2. ADDENDUMS

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ADDENDUM 1

PLAN UTILIZATION AND RATE REVIEW INFORMATION

NAME OF PLAN: _____

SERVICE AREA COVERED: _____

PREMIUM RATES BASED ON:
COMMUNITY RATED EXPERIENCE
STATE EMPLOYEE EXPERIENCE*
LOCAL EMPLOYEE EXPERIENCE*
OTHER (PLEASE SPECIFY BASIS)
* USE SEPARATE ADDENDUM 1 PAGES

This Rate Review information shall be provided June 3, 2016. It must be submitted directly to the Board's Actuary in the prescribed Excel format via e-mail. The accompanying data shall also be submitted on the same date in the prescribed format via a secure file transfer.

The Department will provide written guidelines to the plan concerning the definitions, group numbers or subgroups, report period, and other information required to prepare this report. Additional data may be required on different subgroups (COBRA participants, for example) throughout the contract year.

STATE OF WISCONSIN
ACTUARIAL DATA REPORT
GENERAL TABLE DESCRIPTION

Based upon the membership, experience data, trend assumptions, and assumed administrative costs provided, the data and calculations provided in TABLES 1-15 of the Addendum 1 utilization and experience data request calculate prospective premium rates for calendar year 2017. Any plan for which proposed calendar year 2017 premium rates differ from those developed in Addendum 1 TABLES 1-15 will be required to submit its justification and applicable renewal calculation.

TABLE 1 - MONTHLY ENROLLMENT AND PREMIUMS

TABLE 1 will calculate average contract size and contract mix figures based upon data provided. The number of member months and contracts for the period 1/1/2015-3/31/2016 should be input for single coverage in Columns B and C and for family coverage in Columns D and E.

The contractual premium rates by coverage tier should be entered on line 30. Row 31 should be the dental benefit component of the premium applicable to the prior dental benefit. Row 32 should include any other adjustments that may have been made to the contractual premium rates. The net premium is calculated on row 33 as row 30 less rows 31 and 32.

The remainder of the worksheet will auto calculate, including rows 43-44 that calculate average contract size and mix for single and family coverage.

TABLE 2 - ENROLLMENT AND MEMBER MONTHS BY AGE AND SEX

The first section of TABLE 2 requests the member counts for the period of 4/1/2015-3/31/2016 by age group and sex (regardless of whether the member is an employee or a dependent).

The second section of TABLE 2 requests the member counts for December 2015 by age group and sex (regardless of whether the member is an employee or a dependent).

The third section of TABLE 2 requests the member counts for March 2016 by age group and sex (regardless of whether the member is an employee or a dependent).

A box at the bottom of TABLE 2 will show the automatically calculated average age and average age/sex factor.

The age calculation should be based on the employee or dependent's age on the first day of the month.

All counts should reconcile to TABLE 1.

TABLE 3 - ACTUARIAL DATA REPORTS

TABLE 3A: APRIL 1, 2015 THROUGH MARCH 31, 2016 FEE FOR SERVICE CLAIMS
TABLE 3B: APRIL 1, 2015 THROUGH MARCH 31, 2016 CAPITATION ENCOUNTER

GENERAL DESCRIPTION

TABLE 3 requests fee for service claims and capitation encounter experience information for all health plans, whether they are experience rated or fully or partially capitated. There are separate sections for medical fee for service and capitation encounter data (TABLES 3A and 3B, respectively). Please complete those portions of the data request that are applicable to your type of plan.

- Category: One report is requested for each of the following eight categories:
  - i. State of Wisconsin Employee Plan, Non-Medicare, Non Graduate Assistant
  - ii. State of Wisconsin Employee Plan, Medicare
  - iii. State of Wisconsin Employee Plan, Graduate Assistant
  - iv. State of Wisconsin Local Plan, Non-Medicare
  - v. State of Wisconsin Local Plan, Medicare
  - vi. State of Wisconsin High Deductible Plan
  - vii. Total Organization, Non-Medicare/Commercial
  - viii. Total Organization, Medicare

  A title worksheet is included in the first tab of the workbook. Use the dropdown box to specify the category of each report.

  For the Medicare lines of business (State & Local), the experience and membership provided should include only those members who are Medicare-eligible (no non-Medicare

eligible spouses or other dependents). Please respond to the questions in TABLE 11 and indicate if this is not the case.

Please note that the Total Organization refers to all commercial group business for your organization, including the State of Wisconsin but excluding Medicaid participants. If you offer more than one plan option to either Non-Medicare or Medicare State of Wisconsin Employee or Local Plan participants, please include a separate report for each option.

- Report Period

  The report should include all services rendered from April 1, 2015 through March 31, 2016.

- Benefit Description

  Refer to the section immediately following for a detailed description of services to be included in each benefit category. If you are unable to follow these definitions, indicate the reason why and the actual definition used.

- Total Number of Admissions

  For hospital inpatient services, the total number of admissions rendered for all members during the Report Period.

- Total Number of Days

  For hospital inpatient services, the total number of hospital days rendered for all members during the Report Period.

- Total Billed Charges

  For all services, the total billed charges. Billed charges are defined as undiscounted charges for covered services during the requested Report Period. The experience should not include any billed charges for services not covered by the plan, The experience should also not include any adjustments for incurred but not reported claims; see Incurred Claim Factor below.

- Total Allowed Charges

  For all services, the total allowed charges. Allowed charges are defined as discounted charges for covered services during the requested Report Period. The experience should not include any allowed charges for services not covered by the plan. The experience should also not include any adjustments for incurred but not reported claims; see Incurred Claim Factor below.

- Total COB (including Medicare)

  For all services, the total amount paid for covered services by another carrier or Medicare through coordination of benefits during the requested Report Period.

- Total Member Cost Share

  For all services, the total member cost share. Member cost share is defined as any participant/member liabilities such as copayments, coinsurance or deductibles applicable for covered services during the requested Report Period.

- Total Paid Charges

  For all services, the total paid claims. Paid claims are defined as discounted charges net of employee cost-sharing during the requested Report Period. In other words, the experience should not include any participant/member liabilities such as copayments, coinsurance or deductibles. The experience should also not include any adjustments for incurred but not reported claims; see Incurred Claim Factor below.

- Total Number of Member Months

  The Total Number of Member Months is the number of months each member and dependent is eligible for benefits during the Report Period. Please note that this cell is linked to the total 4/1/2015-3/31/2016 member months from TABLE 1.

- Annual Admissions Per 1,000

  For hospital inpatient services, calculated as the total Number of Admissions divided by the Total Number of Member Months, times 12,000.

- Annual Days Per 1,000

  For hospital inpatient services, calculated as the Total Number of Days divided by the Total Number of Member Months, times 12,000.

- Average Length of Stay

  For hospital inpatient services, calculated as the Total Number of Days divided by Total Number of Admissions.

- Average Paid Charges Per Day

  For hospital inpatient services, calculated as Total Paid Charges divided by the Total Number of Days.

- Average Paid Charges Per Member Per Month

  Calculated as Total Paid Charges divided by the Total Number of Member Months.

- Total Number of Services

  For non-hospital inpatient services, the total number of services rendered for all members during the Report Period. Please note the services are defined in the Benefit Description section.

- Annual Services Per 1,000

  For non-hospital inpatient services, calculated as Total Number of Services divided by the total Number of Member Months, times 12,000.

- Average Paid Charges Per Service

  For non-hospital inpatient services, calculated as the Total Paid Charges divided by the Total Number of Services.

- Fee For Service Incurred Claim Factor

  This factor is the estimated percentage of paid claims for the specified Reporting Period that have not yet been recorded or paid. Incurred Claims will be calculated as (1 + Incurred Claim Factor) multiplied by the Total Paid Charges.

- Number of Runout Months

  This is the number of months of experience that have been included in Paid Charges beyond the specific incurred Reporting Period of 4/1/2015-3/31/2016. For example, if a plan includes experience for claims that were incurred from 4/1/2015-3/31/2016 and paid through 5/31/2016, the Number of Runout Months would equal two, and the Incurred Claim Factor should be reflective of the Number of Runout Months.

- Incurred Fee For Service Total

  Incurred claims will be calculated as (1 + Incurred Claim Factor) multiplied by the Paid Charges. This represents the total amount of claims that have been incurred in the Reporting Period.

- Total Capitation Paid

  The total capitation payments paid during the Report Period. This will calculate automatically from Total Paid Capitation during the Report Period entered on Table 4.

BENEFIT DESCRIPTION FOR TABLES 3A and 3B

TABLE 3A requests medical fee for service utilization and claims experience for the period 4/1/2015-3/31/2016. TABLE 3B requests medical capitation encounter data for the period 4/1/2015-3/31/2016.

The following benefit descriptions should be used in developing the Actuarial Data Report. Where possible, Current Procedural Terminology Codes–CPT 2014 Professional Edition, (CPT-4 codes) has been included to aid in the summarization of information. The appropriate HCFA Common Procedure Coding System (HCPCS) Level II codes are also included. For services affected by the Medicare Resource Based Relative Value System (RBRVS), both the CPT code ranges used prior to RBRVS and the evaluation and management CPT code ranges introduced by RBRVS have been included.

Note: There have been no changes to the mapping this year and the required data submission utilizes identical methodology.

A. HOSPITAL INPATIENT

This benefit includes daily semi-private room and board and ancillary services in short-term community hospitals. Ancillary services include use of surgical and intensive care facilities, inpatient nursing care, pathology and radiology procedures, drugs and supplies. Services are counted as the number of admissions and the number of days confined. Ancillary charges should not include professional charges for hospital-based physicians.

1. Non-Maternity

a. Medical: A medical admission includes a confinement without a major surgery and without a diagnosis indicating a substance abuse or psychiatric condition.

b. Surgical: A surgical admission includes a confinement primarily resulting from a surgery or multiple surgeries.

c. Mental Health: A psychiatric admission includes a confinement with a primary diagnosis involving a psychiatric condition.

d. Substance Abuse: A substance abuse admission includes a confinement with a primary diagnosis involving an alcohol and/or drug abuse condition.

2. Maternity

a. Maternity Deliveries: This benefit includes hospital inpatient room and board and ancillary services for normal and cesarean deliveries for the mother. Charges for the well newborn baby should be included but newborn admissions and days should be excluded.

b. Maternity - Non-Deliveries: This benefit includes hospital inpatient room and board and ancillary services for complications of pregnancy and pregnancies that do not result in a delivery due to miscarriage or therapeutic abortion.

c. Neonatal ICU: This benefit includes hospital inpatient room and board and ancillary services for premature infants or other neonatal care.

3. Extended Care Facility

This benefit includes daily room and board and ancillary services in an approved extended care facility. The facility may be either the extended care ward of a community hospital or an independent skilled nursing facility. Ancillary services include inpatient nursing care, pathology and radiology procedures, drugs and supplies.

B. HOSPITAL OUTPATIENT

1. Emergency Room

This benefit includes services for emergency accident and medical care performed in the emergency area of a hospital outpatient facility. Services are counted as the number of visits to the emergency room. Charges should include facility charges only and not professional charges.

2. Outpatient Surgery

This benefit includes hospital outpatient services for surgery, including surgery performed in a hospital outpatient facility or a freestanding surgical facility. Services are counted as the number of surgical procedures and not the number of outpatient surgical encounters. Charges should include facility charges only and do not include professional charges.

3. Radiology

This benefit includes the technical component of radiology services performed by a hospital outpatient department. Services are counted as the number of procedures. Professional charges should be excluded.

4. Pathology

This benefit includes the technical component of pathology services performed by the hospital outpatient department. Services are counted as the number of procedures. Professional charges should be excluded.

5. Outpatient Mental Health

This benefit includes mental health outpatient services. Services are counted as the number of visits to the outpatient mental health facility. Charges should include facility charges only and not professional charges.

6. Outpatient Substance Abuse

This benefit includes substance abuse outpatient services. Services are counted as the number of visits to the outpatient substance abuse facility. Charges should include facility charges only and not professional charges.

7. Other

This benefit includes hospital outpatient services other than emergency room, surgery, radiology and pathology, such as physical therapy, maternity non-delivery, and supplies. Services are counted as the number of procedures. Charges should include facility charges only and not professional charges.

8. Other Facility

a. Hospice -This benefit includes all facility charges and services provided in a hospice for a terminally ill patient and family. Charges incurred in the hospice ward of a hospital are included as well as in a stand-alone hospice facility.

b. Transitional Care -This benefit includes substance abuse rehabilitation services provided in a transitional care program. Services may be provided in a hospital outpatient or day care setting and charges would include professional and facility charges.

C. PHYSICIAN

1. Surgical Services

a. <u>Inpatient Surgery</u>:

(1) Professional Surgeon (CPT-4 Codes 10021-58999 (except 36415), 59525, 60000-69990)

This benefit includes surgeries performed by a surgeon on an inpatient basis. Services are counted as the number of inpatient surgical procedures and not the number of surgical admissions. Charges should include normal pre-surgical and post-surgical encounters with the surgeon and would include both primary and assistant surgeon charges.

b. Anesthesia:

(1) Inpatient Anesthesia (CPT-4 Codes 00100-01999, 99100-99140 or 10040-69990 with anesthesia modifier)

This benefit includes services by an anesthesiologist or anesthetist for non-maternity and maternity surgeries performed in an inpatient setting. Services are counted as the number of inpatient surgical procedures requiring anesthesia. Charges should include inpatient pre-surgical and post-surgical encounters, and the usual monitoring procedures.

(2) Outpatient Anesthesia (CPT-4 Codes 00100-01999, 99100-99140, or 10040-69990 with anesthesia modifier)

Same as above except in an outpatient setting, including a hospital outpatient department, freestanding surgical facility or physician's office.

c. Maternity:

(1) Normal Deliveries (CPT-4 Codes 59400-59430, 59610-59614)

This benefit includes physician obstetrical care for normal deliveries and complications of pregnancy that result in a normal delivery. Services are counted as the number of maternity cases that result in a normal delivery. Charges should include delivery care and standard pre- and post-natal visits.

(2) Cesarean Deliveries (CPT-4 Codes 59510-59515, 59618-59622)

This benefit includes physician obstetrical care for cesarean deliveries and complications of pregnancy that result in a cesarean delivery. Services are counted as the number of maternity cases that result in a cesarean delivery. Charges should include delivery care and standard pre-natal and post-natal visits.

(3) Other OB Services (CPT-4 Codes 59000-59350, 59812-59899)

This benefit includes physician obstetrical care for pregnancies that do not result in a delivery due to a complication, miscarriage or therapeutic abortion as well as other obstetrical services that are not related to a delivery (e.g. amniocentesis, fetal monitoring, etc.). Services are counted as the number of procedures. Charges should include surgical care and standard pre-natal visits.

d. Outpatient Surgery:

(1) Outpatient Surgical Center (CPT-4 Codes 10021-58999 (except 36415), 59525, 60000-69990)

This benefit provides for surgery by a physician in a hospital outpatient department or a freestanding surgical facility. Services are counted as the

number of outpatient procedures and not the number of outpatient surgical encounters. Charges should include normal pre-surgical and post-surgical encounters with a surgeon.

(2) Office (CPT-4 Codes 10021-58999 (except 36415), 59525, 60000-69990)

This benefit includes surgery by a physician in the physician's office. Services are counted as the number of office outpatient surgical procedures and not the number of office outpatient surgical encounters. Charges should include normal pre-surgical and post-surgical encounters with the physician.

2. Physician — Inpatient Visits

a. Hospital Visits (CPT-4 Codes 99217-99239, 99289-99300, 99460, 99462-99465, HCPCS Codes M0064-M0100)

This benefit includes visits to hospitals by a physician. Services are counted as the number of visits. Physician visits by the surgeon in the case of a surgery should be included in the surgery benefit.

b. Critical Care Visits (CPT-4 Codes 99170-99199, 99289-99292, 99466-99480)

This benefit includes the care of critically ill patients in a variety of medical emergencies that require the constant attention of the physician (e.g. cardiac arrest, shock, bleeding, respiratory failure, etc.). Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, respiratory care unit or an emergency care facility. Services are counted as the number of procedures.

c. Mental Health Visits (CPT-4 Codes 90785-90899; HCPCS Codes G0176-G0177, H0001-H2999, M0064-M0100)

This benefit includes visits to hospitals for a psychiatric patient by a psychiatrist, psychologist, or other professional. Services are counted as the number of visits.

d. Substance Abuse Visits (CPT-4 Codes 90791-90792, 90832-90899, 99406-99409; HCPCS Codes G0396-G0397, H0001-H2999, S9075)

This benefit includes visits to hospitals for a substance abuse patient by a psychiatrist, psychologist, or other professional. Services are counted as the number of visits.

e. Extended Care Visits (CPT-4 Codes 99304-99318, HCPCS Codes M0064-M0100)

This benefit includes physician visits to approved extended care facilities. Services are counted as the number of procedures.

f. Home Health Visits (CPT-4 Codes 99324-99350, 99500-99602, HCPCS Codes M0064-M0100)

This benefit includes physician visits in the insured's home or a custodial facility. It does not include visits by a nurse. Services are counted as the number of visits.

3. Office Services

a. Office Visits (CPT-4 Codes 99143-99150, 99201-99215, HCPCS Codes M0064-M0100)

This benefit includes visits to a physician's office. Physical exams, well baby exams and any pre-surgical or post-surgical visits are included elsewhere. Services are counted as the number of visits. Charges should include professional fees of the primary physician or the referral physician. Charge levels should include only the physician's time; the charges for lab or x-ray procedures performed in the physician's office and medications are included elsewhere.

b. Therapeutic Injections (J Codes) (CPT-4 Codes 96360-96379; HCPCS Codes J0120-J8999, J9019, J9042)

This benefit includes professional services and materials associated with therapeutic injections when administered by the staff of the attending physician. Immunizations are not included. Services are counted as the number of procedures.

c. Allergy Testing/Allergy Immunotherapy (CPT-4 Codes 95004-95079, 95115-95199, HCPCS Codes G0008-G0010, J0171-J8999)

This benefit includes professional services and materials associated with allergy tests when administered by the staff of the attending physician. This benefit also includes professional services and materials associated with allergy immunotherapy (serum, syringes, etc.) when administered by the staff of the attending physician. Services are counted as the number of procedures.

d. Chemotherapy Drugs (HCPCS Codes J9000-J9999, excluding codes J9019 and J9042.)

This benefit includes professional services and materials associated with chemotherapy drugs when administered by the staff of the attending physician. Services are counted as the number of procedures.

e. Diagnostic Testing

This benefit provides for the following professional services:

Service	CPT-4 or HCPCS Codes
Biofeedback	90901-90911
Gastroenterology	91000-91299
Otorhinolaryngology Services	92502-92505, 92511-92526, 92700

Vestibular Function Tests	92531-92548
Non-Invasive Peripheral Vascular Diagnostic Studies	93875-93998
Pulmonary	94002-94799
Neurology	95782, 95783, 95800-96020
Chemotherapy	96401-96549, HCPCS Codes Q0083-Q0085
Dermatology	96900-96999
Miscellaneous	96101-96125, 96150-96155, 99000-99091, 99175-99199, 99354-99360, 99477-99499, HCPCS Code G9143

Not all of the above procedures are necessarily diagnostic testing. They were included in this benefit because they are related to diagnostic testing. Services are counted as the number of procedures.

f. Urgent Care

This benefit includes services for medical care performed in an urgent care facility. Services are counted as the number of visits to the urgent care center. Charges should include both facility and professional charges.

g. Other (HCPCS Codes A4206-A4608, A4641-A4652, A5051-A9999, B4000-B5200, M0075-M0100)

This benefit includes physician office services not included elsewhere. Services are counted as the number of procedures.

4. Other Physician Services

a. Emergency Room Visits (CPT-4 Codes 99281-99288)

This benefit includes visits to the emergency area of a hospital outpatient facility by either a primary care physician or a hospital staff physician. Services are counted as the number of visits.

b. Consults (CPT-4 Codes 99241-99255, 97802-97804, HCPCS G0270-G0271)

This benefit includes a consulting specialist and presumes the primary care physician has due cause to seek consultation. A consultation includes services rendered by a physician or other appropriate source for the further evaluation and/or management of the patient. When the consulting physician assumes responsibility for the continuing care of the patient, any subsequent service rendered by the physician will cease to be a consultation. Consultations can be provided for both inpatient and outpatient care. Services are counted as the number of consultations.

c. Cardiovascular (CPT-4 Codes 92950-93799; HCPCS Codes M0300-M0301, Q0035)

This benefit includes therapeutic services (e.g. CPR), cardiography (e.g. EKGs), cardiac catheterization and other cardiovascular services performed by a physician. Services are counted as the number of procedures.

d. Dialysis (CPT-4 Codes 90935-90999; HCPCS Codes A4650-A4932, E1500-E1699, M0064-M0100)

This benefit includes services by a physician and staff for dialysis treatment including hemodialysis, peritoneal dialysis and miscellaneous dialysis procedures. Services are counted as the number of procedures.

e. Other Physician Services (CPT-4 Codes 96567-96571, 99143-99150, 99363-99380; Miscellaneous HCPCS Codes)

This benefit includes physician services not allocated to other line items. Services are counted as the number of procedures.

f. Radiology:

(1) Inpatient - (Professional Only) (CPT-4 Codes 70010-77032, 77071-79999)

This benefit includes professional services by a physician when the x-ray is performed on an inpatient basis. Services are counted as the number of procedures. Charges for the technical component of radiology services should be included in the hospital inpatient benefit.

(2) Outpatient - (Professional Only) (CPT-4 Codes 70010-77032, 77071-79999)

This benefit includes professional services by the physician when the x-ray is performed in the office, hospital outpatient department or freestanding facility. Services are counted as the number of procedures. This benefit includes only those professional charges that are billed separately from the technical component. The technical component of radiology services should be included in the Hospital Outpatient - Radiology benefit or in the Physician - Radiology - Office (Combined Professional and Technical) benefit.

(3) Office - (Combined Professional and Technical) (CPT-4 Codes 70010-77032, 77071-79999; HCPCS Codes Q0092, R0000-R5999)

This benefit includes both the professional and technical component of radiology services when these services are billed together. Services are counted as the number of procedures. Charges should only be included here when the x-ray is performed in an office or clinic setting.

g. Surgical Pathology:

(1) Inpatient (Professional Only) (CPT-4 Codes 88300-88399)

This benefit includes professional services by a physician when the surgical pathology procedure is performed on an inpatient basis. Services are counted as the number of procedures. Charges for the technical component of pathology services should be included in the hospital inpatient benefit.

(2) Outpatient (Professional Only) (CPT-4 Codes 88300-88399)

This benefit includes professional service by the physician when the surgical pathology procedure is performed in the office, hospital outpatient department or freestanding facility. Services are counted as the number of procedures. This benefit includes only those professional charges that are billed separately from the technical component. The technical component of pathology services should be included in the Hospital Outpatient - Pathology benefit or in the Physician - Pathology - Office (Combined Professional and Technical) benefit.

(3) Office (Combined Professional and Technical) (CPT-4 Codes 88300-88399; HCPCS Code Q0091)

This benefit includes both the professional and technical component of surgical pathology services when these services are billed together. Services are counted as the number of procedures. Charges should only be included here when the lab work is performed in an office or clinic setting.

D. OTHER SERVICES

1. Physical Therapy

(CPT-4 Codes 97001-97002, 97005-97799)

This benefit includes physical therapy when ordered by the attending physician. Services are counted as the number of procedures.

2. Occupational/Speech Therapy

(CPT-4 Codes 92506-92508, 97003-97004, HCPCS Codes V5362-V5364)

This benefit includes occupational therapy when ordered by the attending physician. Services are counted as the number of procedures.

3. Chiropractic

(CPT-4 Codes 98940-98943)

This benefit includes visits to a licensed chiropractor's office including those visits involving manipulations. This benefit includes x-rays taken in the chiropractor's office. Services are counted as the number of procedures.

4. Private Duty Nursing/Home Health

(CPT-4 Codes 99500-99602)

This benefit includes private nursing and home health visits if required by the attending physician and not representing custodial care. Services are counted as the number of procedures.

5. Ambulance

(HCPCS Codes A0000-A0999)

This benefit includes professional ambulance service. Services are counted as the number of procedures.

6. Durable Medical Equipment/Prosthetics

(HCPCS Codes A4611-A4640, B9000-B9999, E0100-E1406, E1700-E8002, K0001-K0900, L0100-L9999, Q0081, V5030-V5299, V5336)

This benefit includes appliances, equipment, and prosthetic devices. Appliances and equipment include braces (orthotics), canes, crutches, glucosan, glucometer, intermittent positive pressure machines, rib belt for treatment of an accident or illness, walker, wheel chairs, etc. Prosthetics includes artificial parts that replace a missing body part or improve a body function (i.e., artificial limb, heart valve, and medically necessary reconstruction). Services are counted as the number of items.

7. Laboratory

(CPT Codes 36415, 80047-88299, 89049-89240; HCPCS Codes G0027, P0000-P9999)

This benefit includes both the professional and technical component of non-physician laboratory services when these services are billed together. Services are counted as the number of procedures.

E. ADDITIONAL BENEFITS

1. Immunizations

(CPT-4 Codes 90281-90749)

This benefit includes the professional services and materials associated with administering immunizations. Services are counted as the number of procedures.

2. Well Baby Exams

(CPT-4 Codes 99381, 99391, 99460-99465)

This benefit includes normal periodic examinations of well children under age one. Services are counted as the number of exams.

3. Well Child Exams

(CPT Codes 99382-99384, 99392-99394, HCPCS Codes M0064-M0100)

This benefit includes routine examinations of children ages 1 through 17. Services are counted as the number of exams.

4. Physical Exams

(CPT-4 Codes 99385-99387, 99395-99397, 99401-99429, HCPCS Codes M0064-M0100)

This benefit includes routine examinations of adults and children over the age of 17. Services are counted as the number of exams.

5. Vision Services

(CPT-4 Codes 92002-92287, 92499)

This benefit includes eye exams and other ophthalmology services conducted by a licensed ophthalmologist or optometrist. Services are counted as the number of procedures.

6. Vision Supplies

(CPT-4 Codes 92310-92371; HCPCS Codes V2020-V2799)

This benefit includes lenses and frames and contact lenses. Services are counted as the number of services.

7. Speech Exams

(CPT-4 Codes 92506-92508; HCPCS Codes V5301-V5364 (except V5336))

This benefit includes speech exams. Services are counted as the number of procedures.

8. Hearing Exams

(CPT-4 Codes 92550-92597; HCPCS Codes V5000-V5020)

This benefit includes hearing exams. Services are counted as the number of procedures.

9. Podiatrist

This benefit includes services performed by a licensed podiatrist. There are no specifically identified CPT codes for this treatment. Services are counted as the number of visits.

10. Mammography Exams

(CPT Codes 77051-77059)

This benefit includes routine mammography examinations of female adults. Charges should include the x-ray associated with the exam. Services are counted as the number of procedures.

11. Outpatient Mental Health

(CPT-4 Codes 90785-90899; HCPCS Codes G0176-G0177, H0001-H2999)

This benefit includes psychiatric treatment by a qualified professional performed on an outpatient basis. Services are counted as the number of visits.

12. Outpatient Substance Abuse

(CPT-4 Codes 90785-90899, 99406-99409; HCPCS Codes G0396-G0397, H0001-H2999, S9075)

This benefit includes treatment of alcohol and/or drug abuse by a qualified professional performed on an outpatient basis. Services are counted as the number of visits.

13. Other Services

This line item would include all services that have not been allocated to any of the above line items.

The Total FFS Incurred Claim Factor and the Number of Runout Months should be input at the bottom of this section.

Note that there are a number of calculated fields in this section that are self-explanatory.

TABLE 4 - PAID CLAIMS AND ENCOUNTER EXPERIENCE BY MONTH

TABLE 4 requests medical fee for service claims, capitation encounter data and capitation payments by month for the period 1/1/2015-3/31/2016.

Claims and encounter data should be entered for the six main service categories consistent with TABLES 3A & 3B: Hospital Inpatient, Hospital Outpatient, Other Facility, Physician, Other Services and Additional Services. There are separate columns for fee-for-service and encounter data. Data entered by month should not include any incurred claim completion factors.

Additional input is required for total actual capitation payment by month for the same period.

TABLE 5 - MEDICAL TREND ASSUMPTIONS

TABLE 5 requests information regarding the trends used in the rate development. **NOTE: The trend periods used in the calculations are listed at the top of the table.**

Step I shows the calculation of the weighted trend for fee-for-service costs. The weighted trend is the trend assumed by the carrier from the midpoint of the experience period to the midpoint of the rating period. Prepare separate tables for each period. Prepare one table for 2015-2016 and another table for 2016-2017 annual trends.

The first column lists the major categories by type of service, which are the same as those shown in the applicable experience table (TABLE 3A or 3B).

The second and third columns represent trend factors for cost and utilization. Estimates of these factors need to be input for both trending periods.

The fourth, fifth, and sixth columns are automatically calculated fields which develop an overall trend factor for both rating periods.

Step 2 calculates the two year weighted trend for fee-for-service costs. The aggregate trend is calculated by multiplying the sum of one plus the weighted trend for the first period (for only 9 months) times the sum of one plus the weighted trend for the second period.

Step 3 requests the aggregate trend for capitated services.

The first column lists the major categories by type of service, which are the same as those shown in the applicable experience table (TABLE 3A or 3B).

The second column requests the projected annual trend for 2015-2016.

The third and fourth columns automatically calculate an overall weighted annual trend for 2015-2016 based on the trend input and the distribution of capitated service categories.

The fifth, sixth and seventh columns are similar to columns one, two and three and four as described above. However, plans should enter projected annual trend for 2016-2017 in the fifth column.

The two year weighted trend for capitated services is then calculated. The aggregate trend is calculated by multiplying the sum of one plus the weighted trend for the first period times the sum of one plus the weighted trend for the second period.

Step 4 is where the carrier should explain any special circumstances which may have caused the trends to be unusually high or low.

TABLE 6 - MEDICAL ADMINISTRATIVE EXPENSES AND OTHER PMPM COSTS

TABLE 6 requires a breakdown of the administrative expenses and any other miscellaneous costs included in the rate development.

Medical Administrative Expenses:

The first column lists a detailed description of the different expense categories requested.

The second column is the 2015 PMPM cost for the expense category.

The third column is the PMPM cost that was included in the 2016 rate calculation.

The fourth column is the estimated PMPM cost included in the 2017 rate calculation.

TABLE 7 - REQUIRED PREMIUM PMPM

TABLE 7 uses the information provided on TABLES 1 - 6 to calculate the required premium per member per month for calendar year 2017. Please note that these automatically calculate and plans are not required to input data.

Line 1 - is the grand total amount of fee-for-service claims cost PMPM for the experience period as shown in TABLE 3A. This amount includes the incurred claim factor supplied to bring the claims to an incurred level.

Line 2 - is the aggregate fee-for-service trend factor as shown in TABLE 5.

Line 3 - is the claims cost trended to the rating period, which is calculated by multiplying Line 1 by Line 2.

Line 4 - is the total capitation cost PMPM from TABLES 3A and/or 3B.

Line 5 - is the aggregate capitated services trend factor from TABLE 5.

Line 6 - is the total capitation cost trended to the rating period and is calculated by multiplying Line 4 by Line 5.

Line 7 - is the total estimated 2017 administrative cost PMPM as shown on TABLE 6.

Line 8 - is the required medical premium PMPM and is calculated by adding lines 3, 6 and 7.

TABLE 8 - 2017 CALCULATED RATES

TABLE 8 includes information from TABLES 1 through 7 to automatically calculate the single and family rates.

Step 1 details the calculation of the conversion factor used to convert the required premium per member per month to single and family rates.

Line 1, Column B - is the contract mix from TABLE 1, row 44 Column B.

Line 2, Column B - is the contract mix from TABLE 1, row 44 Column C.

Line 3, Column B - is the sum of the contract mix for single and family, which must equal 100%.

Line 1, Column C - is the average contract size for single from TABLE 1, row 43 Column B.

Line 2, Column C - is the average contract size for family from TABLE 1, row 43 Column C.

Line 3, Column C - is the average contract size in total from TABLE 1, row 43 Column D.

Line 1, Column D - is the rate ratio for single of 1.0.

Line 2, Column D - is the rate ratio for family of 2.0 for Medicare, 2.5 for non-Medicare.

Line 3, Column D - is the weighted average rate ratio in total for single and family.

Line 1, Column E - is the conversion factor for single and is derived by dividing the total average contract size by the total rate ratio.

Line 2, Column E - is the conversion factor for family and is derived by multiplying the conversion factor for single by the rate ratio for family.

Step 2 details the calculation of the 2017 medical rates using the required premium PMPM and the conversion factor.

Line 4, Column C - is the required premium PMPM from TABLE 7, line 8.

Line 5, Column C - is the conversion factor for single.

Line 6, Column C - is the calculated 2017 rate for single and is derived by multiplying the required premium PMPM by the conversion factor.

Line 4, Column D - is the required premium PMPM from TABLE 7, line 8.

Line 5, Column D - is the conversion factor for family.

Line 6, Column D - is the calculated 2017 rate for family and is derived by multiplying the required premium PMPM by the conversion factor.

Line 7 - The last line pulls the net 2016 inforce medical only rates for single and family coverage from TABLE 1 row 33 columns D & E.

TABLE 9 - CALCULATED LOSS RATIOS

TABLE 9 includes information from TABLES 1 through 8 to automatically calculate the loss ratios for each of the periods.

The experience period loss ratios are calculated by first calculating the monthly revenue from TABLE 1 and pulling the monthly claims and capitation experience from TABLE 4.

The projected 2016 and 2017 loss ratios have a number of calculated fields that utilize the reported claims experience and calculated rates.

TABLE 10 - CLAIMS IN EXCESS OF $100,000
Incurred Period: April 1, 2015 through March 31, 2016

Line 1 - is the total amount of paid claims for individuals with paid claims of $100,000 or greater. Paid claims are defined as medical and pharmacy claims paid by the health plan; do not include pharmacy claims paid by the Department's pharmacy benefit manager in this calculation. For example, if you had five cases with paid claims of $150,000 each, you would enter the value of $150,000 X 5 = $750,000.

Line 2 - is the number of individuals with paid claims of $100,000 or greater.

Line 3 – is the total amount of claims of $100,000 or greater on an individual basis. For example, if you had five cases with paid claims of $150,000 each, this cell would calculate as follows: $150,000*5 - $100,000*5 = $250,000.

Line 4 - is the estimated percentage of paid claims for the specified Reporting Period that have not yet been recorded or paid. Incurred claims will be calculated as (1 + Total Incurred Claim Factor) multiplied by the Paid Charges.

Line 5 - is the number of months of experience that have been included in Paid Charges beyond the specific incurred Reporting Period of 4/1/2015-3/31/2016. For example, if a plan includes experience for claims that were incurred from 4/1/2015-3/31/2016 and paid through 5/31/2016, the Number of Runout Months would equal two.

Line 6 - will be calculated as (1 + Incurred Claim Factor) multiplied by the Paid Charges. This represents the total amount of claims of $100,000 or greater that have been incurred in the Report Period.

TABLE 11 - QUESTIONS REGARDING SUBMITTED DATA

TABLE 11 requests responses to questions regarding the submitted data. We prefer that plans provide responses to the questions in the space provided in TABLE 11. TABLE 11 is considered a part of the required data and must be provided at the same time as all other information.

TABLE 12 - TOP PROVIDER REPORT

TABLE 12 requests plans submit a list of top facility and top professional providers based on Plan Paid dollars for the Addendum population and the time period April 1, 2015 through March 31, 2016. The provider information requested includes name, location, National Provider Identifier number and utilization counts.

Table 12 is only included in three of the eight categories:

i. State of Wisconsin Employee Plan, Non-Medicare
ii. State of Wisconsin Employee Plan, Medicare
iii. State of Wisconsin Local Plan, Non-Medicare

TABLE 13 - REQUIRED DATA FORMAT

Data is to be submitted to the Board's Actuary and match the information in the service categories detailed in TABLES 3A & 3B. It is expected that the data will match both the utilization and billed amounts. In later years more financial information will be required in the detail file.

Please send data for all groups. We are requesting 12 months of incurred data covering the period April 1, 2015 Through March 31, 2016 and paid through the most recent and complete month. Both fee-for-service claims and capitation encounter data should be provided with an appropriate code to separate.

The file should be comma delimited and include Control totals for all groups and files sent. The Control totals should include: Total Record Count, Total Billed Amount, Total Allowed Amount and Total Paid Amount.

TABLE 14 - SERVICE CATEGORY CODES

TABLE 14 provides a mapping of the line items in TABLES 3A & 3B. The data should be grouped as described in that section, with the mapping included in the data sets.

TABLE 15 - ACTUARIAL CERTIFICATION

There is a new requirement to have the rate development, supporting reports and detailed data be certified by an actuary who is a Member of the American Academy of Actuaries. There is a box to allow an actuary to enter their certification language.

The actuary should enter his Name, Firm, Phone and Date of the certification.

If vendors are unable to meet the actuarial certification requirement, they should provide acceptable language and justification. The rates should then be certified by their Chief Financial Officer.

State of Wisconsin
Addendum 1

REPORT CATEGORY

One report is requested for each of the following eight categories:

State of Wisconsin - Employee Plan, Non-Medicare, Non Grad Assistant
State of Wisconsin - Employee Plan, Medicare
State of Wisconsin - Employee Plan, Grad Assistant
State of Wisconsin - Local Plan, Non-Medicare
State of Wisconsin - Local Plan, Medicare
State of Wisconsin - High Deductible Plan
Total Organization - Non-Medicare/Commercial
Total Organization - Medicare

Please specify the category of this report by choosing one option from the dropdown box below:

State of Wisconsin - Employee Plan, Non-Medicare, Non Grad Assistant

TABLE 1
MONTHLY ENROLLMENT AND PREMIUMS
January 1, 2015 Through March 31, 2016

	SINGLE		FAMILY	
Enrollment	Members	Contracts	Members	Contracts
Jan-15	0	0	0	0
Feb-15	0	0	0	0
Mar-15	0	0	0	0
Apr-15	0	0	0	0
May-15	0	0	0	0
Jun-15	0	0	0	0
Jul-15	0	0	0	0
Aug-15	0	0	0	0
Sep-15	0	0	0	0
Oct-15	0	0	0	0
Nov-15	0	0	0	0
Dec-15	0	0	0	0
Total 2015	**0**	**0**	**0**	**0**
Jan-16	0	0	0	0
Feb-16	0	0	0	0
Mar-16	0	0	0	0
Total 2016 Q1	**0**	**0**	**0**	**0**

	2015		2016	
Premiums	Single	Family	Single	Family
Contract Rate	$0.00	$0.00	$0.00	$0.00
Dental Component	$0.00	$0.00		
Other Adjustments	$0.00	$0.00	$0.00	$0.00
Net Premium Rate	**$0.00**	**$0.00**	**$0.00**	**$0.00**

CALCULATION OF CONTRACT MIX AND CONTRACT SIZE
April 1, 2015 Through March 31, 2016

	Single	Family	Total
Member Months	0	0	**0**
Contract Months	0	0	**0**
Contract Size	**0.0**	**0.0**	**0.0**
Contract Mix	**0%**	**0%**	**0%**

TABLE 2
ENROLLMENT AND MEMBER MONTHS BY AGE AND SEX

	Member Months 4/1/15 - 3/31/16		
Age Category	Male	Female	Total
Under 1	0	0	0
1-4	0	0	0
5-14	0	0	0
15-17	0	0	0
18-24	0	0	0
25-34	0	0	0
35-44	0	0	0
45-54	0	0	0
55-64	0	0	0
65-74	0	0	0
75+	0	0	0
TOTAL	0	0	0

	December 2015 Member Counts		
Age Category	Male	Female	Total
Under 1	0	0	0
1-4	0	0	0
5-14	0	0	0
15-17	0	0	0
18-24	0	0	0
25-34	0	0	0
35-44	0	0	0
45-54	0	0	0
55-64	0	0	0
65-74	0	0	0
75+	0	0	0
TOTAL	0	0	0

	March 2016 Member Counts		
Age Category	Male	Female	Total
Under 1	0	0	0
1-4	0	0	0
5-14	0	0	0
15-17	0	0	0
18-24	0	0	0
25-34	0	0	0
35-44	0	0	0
45-54	0	0	0
55-64	0	0	0
65-74	0	0	0
75+	0	0	0
TOTAL	0	0	0

	Age/Sex Factors (using member months)		
Age Category	Male	Female	Total
Under 1	3.66	3.05	0.00
1-4	0.59	0.50	0.00
5-14	0.37	0.33	0.00
15-17	0.52	0.57	0.00
18-24	0.46	0.74	0.00
25-34	0.54	1.25	0.00
35-44	0.78	1.26	0.00
45-54	1.34	1.61	0.00
55-64	2.36	2.26	0.00
65-74	3.07	2.79	0.00
75+	3.07	2.79	0.00
TOTAL	0.00	0.00	0.00

Average age (from 4/15-3/16 member months):	0
Average age/sex factor (using 4/15-3/16 member months):	0.00

State of Wisconsin - Employee Plan, Medicare

TABLE 3A
Fee For Service Claims Experience - Actuarial Data

Type of Service	April 1, 2015 Through March 31, 2016												
	Total # of Admissions	Total # of Days	Total Billed Charges	Total Allowed Charges	Total COB (including Medicare)	Total Member Cost Share	Total Paid Charges	Total # of Member Months	Annual Admissions/ 1,000	Annual Days/1,000	Average Length of Stay	Average Paid Charges per Day	Average Paid Charges PMPM	Percent of Total
Hospital Inpatient														
Medical	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Surgical	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Mental Health (MH)	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Substance Abuse (SA)	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Subtotal Non-Maternity	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Maternity Deliveries	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Maternity Non-Deliveries	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Neonatal ICU	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Subtotal Maternity	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Extended Care Facility	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
1. Total Hospital Inpatient	**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0**	**0**	**0**		**$0.00**	**$0.00**	**0.0%**

Type of Service	Total # of Services	Total Billed Charges	Total Allowed Charges	Total COB (including Medicare)	Total Member Cost Share	Total Paid Charges	Total # of Member Months	Annual Services/ 1,000	Average Paid Charges	Average Paid Charges PMPM	Percent of Total	
Hospital Outpatient												
Emergency Room	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Surgery	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Radiology	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Pathology	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Mental Health (MH)	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Substance Abuse (SA)	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Other (Specify)	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
2. Total Hospital Outpatient	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0**	**0**	**$0.00**	**$0.00**	**0.0%**	
3. TOTAL HOSPITAL		**$0**	**$0**	**$0**	**$0**	**$0**	**0**			**$0.00**		
Other Facility												
Hospice	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Transitional Care	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
4. Total Other Facility	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0**	**0**	**$0.00**	**$0.00**	**0.0%**	
Physician Services												
Inpatient Surgery	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Inpatient Anesthesia	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Outpatient Anesthesia	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
IP Maternity - Normal Deliveries	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
IP Maternity-Cesarean Deliveries	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
IP Other OB Services	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Outpatient Hosp/Surgical Center	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Office Surgery	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Inpatient Hospital Visits	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Inpatient Critical Care Visits	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Inpatient Mental Health Visits	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Inpatient Substance Abuse Visits	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Extended Care Facility Visits	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Home Health Visits	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Office Visits	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Therapeutic Injections (J Codes)	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Allergy Testing/Immunotherapy	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Chemotherapy Drugs	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Diagnostic Testing	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Urgent Care	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Emergency Room	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Consults	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Cardiovascular	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Dialysis	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Inpatient Radiology	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Outpatient Radiology	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Office Radiology	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Inpatient Pathology	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Outpatient Pathology	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Office Pathology	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Other (Specify)	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
5. Total Physician Services	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0**	**0**	**$0.00**	**$0.00**	**0.0%**	
Other Services												
Physical Therapy	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Occupational/Speech Therapy	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Chiropractic Services	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Private Duty Nursing/Home Health Care Services	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Ambulance	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
DME/Prosthetics	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Laboratory	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
6. Total Other Services	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0**	**0**	**$0.00**	**$0.00**	**0.0%**	
Additional Services												
Immunizations	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Well Baby Exams	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Well Child Exams	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Physical Exams	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Vision Services	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Vision Supplies	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Speech Exams	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Hearing Exams	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Podiatry Services	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Mammography	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Outpatient Mental Health	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Outpatient Substance Abuse	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
Other	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00		
7. Total Additional Services	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0**	**0**	**$0.00**	**$0.00**	**0.0%**	
8. Total Fee For Service		**$0**	**$0**	**$0**	**$0**	**$0**	**0**			**$0.00**	**0.0%**	Valid

Valid

9. Total FFS Incurred Claim Factor	0.000%
10. Number of Runout Months	0

11. Incurred Fee For Service Total			$0	0	$0.00	0.0%
12. Total Capitation Paid (From Table 3B Line 9)			$0	0	$0.00	0.0% Valid
13. Incurred Claim Grand Total			$0	0	$0.00	0.0%

TABLE 3B
Capitation Encounter Experience - Actuarial Data

Type of Service	April 1, 2015 Through March 31, 2016												
	Total # of Admissions	Total # of Days	Total Billed Charges	Total Allowed Charges	Total COB (including Medicare)	Total Member Cost Share	Total Paid Charges	Total # of Member Months	Annual Admissions/ 1,000	Annual Days/1,000	Average Length of Stay	Average Paid Charges per Day	Average Paid Charges PMPM	Percent of Total
Hospital Inpatient														
Medical	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Surgical	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Mental Health (MH)	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Substance Abuse (SA)	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Subtotal Non-Maternity	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Maternity Deliveries	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Maternity Non-Deliveries	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Neonatal ICU	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Subtotal Maternity	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
Extended Care Facility	0	0	$0	$0	$0	$0	$0	0	0	0		$0.00	$0.00	
1. Total Hospital Inpatient	**0**	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0**	**0**	**0**		**$0.00**	**$0.00**	**0.0%**

Type of Service	Total # of Services	Total Billed Charges	Total Allowed Charges	Total COB (including Medicare)	Total Member Cost Share	Total Paid Charges	Total # of Member Months	Annual Services/ 1,000	Average Paid Charges	Average Paid Charges PMPM	Percent of Total
Hospital Outpatient											
Emergency Room	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Surgery	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Radiology	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Pathology	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Mental Health (MH)	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Substance Abuse (SA)	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Other (Specify)	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
2. Total Hospital Outpatient	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0**	**0**	**$0.00**	**$0.00**	**0.0%**
3. TOTAL HOSPITAL		**$0**	**$0**	**$0**	**$0**	**$0**	**0**			**$0.00**	
Other Facility											
Hospice	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Transitional Care	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
4. Total Other Facility	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0**	**0**	**$0.00**	**$0.00**	**0.0%**
Physician Services											
Inpatient Surgery	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Inpatient Anesthesia	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Outpatient Anesthesia	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
IP Maternity - Normal Deliveries	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
IP Maternity-Cesarean Deliveries	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
IP Other OB Services	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Outpatient Hosp/Surgical Center	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Office Surgery	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Inpatient Hospital Visits	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Inpatient Critical Care Visits	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Inpatient Mental Health Visits	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Inpatient Substance Abuse Visits	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Extended Care Facility Visits	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Home Health Visits	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Office Visits	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Therapeutic Injections (J Codes)	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Allergy Testing/Immunotherapy	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Chemotherapy Drugs	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Diagnostic Testing	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Urgent Care	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Emergency Room	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Consults	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Cardiovascular	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Dialysis	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Inpatient Radiology	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Outpatient Radiology	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Office Radiology	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Inpatient Pathology	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Outpatient Pathology	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Office Pathology	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Other (Specify)	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
5. Total Physician Services	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0**	**0**	**$0.00**	**$0.00**	**0.0%**
Other Services											
Physical Therapy	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Occupational/Speech Therapy	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Chiropractic Services	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Private Duty Nursing/Home Health Care Services	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Ambulance	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
DME/Prosthetics	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Laboratory	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
6. Total Other Services	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0**	**0**	**$0.00**	**$0.00**	**0.0%**
Additional Services											
Immunizations	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Well Baby Exams	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Well Child Exams	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Physical Exams	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Vision Services	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Vision Supplies	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Speech Exams	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Hearing Exams	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Podiatry Services	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Mammography	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Outpatient Mental Health	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Outpatient Substance Abuse	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
Other	0	$0	$0	$0	$0	$0	0	0	$0.00	$0.00	
7. Total Additional Services	**0**	**$0**	**$0**	**$0**	**$0**	**$0**	**0**	**0**	**$0.00**	**$0.00**	**0.0%**
8. Total Encounter Data Reported		**$0**	**$0**	**$0**	**$0**	**$0**	**0**			**$0.00**	**0.0%**
9. Total Capitation Paid						**$0**	**0**			**$0.00**	
										0%	

Valid

Please provide any documentation necessary

TABLE 4
PAID CLAIMS AND ENCOUNTER EXPERIENCE BY MONTH
January 1, 2015 Through March 31, 2016

	HOSPITAL INPATIENT		HOSPITAL OUTPATIENT		HOSPITAL OTHER	
	Total Paid Fee For Service	Total Paid Encounter Data	Total Paid Fee For Service	Total Paid Encounter Data	Total Paid Fee For Service	Total Paid Encounter Data
Jan-15	$0	$0	$0	$0	$0	$0
Feb-15	$0	$0	$0	$0	$0	$0
Mar-15	$0	$0	$0	$0	$0	$0
Apr-15	$0	$0	$0	$0	$0	$0
May-15	$0	$0	$0	$0	$0	$0
Jun-15	$0	$0	$0	$0	$0	$0
Jul-15	$0	$0	$0	$0	$0	$0
Aug-15	$0	$0	$0	$0	$0	$0
Sep-15	$0	$0	$0	$0	$0	$0
Oct-15	$0	$0	$0	$0	$0	$0
Nov-15	$0	$0	$0	$0	$0	$0
Dec-15	$0	$0	$0	$0	$0	$0
Total 2015	$0	$0	$0	$0	$0	$0
Jan-16	$0	$0	$0	$0	$0	$0
Feb-16	$0	$0	$0	$0	$0	$0
Mar-16	$0	$0	$0	$0	$0	$0
Total 2016 Q1	$0	$0	$0	$0	$0	$0

	PHYSICIAN		OTHER SERVICES		ADDITIONAL SERVICES	
	Total Paid Fee For Service	Total Paid Encounter Data	Total Paid Fee For Service	Total Paid Encounter Data	Total Paid Fee For Service	Total Paid Encounter Data
Jan-15	$0	$0	$0	$0	$0	$0
Feb-15	$0	$0	$0	$0	$0	$0
Mar-15	$0	$0	$0	$0	$0	$0
Apr-15	$0	$0	$0	$0	$0	$0
May-15	$0	$0	$0	$0	$0	$0
Jun-15	$0	$0	$0	$0	$0	$0
Jul-15	$0	$0	$0	$0	$0	$0
Aug-15	$0	$0	$0	$0	$0	$0
Sep-15	$0	$0	$0	$0	$0	$0
Oct-15	$0	$0	$0	$0	$0	$0
Nov-15	$0	$0	$0	$0	$0	$0
Dec-15	$0	$0	$0	$0	$0	$0
Total 2015	$0	$0	$0	$0	$0	$0
Jan-16	$0	$0	$0	$0	$0	$0
Feb-16	$0	$0	$0	$0	$0	$0
Mar-16	$0	$0	$0	$0	$0	$0
Total 2016 Q1	$0	$0	$0	$0	$0	$0

	TOTAL		Capitation
	Total Paid Fee For Service	Total Paid Encounter Data	Total Paid Monthly
Jan-15	$0	$0	$0
Feb-15	$0	$0	$0
Mar-15	$0	$0	$0
Apr-15	$0	$0	$0
May-15	$0	$0	$0
Jun-15	$0	$0	$0
Jul-15	$0	$0	$0
Aug-15	$0	$0	$0
Sep-15	$0	$0	$0
Oct-15	$0	$0	$0
Nov-15	$0	$0	$0
Dec-15	$0	$0	$0
Total 2015	$0	$0	$0
Jan-16	$0	$0	$0
Feb-16	$0	$0	$0
Mar-16	$0	$0	$0
Total 2016 Q1	$0	$0	$0
April 15 to March 16	$0	$0	$0
	Valid	Valid	

TABLE 5
MEDICAL TREND ASSUMPTIONS

	Trend Periods To Be Used In Calculations
Experience Period:	April 1, 2015 Through March 31, 2016
Rating Period:	January 1, 2017 Through December 31, 2017
Midpoint of Experience Period:	October 1, 2015
Midpoint of Rating Period:	July 1, 2017

Step 1. Calculate Weighted Trend for Fee For Service Experience Claims Data

2015-2016 Annual Trend

	Trends				
Category	Cost	Utilization	Combined	% of Total See Table 3A	Weighted Trend
Hospital Inpatient	0.0%	0.0%	0.0%	0.0%	0.0%
Hospital Outpatient	0.0%	0.0%	0.0%	0.0%	0.0%
Other Facility	0.0%	0.0%	0.0%	0.0%	0.0%
Physician Services	0.0%	0.0%	0.0%	0.0%	0.0%
Other Professional Services	0.0%	0.0%	0.0%	0.0%	0.0%
Additional Services	0.0%	0.0%	0.0%	0.0%	0.0%
			Total	0.0%	0.0%

2016-2017 Annual Trend

	Trends				
Category	Cost	Utilization	Combined	% of Total See Table 3A	Weighted Trend
Hospital Inpatient	0.0%	0.0%	0.0%	0.0%	0.0%
Hospital Outpatient	0.0%	0.0%	0.0%	0.0%	0.0%
Other Facility	0.0%	0.0%	0.0%	0.0%	0.0%
Physician Services	0.0%	0.0%	0.0%	0.0%	0.0%
Other Professional Services	0.0%	0.0%	0.0%	0.0%	0.0%
Additional Services	0.0%	0.0%	0.0%	0.0%	0.0%
			Total	0.0%	0.0%

Step 2. Calculate Aggregate Trend Factor for Experience Claims Data

2015-2016 Annual Trend	1.000
2016-2017 Annual Trend	1.000
1) Aggregate Trend Factor	1.000

Step 3. Calculate Weighted Trend for Capitated Services

	2015-2016 Annual Trend			2016-2017 Annual Trend		
	Trends			Trends		
Category	Trends	% of Total See Table 3B	Weighted Trend	Trends	% of Total See Table 3B	Weighted Trend
Hospital Inpatient	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Hospital Outpatient	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other Facility	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physician Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other Professional Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Additional Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Total	0.0%	0.0%	Total	0.0%	0.0%

2015-2016 Annual Trend	1.000
2016-2017 Annual Trend	1.000
2) Aggregate Trend Factor	1.000

Step 4. Describe any special circumstances which may have caused aggregate trends to be unusually high or low.

TABLE 6
MEDICAL
ADMINISTRATIVE EXPENSES AND OTHER PMPM COSTS

Detailed Description of Administrative Expense Category	2015 PMPM Actual	2016 PMPM Per Rate Renewal	2017 PMPM Estimated
ACA Fees	$0.00	$0.00	$0.00
Reinsurance	$0.00	$0.00	$0.00
Risk	$0.00	$0.00	$0.00
Retention	$0.00	$0.00	$0.00
Profit	$0.00	$0.00	$0.00
Claims Processing	$0.00	$0.00	$0.00
Medical Management	$0.00	$0.00	$0.00
Wellness Incentive	$0.00	$0.00	$0.00
Premium Tax	$0.00	$0.00	$0.00
Marketing	$0.00	$0.00	$0.00
Other*	$0.00	$0.00	$0.00
1) TOTAL	**$0.00**	**$0.00**	**$0.00**

*Please list and describe in detail amounts included in Other

TABLE 7
REQUIRED PREMIUM PMPM

DESCRIPTION	COST PMPM
1. Incurred claims cost PMPM for experience period (Table 3A Line 11)	$0.00
2. Aggregate fee for service trend factor (Table 5 Line 1)	1.000
3. Claims cost trended to rating period (1. x 2.)	$0.00
4. Total capitation PMPM (Table 3A Line 12)	$0.00
5. Aggregate capitated services trend factor (Table 5 Line 2)	1.000
6. Capitation cost trended to rating period (Line 4 x Line 5)	$0.00
7. 2017 Administrative cost PMPM (Table 6 Line 1)	$0.00
8 REQUIRED MEDICAL PREMIUM PMPM (3 + 6 + 7)	**$0.00**

TABLE 8
2017 CALCULATED RATES

Step 1

Conversion Factor Calculation

	Contract Mix	Average Contract Size	Rate Ratio	Conversion Factor
1. Employee	0.0%	-	1.0	0.000
2. Family	0.0%	-	2.0	0.000
3. Total	0.0%	-	-	

Step 2

2017 Medical Rate Calculation

	Single	Family
4. Required Premium PMPM	$0.00	$0.00
5. Conversion Factor	0.000	0.000
6. 2017 Calculated Rates	$0.00	$0.00
7. 2016 Inforce Rates	$0.00	$0.00

0.0% Single Rate Increase

TABLE 9
CALCULATED LOSS RATIOS

	January 1, 2015 Through March 31, 2016		
	REVENUE	EXPENSE	MEDICAL LOSS RATIO
Jan-15	$0	$0	0.0%
Feb-15	$0	$0	0.0%
Mar-15	$0	$0	0.0%
Apr-15	$0	$0	0.0%
May-15	$0	$0	0.0%
Jun-15	$0	$0	0.0%
Jul-15	$0	$0	0.0%
Aug-15	$0	$0	0.0%
Sep-15	$0	$0	0.0%
Oct-15	$0	$0	0.0%
Nov-15	$0	$0	0.0%
Dec-15	$0	$0	0.0%
TOTAL 2015	**$0**	**$0**	**0.0%**
Jan-16	$0	$0	0.0%
Feb-16	$0	$0	0.0%
Mar-16	$0	$0	0.0%
TOTAL Q1 2016	**$0**	**$0**	**0.0%**

	Projected CY 2016		
	MONTHLY REVENUE	MONTHLY EXPENSE	MEDICAL LOSS RATIO
TOTAL 2016	**$0**	**$0**	**0.0%**

	Projected CY 2017		
	MONTHLY REVENUE	MONTHLY EXPENSE	MEDICAL LOSS RATIO
TOTAL 2017	**$0**	**$0**	**0.0%**

State of Wisconsin - Employee Plan, Medicare

TABLE 10
LARGE CLAIMANTS > $100,000

4/1/15 - 3/31/16 Service Dates	
1. Total Paid Claims for Individuals with Paid Claims of $100,000 or Greater	$0
2. Number of Individuals with Paid Claims of $100,000 or Greater	0
3. Total Paid Claims Greater than $100,000 on an Individual Basis	$0
4. Total Incurred Claim Factor	0.000%
5. Number of Runout Months	0
6. Incurred Claims Total	$0

TABLE 11

please enter in the space provided below each question

1) When providing information for Medicare lines of business (State & Local), who is being included in the membership.

a) If a Medicare-eligible member with family coverage has a spouse (no other dependents) who is not eligible for Medicare, where are the spouse's membership and claims experience being reflected? In other words, are the spouse and his/her experience reflected in the Medicare (State or Local) experience or the regular employee (State or Local) experience?

b) In a situation similar to that above in (a) where there are also dependent children, how are the children's membership and claims experience being reflected? Are their membership and claims experience included in the Medicare (State or Local) or regular employee (State or Local) experience?

c) What happens when an employee not eligible for Medicare has a Medicare-eligible spouse? In other words, where are the employee and his/her experience reflected (Medicare or regular employee coverage) and where are the spouse and his/her experience reflected (Medicare or regular employee coverage)? If there are any dependent children, where are their membership and claims experience reflected?

2) Please describe the basis for the renewal (experience, community rated etc.)

TABLE 12
TOP PROVIDER REPORT
Based on April 1, 2015 Through March 31, 2016 Incurrals

FACILITY

	Provider Name	City	State	Zip Code	National Provider Identifier	Plan Paid Dollars	Utilization
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

PROFESSIONAL

	Provider Name	City	State	Zip Code	National Provider Identifier	Plan Paid Dollars	Utilization
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							

TABLE 13
REQUIRED DATA FORMAT
Based on April 1, 2015 Through March 31, 2016 Incurrals

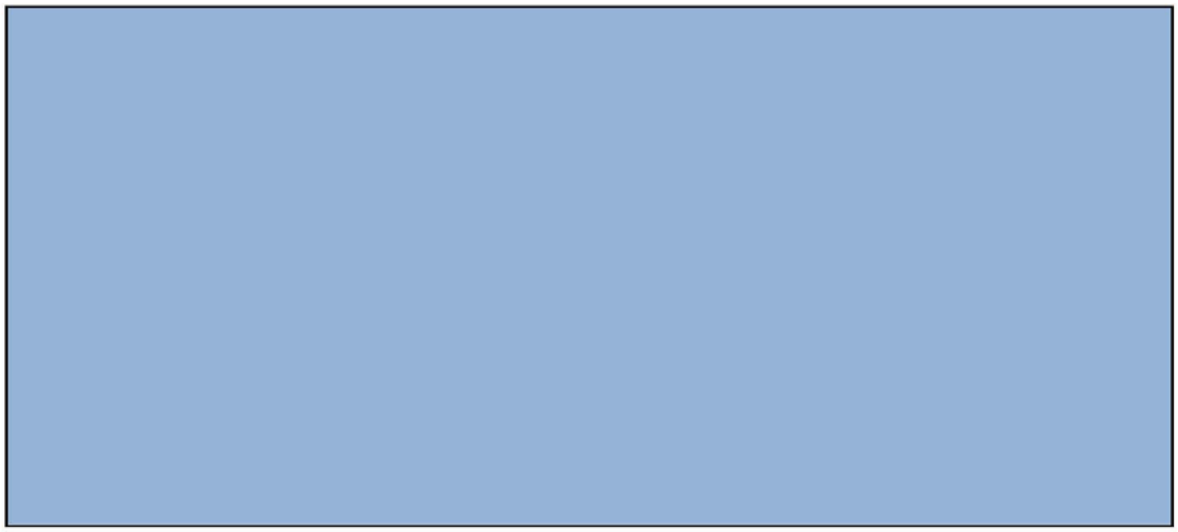
	Field Name	Field Description	Examples/Notes
1	HealthPlanCode	Two-digit plan code	
2	HealthPlanName	Health Plan Name	
3	Group	State or Local	State (S) or Local (L)
4	Plan	Plan Design	Uniform Benefits (U) or HDHP (H)
5	EligibilityStatus	Active Employee, Non-Medicare Retiree, Medicare Retiree, Grad Assistant	Active Employee (1); Non-Medicare Retiree (2); Medicare Retiree (3); Grad Assistant (4)
6	ServiceCategory	Service Category Code	See Service Category Codes in Table 14 for complete listing
7	Capitated	Yes or No	Y, N; Specifies whether a claim is capitated (Y) or not (N)
8	ClaimNumber	Medical claim number	ClaimNumber is an assigned number that identifies a claim
9	ClaimLineNumber	Line number of the claim	ClaimLineNumber identifies the line item detail for each service provided
10	SubscriberID	Subscriber identification number	Navitus Subscriber ID
11	MemberID	Member identification number	Navitus Member ID
12	Relationship	Self, Spouse or Child	Self (1); Spouse (2); Child (3)
13	Member DOB	Date of Birth of member	
14	Member Gender	Gender of member	
15	ProviderID	Provider identification number	National Provider Identification number (NPI); if unable to provide then populate this field with Provider TIN
16	ProviderName	Name of provider	
17	ProviderAddress	Address of provider	
18	ProviderCity	City of Provider	
19	ProviderState	State of Provider	
20	ProviderZipCode	Zip code of Provider	
21	ProviderSpecialty	Specialty description	Use CMS Standard Coding
22	NetworkFlag	In or out of network	Y, N; Specifies whether a claim is in (Y) or out (N) of network.
23	OutOfAreaFlag	Claim is out of area	(1) if out of area
24	PlaceOfServCode	Place of service code	Use CMS Standard Coding
25	ProcTypeFlag	Procedure code type	Code which indicates what types of codes are in the procCode field CPT4 (C), HCPCS (H), revenue codes (R), and DRG, ICD9Proc codes (D)
26	ProcCode	Procedure code	Code for the medical procedure performed. Types of codes include CPT4, HCPCS, revenue codes, etc. If non-standard codes are used, code descriptions are required.
27	ModifierCode	Modifier code for procedure	Used to further define the medical procedure code
28	PrimaryDiagCode	ICD-9 code or ICD10 if applicable	
29	Diag2Code	Additional ICD-9 code or ICD10 if applicable	
30	Diag3Code	Additional ICD-9 code or ICD10 if applicable	
31	Diag4Code	Additional ICD-9 code or ICD10 if applicable	
32	DRG	DRG Code	
33	ServiceFromDate	Date of service start	
34	ServiceToDate	Date of service end	
35	Service Units	Number of units	
36	Discharge Status		Use CMS Standard Coding
37	ClaimPaidDate	Date claim paid	
38	SubmittedAmount	Amount Submitted	
39	NotCoveredAmount	Amount not covered	
40	BilledAmount	Amount billed	Totals must tie to Addendum 1
41	SavingsAmount	Amount of savings as generated by network	
42	AllowedAmount	Amount allowed under contract	Totals must tie to Addendum 1
43	DeductibleAmount	Amount of deductible	Totals must tie to Addendum 1
44	CoinsuranceAmount	Amount of coinsurance	Totals must tie to Addendum 1
45	CoPayAmount	Amount of copay	Totals must tie to Addendum 1
46	MedicarePaid	Amount paid by Medicare	Totals must tie to Addendum 1
47	COBAmount	Coordination of Benefits amount other than Medicare	Totals must tie to Addendum 1
48	PaidAmount	Amount paid	Totals must tie to Addendum 1

TABLE 14
SERVICE CATEGORY CODES

Major Service Category	Detailed Service Category	Code
Hospital Inpatient	Medical	1
Hospital Inpatient	Surgical	2
Hospital Inpatient	Mental Health (MH)	3
Hospital Inpatient	Substance Abuse (SA)	4
Hospital Inpatient	Maternity Deliveries	5
Hospital Inpatient	Maternity Non-Deliveries	6
Hospital Inpatient	Neonatal ICU	7
Hospital Inpatient	Extended Care Facility	8
Hospital Outpatient	Emergency Room	9
Hospital Outpatient	Surgery	10
Hospital Outpatient	Radiology	11
Hospital Outpatient	Pathology	12
Hospital Outpatient	Mental Health (MH)	13
Hospital Outpatient	Substance Abuse (SA)	14
Hospital Outpatient	Other (Specify)	15
Other Facility	Hospice	16
Other Facility	Transitional Care	17
Physician Services	Inpatient Surgery	18
Physician Services	Inpatient Anesthesia	19
Physician Services	Outpatient Anesthesia	20
Physician Services	IP Maternity - Normal Deliveries	21
Physician Services	IP Maternity-Cesarean Deliveries	22
Physician Services	IP Other OB Services	23
Physician Services	Outpatient Hosp/Surgical Center	24
Physician Services	Office Surgery	25
Physician Services	Inpatient Hospital Visits	26
Physician Services	Inpatient Critical Care Visits	27
Physician Services	Inpatient Mental Health Visits	28
Physician Services	Inpatient Substance Abuse Visits	29
Physician Services	Extended Care Facility Visits	30
Physician Services	Home Health Visits	31
Physician Services	Office Visits	32
Physician Services	Therapeutic Injections (J Codes)	33
Physician Services	Allergy Testing/Immunotherapy	34
Physician Services	Chemotherapy Drugs	35
Physician Services	Diagnostic Testing	36
Physician Services	Urgent Care	37
Physician Services	Emergency Room	38
Physician Services	Consults	39
Physician Services	Cardiovascular	40
Physician Services	Dialysis	41
Physician Services	Inpatient Radiology	42
Physician Services	Outpatient Radiology	43
Physician Services	Office Radiology	44
Physician Services	Inpatient Pathology	45
Physician Services	Outpatient Pathology	46
Physician Services	Office Pathology	47
Physician Services	Other (Specify)	48
Other Services	Physical Therapy	49
Other Services	Occupational/Speech Therapy	50
Other Services	Chiropractic Services	51
Other Services	Private Duty Nursing/Home Health Care Services	52
Other Services	Ambulance	53
Other Services	DME/Prosthetics	54
Other Services	Laboratory	55
Additional Services	Immunizations	56
Additional Services	Well Baby Exams	57
Additional Services	Well Child Exams	58
Additional Services	Physical Exams	59
Additional Services	Vision Services	60
Additional Services	Vision Supplies	61
Additional Services	Speech Exams	62
Additional Services	Hearing Exams	63
Additional Services	Podiatry Services	64
Additional Services	Mammography	65
Additional Services	Outpatient Mental Health	66
Additional Services	Outpatient Substance Abuse	67
Additional Services	Other	68

TABLE 15
ACTUARIAL CERTIFICATION

Insert Actuarial Certification Language. The certification should cover the development of the rates, all reporting and that the detailed data matches the submission.



Actuary:	
Firm:	
Phone:	
Date:	

ADDENDUM 2: PLAN QUALIFICATIONS/PROVIDER GUARANTEE

Providers Under Contract Physically Located in Each Major City/County/Zip Code
State and Local Employees

Using the format provided by ETF, record the number of providers under contract sorted by zip-code who are physically located within each county and major city in the service area. Major cities are those that have over 33% of the county population. Those cities are Antigo, Appleton, Ashland, Eau Claire, Florence, Fond du Lac, Green Bay, Janesville, Kenosha, LaCrosse, Madison, Manitowoc, Menomonie, Merrill, Milwaukee, Monroe, Oshkosh, Prairie du Chien, Racine, Sheboygan, Stevens Point, Sturgeon Bay, and Superior.

Provider Guarantee:
In addition to the continuity of care provisions under Wis. Stat. § 609.24, the following provider guarantee provision applies. Providers listed here and/or on any of the plan's publications of providers, including subcontracted providers, are either under contract and available as specified in such publications for all of the ensuing calendar year or the plan will pay charges for benefits on a fee-for-service basis. Fee-for-service means the usual and customary charges the plan is able to negotiate with the provider while the subscriber is held harmless and indemnified. The intent of this provision is to allow patients of plan providers to continue appropriate access to any plan provider until the participant is able to change plans through the next dual-choice enrollment. This applies in the event a provider or provider group terminates its contract with the plan, except that loss of physicians due to normal attrition (death, retirement, a move from the service area;) or as a result of a formal disciplinary action relating to quality of care shall not require fee-for-service payment. Providers also agree to accept new patients unless specifically indicated otherwise. When providers terminate their contractual relationship, subscribers must be notified by the plan prior to the Dual-Choice Enrollment period. Plans shall keep a record of this notification mailing and shall provide documentation, by subscriber and indicating the mailing address used, upon the Department’s request.

If a plan clinic or hospital closes during the contract year, participants using that facility must be notified, in writing, 30 days in advance of the closing. This notice may be provided by the provider. The notification must indicate the participant’s options for other plan clinics or hospitals. If a physician leaves the plan mid-year, his or her patients must be notified, in writing, no less than 14 days prior to that event. In either instance, the subscriber must be advised of the provider guarantee.

This form must be filed annually by all current and new plans with the Department of Employee Trust Funds. The initial listing is due on June 3; the final copy is due on July 22. It is used to determine qualification for the plan's premium rate to be used in calculation of the employer contribution toward premium. Upon request, the Department may review the qualification status of a plan on a county by county basis and make recommendations to the Board. Generally, those qualifications are:

1. The ratio of full time equivalent (FTE) primary physicians accepting new patients to total plan members in a county or major city is at least 1.0/2,000 with a minimum of 5 physicians/county or major city. The primary physicians counted for this qualification requirement must be able to admit patients to a plan hospital in the county where the plan is qualified.

2. There must be at least one general hospital under contract and/or routinely utilized by plan providers per county or major city. If a hospital is not present in the county, plans must sufficiently describe how they provide access to providers.
3. A chiropractor must be available in each county (or major city if applicable).
4. The plan must have a minimum of one year of operation.
5. After being offered to state employees for one year, the plan must have achieved an enrollment of 100 subscribers or 10% of the employees in the service area. Service area means the entire geographic area in which the plan is qualified.

Health plans are responsible for submitting two types of reports to ETF

(1) A listing that includes all providers of any type. All providers should be listed by name and National Provider Identifier (NPI), as specified by the Department. Under no circumstances, should a clinic be listed in lieu of provider names.

(2) Health plans must also submit counts of providers and institutions used by ETF to determine plan qualification by county. Summary counts must be provided for every County and Major City in which a health plan has at least one PCP. ETF not only determines qualification status from the provider counts, but also determines whether or not a health plan will be listed in the "It's Your Choice" booklet as a non-qualified plan. Generally, if a health plan has at least one PCP in a county, the health plan will be listed in the "It's Your Choice" booklet although ETF may choose not to list a plan if it is not practical to do so. For example, ETF would not list a health plan that has a low number of providers in a high population county.

Plans that remove providers from their network for the following calendar year for the group health insurance program are prevented from adding those providers back to the network without approval from the Department until the next benefit year for which they submit a final bid based on inclusion of those providers. This provision does not apply to normal attrition.

Please note that all providers that health plans make available to participants or publish in the provider listings sent to members must be reflected in both the provider listing and the provider counts. Specific instructions on how to submit the information detailed above will be provided to the health plans in advance of the due date. ETF reserves the right to modify instructions and data requests as needed and may also request updated reports from health plans as needed.

SAMPLE FORMAT

Date: _____

Plan: We-Care (*Name of Plan*) La Crosse (*Location/Service Area*)

Counties and Major Cities in Service Area	No. Chiropractors	No. General Hospital Routinely Utilized	No. FTE Primary Care Providers*	Total Members
Crawford	3	0	4	560
Juneau	3	0	3	90
La Crosse (City)	2	2	29	340
La Crosse (County)	4	3	102	680

* Primary care provider as defined in Uniform Benefits and utilized by the plan in the manner described in the definition.

ADDENDUM 3: CLAIMS DATA SPECIFICATIONS

HEALTH PLANS must submit claims data for all PARTICIPANTS, for all claims processed, to the DEPARTMENT'S data warehouse in the file format specified in the most recent Data Specifications - Medical document. The file format as of the date of printing this document is shown below. The DEPARTMENT will specify and communicate a schedule of deliverables and due dates once the data warehouse vendor is under contract.

DATA SPECIFICATIONS – MEDICAL

July 22, 2016 version 1.0

File Specification for: Medical Claims File Submission:

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
HD001	Record Type	Header Record Identifier	Text	char[2]	2	N/A	N/A
HD002	Submitter	Header Submitter Defined by Contractor	Integer	varchar[6]	6	N/A	N/A
HD003	National Plan ID	Header Plan Identification Number (PlanID) Defined by Contractor	Integer	int[10]	10	N/A	N/A
HD004	Type of File	Defines the file type and data expected	Text	char[2]	2	N/A	N/A
HD005	Period Beginning Date	Header Period Start Date	Date Period - Integer	int[6] CCYYMM	6	N/A	N/A
HD006	Period Ending Date	Header Period Ending Date	Date Period - Integer	int[6] CCYYMM	6	N/A	N/A
HD007	Record Count	Header Record Count	Integer	varchar[10]	10	N/A	N/A
HD008	Comments	Header Carrier Comments	Text	varchar[80]	80	N/A	N/A
HD009	Version Number	Submission Guide Version	Decimal - Numeric	char[3]	3	N/A	N/A
MC001	Submitter	Defined and maintained unique identifier	Integer	varchar[6]	6	Loop 1000A Segment NM109	Loop 1000A Segment NM109
MC002	National Plan ID	National Plan Identification Number (PlanID)	Integer	int[10]	10	N/A	N/A
MC003	Insurance Type Code/Product	Type / Product Identification Code	Lookup Table - Text	char[2]	2	N/A	N/A
MC004	Payer Claim Control Number	Payer Claim Control Identification	Text	varchar[35]	35	Loop 2300 Segment CLM01	Loop 2300 Segment CLM01
MC005	Line Counter	Incremental Line Counter	Integer	varchar[4]	4	Loop 2400 Segment LX01	Loop 2400 Segment LX01
MC005A	Version Number	Claim Service Line Version Number	Integer	varchar[4]	4	N/A	N/A
MC006	Insured Group or Policy Number	Group / Policy Number	Text	varchar[30]	30	N/A	N/A
MC007	Subscriber SSN	Subscriber's Social Security Number	Numeric	char[9]	9	Loop 2010BA Segment REF02 where REF01 - SY	Loop 2010BA Segment REF02 where REF01 - SY
MC008	Plan Specific Contract Number	Contract Number	Text	varchar[30]	30	Loop 2300 Segment CN104	Loop 2300 Segment CN104
MC009	Member Suffix or Sequence Number	Member/Patient's Contract Sequence Number	Text	varchar[20]	20	N/A	N/A

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC010	Member SSN	Member/Patient's Social Security Number	Numeric	char[9]	9	Loop 2010BA Segment REF02 where REF01 = SY when Segment SBR02 = 18 - ELSE - Loop 2010CA Segment REF02 where REF01 = SY	Loop 2010BA Segment REF02 where REF01 = SY when Segment SBR02 = 18 - ELSE - Loop 2010CA Segment REF02 where REF01 = SY
MC011	Individual Relationship Code	Patient to Subscriber Relationship Code	Lookup Table - Text	char[2]	2	When present Loop 2000B SBR02 = 18 - ELSE - Loop 2000C Segment PAT01	When present Loop 2000B SBR02 = 18 - ELSE - Loop 2000C Segment PAT01
MC012	Member Gender	Patient's Gender	Lookup Table - Text	char[1]	1	Loop 2010BA Segment DMG03 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment DMG03	Loop 2010BA Segment DMG03 when Loop 2000B Segment SBR02 = 18 - OR - Loop 2010CA Segment DMG03
MC013	Member Date of Birth	Member/Patient's date of birth	Full Date - Integer	int[8] CCYYMMDD	8	Loop 2010BA Segment DMG02 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment DMG02	Loop 2010BA Segment DMG02 when Loop 200B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment DMG02
MC014	Member City Name	City name of the Member/Patient	Text	varchar[30]	30	Loop 2010BA Segment N401 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment N401	Loop 2010BA Segment N401 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment N401
MC015	Member State	State / Province of the Patient	External Code Source 2 - Text	char[2]	2	Loop 2010BA Segment N402 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment N402	Loop 2010BA Segment N402 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment N402
MC016	Member ZIP Code	Zip Code of the Member / Patient	External Code Source 2 - Text	varchar[9]	9	Loop 2010BA Segment N403 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment N403	Loop 2010BA Segment N403 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment N403
MC017	Date Service Approved (AP Date)	Date Service Approved by Payer	Full Date - Integer	int[8] CCYYMMDD	8	N/A	N/A
MC018	Admission Date	Inpatient Admit Date	Full Date - Integer	int[8] CCYYMMDD	8	EITHER - Loop 2300 Segment DTP03 where DTP01 = 435 and DTP02 = D8 - OR- The first eight digits of Loop 2300 Segment DTP03 where DTP01 = 435 and DTP02 = DT	N/A

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC019	Filler	Filler	Filler	char[4]	4	ONLY - The last four digits of Loop 2300 Segment DTP03 where DTP01 = 435 and DTP02 = DT	N/A
MC020	Admission Type	Admission Type Code	External Code Source 14 - Integer	int[1]	1	Loop 2300 Segment CL101	N/A
MC021	Admission Source	Admission Source Code	External Code Source 14 - Text	char[1]	1	Loop 2300 Segment CL102	N/A
MC022	Filler	Filler	Filler	char[4]	4	Loop 2300 Segment DTP03 where DTP01 = 096	N/A
MC023	Discharge Status	Inpatient Discharge Status Code	External Code Source 14 - Numeric	char[2]	2	Loop 2300 Segment CL103	N/A
MC024	Service Provider Number	Service Provider Identification Number	Text	varchar[30]	30	Assuming Service Provider = Billing Provider: Loop 2010AA Segment REF02 where REF01 = G2	Assuming Service Provider = Billing Provider: Loop 2010AA Segment REF02 where REF01 = G2
MC025	Service Provider Tax ID Number	Service Provider's Tax ID number	Numeric	char[9]	9	Assuming Service Provider = Billing Provider: Loop 2010AA Segment REF02 where REF01 = EI or SY	Assuming Service Provider = Billing Provider: Loop 2010AA Segment REF02 where REF01 = EI or SY
MC026	National Provider ID - Service	National Provider Identification (NPI) of the Service Provider	External Code Source 3 - Integer	int[10]	10	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM109	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM109
MC027	Service Provider Entity Type Qualifier	Service Provider Entity Identifier Code	Lookup Table - integer	int[1]	1	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM102 - sets this value = 2 always	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM102 - sets this value = 2 always
MC028	Service Provider First Name	First name of Service Provider	Text	varchar[25]	25	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM104 when present	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM104 when present
MC029	Service Provider Middle Initial	Middle initial of Service Provider	Text	varchar[25]	25	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM105 when present	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM105 when present
MC030	Servicing Provider Last Name or Organization Name	Last name or Organization Name of Service Provider	Text	varchar[60]	60	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM103	Assuming Service Provider = Billing Provider: Loop 2010AA Segment NM103
MC031	Service Provider Suffix	Provider Name Suffix	Lookup Table - Integer	int[1]	1	N/A	N/A

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC032	Service Provider Taxonomy	Taxonomy Code	External Code Source 5 - Text	varchar[10]	10	Assuming Service Provider = Billing Provider: Loop 2000A Segment PRV03	Assuming Service Provider = Billing Provider: Loop 2000A Segment PRV03
MC033	Service Provider City Name	City Name of the Provider	Text	varchar[30]	30	Assuming Service Provider = Billing Provider: Loop 2010AA Segment N401	Assuming Service Provider = Billing Provider: Loop 2010AA Segment N401
MC034	Service Provider State	State of the Service Provider	External Code Source 2 - Text	char[2]	2	Assuming Service Provider = Billing Provider: Loop 2010AA Segment N402	Assuming Service Provider = Billing Provider: Loop 2010AA Segment N402
MC035	Service Provider ZIP Code	Zip Code of the Service Provider	External Code Source 2 - Text	varchar[9]	9	Assuming Service Provider = Billing Provider: Loop 2010AA Segment N403	Assuming Service Provider = Billing Provider: Loop 2010AA Segment N403
MC036	Type of Bill - on Facility Claims	Type of Bill	External Code Source 14 - Integer	int[2]	2	Loop 2300 CLM05-01 where CLM05-02 = A	N/A
MC037	Site of Service - on NSF/ 1500 Claims	Place of Service Code	External Code Source 13 - Numeric	char[2]	2	N/A	Loop 2300 CLM05-01 where CLM05-02 = B
MC038	Claim Status	Claim Line Status	Lookup Table - Numeric	varchar[2]	2	N/A	N/A
MC039	Admitting Diagnosis	Admitting Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Loop 2300 Segment HI01-02 where HI01-01 = ABJ or BJ (ICD Version Dependent)	N/A
MC040	E-Code	ICD Diagnostic External Injury Code	External Code Source 8 - Text	varchar[7]	7	Loop 2300 Segment HI01-02 where HI01-01 = ABN or BN (ICD Version Dependent)	N/A
MC041	Principal Diagnosis	ICD Primary Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Loop 2300 Segment HI01-02 where HI01-01 = ABK or BK (ICD Version Dependent)	Loop 2300 Segment HI01-02 where HI01-01 = ABK or BK (ICD Version Dependent)
MC042	Other Diagnosis - 1	ICD Secondary Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Loop 2300 Segment HI01-02 where HI01-01 = ABF or BF (ICD Version Dependent)	Loop 2300 Segment HI02-02 where HI02-01 = ABF or BF (ICD Version Dependent)
MC043	Other Diagnosis - 2	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Loop 2300 Segment HI02-02 where HI02-01 = ABF or BF (ICD Version Dependent)	Loop 2300 Segment HI03-02 where HI03-01 = ABF or BF (ICD Version Dependent)
MC044	Other Diagnosis - 3	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Loop 2300 Segment HI03-02 where HI03-01 = ABF or BF (ICD Version Dependent)	Loop 2300 Segment HI04-02 where HI04-01 = ABF or BF (ICD Version Dependent)
MC045	Other Diagnosis - 4	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Loop 2300 Segment HI04-02 where HI04-01 = ABF or BF (ICD Version Dependent)	Loop 2300 Segment HI05-02 where HI05-01 = ABF or BF (ICD Version Dependent)

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC046	Other Diagnosis - 5	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Loop 2300 Segment HI05-02 where HI05-01 = ABF or BF (ICD Version Dependent)	Loop 2300 Segment HI06-02 where HI06-01 = ABF or BF (ICD Version Dependent)
MC047	Other Diagnosis - 6	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Loop 2300 Segment HI06-02 where HI06-01 = ABF or BF (ICD Version Dependent)	Loop 2300 Segment HI07-02 where HI07-01 = ABF or BF (ICD Version Dependent)
MC048	Other Diagnosis - 7	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Loop 2300 Segment HI07-02 where HI07-01 = ABF or BF (ICD Version Dependent)	Loop 2300 Segment HI08-02 where HI08-01 = ABF or BF (ICD Version Dependent)
MC049	Other Diagnosis - 8	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Loop 2300 Segment HI08-02 where HI08-01 = ABF or BF (ICD Version Dependent)	Loop 2300 Segment HI09-02 where HI09-01 = ABF or BF (ICD Version Dependent)
MC050	Other Diagnosis - 9	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Loop 2300 Segment HI09-02 where HI09-01 = ABF or BF (ICD Version Dependent)	Loop 2300 Segment HI10-02 where HI10-01 = ABF or BF (ICD Version Dependent)
MC051	Other Diagnosis - 10	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Loop 2300 Segment HI10-02 where HI10-01 = ABF or BF (ICD Version Dependent)	Loop 2300 Segment HI11-02 where HI11-01 = ABF or BF (ICD Version Dependent)
MC052	Other Diagnosis - 11	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Loop 2300 Segment HI11-02 where HI11-01 = ABF or BF (ICD Version Dependent)	Loop 2300 Segment HI12-02 where HI12-01 = ABF or BF (ICD Version Dependent)
MC053	Other Diagnosis - 12	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Loop 2300 Segment HI12-02 where HI12-01 = ABF or BF (ICD Version Dependent)	N/A
MC054	Revenue Code	Revenue Code	External Code Source 14 - Numeric	char[4]	4	As Sent by Provider - Loop 2400 Segment SV201 - OR- As Priced/Reprised - Loop 2400 Segment HCP08 - OR- As Adjudicated - Loop 2430 Segment SVD04	N/A
MC055	Procedure Code	HCPCS / CPT Code	External Code Source 9 - Text	varchar[10]	10	As Sent by Provider - Loop 2400 Segment SV202-02 -OR- As Priced/Reprised - Loop 2400 Segment HCP10 - OR- As Adjudicated - Loop 2430 Segment SVD03-02	As Sent by Provider - Loop 2400 Segment SV202-02 -OR- As Priced/Reprised - Loop 2400 Segment HCP10 -OR- As Adjudicated - Loop 2430 Segment SVD03-02

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC056	Procedure Modifier - 1	HCPCS / CPT Code Modifier	External Code Source 9 - Text	char[2]	2	As Sent by Provider - Loop 2400 Segment SV202-03 - Not present for Pricing/Repricing - OR As Adjudicated - Loop 2430 Segment SVD03-03	As Sent by Provider - Loop 2400 Segment SV202-03 - Not present for Pricing/Repricing -OR As Adjudicated - Loop 2430 Segment SVD03-03
MC057	Procedure Modifier - 2	HCPCS / CPT Code Modifier	External Code Source 9 - Text	char[2]	2	As Sent by Provider - Loop 2400 Segment SV202-04 - Not present for Pricing/Repricing - OR As Adjudicated - Loop 2430 Segment SVC03-04	As Sent by Provider - Loop 2400 Segment SV202-04 - Not present for Pricing/Repricing -OR As Adjudicated - Loop 2430 Segment SVC03-04
MC058	ICD-CM Primary Procedure Code	ICD Primary Procedure Code	External Codes Source 8 - Text	varchar[7]	7	Loop 2300 Segment HI01-02 where HI01-01 = BBR, BR or CAH	N/A
MC059	Date of Service - From	Date of Service	Full Date - Integer	int[8] CCYYMMDD	8	First eight digits of Loop 2400 Segment DTP03 where DTP02 = RD8 - OR- Loop 2400 Segment DTP03 where DTP02 = D8	First eight digits of Loop 2400 Segment DTP03 where DTP02 = RD8 and DTP01 = 472 -OR- Loop 2400 Segment DTP03 where DTP02 = D8 and DTP01 = 472
MC060	Date of Service - To	Date of Service	Full Date - Integer	int[8] CCYYMMDD	8	Last eight digits of Loop 2400 Segment DTP03 where DTP02 = RD8 - OR- Repeat Loop 2400 Segment DTP03 where DTP02 = D8	Last eight digits of Loop 2400 Segment DTP03 where DTP02 = RD8 and DTP01 = 472 -OR- Repeat Loop 2400 Segment DTP03 where DTP02 = D8 and DTP01 = 472
MC061	Quantity	Claim line units of service	Quantity - Integer	±varchar[15]	15	As Sent by Provider - Loop 2400 Segment SV205 - As Priced/Repriced - Loop 2400 Segment HCP12 - As Adjudicated - Loop 2430 Segment SVD05	As Sent by Provider - Loop 2400 Segment SV205 - As Priced/Repriced - Loop 2400 Segment HCP12 - As Adjudicated - Loop 2430 Segment SVD05
MC062	Charge Amount	Amount of provider charges for the claim line	Integer	±varchar[10]	10	Loop 2400 Segment SV203	Loop 2400 Segment SV102
MC063	Paid Amount	Amount paid by the carrier for the claim line	Integer	±varchar[10]	10	Loop 2430 Segment SVD02	Loop 2430 Segment SVD02
MC064	Prepaid Amount	Amount carrier has prepaid towards the claim line	Integer	±varchar[10]	10	N/A	N/A
MC065	Copay Amount	Amount of Copay member/patient is responsible to pay	Integer	±varchar[10]	10	Loop 2430 Segment CAS03, 06, 09, 12, 15 or 18 where CAS01 = PR and	Loop 2430 Segment CAS03, 06, 09, 12, 15 or 18 where CAS01 = PR and
MC065	Copay Amount	Amount of Copay member/patient is responsible to pay	Integer	±varchar[10]	10	Loop 2430 Segment CAS03, 06, 09, 12, 15 or 18 where CAS01 = PR and CAS02 = 3	Loop 2430 Segment CAS03, 06, 09, 12, 15 or 18 where CAS01 = PR and CAS02 = 3

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC066	Coinsurance Amount	Amount of coinsurance member/patient is responsible to pay	Integer	±varchar[10]	10	Loop 2430 Segment CAS03, 06, 09, 12, 15 or 18 where CAS01 = PR and CAS02 = 2	Loop 2430 Segment CAS03, 06, 09, 12, 15 or 18 where CAS01 = PR and CAS02 = 2
MC067	Deductible Amount	Amount of deductible member/patient is responsible to pay on the claim line	Integer	±varchar[10]	10	Loop 2430 Segment CAS03, 06, 09, 12, 15 or 18 where CAS01 = PR and CAS02 = 1	Loop 2430 Segment CAS03, 06, 09, 12, 15 or 18 where CAS01 = PR and CAS02 = 1
MC068	Patient Control Number	Patient Control Number	Text	varchar[20]	20	Loop 2300 Segment CLM01	Loop 2300 Segment CLM01
MC069	Discharge Date	Discharge Date	Full Date - Integer	int[8] CCYYMMDD	8	Last eight digits of Loop 2300 Segment DTP03 where DTP01 = 434	N/A
MC070	Service Provider Country Code	Country name of the Service Provider	External Code Source 1 - Text	char[3]	3	Assuming Service Provider = Billing Provider: Loop 2010AA Segment N404	Assuming Service Provider = Billing Provider: Loop 2010AA Segment N404
MC071	DRG	Diagnostic Related Group Code	External Code Source 15 - Text	varchar[7]	7	Loop 2300 Segment HI01-02 where HI01-01 = DR	N/A
MC072	DRG Version	Diagnostic Related Group Version Number	External Code Source 15 - Text	char[2]	2	N/A	N/A
MC073	Filler	Filler	Filler	char[4]	4	N/A	N/A
MC074	Filler	Filler	Filler	char[2]	2	N/A	N/A
MC075	Drug Code	National Drug Code (NDC)	External Code Source 12 - Text	char[11]	11	Loop 2410 Segment LIN03 where LIN02 = N4	Loop 2410 Segment LIN03 where LIN02 = N4
MC076	Billing Provider Number	Billing Provider Number	Text	varchar[30]	30	Loop 2010AA Segment REF02 where REF01 = G2	Loop 2010AA Segment REF02 where REF01 = G2
MC077	National Provider ID - Billing	National Provider Identification (NPI) of the Billing Provider	External Code Source 3 - Integer	int[10]	10	Loop 2010AA Segment NM109 where NM108 = XX	Loop 2010AA Segment NM109 where NM108 = XX
MC078	Billing Provider Last Name or Organization Name	Last name or Organization Name of Billing Provider	Text	varchar[60]	60	Loop 2010AA Segment NM103	Loop 2010AA Segment NM103
MC079	Product ID Number	Product Identification	Text	varchar[30]	30	N/A	N/A
MC080	Payment Reason	Payment Reason Code	Carrier Defined Table - OR - External Code Source 16 - Text	varchar[30]	30	No direct map - use Loop 2400 Segment CAS iterations to determine payments from denials	No direct map - use Loop 2400 Segment CAS iterations to determine payments from denials
MC081	Capitated Encounter Flag	Indicator - Capitation Payment	Lookup Table - Integer	int[1]	1	N/A for strict application of value - OR- Set value = 1 where Loop 2300 Segment CN101 = 05 - ELSE - set value to 2	N/A for strict application of value - OR- Set value = 1 where Loop 2300 Segment CN101 = 05 - ELSE - set value to 2

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC082	Member Street Address	Street address of the Member/Patient	Text	varchar[50]	50	Loop 2010BA Segment N301 when Loop 2000B SBR02 = 18 - ELSE - Loop 2010CA Segment N301	Loop 2010BA Segment N301 when Loop 2000B SBR02 = 18 - ELSE - Loop 2010CA Segment N301
MC083	Other ICD-CM Procedure Code - 1	ICD Secondary Procedure Code	External Codes Source 8 - Text	varchar[7]	7	Loop 2300 HI01-02 where HI01- 01 = BBQ or BQ	N/A
MC084	Other ICD-CM Procedure Code - 2	ICD Other Procedure Code	External Codes Source 8 - Text	varchar[7]	7	Loop 2300 HI02-02 where HI02- 01 = BBQ or BQ	N/A
MC085	Other ICD-CM Procedure Code - 3	ICD Other Procedure Code	External Codes Source 8 - Text	varchar[7]	7	Loop 2300 HI03-02 where HI03- 01 = BBQ or BQ	N/A
MC086	Other ICD-CM Procedure Code - 4	ICD Other Procedure Code	External Codes Source 8 - Text	varchar[7]	7	Loop 2300 HI04-02 where HI04- 01 = BBQ or BQ	N/A
MC084	Other ICD-CM Procedure Code - 2	ICD Other Procedure Code	External Codes Source 8 - Text	varchar[7]	7	Loop 2300 HI02-02 where HI02- 01 = BBQ or BQ	N/A
MC085	Other ICD-CM Procedure Code - 3	ICD Other Procedure Code	External Codes Source 8 - Text	varchar[7]	7	Loop 2300 HI03-02 where HI03- 01 = BBQ or BQ	N/A
MC086	Other ICD-CM Procedure Code - 4	ICD Other Procedure Code	External Codes Source 8 - Text	varchar[7]	7	Loop 2300 HI04-02 where HI04- 01 = BBQ or BQ	N/A
MC087	Other ICD-CM Procedure Code - 5	ICD Other Procedure Code	External Codes Source 8 - Text	varchar[7]	7	Loop 2300 HI05-02 where HI05- 01 = BBQ or BQ	N/A
MC088	Other ICD-CM Procedure Code - 6	ICD Other Procedure Code	External Codes Source 8 - Text	varchar[7]	7	Loop 2300 HI06-02 where HI06- 01 = BBQ or BQ	N/A
MC089	Paid Date	Paid date of the claim line	Full Date - Integer	int[8] CCYYMMDD	8	Loop 2430 Segment DTP03	Loop 2430 Segment DTP03
MC090	LOINC Code	Logical Observation Identifiers, Names and Codes (LOINC)	External Code Source 11 - Text	varchar[7]	7	N/A	N/A
MC091	Coinsurance Days	Covered Coinsurance Days	Quantity - Integer	±varchar[4]	4	N/A	N/A
MC092	Covered Days	Covered Inpatient Days	Quantity - Integer	±varchar[4]	4	N/A	N/A
MC093	Non Covered Days	Noncovered Inpatient Days	Quantity - Integer	±varchar[4]	4	N/A	N/A
MC094	Type of Claim	Type of Claim Indicator	Lookup Table - Text	char[3]	3	N/A	N/A
MC095	Coordination of Benefits/TPL Liability Amount	Amount due from a Secondary Carrier when known	Integer	±varchar[10]	10	N/A	N/A

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC096	Other Insurance Paid Amount	Amount paid by a Primary Carrier	Integer	±varchar[10]	10	Loop 2320 AMT02 where AMT01 = D - with multiple Loop 2320s allowed, this will need to be calculated for the number of prior payers	Loop 2320 AMT02 where AMT01 = D - with multiple Loop 2320s allowed, this will need to be calculated for the number of prior payers
MC097	Medicare Paid Amount	Amount Medicare paid on claim	Integer	±varchar[10]	10	Loop 2320 AMT02 where AMT01 = D where either MIA or MOA segments are included	Loop 2320 AMT02 where AMT01 = D where MOA segments are included
MC098	Allowed amount	Allowed Amount	Integer	±varchar[10]	10	As Priced/Repriced - Loop 2400 Segment HCP02	As Priced/Repriced - Loop 2400 Segment HCP02
MC099	Non-Covered Amount	Amount of claim line charge not covered	Integer	±varchar[10]	10	Loop 2430 Segment CAS03, 06, 09, 12, 15, and/or 18 where it has been identified in CAS02, 05, 08, 11,	Loop 2430 Segment CAS03, 06, 09, 12, 15, and/or 18 where it has been identified in CAS02, 05, 08, 11, 14 and/or 17 that the
MC100	Delegated Benefit Administrator Organization ID	defined and maintained Org ID for linking across submitters	Integer	varchar[6]	6	N/A	N/A
MC101	Subscriber Last Name	Last name of Subscriber	Text	varchar[60]	60	Loop 2010BA Segment NM103	Loop 2010BA Segment NM103
MC102	Subscriber First Name	First name of Subscriber	Text	varchar[25]	25	Loop 2010BA Segment NM104	Loop 2010BA Segment NM104
MC103	Subscriber Middle Initial	Middle initial of Subscriber	Text	char[1]	1	Loop 2010BA Segment NM105	Loop 2010BA Segment NM105
MC104	Member Last Name	Last name of Member/Patient	Text	varchar[60]	60	Loop 2010BA Segment NM103 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment NM103	Loop 2010BA Segment NM103 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment NM103
MC105	Member First Name	First name of Member/Patient	Text	varchar[25]	25	Loop 2010BA Segment NM104 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment NM104	Loop 2010BA Segment NM104 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment NM104
MC106	Member Middle Initial	Middle initial of Member/Patient	Text	char[1]	1	Loop 2010BA Segment NM105 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment NM105	Loop 2010BA Segment NM105 when Loop 2000B Segment SBR02 = 18 - ELSE - Loop 2010CA Segment NM105
MC107	ICD Indicator	International Classification of Diseases version	Lookup Table - Integer	int[1]	1	Set value here based upon value in Loop 2300 Segment HI01-01 starting with the letter A	Set value here based upon value in Loop 2300 Segment HI01-01 starting with the letter A
MC108	Procedure Modifier - 3	HCPCS / CPT Code Modifier	External Code Source 9 - Text	char[2]	2	As Sent by Provider - Loop 2400 Segment SV202-05 - Not present for Pricing/Repricing - OR As Adjudicated - Loop 2430 Segment SVD03-05	As Sent by Provider - Loop 2400 Segment SV202-05 - Not present for Pricing/Repricing -OR As Adjudicated - Loop 2430 Segment SVD03-05

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC109	Procedure Modifier - 4	HCPCS / CPT Code Modifier	External Code Source 9 - Text	char[2]	2	As Sent by Provider - Loop 2400 Segment SV202-06 - Not present for Pricing/Repricing - OR As Adjudicated - Loop 2430 Segment SVD03-06	As Sent by Provider - Loop 2400 Segment SV202-06 - Not present for Pricing/Repricing -OR As Adjudicated - Loop 2430 Segment SVD03-06
MC110	Claim Processed Date	Claim Processed Date	Full Date - Integer	int[8] CCYYMMDD	8	N/A	N/A
MC111	Diagnostic Pointer	Diagnostic Pointer Number	Integer	varchar[4]	4	N/A	Loop 2400 Segment SVC107-01 and SVC107-02 when present and SVC107-03 when present and SVC107-04 when present
MC112	Referring Provider ID	Referring Provider ID	Text	varchar[30]	30	Loop 2420D Segment REF02 where REF01 = G2	Loop 2420F Segment REF02 where REF01 = G2
MC113	Payment Arrangement Type	Payment Arrangement Type Value	Lookup Table - Numeric	char[2]	2	Loop 2400 Segment HCP01 - table values to be mapped to	Loop 2400 Segment HCP01 - table values to be mapped to
MC114	Excluded Expenses	Amount not covered at the claim line due to benefit/plan limitation	Integer	±varchar[10]	10	Loop 2430 Segment CAS03, 06, 09, 12, 15, and/or 18 where it has been identified in CAS02, 05, 08, 11, 14 and/or 17 that the amounts are considered Excluded.	Loop 2430 Segment CAS03, 06, 09, 12, 15, and/or 18 where it has been identified in CAS02, 05, 08, 11, 14 and/or 17 that the amounts are considered Excluded.
MC115	Medicare Indicator	Indicator - Medicare Payment Applied	Lookup Table - Integer	int[1]	1	When Loop 1000A Segment NM109 is identified as Medicare and Loop 2430 SVD02 >= 0 then set value to 1, when SVD02 < 0 or not present then set value to 2. OR When Loop 2320 Segment SBR09 = MA or MB and Loop 2320 Segment AMT02 >= 0 where AMT01 = D then set value to 1.	When Loop 1000A Segment NM109 is identified as Medicare and Loop 2430 SVD02 >= 0 then set value to 1, when SVD02 < 0 or not present then set value to 2. OR When Loop 2320 Segment SBR09 = MA or MB and Loop 2320 Segment AMT02 >= 0 where AMT01 = D then set value to 1.
MC116	Withhold Amount	Amount to be paid to the provider upon guarantee of performance	Integer	±varchar[10]	10	N/A	N/A
MC117	Filler	Filler	Filler	int[1]	1	Set value = 1 when Loop 2300 Segment REF01 = G1; else value = 2	Set value = 1 when Loop 2400 Segment REF01 = G1; else value = 2
MC118	Referral Indicator	Indicator - Referral Needed	Lookup Table - Integer	int[1]	1	Set value = 1 when Loop 2300 Segment REF01 = 9F; else value = 2	Set value = 1 when Loop 2400 Segment REF01 = 9F; else value = 2
MC119	PCP Indicator	Indicator - PCP Rendered Service	Lookup Table - Integer	int[1]	1	N/A	N/A

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC120	DRG Level	Diagnostic Related Group Code Severity Level	External Code Source 15 - Integer	int[1]	1	N/A	N/A
MC121	Patient Total Out of Pocket Amount	Total amount patient/member must pay	Integer	±varchar[10]	10	N/A	N/A
MC122	Global Payment Flag	Indicator - Global Payment	Lookup Table - Integer	int[1]	1	N/A	N/A
MC123	Denied Flag	Denied Claim Line Indicator	Lookup Table - Integer	int[1]	1	Loop 2430 CAS identification will set value to 1 or 2 - THIS REQUIRES PAYER BY PAYER MAPPING	Loop 2430 CAS identification will set value to 1 or 2 - THIS REQUIRES PAYER BY PAYER MAPPING
MC124	Denial Reason	Denial Reason Code	Carrier Defined Table - OR - External Code Source 16 - Text	varchar[15]	15	Loop 2430 CAS/Carrier Defined Table identification will set value to 1 or 2 - THIS REQUIRES PAYER BY PAYER MAPPING	Loop 2430 CAS/Carrier Defined Table identification will set value to 1 or 2 - THIS REQUIRES PAYER BY PAYER MAPPING
MC125	Attending Provider	Attending Provider ID	Text	varchar[30]	30	N/A	N/A
MC126	Accident Indicator	Indicator - Accident Related	Lookup Table - Integer	int[1]	1	N/A	Presence of Loop 2300 Segment CLM11-01 = AA or OA set value = 1, else value = 2
MC127	Family Planning Indicator	Service is related to Family Planning	Lookup Table - Integer	int[1]	1	N/A	Presence of Loop 2400 Segment SV112 = Y, set value = 1, else value =2
MC128	Employment Related Indicator	Indicator - Accident Related	Lookup Table - Integer	int[1]	1	N/A	Presence of Loop 2300 Segment CLM11-01 = EM set value = 1, else value = 2
MC129	EPSDT Indicator	Service related to Early Periodic Screening, Diagnosis and Treatment (EPSDT)	Lookup Table - Integer	int[1]	1	N/A	Presence of Loop 2400 Segment SV111 = Y, set value = 1, else value =2
MC130	Procedure Code Type	Claim line Procedure Code Type Identifier	Lookup Table - Integer	int[1]	1	As Sent by Provider - Loop 2400 Segment SV202-01 - As Priced/Repriced - Loop 2400 Segment HCP09 - table values to be mapped to values	As Sent by Provider - Loop 2400 Segment SV101-01 - As Priced/Repriced - Loop 2400 Segment HCP09 - table values to be mapped to values
MC131	InNetwork Indicator	Indicator - Network Rate Applied	Lookup Table - Integer	int[1]	1	N/A for strict application of value - OR - Set value = 2 where Loop 2400 Segment HCP14 = 5 and/or Loop 2400 Segment HCP15 = 1 or 3 - ELSE - set value = 1	N/A for strict application of value - OR - Set value = 2 where Loop 2400 Segment HCP14 = 5 and/or Loop 2400 Segment HCP15 = 1 or 3 - ELSE - set value = 1
MC132	Service Class	Service Class Code	Carrier Defined Table - Text	char[2]	2	N/A	N/A
MC133	Bill Frequency Code	Bill Frequency	External Code Source 14 - Text	char[1]	1	Loop 2300 Segment CLM05-03	Loop 2300 Segment CLM05-03

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC134	Plan Rendering Provider Identifier	Plan Rendering Number	Text	varchar[30]	30	Various depending on Line Item: Operating = Loop 2420A Segment REF02 where REF01 = G2 - OR - Other Operating = Loop 2420B Segment REF02 where REF01 = G2 - OR - Rendering = Loop 2420C Segment REF02 where REF01 = G2	Various depending on Line Item: Rendering = Loop 2420A Segment REF02 where REF01 = G2 - OR - Purchased Service Provider = Loop 2420B Segment REF02 where REF01 = G2 - OR - Ordering Provider = Loop 2420E Segment REF02 where REF01 = G2
MC135	Provider Location	Location of Provider	Text	varchar[30]	30	N/A	N/A
MC136	Discharge Diagnosis	ICD Discharge Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	N/A	N/A
MC137	Carrier Specific Unique Member ID	Member's Unique ID	Text	varchar[50]	50	Loop 2010BA Segment NM109 when Loop 2000B SBR02 = 18 - ELSE - Loop 2010CA Segment NM109	Loop 2010BA Segment NM109 when Loop 2000B SBR02 = 18 - ELSE - Loop 2010CA Segment NM109
MC138	Claim Line Type	Claim Line Activity Type Code	Lookup Table - Text	char[1]	1	N/A	N/A
MC139	Former Claim Number	Previous Claim Number	Text	varchar[35]	35	N/A	N/A
MC140	Member Street Address 2	Secondary Street Address of the Member/Patient	Text	varchar[50]	50	Loop 2010BA Segment N302 when Loop 2000B SBR02 = 18 - ELSE - Loop 2010CA Segment N302	Loop 2010BA Segment N302 when Loop 2000B SBR02 = 18 - ELSE - Loop 2010CA Segment N302
MC141	Carrier Specific Unique Subscriber ID	Subscriber's Unique ID	Text	varchar[50]	50	Loop 2010BA Segment NM109	Loop 2010BA Segment NM109
MC142	Other Diagnosis - 13	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Second Iteration of Loop 2300 Segment HI01-02 where HI01-01 = ABF or BF (ICD Version Dependent)	N/A
MC143	Other Diagnosis - 14	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Second Iteration of Loop 2300 Segment HI02-02 where HI02-01 = ABF or BF (ICD Version Dependent)	N/A
MC144	Other Diagnosis - 15	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Second Iteration of Loop 2300 Segment HI03-02 where HI03-01 = ABF or BF (ICD Version Dependent)	N/A
MC145	Other Diagnosis - 16	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Second Iteration of Loop 2300 Segment HI04-02 where HI04-01 = ABF or BF (ICD Version Dependent)	N/A

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC146	Other Diagnosis - 17	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Second Iteration of Loop 2300 Segment HI05-02 where HI05-01 = ABF or BF (ICD Version Dependent)	N/A
MC147	Other Diagnosis - 18	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Second Iteration of Loop 2300 Segment HI06-02 where HI06-01 = ABF or BF (ICD Version Dependent)	N/A
MC148	Other Diagnosis - 19	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Second Iteration of Loop 2300 Segment HI07-02 where HI07-01 = ABF or BF (ICD Version Dependent)	N/A
MC149	Other Diagnosis - 20	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Second Iteration of Loop 2300 Segment HI08-02 where HI08-01	N/A
MC150	Other Diagnosis - 21	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Second Iteration of Loop 2300 Segment HI09-02 where HI09-01	N/A
MC151	Other Diagnosis - 22	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Second Iteration of Loop 2300 Segment HI10-02 where HI10-01	N/A
MC152	Other Diagnosis - 23	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Second Iteration of Loop 2300 Segment HI11-02 where HI11-01	N/A
MC153	Other Diagnosis - 24	ICD Other Diagnosis Code	External Code Source 8 - Text	varchar[7]	7	Second Iteration of Loop 2300 Segment HI12-02 where HI12-01	N/A
MC154	Present on Admission Code (POA) - 01	POA code for Principal Diagnosis	External Code Source 15 - Text	char[1]	1	Loop 2300 Segment HI01-09 where HI01-01 = ABK or BK	N/A
MC155	Present on Admission Code (POA) - 02	POA code for Other Diagnosis - 1	External Code Source 15 - Text	char[1]	1	Loop 2300 Segment HI01-09 where HI01-01 = ABF or BF	N/A
MC156	Present on Admission Code (POA) - 03	POA code for Other Diagnosis - 2	External Code Source 15 - Text	char[1]	1	Loop 2300 Segment HI02-09 where HI02-01 = ABF or BF	N/A
MC157	Present on Admission Code (POA) - 04	POA code for Other Diagnosis - 3	External Code Source 15 - Text	char[1]	1	Loop 2300 Segment HI03-09 where HI03-01 = ABF or BF	N/A
MC158	Present on Admission Code (POA) - 05	POA code for Other Diagnosis - 4	External Code Source 15 - Text	char[1]	1	Loop 2300 Segment HI04-09 where HI04-01 = ABF or BF	N/A
MC159	Present on Admission Code (POA) - 06	POA code for Other Diagnosis - 5	External Code Source 15 - Text	char[1]	1	Loop 2300 Segment HI05-09 where HI05-01 = ABF or BF	N/A
MC160	Present on Admission Code (POA) - 07	POA code for Other Diagnosis - 6	External Code Source 15 - Text	char[1]	1	Loop 2300 Segment HI06-09 where HI06-01 = ABF or BF	N/A

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC161	Present on Admission Code (POA) - 08	POA code for Other Diagnosis - 7	External Code Source 15 - Text	char[1]	1	Loop 2300 Segment HI07-09 where HI07-01 = ABF or BF	N/A
MC162	Present on Admission Code (POA) - 09	POA code for Other Diagnosis - 8	External Code Source 15 - Text	char[1]	1	Loop 2300 Segment HI08-09 where HI08-01 = ABF or BF	N/A
MC163	Present on Admission Code (POA) - 10	POA code for Other Diagnosis - 9	External Code Source 15 - Text	char[1]	1	Loop 2300 Segment HI09-09 where HI09-01 = ABF or BF	N/A
MC164	Present on Admission Code (POA) - 11	POA code for Other Diagnosis - 10	External Code Source 15 - Text	char[1]	1	Loop 2300 Segment HI10-09 where HI10-01 = ABF or BF	N/A
MC165	Present on Admission Code (POA) - 12	POA code for Other Diagnosis - 11	External Code Source 15 - Text	char[1]	1	Loop 2300 Segment HI11-09 where HI11-01 = ABF or BF	N/A
MC166	Present on Admission Code (POA) - 13	POA code for Other Diagnosis - 12	External Code Source 15 - Text	char[1]	1	Loop 2300 Segment HI12-09 where HI12-01 = ABF or BF	N/A
MC167	Present on Admission Code (POA) - 14	POA code for Other Diagnosis - 13	External Code Source 15 - Text	char[1]	1	Second Iteration of Loop 2300 Segment HI01-09 where HI01-01 = ABF or BF	N/A
MC168	Present on Admission Code (POA) - 15	POA code for Other Diagnosis - 14	External Code Source 15 - Text	char[1]	1	Second Iteration of Loop 2300 Segment HI02-09 where HI02-01 = ABF or BF	N/A
MC169	Present on Admission Code (POA) - 16	POA code for Other Diagnosis - 15	External Code Source 15 - Text	char[1]	1	Second Iteration of Loop 2300 Segment HI03-09 where HI03-01 = ABF or BF	N/A
MC170	Present on Admission Code (POA) - 17	POA code for Other Diagnosis - 16	External Code Source 15 - Text	char[1]	1	Second Iteration of Loop 2300 Segment HI04-09 where HI04-01 = ABF or BF	N/A
MC171	Present on Admission Code (POA) - 18	POA code for Other Diagnosis - 17	External Code Source 15 - Text	char[1]	1	Second Iteration of Loop 2300 Segment HI05-09 where HI05-01 = ABF or BF	N/A
MC172	Present on Admission Code (POA) - 19	POA code for Other Diagnosis - 18	External Code Source 15 - Text	char[1]	1	Second Iteration of Loop 2300 Segment HI06-09 where HI06-01 = ABF or BF	N/A
MC173	Present on Admission Code (POA) - 20	POA code for Other Diagnosis - 19	External Code Source 15 - Text	char[1]	1	Second Iteration of Loop 2300 Segment HI07-09 where HI07-01 = ABF or BF	N/A
MC174	Present on Admission Code (POA) - 21	POA code for Other Diagnosis - 20	External Code Source 15 - Text	char[1]	1	Second Iteration of Loop 2300 Segment HI08-09 where HI08-01 = ABF or BF	N/A

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC175	Present on Admission Code (POA) - 22	POA code for Other Diagnosis - 21	External Code Source 15 - Text	char[1]	1	Second Iteration of Loop 2300 Segment HI09-09 where HI09-01 = ABF or BF	N/A
MC176	Present on Admission Code (POA) - 23	POA code for Other Diagnosis - 22	External Code Source 15 - Text	char[1]	1	Second Iteration of Loop 2300 Segment HI10-09 where HI10-01 = ABF or BF	N/A
MC177	Present on Admission Code (POA) - 24	POA code for Other Diagnosis - 23	External Code Source 15 - Text	char[1]	1	Second Iteration of Loop 2300 Segment HI11-09 where HI11-01 = ABF or BF	N/A
MC178	Present on Admission Code (POA) - 25	POA code for Other Diagnosis - 24	External Code Source 15 - Text	char[1]	1	Second Iteration of Loop 2300 Segment HI12-09 where HI12-01 = ABF or BF	N/A
MC179	Condition Code - 1	Condition Code	External Code Source 14 - Text	char[2]	2	Loop 2300 Segment HI01-02 where HI01-01 = BG	Loop 2300 Segment HI01-02 where HI01-01 = BG
MC180	Condition Code - 2	Condition Code	External Code Source 14 - Text	char[2]	2	Loop 2300 Segment HI02-02 where HI02-01 = BG	Loop 2300 Segment HI02-02 where HI02-01 = BG
MC181	Condition Code - 3	Condition Code	External Code Source 14 - Text	char[2]	2	Loop 2300 Segment HI03-02 where HI03-01 = BG	Loop 2300 Segment HI03-02 where HI03-01 = BG
MC182	Condition Code - 4	Condition Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC183	Condition Code - 5	Condition Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC184	Condition Code - 6	Condition Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC185	Condition Code - 7	Condition Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC186	Condition Code - 8	Condition Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC187	Condition Code - 9	Condition Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC188	Condition Code - 10	Condition Code	External Code Source 14 - Text	char[2]	2	N/A	N/A

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC189	Condition Code - 11	Condition Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC190	Condition Code - 12	Condition Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC191	Value Code - 1	Value Code	External Code Source 14 - Text	char[2]	2	Loop 2300 Segment HI01-02 where HI01-01 = BE	N/A
MC192	Value Amount - 1	Amount that corresponds to Value Code - 1	Integer	±varchar[10]	10	Loop 2300 Segment HI01-03 where HI01-01 = BE	N/A
MC193	Value Code - 2	Value Code	External Code Source 14 - Text	char[2]	2	Loop 2300 Segment HI02-02 where HI02-01 = BE	N/A
MC194	Value Amount - 2	Amount that corresponds to Value Code - 2	Integer	±varchar[10]	10	Loop 2300 Segment HI02-03 where HI02-01 = BE	N/A
MC195	Value Code - 3	Value Code	External Code Source 14 - Text	char[2]	2	Loop 2300 Segment HI03-02 where HI03-01 = BE	N/A
MC196	Value Amount - 3	Amount that corresponds to Value Code - 3	Integer	±varchar[10]	10	Loop 2300 Segment HI03-03 where HI03-01 = BE	N/A
MC197	Value Code - 4	Value Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC198	Value Amount - 4	Amount that corresponds to Value Code - 4	Integer	±varchar[10]	10	N/A	N/A
MC199	Value Code - 5	Value Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC200	Value Amount - 5	Amount that corresponds to Value Code - 5	Integer	±varchar[10]	10	N/A	N/A
MC201	Value Code - 6	Value Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC202	Value Amount - 6	Amount that corresponds to Value Code - 6	Integer	±varchar[10]	10	N/A	N/A
MC203	Value Code - 7	Value Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC204	Value Amount - 7	Amount that corresponds to Value Code - 7	Integer	±varchar[10]	10	N/A	N/A
MC205	Value Code - 8	Value Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC206	Value Amount - 8	Amount that corresponds to Value Code - 8	Integer	±varchar[10]	10	N/A	N/A
MC207	Value Code - 9	Value Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC208	Value Amount - 9	Amount that corresponds to Value Code - 9	Integer	±varchar[10]	10	N/A	N/A
MC209	Value Code - 10	Value Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC210	Value Amount - 10	Amount that corresponds to Value Code - 10	Integer	±varchar[10]	10	N/A	N/A

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC211	Value Code - 11	Value Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC212	Value Amount - 11	Amount that corresponds to Value Code - 11	Integer	±varchar[10]	10	N/A	N/A
MC213	Value Code - 12	Value Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC214	Value Amount - 12	Amount that corresponds to Value Code - 12	Integer	±varchar[10]	10	N/A	N/A
MC215	Occurrence Code - 1	Occurrence Code	External Code Source 14 - Text	char[2]	2	Loop 2300 Segment HI01-02 where HI01-01 = BH	N/A
MC216	Occurrence Date - 1	Date that corresponds to Occurrence Code - 1	Full Date - Integer	int[8] CCYYMMDD	8	Loop 2300 Segment HI01-03 where HI01-01 = BH	N/A
MC217	Occurrence Code - 2	Occurrence Code	External Code Source 14 - Text	char[2]	2	Loop 2300 Segment HI02-02 where HI02-01 = BH	N/A
MC218	Occurrence Date - 2	Date that corresponds to Occurrence Code - 2	Full Date - Integer	int[8] CCYYMMDD	8	Loop 2300 Segment HI02-03 where HI02-01 = BH	N/A
MC219	Occurrence Code - 3	Occurrence Code	External Code Source 14 - Text	char[2]	2	Loop 2300 Segment HI03-02 where HI03-01 = BH	N/A
MC220	Occurrence Date - 3	Date that corresponds to Occurrence Code - 3	Full Date - Integer	int[8] CCYYMMDD	8	Loop 2300 Segment HI03-03 where HI03-01 = BH	N/A
MC221	Occurrence Code - 4	Occurrence Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC222	Occurrence Date - 4	Date that corresponds to Occurrence Code - 4	Full Date - Integer	int[8] CCYYMMDD	8	N/A	N/A
MC223	Occurrence Code - 5	Occurrence Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC224	Occurrence Date - 5	Date that corresponds to Occurrence Code - 5	Full Date - Integer	int[8] CCYYMMDD	8	N/A	N/A
MC225	Occurrence Span Code - 1	Occurrence Span Code	External Code Source 14 - Text	char[2]	2	Loop 2300 Segment HI01-02 where HI01-01 = BI	N/A
MC226	Occurrence Span Start Date - 1	Start Date that corresponds to Occurrence Span Code - 1	Full Date - Integer	int[8] CCYYMMDD	8	First eight digits of Loop 2300 Segment HI01-04 where HI01-01 = BI	N/A
MC227	Occurrence Span End Date - 1	End Date that corresponds to Occurrence Span Code - 1	Full Date - Integer	int[8] CCYYMMDD	8	Last eight digits of Loop 2300 Segment HI01-04 where HI01-01 = BI	N/A
MC228	Occurrence Span Code - 2	Occurrence Span Code	External Code Source 14 - Text	char[2]	2	Loop 2300 Segment HI02-02 where HI02-01 = BI	N/A
MC229	Occurrence Span Start Date - 2	Start Date that corresponds to Occurrence Span Code - 2	Full Date - Integer	int[8] CCYYMMDD	8	First eight digits of Loop 2300 Segment HI02-04 where HI02-01 = BI	N/A
MC230	Occurrence Span End Date - 2	End Date that corresponds to Occurrence Span Code - 2	Full Date - Integer	int[8] CCYYMMDD	8	Last eight digits of Loop 2300 Segment HI02-04 where HI02-01 = BI	N/A
MC231	Occurrence Span Code - 3	Occurrence Span Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC232	Occurrence Span Start Date - 3	Start Date that corresponds to Occurrence Span Code - 3	Full Date - Integer	int[8] CCYYMMDD	8	N/A	N/A

Data Element ID	Data Element	Description	Type	Format	Length	PACDR 837I	PACDR 837P
MC233	Occurrence Span End Date - 3	End Date that corresponds to Occurrence Span Code - 3	Full Date - Integer	int[8] CCYYMMDD	8	N/A	N/A
MC234	Occurrence Span Code - 4	Occurrence Span Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC235	Occurrence Span Start Date - 4	Start Date that corresponds to Occurrence Span Code - 4	Full Date - Integer	int[8] CCYYMMDD	8	N/A	N/A
MC236	Occurrence Span End Date - 4	End Date that corresponds to Occurrence Span Code - 4	Full Date - Integer	int[8] CCYYMMDD	8	N/A	N/A
MC237	Occurrence Span Code - 5	Occurrence Span Code	External Code Source 14 - Text	char[2]	2	N/A	N/A
MC238	Occurrence Span Start Date - 5	Start Date that corresponds to Occurrence Span Code - 5	Full Date - Integer	int[8] CCYYMMDD	8	N/A	N/A
MC239	Occurrence Span End Date - 5	End Date that corresponds to Occurrence Span Code - 5	Full Date - Integer	int[8] CCYYMMDD	8	N/A	N/A
MC240	GIC ID	GIC Member ID	Text	varchar[9]	9	N/A	N/A
MC241	ID Code	Member Enrollment Type	Lookup Table - Integer	int[1]	1	N/A	N/A
MC242	National Provider ID - Plan Rendering	National Provider Indentification (NPI) of the Plan Rendering Provider	External Code Source 3 - Integer	Int[10]	10	N/A	N/A
MC243	Benefit Plan Contract ID	Identifier for the benefit plan the member is enrolled in that covers this claim	Text	Varchar[30]	30	N/A	N/A
MC244	Claim Line Paid Flag	Claim Line Paid Indicator	Lookup Table - Integer	int[1]	1	N/A	N/A
MC245	Type of Facility	Type of Facility Indicator	Lookup Table - Integer	int[2]	2	N/A	N/A
MC246	Claim Type	Claim Type Indicator	specific claim type code	Char[1]	1	N/A	N/A
MC247	Rate Code	Rate Code Indicator	Rate code	varchar[3]	3	N/A	N/A
MC899	Record Type	File Type Identifier	Text	char[2]	2	N/A	N/A
TR001	Record Type	Trailer Record Identifier	Text	char[2]	2	N/A	N/A
TR002	Submitter	Trailer Submitter Defined by Contractor	Integer	varchar[6]	6	N/A	N/A
TR003	National Plan ID	Trailer Plan Identification Number (PlanID) Defined by Contractor	Integer	int[10]	10	N/A	N/A
TR004	Type of File	Validates the file type defined in HD004.	Text	char[2]	2	N/A	N/A
TR005	Period Beginning Date	Trailer Period Start Date	Date Period - Integer	int[6] CCYYMM	6	N/A	N/A
TR006	Period Ending Date	Trailer Period Ending Date	Date Period - Integer	int[6] CCYYMM	6	N/A	N/A
TR007	Date Processed	Trailer Processed Date	Full Date - Integer	int[8] CCYYMMDD	8	N/A	N/A

Code	Value
HD001 - Record Type	
HD	Header Elements
HD004 - Type of File	
MC	MEDICAL CLAIM
HD009 - Version Number	
MC003 - Insurance Type Code/Product	
09	Self-pay
10	Central Certification
11	Other Non-Federal Programs
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Risk
17	Dental Maintenance Organization (DMO)
AM	Automobile Medical
BL	Blue Cross / Blue Shield
CC	Commonwealth Care
CE	Commonwealth Choice
CH	Champus
CI	Commercial Insurance Co.
DS	Disability
HM	Health Maintenance Organization
LI	Liability
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
OF	Other Federal Program
TF	HSN Trust Fund
TV	Title V
VA	Veterans Administration Plan
WC	Workers' Compensation
ZZ	Other
MC011 - Individual Relationship Code	
01	Spouse
04	Grandfather or Grandmother
05	Grandson or Granddaughter
07	Nephew or Niece
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
19	Child
20	Self/Employee
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
29	Significant Other
32	Mother
33	Father
36	Emancipated Minor

Code	Value
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
53	Life Partner
76	Dependent
MC012 - Member Gender	
F	Female
M	Male
O	Other
U	Unknown
MC027 - Service Provider Entity Type Qualifier	
1	Person
2	Non-person entity
MC031 - Service Provider Suffix	
0	Unknown / Not Applicable
1	I.
2	II.
3	III.
4	Jr.
5	Sr.
MC038 - Claim Status	
1	Processed as primary
2	Processed as secondary
3	Processed as tertiary
4	Denied
19	Processed as primary, forwarded to additional payer(s)
20	Processed as secondary, forwarded to additional payer(s)
21	Processed as tertiary, forwarded to additional payer(s)
22	Reversal of previous payment
23	Not our claim, forwarded to additional payer(s)
25	Predetermination Pricing Only - no payment
MC081 - Capitated Encounter Flag	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
MC094 - Type of Claim	
001	Professional
002	Facility
003	Reimbursement Form
MC107 - ICD Indicator	
0	ICD-10
9	ICD-9
MC113 - Payment Arrangement Type	
01	Capitation
02	Fee for Service
03	Percent of Charges
04	DRG
05	Pay for Performance
06	Global Payment
07	Other
08	Bundled Payment

Code	Value
09	Payment Amount Per Episode
MC115 - Medicare Indicator	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
MC118 - Referral Indicator	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
MC119 - PCP Indicator	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
MC122 - Global Payment Flag	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
MC123 - Denied Flag	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
MC126 - Accident Indicator	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
MC127 - Family Planning Indicator	
0	Unknown / Not Applicable / Not Avail
1	Family planning services provided
2	Abortion services provided
3	Sterilization services provided
4	No family planning services provided
MC128 - Employment Related Indicator	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
MC129 - EPSDT Indicator	
0	Unknown / Not Applicable / Not Available
1	EPSDT Screen
2	EPSDT Treatment
3	EPSDT Referral

Code	Value
MC130 - Procedure Code Type	
1	CPT or HCPCS Level 1 Code
2	HCPCS Level II Code
3	HCPCS Level III Code (State Medicare code).
4	American Dental Association (ADA) Procedure Code (Also referred
5	State defined Procedure Code
6	CPT Category II
7	CPTCategory III Code
MC131 - InNetwork Indicator	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
MC138 - Claim Line Type	
A	Amendment
B	Back Out
O	Original
R	Replacement
V	Void
MC241 - ID Code	
0	Unknown / Not Applicable
1	FIG - Fully-Insured Commercial Group Enrollee
2	SIG - Self-Insured Group Enrollee
3	GIC - Group Insurance Commission Enrollee
4	MCO - Managed Care Organization Enrollee
5	Supplemental Policy Enrollee
6	ICO - Integrated Care Organization or SCO - Senior Care Option
MC244 - Claim Line Paid Flag	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
MC245 - Type of Facility	
1	General Acute Care Facility
2	Skilled Nursing Facility/Long Term Care Facility
3	Intermediate Care Facility
4	Hospice Facility
5	Designated Cancer Center
6	Designated Inpatient Children's Hospital
7	Inpatient Rehabilitation Facility
8	Inpatient Psychiatric Hospital
9	Critical Access Hospital
70	Other Type of Facility
MC246 - Claim Type	
A	INPATIENT PART A CROSSOVER UB92
B	PROFESSIONAL PART B CROSSOVER
C	OUTPATIENT PART B CROSSOVER UB-04
D	DENTAL
H	HOME HEALTH AND COMMUNITY HEALTH
I	HOSPITAL INPATIENT
L	LONG TERM CARE
M	PHYSICIAN CLAIM

Code	Value
O	HOSPITAL OUTPATIENT
P	PHARMACY
Q	COMPOUND DRUG CLAIMS
MC899 - Record Type	
MC	
TR001 - Record Type	
TR	
TR004 - Type of File	
MC	

ADDENDUM 4: PROVIDER DATA SPECIFICATIONS

HEALTH PLANS must submit provider data for providers under contract to the DEPARTMENT'S data warehouse in the file format specified by the DEPARTMENT in the most recent Data Specifications – Provider document. The file format as of the date of printing this document is shown below. The DEPARTMENT will specify and communicate a schedule of deliverables and due dates once the data warehouse vendor is under contract.

DATA SPECIFICATIONS – PROVIDER (PROPOSED)

July 22, 2016 version 1.0

File Specification for: Provider File Submission (proposed):

Data Element ID	Data Element	Description	Type	Format	Length
HD001	Record Type	Header Record Identifier	Text	char[2]	2
HD002	Submitter	Header Submitter Defined by Contractor	Integer	varchar[6]	6
HD003	National Plan ID	Header Plan Identification Number (PlanID) Defined by Contractor	Integer	int[10]	10
HD004	Type of File	Defines the file type and data expected	Text	char[2]	2
HD005	Period Beginning Date	Header Period Start Date	Date Period - Integer	int[6] CCYYMM	6
HD006	Period Ending Date	Header Period Ending Date	Date Period - Integer	int[6] CCYYMM	6
HD007	Record Count	Header Record Count	Integer	varchar[10]	10
HD008	Comments	Header Carrier Comments	Text	varchar[80]	80
HD009	Version Number	Submission Guide Version	Decimal - Numeric	char[3]	3
PV001	Submitter	Contractor Defined and maintained unique identifier	Integer	varchar[6]	6
PV002	Plan Provider ID	Carrier Unique Provider Code	Text	varchar[30]	30
PV003	Tax Id	Federal Tax ID of non-individual Provider	Numeric	char[9]	9
PV004	UPIN Id	Unique Physician ID	Text	char[6]	6
PV005	DEA ID	Provider DEA	Text	char[9]	9
PV006	License Id	State practice license ID	Text	varchar[25]	25
PV007	Medicaid Id	MassHealth-assigned Provider ID	Text	varchar[25]	25
PV008	Last Name	Last name of the Provider in PV002	Text	varchar[50]	50
PV009	First Name	First name of the Provider in PV002	Text	varchar[50]	50
PV010	Middle Initial	Middle initial of the Provider in PV002	Text	char[1]	1

Data Element ID	Data Element	Description	Type	Format	Length
PV011	Suffix	Suffix of the Provider in PV002	Lookup Table - Integer	int[1]	1
PV012	Entity Name	Group / Facility name	Text	varchar[100]	100
PV013	Entity Code	Provider entity code	Lookup Table - Text	char[2]	2
PV014	Gender Code	Gender of Provider identified in PV002	Lookup Table - Text	char[1]	1
PV015	DOB	Provider's date of birth	Full Date - Integer	int[8] CCYYMMDD	8
PV016	Provider Street Address 1	Street address of the Provider	Text	varchar[50]	50
PV017	Provider Street Address 2	Street Address 2 of the Provider	Text	varchar[50]	50
PV018	City Name	City of the Provider	Text	varchar[35]	35
PV019	State Code	State of the Provider	External Code Source 2 - Text	char[2]	2
PV020	Country Code	Country Code of the Provider	External Code Source 1 - Text	char[3]	3
PV021	Zip Code	Zip code of the Provider	External Code Source 2 - Text	varchar[9]	9
PV022	Taxonomy	Taxonomy Code	External Code Source 5 - Text	char[10]	10
PV023	Mailing Street Address1 Name	Street address of the Provider / Entity	Text	varchar[50]	50
PV024	Mailing Street Address2 Name	Secondary Street address of the Provider / Entity	Text	varchar[50]	50
PV025	Mailing City Name	City name of the Provider / Entity	Text	varchar[35]	35
PV026	Mailing State Code	State name of the Provider / Entity	External Code Source 2 - Text	char[2]	2
PV027	Mailing Country Code	Country name of the Provider / Entity	External Code Source 1 - Text	char[3]	3
PV028	Mailing Zip Code	Zip code of the Provider	External Code Source 2 - Text	varchar[9]	9
PV029	Provider Type Code	Provider Type Code	Carrier Defined Table - Text	varchar[10]	10
PV030	Primary Specialty Code	Specialty Code	External Code Source 4 - Integer	varchar [3]	3
PV031	Provider Organization ID	Contractor defined and maintained Org ID for Providers	Integer	varchar[6]	6
PV032	Registered Provider Organization ID (RPO)	Registered Provider Organization ID	Text	Char[30]	30
PV033	Filler	Filler	Filler	char[0]	0
PV034	Provider ID Code	Provider Identification Code	Lookup Table - Integer	int[1]	1
PV035	SSN Id	Provider's Social Security Number	Numeric	char[9]	9
PV036	Medicare ID	Provider's Medicare Number, other than UPIN	Text	varchar[30]	30
PV037	Begin Date	Provider Start Date	Full Date - Integer	int[8] CCYYMMDD	8
PV038	End Date	Provider End Date	Full Date - Integer	int[8] CCYYMMDD	8
PV039	National Provider ID	National Provider Identification (NPI) of the Provider	External Code Source 3 - Integer	int[10]	10

Data Element ID	Data Element	Description	Type	Format	Length
PV040	National Provider ID 2	National Provider Identification (NPI) of the Provider	External Code Source 3 - Integer	int[10]	10
PV041	Proprietary Specialty Code	Specialty Code	Carrier Defined Table - Text	varchar[10]	10
PV042	Other Specialty Code 2	Specialty Code	Carrier Defined Table - OR - External Code Source 4 - Integer - OR - Carrier Defined Table	varchar[10]	10
PV043	Other Specialty Code 3	Specialty Code	Carrier Defined Table - OR - External Code Source 4 - Integer - OR - Carrier Defined Table	varchar[10]	10
PV044	Pay for Performance Flag	Indicator - Provider Contract Payment	Lookup Table - Integer	int[1]	1
PV045	NonClaims Flag	Indicator - Provider Contract Payment	Lookup Table - Integer	int[1]	1
PV046	Filler	Filler	filler	Char[1]	1
PV047	Filler	Filler	Filler	Char[40]	40
PV048	Accepting New Patients	Indicator - New Patients Accepted	Lookup Table - Integer	int[1]	1
PV049	Filler	Indicator - eVisit Option	Filler	char[1]	1
PV050	Filler	Filler	Filler	char[0]	0
PV051	Has multiple offices	Indicator - Multiple Office Provider	Lookup Table - Integer	int[1]	1
PV052	Filler	Filler	Text	char[0]	0
PV053	Medical / Healthcare Home ID	Medical Home Identification Number	Text	varchar[15]	15
PV054	PCP Flag	Indicator - Provider is a PCP	Lookup Table - Integer	int[1]	1
PV055	Provider Affiliation	Provider Affiliation Code	Text	varchar[30]	30
PV056	Provider Telephone	Telephone number associated with the provider identified in PV002	Numeric	varchar[10]	10
PV057	Delegated Provider Record Flag	Indicator - Delegated Record	Lookup Table - Integer	int[1]	1
PV058	Filler	Filler	Filler	char[0]	0
PV059	Office Type	Office Type Code	Lookup Table - Integer	int[1]	1
PV060	Prescribing Provider	Indicator - Prescribing Authority	Lookup Table - Integer	int[1]	1
PV061	Provider Affiliation Start Date	Provider Start Date	Full Date - Integer	int[8] CCYYMMDD	8
PV062	Provider Affiliation End Date	Provider End Date	Full Date - Integer	int[8] CCYYMMDD	8
PV063	PPO Indicator	Indicator - Provider PPO Contract	Lookup Table - Integer	int[1]	1
PV064	Disbursement Code	Disbursement Method Code	Lookup Table - Integer	int[1]	1
PV065	Filler	Filler	Filler	char[0]	0
PV066	Filler	Filler	Filler	char[0]	0

Data Element ID	Data Element	Description	Type	Format	Length
PV067	Filler	Filler	Filler	char[0]	0
PV068	Filler	Filler	Filler	char[0]	0
PV069	Filler	Filler	Filler	char[0]	0
PV070	Record Type	File Type Identifier	Text	char[2]	2
TR001	Record Type	Trailer Record Identifier	Text	char[2]	2
TR002	Submitter	Trailer Submitter Defined by Contractor	Integer	varchar[6]	6
TR003	National Plan ID	Trailer Plan Identification Number (PlanID) Defined by Contractor	Integer	int[10]	10
TR004	Type of File	Validates the file type defined in HD004.	Text	char[2]	2
TR005	Period Beginning Date	Trailer Period Start Date	Date Period - Integer	int[6] CCYYMM	6
TR006	Period Ending Date	Trailer Period Ending Date	Date Period - Integer	int[6] CCYYMM	6
TR007	Date Processed	Trailer Processed Date	Full Date - Integer	int[8] CCYYMMDD	8

Code	Value
HD001 - Record Type	
HD	Header Elements
HD004 - Type of File	
PV	PROVIDER
HD009 - Version Number	
1	Version 1.0
PV011 - Suffix	
0	Unknown / Not Applicable
1	I.
2	II.
3	III.
4	Jr.
PV013 - Entity Code	
01	Academic Institution
02	Adult Foster Care
03	Ambulance Services
04	Hospital Based Clinic
05	Stand-Alone, Walk-In/Urgent Care Clinic
06	Other Clinic
07	Community Health Center - General
08	Community Health Center - Urgent Care
09	Government Agency

Code	Value
10	Health Care Corporation
11	Home Health Agency
12	Acute Hospital
13	Chronic Hospital
14	Rehabilitation Hospital
15	Psychiatric Hospital
16	DPH Hospital
17	State Hospital
18	Veterans Hospital
19	DMH Hospital
20	Sub-Acute Hospital
21	Licensed Hospital Satellite Emergency Facility
22	Hospital Emergency Center
23	Nursing Home
24	Freestanding Ambulatory Surgery Center
25	Hospital Licensed Ambulatory Surgery Center
26	Non-Health Corporations
27	School Based Health Center
28	Rest Home
29	Licensed Hospital Satellite Facility
30	Hospital Licensed Health Center
31	Other Facility
40	Physician (PV034 = 1)
50	Physician Group (PV034 = 3)
60	Nurse (PV034 = 1)
70	Clinician (PV034 = 1)
80	Technician (PV034 = 1)
90	Pharmacy / Site or Mail Order (PV034 = 4 or 5)
99	Other Individual or Group (PV034 = 1 or 3)
PV014 – Gender Code	
F	Female
M	Male
O	Other
U	Unknown
PV034 – Provider ID Code	
0	Other; any type of entity not otherwise defined that performs health care services.
1	Person; physician, clinician, orthodontist, and any individual that is licensed/certified to perform health care services.
2	Facility; hospital, health center, long term care, rehabilitation and any building that is licensed to transact health care services.
3	Professional Group; collection of licensed/certified health care professionals that are practicing health care services under the same entity name and Federal Tax Identification Number.
4	Retail Site; brick-and-mortar licensed/certified place of transaction that is not solely a health care entity, i.e., pharmacies, independent laboratories, vision services.
5	E-Site; internet-based order/logistic system of health care services, typically in the form of durable medical equipment, pharmacy or vision services. Address assigned should be the address of the company delivering services or order fulfillment.
6	Financial Parent; financial governing body that does not perform health care services itself but directs and finances health care service entities, usually through a Board of Directors.
7	Transportation; any form of transport that conveys a patient to/from a healthcare provider.

Code	Value
PV044 – Pay for Performance Flag	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
PV045 – NonClaims Flag	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
PV048 – Accepting New Patients	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
PV051 – Has Multiple Offices	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
PV054 – PCP Flag	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
PV057 – Delegated Provider Record Flag	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
PV059 – Office Type	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
PV060 – Prescribing Provider	
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable
PV063 – PPO Indicator	
1	Yes
2	No
3	Unknown
4	Other

Code	Value
5	Not Applicable
PV064 – Disbursement Code	
0	Pay
1	State Agency
2	Muni-Med
3	Non-Billing
4	EHR Incentive provider only-No Pay
5	EHR incentive provider expenditure only
6	Other
PV070 – Record Type	
PV	
TR001 – Record Type	
TR	
TR004 – Type of File	
PV	