



State of Tennessee Medical Claims Functional Specification

Med Claims Functional Specifications for File Layout

DESCRIPTION/GENERAL INFORMATION

This interface is designed to produce a medical claims file for plan participants administered through <Data Supplier>.

FILE/DATA FORMATTING AND SUBMISSION

DATA SUBMISSION	<p>[To be determined] Truven Health Analytics supports a number of file submission options including: FTP, Web Submission, as well as physical media.</p> <p>The data will be submitted to Truven Health Analytics on a <monthly/quarterly> basis. <Monthly/Quarterly> files should be submitted on or before the 15th of the month following the close of each <month/quarter>.</p>
FILE FORMAT	<ul style="list-style-type: none"> • Fixed-Record Length, ASCII File • Contains Detail (Data) Layout and Trailer Layout for each layout group
CHARACTER FIELDS	<ul style="list-style-type: none"> • Includes A - Z (lower or upper case), 0 – 9, and spaces • Left justified, right blank/space filled • Unrecorded or missing values in character fields are blank/spaces
DATE FIELDS	<ul style="list-style-type: none"> • Format of all dates should be MM/DD/CCYY
NUMERIC FIELDS	<ul style="list-style-type: none"> • All numeric fields should be right-justified and left zero-filled • Unrecorded or missing values in numeric fields should be set to zero
FINANCIAL FIELDS	<ul style="list-style-type: none"> • All financial fields should be right-justified and left zero-filled • Truven Health Analytics prefers to receive both dollars and cents, with an implied decimal point before the last two digits in the data. For example: "1234567" would represent \$12,345.67 <i>Please do not include an actual decimal point in the data.</i> • Negative signs should be the leading value in the first position. For example: "-1234567" would represent -\$12,345.67 • Unrecorded or missing values in numeric fields should be zero (000 to accommodate the 2-digit implied decimal)
INVALID CHARACTERS	<p>Please note that the following characters should not be included in the data or the descriptions in the data dictionary.</p> <p>* ! ? % _ (under score) , (comma)</p>

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DEFINITIONS

- Fully denied claims should be removed from the extract of claims prior to submission, while partially denied claims should be included. Truven Health defines denied claims as follows:
 - Fully denied claim** : The entire claim has been denied (typical reasons include an ineligible member, an ineligible provider, or a duplicate claims).
 - Partially denied claim** : The claim contains one or more service lines that are denied, but some that are paid. All service lines should be included on the file.
- Fee-for-service claims**: Claims records for services that result in direct payment to providers on a service-specific basis.
- Encounter records**: Utilization records for services provided under capitation arrangements (i.e., plans in which a provider is paid based on the number of enrollees rather than the services rendered.) These records enable documentation of all services provided regardless of whether or not direct payment was made to the provider.
- Facility Data**: Facility data includes all services rendered by an inpatient or outpatient facility. The basis for the requirements of facility data is the information found on the standard UB-04 claim form.
- Professional Data**: Professional data includes all services rendered by a physician or other professional provider, including dental, vision and hearing. The basis for the requirements of professional data is the information found on the standard CMS-1500 claim form.
- Fee-for-Service Equivalents**: Financial amounts for services rendered under a capitated arrangement found within encounter records.

DISCUSSION ITEMS

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

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

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

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

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DISCUSSION ITEMS - PROVIDER

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

Provider Example 1

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

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

Provider Example 2

The following is an example of what is not desired.

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

Provider Example 3

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

Professional

Claim ID	TAXID	Group Name	NPI	Prov Name	Prov Type	Svc Count	Net Payment
11111	121212121	XYZ Pediatrics	222222222	Dr Brown	25	2 \$	2,000.00
22222	121212121	XYZ Pediatrics	333333333	Dr Smith	35	1 \$	100.00

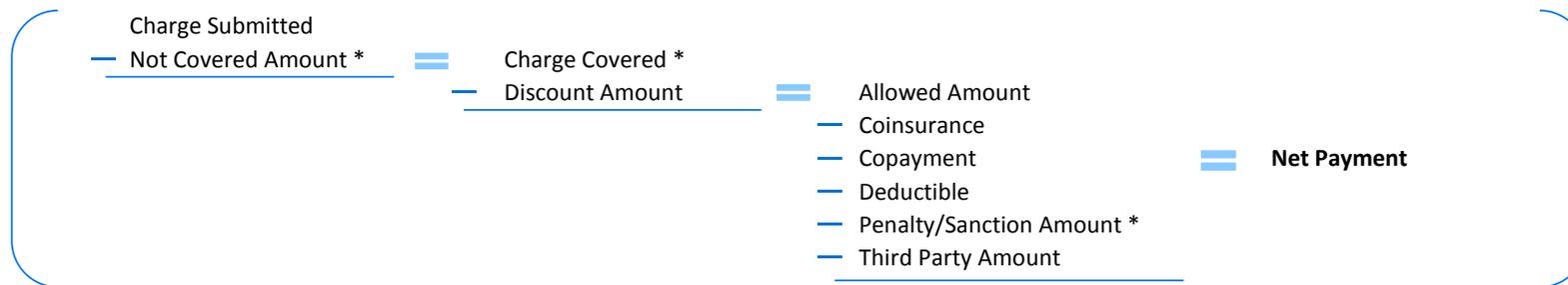
Facility

Claim ID	TAXID	NPI	Provider Name	Prov Type	Rev Code	Net Payment
11111	343434343	222222222	University Hospital	1	110 \$	2,000.00
22222	454545454	333333333	University Children's Hospital	1	120 \$	100.00

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FINANCIAL RELATIONSHIP

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



CORRECTIONS TO PAID CLAIMS

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

VOID/REPLACEMENT

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

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

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

ADJUSTMENT

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

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

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

FACILITY RECORD CONTENT

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

One facility claim with three service lines

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

PROFESSIONAL RECORD CONTENT

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

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

One professional claim with two service lines

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

--- Detail Layout ---

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Fixed-Record Length								
1	Adjustment Type Code	1	1	1	Character	Client-specific code for the claim adjustment type	Yes	Adjustment Type values will be identified in the Data Dictionary.
2	Allowed Amount	2	11	10	Numeric	The maximum amount allowed by the plan for payment.		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
3	Bill Type Code UB	12	15	4	Character	The UB-04 standard code for the billing type, indicating type of facility, bill classification, and frequency of bill.	See Notes	Bill Type values will be identified in the Data Dictionary only if standard codes are not used.
4	Capitated Service Indicator	16	16	1	Character	An indicator that this service (encounter record) was capitated		Applicable field values are “Y” for Capitated services and “N” for non-cap services.
5	Charge Submitted	17	26	10	Numeric	The submitted or billed charge amount		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
6	Claim ID	27	41	15	Character	The client-specific identifier of the claim.		
7	Claim Type Code	42	43	2	Character	Client-specific code for the type of claim	Yes	Claim Type Codes will be identified in the Data Dictionary.
8	Coinsurance	44	53	10	Numeric	The coinsurance paid by the subscriber as specified in the plan provision.		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
9	Copayment	54	63	10	Numeric	The copayment paid by the subscriber as specified by the plan provision.		
10	Date of Birth	64	73	10	Date	Birth date of the person		MM/DD/CCYY format The member’s birth date is part of the Person ID key and is, therefore, critical to tagging claims to eligibility. The four-digit year is required for date of birth. The century cannot be accurately assigned based on a two-digit year.
11	Date of First Service	74	83	10	Date	The date of the first service reported on the claim or authorization record.		MM/DD/CCYY Format
12	Date of Last Service	84	93	10	Date	The date of the last service reported on the claim or authorization record.		MM/DD/CCYY Format
13	Date of Service Facility Detail	94	103	10	Date	The date of service for the facility detail record.		MM/DD/CCYY Format
14	Date Paid	104	113	10	Date	The date the claim or data record was paid.		MM/DD/CCYY format This is the check date.
15	Days	114	119	6	Numeric	The number of inpatient days for the facility claim.		
16	Deductible	120	129	10	Numeric	The amount paid by the subscriber through the deductible arrangement of the plan.		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.

--- Detail Layout ---

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Fixed-Record Length								
17	Diagnosis Code Principal	130	137	8	Character	The first or principal diagnosis code for a service, claim or lab result. Length expanded from 5 to 8 for future use.		No decimal point.
18	Diagnosis Code 2	138	145	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
19	Diagnosis Code 3	146	153	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
20	Diagnosis Code 4	154	161	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
21	Diagnosis Code 5	162	169	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
22	Diagnosis Code 6	170	177	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
23	Diagnosis Code 7	178	185	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
24	Diagnosis Code 8	186	193	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
25	Diagnosis Code 9	194	201	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
26	Diagnosis Code 10	202	209	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
27	Diagnosis Code 11	210	217	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
28	Diagnosis Code 12	218	225	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
29	Diagnosis Code 13	226	233	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
30	Diagnosis Code 14	234	241	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
31	Diagnosis Code 15	242	249	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
32	Diagnosis Code 16	250	257	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
33	Diagnosis Code 17	258	265	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
34	Diagnosis Code 18	266	273	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
35	Diagnosis Code 19	274	281	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
36	Diagnosis Code 20	282	289	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
37	Diagnosis Code 21	290	297	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
38	Diagnosis Code 22	298	305	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
39	Diagnosis Code 23	306	313	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.

--- Detail Layout ---

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Fixed-Record Length								
40	Diagnosis Code 24	314	321	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
41	Diagnosis Code 25	322	329	8	Character	A secondary diagnosis code for the claim. Length expanded from 5 to 8 for future use.		No decimal point.
42	Discharge Status Code UB	330	331	2	Numeric	The UB-04 standard patient status code, indicating disposition at the time of billing.		
43	Discount	332	341	10	Numeric	The discount amount of the claim, applied to charges for any plan pricing reductions.		Format 9(8)v99 (2 – digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
44	Family ID/Employee SSN	342	350	9	Character	The unique identifier (Social Security Number) for the subscriber (contract holder, employee) and their associated dependents.		The subscriber’s social security number is part of the Person ID key and is, therefore, critical to tagging claims to eligibility.
45	Gender	351	351	1	Character	Gender of the person.		M or F The member’s gender is part of the Person ID key and is, therefore, critical to tagging claims to eligibility
46	Line Number	352	353	2	Numeric	The detail line number for the service on the claim		
47	Net Payment	354	363	10	Numeric	The actual check amount for the record		Format 9(8)v99 (2 - digit, implied decimal)
48	Network Paid Indicator	364	364	1	Character	An indicator of whether the claim was paid at in-network or out-of-network level		On facility records, this field must be at the service/detail level as opposed to the header/claim level.
49	Network Provider Indicator	365	365	1	Character	Indicates if the servicing provider participates in the network to which the patient belongs		Y or "N"
50	Ordering Provider ID	366	378	13	Character	The ID number of the provider who referred the patient or ordered the test or procedure.		
51	Ordering Provider Name	379	408	30	Character	The Name of the provider who referred the patient or ordered the test or procedure.		
52	Ordering Provider Zip Code	409	413	5	Character	The zip code of the provider who referred the patient or ordered the test or procedure.		
53	PCP Responsibility Indicator	414	414	1	Character	An indicator signifying that the PCP is the physician considered responsible or accountable for this claim.		
54	Place of Service Code	415	416	2	Character	Client-specific code for the place of service.	See Notes	Truven prefers the CMS place of service values. Place of Service values will be identified in the Data Dictionary only if non-standard values are used.
55	Procedure Code	417	423	7	Character	The procedure code for the service record. Length expanded from 5 to 7 for future use.		CPT/HCPCS codes.
56	Procedure Code UB Surg 1	424	430	7	Character	The primary surgical procedure code (1) on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
57	Procedure Code UB Surg 2	431	437	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
58	Procedure Code UB Surg 3	438	444	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
59	Procedure Code UB Surg 4	445	451	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.

--- Detail Layout ---

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Fixed-Record Length								
60	Procedure Code UB Surg 5	452	458	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
61	Procedure Code UB Surg 6	459	465	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
62	Procedure Code UB Surg 7	466	472	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
63	Procedure Code UB Surg 8	473	479	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
64	Procedure Code UB Surg 9	480	486	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
65	Procedure Code UB Surg 10	487	493	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
66	Procedure Code UB Surg 11	494	500	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
67	Procedure Code UB Surg 12	501	507	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
68	Procedure Code UB Surg 13	508	514	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
69	Procedure Code UB Surg 14	515	521	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
70	Procedure Code UB Surg 15	522	528	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
71	Procedure Code UB Surg 16	529	535	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
72	Procedure Code UB Surg 17	536	542	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
73	Procedure Code UB Surg 18	543	549	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
74	Procedure Code UB Surg 19	550	556	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
75	Procedure Code UB Surg 20	557	563	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
76	Procedure Code UB Surg 21	564	570	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
77	Procedure Code UB Surg 22	571	577	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
78	Procedure Code UB Surg 23	578	584	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
79	Procedure Code UB Surg 24	585	591	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
80	Procedure Code UB Surg 25	592	598	7	Character	The secondary surgical procedure code on the facility claim. Length expanded from 5 to 7 for future use.		ICD-9 or 10 Surgical procedure codes.
81	Procedure Modifier Code 1	599	600	2	Character	The 2-character code of the first procedure code modifier on the professional claim		
82	Provider ID	601	613	13	Character	The unique identifier for the provider of service.		This must be the federal tax ID in order to use the standard hospital identifier lookup (Standard Facility).

--- Detail Layout ---

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Fixed-Record Length								
83	TIN	614	622	9	Character	The federal tax ID of the provider.		Only needed if Provider ID is not the federal tax ID.
84	Provider Qualifier	623	632	10	Character	A qualifier to make Provider ID unique.		Only required if Provider ID is not unique.
85	Provider Type Code Claim	633	635	3	Character	Client-specific code for the provider type on the claim record	Yes	Provider Type codes are further defined in the Data Dictionary
86	Provider Taxonomy Code	636	645	10	Character	The Healthcare Provider Taxonomy code specific to the professional servicing provider associated with the claim. (Note: This is not a standard field in Advantage Suite. Truven asks for this field to aid in the mapping of Provider Type Code Claim to Truven's standard values.)		The National Uniform Claim Committee standard taxonomy code for the provider.
87	Provider Zip Code	646	650	5	Numeric	The 5-digit zip code corresponding to the Provider ID		Provider Location zip code
88	Revenue Code UB	651	654	4	Character	The CMS standard revenue code from the facility claim		This field must be at the service/detail level.
89	Third Party Amount	655	664	10	Numeric	The amount saved due to integration of third party liability (Coordination of Benefits) by all third party payers (including Medicare).		Format 9(8)v99 (2 - digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
90	Units of Service	665	668	4	Numeric	Client-specific quantity of services or units		
91	Provider Name	669	698	30	Character	The description or name corresponding to the Provider ID.		The Provider Name should be specific to the provider and not a group name.
92	Funding Type Code	699	699	1	Character	Specifies whether the claim was paid under a fully or self-funded arrangement		"S" = Self-funded "F" = Fully-funded
93	Account Structure	700	707	8	Character	Client-specific code for the account structure of the plan that the member is enrolled in. This is usually a group number.		Additional fields may be added to the layout if there is more than one component of the account structure.
94	Provider NPI Number	708	717	10	Character	The National Provider ID number for the provider.		
95	Provider Address 1	718	767	50	Character	The current street address1 of the provider of service.		If the provider has multiple addresses, the primary address is preferred.
96	Provider Address 2	768	817	50	Character	The current street address2 of the provider of service.		If the provider has multiple addresses, the primary address is preferred.
97	HRA Amount	818	827	10	Numeric	The amount paid from the HRA as a result of this claim.		Format 9(8)v99 (2 - digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
98	HSA Amount	828	837	10	Numeric	The amount paid from the HSA as a result of this claim.		Format 9(8)v99 (2 - digit, implied decimal) On facility records, this field must be at the service/detail level as opposed to the header/claim level.
99	Present on Admission Principal	838	838	1	Character	The principal POA code for the facility claim. Indicates whether the principal diagnosis was present on admission. Standard Values: 1 – Unreported/Not Used N – No, not present at admission U – Unknown W – Clinically Undetermined Y – Yes, present at admission	See Notes	If standard values are not used, define in the Data Dictionary.

--- Detail Layout ---

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Fixed-Record Length								
100	Present on Admission 02	839	839	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
101	Present on Admission 03	840	840	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
102	Present on Admission 04	841	841	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
103	Present on Admission 05	842	842	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
104	Present on Admission 06	843	843	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
105	Present on Admission 07	844	844	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
106	Present on Admission 08	845	845	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
107	Present on Admission 09	846	846	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
108	Present on Admission 10	847	847	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
109	Present on Admission 11	848	848	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
110	Present on Admission 12	849	849	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
111	Present on Admission 13	850	850	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
112	Present on Admission 14	851	851	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
113	Present on Admission 15	852	852	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
114	Present on Admission 16	853	853	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.

--- Detail Layout ---

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Dictionary Needed	Data Supplier Instructions/Notes
Fixed-Record Length								
115	Present on Admission 17	854	854	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
116	Present on Admission 18	855	855	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
117	Present on Admission 19	856	856	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
118	Present on Admission 20	857	857	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
119	Present on Admission 21	858	858	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
120	Present on Admission 22	859	859	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
121	Present on Admission 23	860	860	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
122	Present on Admission 24	861	861	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
123	Present on Admission 25	862	862	1	Character	A secondary POA code for the facility claim. Indicates whether the secondary diagnosis was present on admission. Standard Values listed in principal field.	See Notes	If standard values are not used, define in the Data Dictionary.
124	DRG MS Payment Code	863	865	3	Numeric	The Diagnosis Related Group (MS-DRG) code under which the claim was paid.		
125	ICD Version	866	866	1	Character	The ICD version or qualifier code that identifies either ICD-9 (9) or ICD-10 (0) diagnosis and procedure codes on the facility claim.	See Notes	If 0 and 9 not used, values defined in the Data Dictionary.
126	Tax Amount	867	876	10	Numeric	The amount charged by some states per medical claim.		Format 9(8)v99 (2 – digit, implied decimal)
127	Tax Type Code	877	877	1	Character	Data Supplier specific code identifying the state and/or type of tax.	Yes	Tax Type Codes will be identified in the Data Dictionary.
128	NDC Number Code	878	888	11	Character	The FDA (Food and Drug Administration) registered number for the drug. Please include for any drugs dispensed in the medical setting if available.		Please leave out the dashes.
129	Filler	889	999	111	Character	Reserved for future use		Fill with blanks
130	Record Type	1000	1000	1	Character	Record type identifier		Hard Code to "D"

--- Trailer Layout ---

Field Number	Field Name	Start	End	Length	Type	Data Element Description	Data Supplier Instructions/Notes
Fixed-Record Length							
1	Data Start Date	1	10	10	Date	Data Start Date	MM/DD/CCYY format – i.e. 09/01/2014 This will represent the 1st day of the month for which data is provided.
2	Data End Date	11	20	10	Date	Data End Date	MM/DD/CCYY format – i.e. 09/30/2014 This will represent the last day of the month for which data is provided.
3	Record Count	21	30	10	Numeric	Number of Records on File	The count of records provided in the data including the Trailer Record.
4	Total Net Payments	31	44	14	Numeric	Total net payments on the file	The sum of net payments provided in the file
5	Filler	45	999	955	Character	Reserved for future use	Fill with Blanks
6	Record Type	1000	1000	1	Character	Record Type Identifier	Hard Code 'T'