Covered California
Enrollment Functional Specification
06/15/2023

REVISION HISTORY

DATE	AUTHOR	DESCRIPTION OF ACTIVITY
6/15/23	Elizabeth Wagner	Updated filler field in Detail layout to 206 bytes
4/5/23	Elizabeth Wagner	Updated specs to include new 6 byte Race field, updated Ethnicity, Language Spoken, Language Written, and Coverage Indicators
1/23/22	Elizabeth Wagner	Updated Population of Policy Holder/Dependent Rcords for DMHC Codes
12/12/22	Elizabeth Wagner	Updated Race & Ethnicity Codes
10/31/22	Dan Lopez	Added additional guidance on race and ethnicity codes
4/28/22	Dan Lopez	Added additional race and ethnicity codes to valid values
3/4/22	Dan Lopez	Added additional language codes to valid values
12/17/21	Dan Lopez	Added a link to California rating regions documentation
9/30/21	Dan Lopez	Added directions for QDPs (Qualified Dental Plans)
3/3/20	Dan Lopez	Added PPO/EPO to the description of risk type code 5. Changed length of DMHC code field to 5 and added a separate field for DMHC Sub ID. Also added new tab for DMHC code more detailed information
2/14/20	Dan Lopez	Removed PCMH indicator and added descriptions of values for indicator fields
1/21/20	Dan Lopez	Added Federal Subsidy Amount
1/17/20	Katie Andrada-Bacorn	Updates for AB929 and Brand updating
1/13/20	Dan Lopez	Fixed length of product type code
10/22/19	Dan Lopez	Add new fields for off-exchange enrollees
1/8/18	Dan Lopez	Added new field, PCP Taxonomy Code
3/15/16	Dan Lopez	Field lenghts of race code increased to 3 bytes, added new field, Cost Share
6/12/15	Dan Lopez	Update after all data summits
5/26/15	Katie Andrada-Bacorn	Update after initial data summit
5/19/15	Dan Lopez	Updated after meeting with Covered CA and CalHEERS
5/11/15	Dan Lopez	Initial document

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a monthly enrollment file for QHP and QDP plan participants.

The data will be provided in a fixed-record length, ASCII file format. The layout contains both a Data layout (identified by a D in the Record Type field), as well as a Trailer record layout (identified by a T in the Record Type field).

QHPs

Data will be provided in a monthly file that reflects the status as of the end of the month, i.e. a "snapshot" as of a point in time. For example, the project requires historical data from January 1, 2014 -current. Merative will expect to receive one file for every month from January 1, 2014 to current. Historical files may be cut by quarter or year if convenient for the QHP. Each file will contain one record per member per month. Ongoing file submissions would include one record for each member for the latest month only.

QDPs

Data will be provided in a monthly file that reflects the status as of the end of each month, i.e. a "snapshot" as of a point in time. For example, the project requires historical data from January 1, 2016 -current. Merative will expect to receive one file for every month from January 1, 2016 to current. Historical files may be cut by quarter or year if convenient for the QDP. Each file will contain one record per member per month. Ongoing file submissions would include one record for each member for each month for the latest month only.

Annually, the QHP/QDP will need to supply a reference table spreadsheet with the following information about each plan offered by the QHP/QDP:

- plan number (16 Character HIOS Code)
- enrollment year
- plan description
- network type
- metal-tier
- enhanced metal tier

The spreadsheet will need to be provided prior to the beginning of each new calendar year

DATA SUBMISSION

The monthly data file submissions will be submitted to Merative via SFTP. Files should be submitted on or before the agreed upon date of the monthly file. Annual plan reference spreadsheet should be submitted via email attachment.

DATA FORMATTING	
CHARACTER FIELDS	• Includes A - Z (lower or upper case), 0 – 9, and spaces • Left justified, right blank/space filled • Unrecorded or missing values in character fields are blank/spaces
NUMERIC FIELDS	• All numeric fields should be right-justified and left zero-filled or left space-filled • Unrecorded or missing values in numeric fields should be set to zero
FINANCIAL FIELDS	• All financial fields should be right-justified and left zero-filled or left space-filled • Merative prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data For example: "1234567" would represent $12,345.67 *Please do not include an actual decimal point in the data.* • Negative signs should be the leading value in the first position For example: "-001234567" would represent -$12,345.67 • Unrecorded or missing values in numeric fields should be zero
INVALID CHARACTERS	Please note that the following characters should not be included in the data or the descriptions in the data dictionary. * ! ? % _ (under score) , (comma)

POPULATION OF DATA ONTO DEPENDENT RECORDS

For certain fields, e.g., Policy Holder ID, we would like to have information copied down from the policy holder to the enrollee record. For others, e.g., Gender or Date of Birth, we would like the data to be specific to the person.

For each field, Merative has noted one of the three values below in the right-most column.

ENROLLEE-SPECIFIC (MEMBER SPECIFIC)	Information relevant to the enrollee (e.g., Date of Birth). Please populate on each record with the information specific to that enrollee.
POLICY-HOLDER-ONLY (SUBSCRIBER ONLY)	Information relevant to the policy holder that Merative would like on the contract holder, i.e., not copied onto the enrollee's records.
POLICY-HOLDER-SPECIFIC (SUBSCRIBER SPECIFIC)	Information relevant to the policy holder, but needs to be copied down to the enrollee. Please populate on each record with the information that has been copied from the policy holder.

***Note: Selections of Rows or Columns for each action must be made **after** pressing the desired button.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Merative Fields										
1	Enrollment Snapshot Month	1	10	10	Date	First day of eligibility snapshot month	MM/DD/CCYY Format			Enrollee-Specific
2	Date of Birth	11	20	10	Date	Birth date of the person	MM/DD/CCYY format			Enrollee-Specific
3	Date of Death	21	30	10	Date	The Date of Death of the enrollee	Required per AB-929			Enrollee-Specific
4	**Note: all fields highlighted in green will be used to set the master person ID** **Required per AB-929 if available marker field used to set master person ID** Subscriber SSN	31	39	9	Character	The policy holder SSN	**Note: all fields highlighted in green will be used to set the master person ID** Required per AB-929 if available marker field used to set master person ID			Policy Holder-Specific
5	CC Subscriber ID	40	59	20	Character	The Covered California subscriber Identifier	Covered California Subscriber ID Required for on-exchange enrollees marker field used to set master person ID			Policy Holder-Specific
6	Enrollee/member SSN	60	68	9	Character	The SSN of the individual enrollee.	Required per AB-929 if available marker field used to set master person ID			Enrollee-Specific
7	CC Member ID	69	88	20	Character	The Covered California member Identifier	Covered California Member ID Required for on-exchange enrollees marker field used to set master person ID			Enrollee-Specific
8	Plan Member ID	89	108	20	Character	The enrollee Identifier as identified by the issuer. The member ID used by the QHP or QDP system	Required per AB-929 marker field used to set master person ID			Enrollee-Specific
9	Policy ID	109	128	20	Character	Identifier of the individual policy for the enrollee	Required per AB-929 marker field used to set master person ID			Policy -holder specific
10	Enrollee First Name	129	188	60	Character	The enrollee's first name.	Required per AB-929 marker field used to set master person ID			Enrollee-Specific
11	Enrollee Last Name	189	248	60	Character	The enrollee's last name.	Required per AB-929 marker field used to set master person ID			Enrollee-Specific
12	Enrollee Middle Initial	249	249	1	Character	The enrollee's middle initial	Required per AB-929 marker field used to set master person ID			Enrollee-Specific
13	Enrollment End Reason Code	250	253	4	Character	The reason for termination of enrollment. Please include death as one of the reasons for termination.	See Reference Tables tab.			Enrollee-specific
14	Address 1	254	303	50	Character	The street address for the residence of the enrollee, for the most recent month of enrollment.	Required per AB-929 marker field used to set master person ID			Enrollee-Specific
15	Address 2	304	333	30	Character	The second part of the street address if needed for the residence of the person, for the most recent month of enrollment.	Required per AB-929 marker field used to set master person ID			Enrollee-Specific
16	City	334	363	30	Character	The city of the residence for the person	Required per AB-929 City of the member marker field used to set master person ID			Enrollee-Specific
17	State Code	364	365	2	Character	The state code of the residence of the person	Required per AB-929 State code of the member marker field used to set master person ID			Enrollee-Specific
18	Zip Code (5 digit)	366	370	5	Character	The 5 digit zip code of the residence of the member at the time of the eligibility month.	Zip code of the member residence			Enrollee-Specific
19	Zip Code plus 4 (last 4)	371	374	4	Character	The last 4 digits of the of the 9 digit zip code of the residence of the member at the time of the eligibility month.	Zip Plus 4 of the member residence			Enrollee-Specific
20	County Code	375	379	5	Character	The state/county FIPS code for the enrollee address of residence.	County code of the member, e.g., 06001 = Alameda County, 06115= Yuba County.			Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Merative Fields										
21	Gender Code	380	380	1	Character	Gender of the enrollee.	M = Male F = Female N = Non-Binary U = Unknown			Enrollee-Specific
22	Relationship Code	381	385	5	Character	Code with values that specify the relationship of the enrollee to the policy-holder.	1 = Employee/Self 2 = Spouse/Partner 3 = Child/Other Dependent			Enrollee-Specific
23	Filler	386	388	3	Character	Reserved for future use	Fill with blanks			Enrollee-Specific
24	Filler	389	391	3	Character	Reserved for future use	Fill with blanks			Enrollee-Specific
25	Filler	392	394	3	Character	Reserved for future use	Fill with blanks			Enrollee-Specific
26	Ethnicity Code	395	400	6	Character	A code specifying the ethnicity of the enrollee / member.	Submit only values from PHIN VADS Ethnicity CDC Value Set (PHVS_Ethnicity_CDC v. 1) (https://phinvads.cdc.gov/vads/ViewValueSet.action?id=34D34BBC-617F-DD11-B38D-00188B398520). HEI will accept the most granular values from the above value set. Alternatively, data suppliers may report "rolled up" OMB equivalents if audited for HEDIS, submitting: 2135-2 Hispanic or Latino 2186-5 Not Hispanic or Latino ASKU Asked but No Answer UNK Unknown			Enrollee-Specific
27	Filler	401	406	6	Character	Reserved for future use	Fill with blanks			Enrollee-Specific
28	Filler	407	412	6	Character	Reserved for future use	Fill with blanks			Enrollee-Specific
29	Language Written Code	413	416	4	Character	Code for the preferred written language of the enrollee	Submit only values from ISO 639-3 language code table.			Enrollee-Specific
30	Language Spoken Code	417	420	4	Character	Code for the preferred spoken language of the enrollee	Submit only values from ISO 639-3 language code table.			Enrollee-Specific
31	Coverage Start Date	421	430	10	Date	The effective date of the current coverage	MM/DD/CCYY Format			Enrollee-Specific
32	Coverage End Date	431	440	10	Date	The end date of the coverage	MM/DD/CCYY Format			Enrollee-Specific
33	Coverage Indicator Dental	441	441	1	Character	Indicator of Dental Coverage	Standard values: Y = Have coverage, N = Do not have coverage QDPs should set this value to "Y" QHPs should set this value to "N" (including embedded pediatric dental)			Enrollee-Specific
34	Coverage Indicator Drug	442	442	1	Character	Indicator of Drug Coverage	Standard values: Y = Have coverage, N = Do not have coverage QDPs should set this value to "N"			Enrollee-Specific
35	Coverage Indicator Hearing	443	443	1	Character	Indicator of Hearing Coverage	Standard values: Y = Have coverage, N = Do not have coverage QDPs should set this value to "N"			Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Merative Fields										
36	Coverage Indicator Medical	444	444	1	Character	Indicator of Medical Coverage	Standard values: Y = Have coverage, N = Do not have coverage QDPs should set this value to "N" QHPs should set this value to "Y" (including embedded pediatric dental)			Enrollee-Specific
37	Coverage Indicator MHSA	445	445	1	Character	Indicator of MHSA Coverage	Standard values: Y = Have coverage, N = Do not have coverage QDPs should set this value to "N"		1	Enrollee-Specific
38	Coverage Indicator Vision	446	446	1	Character	Indicator of Vision Coverage	QHPs and QDPs should set this value to "~"			Enrollee-Specific
39	PCP Type Code	447	450	4	Character	A code indicating the Primary Care Physician's specialty or type ex. General Practice, Family Practice, OB/GYN	See Reference Tables tab. Only needed for managed care plans Required if PCP Taxonomy code is not available QDPs should set this value to "7"			Enrollee-Specific
40	PCP Provider ID TIN	451	463	13	Character	The provider identifier of the Primary Care Physician.	For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated for that record.			Enrollee-Specific
41	Gross Premium	464	473	10	Numeric	The total value of the monthly premium paid for medical or dental benefits. QDPs should populate this field	Required per AB-929 Format 9(8)v99 (2 – digit, implied decimal) This field should contain total premium amounts paid for fully-insured plans and not premium equivalents. It should not be the net amount (minus policy-holder contribution) as this will be calculated within the Merative product. It should be populated only on subscriber records for those subscribers enrolled in fully-insured medical plans. On all other records this field should be zero filled.			Policy Holder/Contract Holder Only
42	Net Premium	474	483	10	Numeric	The monthly amount contributed by the policy-holder for medical benefits QDP - please set to 0	Required per AB-929 Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on non-policy-holder records).			Policy Holder/Contract Holder Only
43	State Subsidy Amount	484	493	10	Numeric	The State government paid monthly premium for medical or dental benefits	Required per AB-929 Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on non-policy holder records).			Policy Holder/Contract Holder Only
44	Product Type/Medical Plan Type	494	497	4	Character	The type of product in which the enrollee is enrolled. Examples include PPO, HMO, POS, etc.	Valid values are: HMO PPO DMO POS EPO			Enrollee-specific

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Merative Fields										
45	Medical Fully Insured Indicator	498	498	1	Character	An indicator of fully insured medical coverage for the member or employee.	Y = Yes - Fully Insured N = No - Not Fully Insured For Covered CA this value will be set to "Y"			Enrollee-specific
46	Drug Fully Insured Indicator	499	499	1	Character	An indicator of fully insured drug coverage for the member or employee.	Y = Yes - Fully Insured drug coverage N = No - Not Fully Insured drug coverage For Covered CA this vale will be set to "Y"			Enrollee-specific
47	HIOS Plan Code	500	515	16	Character	The code for HIOS plan	16 characters - no dashes			Enrollee-Specific
48	Rating Region Code	516	520	5	Character	The code for the geographic region of the person	01 thru 19			Enrollee-Specific
49	Policy Structure Code/Coverage Tier Code	521	524	4	Character	The policy structure code/Family Size QDPs to leave blank	See Reference Tables tab.			Policy Holder-Specific
50	Dental Plan Code	525	530	6	Character	The code for the dental plan in which the member is enrolled.	It's desirable to have a plan code explicitly identifying "Opt-outs".			Enrollee-Specific
51	Dental Policy Structure Code/Coverage Tier Code	531	534	4	Character	The Dental Policy Structure Code (if stand-alone, else Blank)	See Reference Tables tab.			Enrollee-Specific
52	Monthly Policy Holder Dental Contribution	535	544	10	Numeric	The monthly amount contributed by the policy-holder for dental benefits (if stand-alone, else 0) QDPs should populate this field	Required per AB-929 Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on non-policy-holder records).			Policy Holder/Contract Holder Only
53	Monthly Dental Premium	545	554	10	Numeric	The total value of the monthly premium for dental benefits (stand-alone plans) QDPs should populate this field.	Required per AB-929 Format 9(8)v99 (2 – digit, implied decimal) This field should contain total premium amounts paid for fully-insured plans and not premium equivalents. <It should not be the net amount (minus policy-holder contrib.) as this will be calculated within the Merative product. It should be populated only on policy-holder records for those enrolled in fully-insured dental plans. On all other records this field should be zero filled.			Policy Holder/Contract Holder Only
54	Vision Plan Code	555	560	6	Character	The code for the vision plan in which the member is enrolled. QDPs to leave blank	Vision plan code values will be identified in the **Data Dictionary**. It's desirable to have a plan code explicitly identifying "Opt-outs".		Yes	Enrollee-Specific
55	Vision Policy Structure Code/Coverage Tier Code	561	564	4	Character	Vision Coverage Tier Code QDPs to leave blank	Values will be identified in the **Data Dictionary**.		Yes	Enrollee-Specific
56	Monthly Policy Holder Vision Contribution	565	574	10	Numeric	The monthly amount contributed by the policy-holder for their vision benefits QDPs to set ot 0	Required per AB-929 Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on dependent records).			Policy Holder/Contract Holder Only

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Merative Fields										
57	Monthly Vision Premium	575	584	10	Numeric	The total value paid monthly premium for vision benefits if standalone plan else 0 QDPs to set to 0	Required per AB-929 Format 9(8)v99 (2 – digit, implied decimal) This field should contain total premium amounts paid for fully-insured plans and not premium equivalents. <It should not be the net amount (minus policy-holder contrib.) as this will be calculated within the Merative product. It should be populated only on policy-holder records for those enrolled in fully-insured medical plans. On all other records this field should be zero filled.			Policy Holder/Contract Holder Only
58	SHOP Employee Status Code	585	589	5	Character	Customer-specific values of employee status.	See Reference Tables tab.	X	Yes	Policy Holder-Specific
59	SHOP Employee Medicare Eligible Indicator	590	590	1	Character	A code indicating whether an employee is Medicare eligible.	Y = Yes N -No	X		Policy Holder-Specific
60	SHOP Part-Time/Full-time Indicator	591	591	1	Character	A code indicating whether an employee is full-time or part-time.	P = Part-time F - Full-time	X		Policy Holder-Specific
61	Plan Group Number	592	611	20	Character	The enrollee's group number as identified by the plan. This is the plan's internal value.		X		Enrollee-Specific
62	Plan Group Suffix	612	616	5	Character	The enrollee's group suffix as identified by the plan		X		Enrollee-Specific
63	Industry Classification Code (Group Coverage Flag Code)	617	622	6	Character	This field has been re-purposed to designate if the enrollee is in an individual or group coverage policy. Use value of "SBU" for all group coverage enrollees	SBU or IND			Enrollee-Specific
64	Cost Sharing Reduction	623	632	10	Numeric	The Cost Sharing Reduction	Note: If available, this should be the actual CSR, which may not be the same as the CSR amount on the 834.			Policy Holder-Specific
65	PCP Taxonomy Code	633	642	10	Character	The Taxonomy code of the PCP QDPs - only required for managed dental plan enrollees				Enrollee-Specific
66	**ALL fields in red text have been added to the layout for AB-929** PCP NPI	643	652	10	Character	The NPI of the PCP for the enrollee, preferably representing an individual provider (not a group). QDPs - only required for managed dental plan enrollees	**ALL fields in red text have been added to the layout for AB-929** added for AB-929			Enrollee-Specific
67	PCP Plan Provider ID	653	665	13	Character	The QHP or QDP system identifier of the PCP of the enrollee. The internal ID QDPs - only required for managed dental plan enrollees	added for AB-929			Enrollee-Specific
68	On-Exchange Indicator	666	666	1	Character	An indicator to determine if this enrollee is on the Covered California exchange or not	Set to: Y = when the enrollee record is on-exchange N = when the enrollee record is off-exchange added for AB-929			Enrollee-Specific
69	Plan Number	667	686	20	Character	Plan number identifying the plan selected by the enrollee as assigned by the QHP or QDP. The internal ID	added for AB-929		Yes	Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Merative Fields										
70	ACO Identifier	687	716	30	Character	Unique Accountable Care Organization identifier assigned by plan. Use this field to identify members who were assigned to an ACO during the period of the enrollment segment. Please provide a data dictionary with code and name. Code should identify the specific ACO and ACO program as relevant to the plan.	added for AB-929		Yes	Enrollee-Specific
71	DMHC Code	717	721	5	Character	The California Department of Managed Health Care's identifier of the Physician Group to which the PCP belongs. This should be the 5 digit DMHC ID, please do not include the 2 digit SubID in this field (used to identify specific locations). This field should be populated for members of HMOs only. Not required for QDPs **More Detailed explanation can be found on the DMHC Code Info tab in this workbook	added for AB-929			Enrollee-Specific
72	DMHC Sub-ID	722	723	2	Character	This field is not being requested at this time. Default to spaces if not available.	added for AB-929			Enrollee-Specific
73	Risk Type Code	724	724	1	Character	Indicates the type of financial arrangement under which providers are contracted to provide care to the enrollee. See Risk Type Code tab	added for AB-929			Enrollee-Specific
74	Network Type	725	744	20	Character	Network Type Code (not currently in use)	added for AB-929 TBD - may be used for Off-exchange in the future		Yes	Enrollee-Specific
75	Agent License Number	745	751	7	Character	The agent CDI license number for the broker responsible for enrollment	added for AB-929			Enrollee-Specific
76	PCP Assignment Selection Code	752	752	1	Character	Identify if the PCP was auto-assigned by the issuer or selected by the enrollee QDPs - only required for managed dental plan enrollees	Added for AB-929 Valid values are: A- Auto Assigned S- Selected by enrollee O- Other U - Unknown			Enrollee-Specific
77	Other Member Insurance Identifier	753	777	25	Character	Any other member level insurance identifier (not used at this time)	added per AB-929 marker field used to set master person ID			Enrollee-Specific
78	Federal Subsidy Amount	778	787	10	Numeric	The Federal government paid monthly premium for medical or dental benefits	Required per AB-929 Format 9(8)v99 (2 – digit, implied decimal) Only recorded on policy-holder record (zero-filled on non-policy holder records).			Enrollee-Specific

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes	SHOP Only	Data Dictionary Needed	Population of Policy Holder / Dependent Records
Standard Merative Fields										
79	Race Code	788	793	6	Character	A code specifying the race of the enrollee / member.	Submit only values from PHIN vADS Race CDC Value Set (PHVS_Race_CDC v. 2) (https://phinvads.cdc.gov/vads/ViewValueSet.action?id=9152A536-AEEC-E711-ACD6-0017A477041A). HEI will accept the most granular values from the above value set. Alternatively, data suppliers may report "rolled up" OMB equivalents if audited for HEDIS, submitting: 1002-5 American Indian or Alaska Native 2028-9 Asian 2054-5 Black or African American 2076-8 Native Hawaiian or Other Pacific Islander 2106-3 White 2131-1 Other Race ASKU Asked but No Answer MULTRC Two or More Races* UNK Unknown * If all the data supplier's detailed race codes fall into the same race category (e.g., Chinese and Vietnamese are both Asian), populate the applicable 9999-9 format race category code above (e.g., 2028-9 for Asian) instead of MULTRC			Enrollee-Specific
80	Filler	794	999	206	Character	Reserved for future use	Fill with blanks			Enrollee-Specific
81	Record Type	1000	1000	1	Character	Record type identifier	Hard Code to "D"			Enrollee-Specific
End of Layout - Do not remove this row - All field additions to be inserted above the Filler row										

Enrollment Extract Functional Specifications
Trailer Layout

***Note: Selections of Rows or Columns for each action must be made **after** pressing the desired button.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Merative Fields							
1	Eligibility Start Date	1	10	10	Date	Eligibility Begin Date	MM/DD/CCYY format – i.e. 09/01/2015 This will represent the 1st day of the month for which data is provided.
2	Eligibility End Date	11	20	10	Date	Eligibility End Date	MM/DD/CCYY format – i.e. 09/30/2015 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Filler	31	999	969	Character	Reserved for future use	Fill with Blanks
5	Record Type	1000	1000	1	Character	Record Type Identifier	Hard Code 'T'

End of Layout - Do not remove this row - All field additions to be inserted above the Filler row

Enrollment End Reason Code	Description
1	Birth
2	Change of Location
3	Death
4	Disability
5	Divorce
6	Marriage
7	No Reason Given
8	Non Payment
9	Plan Change
10	Termination of Benefits
11	Termination of Employment
12	Voluntary Withdrawal
13	Other

PCP Type Code	Description
1	General Practice
2	Family Practice
3	OB/GYN
4	Pediatrics
5	Internal Medicine
6	Health Center
7	Other

Policy Structure Code	Description
A	Family
B	Subcriber and Spouse/Partner
C	Subsriber Only
D	Subscriber and Dependents
E	Spouse/Partner and Dependents
F	Spouse/Partner Only
G	Dependents Only

Employee Status Code	Description
1	Active Full Time
2	Active Part-Time/Seasonal
3	Early Retiree
4	Medicare Eligible Retiree
5	Retiree (Status Unknown)
6	COBRA Continuee
7	Long Term Disability
8	Surviving Spouse/Dependent
9	Other/Unknown

Explanation of DMHC ID Code

The DMHC ID code is assigned by the Department of Managed Health Care which is a State organization that oversees HMOs. HMOs capitate physician organizations which then "bear risk" (risk bearing organizations). The code is a consistent identifier (across plans) that is being used to identify the physician organization that is responsible for the member . Specifically, the physician organization that provides the members primary care under a capitation contractual agreement for HMO plans.

In California, the physician organization typically provides other care including specialty physician care, lab, imaging etc. as specified in the Division of Financial Responsibility agreement between the plans and the physician organization. The term physician organization includes physician groups and IPAs.

The DMHC ID enables us to identify the same physician organization across multiple plans since it is a common State identifier.

Below is a link to a website that explains the DMHC role

https://www.dmhc.ca.gov/LicensingReporting/RiskBearingOrganizations.aspx

From that page, there is a link to the list of organizations and their DMHC code as of May 2022

https://www.dmhc.ca.gov/Portals/0/Docs/OFR/sb260CapitatedProviders%20May%202022%20Accessible.pdf?ver=PXhGkP0rd-epeivA9OA_RQ%3d%3d

For plans that participate in the Integrated Healthcare Association's (IHA) Value-Based Pay-for-Performance program, in the spring, health plan staff create a mapping of plan-specific identifiers to the DMHC ID. This is done only for physician organizations participating in the IHA program. Some physician organizations do not participate in the program. This process is also known as creating the "AMP PO Master".

If your plan is participating in the IHA Value-Based Pay-for-Performance program, the IT staff that support that data pull may have a crosswalk that you can apply to the Covered California data to fill the DMHC ID data field in the enrollment layout.

Again, this only applies to HMO plans.

Risk Type Code	Description
1	Professional Capitation Only (no hospital capitation)
2	Facility Capitation Only (no professional capitation)
3	Professional and Facility capitation - plan has separate capitation contracts for professional services (i.e., with PCP or Physician Group) and facility services (i.e., with hospital)
4	Global Capitation (contract with Physician Group for both professional and facility services)
5	No capitation, fee-for-service only (Includes PPO/EPO plans)

Rating Regions for California
[California Geographic Rating Areas: Including State Specific Geographic Divisions | CMS]

Please populate with values 01 through 19

Covered California
Medical Claims Functional Specification
08/03/2023

REVISION HISTORY		
DATE	AUTHOR	DESCRIPTION OF ACTIVITY
8/3/23	Elizabeth Wagner	Updated Tooth Code specification to require one code per claim line
2/23/22	Dan Lopez	Added Blue Shield Paid Date - a field to be populated by BSC only
10/11/21	Dan Lopez	Added directions for non-embedded dental claims.
3/9/20	Dan Lopez	Added more detailed descriptions for Third Party Amount, Penalty Amount, Discount Amount, Withhold Amount and Replaced Claim ID fields.
2/14/20	Dan Lopez	Added clarification of values and description for on-exchange indicator field
1/28/20	Dan Lopez	Added clarification on patient/enrollle fields
1/9/20	Dan Lopez	Added fields for AB-929
9/13/19	Dan Lopez	Addded clarification on where to place the sign on negative numeric data
11/8/17	Dan Lopez	Added rendering provider taxonomy code to filler
6/12/15	Dan Lopez	Finalized version after all data summits
6/8/15	Katie Andrada-Bacorn	Revised after initial data summit
5/21/15	Dan Lopez	Initial document

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a medical claims file for plan participants administered through the data supplier.

The data will be provided in a fixed-record length, ASCII file format. The layout contains both a Data layout (identified by a D in the Record Type field), as well as a Trailer record layout (identified by a T in the Record Type field).

DATA SUBMISSION

The data will be submitted to Merative via SFTP on a monthly basis. Monthly files should be submitted on or before the agreed upon date of the month following the close of each month.

Historical files should be submitted in yearly files.

DENIED CLAIMS

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

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

DATA FORMATTING	
CHARACTER FIELDS	• Includes A - Z (lower or upper case), 0 – 9, and spaces • Left justified, right blank/space filled • Unrecorded or missing values in character fields are blank/spaces
NUMERIC FIELDS	• All numeric fields should be right-justified and left zero-filled • Negative signs should be the leading value in the first position • Unrecorded or missing values in numeric fields should be set to zero
FINANCIAL FIELDS	• All financial fields should be right-justified and left zero-filled • Merative prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data For example: "1234567" would represent $12,345.67 *Please do not include an actual decimal point in the data.* • Negative signs should be the leading value in the first position For example: "-1234567" or "-000123457" would represent -$12,345.67 • Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal)
INVALID CHARACTERS	Please note that the following characters should not be included in the data or the descriptions in the data dictionary. * ! ? % _ (under score) , (comma)

DEFINITIONS

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

DISCUSSION ITEMS

- If both fee-for-service claims and encounter records are included on the data file, Merative will rely on the data supplier to explain how to differentiate them, preferably using the field Capitated Service Indicator.
- If encounter records contain fee-for-service equivalents, it is essential for Merative to understand which fields contain these amounts.
- Financial fields should be populated at the service line level, not at the claim level.
- Merative will need to understand the circumstances under which claims are not paid on a line item basis. For example, situations where claims are paid on a per diem basis or paid based on a DRG. It is our preference if the supplier can apply a factor so that the financials are spread across the lines based on the service rendered.

Claim is paid based on the DRG and Net Payment for the entire claim is $3,632.00; financials are applied across lines

CLAIM LEVEL INFORMATION				SERVICE LEVEL DETAIL				
Claim Id	Provider Id	DRG	Provider Type	Line Number	Revenue Code	Service Count	Allowed Amount	Net Payment
11111	121212121	177	25	1	120	2	$ 2,500.00	$ 2,000.00
11111	121212121	177	25	2	250	1	$ 115.00	$ 100.00
11111	121212121	177	25	3	720	10	$ 1,800.00	$ 1,532.00

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

DISCUSSION ITEMS - PROVIDER

- Merative requires unique provider identifiers and associated names. Merative would like both the identifier and the name to be specific to each provider, rather than group level information. TAXID is preferred for the identifier.
- If providers within group practices use a single TAXID, Merative would prefer an additional qualifier that would make each identifier and name unique.
- If only the group name is available with the associated TIN, and a qualifier is not available, Merative prefers another identifier for professional claims and the TAXID for the facility claims. NPI is preferred for the alternate identifier. In this case the TAXID is still requested in addition to the NPI or alternate identifier.

Provider Example 1

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

Claim ID	TAXID	Qualifier	Provider Name	Prov Type	Service Count		Net Payment
11111	121212121	2222	Dr. Brown	25	2	$	2,000.00
22222	121212121	3333	Dr. Smith	35	1	$	100.00

Provider Example 2

The following is an example of what is not desired.

Claim ID	TAXID	Provider Name	Prov Type	Svc Count		Net Payment
11111	121212121	Dr. Brown	25	2	$	2,000.00
22222	121212121	Dr. Smith	35	1	$	100.00
33333	232323232	XYZ	25	1	$	125.00
22222	232323232	XYZ	35	1	$	110.00

DISCUSSION ITEMS - PROVIDER

Provider Example 3

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

Professional

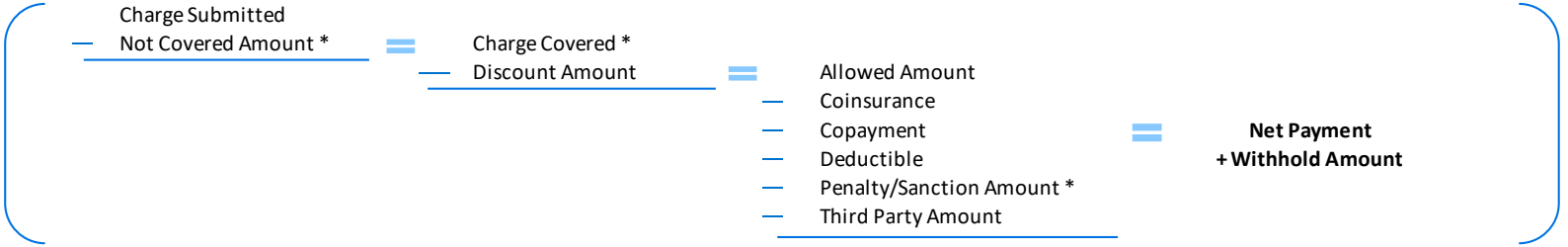
Claim ID	TAXID	Group Name	NPI	Prov Name	Prov Type	Svc Count	Net Payment
11111	121212121	XYZ Pediatrics	2222222222	Dr Brown	25	2	$ 2,000.00
22222	121212121	XYZ Pediatrics	3333333333	Dr Smith	35	1	$ 100.00

Facility

Claim ID	TAXID	NPI	Provider Name	Prov Type	Rev Code	Net Payment
11111	343434343	22222222222	University Hospital	1	110	$ 2,000.00
22222	454545454	33333333333	University Children's Hospital	1	120	$ 100.00

FINANCIAL RELATIONSHIP

Merative defines the relationship among financial fields as follows. Those marked with an asterisk are not required for the data extract.



CORRECTIONS TO PAID CLAIMS

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

VOID/REPLACEMENT

A **void** is a claim that reverses or backs out a previously paid one. All financials and quantities are negated on the void record. A replacement record that contains the corrected information generally follows it. The original, void and replacement need not appear in the same file.

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

Record Type	Svc Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	$ 75.00	$ 25.00	$ -	$ 50.00
Void	-1	$ (75.00)	$ (25.00)	$ -	$ (50.00)
Replacement	1	$ 75.00	$ 10.00	$ -	$ 65.00

ADJUSTMENT

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

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

Record Type	Svc Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	$ 75.00	$ 25.00	$ -	$ 50.00
Adjustment	0	$ -	$ (15.00)	$ -	$ 15.00

FACILITY RECORD CONTENT

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

One facility claim with three service lines

CLAIM LEVEL INFORMATION			SERVICE LEVEL DETAIL			
Claim Id	**Provider Id**	**Provider Type**	**Line Number**	**Revenue Code**	**Service Count**	**Net Payment**
11111	121212121	25	1	120	2	$ 2,000.00
11111	121212121	25	2	250	1	$ 100.00
11111	121212121	25	3	720	10	$ 1,532.00

PROFESSIONAL RECORD CONTENT

Merative does not store separate header/claim-level and detail/service-level information for professional claims. Merative requires the following:

- Each record in the data file should represent one service (detail) line.
- All financials and quantities on each record should pertain to that service only (as opposed to the entire claim).
- The repeating of non-quantitative claim-level information (e.g., Claim ID, Provider ID, Provider Type, etc.) on each record is necessary.
- QHPs with non-embedded dental should submit dental clais/encouters as a professional claim

One professional claim with two service lines

CLAIM LEVEL INFORMATION			SERVICE LEVEL DETAIL			
Claim Id	**Provider Id**	**Provider Type**	**Line Number**	**Procedure Code**	**Service Count**	**Net Payment**
13331	621262121	51	1	99201	1	$ 100.00
13331	621262121	51	2	99175	1	$ 150.00

***Note: Selections of Rows or Columns for each action must be made **after** pressing the desired button.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
1	**Note: all fields highlighted in green will be used to set the master person ID** Subscriber SSN	1	9	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.		**Note: all fields highlighted in green will be used to set the master person ID** Required per AB-929 if available marker field used to set master person ID
2	CC Subscriber ID	10	29	20	Character	The subscriber ID as assigned by Covered California		Required for on-exchange enrollees marker field used to set master person ID
3	Patient SSN	30	38	9	Character	Patient's Social Security Number		Required per AB-929 if available marker field used to set master person ID
4	CC Member ID	39	58	20	Character	The patient's member ID as assigned by Covered California		Required for on-exchange enrollees marker field used to set master person ID
5	Plan Member ID	59	78	20	Character	The patient's member ID as assigned by the plan		Required per AB-929 marker field used to set master person ID
6	Policy ID	79	98	20	Character	Identifier of the individual policy for the patient as assigned by health plan		Required per AB-929 marker field used to set master person ID
7	Rendering Provider ID	99	111	13	Character	The unique identifier for the provider of service. For professional claims (i.e. claims with a place of service provided), this should be the individual who provided the service. If it is a facility claim (i.e. claims with a type of bill populated), this should be the facility ID		This is the unique provider ID of the health plan
8	Rendering Provider TIN	112	120	9	Character	The federal tax ID of the provider of service. Tax IDs for providers that are SSNs are not required. However, Tax IDs for medical groups and facilities are necessary.		For doctors and other healthcare providers where a SSN is provided within the TIN Field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
9	Rendering Provider NPI	121	130	10	Character	The National Provider ID number for the provider of service..		
10	Rendering Provider First Name	131	160	30	Character	The description or name corresponding to the servicing Provider ID.		The Provider Name should be specific to the provider and not a group name.
11	Rendering Provider Last Name	161	190	30	Character	The last name corresponding to the servicing Provider ID.		The Provider Name should be specific to the provider and not a group name.
12	Rendering Provider Middle Initial	191	191	1	Character	The middle initial corresponding to the servicing Provider ID.		
13	Rendering Provider Address 1	192	241	50	Character	The current street address1 of the provider of service.		If the provider has multiple addresses, the primary address is preferred.
14	Rendering Provider Address 2	242	271	30	Character	The current street address2 of the provider of service.		If the provider has multiple addresses, the primary address is preferred.
15	Rendering Provider City	272	301	30	Character	The current city of the provider of service.		
16	Rendering Provider State	302	303	2	Character	The current state of the provider of service.		
17	Rendering Provider County Code	304	308	5	Character	FIPS State/County code of the servicing provider		
18	Rendering Provider Zip Code	309	313	5	Character	The 5-digit zip code corresponding to the servicing Provider ID		Provider Location zip code
19	Rendering Provider Zip Plus 4 Code	314	317	4	Character	The 4 digit zip code extension code of the servicing provider		
20	Rendering Provider Type Code Claim	318	321	4	Character	Client-specific code for the provider type on the claim record	Yes	This field should only be used if the provider taxonomy code is not available. Provider Type codes are further defined in the **Data Dictionary to be suppled by the data supplier** (See provider type tab for examples)
21	Referring Provider ID	322	334	13	Character	The ID number of the provider who referred the patient or ordered the test or procedure.		This is the unique provider ID of the health plan

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
22	Referring Provider TIN	335	343	9	Character	The federal tax ID of the Referring provider. Tax IDs for providers that are SSNs are not required. However, Tax IDs for medical groups and facilities are necessary.		For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
23	Referring Provider NPI	344	353	10	Character	The National Provider ID number for the Referring provider.		
24	Referring Provider First Name	354	383	30	Character	The description or name corresponding to the Referring Provider ID.		
25	Referring Provider Last Name	384	413	30	Character	The last name corresponding to the Provider ID.		
26	Referring Provider Middle Initial	414	414	1	Character	The middle initial corresponding to the Referring Provider ID.		
27	Referring Provider Zip Code	415	419	5	Character	The zip code of the provider who referred the patient or ordered the test or procedure.		
28	Referring Provider Zip Plus 4 Code	420	423	4	Character	The 4 digit zip code extension code of the referring provider		
29	Billing Provider ID	424	436	13	Character	The unique ID number of the Billing provider.		This is the unique provider ID of the health plan
30	Billing Provider TIN	437	445	9	Character	The federal tax ID of the billing provider. Tax IDs for providers that are SSNs are not required. However, Tax IDs for medical groups and facilities are necessary.		For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
31	Billing Provider NPI	446	455	10	Character	The National Provider ID number for the billing provider.		
32	Attending Provider ID	456	468	13	Character	The unique ID number of the attending provider.		This is the unique provider ID of the health plan
33	Attending Provider TIN	469	477	9	Character	The federal tax ID of the attending provider. Tax IDs for providers that are SSNs are not required. However, Tax IDs for medical groups and facilities are necessary.		For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
34	Attending Provider NPI	478	487	10	Character	The National Provider ID number for the attending provider.		
35	PCP Provider ID	488	500	13	Character	The unique ID number of the PCP provider.		For doctors and other healthcare providers where a SSN is provided within the TIN Field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
36	PCP Provider TIN	501	509	9	Character	The federal tax ID of the PCP provider. Tax IDs for providers that are SSNs are not required. However, Tax IDs for medical groups and facilities are necessary.		For doctors and other healthcare providers where a SSN is provided within the TIN Field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs on facility claims must be provided.
37	PCP Provider NPI	510	519	10	Character	The National Provider ID number for the PCP provider.		
38	PCP Responsibility Indicator	520	520	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.		"Y" or "N"
39	Adjustment Type Code	521	521	1	Character	This field identifies the type of adjustment for the Medical claim record: • 1 – Adjustment • 2 – Void • 3 – Original or Replacement • 4 – Bulk Adjustment	Yes	Adjustment Type values will be identified in the **Data Dictionary**.
40	Allowed Amount	522	531	10	Numeric	The maximum amount allowed by the plan for payment.		Required for AB-929 Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
41	Bill Type Code UB	532	535	4	Character	The UB-04 standard code for the billing type, indicating type of facility, bill classification, and frequency of bill. Not required on non-embedded dental claims	See Notes	Bill Type values will be identified in the Data Dictionary only if standard NUBC codes are not used.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
42	Capitated Service Indicator	536	536	1	Character	An indicator that this service (encounter record) was capitated		Applicable field values are "Y" for Capitated services and "N" for non-cap services.
43	Charge Submitted	537	546	10	Numeric	The submitted or billed charge amount		Required for AB-929 Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
44	Claim ID	547	596	50	Character	The plan-specific identifier of the claim.		
45	Claim Type Code	597	599	3	Character	Client-specific code for the type of claim		See Claim Type Code tab
46	Coinsurance	600	609	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.		Required for AB-929 Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
47	Copayment	610	619	10	Numeric	The copayment paid by the subscriber as specified by the plan provision.		Required for AB-929 Format 9(8)v99 (2 – digit, implied decimal)
48	Date of Birth	620	629	10	Date	Birth date of the person		MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
49	Date of First Service	630	639	10	Date	The date of the first service reported on the claim record. Not required on non-embedded dental		MM/DD/CCYY Format
50	Date of Last Service	640	649	10	Date	The date of the last service reported on the claim record. Not required on non-embedded dental		MM/DD/CCYY Format
51	Date of Service Facility Detail	650	659	10	Date	The date of service for the facility detail record. Not required on non-embedded dental		MM/DD/CCYY Format
52	Date Paid	660	669	10	Date	The date the claim or data record was finalized or paid. Note: This field is generally referred to as the paid date. If the claim/encounter was not paid, report the remittance date		MM/DD/CCYY format This is the check date or in some cases it can be the file receipt date
53	Days Stay	670	675	6	Numeric	The number of inpatient days for the facility claim. Not required on non-embedded dental		
54	Deductible	676	685	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.		Required for AB-929 Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
55	Diagnosis Code Principal	686	693	8	Character	The first or principal diagnosis code for a service, claim or lab result. Length expanded from 5 to 8 for future use.		No decimal point.
56	Diagnosis Code 2	694	701	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
57	Diagnosis Code 3	702	709	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
58	Diagnosis Code 4	710	717	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
59	Diagnosis Code 5	718	725	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
60	Diagnosis Code 6	726	733	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
61	Diagnosis Code 7	734	741	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
62	Diagnosis Code 8	742	749	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
63	Diagnosis Code 9	750	757	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
64	Diagnosis Code 10	758	765	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
65	Diagnosis Code 11	766	773	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
66	Diagnosis Code 12	774	781	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
67	Diagnosis Code 13	782	789	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
68	Diagnosis Code 14	790	797	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
69	Diagnosis Code 15	798	805	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
70	Diagnosis Code 16	806	813	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
71	Diagnosis Code 17	814	821	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
72	Diagnosis Code 18	822	829	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
73	Diagnosis Code 19	830	837	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
74	Diagnosis Code 20	838	845	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
75	Diagnosis Code 21	846	853	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
76	Diagnosis Code 22	854	861	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
77	Diagnosis Code 23	862	869	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
78	Diagnosis Code 24	870	877	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
79	Diagnosis Code 25	878	885	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use. Not required on non-embedded dental claims		No decimal point.
80	Discharge Status Code UB	886	887	2	Numeric	The UB-04 standard patient status code, indicating disposition at the time of billing. Not required on non-embedded dental claims		
81	Discount Amount	888	897	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions. If not available on the source system, it should be set to the charge submitted amt - charge allowed amt		Required for AB-929 Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
82	Gender Code	898	898	1	Character	Gender of the Patient		Populate as follows: "M" = Male "F" = Female "N" = Non-Binary "U" = Unknown
83	Filler	899	900	2	Character	no longer being used		This field was previously used for the line number. Line number is field 160 in this layout and is 3 bytes in length
84	Net Payment	901	910	10	Numeric	The paid amount for the record		Required for AB-929 Format 9(8)v99 (2 - digit, implied decimal)
85	Network Paid Indicator	911	911	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level		On facility records, this field must be at the service/detail level as opposed to the header/claim level.
86	Network Provider Indicator	912	912	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs		"Y" or "N"
87	Place of Service Code	913	914	2	Character	CMS code for the place of service.		https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set
88	Procedure Code	915	921	7	Character	The procedure code for the service record. Length expanded from 5 to 7 for future use. On dental claims provide the CDT Code (D000 - D9999)		CPT/HCPCS codes for medical, ADA codes for dental
89	Procedure Code UB Surg 1	922	928	7	Character	The primary surgical procedure code (1) on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental claims		ICD-9 or 10 Surgical procedure codes.
90	Procedure Code UB Surg 2	929	935	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental claims		ICD-9 or 10 Surgical procedure codes.
91	Procedure Code UB Surg 3	936	942	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental claims		ICD-9 or 10 Surgical procedure codes.
92	Procedure Code UB Surg 4	943	949	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental claims		ICD-9 or 10 Surgical procedure codes.
93	Procedure Code UB Surg 5	950	956	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental claims		ICD-9 or 10 Surgical procedure codes.
94	Procedure Code UB Surg 6	957	963	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
95	Procedure Code UB Surg 7	964	970	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
96	Procedure Code UB Surg 8	971	977	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
97	Procedure Code UB Surg 9	978	984	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
98	Procedure Code UB Surg 10	985	991	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
99	Procedure Code UB Surg 11	992	998	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
100	Procedure Code UB Surg 12	999	1005	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
101	Procedure Code UB Surg 13	1006	1012	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
102	Procedure Code UB Surg 14	1013	1019	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
103	Procedure Code UB Surg 15	1020	1026	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
104	Procedure Code UB Surg 16	1027	1033	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
105	Procedure Code UB Surg 17	1034	1040	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
106	Procedure Code UB Surg 18	1041	1047	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
107	Procedure Code UB Surg 19	1048	1054	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
108	Procedure Code UB Surg 20	1055	1061	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
109	Procedure Code UB Surg 21	1062	1068	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
110	Procedure Code UB Surg 22	1069	1075	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
111	Procedure Code UB Surg 23	1076	1082	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
112	Procedure Code UB Surg 24	1083	1089	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
113	Procedure Code UB Surg 25	1090	1096	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use. Not required on non-embedded dental		ICD-9 or 10 Surgical procedure codes.
114	Procedure Modifier Code 1	1097	1098	2	Character	The 2-character code of the first procedure code modifier on the professional claim		
115	Procedure Modifier Code 2	1099	1100	2	Character	The 2-character code of the second procedure code modifier on the professional claim		
116	Procedure Modifier Code 3	1101	1102	2	Character	The 2-character code of the third procedure code modifier on the professional claim		
117	Procedure Modifier Code 4	1103	1104	2	Character	The 2-character code of the fourth procedure code modifier on the professional claim		
118	Revenue Code UB	1105	1108	4	Character	The CMS standard revenue code from the facility claim Not required on non-embedded dental		This field must be at the service/detail level.
119	Third Party Amount	1109	1118	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).		Required for AB-929 if available Format 9(8)v99 (2 - digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
120	Units of Service	1119	1122	4	Numeric	Quantity of services or units		
121	Funding Type Code	1123	1123	1	Character	Specifies whether the claim was paid under a fully or self-funded arrangement "F" = fully funded "S" = self funded		Should be set to "F" for Covered California plans
122	Account Structure	1124	1143	20	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Yes	Populate with the values used by the data supplier.
123	HRA Amount	1144	1153	10	Numeric	The amount paid from the HRA as a result of this claim. Not required on non-embedded dental		
124	HSA Amount	1154	1163	10	Numeric	The amount paid from the HSA as a result of this claim. Not required on non-embedded dental		
125	Present on Admission Principal	1164	1164	1	Character	The principal POA code for the facility claim. Indicates whether the principal diagnosis was present on admission. Standard Values: 1 – Unreported/Not Used N – No, not present at admission U – Unknown W – Clinically Undetermined Y – Yes, present at admission Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
126	Present on Admission 02	1165	1165	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
127	Present on Admission 03	1166	1166	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
128	Present on Admission 04	1167	1167	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
129	Present on Admission 05	1168	1168	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
130	Present on Admission 06	1169	1169	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
131	Present on Admission 07	1170	1170	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
132	Present on Admission 08	1171	1171	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
133	Present on Admission 09	1172	1172	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
134	Present on Admission 10	1173	1173	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
135	Present on Admission 11	1174	1174	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
136	Present on Admission 12	1175	1175	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
137	Present on Admission 13	1176	1176	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
138	Present on Admission 14	1177	1177	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
139	Present on Admission 15	1178	1178	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
140	Present on Admission 16	1179	1179	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
141	Present on Admission 17	1180	1180	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
142	Present on Admission 18	1181	1181	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
143	Present on Admission 19	1182	1182	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
144	Present on Admission 20	1183	1183	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
145	Present on Admission 21	1184	1184	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
146	Present on Admission 22	1185	1185	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
147	Present on Admission 23	1186	1186	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
148	Present on Admission 24	1187	1187	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
149	Present on Admission 25	1188	1188	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field. Not required on non-embedded dental	See Notes	If standard values are not used, define in the **Data Dictionary.**
150	DRG MS Payment Code	1189	1191	3	Character	The Diagnosis Related Group (MS-DRG) code under which the claim was paid. Not required on non-embedded dental		
151	ICD Version	1192	1192	1	Character	The ICD version or qualifier code that identifies either ICD-9 (9) or ICD-10 (0) diagnosis and procedure codes on the facility claim. • 9 – ICD-9 • 0 – ICD-10	See Notes	If 0 and 9 not used, values defined in the **Data Dictionary.**
152	Tax Amount	1193	1202	10	Numeric	The amount charged by some states per medical claim.		Required for AB-929 if available Format 9(8)v99 (2 - digit, implied decimal)
153	Tax Type Code	1203	1203	1	Character	Data Supplier specific code identifying the state and/or type of tax.	Yes	
154	NDC Number Code	1204	1214	11	Character	The FDA (Food and Drug Administration) registered number for the drug. Please include for any drugs dispensed in the medical setting if available.		Please leave out the dashes.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
155	Penalty Amount	1215	1224	10	Numeric	Penalty amount on the claim. This could be a charge for a service that was not pre-authorized or a charge for deviation from plan design.		Required for AB-929 if available Format 9(8)v99 (2 - digit, implied decimal)
156	Referral Indicator	1225	1225	1	Character	Indicates if patient was referred		
157	Non-Medicare Paid Amount	1226	1235	10	Numeric	Third party amount, non-Medicare		Required for AB-929 if available Format 9(8)v99 (2 - digit, implied decimal)
158	Withhold Amount	1236	1245	10	Numeric	The amount that is deducted from the payment to the physician group/physician that may or may not be returned depending on specific predetermined factors. This could be an amount being withheld until an agreed upon quality goal is met. This may be part of an ACO agreement.		Required for AB-929 if available Format 9(8)v99 (2 - digit, implied decimal)
159	Rendering Prov Taxonomy	1246	1255	10	Character	Taxonomy code of the rendering provider		The rendering provider taxonomy code as captured on the claim. The provider taxonomy code is preferable to the provider type code (above in the layout) for better reporting consistency.
160	**All Fields in red text have been added to the layout for AB-929** Line Number	1256	1258	3	Numeric	The detail line number for the service on the claim		**All Fields in red text have been added to the layout for AB-929** This field was previously at position 83, but was moved here to accommodate 3 bytes in length
161	OSHPD ID	1259	1269	11	Character	The California Office of Statewide Health Planning and Development-assigned Hospital Identifier. Required on hospital facility claims only (both inpatient and outpatient).		required for Hospital claims added forAB-929
162	On-Exchange Indicator	1270	1270	1	Character	An indicator used to determine if this Patient is on the Covered California exchange or not		Set to: Y = when the patient is on-exchange N = when the patient is off-exchange added for AB-929
163	Plan Number	1271	1290	20	Character	Plan number identifying the plan selected for the patient as assigned by the QHP	Yes	added for AB-929
164	Tooth Code	1291	1292	2	Character	The standard ADA tooth code for the dental claim record. A - J = Primary (Child) Maxillary Patient Right to Left K - T = Primary (Child) Mandibular Patient Left to Right 1 - 16 = Permanent Maxillary Patient Right to Left 17 -32 = Permanent Mandibular Patient Left to Right		Dental claims only. Ensure that the claim type code is set to the code for dental claim for non-embedded dental records; one Tooth Code per claim line
165	Tooth Surface Code	1293	1297	5	Character	ADA tooth anatomy surface code B = Buccal D = Distal F = Facial (or Labial) I = Incisal L = Lingual M = Mesial O = Occlusal		Dental claims only.
166	Patient First Name	1298	1357	60	Character	The patient's first name		added per AB-929 marker field used to set master person ID
167	Patient Last Name	1358	1417	60	Character	The patient's last name		added per AB-929 marker field used to set master person ID
168	Patient Middle Initial	1418	1418	1	Character	The patient's middle initial		added per AB-929 marker field used to set master person ID
169	Patient Address 1	1419	1468	50	Character	The street address of the patient's residence		added per AB-929 marker field used to set master person ID

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
170	Patient Address 2	1469	1498	30	Character	The second part of the patient's residence street address		added per AB-929 marker field used to set master person ID
171	Patient City	1499	1528	30	Character	The city of the residence of the patient		added per AB-929 marker field used to set master person ID
172	Patient State	1529	1530	2	Character	The state code of the residence of the patient		added per AB-929 marker field used to set master person ID
173	Patient Zip Code	1531	1535	5	Character	The 5 digit zip code of the residence of the patient		added per AB-929 marker field used to set master person ID
174	Patient Zip Plus 4	1536	1539	4	Character	The last 4 digits of the 9 digit zip code of the patient		added per AB-929 marker field used to set master person ID
175	Other Patient Insurance Identifier	1540	1564	25	Character	Any other member level insurance identifier (not used at this time)		added per AB-929 marker field used to set master person ID
176	Replaced Claim ID	1565	1614	50	Character	If the source system issues a new claim ID when voiding or adjusting a claim, provide the replaced claim ID here else set to spaces.		added for AB-929
177	Blue Shield Paid Date	1615	1624	10	Date	This fields should only be populated on BSC records. All other data suppliers should set this field to blanks.		
178	Filler	1625	1699	75	Character	Reserved for future use		Fill with blanks
179	Record Type	1700	1700	1	Character	Record type identifier		Hard Code to "D"
End of Layout - Do not remove this row - All field additions to be inserted above the Filler Row								

Medical Claims / Encounters Extract Functional Specifications
Trailer Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Merative Fields							
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Total Net Payments	31	44	14	Numeric	Total net payments on the file	The sum of net payments provided in the file
5	Filler	45	1699	1655	Character	Reserved for future use	Fill with Blanks
6	Record Type	1700	1700	1	Character	Record Type Identifier	Hard Code 'T'

Provider Type Code	Description
1	Acute Care Hospital
5	Ambulatory Surgery Centers
6	Urgent Care Facility
10	Birthing Center
15	Treatment Center
20	Mental Health/Chemical Dep NEC
21	Mental Health Facilities
22	Chemical Depend Treatment Ctr
23	Mental Hlth/Chem Dep Day Care
25	Rehabilitation Facilities
30	Longterm Care (NEC)
31	Extended Care Facility
32	Geriatric Hospital
33	Convalescent Care Facility
34	Intermediate Care Facility
35	Residential Treatment Center
36	Continuing Care Retirement Com
37	Day/Night Care Center
38	Hospice Facility
40	Other Facility (NEC)
41	Infirmary
42	Special Care Facility (NEC)
100	Dentist - MD & DDS (NEC)
105	Dental Specialist
120	Chiropractor/DCM
130	Podiatry
140	Pain Mgmt/Pain Medicine
145	Pediatric Anesthesiology
150	Anesthesiology
160	Nuclear Medicine
170	Pathology
175	Pediatric Pathology
180	Radiology
185	Pediatric Radiology
200	Medical Doctor - MD (NEC)
202	Osteopathic Medicine
204	Internal Medicine (NEC)
206	MultiSpecialty Physician Group
208	Proctology
210	Urology
215	Dermatology
220	Emergency Medicine
225	Hospitalist

Provider Type Code	Description
227	Palliative Medicine
230	Allergy & Immunology
240	Family Practice
245	Geriatric Medicine
250	Cardiovascular Dis/Cardiology
260	Neurology
265	Critical Care Medicine
270	Endocrinology & Metabolism
275	Gastroenterology
280	Hematology
285	Infectious Disease
290	Nephrology
295	Pulmonary Disease
300	Rheumatology
320	Obstetrics & Gynecology
325	Genetics
330	Ophthalmology
340	Otolaryngology
350	Physical Medicine & Rehab
355	Plastic/Maxillofacial Surgery
360	Preventative Medicine
365	Psychiatry
380	Oncology
400	Pediatrician (NEC)
410	Pediatric Specialist (NEC)
413	Pediatric Nephrology
415	Pediatric Ophthalmology
418	Pediatric Orthopaedics
420	Pediatric Otolaryngology
423	Pediatric Critical Care Med
425	Pediatric Pulmonology
428	Pediatric Emergency Medicine
430	Pediatric Allergy & Immunology
433	Pediatric Endocrinology
435	Neonatal-Perinatal Medicine
438	Pediatric Gastroenterology
440	Pediatric Cardiology
443	Pediatric Hematology-Oncology
448	Pediatric Infectious Diseases
450	Pediatric Rheumatology
453	Sports Medicine (Pediatrics)
455	Pediatric Urology
458	Child Psychiatry

Provider Type Code	Description
460	Pediatric Medical Toxicology
500	Surgeon (NEC)
510	Colon & Rectal Surgery
520	Neurological Surgery
530	Orthopaedic Surgery
535	Abdominal Surgery
540	Cardiovascular Surgery
545	Dermatologic Surgery
550	General Vascular Surgery
555	Head and Neck Surgery
560	Pediatric Surgery (Surgery)
565	Surgical Critical Care
570	Transplant Surgery
575	Traumatic Surgery
580	Cardiothoracic Surgery
585	Thoracic Surgery
805	Dental Technician
810	Dietitian
815	Medical Technician
820	Midwife
822	Nursing Services
824	Psychiatric Nurse
825	Nurse Practitioner
827	Nurse Anesthetist
830	Optometrist
835	Optician
840	Pharmacist
845	Physician Assistant
850	Therapy (Physical)
853	Therapists (Supportive)
855	Therapists (Alternative)
857	Renal Dialysis Therapy
860	Psychologist
865	Acupuncturist
870	Spiritual Healers
900	Health Educator/Agency
905	Transportation
910	Health Resort
915	Hearing Labs
920	Home Health Organiz/Agency
925	Imaging Center
930	Laboratory
935	Pharmacy

Provider Type Code	Description
940	Supply Center
945	Vision Center
950	Public Health Agency
960	Case Manager

Claim Type Code	Description
UB	Facility
HCF	Professional
2	Drug
3	Dental
4	Vision
5	Hearing
7	Life Insurance
10	Long Term Disability (LTD)
11	Short Term Disability (STD)
12	Absenteeism
13	Worker Comp
20	Capitation Payment
21	Administrative Fee
22	Premium Payment
23	Employee Premium Contribution
25	Premium Income (Revenue)
31	Employee Assistance (EAP)
32	Health Risk Appraisal (HRA)
50	Other

Covered California
Drug Functional Specification
03/09/2020

REVISION HISTORY

DATE	AUTHOR	DESCRIPTION OF ACTIVITY
3/4/20	Dan Lopez	Updated description for MAC price, penalty amount, discount amount, withhold amount and replaced claim ID
2/27/20	Dan Lopez	Added new field for replaced claim ID
2/14/20	Dan Lopez	Added expected values and descriptions for indicator fields
1/17/20	Katie Andrada-Bacorn	Updates for AB929 and Brand updating
1/9/20	Dan Lopez	Changed text of fields added for AB-929 to be in red
10/22/19	Dan Lopez	Added new fields for off exchange claims and AB-929
3/16/16	Dan Lopez	Added new field for Pharamcy Name due to data quality reviews
6/12/15	Dan Lopez	Updated following all data summits
6/9/15	Katie Andrada-Bacorn	Updated following initial data summit
5/20/15	Katie Andrada-Bacorn	Added fields to the Detail Layout

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a prescription drug claims file for plan participants administered through the data supplier.

The data will be provided in a fixed-record length, ASCII file format. The layout contains both a Data layout (identified by a D in the Record Type field), as well as a Trailer record layout (identified by a T in the Record Type field).

DATA SUBMISSION

The data will be submitted to Merative via SFTP on a monthly basis. Monthly files should be submitted on or before the agreed upon date of the month following the close of each month.

DEFINITIONS AND DENIED CLAIMS

Prescription drug data are claim records for services that result in direct payment to a pharmacy on a service-specific (for example, prescription-specific) basis.

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

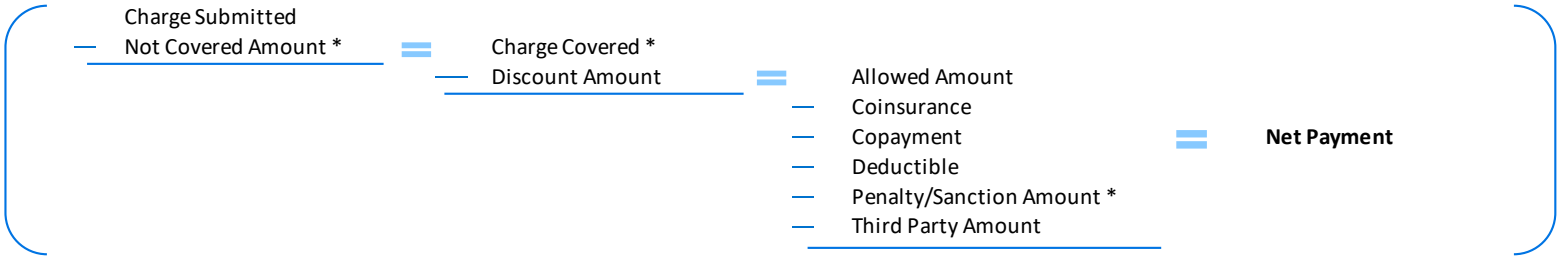
Fully denied claims should be removed from the extract of claims prior to submission, while partially denied claims should be included. Merative defines denied claims as follows:

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

DATA FORMATTING	
CHARACTER FIELDS	• Includes A - Z (lower or upper case), 0 – 9, and spaces • Left justified, right blank/space filled • Unrecorded or missing values in character fields are blank/spaces
NUMERIC FIELDS	• All numeric fields should be right-justified and left zero-filled or left space-filled • Negative signs should be the leading value in the first position • Unrecorded or missing values in numeric fields should be set to zero
FINANCIAL FIELDS	• All financial fields should be right-justified and left zero-filled or left space-filled • Merative prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data For example: "1234567" would represent $12,345.67 *Please do not include an actual decimal point in the data.* • Negative signs should be the leading value in the first position For example: "-1234567" would represent -$12,345.67 • Unrecorded or missing values in numeric fields should be zero
INVALID CHARACTERS	Please note that the following characters should not be included in the data or the descriptions in the data dictionary. * ! ? % _ (under score) , (comma)

FINANCIAL RELATIONSHIP

Merative defines the relationship among financial fields as follows. Those marked with an asterisk are desirable, but not required for the data extract.



CORRECTIONS TO PAID CLAIMS

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

VOID/REPLACEMENT

A **void** is a claim that reverses or backs out a previously paid one. All financials and quantities are negated on the void record. A replacement record that contains the corrected information generally follows it. The original, void and replacement need not appear in the same file.

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

Record Type	Svc Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	$ 75.00	$ 25.00	$ -	$ 50.00
Void	-1	$ (75.00)	$ (25.00)	$ -	$ (50.00)
Replacement	1	$ 75.00	$ 10.00	$ -	$ 65.00

ADJUSTMENT

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

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

Record Type	Svc Count	Charge Submitted	Copay	Deductible	Net Payment
Original	1	$ 75.00	$ 25.00	$ -	$ 50.00
Adjustment	0	$ -	$ (15.00)	$ -	$ 15.00

Drug Claims Extract Functional Specifications
Detail Layout

***Note: Selections of Rows or Columns for each action must be made **after** pressing the desired button.

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
1	**Note: all fields highlighted in green will be used to set the master person ID** Subscriber SSN	1	9	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder) and their associated dependents.		**Note: all fields highlighted in green will be used to set the master person ID** Required per AB-929 if available marker field used to set master person ID
2	CC Subscriber ID	10	29	20	Character	Unique code assigned by CC to the subscriber		marker field used to set master person ID
3	Member SSN	30	38	9	Character	The patient's Social Security Number		Required per AB-929 if available marker field used to set master person ID
4	CC_MemberID	39	58	20	Character	The patient member ID as assigned by Covered California		marker field used to set master person ID
5	Plan_MemberID	59	78	20	Character	Unique code assigned by health plan to identify the patient		Required per AB-929 marker field used to set master person ID
6	Policy ID	79	98	20	Character	Identifier of the individual policy for the patient as assigned by health plan		Required per AB-929 marker field used to set master person ID
7	Claim ID	99	148	50	Character	The client-specific identifier of the claim.		
8	Date of Birth	149	158	10	Date	The birth date of the member.		MM/DD/CCYY format The member's birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
9	Gender Code	159	159	1	Character	The member's gender code.		"M" or "F" The member's gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
10	Adjustment Type Code	160	160	1	Character	This field identifies the type of adjustment for the Rx claim record: • 1 – Adjustment • 2 – Void • 3 – Original or Replacement • 4 – Bulk Adjustment	Yes	Adjustment Type values will be identified in the **Data Dictionary**.
11	Allowed Amount	161	170	10	Numeric	The maximum amount allowed by the plan for payment.		Required for AB-929 Format 9(8)v99 (2 - digit, implied decimal)
12	Charge Submitted	171	180	10	Numeric	The submitted or billed charge amount		Required for AB-929 Format 9(8)v99 (2 - digit, implied decimal)
13	Claim Type Code	181	183	3	Character	Hard code to "2" for drug.		
14	Coinsurance	184	193	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.		Required for AB-929 Format 9(8)v99 (2 - digit, implied decimal)
15	Copayment	194	203	10	Numeric	The copayment paid by the subscriber as specified in the plan provision.		Required for AB-929 Format 9(8)v99 (2 - digit, implied decimal)
16	Date of Service	204	213	10	Date	The date of service for the drug claim.		MM/DD/CCYY format
17	Date Paid	214	223	10	Date	The date the claim or data record was paid.		MM/DD/CCYY format This is the check date.
18	Days Supply	224	227	4	Numeric	The number of days of drug therapy covered by the prescription.		
19	Deductible	228	237	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.		Required for AB-929 Format 9(8)v99 (2 - digit, implied decimal)
20	Dispensing Fee	238	247	10	Numeric	An administrative fee charged by the pharmacy for dispensing the prescription.		Required for AB-929 if available Format 9(8)v99 (2 - digit, implied decimal)
21	Formulary Indicator	248	248	1	Character	An indicator that the prescription drug is included in the formulary.		Y - on formulary N - not on formulary

Drug Claims Extract Functional Specifications
Detail Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
22	Ingredient Cost	249	258	10	Numeric	The charge or cost associated with the pharmaceutical product.		Required for AB-929 Format 9(8)v99 (2 - digit, implied decimal)
23	Metric Quantity Dispensed	259	269	11	Numeric	The number of units dispensed for the prescription drug claim, as defined by the NCPDPD (National Council for Prescription Drug Programs) standard format.		Format 9(8)v999 (3 - digit, implied decimal)
24	NDC Number Code	270	280	11	Character	The FDA (Food and Drug Administration) registered number for the drug, as reported on the prescription drug claims.		Please leave out the dashes.
25	Net Payment	281	290	10	Numeric	The actual check amount for the record		Required for AB-929 Format 9(8)v99 (2 - digit, implied decimal)
26	Network Paid Indicator	291	291	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level.		Y - paid at network level N -paid at out of network level
27	Network Provider Indicator	292	292	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs.		Y - servicing provider is in network N -servicing provider is out of network level
28	PCP Responsibility Indicator	293	293	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.		Y - PCP is the responsible physician for this service N -PCPis not the responsible physican for this service
29	Pharmacy NPI Number	294	303	10	Character	The National Provider Identifier for the pharmacy.		
30	Pharmacy Provider ID	304	316	13	Character	The identifier for the provider of service.		This should be the NCPDP (National Council for Prescription Drug Programs) number. (Note: The pharmacy NPI is collected in field #28 in this layout.)
31	Pharmacy Name	317	356	40	Character	The name of the pharmacy where the prescription was filled.		3/15/16 - Added this field to the layout
32	Pharmacy Address 1	357	406	50	Character	The first line of the address for the pharmacy.		
33	Pharmacy Address 2	407	436	30	Character	The second line of the address for the pharmacy.		
34	Pharmacy County	437	441	5	Character	The FIPS state/county code for the pharmacy.		
35	Pharmacy City	442	471	30	Character	The city for which the pharmacy resides.		
36	Pharmacy State	472	473	2	Character	The state in which the pharmacy resides.		
37	Pharmacy Zip	474	478	5	Character	The zip code of the pharmacy		
38	Pharmacy Zip Plus 4 Code	479	482	4	Character	The zip plus 4 code of the pharmacy		
39	Referring Provider ID	483	495	13	Character	The ID number of the provider who prescribed the drug.		
40	Referring Provider First name	496	525	30	Character	The First Name of the provider who referred the patient or ordered the test or procedure.		
41	Referring Provider Last Name	526	555	30	Character	The Last Name of the provider who referred the patient or ordered the test or procedure.		
42	Referring Provider Middle Initial	556	556	1	Character	The Middle Initial of the provider who referred the patient or ordered the test or procedure.		
43	Referring Provider Address 1	557	606	50	Character	The first line of the Referring provider's address		
44	Referring Provider Address 2	607	636	30	Character	The second line of the Referring provider's address		
45	Referring Provider City	637	666	30	Character	The Referring provider's city		
46	Referring Provider State	667	668	2	Character	The Referring provider's state		
47	Referring Provider Zip Code	669	673	5	Character	The zip code of the provider who referred the patient or ordered the test or procedure.		
48	Referring Provider Zip Plus 4 Code	674	677	4	Character	The zip plus 4 code of the Referring Provider		

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
49	Referring Provider NPI	678	687	10	Character	Referring Provider Submitted National Provider Identifier Type 1		
50	Referring Provider DEA number	688	699	12	Character	The DEA Number of the referring provider		
51	Referring Provider TIN	700	708	9	Character	The Tax ID of the referring provider. Tax IDs for providers that are SSNs are not required. However, Tax IDs for Medical Groups and Facilities are necessary.		For doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record.
52	Rx Dispensed as Written Code	709	709	1	Character	The NCPDP (National Council for Prescription Drug Programs) industry standard code that indicates how the product was dispensed.		
53	Rx Mail or Retail Code	710	710	1	Character	The Merative standard code indicating the purchase place of the prescription. "M" for Mail, "R" for Retail		"M" for Mail, "R" for Retail
54	Rx Payment Tier	711	711	1	Character	This field identifies the type of payment tier for the Rx claim record: • 1 – Generic • 2 – Brand Formulary • 3 – Brand Non Formulary • 4 –Specialty Drug • 5 –ACA Preventive Medication		
55	Rx Refill Number	712	715	4	Numeric	A number indicating the original prescription or the refill number.		This is the refill number, not the number of refills remaining.
56	Tax Amount	716	725	10	Numeric	The amount of sales tax applied to the cost of the prescription.		Required for AB-929 if available Format 9(8)v99 (2 - digit, implied decimal)
57	Third Party Amount	726	735	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).		Required for AB-929 if available Format 9(8)v99 (2 - digit, implied decimal)
58	Discount Amount	736	745	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions. If not available on the source system, it should be set to the charge submitted amt - charge allowed amt		Required for AB-929 Format 9(8)v99 (2 - digit, implied decimal)
59	Funding Type Code	746	746	1	Character	Specifies whether the claim was paid under a fully or self-funded arrangement		Required per AB-929
60	Account Structure	747	766	20	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.	Yes	Populate with the values used by the data supplier.
61	HRA Amount	767	776	10	Numeric	The amount paid from the HRA to pay the provider.		Provide only if applicable to the plan type and if available
62	HSA Amount	777	786	10	Numeric	The financial amount of the healthcare savings account for consumer-driven health plans		Provide only if applicable to the plan type and if available
63	Compound Code	787	787	1	Character	This field identifies the type of compound for an Rx claim record where a compound is used: • 0 – Not Specified • 1 – Not a Compound • 2 – Compound		This should be the NCPDP values
64	Excess Copayment Amount	788	797	10	Numeric	The amount paid by the patient outside of the flat copayment amount. Examples include when the patient chooses brand name instead of the generic alternative or non-formulary drug instead of the formulary option.		Required for AB-929 if available Format 9(8)v99 (2 - digit, implied decimal)
65	Capitation Indicator	798	798	1	Character	Service is/is not capitated (Y/N)		Y - service is paid under a capitated arrangement N -service is not paid under a capitated arrangement
66	NABP Number	799	808	10	Character	National Association of Boards of Pharmacy Number		

Drug Claims Extract Functional Specifications
Detail Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
67	MAC Price	809	818	10	Numeric	The maximum acquisition cost price. MAC prices are the upper limits that a pharmacy benefit manager ("PBM") or prescription drug benefit plan will pay a pharmacy for generic drugs and brand name drugs that have generic versions available (multi-source brands).		Required for AB-929 Format 9(8)v99 (2 - digit, implied decimal)
68	Penalty Amount	819	828	10	Numeric	The penalty amount on the claim. This can be any penalty charged to the patient due to a deviation from plan design or authorization.		Required for AB-929 if avalable Format 9(8)v99 (2 - digit, implied decimal)
69	Withhold Amount	829	838	10	Numeric	The amount withheld from payment. This can be any amount withheld from payment to the pharmacy/provider. As an example, this could be payment held until a particular quality measure or goal is met.		Required for AB-929 if available Format 9(8)v99 (2 - digit, implied decimal)
70	Referring Provider Taxonomy	839	848	10	Character	The Taxonomy code of the prescribing physician		
71	**All Fields in red text have been added to the layout for AB-929** On-Exchange Indicator	849	849	1	Character	An indicator used to determine if this patient is on the Covered California exchange or not		**All Fields in red text have been added to the layout for AB-929** Set to: Y = the patient is on-exchange N = the patient is off-exchange added for AB-929
72	Plan Number	850	869	20	Character	Plan number identifying the plan of the patient as assigned by the QHP	Yes	added for AB-929
73	Patient First Name	870	929	60	Character	The patient's first name		added per AB-929 marker field used to set master person ID
74	Patient Last Name	930	989	60	Character	The patient's last name		added per AB-929 marker field used to set master person ID
75	Patient Middle Initial	990	990	1	Character	The patient's middle initial		added per AB-929 marker field used to set master person ID
76	Patient Address 1	991	1040	50	Character	The street address of the residence of the patient		added per AB-929 marker field used to set master person ID
77	Patient Address 2	1041	1070	30	Character	The second part of the street address of the patient		added per AB-929 marker field used to set master person ID
78	Patient City	1071	1100	30	Character	The city of the residence of the patient		added per AB-929 marker field used to set master person ID
79	Patient State	1101	1102	2	Character	The state code of the residence of the patient		added per AB-929 marker field used to set master person ID
80	Patient Zip Code	1103	1107	5	Character	The 5 digit zip code of the residence of the patient		added per AB-929 marker field used to set master person ID
81	Patient Zip Plus 4	1108	1111	4	Character	The last 4 digits of the 9 digit zip code of the patient		added per AB-929 marker field used to set master person ID
82	Other Patient Insurance Identifier	1112	1136	25	Character	Any other member level insurance identifier (not used at this time)		added per AB-929 marker field used to set master person ID"
83	Replaced Claim ID	1137	1186	50	Character	If the source system issues a new claim ID when voiding or adjusting a claim, provide the replaced claim ID here else set to spaces.		added fpr AB-929
84	Filler	1187	1199	13	Character	Reserved for future use		Fill with blanks
85	Record Type	1200	1200	1	Character	Record type identifier		Hard Code to "D"
End of Layout - Do not remove this row - All field additions to be inserted above the Filler Row								

Drug Claims Extract Functional Specifications
Trailer Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Merative Fields							
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Total Net Payments	31	44	14	Numeric	Total net payments on the file	The sum of net payments provided in the file
5	Filler	45	1199	1155	Character	Reserved for future use	Fill with Blanks
6	Record Type	1200	1200	1	Character	Record Type Identifier	Hard Code 'T'

Covered California
Capitation Functional Specification
01/26/2022

REVISION HISTORY

DATE	AUTHOR	DESCRIPTION OF ACTIVITY
1/26/22	Dan Lopez	Updated general tab to reflect monthly submission of cap files for both Medical and Dental data
9/30/21	Dan Lopez	Updated to include Dental data
3/9/20	Dan Lopez	Added more detailed description for Withhold Amount field.
2/17/20	Dan Lopez	Added expected values for indicator fields
1/17/20	Katie Andrada-Bacorn	Updated fields for AB-929 and brand updates
1/7/20	Dan Lopez	Further Clarification on AB-929 fields
12/2/19	Dan Lopez	Updated for AB-929
6/12/15	Dan Lopez	Updated based on all data summits
5/27/15	Katie Andrada-Bacorn	Updated descriptions based on data summit
5/21/15	Katie Andrada-Bacorn	Initial Documentation

DESCRIPTION/GENERAL INFORMATION

This interface is designed to capture monthly capitation claims. Specifically, this will contain a monthly record for each capitation payment.

The data will be provided in a fixed-record length, ASCII file format. The layout contains both a Data layout (identified by a D in the Record Type field), as well as a Trailer record layout (identified by a T in the Record Type field).

DATA SUBMISSION

QHPs and QDPs - The data will be submitted to Merative via SFTP on a monthly basis. Monthly files should be submitted on or before the scheduled due date following the close of each month.

- **Historical/Implementation** – Initially, Merative is interested in receiving historical data. Historical data can be submitted in annual or quarterly files encompassing all the financial transactions for the full history timeframe requested.
- **Ongoing** – The financial files will be submitted by the data supplier to Merative on a monthly basis, on or before the agreed upon date of the month following the close of each month.

DEFINITIONS AND DISCUSSION ITEMS

- Capitation payments contain information regarding payments made to a physician, facility, or other provider for a pre-determined set of services, regardless if the services are rendered to the enrollee. When services are rendered, an encounter record should be included in the medical claims data.
- Person-level information is preferred; such as, one record contains payment information per person per month
- Provider detail information is also preferred
- **QHPs** - This file should contain a record/transaction for each capitation payment made by the data supplier for the covered (medical coverage) population.
- **QDPs** - This file should contain a record/transaction for each capitation payment made by the data supplier for the covered (dental coverage) population.

DATA FORMATTING	
CHARACTER FIELDS	• Includes A - Z (lower or upper case), 0 – 9, and spaces • Left justified, right blank/space filled • Unrecorded or missing values in character fields are blank/spaces
NUMERIC FIELDS	• All numeric fields should be right-justified and left zero-filled • Unrecorded or missing values in numeric fields should be set to zero
FINANCIAL FIELDS	• All financial fields should be right-justified and left zero-filled • Merative prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data For example: "1234567" would represent $12,345.67 *Please do not include an actual decimal point in the data.* • Negative signs should be the leading value in the first position For example: "-001234567" would represent -$12,345.67 • Unrecorded or missing values in numeric fields should be zero
INVALID CHARACTERS	Please note that the following characters should not be included in the data or the descriptions in the data dictionary. * ! ? % _ (under score) , (comma)

Capitation Extract Functional Specifications
Detail Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Merative Fields								
1	**Note: all fields highlighted in green will be used to set the master person ID** Subscriber SSN	1	9	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.		**Note: all fields highlighted in green will be used to set the master person ID** Required per AB-929 marker field used to set master person ID
2	CC SubscriberID	10	29	20	Character	Unique code assigned by CC to the subscriber		marker field used to set master person ID
3	Enrollee SSN	30	38	9	Character	Member's Social Security Number		Required per AB-929 marker field used to set master person ID
4	CC MemberID	39	58	20	Character	Unique code assigned by CC to the member		marker field used to set master person ID
5	Plan MemberID	59	78	20	Character	Unique code assigned by health plan to identify a member		Required per AB-929 marker field used to set master person ID
6	Policy ID	79	98	20	Character	Policy ID assigned by health plan		Required per AB-929 marker field used to set master person ID
7	Capitation Amount	99	108	10	Numeric	The pre-paid amount paid to plans or providers under risk-based managed care contracts.		Required for AB-929 Format 9(8)v99 (2 - digit, implied decimal)
8	Capitation Type Code	109	109	1	Character	This field identifies the type of capitation payment record: • 1 – Professional • 2 – Facility • 3 – Mental Health • 4 – Drug • 5 – Dental • 6 – Vision • 7 – Hearing • 8 – Blended		
9	Date Paid	110	119	10	Date	The date the transaction was paid.		MM/DD/YYYY Format
10	Date of Service	120	129	10	Date	The date/period of service for the transaction. If the period of service is a month, this can be populated with the first day of that month.		MM/DD/YYYY Format
11	Gender Code	130	130	1	Character	The member's gender code.		M = Male F = Female N = Non-Binary U = Unknown
12	Date of Birth	131	140	10	Date	The birth date of the person.		MM/DD/YYYY format
13	Adjustment Type Code	141	141	1	Character	This field identifies the type of adjustment for the capitation payment record: • 1 – Adjustment • 2 – Void • 3 – Original or Replacement • 4 – Bulk Adjustment		
14	Provider Type Code	142	144	3	Character	This field contains the provider specialty code. This field only needs to be populated if the provider taxonomy code is not available.		See the Provider Type tab
15	Provider TIN	145	157	13	Character	The unique identifier for the provider. Providers include facilities, physicians, PCPs, pharmacies, and professionals.		For Doctors and other healthcare providers where SSN is provided within the TIN field, there is no need to provide a value within the TIN field, as long as the corresponding NPI is populated on that record. However, TINs should be provided on payments to a facility.
16	Provider NPI	158	167	10	Character	The National Provider Identifier for the provider.		

Capitation Extract Functional Specifications
Detail Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Standard Merative Fields								
17	Withhold Amount	168	177	10	Numeric	The amount that is deducted from the payment to the physician group/physician that may or may not be returned depending on specific predetermined factors. This could be an amount being withheld until an agreed upon quality goal is met. This may be part of an ACO agreement.		Required for AB-929 if available Format 9(8)v99 (2 - digit, implied decimal)
18	Provider Taxonomy	178	187	10	Character	The taxonomy code of the provider of payment		
19	**All Fields in red text have been added to the layout for AB-929** On-Exchange Indicator	188	188	1	Character	An indicator used to determine if this enrollee is on the Covered California exchange or not		**All Fields in red text have been added to the layout for AB-929** Added per AB-929 Set to: Y = when the enrollee record is on-exchange N = when the enrollee record is off-exchange
20	Plan Number	189	208	20	Character	Plan number identifying the plan selected by the enrollee as assigned by the QHP or QDP. This is the internal plan ID		added per AB-929
21	Enrollee First Name	209	268	60	Character	The enrollee's first name		added per AB-929 marker field used to set master person ID
22	Enrollee Last Name	269	328	60	Character	The enrollee's last name		added per AB-929 marker field used to set master person ID
23	Enrollee Middle Initial	329	329	1	Character	The enrollee's middle initial		added per AB-929 marker field used to set master person ID
24	Enrollee Address 1	330	379	50	Character	The street address of the enrollee		added per AB-929 marker field used to set master person ID
25	Enrollee Address 2	380	409	30	Character	The second part of the street address of the enrollee		added per AB-929 marker field used to set master person ID
26	Enrollee City	410	439	30	Character	The city of the residence of the enrollee		added per AB-929 marker field used to set master person ID
27	Enrollee State	440	441	2	Character	The state code of the residence of the enrollee		added per AB-929 marker field used to set master person ID
28	Enrollee Zip Code	442	446	5	Character	The 5 digit zip code of the residence of the enrollee		added per AB-929 marker field used to set master person ID
29	Enrollee Zip Plus 4	447	450	4	Character	The last 4 digits of the 9 digit zip code of the enrollee		added per AB-929 marker field used to set master person ID
30	Other Member Insurance Identifier	451	475	25	Character	Any other member level insurance identifier (not used at this time)		added per AB-929 marker field used to set master person ID
31	Filler	476	699	224	Character	Reserved for future use		Fill with blanks
32	Record Type	700	700	1	Character	Record type identifier		Hard Code to "D"

Capitation Extract Functional Specifications
Trailer Layout

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Standard Merative Fields							
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Total Net Payments	31	44	14	Numeric	Total net payments on the file	The sum of net payments provided in the file
5	Filler	45	699	655	Character	Reserved for future use	Fill with Blanks
6	Record Type	700	700	1	Character	Record Type Identifier	Hard Code 'T'

Provider Type Code	Description
1	Acute Care Hospital
5	Ambulatory Surgery Centers
6	Urgent Care Facility
10	Birthing Center
15	Treatment Center
20	Mental Health/Chemical Dep NEC
21	Mental Health Facilities
22	Chemical Depend Treatment Ctr
23	Mental Hlth/Chem Dep Day Care
25	Rehabilitation Facilities
30	Longterm Care (NEC)
31	Extended Care Facility
32	Geriatric Hospital
33	Convalescent Care Facility
34	Intermediate Care Facility
35	Residential Treatment Center
36	Continuing Care Retirement Com
37	Day/Night Care Center
38	Hospice Facility
40	Other Facility (NEC)
41	Infirmary
42	Special Care Facility (NEC)
100	Dentist - MD & DDS (NEC)
105	Dental Specialist
120	Chiropractor/DCM
130	Podiatry
140	Pain Mgmt/Pain Medicine
145	Pediatric Anesthesiology
150	Anesthesiology
160	Nuclear Medicine
170	Pathology
175	Pediatric Pathology
180	Radiology
185	Pediatric Radiology
200	Medical Doctor - MD (NEC)
202	Osteopathic Medicine
204	Internal Medicine (NEC)
206	MultiSpecialty Physician Group
208	Proctology
210	Urology
215	Dermatology
220	Emergency Medicine
225	Hospitalist
227	Palliative Medicine

Provider Type Code	Description
230	Allergy & Immunology
240	Family Practice
245	Geriatric Medicine
250	Cardiovascular Dis/Cardiology
260	Neurology
265	Critical Care Medicine
270	Endocrinology & Metabolism
275	Gastroenterology
280	Hematology
285	Infectious Disease
290	Nephrology
295	Pulmonary Disease
300	Rheumatology
320	Obstetrics & Gynecology
325	Genetics
330	Ophthalmology
340	Otolaryngology
350	Physical Medicine & Rehab
355	Plastic/Maxillofacial Surgery
360	Preventative Medicine
365	Psychiatry
380	Oncology
400	Pediatrician (NEC)
410	Pediatric Specialist (NEC)
413	Pediatric Nephrology
415	Pediatric Ophthalmology
418	Pediatric Orthopaedics
420	Pediatric Otolaryngology
423	Pediatric Critical Care Med
425	Pediatric Pulmonology
428	Pediatric Emergency Medicine
430	Pediatric Allergy & Immunology
433	Pediatric Endocrinology
435	Neonatal-Perinatal Medicine
438	Pediatric Gastroenterology
440	Pediatric Cardiology
443	Pediatric Hematology-Oncology
448	Pediatric Infectious Diseases
450	Pediatric Rheumatology
453	Sports Medicine (Pediatrics)
455	Pediatric Urology
458	Child Psychiatry
460	Pediatric Medical Toxicology
500	Surgeon (NEC)

Provider Type Code	Description
510	Colon & Rectal Surgery
520	Neurological Surgery
530	Orthopaedic Surgery
535	Abdominal Surgery
540	Cardiovascular Surgery
545	Dermatologic Surgery
550	General Vascular Surgery
555	Head and Neck Surgery
560	Pediatric Surgery (Surgery)
565	Surgical Critical Care
570	Transplant Surgery
575	Traumatic Surgery
580	Cardiothoracic Surgery
585	Thoracic Surgery
805	Dental Technician
810	Dietitian
815	Medical Technician
820	Midwife
822	Nursing Services
824	Psychiatric Nurse
825	Nurse Practitioner
827	Nurse Anesthetist
830	Optometrist
835	Optician
840	Pharmacist
845	Physician Assistant
850	Therapy (Physical)
853	Therapists (Supportive)
855	Therapists (Alternative)
857	Renal Dialysis Therapy
860	Psychologist
865	Acupuncturist
870	Spiritual Healers
900	Health Educator/Agency
905	Transportation
910	Health Resort
915	Hearing Labs
920	Home Health Organiz/Agency
925	Imaging Center
930	Laboratory
935	Pharmacy
940	Supply Center
945	Vision Center
950	Public Health Agency

Provider Type Code	Description
960	Case Manager