Types of Authority and Description of Changes to Data Elements Chapter 4653, Appendices A-C

This document documents changes to Appendices A – C, since they were published as proposed data elements. It details the (1) element number as used in the appendices, (2) the element name, (3) the types of authority mandating the collection of the particular element, (4) the written comments received during the 30-day public comment period that are specific to the elements, (5) the Department's response to comments received, and (6) the changes made to the appendices since publication of the proposed rule.

As described on pages 12 to 16 of its memorandum, the Department relies on four types of authority to require submission of each data element. These are:

1. Authority to collect institutional, professional, and pharmacy claims data: Section 62U.04, subd. 4(a)(3).
    A. Data found on a claim and for which the claim is the best source of the data, i.e., the 837I, 837P, or NCPDP transaction.
    B. Data found on a claim, but for which the claim is not the best source of the data. The analogous institutional (837I) or professional (837P) reference for each element is identified in the "type of authority" column. A reference to 837 without an I or P designation indicates that the reference can be either institutional or professional.
2. Authority to collect identifiers for health care homes: Section 62U.04, subd. 4(a)(2)
3. Authority to collect pricing data: Section 62U.04, subd. 5.
4. Authority to collect administrative data fields to ensure data integrity or to enhance the efficiency of data collection: Section 62U.04, subd. 4(a), which states that the data "shall be submitted in the form and manner specified by the commissioner."

The comments, responses, and changes to the data elements are listed in the fourth, fifth, and sixth columns. There were also a few additional clarifying changes to the appendices. First, there are some clarifying changes to the introduction to the appendices. Second, a minor edit was made to the title of the UB-04 column in Appendix B. Finally, Appendix D includes two changes – clarification of information required during registration to the data processor's system (page 45), and clarification of how long the test phase is likely to last (page 48).

Appendix A

Element Number	Element Name	Type of Authority	Submitted Stakeholder Comment	MDH Response	Change
ME001	Payer	4.	No comments received		• The description and the reference standard were changed with a minor edit
ME003	Insurance Type / Product Code	1. B 837/2000 B/SBR/ /09	• HealthPartners sought clarification on 1) which HIPAA dataset must be submitted – 837 or 271, and 2) the codes within the elements -- they are not standards from the 837 or the 271 datasets.	In this and a number of subsequent elements, the Reference Standard was changed to require the submission of only one dataset standard. This will clarify submission requirements and improve data consistency. For this element, the best source of data is the 271 dataset.	• The element name was changed with a minor edit • Max Len was expanded to 6 characters • Codes were added to the description to capture detail on public programs • The reference standard was clarified to specify which dataset is required
ME004	Year	4.	No comments received		No change
ME005	Month	4.	No comments received		No change
ME009	Plan Specific Contract Number	1. B 837/2010 BA/NM1/ MI/09	• HealthPartners said the HIPAA dataset reference referred to the member contract number, not the subscriber number, and either the reference or the element name should be changed.	The best source of data is the 271 dataset, and the reference listed is for the subscriber contract number.	• The threshold was changed from TBD to 99.9% for this element • The reference standard was clarified to specify which dataset is required
ME012	Individual Relationship Code	1. B 837/2000 B/SBR/ /02, 837/2000 C/PAT/ /01	No comments received	The best source of data is the 271 dataset. MDH decided to change the reference from the 837 dataset to the 271, and the coding in the description reflects the standard coding in the 271 dataset.	• The reference standard was clarified to specify which dataset is required • The coding in the description was changed to match the coding in the 271 dataset
ME013	Member Gender	1. B 837/2010	No comments received	For this element, the best source of data is the 271 dataset.	• The reference standard was clarified to specify which dataset is required

Element Number	Element Name	Type of Authority CA/DMG/ /03	Submitted Stakeholder Comment	MDH Response	Change
ME014	Member Date of Birth	1. B 837/2010 CA/DMG/ D8/02	• Multiple payers expressed uncertainty about how the transformation of the Date of Birth element works	• Clarification was needed • For this element, the best source of data is the 271 dataset.	• The description was amended to clarify the process of transforming this data element • The reference standard was clarified to specify which dataset is required
ME015	Member City Name	1. B 837/2010 CA/N4/ /01	No comments received	For this element, the best source of data is the 271 dataset.	• The reference standard was clarified to specify which dataset is required
ME016	Member State or Province	1. B 837/2010 CA/N4/ /02	No comments received	For this element, the best source of data is the 271 dataset.	• The reference standard was clarified to specify which dataset is required
ME017	Member ZIP Code	1. B 837/2010 CA/N4/ /03	No comments received	For this element, the best source of data is the 271 dataset.	• The reference standard was clarified to specify which dataset is required
ME018	Medical Coverage	4.	No comments received		• Explanatory language was moved from the reference standard to the description
ME019	Prescription Drug Coverage	4.	No comments received		• Explanatory language was moved from the reference standard to the description
ME028	Payer Responsibility Sequence Number Code		• Medica said they only track either “primary” or “not primary” payer information • HealthPartners said the HIPAA reference is for a claim (837) not eligibility (271) and that there could be more than one claim in a month.	This element is better captured in Appendix B, in MC038. MDH decided to delete this element	• This element was deleted.
ME032	Health Care	2.	• Medica asked what value	Thresholds are set at zero,	• The element name was

Element Number	Element Name	Type of Authority	Submitted Stakeholder Comment	MDH Response	Change
	Home Assigned Flag		should be entered into all Health Care Home fields (ME032-ME036) prior to certification of health care homes	so a blank field is allowed. MDH decided to change the name to reflect Minnesota's common term for the medical home concept	changed • The threshold was set to 0%
ME033	Health Care Home Number	2.	No comments received	MDH decided to change the name to reflect Minnesota's common term for the medical home concept	• The element name was changed • The threshold was set to 0%
ME034	Health Care Home Tax ID Number	2.	No comments received	MDH decided to change the name to reflect Minnesota's common term for the medical home concept	• The element name was changed • The threshold was set to 0%
ME035	Health Care Home National Provider ID	2.	No comments received	MDH decided to change the name to reflect Minnesota's common term for the medical home concept	• The element name was changed • The threshold was set to 0%
ME036	Health Care Home Name	2.	No comments received	MDH decided to change the name to reflect Minnesota's common term for the medical home concept	• The element name was changed • The threshold was set to 0%
ME101	Subscriber Last Name	1. B 837/2010 BA/NM1/ /03	No comments received	For this element, the best source of data is the 271 dataset.	• The reference standard was clarified to specify which dataset is required
ME102	Subscriber First Name	1. B 837/2010 BA/NM1/ /04	No comments received	For this element, the best source of data is the 271 dataset.	• The reference standard was clarified to specify which dataset is required
ME103	Subscriber Middle Initial	1. B 837/2010 BA/NM1/ /05		• MDH received feedback that middle initial was rarely collected in any field, and decided to make these fields voluntary. • For this element, the	• The threshold was set to 0% • The reference standard was clarified to specify which dataset is required

Element Number	Element Name	Type of Authority	Submitted Stakeholder Comment	MDH Response	Change
				best source of data is the 271 dataset.	
ME104	Member Last Name	1. B 837/2010 CA/NM1/ /03	No comments received	For this element, the best source of data is the 271 dataset.	• The reference standard was clarified to specify which dataset is required
ME105	Member First Name	1. B 837/2010 CA/NM1/ /04	No comments received	For this element, the best source of data is the 271 dataset.	• The reference standard was clarified to specify which dataset is required
ME106	Member Middle Initial	1. B 837/2010 CA/NM1/ /05		For this element, the best source of data is the 271 dataset.	• The threshold was set to 0% • The reference standard was clarified to specify which dataset is required
ME899	Record Type	4.	No comments received		• The reference standard was changed with a minor edit

Appendix B

Element Number	Element Name	Type of Authority	Submitted Stakeholder Comment	MDH Response / Clarification	Change
MC001	Payer	4.	No comments received		• description and the reference standard were changed with a minor edit
MC003	Insurance Type / Product Code	1. B 837/2000B/ SBR/ /09	• BC/BS said the 835 is the best dataset standard for this element • Medica said they don't have a way to capture this data, that members could have multiple code values, and that there should be more MN-specific codes • HealthPartners said there are two HIPAA datasets listed, and codes not in either dataset	MDH agreed that the 835 dataset is the best source of data, Minnesota-specific codes to capture public programs were added.	• Max Len was expanded to 6 characters • Coding was added to capture detail on public programs • The reference standard was clarified to specify which dataset is required
MC004	Payer Claim Control Number	3	• BC/BS wanted to ensure that this field will reflect the last adjudication of a claim, and that this number reflects patient liability or payer paid amount • Medica said they reuse this number after a few years	MHIC can accommodate the differences in how this element is submitted	• The reference standard was clarified to specify which dataset is required
MC004A	Claim Submitter's Identifier	1. A	• BC/BS was concerned that the number used for this element could be used to identify a patient. • Medica said they reuse this number after a few years	• Encryption of this element would not diminish its utility in tracking replacement claims, so MDH decided to encrypt the element • HIPAA allows for 38 characters in this element • MHIC suggested the threshold, based on data submissions in other states. • MHIC can accommodate the differences among submitters in how this element is submitted	• The element will be encrypted • Max Len was expanded from 20 to 38 characters • The threshold was set to 50%

Element Number	Element Name	Type of Authority	Submitted Stakeholder Comment	MDH Response / Clarification	Change
MC005	Line Counter	1. A	• BC/BS wanted to delete the language stating submitters needed approval from MHIC • HealthPartners said this is a pre-adjudication element and that in their system lines may change post-adjudication	Approval from MHIC is not required	• The language requiring approval from MHIC was deleted
MC005A	Version Number	4.	• Multiple payers wanted the threshold set to 0% • HealthPartners requested the ability to submit a "plain English" explanation of how they adjust claims	This is a voluntary field for payers who use this method of tracking replacement claims, and the requested change is appropriate	• The description was changed with a minor edit • The threshold was set to 0% • Ability to describe internal claims adjustment processes was added to the description of Registration, in Appendix D
MC008	Plan Specific Contract Number	1. B 837/2010BA /NM1/MI/09	• Medica sought clarification whether this element is the same as policy number • HealthPartners asked if this number refers to the member or the subscriber	• This encrypted element captures the number which plans use to identify the subscriber – which may be the policy number. • For this element, the best source of data is the 835 dataset.	• Threshold set at 99.9% for this element and the same element in other Appendices • The reference standard was clarified to specify which dataset is required
MC011	Individual Relationship Code	1. A	• Medica said they do not collect this information	This is a defined element in the 837 dataset, and should therefore be reported on a claim. If unknown, it may be coded as 21-Unknown	• A HIPAA standard code was added to the description
MC012	Member Gender	1. A	No comments received		• The reference standard was clarified to specify which dataset is required
MC013	Member Date of Birth	1. A	• Multiple payers expressed uncertainty about how the transformation of the Date of Birth element works	Clarification was needed	• The description was amended to clarify the process of transforming the data in this element. • The Reference Standard was clarified for which dataset is required

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MC014	Member City Name	1. A	• BC/BS wanted clarification whether the member or subscriber city should be submitted (an example is a college student (member) out of state, on her parents' (subscriber) policy)	The data element listed captures the subscriber's address.	•
MC015	Member State or Province	1. A	No comments received		• No change
MC016	Member ZIP Code	1. A	No comments received		• No change
MC017	Check Issue or EFT Effective Date	3.	• BC/BS wanted clarification whether remittance or adjudication date should be submitted	MDH prefers remittance date for this pricing data. This element is required for determining pricing data	• Clarifying language was added to the description for claims with "non-payment" filled. • The threshold was set to 100%
MC018	Admission Date	1. A	• Multiple payers said clarification was needed on the threshold, since these are only institutional claims, not professional	For elements that are only institutional claims, the thresholds have been modified to apply only to the institutional claims within a total submission, not to all institutional and professional claims in the submission	• Clarifying language was added making the threshold apply only to institutional claims.
MC020	Admission Type	1. A	• BC/BS asked to have codes 6-8 removed • HealthPartners sought clarification whether the threshold applied to all claims or only institutional claims	Codes 6-8 have been reserved in the 837 dataset, but not yet assigned to active codes	• Codes 6-8 were deleted • Clarifying language was added making the threshold apply only to institutional claims
MC021	Admission Source	1. A	• HealthPartners sought clarification whether the threshold applied to all claims or only institutional claims		• Clarifying language was added making the threshold apply only to institutional claims.
MC023	Discharge Status	1. A	• HealthPartners sought clarification whether the threshold applied to all claims or only institutional claims		• Clarifying language was added making the threshold apply only to institutional claims.
MC024	Service Provider	1. A	• Multiple payers sought	For the purposes of Provider	• The threshold has been

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	Number		clarification of what provider ID must be reported in this field, justification for the threshold, • HealthPartners asked to change the names of MC024-MC32 from "service" provider to "rendering/attending" provider.	Peer Grouping, MDH is faced with the challenge of collecting various provider IDs prior to and after implementation of the National Provider Index (NPI) in 2008. For administrative simplicity, MDH decided to make provider ID elements an "either-or" requirement rather than set thresholds for pre- or post-NPI data. Codes were added to capture non-NPI identifiers, and the description was clarified	set to zero, with the requirement to fill either MC024 or MC026 • Additional coding was added to the description • The description was clarified to specify the rendering/attending provider
MC025	Service Provider Tax ID Number	1. A	• BC/BS said under HIPAA, the tax ID is only required on the billing provider, that it is not generally submitted and that the threshold should be set to zero • HealthPartners said there are two possible HIPAA references for this element.	MDH decided this element is necessary for the provider peer grouping system, and that the reference standard needed to be corrected.	• The description was clarified to specify the rendering/attending provider • The reference standard elements were corrected
MC026	National Service Provider ID	1. A	• HealthPartners said the name and HIPAA reference should be changed • Medica said not all providers report this information, yet the threshold is set at 75%.	This element captures the NPI number for providers. For administrative simplicity, MDH decided to make this element an "either/or" requirement. If the provider does not have an NPI, MC024 must be filled.	• The threshold was set to zero, with the requirement to fill either MC024 or MC026
MC027	Service Provider Entity Type Qualifier	1. A	• Medica said they do not capture this information, and that the coding under the description is unclear • HealthPartners said the name and HIPAA reference should be changed	This is a HIPAA standard element and is therefore captured on a claim. The description has been clarified to indicate only HIPAA standard coding for the element	• The description was clarified to follow HIPAA standards for coding
MC028	Service Provider First Name	1. A	• HealthPartners said the names and narrative descriptions for	Discrepancies between the name given an element in the MHCCRS	• No change

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			provider name elements should be changed, retaining the HIPAA reference standards.	and names used in HIPAA datasets do not impact the integrity of the data.	
MC029	Service Provider Middle Name	1. A	• Medica said providers may not include their middle name on a claim, and sought clarity on filling "null" values for providers. • BC/BS said this element is generally not submitted by providers and the threshold should be set to 0%	MDH decided to make this a voluntary field. "Null" values for all providers are acceptable	• The threshold was set to 0%
MC030	Service Provider Last Name or Organization Name	1. A	No comments received		• No change
MC031	Service Provider Suffix	1. A	• Medica sought clarity on filling "null" values for providers • BC/BS said this element is generally not submitted by providers and the threshold should be set to 0%	MDH decided to make this a voluntary field. "Null" values for all providers are acceptable	• The threshold was set to 0%
MC032	Service Provider Specialty	1. A	• BC/BS said that providers only submit this information when it is needed for adjudication, that pulling this data from legacy systems is additional work, and that the threshold should be set to 0%, to comport with AUC best practices • Medica asked whether to include credentialed or practicing specialist information, and to whom should they give their data dictionary, or "taxonomy." • HealthPartners said the threshold should be set to 0%, to comport with AUC best practices, and that MHIC	This element is crucial to the validity of the data that will be used to create the provider peer grouping system. Pre-NPI taxonomy lists -- data dictionaries – of specialty providers can be sent directly to MHIC, who will crosswalk the data to match services to specialty providers – reducing the administrative burden on data submission for this element. Under 62U.04, Subd. 4, the state does not have the authority to compel providers to submit data to MHIC.	• No change

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			should ask providers to submit this information directly		
MC033	Service Provider City Name	1. A	• BC/BS sought clarity on the HIPAA reference standard, and recommended collecting the service site facility or billing provider address. • HealthPartners said this element is reported only when the service was provided at an address different than billing provider address, and that the threshold was too high.	MDH decided to clarify the reference standard to capture the city of the referring provider instead of the rendering provider, which could be multiple addresses.	• The reference standard was clarified
MC034	Service Provider State or Province	1. A	• BC/BS sought clarity on the HIPAA reference standard, and recommended collecting the service site facility or billing provider address. • HealthPartners said this element is reported only when the service was provided at an address different than billing provider address, and that the threshold was too high.	MDH decided to clarify the reference standard to capture the state of the referring provider instead of the rendering provider, which could be multiple addresses.	• The reference standard was clarified
MC035	Service Provider ZIP Code	1. A	• BC/BS sought clarity on the HIPAA reference standard, and recommended collecting the service site facility or billing provider address. • HealthPartners said this element is reported only when the service was provided at an address different than billing provider address, and that the threshold was too high.	MDH decided to clarify the reference standard to capture the state of the referring provider instead of the rendering provider, which could be multiple addresses.	• The reference standard was clarified
MC036	Type of Bill - Institutional	1. A	• HealthPartners sought clarification whether the threshold applied to all claims or only institutional claims	The original thresholds for MC036 and MC037 were based on MHIC's projection for the ratio of institutional to professional claims, the two elements equaling 100%.	• Clarifying language was added making the threshold apply only to institutional claims.

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				MDH decided to set the thresholds for these elements at 99% of either institutional or professional claims, whichever applied to the element.	
MC037	Site of Service - on NSF/CMS 1500 Claims	1. A	• HealthPartners sought clarification whether the threshold applied to all claims or only professional claims	The original thresholds for MC036 and MC037 were based on MHIC's projection for the ratio of institutional to professional claims, equaling 100%. MDH decided to set the thresholds for these elements at 99% of either institutional or professional claims, whichever applied to the element.	• Clarifying language was added making the threshold apply only to professional claims
MC038	Claim Status	1. B; 3. 837/2000B/ SBR//01	• BC/BS said this element – particularly code "4-denied" should apply to the entire claim, not to individual lines within a claim. • Medica said they do not capture this information, only whether a claim is paid or denied.	• MDH is aware of the concern regarding this element, and will work with submitters to find a reasonable solution – based on the system capabilities and data available to submitters. MHIC says they receive this level of detail from numerous other submitters. • For this element, the best source of data is the 835 dataset.	• Clarification was added to the description for those submitters whose system allows for only two codes • The reference standard was clarified to specify which dataset is required
MC039	Admitting Diagnosis	1. A	• HealthPartners sought clarification whether the threshold applied to all claims or only institutional claims • BC/BS recommended that the threshold be based on a national standard definition of institutional claims. • Medica said they do not always receive this information for their commercial products.	The threshold was changed to apply only to institutional claims. This is a HIPAA standard data element and is therefore defined and reported on a claim.	• Clarifying language was added making the threshold apply only to institutional claims
MC040	E-Code	1. A	No comments received		• No change
MC041	Principal	1. A	• Allina said that data integrity	Data will be submitted by health	• No change

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	Diagnosis		could be an issue. Providers may only include enough diagnosis or procedure codes required for payment, potentially not reflecting the full complexity of a patient	plans and TPAs, who receive the claims from providers. It is in providers' interest to fill in claims completely. MDH is confident that the required combination of diagnosis and procedure codes will produce sufficient data for risk adjustment	
MC042	Other Diagnosis - 1	1. A	No comments received		• No change
MC043	Other Diagnosis - 2	1. A	No comments received		• No change
MC044	Other Diagnosis - 3	1. A	No comments received		• No change
MC045	Other Diagnosis - 4	1. A	No comments received		• No change
MC046	Other Diagnosis - 5	1. A	No comments received		• No change
MC047	Other Diagnosis - 6	1. A	No comments received		• No change
MC048	Other Diagnosis - 7	1. A	No comments received		• No change
MC049	Other Diagnosis - 8	1. A	• BC/BS said that because professional claims have a maximum of 8 diagnosis codes, the subsequent diagnosis codes should be for institutional claims only.	If more than 8 diagnosis codes are submitted on a claim, MHIC will flag those diagnosis codes as, by definition, institutional claims.	• No change
MC050	Other Diagnosis - 9	1. A	No comments received		• No change
MC051	Other Diagnosis - 10	1. A	No comments received		• No change
MC052	Other Diagnosis - 11	1. A	No comments received		• No change
MC053	Other Diagnosis - 12	1. A	No comments received		• No change
MC054	Revenue Code	1. B; 3. Institutional	• BC/BS recommended technical clarifications in the description and that the threshold apply	• MDH agreed with the technical changes and made the threshold apply	• The description was clarified and the threshold was made to apply only to

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		837/2400/SV2//01	only to institutional claims.	only to institutional claims • For this element, the best source of data is the 835 dataset.	institutional claims • The reference standard was clarified to specify which dataset is required
MC055	Procedure Code	1. B Professional 837/2400/SV1/HC/01-2 Institutional 837/2400/SV2/HC/02	• Medica said they track all procedure codes in only one field and that the element should not have a threshold • HealthPartners commented that the reference standards listed are a mixture of adjudicated and submitted data. • BC/BS sought clarification on dental codes, that the threshold be based on institutional claims, and that the description not include the preference of 835 data.	Rather than alter the element for all submitters, MDH will recommend that Medica apply for an individual variance for this and related elements. MHIC will work with Medica to capture this information consistent with Medica's system capabilities. The state is not collecting dental procedure codes. The reference standard was clarified.	• The reference standard was clarified to specify which dataset is required
MC056	Procedure Modifier – 1	1. B Professional 837/2400/SV1/HC/01-3 Institutional 837/2400/SV2/HC/03	• BC/BS asked to have the language regarding the preference for 835 data removed	The language was removed from the description and the reference standard was clarified that the 835 is the best source of the data.	• The reference standard was clarified to specify which dataset is required
MC057A	Procedure Modifier - 2	1. B Professional 837/2400/SV1/HC/01-4 Institutional 837/2400/SV2/HC/04	• BC/BS asked to have the language regarding the preference for 835 data removed	The language was removed from the description and the reference standard was clarified that the 835 is the best source of the data.	• The reference standard was clarified to specify which dataset is required
MC057B	Procedure Modifier - 3	1. B Professional 837/2400/SV1/HC/01-5 Institutional 837/2400/SV2/HC/05	• BC/BS asked to have the language regarding the preference for 835 data removed	The language was removed from the description and the reference standard was clarified that the 835 is the best source of the data.	• The reference standard was clarified to specify which dataset is required

Element Number	Element Name	Type of Authority	Submitted Stakeholder Comment	MDH Response / Clarification	Change
MC057C	Procedure Modifier - 4	1. B Professional 837/2400/SV1/HC/01-6 Institutional 837/2400/SV2/HC/06	• BC/BS asked to have the language regarding the preference for 835 data removed	The language was removed from the description and the reference standard was clarified that the 835 is the best source of the data.	• The reference standard was clarified to specify which dataset is required
MC058	Principal ICD-9-CM Procedure Code	1. A	• BC/BS recommended that ICD-9 procedure codes be submitted only one way.	MDH agreed that all ICD-9 codes must be submitted one way. The description was clarified.	• The threshold was made to apply only to institutional inpatient claims and increased. • The description was changed to standardize how this element is submitted
MC058A	Other ICD-9-CM Procedure Code - 1	1. A	No comments received	MDH researched four years of inpatient claims to learn the percentage of claims that contain multiple ICD-9 procedure codes. The thresholds set for MC058A-MC058E reflect that research	• The threshold was set at 30% of inpatient claims • The description was changed to standardize how this element is submitted
MC058B	Other ICD-9-CM Procedure Code - 2	1. A	No comments received		• The threshold was set at 15% of inpatient claims • The description was changed to standardize how this element is submitted
MC058C	Other ICD-9-CM Procedure Code - 3	1. A	No comments received		• The threshold was set at 10% of inpatient claims • The description was changed to standardize how this element is submitted
MC058D	Other ICD-9-CM Procedure Code - 4	1. A	No comments received		• The threshold was set at 5% of inpatient claims • The description was changed to standardize how this element is submitted

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MC058E	Other ICD-9-CM Procedure Code - 5	1. A	No comments received		• The threshold was set at 0% • The description was changed to standardize how this element is submitted
MC059	Date of Service - From	1. B 837/2400/DTP/D8/03, 837/2300/DTP/RD8/03	• BC/BS recommended a clarification for institutional claims	MHIC will be able to separate out institutional claims and account for the discrepancy raised by BC/BS	• The reference standard was clarified to specify which dataset is required
MC060	Date of Service - Thru	1. B 837/2400/DTP/D8/03, 837/2300/DTP/RD8/03	• BC/BS recommended a clarification for institutional claims, and that the description allow for future dates	MHIC will be able to separate out institutional claims and account for the discrepancy raised by BC/BS. The description was amended to allow future dates for rented durable medical equipment	• The reference standard was clarified to specify which dataset is required • The description was clarified to allow for future dates
MC061	Quantity	1. B Professional 837/2400/SV1/UN/04 Institutional 837/2400/SV2/UN/05	• HealthPartners said that the reference standards listed are a mixture of adjudicated and submitted data. • BC/BS said that the element should match Minnesota coding standards • Medica said they enter multiple quantities for institutional claims	The reference standard was clarified	• The reference standard was clarified to specify which dataset is required • The description was clarified
MC062	Charge Amount	1. B; 3. Professional 837/2400/SV1//02 Institutional 837/2400/SV2//03	• HealthPartners said the reference standard needs clarity, and that on all dollar-denominated fields, the relationship between header-level and line-level claims should be clarified. • BC/BS said provider withholds should be left out of the amount submitted in this element • Medica asked if this element captures provider discounts, denied amounts, or billed	• For all dollar fields, MDH decided to allow submitters to fill in “all 9s” when the data is not available to the submitter, or does not apply. However, only 1% of all claims submitted may contain all 9s. • For this element, the best source of data is the 835 dataset.	• The reference standard was clarified to specify which dataset is required • The description was clarified to say that only 1% of all claims may contain all 9s

Element Number	Element Name	Type of Authority	Submitted Stakeholder Comment	MDH Response / Clarification	Change
			amounts		
MC063	Paid Amount	3.	• BC/BS said provider withholds should be left out of the amount submitted in this element, and that the threshold is too high • Medica said they do not currently report paid amount	MDH decided to remove provider withholds from the paid amount, as withholds may not be paid until the end of a contract period, separate from the service. This is a standard HIPAA data element, and is therefore defined and reported on an 835 remittance.	• The reference standard was clarified to specify which dataset is required • The description was clarified to remove withholds from the total and to say that only 1% of all claims may contain all 9s
MC063A	Header/ Line Payment Indicator	3.	• HealthPartners said the relationship between header-level and line-level claims should be clarified. • BC/BS asked for an example of how this element should be submitted • Medica sought clarity, saying professional claims are paid on a line level while institutional claims are paid on a header level	The description was clarified to give guidance how to report Header-level and Line-level payment throughout a claim. MHIC will provide submitters with an example in a future meeting with data submitters. Because this element is necessary for the calculation of pricing data, the threshold has been increased to 100%.	• The description was clarified • The threshold was set to 100%
MC063B	Allowed Amount	3.	• HealthPartners said the relationship between header-level and line-level claims should be clarified, and that there is variation in how this element has been collected and reported.	The header/line level concerns have been addressed in changes made to MC063A and will be explained in future data submitter meetings. MHIC will work with submitters to capture this element in a way consistent with how it is collected and reported.	• The description was clarified to say that only 1% of all claims may contain all 9s • The reference standard was clarified
MC063C	Managed Care Withhold	3.	• Medica said this information is rarely reported on a claim and the threshold is too high • BC/BS said payment of withholds are sometimes not determined until the end of a contract period, and that reporting this element before it is paid could skew data.	Because withhold calculations are often processed separate from claims, MDH decided to make submissions of all 9s not count against the threshold.	• The description was clarified to remove submissions of all 9s from the threshold • The reference standard was clarified

Element Number	Element Name	Type of Authority	Submitted Stakeholder Comment	MDH Response / Clarification	Change
MC064	Prepaid Amount	3.	• BC/BS sought clarity for reporting "data not available" and $0. • Medica said this is rarely reported on a claim and the threshold is too high.	Because prepaid amount calculations are often processed separate from claims, MDH decided to make submissions of all 9s not count against the threshold.	• The description was clarified to remove submissions of all 9s from the threshold • The reference standard was clarified
MC065	Copay Amount	3.	• HealthPartners said the relationship between header-level and line-level claims should be clarified. HealthPartners also sought clarity on how to report Coordination of Benefit claims between payers. • Medica said they cannot distinguish between co-pay and coinsurance.	Based on stakeholder input, MDH decided to merge this field with Co-insurance Amount (MC066), and delete MC066. The reference standard is now a sum of Copay amount and Coinsurance amount, to be submitted in the same field.	• MC065 and MC066 were combined • The reference standard was clarified to specify which dataset is required • The description was clarified to say that only 1% of all claims may contain all 9s
MC066	Co-insurance Amount	3.	• Medica said they cannot distinguish between co-pay and coinsurance. • BC/BS sought clarity whether a percent or a dollar amount should be submitted	See response for MC065	• This element was deleted
MC067	Deductible Amount	3.	No comments received		• The reference standard was clarified to specify which dataset is required • The description was clarified to say that only 1% of all claims may contain all 9s
MC070	Service Provider Country Name	1. A	• Medica said they do not collect a country code. • BC/BS recommended that this element be removed	MDH decided that since the provider peer grouping system will not group foreign providers, the element could be deleted	• This element was deleted
MC076	Billing Provider Number	1. A	• HealthPartners said this element does not apply to post-NPI claims • BC/BS said NPI regulations stipulate that this element not	For the purposes of Provider Peer Grouping, MDH is faced with the challenge of collecting various provider IDs prior to and after implementation of the National Provider Index (NPI) in	• The threshold was set to zero, with the requirement to fill either MC076 or MC077 • Additional coding was

Element Number	Element Name	Type of Authority	Submitted Stakeholder Comment	MDH Response / Clarification	Change
			be provided post-NPI implementation, and that the threshold is too high • Medica said this element is used for the UMPI number – for atypical, non-NPI providers, and that the threshold is too high	2008. For administrative simplicity, MDH decided to make provider ID elements an "either-or" requirement rather than set thresholds for pre- or post-NPI data. Codes were added to capture non-NPI identifiers, and the description was clarified	added to the description
MC077	National Billing Provider ID	1. A	• BC/BS asked that the length of the element be 10 integers.	• The length of the element was set to 10 characters • This element captures the NPI number for providers. For administrative simplicity, MDH decided to make this element an "either/or" requirement. If the billing provider does not have an NPI, MC076 must be filled.	• The threshold was set to zero, with the requirement to fill either MC076 or MC077
MC078	Billing Provider Last Name	1. A	No comments received		• No change
MC079	Diagnosis Code Pointer -1	1. A	• BC/BS uses pointers within a professional claim and asked for clarification on how exactly to report these elements in conjunction with other professional claims elements. • Medica said these elements "request information on the referring provider"	The pointer elements refer to one industry method of linking multiple diagnoses and procedures on the same claim, not to information on referring provider. MHIC will continue to work with submitters who use pointers to best capture these elements. Based on MHIC's experience in other states, the thresholds were set accordingly	• The threshold was set to 90%
MC080	Diagnosis Code Pointer -2	1. A	No comments received		• The threshold was set to 10%
MC081	Diagnosis Code Pointer -3	1. A	No comments received		• The threshold was set to 0%
MC082	Diagnosis Code Pointer -4	1. A	No comments received		• The threshold was set to 0%
MC101	Subscriber Last	1. A	No comments received		• No change

Element Number	Element Name	Type of Authority	Submitted Stakeholder Comment	MDH Response / Clarification	Change
	Name				
MC102	Subscriber First Name	1. A	No comments received		• No change
MC103	Subscriber Middle Initial	1. A	• Medica said this information may not be included on a claim and the threshold is too high • BC/BS asked the threshold to be set to 0%	Based on submitter input, MDH decided to make this element voluntary	• The threshold was set to 0%
MC104	Member Last Name	1. A	No comments received		• No change
MC105	Member First Name	1. A	No comments received		• No change
MC106	Member Middle Initial	1. A	• Medica said this information may not be included on a claim and the threshold is too high. • BC/BS asked the threshold to be set to 0%	Based on submitter input, MDH decided to make this element voluntary	• The threshold was set to 0%
MC899	Record Type	4.	No comments received		• The description was clarified

Appendix C

Element Number	Element Name	Level of Authority	Submitted Stakeholder Comment	MDH Response / Clarification	Change
PC001	Payer	4.	No comments received	Throughout Appendix C, the term "data reporter" was changed to "data submitter," making the terminology consistent in all Appendices.	• The reference standard was clarified
PC003	Insurance Type/ Product Code	4.	• Medica said they do not capture this information on a pharmacy claim and that the threshold is too high • HealthPartners said the NCPDP dataset does not include the data listed in the description of this element, and asked that it be removed	MDH is capturing this element for consistency between Appendices	• The threshold was lowered to 99.9% • The reference standard was clarified • Clarifying language was moved from the reference standard to the description • Max Len was increased to 6 characters • Coding was added to the description to capture data on public programs
PC004	Payer Claim Control Number	4.	No comments received	MDH decided to make the thresholds for these related elements consistent throughout the Appendices, and lowered the threshold for this element to 99.9%	• The threshold was changed to 99.9% • The description was clarified
PC005	Line Counter	4.	No comments received		• No change
PC008	Plan Specific Contract Number	1. A	• HealthPartners asked if this number refers to the member or the subscriber • Medica said they do not capture this information on a claim and asked for clarification on the threshold	The reference in the NCPDP dataset refers to the Cardholder ID, which corresponds to the member. The relationship between member and subscriber will be captured in PC011. This is a standard element and is therefore defined and collected on a claim. The threshold was set at 99.9%, making this consistent with similar elements in the other Appendices.	• The threshold was set at 99.9%

Element Number	Element Name	Level of Authority	Submitted Stakeholder Comment	MDH Response / Clarification	Change
PC011	Individual Relationship Code	1. A	• HealthPartners said the description does not match the NCPDP standard dataset	MDH decided to use the standard coding in the NCPDP dataset	• The description was changed to reflect NCPDP coding for this element
PC012	Member Gender	1. A	No comments received		
PC013	Member Date of Birth	1. A	No comments received		• The description of how this element is to be encrypted was clarified
PC014	Member City Name of Residence	1. A	No comments received		• No change
PC015	Member State or Province	1. A	No comments received		• No change
PC016	Member ZIP Code	1. A	No comments received		• No change
PC017	Date Service Approved (AP Date)	3.	• HealthPartners said they pay pharmacy claims in "batch" cycles and that actual dates are not available in their database. They recommend the use of "Fill Date"	"Fill Date" is captured by element PC032. HealthPartners can report the date the batch was paid to satisfy the requirement.	• The reference standard was clarified
PC018	Pharmacy ID	1. A	See comments for PC021	This is an element added in response to stakeholder comment, to capture pharmacy ID numbers prior to NPI implementation	• This is a new element • The threshold was set to 0%, with the requirement to fill either PC018 or PC021
PC020	Pharmacy Name	1. A	No comments received		• No change
PC021	National Pharmacy ID Number	1. A	• HealthPartners asked for guidance on pre-NPI pharmacy identifiers	PC018 was added to capture pre-NPI pharmacy IDs. This element captures the NPI number of the pharmacy.	• The threshold was set to 0%, with the requirement to fill either PC018 or PC021
PC025	Claim Status	4; 3.	• HealthPartners said these data are not available to them and asked to have the element removed • Medica said they only track paid or denied claims and	MHIC will continue to work with submitters to capture this element. HealthPartners may ask for an individual variance, if they do not have access to these data.	• The Max Len was corrected to include 2 characters • The description was clarified

Element Number	Element Name	Level of Authority	Submitted Stakeholder Comment	MDH Response / Clarification	Change
			asked for clarification on how best to submit the data		
PC026	Drug Code	1. A	• HealthPartners asked for clarification on the length of the element	The NCPDP standard allows for 11 characters. MHIC will work with HealthPartners to accommodate their system.	• No change
PC027	Drug Name	1. A	No comments received		• No change
PC028	New Prescription or Refill	1. A	No comments received		• No change
PC029	Generic Drug Indicator	1. A	No comments received		• No change
PC030	Dispense as Written Code	1. A	No comments received		• No change
PC031	Compound Drug Indicator	1. A	• HealthPartners said the description should reflect NCPDP standard coding • Medica said the description should reflect NCPDP standard coding	MDH decided to amend the description to reflect NCPDP standard coding.	• The description was changed to reflect NCPCP coding for this element.
PC032	Date Prescription Filled	1. A	No comments received		• No change
PC033	Quantity Dispensed	1. A	No comments received		• No change
PC034	Days Supply	1. A	No comments received		• No change
PC035	Gross Amount Due	1. A; 3.	No comments received	For all dollar fields, MDH decided to allow submitters to fill in “all 9s” when the data is not available to the submitter, or does not apply. However, only 1% of all claims submitted may contain all 9s.	• The description was clarified to say that only 1% of all claims may contain all 9s • The reference standard was clarified.
PC036	Total Amount Paid	1. A; 3.	No comments received		• The description was clarified to say that only 1% of all claims may contain all 9s • The reference standard was clarified.

Element Number	Element Name	Level of Authority	Submitted Stakeholder Comment	MDH Response / Clarification	Change
PC036A	Other Amount Paid	1. A; 3.	No comments received		• The description was clarified to say that only 1% of all claims may contain all 9s • The reference standard was clarified.
PC036B	Other Payer Amount Recognized	1. A; 3.	No comments received		• The description was clarified to say that only 1% of all claims may contain all 9s • The reference standard was clarified.
PC037	Ingredient Cost/List Price	1. A; 3.	No comments received		• The description was clarified to say that only 1% of all claims may contain all 9s • The reference standard was clarified.
PC039	Dispensing Fee Paid	1. A; 3.	No comments received		• The description was clarified to say that only 1% of all claims may contain all 9s • The reference standard was clarified.
PC040	Copay Amount	1. A; 3.	• HealthPartners said the reference standard is the sum of PC040 and PC041	Based on stakeholder input, MDH decided to merge this field with Co-insurance Amount (PC041), and delete PC041. The reference standard is a sum of Copay amount and Coinsurance amount, to be submitted in the same field.	• This element was renamed to include coinsurance amount • The description was clarified to say that only 1% of all claims may contain all 9s • The reference standard was changed to an element that includes copay and coinsurance.
PC041	Coinsurance Amount		• HealthPartners said the reference standard is the sum of PC040 and PC041	See response for PC040	• This element was deleted
PC042	Deductible Amount	3.	No comments received		• The description was clarified to say that only

Element Number	Element Name	Level of Authority	Submitted Stakeholder Comment	MDH Response / Clarification	Change
					1% of all claims may contain all 9s • The reference standard was clarified.
PC043	Patient Pay Amount	1. A; 3.	No comments received		• The description was clarified to say that only 1% of all claims may contain all 9s • The reference standard was clarified.
PC044	Prescribing Physician First Name	4.	• Medica said they do not track this information and that there is no NCPCP standard for this element	This is a voluntary element that will be used to enhance the provider peer grouping system, if submitted.	• The description was clarified
PC045	Prescribing Physician Middle Name	4.	• Medica said they do not track this information and that there is no NCPCP standard for this element	This is a voluntary element that will be used to enhance the provider peer grouping system, if submitted.	• The description was clarified
PC046	Prescribing Physician Last Name	1. A	• Medica said they do not track this information and that the threshold is too high	This is a standard NCPDP element, and is therefore reported on a claim. It is crucial for the development of the provider peer grouping system. MHIC and MDH will continue to work with submitters to capture these data.	• No change
PC047	Prescribing Physician DEA / Legacy Number	1. A	• HealthPartners said this element should not be required because it was not always reported on pre-NPI claims	For the purposes of Provider Peer Grouping, MDH is faced with the challenge of collecting various provider IDs prior to and after implementation of the National Provider Index (NPI) in 2008. For administrative simplicity, MDH decided to make provider ID elements an “either-or” requirement rather than set thresholds for pre- or post-NPI data. All prescribing physicians are required to have a DEA number in order to prescribe	• The threshold was set to zero, with the requirement to fill either PC047 or PC048 • The description was clarified to allow legacy provider IDs

Element Number	Element Name	Level of Authority	Submitted Stakeholder Comment	MDH Response / Clarification	Change
				schedule 3 drugs. For claims without a DEA number reported, data submitters must include a legacy ID.	
PC048	Prescribing Physician National Provider Identification Number	1. A	No comments received	This is the NPI number of the prescribing physician.	• The threshold was set to zero, with the requirement to fill either PC047 or PC048
PC101	Subscriber Last Name	1. A	No comments received		• No change
PC102	Subscriber First Name	1. A	No comments received		• No change
PC103	Subscriber Middle Initial	4.	No comments received		• The threshold was set to 0% • The description was clarified
PC104	Member Last Name	1. A	No comments received		• No change
PC105	Member First Name	1. A	No comments received		• No change
PC106	Member Middle Initial	4.	No comments received		• The threshold was set to 0% • The description was clarified
PC899	Record Type	4.	No comments received		• The description was clarified