VERMONT DEPARTMENT OF BANKING, INSURANCE, SECURITIES AND HEALTH CARE ADMINISTRATION

REGULATION H-2008-01

Vermont Healthcare Claims Uniform Reporting and Evaluation System ("VHCURES")

Table of Contents

Section 1: Purpose

The purpose of this rule is to set forth the requirements for the submission of health care claims data, member eligibility data, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities by health insurers, managed care organizations, third party administrators, pharmacy benefit managers and others to the Department of Banking, Insurance, Securities and Health Care

Administration and conditions for the use and dissemination of such claims data, all as required by and consistent with the purposes of 18 V.S.A. §9410.

Section 2: Authority

This rule is issued pursuant to the authority vested in the Commissioner of the Department of Banking, Insurance, Securities and Health Care Administration by 18 V.S.A. §9410, as well as 8 V.S.A. §15 and other applicable portions of Chapter 221 of Title 18.

Section 3: Definitions

As used in this Rule

A. "BISHCA" or "Department" means the Vermont Department of Banking, Insurance, Securities and Health Care Administration.

B. "Capitated services" means services rendered by a provider through a contract in which payment are based upon a fixed dollar amount for each member on a monthly basis.

C. "Cell size" means the count of persons that share a set of characteristics contained in a statistical table.

D. "Charge" means the actual dollar amount charged on the claim.

E. "Co-insurance" means the percentage a member pays toward the cost of a covered service.

F. "Commissioner" means the commissioner of the Department of Banking, Insurance, Securities and Health Care Administration or his or her designee.

G. "Co-payment" means the fixed dollar amount a member pays to a health care provider at the time a covered service is provided or the full cost of a service when that is less than the fixed dollar amount.

H. "Current Procedural Terminology (CPT)" means a medical code set of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the U.S. Secretary of Health and Human Services as the standard for reporting physician and other services on standard transactions.

I. "Data set" means a collection of individual data records, whether in electronic or manual files.

J. "Deductible" means the total dollar amount a member pays towards the cost of covered services over an established period of time before the contracted third-party payer makes any payments.

K. "De-identified health information" means information that does not identify an individual patient, member or enrollee and with respect to which no reasonable basis exists to believe that the information can be used to identify an individual patient, member or enrollee. De-identification means that health information is not individually identifiable and requires the removal of Direct Personal Identifiers associated with patients, members or enrollees.

L. "Direct personal identifiers" is information relating to an individual patient, member or enrollee that contains primary or obvious identifiers, including:

(1) Names;

(2) Business names when that name would serve to identify a person;

(3) Postal address information other than town or city, state, and 5-digit zip code;

(4) Specific latitude and longitude or other geographic information that would be used to derive postal address;

(5) Telephone and fax numbers;

(6) Electronic mail addresses;

(7) Social security numbers;

(8) Vehicle Identifiers and serial numbers, including license plate numbers;

(9) Medical record numbers;

(10) Health plan beneficiary numbers;

(11) Certificate and license numbers;

(12) Internet protocol (IP) addresses and uniform resource locators (URL) that identify a business that would serve to identify a person;

(13) Biometric identifiers, including finger and voice prints; and

(14) Personal photographic images.

M. "Disclosure" means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

N. "Encrypted identifier" is a code or other means of record identification to allow patients, members or enrollees to be tracked across the data set without revealing their identity. Encrypted identifiers are not direct identifiers.

O. "Encryption" means a method by which the true value of data has been disguised in order to prevent the identification of persons or groups, and which does not provide the means for recovering the true value of the data.

P. “Health benefit plan” means a policy, contract, certificate or agreement entered into, or offered by a health insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Q. “Healthcare claims data” means information consisting of or derived directly from member eligibility files, medical claims files, pharmacy claims files and other related data pursuant to the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) in effect at the time of the data submission. “Healthcare claims data” does not include analysis, reports, or studies containing information from health care claims data sets if those analyses, reports, or studies have already been released in response to another request for information or as part of a general distribution of public information by BISHCA.

R. “Healthcare premium” means the dollar amount charged for any policies offered by health insurers which partially or fully cover the cost of health care services.

S. “Healthcare Common Procedure Coding System (HCPCS)” means a medical code set that identifies health care procedures, equipment, and supplies for claim submission purposes. These are often known as "local codes".

T. “Health care” means care, services, or supplies related to the health of an individual. It includes but is not limited to (1) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and (2) sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription [45 CFR § 160.103].

U. “Health care facility” shall be defined as per 18 V.S.A §9432, as amended from time to time.

V. "Health care provider" means a person, partnership, corporation, facility or institution, licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical care, treatment or confinement, as per 18 V.S.A. §9432.

W. “Health information” means any information, whether oral or recorded in any form or medium, that 1) is created or received by a health-care provider, health plan, public health authority, employer, life insurer, school or university, or health-care clearinghouse; and 2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual shall be as defined in 45 CFR § 160.103.

X. "Health insurer" means those entities defined in 18 V.S.A. §§ 9402 and 9410(j)(1), and includes any health insurance company, nonprofit hospital and medical service corporation, managed care organization, third party administrator, pharmacy benefit manager, and any entity conducting administrative services for business or possessing claims data, eligibility data, provider files, and other information relating to health care provided to Vermont residents or by Vermont health care providers and facilities. The term may also include, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private entities.

Y. "HIPAA" means the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

Z. "Indirect personal identifiers" means information relating to an individual patient, member or enrollee that a person with appropriate knowledge of and experience with generally accepted statistical and scientific principles and methods could apply to render such information individually identifiable by using such information alone or in combination with other reasonably available information.

Aa. "International Classification of Diseases" or "ICD" shall mean that medical code set maintained by the World Health Organization..

Ab. "Mandated Reporter" means a health insurer as defined herein and at 18 V.S.A. §9410(j)(1) with two hundred (200) or more enrolled or covered members in each month during a calendar year, including both Vermont residents and any non-residents receiving covered services provided by Vermont health care providers and facilities.

Ac. "Medical claims file" means a data file composed of service level remittance information for all non-denied adjudicated claims for each billed service including, but not limited to member demographics, provider information, charge/payment information, and clinical diagnosis and procedure codes, and shall include all claims related to behavioral or mental health.

Ad. "Member" means the insured subscriber and any spouse and/or dependent covered by the subscriber's policy.

Ae. "Member eligibility file" means a data file containing demographic information for each individual member eligible for medical or pharmacy benefits for one or more days of coverage at any time during the reporting month.

Af. "Patient" means any person in the data set that is the subject of the activities of the claim performed by the health care provider.

Ag. "Payer" means a third-party payer or third-party administrator.

Ah. "Payment" means the actual dollar amount paid for a claim by a health insurer.

Ai. "Personal identifiers" means information relating to an individual that contains direct or indirect identifiers to which a reasonable basis exists to believe that the information can be used to identify an individual.

Aj. "Pharmacy Benefit Manager" or "PBM" means a person or entity that performs pharmacy benefit management as that term is defined at 18 V.S.A. §9471(4). The term includes a person or entity in a contractual or employment relationship with an entity performing pharmacy benefit management for a health plan.

Ak. "Pharmacy claims file" means a data file containing service level remittance information from all non-denied adjudicated claims for each prescription including, but not limited to: member demographics; provider information; charge/payment information; and national drug codes.

Al. "Prepaid amount" means the fee for the service equivalent that would have been paid for a specific service if the service had not been capitated.

Am. "Principal Investigator" means the person in charge of a project that makes use of limited use research health care claims data sets. The principal investigator is the custodian of the data and is responsible for compliance with all restrictions, limitations and conditions of use associated with the data release.

An. "Public Use Data Set" means a publicly available data set containing only the public use data elements specified in this Rule as unrestricted data elements in Appendix J.

Ao. "Reporter" means a health insurer as defined herein and at 18 V.S.A. §9410(j)(1), and shall include Voluntary Reporters as defined herein.

Ap. "Subscriber" means the individual responsible for payment of premiums or whose employment is the basis for eligibility for membership in a health benefit plan.

Aq. "Third-party Administrator" means any person who, on behalf of a health insurer or purchaser of health benefits, receives or collects charges, contributions or premiums for, or adjusts or settles claims on or for residents of this State or Vermont health care providers and facilities.

Ar. "Vermont Healthcare Claims Uniform Reporting and Evaluation System" or "VHCURES" means the Department's system for the collection, management and reporting of eligibility, claims and related data submitted pursuant to 18 V.S.A. § 9410.

As. "Voluntary Reporter" includes any entity other than a mandated reporter, including any health benefit plan offered or administered by or on behalf of the federal government where such plan, with the agreement of the federal government, voluntarily submits data to the BISHCA commissioner for inclusion in the database on such terms as may be appropriate.

Section 4: Reporting Requirements

Registration and Reporting Requirements

A. VHCURES Reporter Registration. On an annual basis prior to December 31, Health Insurers shall register with the Department on a form established by the Commissioner and identify whether health care claims are being paid for members who are Vermont residents and whether health care claims are being paid for non-residents receiving covered services from Vermont health care providers or facilities. Where applicable, the completed form shall identify the types of files to be submitted per Section 5. This form shall be submitted to BISHCA or its designee. See Appendix F.

B. Third Party Administrator Registration. Any person or entity that provides third party administration services, a third party administrator or "TPA" as defined in Section 3, shall register with the Department on a form established by the Commissioner, both before doing business in Vermont and on an annual basis prior to December 31 thereafter. 18 V.S.A. §9410. See Appendix G.

C. Pharmacy Benefit Manager Registration. Any person or entity that performs pharmacy benefit management (a pharmacy benefit manager or "PBM") shall register with the Department on a form established by the Commissioner both before doing business in Vermont and on an annual basis prior to December 31. 18 V.S.A. §9421. The registration requirement includes persons or entities in a contractual or employment relationship with a health insurer or PBM performing pharmacy benefit management for a health plan with Vermont enrollees or beneficiaries. 18 V.S.A. §9471. See Appendix H.

D. Health Insurers shall regularly submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents in specified electronic format to the Department for each health line of business (Comprehensive Major Medical, TPA/ASO, Medicare Supplemental, Medicare Part C, and Medicare Part D) per the data submission requirements contained in the appendices to this Rule.

E. Voluntary Reporters may, with the permission of the Commissioner, participate in VHCURES and submit medical claims files, pharmacy claims files, member eligibility files, provider data, and other information relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents in specified electronic format to the Department per the data submission requirements contained in the appendices to this Rule.

Section 5: Required Healthcare Data Files

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

A. General Requirements for Data Submission

(1) Adjustment Records. Adjustment records shall be reported with the appropriate positive or negative fields with the medical and pharmacy claims file submissions. Negative values shall contain the negative sign before the value. No sign shall appear before a positive value.

(2) Behavioral or Mental Health Claims. All claims related to behavioral or mental health shall be included in the medical claims file.

(3) Capitated Service Claims. Claims for capitated services shall be reported with all medical and pharmacy claims file submissions.

(4) Claims Records. Records for the medical and pharmacy claims file submissions shall be reported at the visit, service, or prescription level. The submission of the medical and pharmacy claims is based upon the paid dates and not upon the dates of service associated with the claims.

(5) Codes and Encryption Requirements

(a) Code Sources. Unless otherwise specified in this regulation, the code sources listed and described in Appendix A shall be utilized in association with the member eligibility file and medical and pharmacy claims file submissions.

(b) Member Identification Code. Reporters shall assign to each of their members a unique identification code that is the member's social security number. If a Reporter does not collect the social security numbers for all members, the Reporter shall use the social security number of the subscriber and then assign a discrete two-digit suffix for each member under the subscriber's contract.

If the subscriber's social security number is not collected by the Reporter, a version of the subscriber's certificate or contract

number shall be used in its place. The discrete two-digit suffix shall also be used with the certificate or contract number. The certificate or contract number with the two-digit suffix shall be at least eleven but not more than sixty-four characters in length.

The social security number of the member/ subscriber and the subscriber and member names shall be encrypted prior to submission by the Reporter utilizing a standard encryption methodology provided by BISHCA or its designee. The unique member identification code assigned by each Reporter shall remain with each member/subscriber for the entire period of coverage for that individual.

(c) Specific/Unique Coding. With the exception of provider, provider specialty, and procedure/diagnosis codes, specific or unique coding systems shall not be permitted as part of the health care claims data set submission.

(6) Co-Insurance/Co-Payment. Co-insurance and co-payment are to be reported in two separate fields in the medical and pharmacy claims file submissions.

(7) Coordination of Benefits Claims. Claims where multiple parties have financial responsibility shall be included with all medical and pharmacy claims file submissions.

(8) Denied Claims. Denied claims shall be excluded from all medical and pharmacy claims file submissions. When a claim contains both fully processed/paid service lines and partially processed or denied service lines, only the fully processed/paid service lines shall be included as part of the health care claims data set submittal.

(9) Eligibility Records. Records for the member eligibility file submission shall be reported at the individual member level with one record submitted for each claim type. If a member is covered as both a subscriber and a dependent on two different policies during the same month, two records must be submitted. If a member has 2 contract numbers for 2 different coverage types, 2 member eligibility records shall be submitted.

(10) Exceptions.

(a) Medical Claims File Exclusions. All claims related to services provided under stand-alone health care policies shall be excluded if the services are not covered by comprehensive medical insurance policies and are provided on a stand-alone basis for:

1. Specific disease;
2. Accident:
3. Injury;

4. Hospital indemnity;
5. Disability:
6. Long-term care;
7. Student liability;
8. Vision coverage; or
9. Durable medical equipment.

(b) Claims for pharmacy services containing national drug codes are to be included in the pharmacy claims file, but excluded from the medical claims file.

(c) Member Eligibility File Exclusions. Members without medical or pharmacy coverage for the month reported shall be excluded.

(11) File Format. Each file submission shall be an ASCII file, variable field length, and asterisk delimited. When asterisks are used in any field values, the entire value shall be enclosed in double quotes.

(12) Insured Group or Policy Number Key Look-up Table. Reporters are required to submit a key look-up table when submitting member eligibility files. The key look-up table shall link Insured Group or Policy Number (ME006) to the name of the group associated with each Insured Group or Policy Number, but shall not identify any individual policyholders in connection with non-group policies.

(13) Header and Trailer Records. Each member eligibility file and each medical and pharmacy claims file submission shall contain a header record and a trailer record. The header record is the first record of each separate file submission and the trailer record is the last. The header and trailer record formats shall be as detailed in Appendices B-1 and B-2.

(14) Pharmacy Claims. Claims for pharmacy services shall be included in the following files:

(a) If the pharmacy claims are covered under the medical benefit then the claim shall be included in the medical claims file and not the pharmacy claims file; and

(b) If the claim is covered under the prescription benefit then the claim shall be included in the pharmacy claims file.

(15) Prepaid Amount. Any prepaid amounts are to be reported in a separate field in the medical and pharmacy claims file submissions.

(16) Supplemental Health Insurance. Claims related to supplemental health insurance are to be included if the policies are for health care services entirely excluded by the Medicare, Tricare, or other publicly funded health benefit programs.

B. Detailed File Specifications.

(1) Filled Fields. All required fields shall be filled where applicable. Non-required text, date, and integer fields shall be set to null when unavailable. Non-applicable decimal fields shall be filled with one zero and shall not include decimal points when unavailable.

(2) Position. All text fields are to be left justified. All integer and decimal fields are to be right justified.

(3) Signs. Positive values are assumed and need not be indicated as such. Negative values must be indicated with a minus sign and must appear in the left-most position of all integer and decimal fields. Over-punched signed integers or decimals are not to be utilized.

(4) Individual Elements and Mapping. Individual data elements, data types, field lengths, field description/code assignments, and mapping locators (UB-04, HCFA 1500, ANSI X12N 270/271, 835, 837) for each file shall be as detailed in the following appendices:

(a) (1) Member Eligibility File Specifications – Appendix C-1

(2) Member Eligibility File Mapping to National Standard Formats – Appendix C-2

(b) (1) Medical Claims File Specifications – Appendix D-1

(2) Medical Claims File Mapping to National Standard Formats – Appendix D-2

(c) (1) Pharmacy Claims File Specifications – Appendix E-1

(2) Pharmacy Claims File Mapping to National Standard Formats – Appendix E-2

Section 6: Submission Requirements

Data submission requirements shall be as detailed in the attached appendices.

A. Registration Form. It is the responsibility of each Health Insurer to resubmit or amend the registration form required by Section 4 (A) whenever modifications occur relative to the data files or contact information.

B. File Organization. The member eligibility file, medical claims file and pharmacy claims file shall be submitted to BISHCA or its designee as separate ASCII files.

Each record shall terminate with a carriage return (ASCII 13) or a carriage return line feed (ASCII 13, ASCII 10).

C. Filing Media. Files shall be submitted utilizing one of the following media: diskette (1.44 MB), CD-ROM (650 MB), DVD, secure SSL web upload interface, or electronic transmission through a File Transfer Protocol. E-mail attachments shall not be accepted. Space permitting, multiple data files may be submitted utilizing the same media if the external label identifies the multiple files.

D. Transmittal Sheet. All file submissions on physical media shall be accompanied by a hard copy transmittal sheet containing the following information: identification of the Reporter, file name, type of file, data period(s), date sent, record count(s) for the file(s), and a contact person with telephone number and E-mail address. The information on the transmittal sheet shall match the information on the header and trailer records. See Appendix I.

E. Testing of Files. At least sixty days prior to the initial submission of the files or whenever the data element content of the files as described in Section 5 is subsequently altered, each Reporter shall submit to BISHCA or its designee a data set for comparison to the standards listed in Section 7. The size, based upon a calendar period of one month, quarter, or year, of the data files submitted shall correspond to the filing period established for each Reporter under subsection I of this Section.

F. Rejection of Files. Failure to conform to subsections A, B, or C of this Section shall result in the rejection and return of the applicable data file(s). All rejected and returned files shall be resubmitted in the appropriate, corrected form to BISHCA or its designee within 10 days.

G. Replacement of Data Files. No Reporter may replace a complete data file submission more than one year after the end of the month in which the file was submitted unless it can establish exceptional circumstances for the replacement. Any replacements after this period must be approved by BISHCA. Individual adjustment records may be submitted with any monthly data file submission.

H. Run-Out Period. Reporters shall submit medical and pharmacy claims files for at least a six month period following the termination of coverage date for all members who are Vermont residents or non-residents receiving covered services provided by Vermont health care providers or facilities.

I. Data Submission Schedule. The reporting period for submission of each specified file listed in Section 5 shall be determined on a separate basis for Vermont members and non-resident members by the highest total number of Vermont resident members or non-resident members receiving covered services provided by Vermont providers or facilities for which claims are being paid for any one month of the calendar year. Data files are to be submitted in accordance with the following schedule:

Total # of Members	Reporting Period	Reporting Schedule
≥ 2,000	Monthly	Prior to the end of the month following the month in which claims were paid
500 – 1,999	Quarterly	Prior to April 30, July 31, October 31, January 31 for each preceding calendar quarter in which claims were paid
200 - 499	Annually	Prior to April 30 of the following year for the preceding twelve months in which claims were paid
< 200	N/A	

If the data files submitted by an individual Reporter support or are related to the files submitted by another Reporter, BISHCA shall establish a filing period for the parties involved.

Section 7: Compliance with Data Standards

A. Standards. BISHCA or its designee shall evaluate each member eligibility file, medical claims file and pharmacy claims file in accordance with the following standards:

(1) The applicable code for each data element shall be as identified in Appendices C-1, D-1, and E-1 and shall be included within eligible values for the element;

(2) Coding values indicating "data not available", "data unknown", or the equivalent shall not be used for individual data elements unless specified as an eligible value for the element;

(3) Member sex, diagnosis and procedure codes, and date of birth and all other date fields shall be consistent within an individual record;

(4) Member identifiers shall be consistent across files; and

(5) Files submitted shall not contain direct personal identifiers.

B. Notification. Upon completion of this evaluation, BISHCA or its designee will promptly notify each Reporter whose data submissions do not satisfy the standards for any reporting period. This notification will identify the specific file and the data elements that are determined to be unsatisfactory.

C. Response. Each Reporter notified under subsection 7.B shall resubmit within 60 days of the date of notification with the required changes.

D. Compliance. Failure to file, report, or correct health care claims data sets in accordance with the provisions of this regulation may be considered a violation of 18 V.S.A. § 9410 (g).

Section 8: Procedures for the Approval and Release of Claims Data

The requirements, procedures and conditions under which persons other than the Department may have access to health care claims data sets and related information received or generated by the Department or its designee pursuant to this regulation shall depend upon the requestor and the characteristics of the particular information requested, all as set forth below.

A. Classification of Data Elements

(1) Unrestricted Data Elements: Data elements designated in Appendix J as "Unrestricted" shall be available for general use and public release as part of a Public Use File.

(2) Restricted Data Elements: Data elements designated in Appendix J as "Restricted" shall not be available for use and release outside the Department except as part of a Limited Use Research Health Care Claims Data Set approved by the commissioner pursuant to the requirements of this regulation.

(3) Unavailable Data Elements: Data elements which are not designated in Appendix J as either Unrestricted or Restricted, or are designated as "Unavailable", shall not be available for release or use outside the Department in any data set or disclosed in publicly released reports in any circumstance.

B. Public Use Data Sets: Release and Availability

(1) Unrestricted Data Elements collected or generated by the Department or its designee shall be made available in public use files and provided to any person upon written request, except where otherwise prohibited by law.

(2) The Department shall maintain a public record of all requests for and releases of public use data sets.

C. Limited Use Health Care Claims Research Data Sets- Release and Availability

(1) Limited Use Health Care Claims Research Data Sets shall be those sets which contain restricted data elements, shall not be available to the general public and shall be released to a requestor only for the purpose of research upon a determination by the Commissioner that the following conditions have been met:

(a) Application: Any person requesting access to or use of Limited Use Health Care Claims Research Data Sets shall submit an application, in written and electronic form, to the Commissioner disclosing the information listed below. Studies utilizing data sets for longer than 2 years may be required to reapply.

(1) Identity of principal investigator:

(a) Name, address, and phone number;

(b) Organizational affiliation;

(c) Professional qualification; and

(d) Phone number of principal investigator's contact person, if any.

(2) Identity of person requesting access, including any entities for whom that person is acting in requesting the data.

(a) Name, address, and phone number;

(b) Organizational affiliation;

(c) Professional qualification; and

(d) Name and phone number of contact person.

(3) Identity of and qualifications of any other persons who may have access to the data.

(4) A detailed research protocol, to include:

(a) A summary of background, purposes, and origin of the research;

(b) A statement of the health-related problem or issue to be addressed by the research;

(c) The research design and methodology, including either the topics of exploratory research or the specific research hypotheses to be tested;

(d) The procedures that will be followed to maintain the confidentiality of any data or copies of records provided to the principal investigator or other persons; and

(e) The intended research completion date;

(5) Particular data set requested, including:

(a) The time period of the data requested;

(b) The specific data elements or fields of information required;

(c) A justification of the need for each restricted element or field, as identified in the data release schedule;

(d) The minimum needed specificity of the requested data elements, including the manner in which the data may be recoded by the department to be less specific;

(e) The selection criteria for the minimum needed data records required; and

(f) Any particular format or layout of data requested by the principal investigator.

(6) Any changes to information submitted as part of an application pursuant to (a)(1)-(4) shall require notice to the Department by the applicant and shall be subject to the approval of the Commissioner.

(b) The person or entity requesting access and the principal investigator or investigators shall be subject to the following requirements and limitations and shall, in addition, sign and submit a data use agreement acknowledging and accepting these same provisions as a necessary condition to any data access:

(1) Use of data for any purpose other than as specified in the application and approved by the Commissioner shall be prohibited;
(2) Appropriate safeguards to protect the confidentiality of the data and prevent unauthorized use of the data shall be established;

(3) The use or disclosure, sale, or dissemination of the data set or statistical tabulations derived from the data set to any person or organization for any purpose other than as described in the application and as permitted by the data use agreement shall be prohibited without the express written consent of the Commissioner.

(4) The use or disclosure, sale, or dissemination of any information contrary to law shall be prohibited;

(5) No person shall disclose the identity of patients, employer groups or purchaser groups from information contained in the limited use data set;

(6) No person shall disclose any of the information that has been encrypted or removed from the data;

(7) The content of cells that contain counts of persons in statistical tables in which the cell size is more than 0 and less than 5 shall not be disclosed, published or made public in any manner except as "<5";

(8) The publication, dissemination or disclosure of any information that could be used to identify providers of abortion services shall be prohibited;

(9) Any use or disclosure of the information that is contrary to the Data Use Agreement or this Regulation shall be reported to the Department within five (5) days of when the principal investigator becomes aware of such disclosure.

(10) The Department and the "Vermont Healthcare Claims Uniform Reporting and Evaluation System" shall be acknowledged as the source and owner of the data in any and all public reports, publications, or presentations generated from the data;

(11) Written materials shall prominently state that the analyses, conclusions and recommendations drawn from such data are solely those of the requestor or principal investigator and are not necessarily those of the Department;

(12) The Department shall be provided with a copy of any proposed report or publication containing information derived from the data at least 15 days prior to any publication or release to allow the department to review the proposed report or publication and confirm that the conditions of the agreement have been applied. When

multiple reports of a similar nature will be created from the data, the Department may, on request, waive the requirement that any subsequent reports or publications be provided to the Department prior to release by the requesting party

(13) Data elements shall not be retained for any period of time beyond that necessary to fulfill the requirements of the data request.

(14) Within 30 days after the scheduled completion date of the project, the requestor shall delete, destroy or otherwise render the data unreadable, so certifying by submitting a written notice to the Department or by reapplying for approval if the end date of the project needs to be extended;

(15) Any draft reports or publications supplied to the department shall be considered confidential and exempt from public review under 1 V.S.A. §315 et seq. and shall not be released by the Department; and

(16) Failure to adhere to the data use agreement or the limitations and restrictions detailed above will be cause for immediate recall by the Department of the data, revocation of permission to use the data, and grounds for civil or administrative enforcement action by the Department under applicable Vermont state law.

(c) The Department shall establish a claims data release advisory committee with a chair person and members appointed annually by the Commissioner, to provide non-binding advice and opinion to the Commissioner, as and when requested, on the merits of applications for access to limited use data sets. If the Commissioner has requested a review of the application, the claims data release advisory committee shall provide the Commissioner with any comment on the merits of the application and the research protocol described therein within thirty (30) days. The committee shall be comprised of seven (7) members and include:

(1) At least one member representing health insurers;

(2) At least one member representing health care facilities;

(3) At least one member representing health care providers;

(4) At least one member representing purchasers of health insurance or health benefits; and

(5) At least one member representing healthcare researchers.

(2) The Commissioner may approve the release of limited use data sets only when the Commissioner is satisfied as to the following:

(a) The application submitted is complete and the requesting individuals or entities and principal investigator have signed a data use agreement as specified;

(b) Procedures to ensure the confidentiality of any patient and any confidential data are documented;

(c) The qualifications of the investigator and research staff, as evidenced by:

(1) Training and previous research, including prior publications; and

(2) An affiliation with a university, private research organization, medical center, state agency, or other qualified institutional entity.

(d) No other state or federal law or regulation prohibits release of the requested information.

(3) If the Commissioner declines to release the requested limited use data sets within 60 days of receipt of a complete application, the Department shall give written notice of the basis for denial of the application and the requestor shall have leave to resubmit or supplement the application to address the Commissioner's concerns. Any adverse decision regarding an application may be appealed within 30 days by filing a request for hearing with the Commissioner pursuant to Department Rule 82-1.

Section 9: Prices for Data Sets, Fees for Programming and Report Generation, Duplication Rates

This Section lists the prices for data sets from the Vermont Healthcare Claims Uniform Reporting and Evaluation System, including the fees for programming and report generation, duplicating charges and other costs associated with the production and transmission of data sets approved for release by the Department.

A. An annual public use file consisting of unrestricted fields and data elements shall be made available to any person upon request at the cost required for the Department to process, package and ship the data set, including any electronic medium used to store the data.

B. Limited Use Research Health Care Claims Data Sets approved by the Department shall be made available to the requesting party at the cost charged by the Department's designated vendor to program and process the requested data extract, including any consulting services and costs to package and ship the data set on particular electronic medium.

C. Payments are due in full from the requesting party within thirty days of receipt of BISHCA data sets, files, reports, or other released material.

Section 10: Enforcement

Violations of data submission requirements, confidentiality requirements, data use limitations or any other provisions of this rule shall be subject to sanction by the Commissioner as set out in 18 V.S.A. §9410 in addition to any other powers granted to the Commissioner to investigate, subpoena, fine or seek other legal or equitable remedies.

Section 11: Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provisions to other persons or circumstances shall be not affected thereby.

Appendix A: Source Codes

Admission Source Code
(Data Element: MC021)

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes explaining who recommended admission to a medical facility.

Admission Type Code
(Data Element: MC020)

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes explaining the priority of the admission to a medical facility.

Current Procedural Terminology (CPT) Codes
(Data Element: MC055)

SOURCE: Physicians' Current Procedural Terminology (CPT) Manual

AVAILABLE FROM:
Order Department
American Medical Association
515 North State Street
Chicago, IL 60610

ABSTRACT: A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

Health Care Common Procedural Coding System
(Data Element: MC055)

SOURCE: Health Care Common Procedural Coding System

AVAILABLE FROM:
www.cms.gov/medicare/hcpcs.htm
Centers for Medicare and Medicaid Services
Center for Health Plans and Providers
CCPP/DCPC
C5-08-27
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT: HCPCS is the Centers for Medicare and Medicaid Services (CMS) coding scheme to group procedures performed for payment to providers.

Appendix A: Source Codes

Centers for Medicare and Medicaid Services National Plan ID
(Data Elements: HD003, MC002, ME002, PC002, TR003)

SOURCE: Plan ID Database

AVAILABLE FROM:
Centers for Medicare and Medicaid Services
Center for Beneficiary Services
Administration Group
Division of Membership Operations
SI-05-06
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT: The Centers for Medicare and Medicaid Services is developing the Plan ID, which will be proposed as the standard unique identifier for each health plan under the Health Insurance Portability and Accountability Act of 1996.

Centers for Medicare and Medicaid Services National Provider Identifier
(Data Elements: MC026)

SOURCE: National Provider System

AVAILABLE FROM:
Centers for Medicare and Medicaid Services
Office of Information Services
Security and Standards Group
Director, Division of Health Care Information Systems
7500 Security Boulevard
Baltimore, MD 21244-1850

ABSTRACT: The Centers for Medicare and Medicaid Services is developing the National Provider Identifiers, which is proposed as the standard unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

Discharge Status Code
(Data Element: MC023)

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes indicating Member status as of the date of service-thru field.

Appendix A: Source Codes

International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure
(Data Elements: MC040, MC041, MC042, MC043, MC044, MC045, MC046, MC047, MC048, MC049, MC050, MC051, MC052, MC053, MC058)

SOURCE: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)

AVAILABLE FROM:
U.S. National Center for Health Statistics
Commission of Professional and Hospital Activities
1968 Green Road
Ann Arbor, MI 48105

ABSTRACT: The International Classification of Diseases, 9th Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations.

National Association of Boards of Pharmacy Number
(Data Element: PC021)

SOURCE: National Association of Boards of Pharmacy Database and Listings

AVAILABLE FROM:
National Council for Prescription Drug Programs
4201 North 24th Street
Suite 365
Phoenix, AZ 85016

ABSTRACT: A unique number assigned in the U.S. and its territories to individual clinic, hospital, chain, and independent pharmacy locations that conduct business at retail by billing third-party drug benefit payers. The National Council for Prescription Drug Programs (NCPDP) maintains this database under contract from the National Association of Boards of Pharmacy. The National Association of Boards of Pharmacy is a seven-digit numeric number with the following format SSNNNNC, where SS=NCPDP assigned state code number, NNNN=NCPDP assigned pharmacy location number, and C=check digit calculated by algorithm from previous six digits.

National Association of Insurance Commissioners (NAIC) Code
(Data Elements: HD002, MC001, ME001, PC001, TR002)

SOURCE: National Association of Insurance Commissioners Company Code List Manual

AVAILABLE FROM:
National Association of Insurance Commission Publications Department
12th Street, Suite 1100
Kansas City, MO 64105-1925

ABSTRACT: Codes that uniquely identify each insurance company.

Appendix A: Source Codes

National Drug Code
(Data Element: PC026)

SOURCE: Blue Book, Price Alert, National Drug Data File

AVAILABLE FROM:
First Databank, The Hearst Corporation
1111 Bayhill Drive
San Bruno, CA 94066

ABSTRACT: The National Drug Code is a coding convention established by the Food and Drug Administration to identify the labeler, product number, and package sizes of FDA-approved prescription drugs. There are over 170,000 National Drug Codes on file.

National Uniform Billing Committee (NUBC) Codes
(Data Element: MC054)

SOURCE: National Uniform Billing Data Element Specifications

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: Revenue codes are a classification of hospital charges in a standard grouping that is controlled by the National Uniform Billing Committee. Place of service codes specify the type of location where a service is provided.

States and Outlying Areas of the U.S.
(Data Elements: MC015, MC034, ME016, PC015, PC023)

SOURCE: National Zip Code and Post Office Directory

AVAILABLE FROM:
U.S. Postal Service
National Information Data Center
P.O. Box 2977
Washington, DC 20013

ABSTRACT: Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The entities listed are considered to be the first order divisions of the U.S. Microfiche AVAILABLE FROM: NTIS (same as address above). The Canadian Post Office lists the following as "official" codes for Canadian Provinces:

AB - Alberta
BC - British Columbia
MB - Manitoba
NB - New Brunswick
NF - Newfoundland
NS - Nova Scotia
NT - North West Territories
ON - Ontario
PE - Prince Edward Island
PQ - Quebec
SK - Saskatchewan
YT – Yukon

Appendix A: Source Codes

Uniform Billing Claim Form Bill Type
(Data Element: MC036)

SOURCE: National Uniform Billing Data Element Specifications Type of Bill Positions 1 and 2

AVAILABLE FROM:
National Uniform Billing Committee
American Hospital Association
840 Lake Shore Drive
Chicago, IL 60697

ABSTRACT: A variety of codes describing the type of medical facility.

X12 Directories

SOURCE: X12.3 Data Element Dictionary
X12.22 Segment Directory

AVAILABLE FROM:
Data Interchange Standards Association, Inc. (DISA)
Suite 200
1800 Diagonal Road
Alexandria, VA 22314-2852

ABSTRACT: The data element dictionary contains the format and descriptions of data elements used to construct X12 segments. It also contains code lists associated with these data elements. The segment directory contains the format and definitions of the data segments used to construct X12 transaction sets.

ZIP Code
(Data Elements: MC016, MC035, ME017, PC016, PC024)

SOURCE: National ZIP Code and Post Office Directory, Publication 65
The USPS Domestic Mail Manual

AVAILABLE FROM:
U.S Postal Service
Washington, DC 20260

New Orders
Superintendent of Documents
P.O. Box 371954
Pittsburgh, PA 15250-7954

ABSTRACT: The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two right-most digits identify a local delivery area. In the nine digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery area. The two leftmost digits identify a sector which may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes.

The USPS Domestics Mail Manual includes information on the use of the new 11-digit zip code.

Appendix B-1: Header Record Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
HD001	Record Type	1/31/2007	Text	2	HD
HD002	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
HD003	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
HD004	Type of File	1/31/2007	Text	2	DC Dental Claims ME Member Eligibility MC Medical Claims PC Pharmacy Claims
HD005	Period Beginning Date	1/31/2007	Integer	6	CCYYMM Beginning of paid period for Claims Beginning of month covered for Eligibility
HD006	Period Ending Date	1/31/2007	Integer	6	CCYYMM End of paid period for Claims End of month covered for Eligibility
HD007	Record Count	1/31/2007	Integer	10	Total number of records submitted in this file Exclude header and trailer record in count
HD008	Comments	1/31/2007	Text	80	Submitter may use to document this submission by assigning a filename, system source, etc.

Appendix B-2: Trailer Record Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
TR001	Record Type	1/31/2007	Text	2	TR
TR002	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
TR003	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
TR004	Type of File	1/31/2007	Text	2	DC Dental Claims ME Member Eligibility MC Medical Claims PC Pharmacy Claims
TR005	Period Beginning Date	1/31/2007	Integer	6	CCYYMM Beginning of paid period for Claims Beginning of month covered for Eligibility
TR006	Period Ending Date	1/31/2007	Integer	6	CCYYMM End of paid period for Claims End of month covered for Eligibility
TR007	Date Processed	1/31/2007	Date	8	CCYYMMDD Date file was created

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME001	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
ME002	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
ME003	Insurance Type Code/Product	1/31/2007	Text	2	12 Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan 13 Medicare Secondary End-Stage Renal Disease Beneficiary in the 12 month coordination period with an employer's group health plan 14 Medicare Secondary, No-fault insurance including Auto is primary 15 Medicare Secondary Worker's Compensation 16 Medicare Secondary Public Health Service or Other Federal Agency 41 Medicare Secondary Black Lung 42 Medicare Secondary Veteran's Administration 43 Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) 47 Medicare Secondary, Other Liability Insurance is Primary * AP Auto Insurance Policy CP Medicare Conditionally Primary * D Disability * DB Disability Benefits EP Exclusive Provider Organization HM Health Maintenance Organization (HMO) HN Health Maintenance Organization (HMO) Medicare Advantage HS Special Low Income Medicare Beneficiary IN Indemnity * LC Long Term Care * LD Long Term Policy * LI Life Insurance * LT Litigation MA Medicare Part A MB Medicare Part B MD Medicare Part D MC Medicaid MH Medigap Part A MI Medigap Part B MP Medicare Primary

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME003 (Cont'd)	Insurance Type Code/Product				PC Personal Care PE Property Insurance – Personal PR Preferred Provider Organization (PPO) PS Point of Service (POS) QM Qualified Medicare Beneficiary SP Supplemental Policy * WC Workers' Compensation * Indicates that code is not to be included in Vermont submissions. Included in data set for harmonization with other New England states' data collection rules.
ME004	Year	1/31/2007	Integer	4	The year for which eligibility is reported in this submission.
ME005	Month	1/31/2007	Integer	2	The month for which eligibility is reported in this submission.
ME006	Insured Group or Policy Number	1/31/2007	Text	30	The group or policy number - not the number that uniquely identifies the subscriber.
ME007	Coverage Level Code	1/31/2007	Text	3	Benefit coverage level CHD Children Only DEP Dependents Only ECH Employee and Children EMP Employee Only ESP Employee and Spouse FAM Family IND Individual SPC Spouse and Children SPO Spouse Only
ME008	Encrypted Subscriber Unique Identification Number	1/31/2007	Text	128	The encrypted subscriber's social security number; used to create unique member ID. Set as null if unavailable.
ME009	Plan Specific Contract Number	1/31/2007	Text	128	The encrypted plan assigned contract number. Set as null if contract number equals subscriber's social security number.

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME010	Member Suffix or Sequence Number	1/31/2007	Integer	20	The unique number of the member within the contract.
ME011	Member Identification Code	1/31/2007	Text	128	The encrypted member's social security number; used to create unique member ID. Set as null if unavailable.
ME012	Individual Relationship Code	1/31/2007	Integer	2	Member's relationship to insured as shown below: 01 Spouse 18 Self/Employee 19 Child 21 Unknown 34 Other Adult
ME013	Member Gender	1/31/2007	Text	1	M Male F Female U Unknown
ME014	Member Date of Birth	1/31/2007	Date	8	CCYYMMDD
ME015	Member City Name	1/31/2007	Text	30	The city location of the member.
ME016	Member State or Province	1/31/2007	Text	2	As defined by the US Postal Service
ME017	Member ZIP Code	1/31/2007	Text	11	ZIP Code of member - may include non-US codes. Do not include dash.
ME018	Medical Coverage	1/31/2007	Text	1	Y Yes – must be mutually exclusive with MC019. N No
ME019	Prescription Drug Coverage	1/31/2007	Text	1	Y Yes – must be mutually exclusive with MC018. N No
ME020	Placeholder		Text	1	Used and or proposed by other states for – Dental coverage.
ME021	Placeholder		Text	6	Used and or proposed by other states for - Race 1.
ME022	Placeholder		Text	6	Used and or proposed by other states for - Race 2.

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME023	Placeholder		Text	15	Used and or proposed by other states for – Other Race.
ME024	Placeholder		Text	1	Used and or proposed by other states for – Hispanic indicator.
ME025	Placeholder		Text	6	Used and or proposed by other states for – Ethnicity 1.
ME026	Placeholder		Text	6	Used and or proposed by other states for – Ethnicity 2.
ME027	Placeholder		Text	20	Used and or proposed by other states for – Other Ethnicity.
ME028	Primary Insurance Indicator	1/31/2007	Text	1	1 Yes, primary insurance 2 No, secondary or tertiary insurance
ME029	Coverage Type	1/31/2007	Text	3	ASW for self-funded plans that are administered by a third party administrator, where the employer has purchased stop-loss, or group excess, insurance coverage ASO for self funded plans that are administered by a third-party administrator, where the employer has not purchased stop-loss, or group excess insurance coverage STN for short-term non-renewable health insurance. UND for plans underwritten by the insurer OTH for any other plan. Insurers using this code shall obtain prior approval from BISHCA
ME030	Market Category Code	1/31/2007	Text	4	IND for policies sold and issued directly to individuals. (Non-group) FCH or policies sold and issued directly to individuals on a franchise basis. GCV for policies sold and issued directly to individuals as group conversion policies. GS1 for policies sold and issued directly to employers having exactly one employee GS2 for policies sold and issued directly to employers having between two and nine employees GS3 for policies sold and issued directly to employers having between 10 and 25 employees GS4 for policies sold and issued directly to employers having between 26 and 50 employees

Appendix C-1: Member Eligibility File Specifications

Data Element #	Element	Required Start Date	Type	Maximum Length	Description/Codes/Sources
ME030 (Cont'd)	Market Category Code (Cont'd)	1/31/2007	Text	4	GLG1 for policies sold and issued directly to employers having between 51 and 99 employees GLG2 for policies sold and issued directly to employers having 100 or more employees GSA for policies sold and issued directly to small employers through a qualified association trust OTH For policies sold to other types of entities. Insurers using this market code shall obtain prior approval from BISHCA
ME031	Placeholder		Text	3	Used and or proposed by other states for Special Coverage. 0 N/A 1 NH HealthFirst 2 VT Catamount
ME101	Encrypted Subscriber Last Name	1/31/2007	Text	128	The encrypted subscriber last name.
ME102	Encrypted Subscriber First Name	1/31/2007	Text	128	The encrypted subscriber first name.
ME103	Encrypted Subscriber Middle Initial	1/31/2007	Text	1	The encrypted subscriber middle initial.
ME104	Encrypted Member Last Name	1/31/2007	Text	128	The encrypted member last name.
ME105	Encrypted Member First Name	1/31/2007	Text	128	The encrypted member first name.
ME106	Encrypted Member Middle Initial	1/31/2007	Text	1	The encrypted member middle initial.
ME899	Record Type	1/31/2007	Text	2	Value = ME

Appendix C-2: Member Eligibility File Mapping to National Standards

Data Element #	Element	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
ME001	Payer	N/A
ME002	National Plan ID	271/2100A/NM1/XV/09
ME003	Insurance Type Code/Product	271/2110C/EB/ /04, 271/2110D/EB/ /04
ME004	Year	N/A
ME005	Month	N/A
ME006	Insured Group or Policy Number	271/2100C/REF/1L/02, 271/2100C/REF/IG/02, 271/2100C/REF/6P/02, 271/2100D/REF/1L/02, 271/2100D/REF/IG/02, 271/2100D/REF/6P/02
ME007	Coverage Level Code	271/2110C/EB/ /03, 271/2110D/EB/ /03
ME008	Encrypted Subscriber Unique Identification Number	271/2100C/NM1/MI/09
ME009	Plan Specific Contract Number	271/2100C/NM1/MI/09
ME010	Member Suffix or Sequence Number	N/A
ME011	Member Identification Code	271/2100C/NM1/MI/09, 271/2100D/NM1/MI/09
ME012	Individual Relationship Code	271/2100C/INS/Y/02, 271/2100D/INS/N/02
ME013	Member Gender	271/2100C/DMG/ /03, 271/2100D/DMG/ /03
ME014	Member Date of Birth	271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02
ME015	Member City Name	271/2100C/N4/ /01, 271/2100D/N4/ /01
ME016	Member State or Province	271/2100C/N4/ /02, 271/2100D/N4/ /02
ME017	Member ZIP Code	271/2100C/N4/ /03, 271/2100D/N4/ /03
ME018	Medical Coverage	N/A
ME019	Prescription Drug Coverage	N/A
ME020	Placeholder	N/A
ME021	Placeholder	N/A
ME022	Placeholder	N/A
ME023	Placeholder	N/A
ME024	Placeholder	N/A
ME025	Placeholder	N/A
ME026	Placeholder	N/A
ME027	Placeholder	N/A

Appendix C-2: Member Eligibility File Mapping to National Standards

Data Element #	Element	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
ME028	Primary Insurance Indicator	N/A
ME029	Coverage Type	N/A
ME030	Market Category Code	N/A
ME031	Placeholder	N/A
ME101	Encrypted Subscriber Last Name	N/A
ME102	Encrypted Subscriber First Name	N/A
ME103	Encrypted Subscriber Middle Initial	N/A
ME104	Encrypted Member Last Name	N/A
ME105	Encrypted Member First Name	N/A
ME106	Encrypted Member Middle Initial	N/A
ME899	Record Type	N/A

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC001	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
MC002	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
MC003	Insurance Type/Product Code	1/31/2007	Text	2	12 Preferred Provider Organization (PPO) 13 Point of Service (POS) 14 Exclusive Provider Organization (EPO) 15 Indemnity Insurance 16 Health Maintenance Organization (HMO) Medicare Advantage HM Health Maintenance Organization MA Medicare Part A MB Medicare Part B MD Medicare Part D MC Medicaid OF Other Federal Program (e.g. Black Lung) TV Title V VA Veteran Administration Plan * WC Worker's Compensation * Indicates that code <u>is not</u> to be included in Vermont submissions. Included in data set for harmonization with other New England states' data collection rules.
MC004	Payer Claim Control Number	1/31/2007	Text	35	Must apply to the entire claim and be unique within the payer's system.
MC005	Line Counter	1/31/2007	Integer	4	The line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.
MC005A	Version Number	1/31/2007	Integer	4	The version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line.
MC006	Insured Group or Policy Number	1/31/2007	Text	30	Group or policy number - not the number that uniquely identifies the subscriber.

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC007	Encrypted Subscriber Unique Identification Number	1/31/2007	Text	128	The encrypted subscriber's social security number; used to create unique member ID. Set as null if unavailable.
MC008	Plan Specific Contract Number	1/31/2007	Text	128	The encrypted plan assigned contract number. Set as null if contract number equals subscriber's social security number.
MC009	Member Suffix or Sequence Number	1/31/2007	Integer	20	The unique number of the member within the contract.
MC010	Member Identification Code	1/31/2007	Text	128	The encrypted member's social security number; used to create unique member ID. Set as null if unavailable.
MC011	Individual Relationship Code	1/31/2007	Integer	2	Member's relationship to insured as shown below: 01 Spouse 04 Grandfather or Grandmother 05 Grandson or Granddaughter 07 Nephew or Niece 10 Foster Child 15 Ward 17 Stepson or Stepdaughter 19 Child 20 Employee/Self 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 36 Emancipated Minor 39 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Child Where Insured Has No Financial Responsibility 53 Life Partner 76 Dependent

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC012	Member Gender	1/31/2007	Text	1	M Male F Female U Unknown
MC013	Member Date of Birth	1/31/2007	Date	8	CCYYMMDD
MC014	Member City Name	1/31/2007	Text	30	The city name of the member.
MC015	Member State or Province	1/31/2007	Text	2	As defined by the US Postal Service
MC016	Member ZIP Code	1/31/2007	Text	11	ZIP Code of member - may include non-US codes. Do not include dash.
MC017	Date Service Approved/Accounts Payable Date/Actual Paid Date	1/31/2007	Date	8	CCYYMMDD
MC018	Admission Date	1/31/2007	Date	8	Required for all inpatient claims. CCYYMMDD
MC019	Admission Hour	1/31/2007	Integer	4	Required for all inpatient claims. Time is expressed in military time – HHMM
MC020	Admission Type	1/31/2007	Integer	1	Required for all inpatient claims. Refer to Appendix A.
MC021	Admission Source	1/31/2007	Text	1	Required for all inpatient claims. Refer to Appendix A.
MC022	Discharge Hour	1/31/2007	Integer	4	Hour in military time - HHMM
MC023	Discharge Status	1/31/2007	Integer	2	Required for all inpatient claims. 01 Discharged to home or self care 02 Discharged/transferred to another short term general hospital for inpatient care 03 Discharged/transferred to skilled nursing facility (SNF) 04 Discharged/transferred to nursing facility (NF)

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC023 (Cont'd)	Discharge Status (Cont'd)				05 Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution 06 Discharged/transferred to home under care of organized home health service organization 07 Left against medical advice or discontinued care 08 Discharged/transferred to home under care of a Home IV provider 09 Admitted as an inpatient to this hospital 20 Expired 30 Still patient or expected to return for outpatient services 40 Expired at home 41 Expired in a medical facility 42 Expired, place unknown 43 Discharged/transferred to a Federal Hospital 50 Hospice – home 51 Hospice – medical facility 61 Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed 62 Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital 63 Discharged/transferred to a long term care hospital 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
MC024	Service Provider Number	1/31/2007	Text	30	Payer assigned provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. In many cases, it will be the provider Medicare number.
MC025	Service Provider Tax ID Number	1/31/2007	Text	10	Federal taxpayer's identification number.
MC026	National Service Provider ID	1/31/2007	Text	20	Required if National Provider ID is mandated for use under HIPAA. The preferred code for this element is for the rendering provider. For the billing provider, see MC077.

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC027	Service Provider Entity Type Qualifier	1/31/2007	Text	1	HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "person", and these shall be coded as a person. Insurers and health care processors shall code according to: 1 Person 2 Non-Person Entity
MC028	Service Provider First Name	1/31/2007	Text	25	Individual first name. Set to null if provider is a facility or organization.
MC029	Service Provider Middle Name	1/31/2007	Text	25	Individual middle name or initial. Set to null if provider is a facility or organization.
MC030	Service Provider Last Name or Organization Name	1/31/2007	Text	60	Full name of provider organization or last name of individual provider.
MC031	Service Provider Suffix	1/31/2007	Text	10	Suffix to individual name. Set to null if provider is a facility or organization. The service provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III.), if applicable, rather than the clinician's degree (e.g., MD, LCSW).
MC032	Service Provider Specialty	1/31/2007	Text	50	As defined by payer Dictionary for specialty code values must be supplied during testing.
MC033	Service Provider City Name	1/31/2007	Text	30	City name of provider and preferably the practice location.
MC034	Service Provider State or Province	1/31/2007	Text	2	As defined by the US Postal Service.
MC035	Service Provider ZIP Code	1/31/2007	Text	11	ZIP Code of provider - may include non-US codes. Do not include dash.
MC036	Type of Bill - Institutional/ Facility Claims, such as those submitted using on UB04 forms	1/31/2007	Integer	2	Required for institutional claims. Not to be used for professional claims. **Type of Facility - First Digit** 1 Hospital 2 Skilled Nursing

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC036 (Cont'd)	Type of Bill - Institutional/ Facility Claims (Cont'd)				3 Home Health 4 Christian Science Hospital 5 Christian Science Extended Care 6 Intermediate Care 7 Clinic 8 Special Facility **Bill Classification - Second Digit if First Digit = 1-6** 1 Inpatient (Including Medicare Part A) 2 Inpatient (Medicare Part B Only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Nursing Facility Level I 6 Nursing Facility Level II 7 Intermediate Care - Level III Nursing Facility 8 Swing Beds **Bill Classification - Second Digit if First Digit = 7** 1 Rural Health 2 Hospital Based or Independent Renal Dialysis Center 3 Free Standing Outpatient Rehabilitation Facility (ORF) 5 Comprehensive Outpatient Rehabilitation Facilities (CORF) 6 Community Mental Health Center 9 Other **Bill Classification - Second Digit if First Digit = 8** 1 Hospice (Non Hospital Based) 2 Hospice (Hospital-Based) 3 Ambulatory Surgery Center 4 Free Standing Birthing Center 9 Other
MC037	Site of Service – on NSF/CMS 1500 Claims	1/31/2007	Text	2	Required for professional claims. Not to be used for institutional claims. 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC037 (Cont'd)	Site of Service – on NSF/CMS 1500 Claims (Cont'd)				23 Emergency Room - Hospital 24 Ambulatory Surgery Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 35 Boarding Home 41 Ambulance - Land 42 Ambulance - Air or Water 50 Federally Qualified Center 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory 99 Other Unlisted Facility
MC038	Claim Status	1/31/2007	Integer	2	01 Processed as primary 02 Processed as secondary 03 Processed as tertiary 04 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

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC039	Admitting Diagnosis	1/31/2007	Text	5	Required on all inpatient admission claims and encounters using the ICD-9-CM. Do not code decimal point.
MC040	E-Code	1/31/2007	Text	5	Describes an injury, poisoning or adverse effect using the ICD-9-CM. Do not include decimal point.
MC041	Principal Diagnosis	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC042	Other Diagnosis – 1	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC043	Other Diagnosis – 2	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC044	Other Diagnosis – 3	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC045	Other Diagnosis – 4	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC046	Other Diagnosis – 5	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC047	Other Diagnosis – 6	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC048	Other Diagnosis – 7	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC049	Other Diagnosis – 8	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC050	Other Diagnosis – 9	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC051	Other Diagnosis – 10	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC052	Other Diagnosis – 11	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC053	Other Diagnosis – 12	1/31/2007	Text	5	ICD-9-CM. Do not code decimal point.
MC054	Revenue Code	1/31/2007	Integer	4	National Uniform Billing Committee Codes. Code using leading zeroes, left justified and four digits.
MC055	Procedure 1 Code	1/31/2007	Text	5	Health Care Common Procedural Coding System (HCPCS). This includes the CPT codes of the American Medical Association.

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC056	Procedure 1 Modifier – 1	1/31/2007	Text	2	Procedure modifier required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. When the insurer utilizes a local code system for modifiers, a reference table shall be submitted.
MC057	Procedure 1 Modifier – 2	1/31/2007	Text	2	Procedure modifier required when a modifier clarifies or improves the reporting accuracy of the associated procedure code. When the insurer utilizes a local code system for modifiers, a reference table shall be submitted.
MC058	ICD-9-CM Procedure Code	1/31/2007	Text	4	Primary ICD-9-CM code for this line of service. Do not code decimal point.
MC059	Date of Service – From	1/31/2007	Date	8	First date of service for this service line. CCYYMMDD
MC060	Date of Service – Thru	1/31/2007	Date	8	Last date of service for this service line. CCYYMMDD
MC061	Quantity	1/31/2007	Integer	3	Count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay.
MC062	Charge Amount	1/31/2007	Decimal	10	Do not code decimal point.
MC063	Paid Amount	1/31/2007	Decimal	10	Includes any withhold amounts. Do not code decimal point. This element includes all payments made by the insurer except capitation.
MC064	Prepaid Amount	1/31/2007	Decimal	10	For capitated services - the fee for service equivalent amount. Do not code decimal point.
MC065	Co-pay Amount	1/31/2007	Decimal	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.
MC066	Coinsurance Amount	1/31/2007	Decimal	10	The dollar amount an individual is responsible for – not the percentage. Do not code decimal point.

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC067	Deductible Amount	1/31/2007	Decimal	10	The dollar amount of the deductible. Do not code decimal point.
MC068	Patient Account/Control Number	1/31/2007	Text	20	Number assigned by hospital.
MC069	Discharge Date	1/31/2007	Date	8	Date patient discharged. Required for all inpatient claims. CCYYMMDD
MC070	Service Provider Country Name	1/31/2007	Text	30	Code US for United States.
MC071	DRG	1/31/2007	Text	10	Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to DRGs transmitted from the hospital provider. When the CMS methodology for DRGs is not available, but the All Payer DRG system is used, the insurer shall format the DRG and the complexity level within the same field with an "A" prefix, and with a hyphen separating the DRG and the complexity level (e.g. AXXX-XX)
MC072	DRG Version	1/31/2007	Text	2	Version number of the grouper used.
MC073	APC	1/31/2007	Text	4	Insurers and health care claims processors shall code using the CMS methodology when available. Precedence shall be given to APCs transmitted from the health care provider.
MC074	APC Version	1/31/2007	Text	2	Version number of the grouper used.
MC075	Drug Code	1/31/2007	Text	11	Insurers and health care claims processors shall code according to NDC code.
MC076	Billing Provider Number	1/31/2007	Text	30	Payer assigned provider number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change.
MC077	National Billing Provider ID	1/31/2007	Text	20	National Provider ID mandated for use under HIPAA.
MC078	Billing Provider Last Name	1/31/2007	Text	60	Full name of billing organization or last name of individual billing or Organization Name.

Appendix D1: Medical Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
MC101	Encrypted Subscriber Last Name	1/31/2007	Text	128	The encrypted subscriber last name.
MC102	Encrypted Subscriber First Name	1/31/2007	Text	128	The encrypted subscriber first name.
MC103	Encrypted Subscriber Middle Initial	1/31/2007	Text	1	The encrypted subscriber middle initial.
MC104	Encrypted Member Last Name	1/31/2007	Text	128	The encrypted member last name.
MC105	Encrypted Member First Name	1/31/2007	Text	128	The encrypted member first name.
MC106	Encrypted Member Middle Initial	1/31/2007	Text	1	The encrypted member middle initial.
MC899	Record Type	1/31/2007	Text	2	Value = MC

Appendix D2: Medical Claims File Mapping to National Standards

Data Element #	Locator and field changes with updated forms (UB-04) shall comply with standard practices. Data Element Name	UB-92 Form Locator	UB-92 (Version 6.0) Record Type / Field #	HCFA 1500 #	NSF (National Standard Format) Locator	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
MC001	Payer	N/A	N/A	N/A	N/A	N/A
MC002	National Plan ID	N/A	N/A	N/A	N/A	835/1000A/N1/XV/04
MC003	Product/Claim Filing Indicator Code	N/A	30/4	N/A	N/A	835/2100/CLP/ /06
MC004	Payer Claim Control Number	N/A	N/A	N/A	FA0-02.0, FB0-02.0, FB1-02.0, GA0-02.0, GC0-02.0, GX0-02.0, GX2-02.0, HA0-02.0, FB2-02.0, GU0-02.0	835/2100/CLP/ /07
MC005	Line Counter	N/A	N/A	N/A	N/A	837/2400/LX/ /01
MC005A	Version Number	N/A	N/A	N/A	N/A	N/A
MC006	Insured Group or Policy Number	62 (A-C)	30/10	11C	DA0-10.0	837/2000B/SBR/ /03
MC007	Encrypted Subscriber Unique Identification Number	N/A	N/A	N/A	N/A	835/2100/NM1/34/09
MC008	Plan Specific Contract Number	N/A	N/A	N/A	N/A	835/2100/NM1/HN/09
MC009	Member Suffix or Sequence Number	N/A	N/A	N/A	N/A	N/A
MC010	Member Identification Code	N/A	N/A	N/A	N/A	835/2100/NM1/MI/08
MC011	Individual Relationship Code	59 (A-C)	30/18	6	DA0-17.0	837/2000B/SBR/ /02, 837/2000C/PAT/ /01
MC012	Member Gender	15	20/7	3	CA0-09.0	837/2010CA/DMG/ /03
MC013	Member Date of Birth	14	20/8	3	CA0-08.0	837/2010CA/DMG/D8/02
MC014	Member City Name	13	20/14	5	CA0-13.0	837/2010CA/N4/ /01
MC015	Member State or Province	13	20/15	5	CA0-14.0	837/2010CA/N4/ /02
MC016	Member ZIP Code	13	20/16	5	CA0-15.0	837/2010CA/N4/ /03
MC017	Date Service Approved	N/A	N/A	N/A	N/A	N/A
MC018	Admission Date	17	20/17	N/A	N/A	837/2300/DTP/435/03
MC019	Admission Hour	18	20/18	N/A	N/A	837/2300/DTP/435/03
MC020	Admission Type	19	20/10	N/A	N/A	837/2300/CL1/ /01
MC021	Admission Source	20	20/11	N/A	N/A	837/2300/CL1/ /02
MC022	Discharge Hour	21	20/22	N/A	N/A	837/2300/DTP/096/03
MC023	Discharge Status	22	20/21	N/A	N/A	837/2300/CL1/ /03

Appendix D2: Medical Claims File Mapping to National Standards

Data Element #	Locator and field changes with updated forms (UB-04) shall comply with standard practices. Data Element Name	UB-92 Form Locator	UB-92 (Version 6.0) Record Type / Field #	HCFA 1500 #	NSF (National Standard Format) Locator	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
MC024	Service Provider Number	N/A	N/A	N/A	N/A	835/2100/NM1/BD/09, 835/2100/NM1/BS/09, 835/2100/NM1/MC/09, 835/2100/NM1/PC/09
MC025	Service Provider Tax ID Number	5	10/4-5	25	BA0-09.0, CA0-28.0, BA0-02.0, BA1-02.0, YA0-02.0, BA0-06.0, BA0-10.0, BA0-12.0, BA0-13.0, BA0-14.0, BA0-15.0, BA0-16.0, BA0-17.0, BA0-24.0, YA0-06.0	835/2100/NM1/FI/09
MC026	National Service Provider ID	N/A	10/6	N/A	N/A	835/2100/NM1/XX/09
MC027	Service Provider Entity Type Qualifier	N/A	N/A	N/A	N/A	835/2100/NM1/82/02
MC028	Service Provider First Name	1	10/12	33	BA0-20.0	835/2100/NM1/82/04
MC029	Service Provider Middle Name	1	10/12	33	BA0-21.0	835/2100/NM1/82/05
MC030	Service Provider Last Name or Organization Name	1	10/12	33	BA0-18.0, BA0-19.0	835/2100/NM1/82/03
MC031	Service Provider Suffix	1	10/12	33	BA0-22.0	835/2100/NM1/82/07
MC032	Service Provider Specialty	N/A	N/A	N/A	N/A	837/2000A/PRV/ZZ/03
MC033	Service Provider City Name	1	10/14	N/A	BA1-09.0, 15.0	837/2010A/N4/ /01
MC034	Service Provider State or Province	1	10/15	N/A	BA1-10.0, 16.0	837/2010A/N4/ /02
MC035	Service Provider ZIP Code	1	10/16	N/A	BA1-11.0, 17.0	837/2010A/N4/ /03
MC036	Type of Bill - Institutional/ Facility Claims	4	Positions 1-2: 40/4	N/A	N/A	837/2300/CLM/ /05-1
MC037	Site of Service – on NSF/CMS 1500 Claims	N/A	N/A	24B	FA0-07.0, GU0-0.50	837/2300/CLM/ /05-1
MC038	Claim Status	N/A	N/A	N/A	N/A	835/2100/CLP/ /02
MC039	Admitting Diagnosis	76	70/25	N/A	N/A	837/2300/HI/BJ/02-2
MC040	E-Code	77	70/26	N/A	N/A	837/2300/HI/BN/03-2
MC041	Principal Diagnosis	67	70/4	21.1	EA0-32.0, GX0-31.0, GU0-12.0	837/2300/HI/BK/01-2
MC042	Other Diagnosis – 1	68	70/5	21.2	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/01-2

Appendix D2: Medical Claims File Mapping to National Standards

Data Element #	Locator and field changes with updated forms (UB-04) shall comply with standard practices. Data Element Name	UB-92 Form Locator	UB-92 (Version 6.0) Record Type / Field #	HCFA 1500 #	NSF (National Standard Format) Locator	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
MC043	Other Diagnosis – 2	69	70/6	21.3	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/02-2
MC044	Other Diagnosis – 3	70	70/7	21.4	EA0-33.0, GX0-32.0, GU0-13.0	837/2300/HI/BF/03-2
MC045	Other Diagnosis – 4	71	70/8	N/A	EA0-35.0, GX0-34.0, GU0-15.0	837/2300/HI/BF/04-2
MC046	Other Diagnosis – 5	72	70/9	N/A	N/A	837/2300/HI/BF/05-2
MC047	Other Diagnosis – 6	73	70/10	N/A	N/A	837/2300/HI/BF/06-2
MC048	Other Diagnosis – 7	74	70/11	N/A	N/A	837/2300/HI/BF/07-2
MC049	Other Diagnosis – 8	75	70/12	N/A	N/A	837/2300/HI/BF/08-2
MC050	Other Diagnosis – 9	N/A	N/A	N/A	N/A	837/2300/HI/BF/09-2
MC051	Other Diagnosis –10	N/A	N/A	N/A	N/A	837/2300/HI/BF/10-2
MC052	Other Diagnosis –11	N/A	N/A	N/A	N/A	837/2300/HI/BF/11-2
MC053	Other Diagnosis –12	N/A	N/A	N/A	N/A	837/2300/HI/BF/12-2
MC054	Revenue Code	42	50/5,11-13, 60/5,15-16, 61/5,15-16	N/A	N/A	835/2110/SVC/RB/01-2, 835/2110/SVC/NU/01-2
MC055	Procedure Code	44	60/6,15-16, 61/6,15-16	24.1-6 D	FA0-09.0, FB0-15.0, GU0-07.0	835/2110/SVC/HC/01-2
MC056	Procedure Modifier – 1	44	60/7,15-16, 61/7, 15-16	24.1-6 D	FA0-10.0, GU0-08.0	835/2110/SVC/HC/01-3
MC057	Procedure Modifier – 2	44	60/8,15-16, 61/8,15-16	24.1-6 D	FA0-11.0	835/2110/SVC/HC/01-4
MC058	ICD-9-CM Procedure Code	80, 81(A-E)	70/13, 15, 17, 19, 21, 23	N/A	N/A	835/2110/SVC/ID/01-2
MC059	Date of Service – From	45	61/13, 15-16, 61/13, 15-16	24.1-6 A	N/A	835/2110/DTM/150/02
MC060	Date of Service – Thru	N/A	N/A	24.1-6 A	FA0-05.0, FA0-06.0	835/2110/DTM/151/02
MC061	Quantity	46	50/7, 11-13, 60/9,15-16, 61/9,15-16	24.1-6 G	FA0-19.0, FB0-16.0	835/2110/SVC/ /05
MC062	Charge Amount	47	50/8,11-13, 60/10, 15-16, 61/11,15-16	24.1-6 F	FA0-13.0	835/2110/SVC/ /02
MC063	Paid Amount	48	N/A	N/A	N/A	835/2110/SVC/ /03
MC064	Prepaid Amount	N/A	N/A	N/A	N/A	N/A
MC065	Co-pay Amount	N/A	N/A	N/A	N/A	N/A

Appendix D2: Medical Claims File Mapping to National Standards

Data Element #	Locator and field changes with updated forms (UB-04) shall comply with standard practices. Data Element Name	UB-92 Form Locator	UB-92 (Version 6.0) Record Type / Field #	HCFA 1500 #	NSF (National Standard Format) Locator	HIPAA Reference Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator
MC066	Coinsurance Amount	N/A	N/A	N/A	N/A	N/A
MC067	Deductible Amount	N/A	N/A	N/A	N/A	N/A
MC068	Patient Account/Control Number	3	20/3	26	CAO-03.0	837/2300/CLM//01
MC069	Discharge Date	6	20/20	24A	EAO-29.0	N/A
MC070	Service Provider Country Name	9	N/A	N/A	N/A	837/2310E/N4/04
MC071	DRG	N/A	N/A	N/A	N/A	N/A
MC072	DRG Version	N/A	N/A	N/A	N/A	N/A
MC073	APC	N/A	N/A	N/A	N/A	N/A
MC074	APC Version	N/A	N/A	N/A	N/A	N/A
MC075	Drug Code	N/A	N/A	N/A	N/A	N/A
MC076	Billing Provider Number	N/A	N/A	N/A	N/A	N/A
MC077	National Billing Provider ID	N/A	N/A	N/A	N/A	N/A
MC078	Billing Provider Last Name	N/A	N/A	N/A	N/A	N/A
MC101	Encrypted Subscriber Last Name	N/A	N/A	N/A	N/A	N/A
MC102	Encrypted Subscriber First Name	N/A	N/A	N/A	N/A	N/A
MC103	Encrypted Subscriber Middle Initial	N/A	N/A	N/A	N/A	N/A
MC104	Encrypted Member Last Name	N/A	N/A	N/A	N/A	N/A
MC105	Encrypted Member First Name	N/A	N/A	N/A	N/A	N/A
MC106	Encrypted Member Middle Initial	N/A	N/A	N/A	N/A	N/A
MC899	Record Type	N/A	N/A	N/A	N/A	N/A

Appendix E-1: Pharmacy Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
PC001	Payer	1/31/2007	Text	8	Payer submitting payments BISHCA Submitter Code
PC002	National Plan ID	1/31/2007	Text	30	CMS National Plan ID
PC003	Insurance Type/Product Code	1/31/2007	Text	2	12 Preferred Provider Organization (PPO) 13 Point of Service (POS) 14 Exclusive Provider Organization (EPO) 15 Indemnity Insurance 16 Health Maintenance Organization (HMO) Medicare Advantage * AM Automobile Medical * DS Disability HM Health Maintenance Organization * LI Liability * LM Liability Medical MA Medicare Part A MB Medicare Part B MD Medicare Part D MC Medicaid OF Other Federal Program (e.g. Black Lung) TV Title V VA Veteran Administration Plan * WC Workers' Compensation * Indicates that code <u>is not</u> to be included in Vermont submissions. Included in data set for harmonization with other New England states' data collection rules
PC004	Payer Claim Control Number	1/31/2007	Text	35	Must apply to the entire claim and be unique within the payer's system.
PC005	Line Counter	1/31/2007	Integer	4	Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim.
PC006	Insured Group Number	1/31/2007	Text	50	The group or policy number – not the number that uniquely identifies the subscriber.

Appendix E-1: Pharmacy Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
PC007	Encrypted Subscriber Unique Identification Number	1/31/2007	Text	128	The encrypted subscriber's social security number; used to create unique member ID. Set as null if unavailable.
PC008	Plan Specific Contract Number	1/31/2007	Text	128	The encrypted plan assigned contract number. Set as null if contract number equals subscriber's social security number.
PC009	Member Suffix or Sequence Number	1/31/2007	Integer	20	The unique number that identifies the member within the contract.
PC010	Member Identification Code	1/31/2007	Text	128	The encrypted member's social security number; used to create unique member ID. Set as null if unavailable.
PC011	Individual Relationship Code	1/31/2007	Integer	2	Member's relationship to insured as shown below: 01 Spouse 04 Grandfather or Grandmother 05 Grandson or Granddaughter 07 Nephew or Niece 10 Foster Child 15 Ward 17 Stepson or Stepdaughter 19 Child 20 Employee/Self 21 Unknown 22 Handicapped Dependent 23 Sponsored Dependent 24 Dependent of a Minor Dependent 29 Significant Other 32 Mother 33 Father 36 Emancipated Minor 39 Organ Donor 40 Cadaver Donor 41 Injured Plaintiff 43 Child Where Insured Has No Financial Responsibility 53 Life Partner 76 Dependent

Appendix E-1: Pharmacy Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
PC012	Member Gender	1/31/2007	Integer	1	1 Male 2 Female 3 Unknown
PC013	Member Date of Birth	1/31/2007	Date	8	CCYYMMDD
PC014	Member City Name of Residence	1/31/2007	Text	30	The city name of member.
PC015	Member State or Province	1/31/2007	Text	2	As defined by the US Postal Service
PC016	Member ZIP Code	1/31/2007	Text	9	ZIP Code of member – may include non-US codes. Do not include dash.
PC017	Date Service Approved (AP Date)	1/31/2007	Date	8	CCYYMMDD This date is generally the same date as the paid date or the pharmacy benefits manager's billing date.
PC018	Pharmacy Number	1/31/2007	Text	30	The payer assigned pharmacy number. This number should be the identifier used by the payer for internal identification purposes, and does not routinely change. An AHFS number is acceptable.
PC019	Pharmacy Tax ID Number	1/31/2007	Text	10	Federal taxpayer's identification number. Insurers and health care claims processors shall provide the pharmacy chain's federal tax identification number, if the individual retail pharmacy's tax ID# is not available.
PC020	Pharmacy Name	1/31/2007	Text	30	The name of pharmacy
PC021	National Pharmacy ID Number	1/31/2007	Text	20	Required if National Provider ID is mandated for use under HIPAA
PC022	Pharmacy Location City	1/31/2007	Text	30	The city name of pharmacy, preferably pharmacy location.
PC023	Pharmacy Location State	1/31/2007	Text	2	As defined by the US Postal Service
PC024	Pharmacy ZIP Code	1/31/2007	Text	10	ZIP Code of pharmacy – may include non-US codes. Do not include dash.
PC024A	Pharmacy Country Name	1/31/2007	Text	30	Code US for United States

Appendix E-1: Pharmacy Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
PC025	Claim Status	1/31/2007	Integer	2	01 Processed as primary 02 Processed as secondary 03 Processed as tertiary 04 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
PC026	Drug Code	1/31/2007	Text	11	NDC Code
PC027	Drug Name	1/31/2007	Text	80	Text name of drug
PC028	New Prescription or Refill	1/31/2007	Integer	2	00 New prescription 01-99 Number of refill
PC029	Generic Drug Indicator	1/31/2007	Text	1	N No, branded drug Y Yes, generic drug
PC030	Dispense as Written Code	1/31/2007	Integer	1	0 Not dispensed as written 1 Physician dispense as written 2 Member dispense as written 3 Pharmacy dispense as written 4 No generic available 5 Brand dispensed as generic 6 Override 7 Substitution not allowed – brand drug mandated by law 8 Substitution allowed – generic drug not available in marketplace 9 Other
PC031	Compound Drug Indicator	1/31/2007	Text	1	N Non-compound drug Y Compound drug U Non-specified drug compound
PC032	Date Prescription Filled	1/31/2007	Date	8	CCYYMMDD

Appendix E-1: Pharmacy Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
PC033	Quantity Dispensed	1/31/2007	Integer	5	The number of metric units of medication dispensed.
PC034	Days Supply	1/31/2007	Integer	3	The estimated number of days the prescription will last.
PC035	Charge Amount	1/31/2007	Decimal	10	Do not code decimal point.
PC036	Paid Amount	1/31/2007	Decimal	10	Includes all health plan payments and excludes all member payments. Do not code decimal point.
PC037	Ingredient Cost/List Price	1/31/2007	Decimal	10	The cost of the drug dispensed. Do not code decimal point.
PC038	Postage Amount Claimed	1/31/2007	Decimal	10	Do not code decimal point.
PC039	Dispensing Fee	1/31/2007	Decimal	10	Do not code decimal point.
PC040	Co-pay Amount	1/31/2007	Decimal	10	The preset, fixed dollar amount for which the individual is responsible. Do not code decimal point.
PC041	Coinsurance Amount	1/31/2007	Decimal	10	The dollar amount an individual is responsible for – not the percentage. Do not code decimal point.
PC042	Deductible Amount	1/31/2007	Decimal	10	Do not code decimal point.
PC044	Prescribing Physician First Name	1/31/2007	Text	25	Physician first name. Required if PC046 is not filled.
PC045	Prescribing Physician Middle Name	1/31/2007	Text	25	Physician middle name or initial. Required if PC046 is not filled.
PC046	Prescribing Physician Last Name	1/31/2007	Text	60	Physician last name. Required if PC046 is not filled.
PC047	Prescribing Physician Number	1/31/2007	Text	20	The DEA or NPI number for the prescribing physician.
PC101	Encrypted Subscriber Last Name	1/31/2007	Text	128	The encrypted subscriber last name.
PC102	Encrypted Subscriber First Name	1/31/2007	Text	128	The encrypted subscriber first name.
PC103	Encrypted Subscriber Middle Initial	1/31/2007	Text	1	The encrypted subscriber middle initial.

Appendix E-1: Pharmacy Claims File Specifications

Data Element #	Data Element Name	Required Start Date	Type	Maximum Length	Description/Codes/Sources
PC104	Encrypted Member Last Name	1/31/2007	Text	128	The encrypted member last name.
PC105	Encrypted Member First Name	1/31/2007	Text	128	The encrypted member first name.
PC106	Encrypted Member Middle Initial	1/31/2007	Text	1	The encrypted member middle initial.
PC899	Record Type	1/31/2007	Text	2	Value = PC

Appendix E-2: Pharmacy Claims Mapping to National Standards

Data Element #	Data Element Name	National Council for Prescription Drug Programs Field #
PC001	Payer	N/A
PC002	Plan ID	N/A
PC003	Insurance Type/Product Code	N/A
PC004	Payer Claim Control Number	N/A
PC005	Line Counter	N/A
PC006	Insured Group Number	301-C1
PC007	Encrypted Subscriber Unique Identification Number	302-C2
PC008	Plan Specific Contract Number	N/A
PC009	Member Suffix or Sequence Number	N/A
PC010	Member Identification Code	302-CY
PC011	Individual Relationship Code	306-C6
PC012	Member Gender	305-C5
PC013	Member Date of Birth	304-C4
PC014	Member City Name of Residence	323-CN
PC015	Member State or Province	324-CO
PC016	Member ZIP Code	325-CP
PC017	Date Service Approved (AP Date)	N/A
PC018	Pharmacy Number	202-B2
PC019	Pharmacy Tax ID Number	N/A
PC020	Pharmacy Name	833-5P
PC021	National Pharmacy ID Number	N/A
PC022	Pharmacy Location City	831-5N
PC023	Pharmacy Location State	832-6F
PC024	Pharmacy ZIP Code	835-5R
PC024A	Pharmacy Country Name	N/A
PC025	Claim Status	N/A
PC026	Drug Code	407-D7
PC027	Drug Name	516-FG

Appendix E-2: Pharmacy Claims Mapping to National Standards

Data Element #	Data Element Name	National Council for Prescription Drug Programs Field #
PC028	New Prescription or Refill	403-D3
PC029	Generic Drug Indicator	N/A
PC030	Dispense as Written Code	408-D8
PC031	Compound Drug Indicator	406-D6
PC032	Date Prescription Filled	401-D1
PC033	Quantity Dispensed	442-E7
PC034	Days Supply	405-D5
PC035	Charge Amount	804-5B
PC036	Paid Amount	509-F9
PC037	Ingredient Cost/List Price	506-F6
PC038	Postage Amount Claimed	428-DS
PC039	Dispensing Fee	507-F7
PC040	Co-pay Amount	518-FI
PC041	Coinsurance Amount	518-FI
PC042	Deductible Amount	505-F5
PC044	Prescribing Physician First Name	N/A
PC045	Prescribing Physician Middle Name	N/A
PC046	Prescribing Physician Last Name	N/A
PC047	Prescribing Physician Number	N/A
PC101	Encrypted Subscriber Last Name	N/A
PC102	Encrypted Subscriber First Name	N/A
PC103	Encrypted Subscriber Middle Initial	N/A
PC104	Encrypted Member Last Name	N/A
PC105	Encrypted Member First Name	N/A
PC106	Encrypted Member Middle Initial	N/A
PC899	Record Type	N/A

Appendix F: Reporter Registration Form

Vermont Healthcare Claims Uniform Reporting and Evaluation System Registration Form

Company Name: _____

Mailing Address: _____
_____
_____

1. Does your company currently conduct health insurance related business for 200 or more residents of the state of Vermont? _____ Yes _____ No

2. Does your company currently conduct health insurance related business for health care provided by Vermont health care providers and facilities? _____ Yes _____ No

   If 1 and 2 are both No (Skip to #6)

3. Please complete information below in relationship to the eligibility data your company will be submitting.

	Medical	Pharmacy
Estimated # Members/Covered Lives/Eligibles for 1 Month:	_____	_____

   Estimated # Medicare Supplemental Covered Lives in one month: _____

   Contact Name: _____ Phone: _____

   Email Address: _____ Fax: _____

   Company Name: _____

   Mailing Address: _____
   _____

   Data files will be submitted utilizing which media?

   _____ CD-ROM _____DVD-ROM _____Secure SSL Web Upload _____FTP

4. Will your company be submitting medical claims data? _____Yes _____ No (Skip to #6)

   Estimated # of medical claims paid per month: _____

   Estimated total $ amount of medical claims paid per month: _____

   Estimated $ amount of total premiums* earned per month for Vermont residents: _____

   Is the Contact for Medical the same as Eligibility? _____ Yes _____ No

Appendix F: Reporter Registration Form

Contact Name: _____ Phone: _____

Email Address: _____ Fax: _____

Company Name: _____

Mailing Address: _____
_____

Data files will be submitted utilizing which media?

_____CD-ROM _____DVD-ROM _____Secure SSL Web Upload _____FTP

5. Will your company be submitting pharmacy claims data? _____Yes _____No (Skip to #6)

Estimated # of pharmacy claims paid per month: _____

Estimated total $ amount of pharmacy claims paid per month: _____

Estimated $ amount of total premiums* earned per month for Vermont residents: _____

Is the contact for Pharmacy the same contact as: Eligibility _____ Yes _____ No
Medical _____ Yes _____ No

Contact Name: _____ Phone: _____

Email Address: _____ Fax: _____

Company Name: _____

Mailing Address: _____
_____

Data files will be submitted utilizing which media?

_____ CD-ROM _____DVD-ROM _____Secure SSL Web Upload _____FTP

6. Person completing this form:

Contact Name: _____ Phone: _____

Email Address: _____ Fax: _____

Company Name: _____

Mailing Address: _____
_____

Date Completed: _____

Appendix F: Reporter Registration Form

7. Is the person completing this form the compliance contact? _____ Yes _____ No
   If no, provide legal/compliance contact information.

   Contact Name: _____ Phone: _____

   Email Address: _____ Fax: _____

   Company Name: _____

   Mailing Address: _____
   _____

_____

*Total Premiums = Total amount of premium from policyholders to provide insurance coverage. This is commonly referred to as "earned" premium. Earned premium = premiums collected + change in due and uncollected - change in unearned and advance premium. If premium is collected prior to January 1 to provide insurance coverage in the following year, it must be included. **Third party administrators** shall calculate the earned premium equivalent based on the contribution rates established for the coverages being reported. These premium equivalents shall include all funds collected by the TPA from the account in relation to the TPA's administration of the group's or employer's health plan. These funds include provisions for claims, administration, stop-loss insurance, wellness programs, network fees, and disease management programs. **Pharmacy Benefit Managers** shall calculate the earned premium equivalent based on the contribution rates established for the coverages being reported. These premium equivalents shall include all funds collected by the PBM from the account in relation to the PBM's administration of the group's or employer's pharmacy benefit plan. These funds include provisions for mail service pharmacy, claims processing, retail network management, payment of claims to pharmacies for prescription drugs dispensed to beneficiaries, clinical formulary development and management services, rebate contracting and administration, patient compliance, therapeutic interventions, generic substitution programs, and disease or chronic care management programs.

Appendix G: Third Party Administrator Registration Form

Vermont Third Party Administrator Registration Form

Company Name: _____

Mailing Address: _____
_____
_____

Domicile: _____ Domicile outside of US _____

FEIN #: _____ NAIC #: _____

D.B.A.: _____

Parent Company Name: _____

Parent FEIN #: _____ Parent NAIC #: _____

Contact Name: _____ Phone: _____

Email Address: _____ Fax: _____

Company Name: _____

Mailing Address: _____
_____

1) Did the company provide administrative services for a health line of business for 50 or more Vermont residents within any of the listed health lines for any given month within calendar year 2007 or within the most current business year? Check all that apply

Comprehensive Major Medical	_____	Other Medical (Non-Comprehensive	_____
Pharmacy	_____	Specified Named Disease	_____
Medicare Supplemental (Medigap)	_____	Limited Benefit	_____
Behavioral Health	_____	Student Policy	_____
Substance Abuse	_____	Workers Compensation	_____
Long Term Care	_____	Accident Only or AD&D	_____
Disability	_____	Stop Loss	_____
Dental	_____	Vision	_____

Appendix G: Third Party Administrator Registration Form

2) Does the company provide the following business services for plan sponsors, insurers or other entities providing benefits for the following health lines of business?

Business Services	Comprehensive Major Medical	Pharmacy	Behavioral Health	Medicare Supplement
Collect and handle premiums	_____	_____	_____	_____
Adjust claims	_____	_____	_____	_____
Pay claims	_____	_____	_____	_____
Utilization review	_____	_____	_____	_____

3) List all plan sponsors that are entities that have self-funded ERISA plans that include any Vermont residents. Check all health lines of business that apply for each plan sponsor.

Plan Sponsor Name	Comprehensive Major Medical	Pharmacy	Behavioral Health
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4) List all carriers and government insurers and payers covering any Vermont resident that are contracting with your company for third party administration business services in any of the health lines of business.

_____

_____

_____

_____

Appendix H: Pharmacy Benefit Manager Registration Form

Vermont Pharmacy Benefit Manager Registration Form

Filing Information for Person Completing This Form

Filing Date (mm/dd/yyyy): _____

First Name of person completing this form: _____

Last Name of person completing this form: _____

Title of person completing this form: _____

Phone # of person completing this form: _____

Email address of person completing this form: _____

Mailing Address for Person Completing Form

P.O. Box and/or Street Address: _____

City: _____

State: _____

ZIP or Postal Code: _____

Country: _____

Company Information

Company Name: _____

Domicile (U.S.)/ State of Incorporation or Organizations: _____

Domicile (Outside of U.S.)/Country of Incorporation or Organizations: _____

FEIN: _____ NAIC # (if applicable): _____

DBA/ Trade Name 1 (if applicable): _____

DBA/ Trade Name 2 (if applicable): _____

Appendix H: Pharmacy Benefit Manager Registration Form

Principal Office or Headquarters Mailing Address

P.O. Box and/or Street: _____

City: _____

State: _____

ZIP/Postal Code: _____

Country: _____

Parent Company: _____
(Another company owns Company named above in Company Information)

Parent Company NAIC # (if applicable): _____

Parent Company FEIN: _____

Company Contact Information

Contact for notices related to regulatory bulletins, rule making and compliance issues:

First Name: _____

Last Name: _____

Title/Position: _____

Phone: _____

Email: _____

Fax: _____

P.O. Box and/or Street: _____

City: _____

State: _____

ZIP or Postal Code: _____

Country: _____

Appendix H: Pharmacy Benefit Manager Registration Form

ADDITIONAL REQUIRED INFORMATON

1. Do you perform pharmacy benefit management for individuals enrolled in a health plan in which coverage of prescription drugs is administered by a PBM and includes their dependents or other persons provided health coverage through that health plan, per 18 V.S.A § 9471?

   ( ) Yes ( ) No

2. Do you perform pharmacy benefit management for a health benefit plan offered, administered, or issued by a health insurer doing business in Vermont? For these purposes, “health insurer” includes a health insurance company, a nonprofit hospital and medical service corporation, and health maintenance organizations as well as an employer, labor union, or other group of persons organized in Vermont that provides a health plan to beneficiaries employed or residing in Vermont, per 18 V.S.A. §9471.

   ( ) Yes ( ) No

3. Check any pharmacy benefit management services that you provide for Vermont residents or employees. (Check all that apply)

   ( ) Mail service pharmacy
   ( ) Claims processing
   ( ) Retail network management
   ( ) Payment of claims to pharmacies for prescription drugs dispensed to beneficiaries
   ( ) Clinical formulary development and management services
   ( ) Rebate contracting and administration
   ( ) Patient compliance, therapeutic intervention, and generic substitution programs
   ( ) Disease or chronic care management programs.
   ( ) Other: _____

Contact Information for claims data management information services and/or information technology:

Contact First Name: _____

Contact Last Name: _____

Contact Title/Position: _____

Phone: _____

Email: _____

Fax: _____

P.O. Box and/or Street: _____

City: _____

State: _____

ZIP or Postal Code: _____

Country: _____

Appendix I: Data Transmittal Sheet

Vermont Healthcare Claims Uniform Reporting and Evaluation System
Claims Data Submission Form

Payer Name: _____

VHCURES Submitter Code: _____

Contact Person

Name: _____

Address: _____

City, State, Postal Code: _____

Phone: _____

E-mail: _____

	Eligibility	Medical	Prescription Drugs
File Name			
Period Beginning Date			
Period Ending Date			
Record Count†			
Date Processed			
Original Submission			
Resubmission			

† *Excluding header and trailer record*

Media: _____ CD ROM 650 MB _____ FTP _____ DVD

Do not use below

Date Received: _____ Date Loaded: _____

Comments: _____

_____

DATA RELEASE SCHEDULE: PUBLIC USE DENOMINATOR FILE

DATA ELEMENT NUMBER	ELEMENT NAME

Unrestricted	Included in the public use file for public release and general use.
Restricted	May be included in limited use research health care data sets as approved by BISHCA.
Unavailable for release	Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

ME004	Year
ME005	Month
ME007	Coverage Level Code
ME013	Member Gender
ME016	Member State or Province
ME018	Medical Coverage
ME019	Prescription Drug Coverage
ME028	Primary Insurance Indicator
ME029	Coverage Type
ME030	Market Category Code
Derived or calculated from submitted data	
PAYER901	Payer Name
ME902	Record ID#
ME905	Medicare coverage
ME911	Standardized Insurance Individual Relationship Code
ME912	Standardized Insurance Type/Product Code
ME914	Eligibility Year and Month
ME915	Member County Code
*	Member Age by Age Group (0-17, 18-29, 30-44, 45-54, 55-64, 65+)
*	Unique Member Number (Derived from ME910 and for use only in the Public Use Denominator File)

* No assigned data element number

DATA RELEASE SCHEDULE: MEDICAL MEMBER ELIGIBILITY FILE

DATA ELEMENT NUMBER	ELEMENT NAME
Unrestricted	Included in the public use file for public release and general use.
Restricted	May be included in limited use research health care data sets as approved by BISHCA.
Unavailable for release	Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

ME007	Coverage Level Code
ME013	Member Gender
ME016	Member State or Province
ME018	Medical Coverage
ME028	Primary Insurance Indicator
ME029	Coverage Type
ME030	Market Category Code
	Derived or calculated from submitted data
ME901	Member Age: VT aggregate 90+
ME902	Record ID#
ME905	Medicare coverage
ME910	Double Encrypted Member ID
ME911	Standardized Insurance Individual Relationship Code
ME912	Standardized Insurance Type/Product Code
ME914	Eligibility Year and Month
ME915	Member County Code

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

ME001	Payer
ME002	National Plan ID
ME006	Insured Group or Policy Number
ME015	Member City Name
ME017	Member ZIP Code
	Derived or calculated from submitted data
ME907	Double Encrypted Subscriber SSN
ME908	Double Encrypted Plan Specific Contract Number
ME909	Double Encrypted Member Identification Code
*	Insured Group Name (Derived from ME006 and Key Look-up Table)

* No assigned data element number

UNAVAILABLE FOR RELEASE

ME004	Year
ME005	Month
ME003	Insurance Type/Product Code
ME008	Encrypted Subscriber Social Security Number
ME009	Plan Specific Contract Number
ME010	Member Suffix or Sequence Number
ME011	Member Identification Code
ME012	Individual Relationship Code
ME014	Member Date of Birth
ME019	Prescription Drug Coverage
ME101	Encrypted Subscriber Last Name
ME102	Encrypted Subscriber First Name
ME103	Encrypted Subscriber Middle Initial
ME104	Encrypted Member Last Name
ME105	Encrypted Member First Name
ME106	Encrypted Member Middle Initial
ME899	Record Type
	Derived or calculated from submitted data
ME903	BISHCA Extract Date
ME904	Unique Member ID
ME906	Submission ID#
ME913	Duplicate Member Flag

DATA RELEASE SCHEDULE: PHARMACY MEMBER ELIGIBILITY FILE

DATA ELEMENT NUMBER	ELEMENT NAME

Unrestricted	Included in the public use file for public release and general use.
Restricted	May be included in limited use research health care data sets as approved by BISHCA.
Unavailable for release	Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

PE004	Year
PE005	Month
PE007	Coverage Level Code
PE013	Member Gender
PE016	Member State or Province
PE019	Prescription Drug Coverage
PE028	Primary Insurance Indicator
PE029	Coverage Type
PE030	Market Category Code
Derived or calculated from submitted data	
PE901	Member Age: VT aggregate 90+
PE902	Record ID#
PE905	Medicare coverage
PE910	Double Encrypted Member ID
PE911	Standardized Insurance Individual Relationship Code
PE912	Standardized Insurance Type/Product Code
PE914	Eligibility Year and Month
PE915	Member County Code

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

PE001	Payer
PE002	National Plan ID
PE006	Insured Group or Policy Number
PE015	Member City Name
PE017	Member ZIP Code
Derived or calculated from submitted data	
PE907	Double Encrypted Subscriber SSN
PE908	Double Encrypted Plan Specific Contract Number
PE909	Double Encrypted Member Identification Code
*	Insured Group Name (Derived from PE006 and Key Look-up Table)

* No assigned data element number

UNAVAILABLE FOR RELEASE

PE003	Insurance Type/Product Code
PE008	Encrypted Subscriber Social Security Number
PE009	Plan Specific Contract Number
PE010	Member Suffix or Sequence Number
PE011	Member Identification Code
PE012	Individual Relationship Code
PE014	Member Date of Birth
PE018	Medical Coverage
PE101	Encrypted Subscriber Last Name
PE102	Encrypted Subscriber First Name
PE103	Encrypted Subscriber Middle Initial
PE104	Encrypted Member Last Name
PE105	Encrypted Member First Name
PE106	Encrypted Member Middle Initial
PE899	Record Type

Derived or calculated from submitted data

PE903	BISHCA Extract Date
PE904	Unique Member ID
PE906	Submission ID#
PE913	Duplicate Member Flag

DATA RELEASE SCHEDULE: MEDICAL CLAIMS FILE

DATA ELEMENT NUMBER	ELEMENT NAME

Unrestricted — Included in the public use file for public release and general use.

Restricted — May be included in limited use research health care data sets as approved by BISHCA.

Unavailable for release — Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

MC005A	Version Number
MC011	Individual Relationship Code
MC012	Member Gender
MC015	Member State or Province
MC020	Admission Type
MC021	Admission Source
MC023	Discharge Status
MC032	Service Provider Specialty**
MC033	Service Provider City Name**
MC034	Service Provider State or Province**
MC035	Service Provider ZIP Code**
MC036	Type of Bill - Institutional/Facility Claims
MC037	Site of Service- NSF/CMS 1500 Claims
MC038	Claim Status
MC039	Admitting Diagnosis
MC040	E-Code
MC041	Principal Diagnosis
MC042	Other Diagnosis 1
MC043	Other Diagnosis 2
MC044	Other Diagnosis 3
MC045	Other Diagnosis 4
MC046	Other Diagnosis 5
MC047	Other Diagnosis 6
MC048	Other Diagnosis 7
MC049	Other Diagnosis 8
MC050	Other Diagnosis 9
MC051	Other Diagnosis 10
MC052	Other Diagnosis 11
MC053	Other Diagnosis 12
MC054	Revenue Code
MC055	Procedure 1 Code
MC056	Procedure 1 Modifier- 1
MC057	Procedure 1 Modifier- 2
MC058	ICD-9-CM Procedure Code

MC061	Quantity
MC063	Paid Amount
MC064	Prepaid Amount
MC065	Copay Amount
MC066	Coinsurance Amount
MC067	Deductible Amount
MC070	Service Provider Country Name**
MC071	DRG
MC072	DRG Version
MC073	APC
MC074	APC Version
MC075	Drug Code

Derived or calculated from submitted data

MC901	Member Age: VT aggregate 90+
MC902	Record ID#
MC905	Medicare Coverage
MC911	Double Encrypted Member ID#
MC913	Standardized Insurance Type/Product Code
MC914	Medical Abortion Flag**
MC915	Year Paid
MC916	Month Paid
MC917	Year of Service
MC918	Month of Service
MC919	Payment Quarter
MC920	Quarter Service Performed
*	Medication Abortion Flag**
*	Service Provider County Code**
*	Member County Code
*	Admission Year
*	Discharge Year
*	Length of Stay
*	Service Event Primary Key
*	Length of Service in Days

* No assigned data element number

**Provider data elements will not be released in records where the Medical Abortion Flag MC914 or Medication Abortion Flag=1.

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

MC001	Payer
MC002	National Plan ID
MC006	Insured Group or Policy Number
MC014	Member City Name
MC016	Member ZIP Code
MC017	Date Service Approved (AP Date)
MC018	Admission Date
MC019	Admission Hour
MC022	Discharge Hour
MC024	Service Provider Number**

MC026	National Service Provider ID**
MC027	Service Provider Entity Type Qualifier
MC028	Service Provider First Name**
MC029	Service Provider Middle Name**
MC030	Service Provider Last Name or Organization Name**
MC031	Service Provider Suffix**
MC059	Date of Service From
MC060	Date of Service Thru
MC062	Charge Amount
MC076	Billing Provider Number**
MC077	National Billing Provider ID**
MC078	Billing Provider Last Name or Organization**
MC069	Discharge Date
	Derived or calculated from submitted data
MC907	Double Encrypted Payer Claim Control Number
MC908	Double Encrypted Subscriber Social Security Number
MC909	Double Encrypted Plan Specific Contract Number
MC910	Double Encrypted Member Identification Code
MC912	Provider ID#
*	Insured Group Name (Derived from MC006 and Key Look-up Table)

* No assigned data element number

**Provider data elements not be released in records where the Medical Abortion Flag MC914 or Medication Abortion Flag=1.

UNAVAILABLE FOR RELEASE

MC003	Insurance Type/Product Code
MC004	Payer Claim Control Number
MC005	Line Counter
MC007	Encrypted Subscriber Social Security Number
MC008	Plan Specific Contract Number
MC009	Member Suffix or Sequence Number
MC010	Member Identification Code
MC013	Member Date of Birth
MC025	Service Provider Tax ID Number
MC027	Service Provider Entity Type Qualifier
MC068	Patient Account/Control Number
MC101	Encrypted Subscriber Last Name
MC102	Encrypted Subscriber First Name
MC103	Encrypted Subscriber Middle Initial
MC104	Encrypted Member Last Name
MC105	Encrypted Member First Name
MC106	Encrypted Member Middle Initial
MC899	Record Type
	Derived or calculated from submitted data
MC903	BISHCA Extract Date
MC904	Encrypted Member ID#
MC906	Submission ID#

DATA RELEASE SCHEDULE: PHARMACY CLAIMS FILE

DATA ELEMENT NUMBER	ELEMENT NAME

Unrestricted — Included in the public use file for public release and general use.

Restricted — May be included in limited use research health care data sets as approved by BISHCA.

Unavailable for release — Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

PC011	Individual Relationship Code
PC012	Member Gender
PC015	Member State or Province
PC023	Pharmacy Location State
PC024A	Pharmacy Country Name
PC025	Claim Status
PC026	Drug Code
PC027	Drug Name
PC028	New Prescription or Refill
PC029	Generic Drug Indicator
PC030	Dispense as Written Code
PC031	Compound Drug Indicator
PC033	Quantity Dispensed
PC034	Days Supply
PC036	Paid Amount
PC037	Ingredient Cost/List Price
PC038	Postage Amount Claimed
PC039	Dispensing Fee
PC040	Copay Amount
PC041	Coinsurance Amount
PC042	Deductible Amount
	Derived or calculated from submitted data
PC901	Member Age: VT aggregate 90+
PC902	Record ID#
PC910	Double Encrypted Member ID#
PC911	Standardized Member Gender
PC912	Standardized Insurance Type/Product Code
PC914	Year Paid
PC916	Year of Service
PC918	Payment Quarter
PC919	Quarter Service Performed
*	Member County Code
*	Year Prescription Filled
*	Medication Abortion Flag**

* No assigned data element number

LIMITED USE FILE-RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

PC001	Payer
PC002	National Plan ID
PC006	Insured Group Number
PC014	Member City Name of Residence
PC016	Member ZIP Code
PC017	Date Service Approved (AP Date)
PC018	Pharmacy Number
PC020	Pharmacy Name
PC021	National Pharmacy ID Number
PC022	Pharmacy Location City
PC024	Pharmacy ZIP Code
PC032	Date Prescription Filled
PC035	Charge Amount
PC044	Prescribing Physician First Name**
PC045	Prescribing Physician Middle Name**
PC046	Prescribing Physician Last Name**
	Derived or calculated from submitted data
PC906	Double Encrypted Payer Claim Control Number
PC907	Double Encrypted Subscriber Social Security Number
PC908	Double Encrypted Plan Specific Contract Number
PC909	Double Encrypted Member Identification Code
PC913	Pharmacy ID #
PC915	Month Paid
PC917	Month of Service
PC920	Prescribing Physician ID# **
*	Insured Group Name (Derived from PC006 and Key Look-up Table)

* No assigned data element number

**Provider data elements will not be released in records where the Medication Abortion Flag =1.

UNAVAILABLE FOR RELEASE

PC003	Insurance Type/Product Code
PC004	Payer Claim Control Number
PC005	Line Counter
PC007	Encrypted Subscriber Social Security Number
PC008	Plan Specific Contract Number
PC009	Member Suffix or Sequence Number
PC010	Member Identification Code
PC013	Member Date of Birth
PC019	Pharmacy Tax ID Number
PC047	Prescribing Physician DEA Number
PC101	Encrypted Subscriber Last Name
PC102	Encrypted Subscriber First Name

PC103	Encrypted Subscriber Middle Initial
PC104	Encrypted Member Last Name
PC105	Encrypted Member First Name
PC106	Encrypted Member Middle Initial
PC899	Record Type
	Derived or calculated from submitted data
PC903	BISHCA Transfer Date
PC904	Unique Member ID
PC905	Submission ID#

DATA RELEASE SCHEDULE: MEDICAL SERVICE PROVIDER FILE

Special Note: Provider data elements will not be released in records where the Medical Abortion Flag MC914 or Medication Abortion Flag=1.

DATA ELEMENT NUMBER	ELEMENT NAME

Unrestricted	Included in the public use file for public release and general use.
Restricted	May be included in limited use research health care data sets as approved by BISHCA.
Unavailable for release	Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

MCSP010	Service Provider Specialty
MCSP011	Service Provider City Name
MCSP012	Service Provider State or Province
MCSP013	Service Provider ZIP Code
MCSP015	Taxonomy Code
	Derived or calculated from submitted data
*	Service Provider County Code

* No assigned data element number

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

MCSP001	Provider ID#
MCSP002	Payer
MCSP006	Service/Prescribing Provider First Name
MCSP007	Service/Prescribing Provider Middle Name
MCSP008	Service/Prescribing Provider Last Name or Organization Name
MCSP009	Service Provider Suffix
MCSP018	National Provider Identifier

UNAVAILABLE FOR RELEASE

MCSP003	Service Provider Number
MCSP004	Service Provider Tax ID Number
MCSP005	Service Provider Entity Type Qualifier
MCSP017	Prescribing Physician's DEA (Drug Enforcement Authority) Registration Number
MCSP019	Indicates Source of Information as Medical or Pharmacy File

DATA RELEASE SCHEDULE: MEDICAL PROVIDER MASTER FILE

Special Note: Provider data elements will not be released in records where the Medical Abortion Flag MC914 or Medication Abortion Flag=1.

DATA ELEMENT NUMBER	ELEMENT NAME
Unrestricted	Included in the public use file for public release and general use.
Restricted	May be included in limited use research health care data sets as approved by BISHCA.
Unavailable for release	Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

MPM904	Service Provider Facility Code
MPM910	Service Provider State or Province
MPM911	Taxonomy Code
Derived or calculated from submitted data	
*	Service Provider County Code

* No assigned data element number

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

MPM901	Data Processing Center Code
MPM903	Service Provider Facility Name
MPM905	Service Provider First Name
MPM906	Service Provider Middle Name
MPM907	Service Provider Last Name
MPM908	Service Provider Suffix
MPM909	Service Provider Title
MPM912	Unique Physician Identification Number
MPM913	National Provider Identifier

UNAVAILABLE FOR RELEASE

MPM902	Service Provider Tax ID Number
MPM914	Prescribing Physician's DEA Registration Number

DATA RELEASE SCHEDULE: PHARMACY DETAIL FILE

DATA ELEMENT NUMBER	ELEMENT NAME

Unrestricted	Included in the public use file for public release and general use.
Restricted	May be included in limited use research health care data sets as approved by BISHCA.
Unavailable for release	Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

PCSP908	Pharmacy Location State

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

PCSP901	Payer
PCSP902	Data Processing Center Code
PCSP903	Pharmacy Number
PCSP905	Pharmacy Name
PCSP906	National Pharmacy ID Number
PCSP907	Pharmacy Location City
PCSP909	Pharmacy ZIP Code
PCSP910	Key to Pharmacy Claims

UNAVAILABLE FOR RELEASE

PCSP904	Pharmacy Tax ID Number

DATA RELEASE SCHEDULE: PHARMACY MASTER FILE

DATA ELEMENT NUMBER	ELEMENT NAME

Unrestricted — Included in the public use file for public release and general use.

Restricted — May be included in limited use research health care data sets as approved by BISHCA.

Unavailable for release — Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

PM906	Pharmacy Location State

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

PM901	Data Processing Center Code
PM903	Pharmacy Name
PM904	National Pharmacy ID Number
PM905	Pharmacy Location City
PM907	Pharmacy ZIP Code

UNAVAILABLE FOR RELEASE

PM902	Pharmacy Tax ID Number

DATA RELEASE SCHEDULE: LOCAL CPT CODES

DATA ELEMENT NUMBER	ELEMENT NAME

Unrestricted	Included in the public use file for public release and general use.
Restricted	May be included in limited use research health care data sets as approved by BISHCA.
Unavailable for release	Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

Currently there are no fields or data elements in this release category from this file.

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

HGCPT901	Procedure Code
HGCPT902	Payer Code
HGCPT903	Procedure Code Description
HGCPT904	Date HGCPT code was inserted into table

UNAVAILABLE FOR RELEASE

Currently there are no fields or data elements in this release category from this file.

DATA RELEASE SCHEDULE: LOCAL DIAGNOSIS CODES

DATA ELEMENT NUMBER	ELEMENT NAME

Unrestricted	Included in the public use file for public release and general use.
Restricted	May be included in limited use research health care data sets as approved by BISHCA.
Unavailable for release	Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

Currently there are no fields or data elements in this release category from this file.

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

HGDX901	Principal Diagnosis
HGDX902	Payer Code
HGDX903	Principal Diagnosis Description

UNAVAILABLE FOR RELEASE

Currently there are no fields or data elements in this release category from this file.

DATA RELEASE SCHEDULE: PAYER SPECIALTY CODES

Special Note: Provider data elements will not be released in records were the Abortion Flag MC914=1.

DATA ELEMENT NUMBER	ELEMENT NAME

Unrestricted	Included in the public use file for public release and general use.
Restricted	May be included in limited use research health care data sets as approved by BISHCA.
Unavailable for release	Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

Currently there are no fields or data elements in this release category from this file.

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

PS901	Service Provider Specialty
PS902	Payer Code
PS903	Service Provider Specialty Description

UNAVAILABLE FOR RELEASE

Currently there are no fields or data elements in this release category from this file.

DATA RELEASE SCHEDULE: PAYER CODES

DATA ELEMENT NUMBER	ELEMENT NAME

Unrestricted	Included in the public use file for public release and general use.
Restricted	May be included in limited use research health care data sets as approved by BISHCA.
Unavailable for release	Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

Currently there are no fields or data elements in this release category from this file.

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

PAYER901	Payer Name
PAYER902	Payer Code

UNAVAILABLE FOR RELEASE

Currently there are no fields or data elements in this release category from this file.

DATA RELEASE SCHEDULE: TAXONOMY FOR PROVIDER SPECIALTY CODES

Special Note: Provider data elements will not be released in records were the Abortion Flag MC914=1.

DATA ELEMENT NUMBER	ELEMENT NAME

Unrestricted	Included in the public use file for public release and general use.
Restricted	May be included in limited use research health care data sets as approved by BISHCA.
Unavailable for release	Unavailable for release by the department due to a variety of factors including: used for internal tracking purposes only; used to calculate other more useful variables; unreliable data; and potential for misuse.

PUBLIC USE FILE- UNRESTRICTED DATA ELEMENTS

TX901	Category
TX902	Provider Type
TX903	Classification
TX904	Area of Specialization
TX905	Taxonomy Code

LIMITED USE FILE- RESTRICTED DATA ELEMENTS (Release of each restricted data element must be approved by BISHCA)

Currently there are no fields or data elements in this release category from this file.

UNAVAILABLE FOR RELEASE

Currently there are no fields or data elements in this release category from this file.