Administrative Uniformity Committee

Streamlining Health Care Administrative Transactions in Minnesota

AUC OPERATIONS COMMITTEE AGENDA

2:00 p.m. – 4:00 p.m., Tuesday, March 8, 2016

TIES Event Center, Hamline Room

1644 Larpenteur Avenue West, Falcon Heights, MN 55108

Note: The TIES Event Center is on the western end of the TIES complex on the corner of Larpenteur and Snelling avenues, close to the state fair grounds and the St. Paul campus of the University of Minnesota. Free parking is available in the lot immediately adjacent to the event center, on the south side of Larpenteur, about ½ block west of the Snelling/Larpenteur intersection.

Teleconference line: 1-712-832-8300 Participant passcode: 337213

*Note: Please place your phone on mute you do not wish to be heard. (Press the mute button on your phone or press *6 to mute/unmute your line.) Please do not place your phone on hold.*

WebEx instructions:

1. To start the WebEx session, go to: https://health-state-mn-ustraining.webex.com
2. Under "Attend a Session," click "Live Sessions"
3. Click on the session for "AUC Operations"
4. Provide your name, email address, and the following password: Ops2010! (Note: The exclamation mark at the end is part of the password.)
5. Click "Join now"

Key Meeting Objectives:

- Review and vote on proposed changes to the Acknowledgment Companion Guides
- Review and vote on proposed data content and format for ACO attributed member files
- Recognize immediate past co-chairs
- Explore the "state of the art" in health care administrative simplification
- Review and discuss TAG updates and Department of Labor and Industry (DLI) updates regarding requirements for workers' compensation payers

Please see agenda on the next page

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Agenda

Note: The minutes of the last AUC Operations meeting on December 8, 2015 were approved by an email vote and are available at the Operations Committee Archived Meeting Materials webpage.

1. Meeting to order – Ann Hale, co-chair
2. Anti-trust statement: http://www.health.state.mn.us/auc/pdfs/antitrust.pdf
3. Introductions - Please e-mail your attendance to health.auc@state.mn.us
4. Recognize immediate past co-chairs
5. Review and vote on proposed changes to the Acknowledgment Companion Guides
6. Review and vote on proposed data content and format for ACO attributed member files
7. Explore the "state of the art" in health care administrative simplification
    a. Review and discuss: recent NCVHS findings and testimony; 2015 survey of ambulatory clinics' use of key administrative transactions; results of recent AUC "customer satisfaction survey;" other continued monitoring and reporting on the state of the art.
8. Technical Advisory Group (TAG) and SBAR (questions/change requests) updates
9. Update regarding Department of Labor (DLI) requirements for workers' compensation insurers
10. Other Business

Next Meeting: 2:00 p.m. – 4:00 p.m., June 14, 2016 (In-person & Teleconference/WebEx)
TIES Event Center, 1644 Larpenteur Avenue West, Falcon Heights, MN 55108

MDH Minnesota Department of Health

Minnesota Department of Health (MDH) Proposed Rule

Title:	Proposed Minnesota Uniform Companion Guide (MUCG) for the ASC X12/005010X214E2 Health Care Claim Acknowledgment (277) Version 54.0.
~~Pursuant to Statute~~Applicable statute(s):	Minnesota Statutes section 62J.536 and section 62J.61
Applies to/~~interested parties~~likely of interest to:	Health care providers, group purchasers (payers), and clearinghouses subject to Minnesota Statutes, section 62J.536 and others
Description of this document:	[Placeholder: Express permission to use ASC copyrighted materials within this document has been granted.] This document: • Describes the proposed data content and other transaction specific information to be used with the *ASC X12/005010X214E2 Health Care Claim Acknowledgment (277)* hereinafter referred to as *005010X214E2,* by entities subject to Minnesota Statutes, section 62J.536; • Is intended to be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications); • Was prepared by the Minnesota Department of Health (MDH) with the assistance of the Minnesota Administrative Uniformity Committee (AUC).
Status of this document:	This version ~~4~~5.0 (v5~~4~~.0) Minnesota Uniform Companion Guide (MUCG) for the ASC X12/005010X214E2 Health Care Claim Acknowledgment (277) is a proposed rule for public comment with proposed changes from v4.0. An announcement of v5.0's availability and information about a related 30-day public comment period was published in the Minnesota State Register, Volume 40, Number 21, November 23, 2015. ~~supersedes version 3.0 and all previous versions. Version 3.0 (v3.0) was announced as a proposed rule for public comment in the Minnesota State Register, Volume , Number 26,~~

MDH Minnesota Department *of* Health

Title:	Proposed Minnesota Uniform Companion Guide (MUCG) for the ASC X12/005010X214E2 Health Care Claim Acknowledgment (277) Version 54.0.
	~~December 24, 2012, pursuant to Minnesota Statutes, sections 62J.536 and 62J.61. Public comments regarding v3.0 were accepted through January 22, 2013. The comments received were reviewed with the assistance of the AUC and changes were made to v3.0 that were incorporated in v4.0. Until a version of this document subsequent to v4.0 is adopted and becomes effective, v4.0 remains in force.~~ Note: v4.0 of this MUCG remains in force until a subsequent version is adopted into rule. Copies of the MUCGs most recently adopted into rule are available at: http://www.health.state.mn.us/auc/guides.htm. ~~An announcement of the adoption of this rule (version 4.0) was published in the Minnesota State Register, Volume 37, Number 40, April 8, 2013.~~ This document is available at no charge at: www.health.state.mn.us/asa.

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1.0 Overview

1.1 Statutory basis for this proposed rule

Minnesota Statutes, section 62J.536 requires the Commissioner of Health to adopt rules for the standard, electronic exchange of specified health care administrative transactions. The state's rules are promulgated and adopted pursuant to Minnesota Statutes, section 62J.61.

1.2 Applicability of state statute and related rules

The following entities must exchange certain transactions electronically pursuant to Minnesota Statutes, section 62J.536: all group purchasers (payers) and health care clearinghouses licensed or doing business in Minnesota; and health care providers providing services for a fee in Minnesota and who are otherwise eligible for reimbursement under the state's Medical Assistance program. The only exceptions to the statutory requirements are as follows:

- The requirements do NOT apply to the exchange of covered transactions with Medicare and other payers for Medicare products; and
- See section 1.2.1 "Exceptions to Applicability" below regarding a year-to-year exception for only non-HIPAA covered entities and only for the eligibility inquiry and response transaction.

Minnesota Statutes, section 62J.03, Subd. 6 defines "group purchaser" as follows:

> *"Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota Comprehensive Health Association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.*

Minnesota Statutes, section 62J.03, Subd. 8 defines "provider" or health care provider" as follows:

> *"Provider" or "health care provider" means a person or organization other than a nursing home that provides health care or medical care services within Minnesota for a fee and is eligible for reimbursement under the medical assistance program under chapter 256B. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a group purchaser, health carrier, or individual for providing health care services. For purposes of this subdivision, "eligible for reimbursement under the medical assistance program" means that the provider's services would be reimbursed by the medical assistance program if the*

services were provided to medical assistance enrollees and the provider sought reimbursement, or that the services would be eligible for reimbursement under medical assistance except that those services are characterized as experimental, cosmetic, or voluntary.

Minnesota Statutes, section 62J.536, Subd. 3 defines "health care provider" to also include licensed nursing homes, licensed boarding care homes, and licensed home care providers.

Minnesota Statutes, section 62J.51, Subd. 11a defines “health care clearinghouse” as follows:

"Health care clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches that does any of the following functions:

(1) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction;

(2) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity;

(3) acts on behalf of a group purchaser in sending and receiving standard transactions to assist the group purchaser in fulfilling its responsibilities under section 62J.536;

(4) acts on behalf of a health care provider in sending and receiving standard transactions to assist the health care provider in fulfilling its responsibilities under section 62J.536; and

(5) other activities including but not limited to training, testing, editing, formatting, or consolidation transactions.

A health care clearinghouse acts as an agent of a health care provider or group purchaser only if it enters into an explicit, mutually agreed upon arrangement or contract with the provider or group purchaser to perform specific clearinghouse functions.

Entities performing transactions electronically pursuant to Minnesota Statutes, section 62J.536 via direct data entry system (i.e., Internet-based interactive applications) must also comply with the data content requirements established in this document.

1.2.1 Exceptions to Applicability

Minnesota Statutes, section 62J.536, Subd. 4 authorizes the Commissioner of Health to exempt group purchasers not covered by HIPAA (group purchasers not covered under United States Code, title 42, sections 1320d to 1320d-8) from one or more of the requirements to exchange information electronically as required by Minnesota Statutes, section 62J.536 if the Commissioner determines that:

i. a transaction is incapable of exchanging data that are currently being exchanged on paper and is necessary to accomplish the purpose of the transaction; or

ii. *another national electronic transaction standard would be more appropriate and effective to accomplish the purpose of the transaction.*

If group purchasers are exempt from one or more of the requirements, providers shall also be exempt from exchanging those transactions with the group purchaser.

The Commissioner has determined that criterion (i) above has been met for the eligibility inquiry and response electronic transaction only, and that group purchasers not covered by HIPAA, including workers' compensation, auto, and property and casualty insurance carriers, are not required to comply with the rules for the eligibility inquiry and response transaction. ***This exception ~~is now in force for 2013 and~~ pertains only to those group purchasers not covered by HIPAA, and only for the rules for the health care eligibility inquiry and response electronic transaction (ASC12/005010X279A1 Health Care Eligibility Benefit Inquiry and Response (270/271), hereinafter 005010X279A1).*** This exception shall be reviewed on an annual basis. The current status of the exception can be found at: http://www.health.state.mn.us/asa/implement.html.

While the exception above is in effect, health care providers are also exempt from the rules for transactions with group purchasers who have been exempted. This exception is only for the rules for the eligibility inquiry and response electronic transaction (*005010X279A1*) with group purchasers not covered by HIPAA.

The year-to-year exception above is not in effect for this ASC X12/005010X214E2 Health Care Claim Acknowledgment (277) transaction. The exception applies only to the 005010X279A1 (270/271) transaction described above.

1.3 Statutory requirements for the standard, electronic exchange of acknowledgements

Minnesota Statutes, section 62J.536, subd.1(e) states that:

Beginning January 1, 2012, all health care providers, health care clearinghouses, and group purchasers must provide an appropriate, standard, electronic acknowledgment when receiving the health care claims or equivalent encounter information transaction or the health care payment and remittance advice transaction. The acknowledgment provided must be based on one or more of the following American National Standards Institute, Accredited Standards Committee X12 standard transactions or National Council for Prescription Drug Program (NCPDP) standards:

(1) TA1;

(2) 999;

(3) 277CA; or

(4) the appropriate NCPDP response standard as the electronic acknowledgment.

Health care providers, health care clearinghouses, and group purchasers may send and receive more than one type of standard acknowledgment as mutually agreed upon. The mutually agreed upon acknowledgments must be exchanged electronically. Electronic exchanges of acknowledgments do not include e-mail or facsimile.

1.4 About the Minnesota Department of Health (MDH)

MDH is responsible for protecting, maintaining and improving the health of Minnesotans. The

department operates programs in the areas of disease prevention and control, health promotion, community public health, environmental health, health care policy, and registration of health care providers. For more information, go to: http://www.health.state.mn.us.

1.4.1 Contact for further information regarding this document

Minnesota Department of Health
Division of Health Policy
Center for Health Care Purchasing Improvement
P.O. Box 64882
St. Paul, Minnesota 55164-0882

Phone: (651) 201-3570
Fax: (651) 201-5179
Email: health.ASAguides@state.mn.us

1.5 About the Minnesota Administrative Uniformity Committee

The Administrative Uniformity Committee (AUC) is a broad-based, voluntary organization representing Minnesota health care public and private payers, hospitals, health care providers and state agencies. The mission of the AUC is to develop agreement among Minnesota payers and providers on standardized health care administrative processes when implementation of the processes will reduce administrative costs. The AUC acts as a consulting body to various public and private entities, but does not formally report to any organization and is not a statutory committee. For more information, go to the AUC website at: http://www.health.state.mn.us/auc/index.html.

1.6 Minnesota Best Practices for the Implementation of Electronic Health Care Transactions

The AUC develops and publicizes best practices for the implementation of health care administrative transactions and processes. The best practices are not required to be used as part of this document. However, their use is strongly encouraged to aid in meeting the state's requirements, and to help meet goals for health care administrative simplification.

Please visit the AUC website at http://www.health.state.mn.us/auc/index.html for more information about best practices for implementing electronic health care transactions in Minnesota.

1.7 Document Changes

The content of this document is subject to change. The version, release and effective date of the document is included in the document, as well as a description of the process for future updates or changes.

1.8 Process for updating this document

The process for updating this document, including: submitting and collecting change requests; reviewing and evaluating the requests; proposing changes; and adopting and publishing a new version of the document is available from MDH's website at http://www.health.state.mn.us/asa/index.html.

1.9 Document revision history

Version	Revision Date	Summary Changes
1.0	September 27, 2010	Version released for public comment
2.0	December 27, 2010	Final published version for implementation
3.0	December 24, 2012	Incorporated proposed technical changes and updates to v2.0
4.0	April 8, 201~~2~~3	Incorporated v3.0 and additional changes to v3.0
5.0	November 23, 2015	Proposed changes and updates to v4.0

2.0 Purpose of this document and its relationship with other applicable regulations

2.1 Reference for this document

The reference for this document is the *ASC X12/005010X214E2 Health Care Claim Acknowledgment (277)* (Copyright © 2008, Data Interchange Standards Association on behalf of ASC X12. Format © 2008, Washington Publishing Company. All Rights Reserved), hereinafter described below as *005010X214E2.* A copy of the full *005010X214E2* can be obtained from ~~the Washington~~ ASC X12 at: http://store.x12.org/store/.

2.2 Permission to use copyrighted information

[Placeholder: Express permission to use ASC X12 copyrighted materials within this document has been granted.]

2.3 Purpose and relationship

This document:

- Serves as transaction specific information to the *005010X214E2*;
- Must be used in conjunction with all applicable Minnesota and federal regulations, including 45 CFR Parts 160, 162, and 164 (HIPAA Administrative Simplification, including adopted federal operating rules) and related ASC X12N and retail pharmacy specifications (ASCX12N and NCPDP implementation specifications);
- Supplements, but does not otherwise modify the *005010X214E2* in a manner that will make its implementation by users to be out of compliance.
- Must be appropriately incorporated by reference and/or the relevant transaction information must be displayed in any companion guides provided by entities subject to Minnesota Statutes, section 62J.536.

Note: Using this Companion guide does not mean that a claim will be paid, nor does it imply payment policies of payers, or the benefits that have been purchased by the employer or subscriber.

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3.0 How to use this document

3.1 Classification and display of Minnesota-specific requirements

This document has been prepared for use by entities subject to Minnesota's requirements for the standard, electronic exchange of health care administrative transactions (Minnesota statutes, section 62J.536 and related rules) and other interested parties. It provides transaction specific information to be used in conjunction with the *005010X214E2* and other applicable information and specifications noted in section 2.0 above.

Table 4.2 of this document contains a row for each segment for which there is additional information over and above the information in the*005010X214E2*. The tables show the relevant loop and corresponding segment(s) with the additional information. In instances in which the additional information is at the data element level, the relevant loop, segment, and data element are shown.

This document also contains the following appendix:

- Appendix A: Minnesota Allowable Values for Claim Status Category and Claim Status Codes on the Health Care Claim Acknowledgment (277)

Appendix A includes tables displaying Claim Status Category Codes that may be reported as part of this MUCG, as well as Claim Status Codes to use with the appropriate Claim Status Category Code.

See also section 2.2 above regarding the incorporation of the information in this document in any companion guides provided by or on behalf of entities subject to Minnesota Statutes, section 62J.536.

3.2 Information About the Health Care Claim Acknowledgment (277) Transaction

3.2.1 Business Terminology

No terms have been uniquely defined for use of this Companion Guide.

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4.0 ASC X12/005010X214E2 Health Care Claim Acknowledgment (277) -- Transaction Specific Information

4.1 Introduction to Table

The following table provides information needed to implement the *ASC X12/005010X214E2 Health Care Claim Acknowledgment (277)* transaction. It includes a row for each segment for which there is additional information over and above the information in the *005010X214E2* and shows the relevant loop and corresponding segment(s) with the additional information. ~~In instances in which the additional information is at the data element level, the relevant loop, segment, and data element are shown.~~

Please also see section 2.2 above.

4.2 *005010X214E2* Acknowledgment (277) -- Transaction Table

Table 1. *005010X214E2* Acknowledgment (277) Transaction Specific Information

This table summarizes transaction specific information to be used in conjunction with the 005010X222A1 and any other applicable information and specifications noted in section 2.2 above.

Loop	Segment(s)	~~Data Element (if applicable)~~ Value Definition and Notes
2200B - INFORMATION RECEIVER APPLICATION TRACE	STC - Information Receiver Status Information	Refer to Appendix A for codes and usage
2200C - PROVIDER OF SERVICE INFORMATION TRACE IDENTIFIER	TRN - Provider of Service Information Trace Identifier	Use the HL reference of the billing loop. If using "0", must have detail for all claims (patient level).
	STC - Billing Provider Status Information	Refer to Appendix A for codes and usage
2200D - CLAIM STATUS TRACKING NUMBER	STC - Claim Level Status Information	Refer to Appendix A for codes and usage
2220D - SERVICE LINE INFORMATION	STC - Service Line Level Status Information	Refer to Appendix A for codes and usage

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5.0 List of Appendices

Appendix A: Minnesota Allowable Values for Claim Status Category and Claim Status Codes on the Health Care Claim Acknowledgment (277)

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Appendix A: Minnesota Allowable Values for Claim Status Category and Claim Status Codes on the Health Care Claim Acknowledgment (277)

The tables in this appendix list the Minnesota allowable values for Claim Status Category and Claim Status Codes for use by group purchasers, providers, and clearinghouses. National organizations are responsible for maintenance of these codes and periodically add, delete, or make other changes to them. This MUCG and appendix incorporate by reference any changes adopted by national organizations with responsibilities for these codes.

Claim Status Category Codes and Claim Status codes, including updates (additions, deletions, changes), are published by Washington Publishing Company and are available at: http://www.wpc-edi.com/reference/.

Claim Status Category Codes

- Table A.1 of this appendix shows Claim Status Category Codes for use by entities subject to Minnesota Statutes, section 62J.536 and related rules.
- Not all Claim Status Category Codes are intended for use in a 005010X214E2. Some Claim Status Category Codes were developed for use in the 276/277 Claim Status transaction or the 277U unsolicited claim status transaction. This appendix indicates which codes may be used on the 005010X214E2.

Claim Status Code Crosswalk

- The Claim Status Code Crosswalk, table A.2, shows Claim Status Codes to be used with the Claim Status Category Code value(s) specified on the table.
- In some cases a Claim Status Code may not be used but a related Claim Status Code must be used instead to communicate the status.
- Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Use ~~O~~of Inactive Claim Status Codes

- Group purchasers, providers, and clearinghouses must not use inactive codes.

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Table A.1

Claim Status Category Codes for use by entities subject to Minnesota Statutes, section 62J.536 and related rules

Check http://www.wpc-edi.com/reference/ for current list of Claims Status Category Codes

Claim Status Category Code	Code Description	~~Available for use on this MN Uniform Companion Guide for the 005010X214E2~~ ~~(Y=yes, N=No)~~ Comments
A0	Acknowledgement/Forwarded-The claim/encounter has been forwarded to another entity.	~~Y~~
A1	Acknowledgement/Receipt-The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.	~~Y~~Allow for non-HIPAA covered entities
A2	Acknowledgement/Acceptance into adjudication system-The claim/encounter has been accepted into the adjudication system.	~~Y~~
A3	Acknowledgement/Returned as unprocessable claim- The claim/encounter has been rejected and has not been entered into the adjudication system.	~~Y~~ Require Claim Status code
A5	Acknowledgement/Split Claim-The claim/encounter has been split upon acceptance into the adjudication system.	~~Y~~
A6	Acknowledgement/Rejected for Missing Information - The claim/encounter is missing the information specified in the Status details and has been rejected.	~~Y~~
A7	Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid	~~Y~~

	information as specified in the Status details and has been rejected.	
A8	Acknowledgement / Rejected for relational field in error.	~~¥~~

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Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
16	~~Claim/encounter has been forwarded to entity. This change effective 11/1/2010:~~ Claim/encounter has been forwarded to entity. Note: This code requires use of an Entity Code.	A0	
17	~~Claim/encounter has been forwarded by third party entity to entity. This change effective 11/1/2010:~~ Claim/encounter has been forwarded by third party entity to entity. Note: This code requires use of an Entity Code.	A0	
20	Accepted for processing.	A2	
21	Missing or invalid information. Note: At least one other status code is required to identify the missing or invalid information.	A3, A6, A7, A8~~-~~	If a more specific code is available, it should be used rather than using this code.
23	~~Returned to Entity. This change effective 11/1/2010:~~ Returned to Entity. Note: This code requires use of an Entity Code.	A3	
24	~~Entity not approved as an electronic submitter. This change effective 11/1/2010:~~ Entity not approved as an electronic submitter. Note: This code	A3	Using code 24 to indicate the transaction is being rejected because the entity (trading ~~P~~partner) is not

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
	requires use of an Entity Code.		approved as an electronic submitter - thus all transactions would be rejected.
25	~~Entity not approved. This change effective 11/1/2010:~~ Entity not approved. Note: This code requires use of an Entity Code.	A3	Use when rejecting some but not all transactions. For example: clearinghouse may be servicing several providers. Provider 1 is approved and registered with the payer as is Provider 3. Provider 2 is not approved to bill the payer and the use of this code would require using the data element 98 in the composite data element of the STC segment in the 277, which would indicate that the Billing Provider is not approved. By indicating that all claims under Provider 2 are being rejected, the payer can accept and process claims

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
			for Provider 1 and Provider 3 per the payer's adjudication processes without having to reject an entire transaction.
26	~~Entity not found. This change effective 11/1/2010:~~ Entity not found. Note: This code requires use of an Entity Code.	A3	
27	Policy canceled.	A3	
29	Subscriber and policy number/contract number mismatched.	A3, A7, A8	
30	Subscriber and subscriber id mismatched.	A3, A7, A8	
31	Subscriber and policyholder name mismatched.	A3, A7, A8	
33	Subscriber and subscriber id not found.	A3,A7	
51	Investigating occupational illness/accident.	A1	
54	Duplicate of a previously processed claim/line.	A3	
78	Duplicate of an existing claim/line, awaiting processing.	A3	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
85	~~Entity not primary. This change effective 11/1/2010:~~ Entity not primary. Note: This code requires use of an Entity Code.	A0, A3, A7	
86	Diagnosis and patient gender mismatch.	A3, A7, A8	
88	~~Entity not eligible for benefits for submitted dates of service. This change effective 11/1/2010:~~ Entity not eligible for benefits for submitted dates of service. Note: This code requires use of an Entity Code.	A3	
89	~~Entity not eligible for dental benefits for submitted dates of service. This change effective 11/1/2010:~~ Entity not eligible for dental benefits for submitted dates of service. Note: This code requires use of an Entity Code.	A3	
90	~~Entity not eligible for medical benefits for submitted dates of service. This change effective 11/1/2010:~~ Entity not eligible for medical benefits for submitted dates of service. Note: This code requires use of an Entity Code.	A3	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
91	~~Entity not eligible/not approved for dates of service. This change effective 11/1/2010:~~ Entity not eligible/not approved for dates of service. Note: This code requires use of an Entity Code.	A3	
92	~~Entity does not meet dependent or student qualification. This change effective 11/1/2010:~~ Entity does not meet dependent or student qualification. Note: This code requires use of an Entity Code.	A3	
93	~~Entity is not selected primary care provider. This change effective 11/1/2010:~~ Entity is not selected primary care provider. Note: This code requires use of an Entity Code.	A3	
94	~~Entity not referred by selected primary care provider. This change effective 11/1/2010:~~ Entity not referred by selected primary care provider. Note: This code requires use of an Entity Code.	A3	
96	~~No agreement with entity. This change effective 11/1/2010:~~ No agreement	A3	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
	with entity. Note: This code requires use of an Entity Code.		
97	~~Patient eligibility not found with entity. This change effective 11/1/2010:~~ Patient eligibility not found with entity. Note: This code requires use of an Entity Code.	A3	
106	~~This amount is not entity's responsibility. This change effective 11/1/2010:~~ This amount is not entity's responsibility. Note: This code requires use of an Entity Code.	A3	
107	Processed according to contract provisions (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services)	A3	
109	~~Entity not eligible. This change effective 11/1/2010:~~ Entity not eligible. Note: This code requires use of an Entity Code.	A3	
110	Claim requires pricing information.	A6	
116	Claim submitted to incorrect payer.	A3	
117	Claim requires signature-on-file	A3	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
	indicator.		
121	Service line greater than maximum	A3	
124	~~Entity's name, address, phone and id number. This change effective 11/1/2010:~~ Entity's name, address, phone and id number. Note: This code requires use of an Entity Code.	A3, A6, A7	When using A3 it must be in combination with another claim status code
125	~~Entity's name. This change effective 11/1/2010:~~ Entity's name. Note: This code requires use of an Entity Code.	A3, A6, A7, A8	When using A3 it must be in combination with another claim status code
126	~~Entity's address. This change effective 11/1/2010:~~ Entity's address. Note: This code requires use of an Entity Code.	A3, A6, A7, A8	When using A3 it must be in combination with another claim status code
127	~~Entity's phone number. This change to be effective 7/1/2010:~~ Entity's Communication Number. This change effective 11/1/2010: Entity's Communication Number. Note: This code requires use of an Entity Code.	A3, A6, A7, A8	When using A3 it must be in combination with another claim status code
128	~~Entity's tax id. This change effective 11/1/2010:~~ Entity's tax id. Note: This code requires use of an Entity Code.	A3, A6, A7, A8	When using A3 it must be in combination with another claim status code
132	~~Entity's Medicaid provider id. This change effective 11/1/2010:~~ Entity's	A3, A6, A7	When using A3 it must be in combination with

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
	Medicaid provider id. Note: This code requires use of an Entity Code.		another claim status code (should only be used for atypical providers)
135	~~Entity's commercial provider id. This change effective 11/1/2010:~~ Entity's commercial provider id. Note: This code requires use of an Entity Code.	A3, A6, A7	When using A3 it must be in combination with another claim status code (should only be used for atypical providers)
145	~~Entity's specialty/taxonomy code. This change effective 11/1/2010:~~ Entity's specialty/taxonomy code. Note: This code requires use of an Entity Code..	A3, A6, A7,A8	When using A3 it must be in combination with another claim status code
148	~~Entity's social security number. This change effective 11/1/2010:~~ Entity's social security number. Note: This code requires use of an Entity Code.	A7, A8	
153	~~Entity's id number. This change effective 11/1/2010:~~ Entity's id number. Note: This code requires use of an Entity Code.	A6, A7, A8	
156	Patient relationship to subscriber. Start: 01/01/1995	A6, A7	
157	~~Entity's Gender. This change effective 11/1/2010:~~ Entity's Gender. Note: This	A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
	code requires use of an Entity Code.		
	~~Start: 01/01/1995 | Last Modified: 02/11/2010~~		
158	~~Entity's date of birth. This change effective 11/1/2010:~~ Entity's date of birth. Note: This code requires use of an Entity Code.	A6, A7, A8	
159	~~Entity's date of death. This change effective 11/1/2010:~~ Entity's date of death. Note: This code requires use of an Entity Code.	A7, A8	
162	~~Entity's health insurance claim number (HICN). This change effective 11/1/2010:~~ Entity's health insurance claim number (HICN). Note: This code requires use of an Entity Code.	A6, A7, A8	
163	~~Entity's policy number. This change effective 11/1/2010:~~ Entity's policy number. Note: This code requires use of an Entity Code.	A6, A7, A8	
164	~~Entity's contract/member number. This change effective 11/1/2010:~~ Entity's contract/member number. Note: This code requires use of an Entity Code.	A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
171	Other insurance coverage information (health, liability, auto, etc.).	A6, A7,A8	
173	Entity's name, address, phone, gender, DOB, marital status, employment status and relation to subscriber. Note: This code requires use of an Entity Code.	A7, ~~-~~A8	
178	Submitted charges.	A6, A7	
182	~~Allowable/paid from primary coverage. This change to be effective 11/1/2010:~~ Allowable/paid from other entities coverage N~~OTE~~ote: This code requires the use of an entity code.	A6, A7, A8	
183	~~Amount entity has paid. This change effective 11/1/2010:~~ Amount entity has paid. Note: This code requires use of an Entity Code.	A6, A7, A8	
184	Purchase price for the rented durable medical equipment.	A6, A7, A8	
185	Rental price for durable medical equipment.	A6, A7, A8	
186	Purchase and rental price of durable medical equipment. .	A6,A7,A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
187	Date(s) of service.	A6, A7, A8	
188	Statement from-through dates.~~-~~	A6, A7, A8	A3 for outpatient when claim spans calendar year only
189	Facility admission date.	A6, A7, A8	
190	Facility discharge date.	A6, A7, A8	
191	Date of Last Menstrual Period (LMP)	A6, A7, A8	
192	Date of first service for current series/symptom/illness.	A6, A7, A8	
195	Unable to work dates. This change to be effective 7/1/2010: Unable to work dates/Disability Dates.	A6, A7, A8	
196	Return to work dates.	A6, A7, A8	
197	Effective coverage date(s).	A3	
198	Medicare effective date.	A3	
201	Date of dental appliance prior placement.	A6, A7, A8	
202	Date of dental prior replacement/reason for replacement.	A6, A7, A8	
203	Date of dental appliance placed.	A6, A7, A8	
210	Date of the last x-ray.	A6, A7, A8	
213	Date of first routine dialysis.	A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
214	Original date of prescription/orders/referral.	A7	
215	Date of tooth extraction/evolution.	A6, A7, A8	
216	Drug information.	A6, A7, A8	
218	NDC number.	A6, A7, A8	
219	Prescription number.	A6, A7, A8	
228	Type of bill for UB claim	A6, A7, A8	
229	Hospital admission source.	A6, A7, A8	
230	Hospital admission hour.	A6, A7, A8	
231	Hospital admission type.	A6, A7, A8	
232	Admitting diagnosis.	A6, A7, A8	
233	Hospital discharge hour.	A6, A7, A8	
234	Patient discharge status.	A6, A7, A8	
238	Separate claim for mother/baby charges.	A3	
240	Tooth surface(s) involved.	A6, A7, A8	
242	Tooth numbers, surfaces, and/or quadrants involved.	A6, A7, A8	
243	Months of dental treatment remaining.	A6, A7, A8	
244	Tooth number or letter.	A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
245	Dental quadrant/arch.	A6, A7, A8	
249	Place of service.	A6, A7, A8	
251	Total anesthesia minutes.	A6, A7	
252	~~Authorization/certification number.~~ Entity's authorization/certification number. Note: This code requires the use of an Entity Code.	A6, A7	
254	Pr~~imary~~incipal diagnosis code.	A6, A7	
255	Diagnosis code.	A7, A8	
256	DRG code(s).	A6, A7, A8	
258	Days/units for procedure/revenue code.	A6, A7, A8	
259	Frequency of service.	A6, A7, A8	
260	Length of medical necessity, including begin date.	A6,A7,A8	
266	Facility point of origin and destination - ambulance.	A3, A6, A7, A8	
267	Number of miles patient was transported.	A6, A7, A8	
273	Weight.	A6, A7	
277	Paper claim.	A3	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
286	Other payer's Explanation of Benefits/payment information.	A6, A7	
294	Supporting documentation.	A6, A7, A8	If another more specific status code is available it must be used
295	Attending physician report.	A6, A7, A8	
296	Nurse's notes.	A6, A7, A8	
297	Medical notes/report.	A6, A7, A8	
298	Operative report.	A6, A7, A8	
299	Emergency room notes/report.	A6, A7, A8	
300	Lab/test report/notes/results.	A6, A7, A8	
301	MRI report.	A6, A7, A8	
305	~~X-ray reports/interpretation.~~ Radiology/x-ray reports and/or interpretation	A6, A7, A8	
306	Detailed description of service.	A6, A7, A8	
307	Narrative with pocket depth chart.	A6, A7, A8	
308	Discharge summary.	A6, A7, A8	
310	Progress notes for the six months prior to statement date.	A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
311	Pathology notes/report.	A6, A7, A8	
312	Dental charting.	A6, A7, A8	
313	Bridgework information.	A6, A7, A8	
314	Dental records for this service.	A6, A7, A8	
315	Past perio treatment history.	A6, A7, A8	
316	Complete medical history.	A6, A7, A8	
318	~~X-rays.~~ X-rays/radiology films	A6, A7, A8	
319	Pre/post-operative x-rays/photographs.	A6, A7, A8	
320	Study models.	A6, A7, A8	
322	~~Recent fm x-rays.~~ Recent Full Mouth X-rays	A6, A7, A8	
323	Study models, x-rays, and/or narrative.	A6, A7, A8	
324	Recent x-ray of treatment area and/or narrative.	A6, A7, A8	
325	Recent fm x-rays and/or narrative.	A6, A7, A8	
326	Copy of transplant acquisition invoice.	A6, A7, A8	
327	Periodontal case type diagnosis and recent pocket depth chart with narrative.	A6, A7, A8	
329	Exercise notes.	A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
330	Occupational notes.	A6, A7, A8	
331	History and physical.	A6, A7, A8	
333	Patient release of information authorization.	A6, A7, A8	
334	Oxygen certification.	A6, A7, A8	
335	Durable medical equipment certification.	A6, A7, A8	
336	Chiropractic certification.	A6, A7, A8	
337	Ambulance certification/documentation.	A6, A7, A8	
339	Enteral/parenteral certification.	A6, A7, A8	
345	Treatment plan for service/diagnosis	A6, A7, A8	
352	Duration of treatment plan.	A6, A7, A8	
353	Orthodontics treatment plan.	A6, A7, A8	
387	~~Date patient last examined by entity. This change effective 11/1/2010:~~ Date patient last examined by entity. Note: This code requires use of an Entity Code.	A6, A7, A8	
388	Date post-operative care assumed.	A6, A7, A8	
389	Date post-operative care relinquished.	A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
394	Date(s) of most recent hospitalization related to service.	A6, A7, A8	
397	Date of onset/exacerbation of illness/condition.	A6, A7, A8	
400	Claim is out of balance.	A3, A7	
401	Source of payment is not valid.	A6, A7, A8	
402	Amount must be greater than zero. Note: At least one other status code is required to identify which amount element is in error.	A3, A6, A7	
403	Entity referral notes/orders/prescription.	A6, A7	
408	Initial certification.	A6	
417	Prior testing, including result(s) and date(s) as related to service(s).	A6, A7, A8	
419	Individual test(s) comprising the panel and the charges for each test.	~~A3~~, A6, A7, A8	
420	Name, dosage and medical justification of contrast material used for radiology procedure	A6, A7, A8	
428	Reason for transport by ambulance.	A6, A7, A8	
453	Procedure Code Modifier(s) for	A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
	Service(s) Rendered.		
454	Procedure code for services rendered.	A6, A7, A8	
455	Revenue code for services rendered.	A6, A7, A8	
456	Covered Day(s)	A6, A7, A8	
457	Non-Covered Day(s)	A6, A7, A8	
458	Coinsurance Day(s)	A6, A7, A8	
459	Lifetime Reserve Day(s)	A6, A7, A8	
460	NUBC Condition Code(s)	A6, A7, A8	
464	Payer Assigned Claim Control Number	A6, A7, A8	
465	Principal Procedure Code for Service(s) Rendered	A6, A7, A8	
468	Patient Signature Source.	A6, A7	
469	Purchase Service Charge.	A6, A7	
473	Missing or invalid lab indicator.	A6, A7, A8	
474	Procedure code and patient gender mismatch.	A8	
475	Procedure code not valid for patient age	A8	
476	Missing or invalid units of service.	A6, A7	
477	Diagnosis code pointer is missing or	A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
	invalid.		
478	~~Claim submitter's identifier (patient account number) is missing. This change to be effective 11/1/2010 –~~ Claim submitter's identifier.	A6, A7	
479	Other Carrier payer ID is missing or invalid.	A6, A7	
480	Other Carrier Claim filing indicator is missing or invalid.	A6, A7	
481	Claim/submission format is invalid.	A3	
~~482~~	~~Date Error, Century Missing.~~	~~A6, A7~~	
486	Principal Procedure Date.	A6, A7, A8	
488	Diagnosis code(s) for the services rendered.	A6, A7, A8	
489	Attachment Control Number.	A6, A7, A8	
490	Other Procedure Code for Service(s) Rendered.	A7, A8	
491	~~Entity not eligible for encounter submission. This change effective 11/1/2010:~~ Entity not eligible for encounter submission. Note: This code requires use of an Entity Code.	A3	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
492	Other Procedure Date.	A6, A7, A8	
493	Version/Release/Industry ID code not currently supported by information holder.	A3	
496	~~Submitter not approved for electronic claim submissions on behalf of this entity. This change effective 11/1/2010:~~ Submitter not approved for electronic claim submissions on behalf of this entity. Note: This code requires use of an Entity Code.	A3, A8	Use Code 25
500	~~Entity's Postal/Zip Code. This change effective 11/1/2010:~~ Entity's Postal/Zip Code. Note: This code requires use of an Entity Code.	A6, A7	
501	~~Entity's State/Province. This change effective 11/1/2010:~~ Entity's State/Province. Note: This	A6, A7	
	code requires use of an Entity Code.		
502	~~Entity's City. This change effective 11/1/2010:~~ Entity's City. Note: This code requires use of an Entity Code.	A6, A7	
503	~~Entity's Street Address. This change effective 11/1/2010:~~ Entity's Street	A6, A7	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
	Address. Note: This code requires use of an Entity Code.		
504	~~Entity's Last Name. This change effective 11/1/2010:~~ Entity's Last Name. Note: This code requires use of an Entity Code.	A6, A7, A8	
505	~~Entity's First Name. This change effective 11/1/2010:~~ Entity's First Name. Note: This code requires use of an Entity Code.	A6, A7, A8	
506	~~Entity is changing processor/clearinghouse. This claim must be submitted to the new processor/clearinghouse. This change effective 11/1/2010:~~ Entity is changing processor/clearinghouse. This claim must be submitted to the new processor/clearinghouse. Note: This code requires use of an Entity Code.	A3	
507	HCPCS	A6, A7, A8	
508	ICD9 NOTE: At least one other status code is required to identify the related procedure code or diagnosis code.	A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
509	~~E Code~~External Cause of Injury Code	A7, A8	
510	~~Future date. This change to be effective 7/1/2010:~~ Future date. Note: At least one other status code is required to identify the data element in error.	A7, A8	
511	~~Invalid character. This change to be effective 7/1/2010:~~ Invalid character. Note: At least one other status code is required to identify the data element in error.	A7, A8	
512	Length invalid for receiver's application system. This change to be effective 7/1/2010: Length invalid for receiver's application system. Note: At least one other status code is required to identify the data element in error.	A7, A8	
513	HIPPS Rate Code for services Rendered	A6, A7, A8	
514	Entity's Middle Name Note: This code requires use of an Entity Code.	A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
516	~~Adjudication or Payment Date. This change to be effective 7/1/2010:~~ Other Entity's Adjudication or Payment/Remittance Date. Note: An Entity code is required to identify the Other Payer Entity, i.e. primary, secondary.	A6, A7, A8	
517	Adjusted Repriced Claim Reference Number	A6, A7, A8~~-~~	
518	Adjusted Repriced Line item Reference Number	A6, A7, A8	
519	Adjustment Amount	A6, A7, A8	
520	Adjustment Quantity	A6, A7, A8	
521	Adjustment Reason Code	A6, A7, A8	
522	Anesthesia Modifying Units	A6, A7, A8	
523	Anesthesia Unit Count	A6, A7, A8	
524	Arterial Blood Gas Quantity	A6, A7, A8	
525	Begin Therapy Date	A6, A7, A8	
526	Bundled or Unbundled Line Number	A6, A7, A8	
527	Certification Condition Indicator	A6, A7, A8	
528	Certification Period Projected Visit	A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
	Count		
529	Certification Revision Date	A6, A7, A8	
530	Claim Adjustment Indicator	A6, A7, A8	
531	Claim Disproportionate Share Amount	A6, A7, A8	
532	Claim DRG Amount	A6, A7, A8	
534	Claim ESRD Payment Amount	A6, A7, A8	
535	Claim Frequency Code	A6, A7, A8	
536	Claim Indirect Teaching Amount	A6, A7, A8	
537	Claim MSP Pass-through Amount	A6, A7, A8	
538	Claim or Encounter Identifier	A3, A7	
539	Claim PPS Capital Amount	A6, A7, A8	
540	Claim PPS Capital Outlier Amount	A6, A7, A8	
542	Claim Total Denied Charge Amount	A6, A7, A8	
543	Clearinghouse or Value Added Network Trace	A6, A7, A8	
544	Clinical Laboratory Improvement Amendment	A6, A7, A8	
545	Contract Amount	A6, A7, A8	
546	Contract Code	A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
547	Contract Percentage	A6, A7, A8	
548	Contract Type Code	A6, A7, A8	
549	Contract Version Identifier	A6, A7, A8	
552	Cost Report Day Count	A6, A7, A8	
554	Date Claim Paid	A6, A7, A8	
555	Delay Reason Code	A6, A7, A8	
556	Demonstration Project Identifier	A6, A7, A8	
557	Diagnosis Date	A6, A7, A8	
559	Document Control Identifier	A6, A7, A8	
560	~~Entity's Additional/Secondary Identifier. This change effective 11/1/2010:~~ Entity's Additional/Secondary Identifier. Note: This code requires use of an Entity Code.	A6, A7, A8	
561	~~Entity's Contact Name. This change effective 11/1/2010:~~ Entity's Contact Name. Note: This code requires use of an Entity Code.	A6, A7, A8~~-~~	
562	~~Entity's National Provider Identifier (NPI). This change effective 11/1/2010:~~ Entity's National Provider Identifier	A3, A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
	(NPI). Note: This code requires use of an Entity Code. .		
563	~~Entity's Tax Amount. This change effective 11/1/2010:~~ Entity's Tax Amount. Note: This code requires use of an Entity Code.	A6, A7, A8	
564	EPSDT Indicator .	A6, A7, A8	
565	Estimated Claim Due Amount	A6, A7, A8	
566	Exception Code	A6, A7, A8	
567	Facility Code Qualifier	A6, A7, A8	
568	Family Planning Indicator	A6, A7, A8	
569	Fixed Format Information	A6, A7, A8	
~~570~~	~~Free Form Message Text~~	~~A6, A7~~	
573	Functional Limitation Code	A6, A7, A8	
574	HCPCS Payable Amount Home Health	A6,A7, A8	
575	Homebound Indicator	A6, A7, A8	
576	Immunization Batch Number	A6, A7, A8	
577	Industry Code	A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
578	Insurance Type Code	A6, A7, A8	
579	Investigational Device Exemption Identifier	A6, A7, A8	
580	Last Certification Date	A6, A7, A8	
581	Last Worked Date	A6, A7, A8	
582	Lifetime Psychiatric Days Count	A6, A7, A8	
583	Line Item Charge Amount	A3, A6, A7, A8	
584	Line Item Control Number	A6, A7, A8	
585	Denied Charge or Non-covered Charge	A6, A7, A8	
586	Line Note Text	A6, A7, A8	
587	Measurement Reference Identification Code	A6, A7, A8	
588	Medical Record Number	A6, A7, A8	
589	Medicare Assignment Code	A6, A7, A8	
593	Medicare Section 4081 Indicator	A6, A7, A8	
594	Mental Status Code	A6, A7, A8	
595	Monthly Treatment Count	A6, A7, A8	
596	Non-covered Charge Amount	A6, A7, A8	
597	Non-payable Professional Component Amount	A6,A7,A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
598	Non-payable Professional Component Billed Amount	A6, A7, A8	
599	Note Reference Code	A6, A7, A8	
603	Old Capital Amount	A7, A8	
604	Originator Application Transaction Identifier	A6, A7, A8	
605	Orthodontic Treatment Months Count	A7, A8	
608	Paid Service Unit Count	A6, A7, A8	
609	Participation Agreement	A7, A8	
611	Peer Review Authorization Number	A6, A7, A8	
615	Policy Compliance Code	A3, A7, A8	
617	Postage Claimed Amount	A7, A8	
618	PPS-Capital DSH DRG Amount	A7, A8	
619	PPS-Capital Exception Amount	A7, A8	
620	PPS-Capital FSP DRG Amount	A7, A8	
621	PPS-Capital HSP DRG Amount	A7, A8	
622	PPS-Capital IME Amount	A7, A8	
623	PPS-Operating Federal Specific DRG Amount	A7, A8	
624	PPS-Operating Hospital Specific DRG	A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
	Amount		
625	Predetermination of Benefits Identifier	A3, A7 , A8	
626	Pregnancy Indicator	A7, A8	
628	Pricing Methodology	A3, A7, A8	
629	Property Casualty Claim Number	A3, A6, A7, A8	
630	Referring CLIA Number	A6, A7, A8	
631	Reimbursement Rate	A7, A8	
632	Reject Reason Code	A3, A6, A7	
633	Related Causes Code	A3, A7, A8	
634	Remark Code	A7, A8	
635	Repriced Ambulatory Patient Group. This change effective 11/1/2010: Repriced Ambulatory Patient Group Code	A3, A7, A8	
636	Repriced Line Item Reference Number	A3, A6, A7, A8	
637	Repriced Saving Amount	A3, A7, A8	
638	Repricing Per Diem or Flat Rate Amount	A3, A7, A8	
639	Responsibility Amount	A3, A6, A7, A8	
640	Sales Tax Amount	A6, A7, A8	
642	Service Authorization Exception Code	A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
643	Service Line Paid Amount	A6, A7, A8	
645	Service Tax Amount	A7, A8	
647	Shipped Date	A7, A8	
650	Special Program Indicator	A3, A7, A8	
651	State Industrial Accident Provider Number	A3, A7, A8	
652	Terms Discount Percentage	A3, A7, A8	
653	Test Performed Date	A3, A6, A7, A8	
654	Total Denied Charge Amount	A3, A7, A8	
655	Total Medicare Paid Amount	A3, A7, A8	
656	Total Visits Projected This Certification Count	A3, A7, A8	
657	Total Visits Rendered Count	A3, A7, A8	
658	Treatment Code	A7, A7, A8	
659	Unit or Basis for Measurement Code	A3, A6, A7, A8	
660	Universal Product Number	A3, A6, A7, A8	
661	Visits Prior to Recertification Date Count CR702	A3, A7, A8	
662	X-ray Availability Indicator	A3	
663	Entity's Group Name. Note: This code	A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
(CMS)	requires use of an Entity Code.		
664	Orthodontic Banding Date	A6, A7, A8	
665	Surgery Date	A3,A7, A8	
672	Other Payer's payment information is out of balance.	A7, A8	
673	Patient Reason for Visit	A6, A7, A8	
675	Facility admission through discharge dates.	A3, A6, A7, A8	
677	~~Entity not affiliated. This change effective 11/1/2010:~~ Entity not affiliated. Note: This code requires use of an Entity Code.	A3	Blues use this to indicate that the claim must be submitted to the local Blue Plan
678	Revenue code and patient gender mismatch.	A8	
679	Submit newborn services on mother's claim	A3	
680	~~Entity's Country. This change effective 11/1/2010:~~ Entity's Country. Note: This code requires use of an Entity Code.	A7, A8	
681	Claim currency not supported	A7	
682	Cosmetic procedure	A3	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
684	Rejected. Syntax error noted for this claim/service/inquiry. See Functional or Implementation Acknowledgement for details. (Note: Only for use to reject claims or status requests in transactions that were 'accepted with errors' on a 997 or 999 Acknowledgement.)	A3	~~Only use 684 when transaction has been accepted with syntax errors~~
688	Present on Admission Indicator for reported diagnosis code(s).	A6, A7, A8	
	~~diagnosis code(s).~~		
693	Amount must be greater than or equal to zero. Note: At least one other status code is required to identify which amount element is in error.	A7, A8	
694	Amount must not be equal to zero. Note: At least one other status code is required to identify which amount element is in error.	A7, A8	
695	Entity's Country Subdivision Code. This change effective 11/1/2010: Entity's Country Subdivision Code. Note: This code requires use of an Entity Code. Start: 01/25/2009 | Last	A7	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
	Modified: 02/11/2010		
696	Claim Adjustment Group Code.	A6, A7, A8	
697	Invalid Decimal Precision. Note: At least one other status code is required to identify the data element in error.	A7	
698	Form Type Identification	A6, A7, A8	
699	Question/Response from Supporting Documentation Form.	A6, A7, A8	
700	ICD10. Note: At least one other status code is required to identify the related procedure code or diagnosis code.	A6, A7, A8	
701	Initial Treatment Date	A6, A7, A8	
702	Repriced Claim Reference Number.	A6, A7, A8	
703	Advanced Billing Concepts (ABC) code.	A6, A7, A8	
704	Claim Note Text	A7	
705	Repriced Allowed Amount.	A6, A7, A8	
706	Repriced Approved Amount.	A6, A7, A8	
707	Repriced Approved Ambulatory Patient Group Amount.	A6, A7, A8	
708	Repriced Approved Revenue Code.	A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
709	Repriced Approved Service Unit Count.	A6, A7, A8	
710	Line Adjudication Information. Note: At least one other status code is required to identify the data element in error.	A6, A7, A8	
711	Stretcher purpose	A6, A7, A8	
712	Obstetric Additional Units	A6, A7, A8	
713	Patient Condition Description	A6, A7, A8	
714	Care Plan Oversight Number	A6, A7, A8	
715	Acute Manifestation Date	A6, A7, A8	
716	Repriced Approved DRG Code	A6, A7, A8	
717	This claim has been split for processing.	A5	
718	Claim/service not submitted within the required timeframe (timely filing).	A3	
719	NUBC Occurrence Code(s)	A6, A7, A8	
720	NUBC Occurrence Code Date(s)	A6, A7, A8	
721	NUBC Occurrence Span Code(s)	A6, A7, A8	
722	NUBC Occurrence Span Code Date(s)	A6, A7, A8	
723	Drug days supply	A6, A7, A8	
724	Drug dosage	A6, A7, A8	
725	NUBC Value Code(s)	A6, A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
726	NUBC Value Code Amount(s)	A6, A7, A8	
727	Accident date	A6, A7, A8	
728	Accident state	A6, A7, A8	
730	Accident cause	A6, A7, A8	
731	Measurement value/test result	A6, A7, A8	
732	Information submitted inconsistent with billing guidelines. Note: At least one other status code is required to identify the inconsistent information.	A3, A6, A7, A8	
733	Prefix for entity's contract/member number.	A6, A7	
737	Current Dental Terminology (CDT) code	A6, A7, A8	
738	Home Infusion EDI Coalition (HIEC) Product/Service Code	A6, A7, A8	
739	Jurisdiction Specific Procedure and Supply Code	A6, A7, A8	
740	Drop off location	A6, A7, A8	
741	Entity must be a person	A3	
742	Payer responsibility sequence number code	A6, A7, A8	
745	Identifier Qualifier Note: At least one	A6, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
	other status code is required to identify the specific identifier qualifier in error.		
746	Duplicate Submission Note: use only at the information receiver level in the Health Care Claim Acknowledgement transaction	A3	
747	Hospice Employee Indicator	A7, A8	
748	Corrected Data Note: Requires a second status code to identify the corrected data.	A7, A8	
749	Date of Injury/Illness	A7, A8	
750	Auto Accident State or Province Code	A7, A8	
751	Ambulance Pick-up State or Province Code	A7, A8	
752	Ambulance Drop-off State or Province Code	A7, A8	
753	Co-pay status code.	A7, A8	
754	Entity Name Suffix. Note: This code requires the use of an Entity Code.	A7, A8	
755	Entity's primary identifier. Note: This code requires the use of an Entity	A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
	Code.		
756	Entity's Received Date. Note: This code requires the use of an Entity Code.	A7, A8	
757	Last seen date.	A7, A8	
758	Repriced approved HCPCS code.	A7, A8	
759	Round trip purpose description.	A7, A8	
760	Tooth status code.	A7, A8	
761	Entity's referral number. Note: This code requires the use of an Entity Code.	A7, A8	
762	Locum Tenens Provider Identifier. Code must be used with Entity Code 82 - Rendering Provider	A7, A8	
763	Ambulance Pickup ZipCode	A7, A8	
764	Professional charges are non covered.	A7, A8	
765	Institutional charges are non covered.	A7, A8	
766	Services were performed during a Health Insurance Exchange (HIX) premium payment grace period.	A7, A8	
767	Qualifications for emergent/urgent care	A7, A8	

Table A.2

Crosswalk for Health Care Claim Status Codes and Claim Status Category Codes.

For entities subject to Minnesota Statutes, section 62J.536 and related rules.

Note: Health Care Claim Status Codes convey the status of an entire claim or a specific service line.

Claim Status Code	Claim Status Code Description	Claim Status Category Codes Allowed	Comments
768	Service date outside the accidental injury coverage period.	A7, A8	
769	DME Repair or Maintenance	A7, A8	
770	Duplicate of a claim processed or in process as a crossover/coordination of benefits claim.	A3	
771	Claim submitted prematurely. Please resubmit after crossover/payer to payer COB allotted waiting period.	A3	

MDH Minnesota Department of Health

Minnesota Uniform Companion Guide version 3.0 for the Implementation of the TA1, Interchange Acknowledgment Segment (Appendix C.1 of the ASC X12C/005010X231 Implementation Acknowledgment for Health Care Insurance (999))

Note: The v3.0 document below shows proposed changes to the Minnesota Uniform Companion Guide (MUCG) v2.0 for the Implementation of the TA1, Interchange Acknowledgment Segment (Appendix C.1 of the ASC X12C/005010X231 Implementation Acknowledgment For Health Care Insurance (999)). Changes are shown in underline-strikeout.

This document is being released for comment during a 30 day public comment period, December 14, 2015 – January 13, 2016. The public comments will be reviewed, and final changes to v2.0 resulting from the proposed v3.0 changes below and any corresponding public comments will be adopted into rule as v4.0. When adopted, v4.0 will supersede v2.0 and will become effective as rule 30 days after adoption.

~~**Rule adopted December 27, 2010**~~

~~**Minnesota Uniform Companion Guide for the Implementation of the TA1, Interchange Acknowledgment Segment (Appendix C.1 of the ASC X12C/005010X231 Implementation Acknowledgment For Health Care Insurance (999))**~~

The Minnesota Department of Health (MDH) adopts and incorporates by reference as the above-named Companion Guide the instructions in the EDI Control Directories found in Appendix C.1 of the ASC X12C/005010X231 Implementation Acknowledgment For Health Care Insurance (999) for the TA1, Interchange Acknowledgment Segment.

This Companion Guide must be used in compliance with all applicable federal and state regulations and statutes.

Document Revision History

Version	Revision Date	Summary Changes
1.0	September 27, 2010	Version released for public comment

2.0	December 27, 2010	Adopted into rule and incorporates any changes from v1.0
3.0	December 14, 2015	Incorporates proposed revisions and updates to v2.0 for public comment

MDH Minnesota Department of Health

Minnesota Uniform Companion Guide (MUCG) version 3.0 for the Implementation of the ASC X12C/005010X231 Implementation Acknowledgment for Health Care Insurance (999)

Note: The v3.0 document below shows proposed changes to the Minnesota Uniform Companion Guide (MUCG) v2.0 for the Implementation of the ASC X12C/005010X231 Implementation Acknowledgment For Health Care Insurance (999). Changes are shown in underline-strikeout.

This document is being released for comment during a 30 day public comment period, December 14, 2015 – January 13, 2016. The public comments will be reviewed, and final changes to v2.0 resulting from the proposed v3.0 changes below and any corresponding public comments will be adopted into rule as v4.0. When adopted, v4.0 will supersede v2.0 and will become effective as rule 30 days after adoption.

~~**Rule Adopted by the Minnesota Department of Health (MDH) December 27, 2010**~~

~~**Minnesota Uniform Companion Guide for the Implementation of the ASC X12C/005010X231 Implementation Acknowledgment For Health Care Insurance (999)**~~

The Minnesota Department of Health (MDH) adopts and incorporates by reference as the above-named Companion Guide the ASC X12C/005010X231 Implementation Acknowledgment For Health Care Insurance (999) ~~with the following clarifications~~.

~~Clarifications:~~

~~Segment CTX, Business Unit Identifier, is used to identify the Business Unit (i.e. the claim) that was in error. This is linked to the business unit by linking to one of the values in the CTX01-1. For example the CLM01 in the 837 transactions contains the identifier that would be used to link the 999 back to the claim. Another example is the use of the TRN02, check or trace number, from the 835 transaction.~~

~~Data Element IK403, value I12 – Implementation Pattern Match Failure, references a failure of a pattern match of data as required by a TR3. For example, if you wanted to receive a driver's license number and it had a specific pattern (ANN-ANN-NNNNNNN) and the data did not syntactically match the known pattern – this code would be used. Some health care examples might be NPI or TIN which have a set pattern of structure.~~

~~The only code choices allowed for the IK5 – TRANSACTION SET RESPONSE TRAILER, in loop 2000 - AK2 — TRANSACTION SET RESPONSE, are:~~

~~A – Accepted;~~

~~E -- Accepted But Errors Were Noted: The transaction set indicated in this AK2 loop contained errors, but was forwarded for further processing;~~

~~R -- Rejected: The transaction set indicated in this AK2 loop contained errors, and was NOT forwarded for further processing. It will need to be corrected and resubmitted.~~

This Companion Guide must be used in compliance with all applicable federal and state regulations and statutes.

Document Revision History

Version	Revision Date	Summary Changes
1.0	September 27, 2010	Version released for public comment
2.0	December 27, 2010	Adopted into rule and incorporates any changes from v1.0 and related public comments
3.0	December 14, 2015	Incorporates proposed revisions and updates to v2.0 for public comment

ACO Data Analytics Technical Advisory Group (TAG)

Meetings Notes

Thursday, January 14, 2016

8:30 a.m. – 10:30 a.m.

Agenda Item	Notes and Follow-up
1. Meeting to order – Vicky Swanson, co-chair	The meeting was called to order by Vicky Swanson at approximately 8:30 am
2. AUC anti-trust statement: http://www.health.state.mn.us/auc/pdfs/antitrust.pdf	Vicky Swanson reminded members of the anti-trust guidelines to be followed during the meeting. Participants introduced themselves.
3. Introductions - Please e-mail your attendance to Susie.veness@state.mn.us	
4. Review and discussion of feedback on December 16	Following the TAG's last meeting on December 16, 2016, the Minnesota Department of Health (MDH) prepared a summary of the TAG's recommendations from the meeting and related background materials. The materials included a list of the TAG's 20 proposed standard ACO member and provider data elements and their characteristics (data type, field length, etc.). The materials were forwarded to the TAG with a request for any questions or comments by January 7. The responses received were organized into the categories below. Discussion of each of the categories followed.

Agenda Item	Notes and Follow-up
meeting products	• **<u>"Supplemental" data elements:</u>** MDH received questions regarding whether and how "supplemental" data elements would be permitted and exchanged as part of the data file. In discussion, the co-chair noted that the TAG discussed including two supplemental elements, numbers 19 and 20 of the TAG's proposed list, for "county of residence" and "clinic name," at its December 16 meeting. The TAG agreed that the two data elements should be included in the TAG's list of proposed data elements. In subsequent discussion, a suggestion was made to allow payers to send additional data elements beyond the 20 shown in the list, provided that any additional elements were also sent in a pipe-delimited file as required for the original 20 elements. The TAG agreed with the proposal and recommended that it be included as a note following the descriptions of elements 19 and 20 on the TAG's proposed data elements list. • **<u>Frequency and timing of the member file exchanges:</u>** MDH received a question about how often, and at what intervals, the member files will be exchanged. Several payers reported that they currently compile 12 month rolling enrollment data with quarterly reports; some report on a monthly basis. In discussion, distinctions were drawn between the time and effort necessary to gather and report data from "enrollment" programs vs. "attributed" programs, with the attributed programs requiring greater effort and time. It was also noted that the availability and timing of the member and provider data may also be influenced by the type of product and terms of contracts. Providers reported that the availability and timing of desired data now depends on agreements between payers and providers. Receiving data more frequently is important for some uses, such as "onboarding" of members. Given the distinction made between enrollment and attributed data, questions were raised about the scope of the TAG's recommendations, and particularly whether they were limited to files for members and providers attributed to an ACO. The TAG agreed that its recommendations were intended for an attributed population, rather than an enrolled population, and that the clarification should be incorporated in its list of proposed data elements. • **<u>File naming convention:</u>** MDH received a question about whether file naming conventions should be considered. A related comment suggested the need to also consider "time stamps" on the files (either as part of the naming convention, or within the file) to help distinguish among potentially frequent demographic data feeds. Several members indicated that a uniform file naming convention is important and desired, especially to understand the time period being reported by the file, and when the file was issued. The TAG discussed variations in a single

Agenda Item	Notes and Follow-up

naming convention, as well as the tradeoffs between longer, more detailed file names versus shorter, but less detailed names. The group agreed to the following naming convention, comprised of ~~three~~ four parts, each separated by a period: payer abbreviation.product/provider.member.date. "Payer abbreviation" is a short acronym for the name of the payer. "Product/provider" is the name of the ACO product/provider. "Member" indicates that the data file is a member file (use the abbreviation "mbr.") "Date" is the date the file was created (in YYYYMMDD format).

- Example filename, based on discussion at the meeting: BCBSM.WellcareACO.mbr.20160114

Please note: the corrections in underline-strikeout format above were made by MDH staff on 2/5/16 after receiving comments from TAG members regarding the need for the correction.

Additional clarification of data elements: MDH received suggestions to clarify the TAG's proposed data elements nos. 13, 17 and 18 with additional description as shown in the highlighted sections below.

Data Element Name (names used at 12/16 TAG mtg)	**Ele-ment Order**	**Data "sub-element" if applicable**	**Format**	**Usage**	**Field length (min/ max)**	**Required (R) or Situational (aka Optional) (S)**	**Notes**
[Attributed]-Provider Name	13	Provider Last Name		AN	1/60	S	Individual last name ~~or organization name~~
[Attributed]-Provider ID	17	National Provider Identifier (NPI)		AN	10	S	Code identifying a party. Use TYPE 1 NPI. This is the individual provider such as a MD, PA, NP.

Agenda Item	Notes and Follow-up

	[Attributed] Provider Clinic Information	18	National Provider Identifier (NPI)		AN	10	S	Code identifying a party. Use NPI Type 2 Situational Field - This field represents a single clinic or in some cases a grouping of Type 2 NPIs. In the case of a grouping of Type 2 NPIs, no single identifier exists that reflects this relationship so field will often be blank.

The TAG quickly agreed that the highlighted changes were helpful and approved the changes.

- Implementation of recommendations: MDH received a comment about system changes that may be needed to implement the TAG's recommendations, and to consider such changes when planning implementation of the recommendations.

  In discussion it was noted that implementation of the TAG's recommendations is a two-way street, involving planning and changes on the part of both providers and payers. Planning in turn may be affected by a number of factors, including contract provisions requiring advance notice of changes. The group noted tradeoffs between a "soft" and "hard" crossover in data file exchanges. A "soft" crossover would temporarily allow both the phasing out of the current exchange of data files in varying formats, as well as adoption of the TAG's standard files. This gradual conversion to a more standard file format provides flexibility but can be burdensome while varying file formats continue to be exchanged. A "hard" crossover would move everyone at one time to a single, standard file layout. This approach, while potentially quicker and more streamlined, would presumably be less flexible and may be demanding in its own right. The TAG noted the importance of testing as part of any implementation of changes, and agreed that more conversation about implementing the TAG's file standardization recommendations is needed. TAG members were encouraged to discuss the TAG's data file recommendations with others in their organizations.

5. Clarification and summary of TAG recommendati	Dave Haugen of MDH clarified that the TAG would be voting on two recommendations at the meeting: a list of "20 Recommended ACO-Attributed Member and Provider Data Elements and Data Formats" incorporating the changes noted above; and the uniform file naming convention also described above. The co-chair then called for a voice vote and the TAG unanimously approved both recommendations.

Agenda Item	Notes and Follow-up
ons and TAG vote on recommendations Following discussion of the responses above, the TAG's recommendations will be clarified and summarized for a TAG vote to approve them.	[See the attachment "TAG final data recommendations 1-14-16 2" submitted with these meeting notes for a copy of the "Recommended ACO-Attributed Member and Provider Data Elements and Data Formats" approved at the meeting.]
6. Wrap-up and next steps	The TAG's approved recommendations will be summarized for distribution, and then distributed to the TAG. The recommendations will also submitted to the AUC Executive Committee for review as an agenda item for the next regularly scheduled full AUC meeting on March 8, 2016.
7. Other Business	A meeting of the TAG had been previously scheduled for February 10, 2016 if needed. The TAG agreed that with its recommendations completed, the meeting was not needed and should be canceled. There being no other business, the meeting was adjourned at approximately 10:20 a.m.

ACO Data Analytics TAG

Recommended ACO-Attributed Member and Provider Data Elements and Data Formats

ACO Data Analytics TAG and interested parties:

The TAG met January 14, 2016 and unanimously approved the accompanying list of "*Recommended ACO-Attributed Member and Provider Data Elements and Data Formats*" beginning on the following page. The instructions below were also adopted and incorporated as part of the TAG's recommended data elements and data formats.

Instructions for exchanging the ACO-attributed data elements shown in the accompanying list

- **Provide the data elements in the order listed in the table below, in a pipe-delimited text file.**
    - Note:
        - Provider data is for the attributed provider.
        - Send situational elements that are available.
        - Payers may send additional data beyond the 20 data elements above, but the data must be sent in a pipe-delimited file format.
- **Name the data file according to the following ~~three~~four-part naming convention:** payer abbreviation.product/provider.member.date. "Payer abbreviation" is a short acronym for the name of the payer. "Product/provider" is the name of the ACO product/provider. "Member" indicates that the data file is a member file (use the abbreviation "mbr.") "Date" is the date the file was created (YYYYMMDD format).
    - Example filename: BCBSM.WellcareACO.mbr.20160114

Please note: the corrections in underline-strikeout format above were made by MDH staff on 2/5/16 after receiving comments from TAG members regarding the need for the correction.

AUC ACO Data Analytics TAG

Recommended ACO-Attributed Member and Provider Data Elements and Data Formats

Provide the data elements in the order listed below. Provider data is for the attributed provider. Send situational elements that are available.

Approved by the AUC ACO Data Analytics TAG January 14, 2016

Data Element Name	Element Order	Data "sub-element" if applicable	Format	Usage	Field length (min/max)	Required (R) or Situational (aka Optional) (S)	Notes
Patient Name	1	Patient Last Name		AN	1/60	R	Individual last name
	2	Patient First Name		AN	1/35	S	Individual first name
	3	Patient Middle Name or Initial		AN	1/25	S	Individual middle name or initial
	4	Patient Name Suffix		AN	1/10	S	Suffix to individual name
Patient Date of Birth	5	Patient Date of Birth	CCYYMMDD	AN	1/35	R	Patient's date of birth
Patient ID	6	Patient ID		AN	2/80	S	This is the unique number that the payer uses to identify the insured. The information desired from the payer is for the patient.
Patient Gender	7	Patient Gender	F, M, or U	ID	1/1	R	F = Female M = Male U = Unknown Unknown is to be used only when the gender is unknown or when it cannot be sent due to reporting restrictions.
Patient Address	8	Patient Street Address 1		AN	1/55	R	Address information

AUC ACO Data Analytics TAG

Recommended ACO-Attributed Member and Provider Data Elements and Data Formats

Provide the data elements in the order listed below. Provider data is for the attributed provider. Send situational elements that are available.

Approved by the AUC ACO Data Analytics TAG January 14, 2016

Data Element Name	Element Order	Data "sub-element" if applicable	Format	Usage	Field length (min/max)	Required (R) or Situational (aka Optional) (S)	Notes
	9	Patient Street Address 2		AN	1/55	S	Address information
	10	Patient City Name	Free form text	AN	2/30	R	Free form text for city name
	11	Patient State	Use source code 22: States and Provinces (from US Post Office)	ID	2/2	S	Required when address is in US or Canada.
	12	Patient Postal Code	Exclude punctuation and blanks. Use source code 51	ID	3/15	S	Code defining international postal zone code excluding punctuation and blanks (zip code for United States)
[Attributed] Provider Name	13	Provider Last Name		AN	1/60	S	Individual last name
	14	Provider First Name		AN	1/35	S	Individual first name
	15	Provider Middle Name or initial		AN	1/25	S	Individual middle name or initial
	16	Provider name Suffix		AN	1/10	S	Suffix to individual name

AUC ACO Data Analytics TAG

Recommended ACO-Attributed Member and Provider Data Elements and Data Formats

Provide the data elements in the order listed below. Provider data is for the attributed provider. Send situational elements that are available.

Approved by the AUC ACO Data Analytics TAG January 14, 2016

Data Element Name	Element Order	Data "sub-element" if applicable	Format	Usage	Field length (min/max)	Required (R) or Situational (aka Optional) (S)	Notes
[Attributed] Provider ID	17	National Provider Identifier (NPI)		AN	10	S	Code identifying a party. Use Type 1 NPI. This is the individual provider such as a MD, PA, NP.
[Attributed] Provider Clinic Information	18	National Provider Identifier (NPI)		AN	10	S	Code identifying a party. Use NPI Type 2. Situational Field - This field represents a single clinic or in some cases a grouping of Type 2 NPIs. In the case of a grouping of Type 2 NPIs, no single identifier exists that reflects this relationship so the field will often be blank.

Supplemental (optional) data elements -- also send if available

Data Element Name	Element Order	Data "sub-element" if applicable	Format	Usage	Field length (min/max)	Required (R) or Situational (aka Optional) (S)	Notes
Patient county of residence*	19			AN	1/17	Optional	Free form text
Clinic name**	20			AN	1/60	Optional	

Note: Payers may send additional data beyond the 20 data elements above, but the data must be sent in a pipe-delimited file format.