Family Care Encounter Reporting --- Data Dictionary View (HEADER)

This document describes the various data elements contained in the encounter record you will extract and send to the State. The description includes things like data element name, length and data type. In addition, there is a brief definition of the data element as well as some of the validation rules Encounter Reporting will use to verify the data you send us. It's primarily intended as a technical document to assist the MCO IT personnel in creating an extract from your claims history data.

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	ID#	Error Cat.
Begin Posting Date	10 Fixed	D (CCYY-MM-DD)	Y	None	H003	H
Data Element Description:	The beginning process date used to extract encounter records for the submission.					
Validation Rules:	Valid date format, valid month and valid day for that month. Must be equal to the first day of the posting month. Must be less than or equal to the current date.					
End Posting Date	10 Fixed	D (CCYY-MM-DD)	Y	None	H004	H
Data Element Description:	The ending process date used to extract encounter records for the submission.					
Validation Rules:	Valid date format, valid month and valid day for that month. Must be equal to the last day of the posting month. Must be the same year and month as the begin posting date.					
FC: Submission Type	10 Max	A	Y	None	H006	H
Data Element Description:	The submission type must be Production.					

Validation Rules:	Must be Production. This value is not case sensitive.					
Number of Records Transmitted	8 Max	N (99999999)	Y	None	H005	H
Data Element Description:	The number of detail records that are contained within the submission.					
Validation Rules:	Number of Records Transmitted must be equal to the number of detail records in a submission.					
Submission Date	10 Fixed	D (CCYY-MM-DD)	Y	None	H002	H
Data Element Description:	The date the submission was generated at the submitting organization.					
Validation Rules:	Valid date format, valid month and valid day for that month. Must be greater than or equal to the header posting end dates. Must be less than or equal to the current date.					
Submitter Organization ID	8 Fixed	N (99999999)	Y	None	H001	H
Data Element Description:	Eight digit certified Medicaid provider number assigned to the submitting organization.					
Validation Rules:	Must exist in the Submitter Organization ID lookup table.					

Family Care Encounter Reporting --- Data Dictionary View (DETAIL)

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Adjustment Type	1 Fixed	A	S	None	NA	D009	A
Data Element Description:	The type of adjustment. Only applicable for transactions that are adjusting a former Encounter Transaction. These may be assigned by the MCO for credit/debit Encounter Transactions. R = A transaction that is the credit to reverse the adjusted transaction. N = A transaction that is the debit to replace the adjusted transaction.						
Validation Rules:	Required if Record Type is C.						
Adjustment Type Detail	2 Fixed	A	N	None	NA	D010	A
Data Element Description:	Specifies the type of adjustment. FC = An adjustment that fully reverses the adjusted transaction. PC = An adjustment that partially reverses the adjusted transaction. NC = An adjustment that has no financial affect but changes demographic or other statistical data.						
Validation Rules:	Must be FC, NC or PC.						
Admit Start Care Date	10 Fixed	D (CCYY-MM-DD)	S	None	Admission/Start of Care Date (AN, L=10)	D096	S
Data Element Description:	The date the patient was admitted to the provider for inpatient care, outpatient service or start of care.						
Validation Rules:	Required on Institutional claims. Must be NULL for Member Share transactions. Valid date format, valid month and valid day for that month.						
Admitting Diagnosis Code	30 Max	AN	S	None	Admitting Diagnosis (AN, L=30)	D094	S
Data Element Description:	The ICD diagnosis code provided at the time of admission as stated by the physician.						
Validation Rules:	Must exist in the Admitting Diagnosis Code lookup table. Must be NULL for Member Share transactions.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Allowed Amount	18 Max.	N (999999999999999.99)	N	None	NA	D061	S
Data Element Description:	The maximum amount determined by the payer as being allowable under the provisions of the contract prior to the determination of actual payment. The lesser of the Medicaid Rate, MCO Contracted Rate or the amount Billed/Charged by the Provider. Example, the dollar amount of 35.50 can be sent as 35.5 or 35.50.						
Validation Rules:	Must be NULL for Member Share transactions.						
Ambulance Drop Off Location	60 Max	AN	N	None	Ambulance Drop Off Location (AN, L=60 max)	D156	S
Data Element Description:	Name of the Individual or Organization where the ambulance transport dropped off the rider						
Validation Rules:	Must be NULL for Member Share transactions.						
Anesthesia Related Surgical Procedure Primary	30 Max	AN	S	None	Anesthesia Related Surgical Procedure (AN, L=30 max)	D154	S
Data Element Description:	Code identifying the surgical procedure performed during this anesthesia session.						
Validation Rules:	Must be NULL for Member Share transactions. Not valid on Institutional claims. Must be a valid ICD value.						
Anesthesia Related Surgical Procedure Secondary	30 Max	AN	S	None	Anesthesia Related Surgical Procedure	D155	S
Data Element Description:	Code identifying the surgical procedure performed during this anesthesia session.						
Validation Rules:	Must be NULL for Member Share transactions. Not valid on Institutional claims. Must be a valid ICD value.						
Benefit Stage Amount	9 Max	N(999999.99)	N	None	Benefit Stage Amount (N, L=9 max)	D164	S
Data Element Description:	The amount of claim allocated to the Medicare stage identified by the 'Benefit Stage Qualifier' (393-MV).						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Validation Rules:	Must be zero for Member Share transactions.						
Benefit Stage Count	1 Fixed	N(9)	N	None	Benefit Stage Count (N, L=1)	D162	S
Data Element Description:	Count of 'Benefit Stage Amount' (394-MW) occurrences.						
Validation Rules:	Must be zero for Member Share transactions. Max count of 4.						
Benefit Stage Qualifier	2 Fixed	N(99)	N	None	Benefit Stage Qualifier (N, L=2)	D163	S
Data Element Description:	Code qualifying the 'Benefit Stage Amount' (394-MW).						
Validation Rules:	Must be NULL for Member Share transactions. When provided, it must be a valid value - 01 = Deductible, 02 = Initial Benefit, 03 = Coverage Gap (donut hole), 04 = Catastrophic Coverage.						
Billing Provider First Name	35 Max.	ANPlus	N	None	Billing Provider First Name (AN, L=35)	D022	P
Data Element Description:	First name of the billing provider.						
Validation Rules:	None, except, if the Billing Provider is an individual, use the Billing Provider First Name.						
Billing Provider ID	80 Max.	ANPlus	S	None	Billing Provider Identifier (AN, L=80)	D020	P
Data Element Description:	The Provider's Employer ID, SSN, National Provider ID, or MCO specific ID.						
Validation Rules:	Required when MA Billing Provider ID is not supplied otherwise it is optional. Required when Billing Provider ID-Qualifier is supplied. Field must be a valid NPI, with a fixed length of 10.						
Billing Provider ID-Qualifier	2 Max.	AN	S	None	ID Code Qualifier (AN, L=2)	D019	P
Data Element Description:	Qualifies what identification is used in the Billing Provider ID field. EIN = 24, SSN = 34, NPI = XX, or MCO specific = CO.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Validation Rules:	Must be one of the following: 24, 34, XX or CO. Required when Billing Provider ID is supplied. Must be XX if the SPC code is a medical service and the Rendering Provider ID-Qualifier is not XX.						
Billing Provider Last Name or Organization	60 Max.	ANPlus	Y	None	Billing Provider Last Name or Organization (AN, L=60)	D021	P
Data Element Description:	Last name of the billing provider or the name of the individual group/clinic, or organization.						
Validation Rules:	None						
Billing Provider Middle Name	25 Max.	ANPlus	N	None	Billing Provider Middle Name (AN, L=25)	D023	P
Data Element Description:	Full middle name of the billing provider.						
Validation Rules:	None						
Billing Provider Secondary Identifier	50 Max	AN	N	None	Payer Additional Identifier (AN, L=50 max)	D149	S
Data Element Description:	Secondary identification number for the provider or organization in whose name the bill is submitted and to whom payment should be made.						
Validation Rules:	Must be NULL for Member Share transactions.						
Care Plan Oversight Number	50 Max	AN	N	None	Care Plan Oversight Number (AN, L=50 max)	D153	S
Data Element Description:	Medicare provider number of the home health agency or hospice providing Medicare covered services to the patient for the period during which CPO services were furnished and for which the physician signed the plan of care.						
Validation Rules:	None.						
Charges	18 Max.	N (999999999999999.99)	S	None	Line Item Charge Amount (AN, L-18)	D056	S

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Data Element Description:	The amount charged by the Provider. (This is the amount billed for this line item only. If multiple details are being billed on one claim do not enter the total claim billed amount). Example, the dollar amount of 35.50 can be sent as 35.5 or 35.50.						
Validation Rules:	Must be provided for an Encounter transaction. Must be NULL for Member Share transactions.						
Claim Adjustment Reason Code	5 Max.	AN	S	None	Claim Adjustment Reason Code (ID, L=5)	D011	S
Data Element Description:	Code from the Claim Adjustment Reason Code table identifying the reason for the adjustment.						
Validation Rules:	Must exist in the Claim Adjustment Reason Code table. If the Claim Status field = D or if the amount paid differs from the amount charged a reason code must be provided in the Claim Adjustment Reason Code field. Service Date From and To must be between the Claim Adjustment Reason Code begin and end dates for the Claim adjustment Reason Code to be valid for this record.						
Claim Adjustment Reason Code 2	5 Max.	AN	N	None	Claim Adjustment Reason Code (ID, L=5)	D012	S
Data Element Description:	Code from the Claim Adjustment Reason Code table identifying the reason for the adjustment.						
Validation Rules:	Must exist in the Claim Adjustment Reason Code table. Service Date From and To must be between the Claim Adjustment Reason Code begin and end dates for the Claim adjustment Reason Code to be valid for this record.						
Claim Adjustment Reason Code 3	5 Max.	AN	N	None	Claim Adjustment Reason Code (ID, L=5)	D013	S
Data Element Description:	Code from the Claim Adjustment Reason Code table identifying the reason for the adjustment.						
Validation Rules:	Must exist in the Claim Adjustment Reason Code table. Service Date From and To must be between the Claim Adjustment Reason Code begin and end dates for the Claim adjustment Reason Code to be valid for this record.						
Claim Adjustment Reason Code 4	5 Max.	AN	N	None	Claim Adjustment Reason Code (ID, L=5)	D014	S
Data Element Description:	Code from the Claim Adjustment Reason Code table identifying the reason for the adjustment.						
Validation Rules:	Must exist in the Claim Adjustment Reason Code table. Service Date From and To must be between the Claim Adjustment Reason Code begin and end dates for the Claim adjustment Reason Code to be valid for this record.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Claim Adjustment Reason Code 5	5 Max.	AN	N	None	Claim Adjustment Reason Code (ID, L=5)	D015	S
Data Element Description:	Code from the Claim Adjustment Reason Code table identifying the reason for the adjustment.						
Validation Rules:	Must exist in the Claim Adjustment Reason Code table. Service Date From and To must be between the Claim Adjustment Reason Code begin and end dates for the Claim adjustment Reason Code to be valid for this record.						
Claim Adjustment Reason Code 6	5 Max.	AN	N	None	Claim Adjustment Reason Code (ID, L=5)	D016	S
Data Element Description:	Code from the Claim Adjustment Reason Code table identifying the reason for the adjustment.						
Validation Rules:	Must exist in the Claim Adjustment Reason Code table. Service Date From and To must be between the Claim Adjustment Reason Code begin and end dates for the Claim adjustment Reason Code to be valid for this record.						
Claim Status	1 Fixed	A	Y	None	NA	D007	R
Data Element Description:	The current status of the encounter. (P = Paid; D = Denied)						
Validation Rules:	Must be either P or D.						
Claim Type	2 Max	AN	Y	None	NA	D097	S
Data Element Description:	Claim form used to fill out the claim.						
Validation Rules:	When provided for an encounter transaction it must be one of the following values: DE = Dental, IN = Institutional, PH = Pharmacy, and PR = Professional. Must be NULL for Member Share. This will become mandatory in January, 2011 to enforce the required field, DCN Primary.						
CMO Reason Code	6 Max.	ANPlus	N	None	NA	D017	S
Data Element Description:	County specific reason code. This is a reason code created and maintained by the county.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Validation Rules:	CMO Reason Code must be an alphanumeric and/or special characters value with a max length of 6.						
Data Source	2 Fixed	AN	Y	01	NA	D003	R
Data Element Description:	Identifies the source of data. Current valid values for Family Care are 01 = Claim System and 03 = Accounts Receivable.						
Validation Rules:	Must exist in the Data Source table and be valid for Family Care.						
Diagnosis Code Additional 2	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D035	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 3	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D036	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 4	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D037	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additonal 5	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D038	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 6	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D039	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 7	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D040	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 8	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D041	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 9	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D077	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 10	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D111	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 11	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D112	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 12	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D113	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additonal 13	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D114	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 14	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D115	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 15	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D116	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 16	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D117	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 17	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D118	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 18	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D119	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 19	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D120	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 20	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D121	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 21	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D122	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 22	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D123	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 23	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D124	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 24	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D125	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Additional 25	30 Max.	ANDot	N	None	Additional Diagnosis (AN, L=30)	D126	S
Data Element Description:	Additional ICD code for conditions that may coexist at the time services were rendered or at the time of discharge.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Validation Rules:	Must exist in the Diagnosis Code lookup table. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record. Must be null for Member Share.						
Diagnosis Code Principal	30 Max.	ANDot	N	None	Principal Diagnosis (AN, L=30)	D075	S
Data Element Description:	The full ICD code describing the diagnosis code principal (I.e. the condition established after study to be chiefly responsible for causing the admission or health care episode). The Diagnosis Code Principal found on the Encounter.						
Validation Rules:	Must exist in the Diagnosis Code lookup table. Must be NULL for Member Share. Diagnosis Code Principal and additional diagnosis codes must be supplied sequentially without gaps. Service Date From or To must be between the Diagnosis Code begin and end dates for the Diagnosis Code to be valid for this record.						
DCN Primary	26 Max.	ANPlus	S	None	Primary DCN (AN, L=26)	D127	S
Data Element Description:	The Document Control Number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. Required for Inpatient (IN) Claim Type or if Claim Type is not supplied.						
Validation Rules:	DCN Primary and additional DCN codes must be supplied sequentially without gaps.						
DCN Secondary	26 Max.	ANPlus	N	None	Secondary DCN (AN, L=26)	D128	S
Data Element Description:	The Document Control Number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.						
Validation Rules:	DCN Primary and additional DCN codes must be supplied sequentially without gaps.						
DCN Tertiary	26 Max.	ANPlus	N	None	Tertiary DCN (AN, L=26)	D129	S
Data Element Description:	The Document Control Number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control.						
Validation Rules:	DCN Primary and additional DCN codes must be supplied sequentially without gaps.						
Dispense As Written Ind	1 Fixed	N(9)	S	None	Dispense as Written Code (ID, L=1)	D101	S

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Data Element Description:	Indicator showing whether a drug substitution is permitted by the prescriber.						
Validation Rules:	Required on Pharmacy claims. Must be NULL for Member Share transactions. Must be 0-9 if supplied.						
DRG	3 Max.	N (999)	N	None	DRG (N, L< =3)	D073	S
Data Element Description:	DRG (Diagnosis Related Group) Code.						
Validation Rules:	Must exist in the DRG Code lookup table and be valid for the Service Date range. Must be null for Member Share.						
EPSDT Condition Code 1	2-3	AN	N	None	EPSDT REFERRAL Condition Code (AN, L=2-3)	D145	S
Data Element Description:	Code(s) used to identify condition(s) relating to this bill or relating to the patient.						
Validation Rules:	Must be a valid value - AV=Available, NU=Not Used, S2=Under Treatment or ST=New Service. Must be NULL for Member Share transactions.						
EPSDT Condition Code 2	2-3	AN	N	None	EPSDT REFERRAL Condition Code (AN, L=2-3)	D146	S
Data Element Description:	Code(s) used to identify condition(s) relating to this bill or relating to the patient.						
Validation Rules:	Must be a valid value - AV=Available, NU=Not Used, S2=Under Treatment or ST=New Service. All codes must be supplied sequentially without gaps and cannot duplicate a previously-listed condition code. Must be NULL for Member Share transactions.						
EPSDT Condition Code 3	2-3	AN	N	None	EPSDT REFERRAL Condition Code (AN, L=2-3)	D147	S
Data Element Description:	Code(s) used to identify condition(s) relating to this bill or relating to the patient.						
Validation Rules:	Must be a valid value - AV=Available, NU=Not Used, S2=Under Treatment or ST=New Service. All codes must be supplied sequentially without gaps and cannot duplicate a previously-listed condition code. Must be NULL for Member Share transactions.						
External Cause of Injury Code 1	30 Max	AN	S	None	External Cause of Injury (AN, L=30)	D095	S

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Data Element Description:	Code for the external cause of an injury, poisoning or adverse effect.						
Validation Rules:	Must exist in the ICD lookup table. Must be NULL for Member Share transactions.						
External Cause of Injury Code 2	30 Max	AN	S	None	External Cause of Injury (AN, L=30)	D134	S
Data Element Description:	Code for the external cause of an injury, poisoning or adverse effect.						
Validation Rules:	Must exist in the ICD lookup table. All codes must be supplied sequentially without gaps and cannot duplicate a previously-listed injury code. Must be NULL for Member Share transactions.						
External Cause of Injury Code 3	30 Max	AN	S	None	External Cause of Injury (AN, L=30)	D135	S
Data Element Description:	Code for the external cause of an injury, poisoning or adverse effect.						
Validation Rules:	Must exist in the ICD lookup table. All codes must be supplied sequentially without gaps and cannot duplicate a previously-listed injury code. Must be NULL for Member Share transactions.						
External Cause of Injury Code 4	30 Max	AN	S	None	External Cause of Injury (AN, L=30)	D136	S
Data Element Description:	Code for the external cause of an injury, poisoning or adverse effect.						
Validation Rules:	Must exist in the ICD lookup table. All codes must be supplied sequentially without gaps and cannot duplicate a previously-listed injury code. Must be NULL for Member Share transactions.						
External Cause of Injury Code 5	30 Max	AN	S	None	External Cause of Injury (AN, L=30)	D137	S
Data Element Description:	Code for the external cause of an injury, poisoning or adverse effect.						
Validation Rules:	Must exist in the ICD lookup table. All codes must be supplied sequentially without gaps and cannot duplicate a previously-listed injury code. Must be NULL for Member Share transactions.						
External Cause of Injury Code 6	30 Max	AN	S	None	External Cause of Injury (AN, L=30)	D138	S

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Data Element Description:	Code for the external cause of an injury, poisoning or adverse effect.						
Validation Rules:	Must exist in the ICD lookup table. All codes must be supplied sequentially without gaps and cannot duplicate a previously-listed injury code. Must be NULL for Member Share transactions.						
External Cause of Injury Code 7	30 Max	AN	S	None	External Cause of Injury (AN, L=30)	D139	S
Data Element Description:	Code for the external cause of an injury, poisoning or adverse effect.						
Validation Rules:	Must exist in the ICD lookup table. All codes must be supplied sequentially without gaps and cannot duplicate a previously-listed injury code. Must be NULL for Member Share transactions.						
External Cause of Injury Code 8	30 Max	AN	S	None	External Cause of Injury (AN, L=30)	D140	S
Data Element Description:	Code for the external cause of an injury, poisoning or adverse effect.						
Validation Rules:	Must exist in the ICD lookup table. All codes must be supplied sequentially without gaps and cannot duplicate a previously-listed injury code. Must be NULL for Member Share transactions.						
External Cause of Injury Code 9	30 Max	AN	S	None	External Cause of Injury (AN, L=30)	D141	S
Data Element Description:	Code for the external cause of an injury, poisoning or adverse effect.						
Validation Rules:	Must exist in the ICD lookup table. All codes must be supplied sequentially without gaps and cannot duplicate a previously-listed injury code. Must be NULL for Member Share transactions.						
External Cause of Injury Code 10	30 Max	AN	S	None	External Cause of Injury (AN, L=30)	D142	S
Data Element Description:	Code for the external cause of an injury, poisoning or adverse effect.						
Validation Rules:	Must exist in the ICD lookup table. All codes must be supplied sequentially without gaps and cannot duplicate a previously-listed injury code. Must be NULL for Member Share transactions.						
External Cause of Injury Code 11	30 Max	AN	S	None	External Cause of Injury (AN, L=30)	D143	S

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Data Element Description:	Code for the external cause of an injury, poisoning or adverse effect.						
Validation Rules:	Must exist in the ICD lookup table. All codes must be supplied sequentially without gaps and cannot duplicate a previously-listed injury code. Must be NULL for Member Share transactions.						
External Cause of Injury Code 12	30 Max	AN	S	None	External Cause of Injury (AN, L=30)	D144	S
Data Element Description:	Code for the external cause of an injury, poisoning or adverse effect.						
Validation Rules:	Must exist in the ICD lookup table. All codes must be supplied sequentially without gaps and cannot duplicate a previously-listed injury code. Must be NULL for Member Share transactions.						
Health Plan-Funded Assistance Amount	9 Max	N(999999.99)	N	None	Health Plan-Funded Assistance Amount	D166	S
Data Element Description:	The amount from the health plan-funded assistance account for the patient that was applied to reduce Patient Pay Amount (5Ø5-F5). This amount is used in Healthcare Reimbursement Account (HRA) benefits only. This field is always a negative amount or zero.						
Validation Rules:	Must be zero for Member Share transactions.						
Length of Need Qualifier	2 Max	N(99)	N	None	Length of Need Qualifier (N, L=2 max)	D165	S
Data Element Description:	Required if Length of Need (370-2R) is used. Defines the unit associated with length of need.						
Validation Rules:	Must be NULL for Member Share transactions. When provided, it must be a valid value - 0 = Not Specified, 1 = Hours, 2 = Days, 3 = Weeks, 4 = Months, 5 = Years, 6 = Lifetime.						
MA Billing Provider ID	8 Fixed	N (99999999)	S	None	NA	D018	P
Data Element Description:	Medicaid Provider ID that is billing for the encounter.						
Validation Rules:	Medicaid Provider ID that is billing for the encounter. Required when Billing Provider ID field is not used otherwise it is optional. Must exist in the MA Billing Provider ID lookup table. Service Date From and To must be between the MA Billing Provider ID begin and end dates for the MA Billing Provider ID to be valid for this record.						
MA Rendering Provider ID	8 Fixed	N (99999999)	S	None	NA	D024	P

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Data Element Description:	Medicaid Provider ID that is providing the service for the encounter.						
Validation Rules:	Must exist in the MA Rendering Provider ID lookup table and be valid for the service date range. Required for Member Share transaction and must equal the Submitter Organization ID. For non-Member Share records it must not equal the Submitter Organization ID. Service Date From and To must be between the MA Rendering Provider ID begin and end dates for the MA Rendering Provider ID to be valid for this record.						
Medicare COB Type	2 Max.	A	S	None	Medicare COB Type (Decimal, L=18)	D104	S
Data Element Description:	Code to identify the type of Medicare Coordination of Benefits.						
Validation Rules:	The Medicare COB Type must be provided if the Medicare Paid Amount is greater than zero. Must be MA.						
Medicare Paid Amount	18 Max.	N (999999999999999.99)	Y	None	Medicare Paid Amount (Decimal, L=18)	D103	S
Data Element Description:	Amount paid by Medicare., combined with other paid amounts to determine COB Paid Amount before Family Care covers the remaining balance.						
Validation Rules:	The Medicare Paid Amount must be greater than or equal to zero, and must be equal to zero on Member Share transactions.						
Member Share	1 Fixed	A	Y	N	NA	D063	A
Data Element Description:	The type of member's share. Supported services are: C = Cost Share, R = Room & Board, V = Voluntary Contribution, S= Spenddown or N = None.						
Validation Rules:	Must be either C, R, V, S or N.						
National Health Plan ID	80 Max.	AN	N	None	Health Plan Identification Number (AN, L=80)	D064	M
Data Element Description:	The National Health Plan Identifier for this plan.						
Validation Rules:	None						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
National Recipient ID	80 Max.	AN	N	None	NA	D065	M
Data Element Description:	The Member's National Subscriber Identifier.						
Validation Rules:	None						
Non-Covered Amount	18 Max	N (9999999.99)	N	None	Non-Covered Amount (N, L=18 max)	D157	S
Data Element Description:	Charges pertaining to the related revenue center code that the primary payer will not cover.						
Validation Rules:	Amount cannot be greater than the charges. Must be zero for Member Share transactions.						
Obstetric Additional Units	15 Max	N (999999999999999)	N	None	Obstetric Additional Units (N, L=15 max)	D158	S
Data Element Description:	Additional anesthesia units reported by anesthesiologist to report additional complexity beyond the normal services reflected by the base units for the reported procedure and anesthesia time.						
Validation Rules:	Must be zero for Member Share transactions.						
Original ID	80 Max.	ANPlus	Y	None	NA	D006	A
Data Element Description:	The Record ID of the Original record for which all subsequent adjustments were made. This ID will always reference a Record ID.						
Validation Rules:	Must match Record ID of original record.						
Other Payer COB Type Primary	2 Max.	A	S	None	Other Payer COB Type Primary (A, L=2)	D106	S
Data Element Description:	Other Payer COB (Coordination of Benefits) Type Primary is included in the total payment amount, along with other agencies making payment.						
Validation Rules:	The Other Payer COB Type Primary must be provided if the Other Payer Paid Amount Primary is greater than zero. Must be either WC, VA, SB, OP or MP. Must be null for Member Share.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Other Payer COB Type Secondary	2 Max.	A	S	None	Other Payer COB Type Secondary (A, L=2)	D108	S
Data Element Description:	Other Payer COB Type Secondary is included in the total payment amount, along with other agencies making payment.						
Validation Rules:	The Other Payer COB Type Secondary must be provided if the Other Payer Paid Amount Secondary is greater than zero. Must be either WC, VA, SB, OP or MP. Must be null for Member Share.						
Other Payer Paid Amount Primary	18 Max.	N (999999999999999.99)	Y	None	Other Payer Paid Amount Primary (Decimal, L=18)	D105	S
Data Element Description:	Amount paid by another payer.						
Validation Rules:	The Other Payer Paid Amount Primary must be greater than or equal to zero, and must be equal to zero on Member Share transactions.						
Other Payer Paid Amount Secondary	18 Max.	N (999999999999999.99)	Y	None	Other Payer Paid Amount Secondary (Decimal, L=18)	D107	S
Data Element Description:	Amount paid by another payer.						
Validation Rules:	The Other Payer Paid Amount Secondary must be greater than or equal to zero, and must be equal to zero on Member Share transactions.						
Paid Amount	18 Max.	N (999999999999999.99)	Y	None	Payer Paid Amount (AN, L=18)	D058	S
Data Element Description:	The amount paid by the MCO to the provider. (This is the amount paid for this line item only. If multiple details are being paid on one claim do not enter the total claim paid amount). *Field size expanded to 18 (15+decimal+2decimals) to comply with HIPAA.*						
Validation Rules:	Must be less than or equal to Charges. Example, the dollar amount of 35.50 can be sent as 35.5 or 35.50.						
Parent Record ID	80 Max.	ANPlus	S	None	NA	D005	A
Data Element Description:	The Record ID of the record being adjusted. This field is used only when adjusting an existing encounter record. In a credit/debit adjustment both the credit and debit transactions will reference the same transaction Record ID being adjusted.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Validation Rules:	Must be null on original (O) record types. Required when the record being submitted is an adjustment. Must match the Record ID of an existing record being adjusted. Cannot equal the Record ID of the record being submitted. An adjustment record with the same adjustment type cannot reference the same parent record.						
Patient Discharge Status	2	AN	S	None	Patient Discharge Status (N, L=2)	D078	S
Data Element Description:	A code indicating the disposition or discharge status of the patient at the end of service for the period covered on this bill, as reported in FL06, Statement Covers Period.						
Validation Rules:	Must exist in the Patient Status Code lookup table. Required on Institutional Claims. Must be NULL for Member Share transactions.						
Patient Reason for Visit 1	30 Max	AN	S	None	Patient Reason For Visit (AN, L=30 max)	D131	S
Data Element Description:	The diagnosis code describing the patient's reason for visit at the time of outpatient registration.						
Validation Rules:	Must exist in the National Codeset lookup table and must be valid for the service dates provided. All reasons must be supplied sequentially without gaps. Must be NULL for Member Share transactions.						
Patient Reason for Visit 2	30 Max	AN	S	None	Patient Reason For Visit (AN, L=30 max)	D132	S
Data Element Description:	The diagnosis code describing the patient's reason for visit at the time of outpatient registration.						
Validation Rules:	Must exist in the National Codeset lookup table and must be valid for the service dates provided. All reason codes must be supplied sequentially without gaps and cannot duplicate a previously-listed reason code. Must be NULL for Member Share transactions.						
Patient Reason for Visit 3	30 Max	AN	S	None	Patient Reason For Visit (AN, L=30 max)	D133	S
Data Element Description:	The diagnosis code describing the patient's reason for visit at the time of outpatient registration.						
Validation Rules:	Must exist in the National Codeset lookup table and must be valid for the service dates provided. All reason codes must be supplied sequentially without gaps and cannot duplicate a previously-listed reason code. Must be NULL for Member Share transactio						
Patient Residence	2 Max	N (99)	N	None	Patient Residence (N, L=2 max)	D160	M
Data Element Description:	Code identifying the patient's place of residence.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Validation Rules:	Must enter a valid value. Valid values are: 1-Home, 2-Skilled Nursing Facility, 3-Nursing Facility, 4-Assisted Living Facility, 5-Custodial Care Facility, 6-Group Home, 7-Inpatient Psychiatric Facility, 8-Psychiatric Facility-Partical Hospitalization, 9-Intermediate Care Facility/MH, 10-Residential Substance Abuse Treatment Facility, 11-Hospice, 12-Psychiatric Residential Treatment Facility, 13-Comprehensive Inpatient						
Payer Paid Amount	10 Max	N (9999999.99)	N	None	Payer Paid Amount (AN, L=10)	D152	S
Data Element Description:	The amount paid by the payer on this claim.						
Validation Rules:	The amount cannot be greater than the charges for the encounter. Must be zero for Member Share transactions.						
Pay to Plan Organizational Name	60 Max	AN	N	None	NA	D159	P
Data Element Description:	Organization name of the health plan that is seeking reimbursement (Pay-To Plan).						
Validation Rules:	Must be NULL for Member Share transactions.						
Pharmacy Service Type	2 Max	N(99)	N	None	Pharmacy Service Type (N, L=2 max)	D161	S
Data Element Description:	The type of service being performed by a pharmacy when different contractual terms exist between a payer and the pharmacy, or when benefits are based upon the type of service performed.						
Validation Rules:	Must be a valid value. Valid values are: 1-Community/Retail, 2-Compounding, 3-Home Infusion Therapy , 4-Institutional, 5-Long Term Care, 6-Mail Order, 7-Managed Care Organization, 99-Other. Must be NULL for Member Share transactions.						
Place of Service	2 Max.	AN	S	None	Place of Service Code (AN, L=2)	D044	S
Data Element Description:	Place of Service code. (Refer to the place of service appendix in Part K of the Wisconsin Medical Assistanct Program-WMAP handbook).						
Validation Rules:	Must exist in the Place of Service code lookup table. Must be NULL for Member Share.						
POA Indicator	22 Max.	AN	S	None	POA_Indicator (AN, L=22)	D110	R

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Data Element Description:	Diagnosis Present on Admission (POA) Indicator must contain the letters POA followed by a single POA indicator for every secondary diagnosis of patients effective for discharge on or after October 1, 2007. Valid values are: Y = Yes, N = No, U = Unknown, W = Clinically undetermined, 1 = Unrecognized or exempt for POA reporting.						
Validation Rules:	POA_Indicator must contain letters POA, followed by a single POA indicator for every diagnosis code that is reported. Valid values are Y, N, U, W or 1. An "X" or "Z" must follow the last POA indicator associated with the last reported Other Diagnosis. Examples: POAYZ (Principal diagnosis code was reported), POAYNUW1Z (Five diagnosis codes were reported), POAYNUW1YNUW1YNUZ (Thirteen						
Posting Date	10 Fixed	D (CCYY-MM-DD)	Y	None	Adjudication or Payment Date (AN, L=10)	D059	R
Data Element Description:	The date the claim was finalized.						
Validation Rules:	Valid date format, valid month and valid day for that month. Must be within the header posting begin and end dates.						
Prescription Number	8 max	AN	S	None	Prescription Number (AN, L=8 max)	D099	S
Data Element Description:	The unique identification number assigned by the pharmacy or supplier to the prescription.						
Validation Rules:	Required on Pharmacy claims. Must be NULL for Member Share transactions.						
Prior Authorization Number	50 Max	AN	S	None	Prior Authorization or Referral Number (AN, L=50 max)	D130	S
Data Element Description:	A number, code or other value that indicates the services provided on this claim have been authorized by the payee or other service organization.						
Validation Rules:	None.						
Procedure Code	48 Max.	AN	S	None	Procedure Code (AN, L=48)	D046	S
Data Element Description:	National codesets - CPT, HCPCS, NDC, HIPPS.						
Validation Rules:	Must exist in the Procedure Code lookup table. Required if Revenue Code is not present. Service Date From and To must be between the Procedure Code begin and end dates for the Procedure Code to be valid for this record.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Procedure Code Modifier 1	2 Max.	AN	N	None	Procedure Code Modifier 1 (AN, L=2)	D047	S
Data Element Description:	Additional two digit modifier code for the procedure code.						
Validation Rules:	Must exist in the Procedure Code Modifier lookup table. Modifiers must be filled sequentially without gaps. Service Date From and To must be between the Procedure Code Modifier begin and end dates for the Procedure Code Modifier to be valid for this record.						
Procedure Code Modifier 2	2 Max.	AN	N	None	Procedure Code Modifier 2 (AN, L=2)	D048	S
Data Element Description:	Additional two digit modifier code for the procedure code.						
Validation Rules:	Must exist in the Procedure Code Modifier lookup table. Service Date From and To must be between the Procedure Code Modifier begin and end dates for the Procedure Code Modifier to be valid for this record.						
Procedure Code Modifier 3	2 Max.	AN	N	None	Procedure Code Modifier 3 (AN, L=2)	D049	S
Data Element Description:	Additional two digit modifier code for the procedure code.						
Validation Rules:	Must exist in the Procedure Code Modifier lookup table. Service Date From and To must be between the Procedure Code Modifier begin and end dates for the Procedure Code Modifier to be valid for this record.						
Procedure Code Modifier 4	2 Max.	AN	N	None	Procedure Code Modifier 4 (AN, L=2)	D050	S
Data Element Description:	Additional two digit modifier code for the procedure code.						
Validation Rules:	Must exist in the Procedure Code Modifier 4 lookup table. Service Date From and To must be between the Procedure Code Modifier begin and end dates for the Procedure Code Modifier to be valid for this record.						
Quantity	15 Max.	N (99999999999.999)	S	None	Service Unit Count (AN, L=15)	D052	S
Data Element Description:	The quantitative measure of service rendered according to the service. Example, the quantity of 35 1/2 can be sent as 35.5, 35.50 or 35.500.						
Validation Rules:	Must be present for Encounter Transactions. Must be NULL for Member Share transactions.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Receipt Date	10 Fixed	D (CCYY-MM-DD)	Y	None	NA	D057	S
Data Element Description:	The date the claim was received by the MCO from the provider.						
Validation Rules:	Valid date format, valid month and valid day for that month. Must be less than or equal to the detail record posting date.						
Recipient Birth Date	10 Fixed	D (CCYY-MM-DD)	N	None	Birth Date (AN, L=10)	D071	M
Data Element Description:	Birth date for the Recipient.						
Validation Rules:	When supplied, it must be less than or equal to the Service Date From; birth date plus 150 years must be greater than or equal to the Service Date To; if the recipient is MA eligible then this birth date must equal the birth date found in the MMIS Eligibility lookup table.						
Recipient Death Date	10 Fixed	D (CCYY-MM-DD)	N	None	Death Date (AN, L=10)	D072	M
Data Element Description:	Death date for the Recipient.						
Validation Rules:	When supplied, it must be less than or equal to the Posting Date; death date plus 2 months must be greater than or equal to Service Date To; if the recipient is MA eligible then this death date must equal the death date found in the MMIS Eligibility lookup table; required if MMIS Eligibility table has a death date for this recipient.						
Recipient First Name	35 Max.	ANPlus	Y	None	Patient First Name (AN, L=35)	D032	M
Data Element Description:	First name of recipient.						
Validation Rules:	None						
Recipient ID	10 Fixed	N (9999999999)	Y	None	Patient's Primary Identification Number (N, L=10)	D030	M
Data Element Description:	Recipient's ten digit Medicaid identification number with no dashes. Fixed length of 10 digits.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Validation Rules:	Must exist in the Recipient ID lookup table and be eligible for services from the submitting organization.						
Recipient Last Name	60 Max.	ANPlus	Y	None	Patient Last Name (AN, L=60)	D031	M
Data Element Description:	Last name of recipient.						
Validation Rules:	None						
Recipient Middle Name	25 Max.	ANPlus	N	None	Patient Middle Name (AN, L=25)	D033	M
Data Element Description:	Full middle name of recipient.						
Validation Rules:	None						
Recipient Suffix Name	10 Max.	ANPlus	I	None	NA	D252	M
Data Element Description:	The member's full Suffix Name.						
Validation Rules:	None.						
Record ID	80 Max.	ANPlus	Y	None	NA	D004	R
Data Element Description:	Unique ID assigned by the submitting organization to uniquely identify the record within their organization.						
Validation Rules:	Must not exist for the Organization in the Record ID lookup table detail.						
Record Type	1 Fixed	A	Y	None	NA	D008	R
Data Element Description:	The type of Encounter Transaction. O = An unadjusted transaction. C = Adjusting entries that usually come in pairs, used in conjunction with adjustment type. A Credit (CR) will reverse the prior transaction being adjusted and a Debit (CN) will replace the transaction being adjusted.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Validation Rules:	Must be O or C.						
Remaining Patient Liability Amount	18 Max	N (9999999.99)	N	None	Remaining Patient Liability Amount (N, L=18 max)	D148	S
Data Element Description:	In the judgement of the provider, the amount that remained to be paid after adjudication by this Other Payer.						
Validation Rules:	Amount cannot be greater than the charges for this encounter. Must be zero for Member Share transactions.						
Rendering Provider First Name	35 Max.	ANPlus	N	None	Rendering Provider First Name (AN, L=35)	D028	P
Data Element Description:	First name of the rendering provider.						
Validation Rules:	None						
Rendering Provider ID	80 Max.	ANPlus	S	None	Rendering Provider Identifier (AN, L=80)	D026	P
Data Element Description:	The Rendering Provider's Employer ID, SSN, National Provider ID, or MCO specific ID.						
Validation Rules:	Required if Rendering Provider Last Name is supplied. Required when Rendering Provider ID-Qualifier is supplied. When the Rendering Provider ID-Qualifier is XX then this field must be alphanumeric and a fixed length of 10. If it is a Pharmacy claim, the Rendering Provider ID-Qualifier is required and must be XX.						
Rendering Provider ID-Qualifier	2 Max.	AN	S	None	ID Code Qualifier (AN, L=2)	D025	P
Data Element Description:	Qualifies what identification is used in the Rendering Provider ID field. EIN = 24, SSN = 34, NPI = XX, or MCO specific = CO.						
Validation Rules:	Must be one of the following: 24, 34, XX or CO. Required if Rendering Provider ID is supplied. Must be XX if the SPC code is a medical service and the Billing Provider ID-Qualifier is not XX.						
Rendering Provider Last Name	60 Max.	ANPlus	S	None	Rendering Provider Last Name (AN, L=60)	D027	P
Data Element Description:	Last name of the rendering provider.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Validation Rules:	Required if Rendering Provider ID is supplied.						
Rendering Provider Middle Name	25 Max.	ANPlus	N	None	Rendering Provider Middle Name (AN, L=25)	D029	P
Data Element Description:	Full middle name of the rendering provider.						
Validation Rules:	None						
Rendering Provider Name Suffix	10 Max	AN	N	None	Rendering Provider Name Suffix (AN, L=10 max)	D150	P
Data Element Description:	Suffix to be added to the name of the rendering provider.						
Validation Rules:	None						
Renderng Provider Secondary Identifier	50 Max	AN	N	None	Rendering Provider Secondary Identifier (AN, L=50 max)	D151	P
Data Element Description:	Additional identifier for the provider providing care to the patient.						
Validation Rules:	Must be NULL for Member Share transactions.						
Revenue Code	4 Max.	AN	S	None	NA	D051	S
Data Element Description:	A code which identifies a specific accommodation, ancillary service or billing calculation.						
Validation Rules:	Must exist in the Revenue Code lookup table. Required if Procedure Code is not present. Service Date From and To must be between the Revenue Code begin and end dates for the Revenue Code to be valid for this record.						
Service Date From	10 Fixed	D (CCYY-MM-DD)	Y	None	Service Date From (AN, L=10) Service Date From and Service Date To are combined into one field on the HIPAA 837 layout.	D042	S

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Data Element Description:	The date this particular service started.						
Validation Rules:	Valid date format, valid month and valid day for that month. Must be less than or equal to the last day of the posting month.						
Service Date To	10 Fixed	D (CCYY-MM-DD)	Y	None	Service Date To (AN, L=10) Service Date To and Service Date From are combined into one field on the HIPAA 837 layout.	D043	S
Data Element Description:	Date this particular serviced ended.						
Validation Rules:	Valid date format, valid month and valid day for that month. Must be greater than or equal to the Service Date From.						
Service Delivery Type	2 Fixed	A	N	None	NA	D076	R
Data Element Description:	The service delivery mechanism. Examples are PC = Program Contract providers, NC = non-program Contract providers, IS = Informal Supports, PH = Public Health, etc.						
Validation Rules:	Must exist in the Service Delivery Type lookup table.						
SPC	6 Max.	AN	Y	None	NA	D074	S
Data Element Description:	The specific program (SPC and Subprogram code) which is provided to the client. The subprogram relates to narrow program initiative if appropriate. Refer to applicable manuals for SPC definitions. Decimal is considered character in a non-numeric field.						
Validation Rules:	Must exist in the SPC Code lookup table. Service Date From and To must be between the SPC begin and end dates for the SPC to be valid for this record.						
Statement From Date	10 Fixed	D (CCYY-MM-DD)	S	None	Statement Covers Period (From-Through) (D, L=10)	D092	S
Data Element Description:	The date of the start of the period covered on the claim.						
Validation Rules:	Required on Institutional claims. Must be NULL for Member Share transactions.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
Statement To Date	10 Fixed	D (CCYY-MM-DD)	S	None	Statement Covers Period (From-Through) (D, L=10)	D093	S
Data Element Description:	The date of the end of the period covered on the claim.						
Validation Rules:	Required on Institutional claims. Must be NULL for Member Share transactions.						
Submitter Organization ID	8 Fixed	N (99999999)	Y	None	NA	D002	R
Data Element Description:	Eight digit certified Medicaid provider number assigned to the submitting organization.						
Validation Rules:	Must exist in the Submitter Organization ID lookup table.						
Support Indicator	1 Fixed	A	Y	C	NA	D062	S
Data Element Description:	The type of support this service line item represents. S = Self-directed; C = MCO-directed; N = Non-Services						
Validation Rules:	Must be either C, N or S. Must be N for Member Share.						
TPL Paid Amount	18 Max	N (999999999999999.99)	N	None	NA	D060	S
Data Element Description:	Detail claim amount paid by third party insurer. (This is the TPL amount paid for this line item only. If multiple TPL details are being paid on one claim do not enter the total TPL paid amount). Example the dollar amount of 35.50 can be sent as 35.5 or 35.50.						
Validation Rules:	Values supplied after 1/1/2008 are ignored.						
Type of Bill	4 Max.	AN	S	None	Type of Bill (AN, L=4)	D091	S
Data Element Description:	A code indicating the specific type of bill. This four digit code requires the following sequence: 1) Type of facility (has a leading zero when one digit), 2) Bill Classification, 3) Frequency. UB04 is a four position field.						
Validation Rules:	Must be on the master lookup table. Required on Institutional claims. Must be null for Member Share.						

Data Element	Length	Type (AN, N, D, A, ANPlus, or ANDot)	Required Y=Yes, N=No, S=Situational	Default Value	HIPAA (837 or NCPDP) Name and Characteristics	ID#	Error Cat.
nd name changing to Special Packagin	1 Fixed	N (9)	S	None	Unit dose Code (N, L=1) name change to Special Packaging Indicator	D100	S
Data Element Description:	Indicator used when billing unit dose drugs. Valid values are 0 - 5: 0 - Not Specified, 1 - Not Unit Dose, 2 - Manufacturer Unit Dose, 3 - Pharmacy Unit Dose, 4 - Custom Packaging, 5 - Multi-drug compliance packaging						
Validation Rules:	Required on Pharmacy claims. Must be NULL for Member Share transactions. Must be a valid value.						
Unit or Basis for Measurement Code	2 Max.	AN	S	None	Unit or Basis for Measurement Code (AN, L=2)	D053	S
Data Element Description:	Describes what format the Quantity field is in. Valid values are MJ (Minutes), HR (Hours), DA (Days), WK (Weeks), YR (Years), Q1 (Quarter), F2 (International Units), UN (Unit), DH (Miles), MI (Metric), VS (Visit), EA (Each), MO (Month).						
Validation Rules:	Must be present for Encounter Transactions. Must be NULL for Member Share transactions.						

	Information regarding Data Type										
AN	Alpha numeric										
ANPlus	Alpha numeric + special characters										
ANDot	Alpha numeric + period										
A	Alpha										
N	Numeric										
D	Data										
	Information regarding length										
(000)	fixed length		**(999)**	variable length							
	Information regarding required field										
Y	Yes, Data is required in this field for Original or Change New transactions										
N	No, Data is not required in this field										
S	Situational, Data is required in this field only when certain other criteria is met										
	Please note, the DD does not specify the severity of the edit. In most cases, it makes sense to										
	set the severity to batch accept or batch reject. But, for business reasons, it may have been set to a Warning										
	Validation rule										
	This information is limited to business decisions. We do not go into parser validations, or data integrity validations										
	Error Category										
A	Adjustment attribute										
H	Header Attribute										
M	Member (recipient) identification attribute										
P	Provider identification attribute										
R	Record attribute										
S	Service Attribute										

Date	Changes	Changed By	Remarks/Reason
4/26/2005	(First draft)		
6/30/2007	Document is baselined at version 6. From now on, all changes will be implemented into the baseline document, and documented into the change log	Syed Aziz	One time document baselining.
6/30/2007	HIPAA related Tag (and DB) name changes.	Syed Aziz	Bugzilla 2255 and 2256.
7/25/2007	Changed existing baselined XML tag names to new baseline XML tag names.	Ramona Johnson	Update document baselining XML tag names.
8/10/2007	Reformat cells, update data element descriptions and field lengths. Under Validation Rules: List all Data Element lookup table names.	Ramona Johnson	Required HIPAA naming conventions.
8/16/2007	Added and removed text from several field descriptions and validations	Charles Rumberger	Sent back to EDS for review.
8/17/2007	Added and removed text from several field descriptions and validations.	Ramona Johnson	Analysis: Required and requested revisions.
8/18/2007	Reviewed updated text from several field descriptions and validations: Fixed length Type A (0) and A (00) changed to A. FC Posting Date Type N (999999999999999.99) changed to D (CCYY-MM-DD). Quotation marks were removed for readability and consistency. The word lookup added where the word table exists; the misspelled words and or punctuation corrections. Going forward, the revision history will be included in the Change Log.	Ramona Johnson	Analysis: Required and requested revisions.
8/23/2007	Revised the Data Source validation and description	Charles Rumberger	Additional information discovered about Data Source validation
8/24/2007	Data Elements: Updated the Data Source, Billing Provider First, Middle, and Last Name validation rules and/or descriptions. Made additional grammar/punctuation, and spelling corrections, and change log updated to reflect recent entries. The entry on 8/18/2007: The Fixed length Type A (0) and A (00) change to A should be disregarded. Question whether to show the DD field format as Type A and then drop the (0) and/or (00), but may be better to leave as is.	Ramona Johnson	Analysis: Required and requested revisions.
8/27/2007	Changed MCO to submitting organization in the header on the header tab.	Charles Rumberger	Sent for final review.
	Reviewed per the 'July 2007 Release Notes for Encounter' 'XML tag names 6/16/2007' section and found to comply	C. J. Kooyman	

Date	Changes	Changed By	Remarks/Reason
	Changed release from 2.5 to 2.6 and changed CMO to FC on header tab submission type	Charles Rumberger	
8/29/2007	FC DD Elements: The header and detail page alphabetically sorted.	Ramona Johnson	Analysis: Client approved the required and requested FC DD for publication as of 08/29/07.
10/20/2007	Removed the existing TPL Paid Amount data element field to include new additional data elements fields that will be used to store the cumulative sum of the three types of TPL records for a service record. i.e., total_medicare_paid_amount, medicare_tpl_type, other_payer_amount_paid_primary, other_payer_tpl_type_primary, other_payer_amount_paid_secondary, other_payer_tpl_type_secondary	Ramona Johnson	Analysis: Client required and requested 6 additional data elements be added: TPLs for medicare. Contains revised/added edit numbers and related edit details: Bug 2242
12/12/2007	FC, WPP & SSI data element revisions: A006A Original ID changed to a mandatory alphanumeric field with a maximum length of 80 characters must be provided. Edit D006E changed in functionality, description, message and severity. The new functionality checks for record types 'O and C' with an adjustment type of N. This edit will not apply to reversal records. And the value must be supplied not derived.	Ramona Johnson	FC, WPP & SSI Parser and Content Edit: Original ID D006A & E will be a required field beginning 2008 posting dates. Refer to Bug 2317.
1/17/2008	Reintroduced the TPL Paid Amount field with a validation change and required became situational. Changed id # on new COB fields from D03, D04, D05, D06, D07 and D08 to D103, D104, D105, D106, D107 and D108.	Charles Rumberger	Clarification for changes implementing on 1/1/2008
4/30/2008	Added documentation for POA_Indicator. Also added rows for additional Diagnosis Codes 10-18.	Phyllis Schmoller	Additional data needed for new fields.
10/8/2008	Modified Service Delivery Type to be an optional field.	Phyllis Schmoller	Changed per Charles request (Bug 2257).
10/14/2008	Added Claim Type for this LOB.	Phyllis Schmoller	Changed per Bug 2370.
11/14/2008	Modified ID# to be a 4-character field.	Phyllis Schmoller	Changed per Charles request.
11/17/2008	Changed validation rules to 'None' for National Health Plan ID, National Recipient ID and Rendering Provider First Name.	Phyllis Schmoller	Changes made per Bugzilla 2382.

Date	Changes	Changed By	Remarks/Reason
11/18/2008	Added valid values for Medicare COB Type, Other Payer COB Type Primary and Other Payer COB Type Secondary.	Phyllis Schmoller	Changed per Charles request.
12/30/2009	Added Diagnosis Code Additional 19 through 25.	Phyllis Schmoller	Added per Directive 2009-12-1080.
1/12/2010	Added DCN_Primary, _Secondary and _Tertiary.	Phyllis Schmoller	Added per Directive 2009-12-1080, CO 30640.
3/25/2010	Changed all Type fields to be consistent - all N will be defined with 9's and all A will have nothing following.	Phyllis Schmoller	Changed as a result of meeting with Bob to discuss documentation questions.
6/4/2010	Description and Validation field changes for clarification.	Phyllis Schmoller	Changed as a result of meeting with Bob to discuss documentation questions.
11/17/2010	Description and Validation field, etc. changes.	Phyllis Schmoller	Changed as a result of the weekly documentation meeting.
12/10/2010	Changed type to ANPlus for DCN fields to allow special characters.	Phyllis Schmoller	Changed per User request. CO 37567
1/12/2011	Added MO (Month) to Unit or Basis for Measurement Code.	Phyllis Schmoller	Changed per Charles' email dated 1/12/2011.
3/10/2011	Changed date requirements for Diagnosis Code fields.	Phyllis Schmoller	Changed per CO 38601.

Date	Changes	Changed By	Remarks/Reason
8/11/2011	Added the following fields for the 5010 project: Ambulance Drop Off Location, Anesthesia Related Surgical Procedure Primary and Secondary, Benefit Stage Amount, Count and Qualifier, Billing Provider Secondary ID, Care Plan Oversight Number, EPSDT Condition Code 1-3, External Cause of Injury Code 2-12, Health Plan Funded Assistance Amount, Length of Need Qualifier, Non-Covered Amount, Obstetric Additional Units, Patient Reason for Visit 1-3, Patient Residence, Pay to Plan Organizational Name, Payer Paid Amount, Pharmacy Service Type, Remaining Patient Liability Amount, Rendering Provider Name Suffix and Rendering Provider Secondary ID. Changed the following fields: Admitting Diagnosis Code, Admit Start Care Date, Dispense as Written Ind, External Cause of Injury Code 1, Patient Discharge Status, Prescription Number, Prior Auth Number, Statement From and To Date, Type of Bill and Unit Dose Ind.	Phyllis Schmoller	Changed for 5010 Project, CO 39812.
11/16/2011	Benefit Stage Amount, Benefit Stage Count, Benefit Stage Qualifier, Health Plan-Funded Assistance Amount, Length of Need Qualifier, Patient Residence, and Pharmacy Service Type, Data Element Description: updated directly from NCPDP	Sven Ahlstrom	Needs to be reviewed by the State and published
11/18/2011	Fields reviewed and minor updates made.	Phyllis Schmoller	Changed for 5010 Project, CO 39812.