principal ICD Procedure Code	N	Text	7	Use this field to report the principal ICD procedure code on inpatient claims only. **Notes:** The ICD procedure must be repeated for all lines of the claim if necessary. This field must be null for professional claims. Do not include the decimal point when coding this field.	74	N/A	*Institutional* 837/2300/HI/BR/01-2 837/2300/HI/BBR/01-2	10%	Institutional inpatient hospital
60	MC059	Date of Service (From)	N	Date	8	Use this field to report the first date of service for this service line using an 8-digit format of CCYYMMDD (e.g., January 18, 2014, would be coded as "20140118"). **Notes:** Dates subsequent to the Paid Date are not acceptable.	45	24 A	835/2110/DTM/472/02, 835/2110/DTM/150/02	99.5%	All
61	MC060	Date of Service (Through)	N	Date	8	Use this field to report the last date of service for this service line using an 8-digit format of CCYYMMDD (e.g., January 18, 2014, would be coded as "20140118"). **Notes:** Dates subsequent to the Date of Service (From) and the Paid Date are not acceptable.	N/A	24 A	835/2110/DTM/472/02, 835/2110/DTM/151/02	99.5%	All
62	MC061	Quantity	N	Integer	3	Use this field to report a count of services performed. **Notes:** This field may be negative. When coding this field, please round to the nearest whole number so no decimal places are included.	46	24 G	835/2110/SVC/ /05	99.5%	All
63	MC062	Charge Amount	N	Decimal	10,2	Use this field to report the total charges for the service. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	47	24 F	835/2110/SVC/ /02	99.5%	All
64	MC063	Paid Amount	N	Decimal	10,2	Use this field to report the total dollar amount paid to the provider, including all health plan payments and withholds. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	N/A	N/A	835/2110/SVC/ /03	0%	All
65	MC064	Prepaid Amount	N	Decimal	10,2	Use this field to report capitated services, the fee for service equivalent amount. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	N/A	N/A	N/A	0%	All

MEDICAL CLAIMS											
#	ID	Element Name	Hash?	Type	Length	Description	UB-04 Ref.	CMS 1500 Ref.	X12 Ref.	Threshold	Denom.
66	MC065	Copay Amount	N	Decimal	10,2	Use this field to report the preset, fixed dollar amount payable by a member, often on a per visit/service basis. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	N/A	N/A	835/2110/CAS/PR/3-03	0%	All
67	MC066	Coinsurance Amount	N	Decimal	10,2	Use this field to report the dollar amount that a member must pay toward the cost of a covered service, which is often a percentage of total cost. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	N/A	N/A	835/2110/CAS/PR/2-03	0%	All
68	MC067	Deductible Amount	N	Decimal	10,2	Use this field to report the dollar amount that a member must pay before the health plan benefits will begin to reimburse for services. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	N/A	N/A	835/2110/CAS/PR/1-03	0%	All
69	MC068	Medical Record Number	N	Text	20	Use this field to report the member's medical record number.	3B	N/A	837/2300/REF/EA/02	90%	All
70	MC069	Discharge Date	N	Date	8	Use this field to report the discharge date of the patient from inpatient care using an 8-digit format of CCYYMMDD (e.g., January 18, 2014, would be coded as "20140118").	6	18	*Institutional* 837/2300/DTP/RD8/04 *Professional* 837/2300/DTP/D8/03	95%	Institutional inpatient
71	MC070	Rendering Provider Country	N	Text	30	Use this field to report the name of the country where the service was rendered. **Notes:** Please code only a two-digit response — "US" — to indicate the United States.	N/A	N/A	837/2310C/N4/07	95%	All
72	MC071	DRG	N	Text	7	Use this field to report the Diagnosis-Related Group (DRG) if available.	N/A	N/A	*Institutional* 837/2300/HI/DR/01-2	0%	Institutional inpatient hospital
73	MC072	DRG Version	N	Text	2	Use this field to declare the version of Diagnosis-Related Group (DRG) reported in MC071.	N/A	N/A	N/A	0%	Institutional inpatient hospital
74	MC073	APC	N	Text	4	Use this field to report the Ambulatory Payment Classification (APC) if available.	N/A	N/A	835/2110/REF/APC/02	0%	Institutional outpatient hospital
75	MC074	APC Version	N	Text	2	Use this field to declare the version of the Ambulatory Payment Classification (APC) reported in MC073.	N/A	N/A	N/A	0%	Institutional outpatient hospital

MEDICAL CLAIMS											
#	ID	Element Name	Hash?	Type	Length	Description	UB-04 Ref.	CMS 1500 Ref.	X12 Ref.	Threshold	Denom.
76	MC075	National Drug Code	N	Text	11	Use this field to report the National Drug Code (NDC) assigned by the U.S. Food and Drug Administration (FDA).	43	24	837/2410/LIN/N4/03	0%	All
77	MC076	Billing Provider Plan ID	N	Text	30	Use this field to report the submitter-assigned billing provider number. **Notes:** This should be the identifier used by the submitter for internal reasons and should not routinely change.	57	33b	837/2010BB/REF/G2/02	90%	All
78	MC077	Billing Provider NPI	N	Text	10	Use this field to report the National Provider Identifier (NPI) for the billing provider.	56	33a	837/2010AA/NM1/XX/09	65%	All
79	MC078	Billing Provider Last Name or Organization Name	N	Text	60	Use this field to report the last name of the billing provider if an individual or the full name if an organization.	1	33	837/2010AA/NM1/ /03	99.5%	All
80	MC101	Subscriber Last Name	Y	Text	60	Use this field to report the subscriber's last name. **Notes:** The value reported for this field should be consistent with the value reported in the "Subscriber Last Name" field (ME101) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	58(A-C)	4	837/2010BA/NM1/ /03	100%	All
81	MC102	Subscriber First Name	Y	Text	35	Use this field to report the subscriber's first name. **Notes:** The value reported for this field should be consistent with the value reported in the "Subscriber First Name" field (ME102) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	58(A-C)	4	837/2010BA/NM1/ /04	100%	All
82	MC103	Subscriber Middle Initial	Y	Text	1	Use this field to report the subscriber's middle initial. **Notes:** The value reported for this field should be consistent with the value reported in the "Subscriber Middle Initial" field (ME103) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	58(A-C)	4	837/2010BA/NM1/ /05	50%	All

MEDICAL CLAIMS											
#	ID	Element Name	Hash?	Type	Length	Description	UB-04 Ref.	CMS 1500 Ref.	X12 Ref.	Threshold	Denom.
83	MC104	Member Last Name	Y	Text	60	Use this field to report the member's last name. **Notes:** If the member is the subscriber, report the subscriber's last name again in this field. The value reported for this field should be consistent with the value reported in the "Member Last Name" field (ME104) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	8a	2	837/2010CA/NM1/ /03, 837/2010BA/NM1/ /03	100%	All
84	MC105	Member First Name	Y	Text	35	Use this field to report the member's first name. **Notes:** If the member is the subscriber, report the subscriber's first name again in this field. The value reported for this field should be consistent with the value reported in the "Member First Name" field (ME105) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	8a	2	837/2010CA/NM1/ /04, 837/2010BA/NM1/ /04	100%	All
85	MC106	Member Middle Initial	Y	Text	1	Use this field to report the member's middle initial. **Notes:** If the member is the subscriber, report the subscriber's middle initial again in this field. The value reported for this field should be consistent with the value reported in the "Member Middle Initial" field (ME106) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	8a	2	837/2010CA/NM1/ /05, 837/2010BA/NM1/ /05	50%	All
86	MC899	Record Type	N	Text	2	Use this field to report the constant value of "MC" to denote a medical claims record.	N/A	N/A	N/A	100%	All
1	TR001	Record Type	N	Text	2	This field must be coded "TR" to indicate the start of the trailer record.	N/A	N/A	N/A	100%	All
2	TR002	Submitter Code	N	Text	8	This field must contain the submitter code assigned to you by Onpoint Health Data.	N/A	N/A	N/A	100%	All
3	TR003	National Plan ID	N	Text	30	Use this field to report the CMS National Plan ID when implemented by the U.S. Centers for Medicaid & Medicare Services (CMS). Until CMS issues a National Plan ID, report this field as null.	N/A	N/A	N/A	0%	All
4	TR004	Type of File	N	Text	2	This field must be coded "MC" to indicate submission of medical claims data.	N/A	N/A	N/A	100%	All

MEDICAL CLAIMS											
#	ID	Element Name	Hash?	Type	Length	Description	UB-04 Ref.	CMS 1500 Ref.	X12 Ref.	Threshold	Denom.
5	TR005	Period Beginning Date	N	Integer	6	Use this field to report the earliest payment year/month included in the submission in CCYYMM format. Submissions with records containing a Payment Date / Settlement Date (MC017) outside of the date range indicated in this file's header and trailer records will fail.	N/A	N/A	N/A	100%	All
6	TR006	Period Ending Date	N	Integer	6	Use this field to report the latest payment year/month included in the submission in CCYYMM format. Submissions with records containing a Payment Date / Settlement Date (MC017) outside of the date range indicated in this file's header and trailer records will fail.	N/A	N/A	N/A	100%	All
7	TR007	Date Processed	N	Date	8	Use this field to report the date on which the file was created in CCYYMMDD format.	N/A	N/A	N/A	0%	All

9. Pharmacy Claims

The Basics

Key References Regulation H-2008-01, §6.I

Covered Parties All

Required Frequency Monthly, quarterly, or annually based on number of covered members

Important Notes

- All lines of partially denied claims are to be reported. Only fully denied claims are to be excluded.
- One record must be submitted for each service adjudicated during the period reported in the header and trailer records.
- Submissions must cover full months of data; partial months must not be reported.

Columns Included in the Pharmacy Claims File

Indicates the element's required position within the submission file	Indicates the element's reference number	Indicates the element's name	Indicates whether or not the element's true value has been rendered permanently non-recoverable by one-way hashing prior to submission to Onpoint	Indicates whether the type of data for the element is a date, decimal, integer, or text	Indicates the maximum length allowed for this element	Provides a general description of the data element, including valid codes vary from industry standards and for elements that lack a national standard altogether. Values appended with superscript text in blue (e.g., + 01/01/2012) note the effective date of newly valid values; those with strikethrough text (i.e., ~~strikethrough~~) are no longer valid and have their expiration dates appended in red superscript text (e.g., x 12/31/2011).	Indicates the element's NCPDP reference standard	Indicates the percent of submitted records for which this element must have a valid code	Indicates the type of records to be used to calculate the threshold percent for submission.
↓	↓	↓	↓	↓	↓	↓	↓	↓	↓
#	ID	Name	Hash?	Type	Length	Description	NCPDP Ref.	Threshold	Denominator

File Layout & Specifications

PHARMACY CLAIMS									
#	ID	Name	Hash?	Type	Length	Description	NCPDP Ref.	Threshold	Denominator
1	HD001	Record Type	N	Text	2	This field must be coded "HD" to indicate the start of the header record.	N/A	100%	All
2	HD002	Submitter Code	N	Text	8	This field must contain the submitter code assigned to you by Onpoint Health Data.	N/A	100%	All
3	HD003	National Plan ID	N	Text	30	Use this field to report the CMS National Plan ID when implemented by the U.S. Centers for Medicaid & Medicare Services (CMS). Until CMS issues a National Plan ID, report this field as null.	N/A	0%	All
4	HD004	Type of File	N	Text	2	This field must be coded "PC" to indicate submission of pharmacy claims data.	N/A	100%	All
5	HD005	Period Beginning Date	N	Integer	6	Use this field to report the earliest date service approved year/month included in the submission in CCYYMM format. Submissions with records containing a Payment Date / Settlement Date value (PC017) outside of the date range indicated in this file's header and trailer records will fail.	N/A	100%	All
6	HD006	Period Ending Date	N	Integer	6	Use this field to report the latest date service approved year/month included in the submission in CCYYMM format. Submissions with records containing a Payment Date / Settlement Date value (PC017) outside of the date range indicated in this file's header and trailer records will fail.	N/A	100%	All
7	HD007	Record Count	N	Integer	10	Use this field to report the total number of records in the submission, excluding the header and trailer records. If the number of records within the submission does not equal the number reported in this field, the submission will fail.	N/A	100%	All
8	HD008	Comments	N	Text	80	This field may be used by the submitter to document a file name, system source, or other administrative device to assist with their internal tracking of the submission.	N/A	0%	All
1	PC001	Submitter Code	N	Text	8	Use this field to report your Onpoint-assigned submitter code for the data submitter. Note that the first two characters of the submitter code are used to indicate the client and the third character designates the type of submitter. For Vermont's APCD collection, valid prefixes include: VTC .....Commercial carrier VTG.....Governmental agency VTT .....Third-party administrator **Notes:** A single data submitter may have multiple submitter codes if they are submitting from more than one system or from more than one location. All submitter codes associated with a single data submitter will have the same first six characters. A suffix will be used to distinguish the location and/or system variations. This field contains a constant value and is primarily used for tracking compliance by data submitter.	N/A	100%	All
2	PC002	National Plan ID	N	Text	30	Use this field to report the CMS National Plan ID when implemented by the U.S. Centers for Medicaid & Medicare Services (CMS). Until CMS issues a National Plan ID, report this field as null.	N/A	0%	All

PHARMACY CLAIMS									
#	ID	Name	Hash?	Type	Length	Description	NCPDP Ref.	Threshold	Denominator
3	PC003	Insurance Type / Product Code	N	Text	2	Use this field to report the member's type of insurance or insurance product. Valid codes include: 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 / Medicare Part C HM .....Health Maintenance Organization MC.....Medicaid MD .....Medicare Part D OF.....Other Federal Program PC.....Personal care TV.....Title V VA .....Veterans Administration Plan **Notes:** Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	N/A	100%	All
4	PC004	Payer Claim Control Number	N	Text	35	Use this field to report the claim number used by the data submitter to internally track the claim. **Notes:** In general, the claim number is associated with all service lines of the claim. It must apply to the entire claim and be unique within the data submitter's system. The value reported in this field should remain consistent over time.	993-A7	100%	All
5	PC005	Line Counter	N	Integer	4	Use this field to report the line number for this service. **Notes:** The line counter should begin with 1 and be incremented by 1 for each additional service line of a claim.	N/A	99.5%	All
6	PC006	Insured Group or Policy Number	N	Text	50	Use this field to report the group or policy number. **Notes:** This is not the number that uniquely identifies the subscriber. The value reported for this field should be consistent with the value reported in the "Insured Group or Policy Number" field (ME006) in the eligibility file. If a policy is sold to an individual as a non-group policy, then this field should be reported with a value of "IND".	301-C1	99.5%	All
7	PC007	Subscriber Social Security Number	Y	Text	9	Use this field to report the subscriber's 9-digit Social Security number. **It is important to note that if this field is not reported, PC008 (Plan-Specific Contract Number) must be populated.** **Notes:** The value reported for this field should be consistent with the value reported in the "Subscriber Social Security Number" field (ME008) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	N/A	0% (please see the description's **bolded note**)	All

PHARMACY CLAIMS									
#	ID	Name	Hash?	Type	Length	Description	NCPDP Ref.	Threshold	Denominator
8	PC008	Plan-Specific Contract Number	Y	Text	80	Use this field to report the submitter-assigned contract number for the subscriber. **It is important to note that if this field is not reported, the "Subscriber Social Security Number" field (PC007) must be populated.** **Notes:** The value reported for this field should be consistent with the value reported in the "Plan-Specific Contract Number" field (ME009) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	302-C2	0% (please see the description's **bolded note**)	All
9	PC009	Member Suffix or Sequence Number	N	Text	20	Use this field to report the unique number of the member within the contract.	N/A	90%	All
10	PC010	Member Social Security Number	Y	Text	9	Use this field to report the member's 9-digit Social Security number. **Notes:** The value reported for this field should be consistent with the value reported in the "Member Social Security Number" field (ME011) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	N/A	0%	All
11	PC011	Member Relationship	N	Text	2	Use this field to report the member's relationship to the subscriber or the insured. Valid codes include: 01.....Spouse ~~04.....Grandfather or Grandmother~~ x 12/31/2011 ~~05.....Grandson or Granddaughter~~ x 12/31/2011 ~~07.....Nephew or Niece~~ x 12/31/2011 ~~10.....Foster Child~~ x 12/31/2011 ~~15.....Ward~~ x 12/31/2011 ~~17.....Stepson or Stepdaughter~~ x 12/31/2011 18.....Self 19.....Child 20.....Employee 21.....Unknown ~~22.....Handicapped Dependent~~ x 12/31/2011 ~~23.....Sponsored Dependent~~ x 12/31/2011 ~~24.....Dependent of a Minor Dependent~~ x 12/31/2011 ~~29.....Significant Other~~ x 12/31/2011 ~~32.....Mother~~ x 12/31/2011 ~~33.....Father~~ x 12/31/2011 ~~34.....Other Adult~~ x 12/31/2011 ~~36.....Emancipated Minor~~ x 12/31/2011 39.....Organ Donor 40.....Cadaver Donor ~~41.....Injured Plaintiff~~ x 12/31/2011 ~~43.....Child Where Insured Has No Financial Responsibility~~ x 12/31/2011 53.....Life Partner G8.....Other relationship + 01/01/2012 **Notes:** The value reported for this field should be consistent with the value reported in the "Member Relationship" field (ME012) in the eligibility file.	N/A	100%	All

PHARMACY CLAIMS									
#	ID	Name	Hash?	Type	Length	Description	NCPDP Ref.	Threshold	Denominator
12	PC012	Member Gender	N	Integer	1	Use this field to report the member's gender. **Notes:** The value reported for this field should be consistent with the value reported in the "Member Gender" field (ME013) in the eligibility file. Note that while the code used in pharmacy claims to report this field differs from the code used in eligibility and medical claims (e.g., male =1 in PC, but M in both ME and MC), the value (i.e., the gender) reported for this field should be consistently reported across all file types for the same member. Valid codes are maintained by the National Council for Prescription Drug Programs (NCPDP) and are available in the NCPDP standards set.	305-C5	100%	All
13	PC013	Member Date of Birth	N	Date	8	Use this field to report the member's date of birth using an 8-digit format of CCYYMMDD (e.g., February 17, 1972, would be coded as "19720217"). **Notes:** The value reported for this field should be consistent with the value reported in the "Member Date of Birth" field (ME014) in the eligibility file.	304-C4	99.5%	All
14	PC014	Member City	N	Text	30	Use this field to report the name of the member's city of residence.	323-CN	99.5%	All
15	PC015	Member State or Province	N	Text	2	Use this field to report the member's state or province using the two-character abbreviation code defined by the U.S. Postal Service(for U.S. states) and Canada Post (for Canadian provinces).	324-CO	99.5%	All
16	PC016	Member ZIP/Postal Code	N	Text	9	Use this field to report the ZIP/postal code associated with the member's residence. **Notes:** For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code). Do not code dashes or spaces within ZIP/postal codes.	325-CP	99.5%	All
17	PC017	Payment Date / Settlement Date	N	Date	8	Use this field to report the date on which the record was approved for payment using an 8-digit format of CCYYMMDD (e.g., January 18, 2014, would be coded as "20140118"). **Notes:** This is generally referred to as the paid date and reported with a CCYYMMDD format.	216	100%	All
18	PC018	Pharmacy Number	N	Text	30	Use this field to report the payer-assigned pharmacy number.	201-B1	99.5%	All
19	PC019	Pharmacy Tax ID Number	N	Text	10	Use this field to report the pharmacy's federal taxpayer's identification number.	N/A	10%	All
20	PC020	Pharmacy Name	N	Text	30	Use this field to report the name of the pharmacy.	833-5P	99.5%	All
21	PC021	National Pharmacy ID Number	N	Text	10	Use this field to report the National Provider Identification (NPI) of the pharmacy.	201-B1	90%	All
22	PC022	Pharmacy Location City	N	Text	30	Use this field to report the city where the prescription was filled.	728	99.5%	All
23	PC023	Pharmacy Location State or Province	N	Text	2	Use this field to report the state or province where the prescription was filled using the two-character abbreviation defined by the U.S. Postal Service (for U.S. states) and Canada Post (for Canadian provinces).	729	99.5%	All
24	PC024	Pharmacy ZIP/Postal Code	N	Text	10	Use this field to report the ZIP/postal code where the prescription was filled. **Notes:** For U.S. ZIP codes, include the ZIP+4 (also referred to as the "plus-four" or "add-on" code). Do not code dashes or spaces within ZIP/postal codes.	730	99.5%	All

PHARMACY CLAIMS									
#	ID	Name	Hash?	Type	Length	Description	NCPDP Ref.	Threshold	Denominator
25	PC024 A	Pharmacy Country	N	Text	30	Use this field to report the name of the country where the prescription was filled. **Notes:** Please code only a two-digit response — "US" — to indicate the United States.	N/A	99.5%	All
26	PC025	Claim Status	N	Text	2	Use this field to report the status of the claim — whether paid as primary, paid as secondary, denied, etc. **Notes:** Valid codes are maintained by the Accredited Standards Committee (ASC) and are available in the ASC X12 transaction set.	N/A	99.5%	All
27	PC026	National Drug Code	N	Text	11	Use this field to report the National Drug Code (NDC) assigned by the U.S. Food and Drug Administration (FDA).	407-D7	99.5%	All
28	PC027	Drug Name	N	Text	80	Use this field to report the text name of the drug.	516-FG	99.5%	All
29	PC028	New Prescription or Refill	N	Text	2	Use this field to report whether this is a new prescription or refill. The only valid codes for this field are: 00.....New prescription 01–99.....Number of refill(s)	403-D3	99.5%	All
30	PC029	Generic Drug Indicator	N	Text	1	Use this field to report whether the drug is a branded drug or a generic drug. The only valid codes for this field are: N.....No, branded drug Y.....Yes, generic drug	425-DP	99.5%	All
31	PC030	Dispense as Written Code	N	Integer	1	Use this field to report the instructions given to the pharmacist for filling the prescription. **Notes:** Valid codes are maintained by the National Council for Prescription Drug Programs (NCPDP) and are available in the NCPDP standards set.	408-D8	99.5%	All
32	PC031	Compound Drug Indicator	N	Text	1	Use this field to indicate whether or not the drug is a compound drug. The only valid codes for this field are: Y.....Compound N.....Not compound U.....Not specified	N/A	99.5%	All
33	PC032	Date Prescription Filled	N	Date	8	Use this field to report the date on which the prescription was filled using an 8-digit format of CCYYMMDD (e.g., January 18, 2014, would be coded as "20140118").	401-D1	99.5%	All
34	PC033	Quantity Dispensed	N	Integer	5	Use this field to report the total unit dosage in metric units. **Notes:** This field may contain a negative value. When coding this field, please round to the nearest whole number so no decimal places are included.	442-E7	99.5%	All
35	PC034	Days' Supply	N	Integer	3	Use this field to report the days' supply for the prescription based on the metric quantity dispensed. **Notes:** This field may contain a negative value.	405-D5	95%	All
36	PC035	Charge Amount	N	Decimal	10,2	Use this field to report total charges for the prescription as reported by the pharmacy. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	430-DU	99.5%	All

PHARMACY CLAIMS									
#	ID	Name	Hash?	Type	Length	Description	NCPDP Ref.	Threshold	Denominator
37	PC036	Paid Amount	N	Decimal	10,2	Use this field to report the total dollar amount paid to the provider, including all health plan payments and excluding all member payments and withholds from providers. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	509-F9	0%	All
38	PC037	Ingredient Cost / List Price	N	Decimal	10,2	Use this field to report the cost of the drug that was dispensed. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	506-F6	0%	All
39	PC038	Postage Amount Claimed	N	Decimal	10,2	Use this field to report the cost of postage included in the Paid Amount field (PC036). **Notes:** Do not include the decimal point when coding this field.	N/A	0%	All
40	PC039	Dispensing Fee	N	Decimal	10,2	Use this field to report the amount charged for dispensing the prescription. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	507-F7	0%	All
41	PC040	Copay Amount	N	Decimal	10,2	Use this field to report the preset, fixed dollar amount payable by a member, often on a per visit/service basis. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	518-FI	0%	All
42	PC041	Coinsurance Amount	N	Decimal	10,2	Use this field to report the dollar amount that a member must pay toward the cost of a covered service. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	572-4U	0%	All
43	PC042	Deductible Amount	N	Decimal	10,2	Use this field to report the dollar amount that a member must pay before the health plan benefits will begin to reimburse for services. **Notes:** This is a money field containing dollars and cents with an implied decimal point. Do not include the decimal point when coding this field. This field may contain a negative value. A reported value of 0 is acceptable.	517-FH	0%	All
44	PC043	Placeholder	N/A	N/A	N/A	N/A	N/A	N/A	N/A
45	PC044	Prescribing Provider First Name	N	Text	25	Use this field to report the first name of the prescribing provider.	N/A	40%	All
46	PC045	Prescribing Provider Middle Name	N	Text	25	Use this field to report the middle name or initial of the prescribing provider.	N/A	0.5%	All
47	PC046	Prescribing Provider Last Name	N	Text	60	Use this field to report the last name of the prescribing provider.	427-DR	40%	All
48	PC047	Prescribing Provider Number	N	Text	9	Use this field to report the prescribing provider's Drug Enforcement Agency (DEA) or NPI number.	421-DL	95%	All

PHARMACY CLAIMS									
#	ID	Name	Hash?	Type	Length	Description	NCPDP Ref.	Threshold	Denominator
49	PC101	Subscriber Last Name	Y	Text	60	Use this field to report the subscriber's last name. **Notes:** The value reported for this field should be consistent with the value reported in the "Subscriber Last Name" field (ME101) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	313-CD	100%	All
50	PC102	Subscriber First Name	Y	Text	35	Use this field to report the subscriber's first name. **Notes:** The value reported for this field should be consistent with the value reported in the "Subscriber First Name" field (ME102) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	312-CC	100%	All
51	PC103	Subscriber Middle Initial	Y	Text	1	Use this field to report the subscriber's middle initial. **Notes:** The value reported for this field should be consistent with the value reported in the "Subscriber Middle Initial" field (ME103) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	N/A	50%	All
52	PC104	Member Last Name	Y	Text	60	Use this field to report the member's last name. **Notes:** If the member is the subscriber, report the subscriber's last name again in this field. The value reported for this field should be consistent with the value reported in the "Member Last Name" field (ME104) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	311-CB	100%	All
53	PC105	Member First Name	Y	Text	35	Use this field to report the member's first name. **Notes:** If the member is the subscriber, report the subscriber's first name again in this field. The value reported for this field should be consistent with the value reported in the "Member First Name" field (ME105) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	310-CA	100%	All

PHARMACY CLAIMS									
#	ID	Name	Hash?	Type	Length	Description	NCPDP Ref.	Threshold	Denominator
54	PC106	Member Middle Initial	Y	Text	1	Use this field to report the member's middle initial. **Notes:** If the member is the subscriber, report the subscriber's middle initial again in this field. The value reported for this field should be consistent with the value reported in the "Member Middle Initial" field (ME106) in the eligibility file. This field will be rendered non-recoverable through the use of a one-way hashing algorithm prior to transmission to Onpoint. Upon receipt by Onpoint, this field will be a text field with a length of 128.	N/A	50%	All
55	PC899	Record Type	N	Text	2	Use this field to report the constant value of "PC" to denote a pharmacy claims record.	N/A	100%	All
1	TR001	Record Type	N	Text	2	This field must be coded "TR" to indicate the start of the trailer record.	N/A	100%	All
2	TR002	Submitter Code	N	Text	8	This field must contain the submitter code assigned to you by Onpoint Health Data.	N/A	100%	All
3	TR003	National Plan ID	N	Text	30	Use this field to report the CMS National Plan ID when implemented by the U.S. Centers for Medicaid & Medicare Services (CMS). Until CMS issues a National Plan ID, report this field as null.	N/A	0%	All
4	TR004	Type of File	N	Text	2	This field must be coded PC to indicate submission of pharmacy claims data.	N/A	100%	All
5	TR005	Period Beginning Date	N	Integer	6	Use this field to report the earliest date service approved year/month included in the submission in CCYYMM format. Submissions with records containing a Payment Date / Settlement Date value (PC017) outside of the date range indicated in this file's header and trailer records will fail.	N/A	100%	All
6	TR006	Period Ending Date	N	Integer	6	Use this field to report the latest date service approved year/month included in the submission in CCYYMM format. Submissions with records containing a Payment Date / Settlement Date value (PC017) outside of the date range indicated in this file's header and trailer records will fail.	N/A	100%	All
7	TR007	Date Processed	N	Date	8	Use this field to report the date on which the file was created in CCYYMMDD format.	N/A	0%	All

10. Announcements & Additional Information

GMCB Announces Reporting Change for Medicare Supplement Insurers

Notification Regarding Exception to VHCURES Regulation H-2008-01:

Suspension of the Requirement to Submit Eligibility and Claim Data to the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) for Vermont Residents Enrolled in Medicare Supplement Insurance Policies

April 28, 2015 – The purpose of this notice is to clarify the Green Mountain Care Board's (GMCB) reporting requirements for the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES). This mandated reporting system was created under V.S.A. 18 §9410 and transferred by legislative mandate to GMCB in 2013. This notification replaces the prior notification addressing Medicare Supplement reporting dated April 10, 2010 titled, "Notification Regarding VHCURES Regulation H-2008-01 Exempting Medicare Supplement Insurers from Requirement to Submit Claims Data." Following that notification, Medicare Supplement insurers were required to submit eligibility records only for Vermont members.

GMCB has suspended the requirement in Regulation H-2008-01 Sections 4 and 5 that stipulates the filing of eligibility and claims data by Medicare Supplement insurers until such time that GMCB may reverse the suspension of the requirement. If and when the suspension that grants an exception to the Regulation is reversed, the state will provide advance notification to affected insurers regarding the reporting requirements. Call (802) 828-2177 and request to speak with a staff member from the VHCURES program if there are any questions about this notification.

To download a PDF copy of this notice for your records, please click here.

11. Change Log

The following log charts key changes since the release of the Data Submission Guide for VHCURES (Version 2.0).

#	Item	Action	Table Name	Field ID	Common Name	Effective Version	Notes
1	Description	Changed	Medical Claims	MC061	Quantity	2.1	The instructions for reporting this field have been corrected to note that no implied decimal places should be included; please round to the nearest whole number instead.
2	Description	Changed	Pharmacy Claims	PC033	Quantity Dispensed	2.1	The instructions for reporting this field have been corrected to note that no implied decimal places should be included; please round to the nearest whole number instead.
3	Denominator	Updated	Eligibility	ME030	Market Category Code	2.2	The denominator for this field has been updated to “all”.
4	Field	Changed	Eligibility	ME031	Blueprint Medical Home (BPMH) Indicator and Vermont ACO Participation Indicator	2.2	This field has been expanded to include additional content, the Vermont ACO Participation Indicator.
5	Length	Expanded	Eligibility	ME031	Blueprint Medical Home (BPMH) Indicator and Vermont ACO Participation Indicator	2.2	To accommodate the change noted above, the length for this field has been expanded from 1 to 2.
6	Description	Changed	Eligibility	ME032	Group Name	2.2	This field’s description has been updated to eliminate the instruction that the word “BLANK” should be reported if group name information is not available. If not available, please report as null.
7	Field	Changed	Medical Claims	MC055	Procedure Code | ACO Payment Arrangement Indicator	2.2	This field has been expanded to include additional content, the Vermont ACO Payment Arrangement Indicator, following the traditionally reported procedure code and separated from the procedure code by the pipe character.
8	Length	Expanded	Medical Claims	MC055	Procedure Code | ACO Payment Arrangement Indicator	2.2	To accommodate the change noted above, the length for this field has been expanded from 5 to 7.

Reliable data. Informed decisions. Strategic advantage.

75 Washington Avenue
Suite 1E
Portland, ME 04101

207 623-2555

www.OnpointHealthData.org