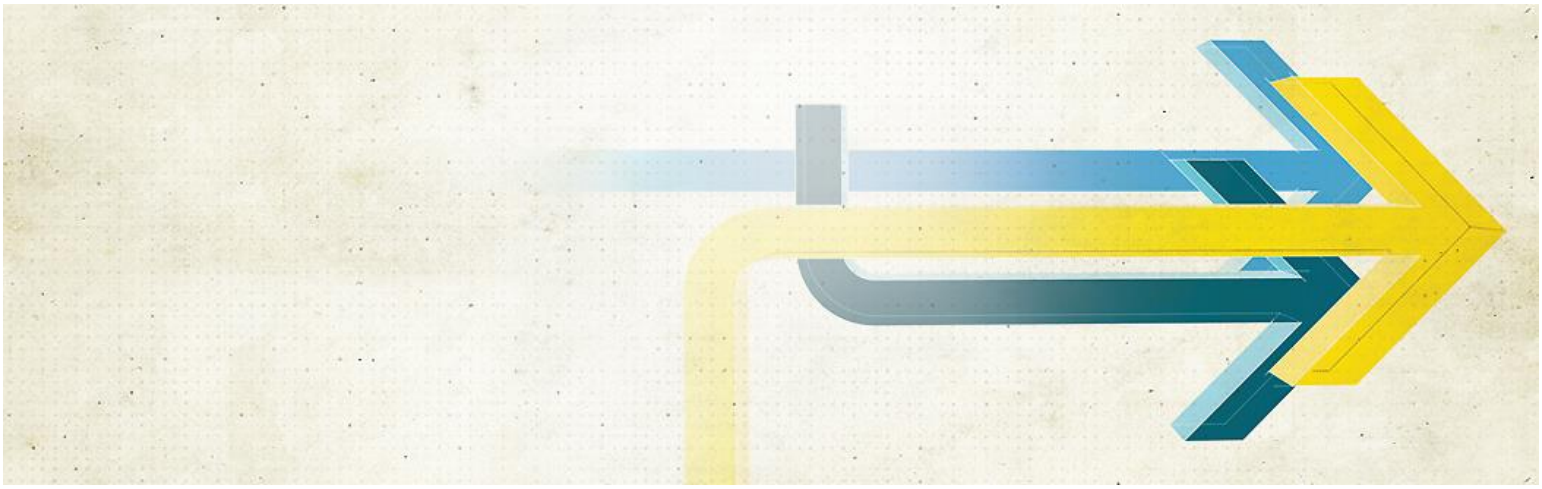

MedInsight File, Field, and Quality Checks

State of New Hampshire User Guide

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Introduction

The MedInsight File, Field, and Quality Checks (FFQC) system is a highly-automated data audit tool for data file intake verification and processing. The system checks data files submitted through a Secure File Transfer Protocol (SFTP) for conformity to data submission requirements determined by MedInsight and customized by the State of New Hampshire. These submission requirements include data file structure requirements, field detail requirements (type and max/min length), % filled field frequency default thresholds, and data quality checks with maximum and minimum default thresholds.

The FFQC system is a self-service, online tool designed to provide feedback that allows carriers and third-party administrators to identify and take action on resolving data quality issues. The system is designed to send audit results in a very short period of time via email reports that outline the outcomes of all phases of the data checking process.

While primarily an automated self-service system for carriers and third-party administrators, MedInsight also provides support for the FFQC system through its standard Client Services programs. A client-specific ticketing system has been created for New Hampshire and is managed by MedInsight Client Services staff to allow carriers and third-party administrators to submit any questions or issues that may arise during the FFQC process. As subscribers to all tickets created in the New Hampshire category, the State of New Hampshire Comprehensive Health Care Information System (NH CHIS) staff will be informed of the discussions between the carriers and third-party administrators and Milliman staff.

The FFQC system allows carriers and third-party administrators to submit threshold exception (adjustment) requests resulting from non-catastrophic data completeness and quality failures to identified NH CHIS staff. The exception process takes into account the unique data needs of the individual carrier or third-party administrator. In order to establish alternate threshold rates and timetables which meet the needs of the carriers and third-party administrators while still maintaining the integrity of the data, Milliman will assist the NH CHIS staff in reviewing the threshold exception requests during the initial implementation of the system to re-establish payer specific threshold exceptions. After the implementation phase, Milliman will continue to work with NH CHIS staff and the carriers and third-party administrators to resolve threshold adjustment issues. Final approval of all data submission results and threshold adjustments is the responsibility of the NH CHIS staff.

This manual is designed to work alongside the New Hampshire File, Field, and Quality Checks workbook (Appendix A) which provides the details of the field level checks and data quality audits in accordance with the State of New Hampshire's claims data submission rules (Chapter Ins 4000 – Uniform Reporting System for Health Care Claims Data Sets). The workbook has been created to guide carriers and third-party administrators who are submitting data files to the SFTP site.

Possible Failures

Catastrophic Failures

There are a number of catastrophic failures that may occur with the data. These are failures that must be fixed by the data supplier and that cannot be overwritten using an exception request. These include:

- **Naming Convention Error.** If the system identifies a naming convention error, the data supplier must edit the file name and resubmit the data.
- **Structural and File Errors.** If there are structural/file errors, the data will be deleted immediately, and the data supplier will have to submit new data files. The system must verify that there are no structural or file errors before the data can be reviewed for field errors.
- **Field Errors.** Once the data has been reviewed for structural and file errors, the system simultaneously reviews the data for field format and maximum length errors.

Standard Failures

There are a number of standard non-catastrophic failures that may occur as the data files are submitted. If a standard failure occurs, the data supplier should first verify that the data is being pulled appropriately and should consult with their business/claims subject matter expert to determine that the data is of the highest attainable quality. If the data is determined to be of the highest possible quality and a standard failure still occurs, the data supplier may submit an exception request through the MedInsight FFQC system to identified NH CHIS staff. These failures include:

- **Threshold Requirement Errors.** Threshold requirement errors can occur when the filled percentage of values for a field do not meet a pre-established threshold value or and can occur if a pre-established threshold value is not met for a data quality check (e.g., records w/gender = male between 20% and 80%).
- **Valid Value Errors.** There are a number of data elements that require a defined set of pre-determined values or codes. If a file contains invalid values for a data element (e.g., invalid ICD codes), the file will incur a non-catastrophic error.
- **Minimum Length Errors.** There are a number of data elements that require their values to be a certain length. If a file contains values that do not adhere to these rules (e.g., modifier codes with two characters), the file will incur a non-catastrophic error.

File, Field, and Quality Checks Process

The File, Field, and Quality Checks (FFQC) system reviews and verifies all data files using the process described below. For a visual representation of this process, see the File, Field, and Quality Checks Process Diagram on page 7. In accordance with New Hampshire Insurance Department rules (Ins 4005.04), all rejected and returned files should be resubmitted in the appropriate, corrected form within 10 days, or the carrier or third-party administrator may request an exemption to adjust the threshold for the failing field(s).

1. Using the pre-processor supplied by Milliman to hash PHI direct identifiers, the carrier or third-party administrator submits data files to the MedInsight FFQC via a protected file folder within the SFTP site. Files can be sent individually or en masse.

2. The data files are processed through a file sniffer. This system checks all data files to verify that appropriate naming conventions were used. The file sniffer cycle runs through all files and folders on the target SFTP site every 30 minutes (or less).

    a. If files are not correctly titled, the carrier or third-party administrator is sent a notification email stating that the files did not adhere to the established naming conventions. These files are automatically deleted from the system within 7 calendar days of submission. A carrier or third-party administrator is required to resubmit corrected files with the proper naming conventions within 10 calendar days.

    b. If files do have the correct naming convention, they proceed to step 3.

3. The data files are then processed through a file checker system. This system verifies that all files have the correct structure, file format, and minimum and maximum field lengths. It also verifies that all values are valid for their given fields. (For further detail regarding these checks, refer to identified State of New Hampshire File, Field, and Quality Checks Workbook (Appendix A).

    a. The system reviews the following aspects of each data file:

        i. Data file structure (number of columns, record delimiters, and field delimiters); and

        ii. Field level detail (format, valid values, and max/min length).

    Note: *The FFQC system does not actively check the header and trailer record date ranges and record counts against the contents of the data file. The header and trailer records are purely informational for Milliman and the data suppliers.*

    If data files fail the structure, format, or maximum length field level detail review, they are immediately deleted and the carrier or third-party administrator is sent a

failure report that details the catastrophic failure(s). The carrier or third-party administrator must revise and resubmit all failed files with catastrophic failures within 10 calendar days. The user is not allowed to submit an exception request for these types of failures. Examples of catastrophic failures include incorrect number of data columns, invalid record delimiters, and entries that exceed the maximum length standards.

b. If the files pass structure tests and they do not contain catastrophic failures within the field level detail review, the files proceed to step 4.

4. Data files are next processed through a quality checker system (a subsystem of the file checker). The customized, multifaceted quality checks run custom SQL queries to produce one number that can be compared against a predefined acceptable threshold. These checks include both the % filled field frequency default threshold comparisons and the data quality maximum and minimum default threshold comparisons.

    a. If files fail the quality checker review, the data supplier receives a standard report that highlights (with color codes) the field level failures and/or quality audit failures (Appendix B), and the system provides the carrier or third-party administrator with one-click access to the web-based response to the failure. The failure notification email includes guidance for file correction and resubmission, and also contains a link to an electronic form that allows the data supplier to submit an exception request (step 5). If the carrier or third-party administrator has questions about the report, they can contact Milliman staff through the email ticketing system previously described.

        The system does not allow the carrier or third-party administrator to manually delete failed file submissions. If the carrier or third-party administrator does not request an exception, the system will automatically delete the failed files after 10 days.

    b. If the files pass all checks within the quality checker, the data supplier receives a success report via email and the files proceed to step 6.

5. In order to request an exception, the carrier or third-party administrator must complete the web-based exception form. The carrier or third-party administrator can submit a request for complete file acceptance (Appendix C), or can request a change to thresholds for each failure on their report. On the page, the supplier can also view the exception history of each file by clicking on the hyperlinked Field Names (Positions) in the table.

    Once exceptions are submitted, the NH CHIS staff receives an email with a link to the automated threshold request/ruling page (Appendix D). All of the outstanding exception requests are listed by file name and are hyperlinked. Clicking on the file name will send the user to all of the exceptions associated with that file. These files contain hyperlinked

test names (field and quality) that will open a new page and provide the following information to identified NH CHIS staff:

a. Mean and standard deviation for the specific test and data supplier; and

b. Mean and standard deviation for the specific test across all data suppliers; and

c. All individual file results for the specific test and their comparative thresholds.

All results and calculations are determined using all files that were not catastrophically failed. The NH CHIS staff (with input from Milliman, as requested) must then approve or deny the exception request(s).

a. If the exception requests are approved, the NH CHIS staff will determine if it is a time-limited or permanent exception, and the files will then proceed to step 7.

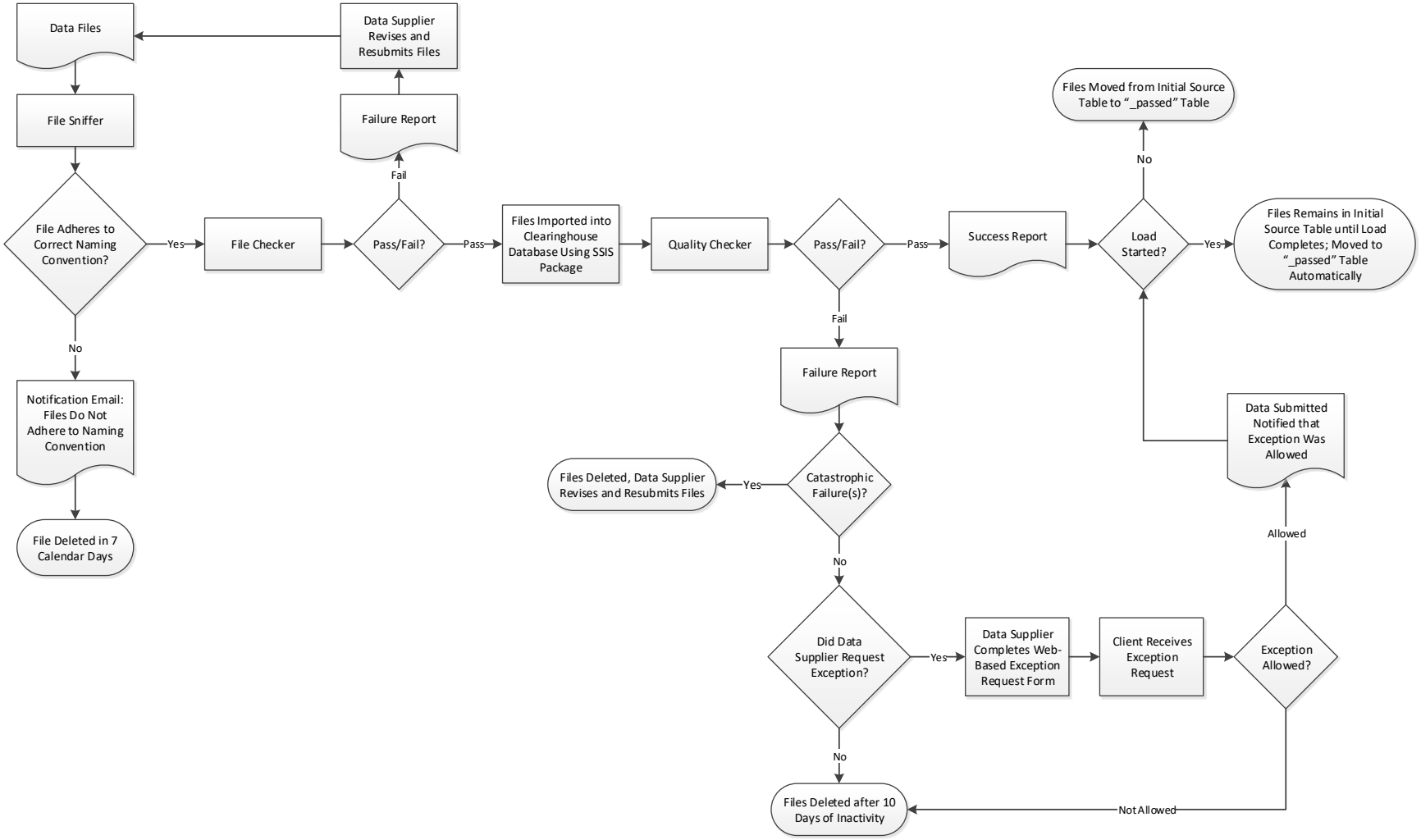
b. If the NH CHIS staff and Milliman do not allow the exception, the carrier or third-party administrator will receive a denial notification and the files will be deleted immediately. If an exception request is altered or rejected, the carrier or third-party administrator will be able to contact Milliman using the email ticketing process previously described to request assistance/guidance in meeting the thresholds.

c. If the carrier or third-party administrator does not request an exception within 10 calendar days, Milliman will assume that the carrier or third-party administrator will resubmit the files with corrected data and the original failed files will be deleted. Milliman has a file tracking system that will identify where there are gaps in file submissions. Should the carrier or third-party administrator fail to resubmit their files, Milliman will contact the carrier or third-party administrator to determine when the file(s) will be resubmitted.

The FFQC system takes into account only one exception date, which is the most current assigned. There are no date ranges. When an exception is granted, an expiration date is assigned to that exception (e.g., six months, a year, two years, etc.) Once an expiration date is reached, the system will automatically revert to the default threshold, unless it is extended prior to that date. Each submission (whether it is a rolling eligibility file submission or a file resubmission) will be evaluated on the most current threshold rates. If for some reason a resubmission fails when it passed previously, the FFQC system has a function that bypasses the threshold and allows the file to be accepted. This would only apply to the file in question and must be approved by the NH CHIS staff.

6. Once all checks have occurred and all files have been approved, the data is accepted into the MedInsight System.

File, Field, and Quality Checks Process Diagram



Appendix A – New Hampshire File, Field, and Quality Checks Workbook

Introduction

This workbook is organized to correspond directly to the State of New Hampshire rules governing the submission of claims data (Chapter Ins 4000 - Uniform Reporting System for Health Care Claims Data Sets) and contains field and quality checks for the data elements (fields) listed in the Member File, Medical Claims File, Pharmacy Claims File, Dental Claims File, and Provider File of the Chapter Ins 4000 rules. The workbook contains Field Check and Quality Check tables for the data elements (fields) listed in each of the five files and also contains code tables (where appropriate) for specific data elements. The code tables within this workbook are identical to those found within the Chapter Ins 4000 rules.

Each Field Check table in this workbook contains the following information:

- Element # - data element number as listed in the Chapter Ins 4000 rules
- Element Name - data element name as listed in the Chapter Ins 4000 rules
- Minimum Element Length - the minimum number of characters that must be in the field
- Maximum Element Length - the maximum number of characters that can be in the field
- Element Filled Threshold (%) - the minimum (default) percentage of filled fields in the column for the entire file
- Element Format - the required data type
- Valid Code Value - where applicable, the list (or references to lists) of acceptable codes
- Valid Value Blanks Accepted - defines whether a field can be left blank or must be filled with a value, including "0" for specific integer or decimal fields
- Valid Code Value Threshold (%) - the minimum (default) percentage of valid codes in the field column for the entire file

Each Quality Check table in this workbook contains the following information:

- Table Name - file type
- Quality Validation Identifier - identifier for specific quality check
- Quality Validation Name - name of specific quality check
- Description of Quality Validation - general logic for each validation, including references to specific data fields used in the logic
- Threshold Low - low value of acceptable result range
- Threshold High - high value of acceptable result range

The FFQC system utilizes the following standards:

- **Text Fields** - Text fields must be left blank when not applicable or if the data are not available ("blank" means do not supply any value at all between field delimiters).
- **Numeric Fields** - Numeric fields (number, decimal) without a value are to be filled with a zero.
- **Decimal Values** - A decimal value can be a number with up to 3 digits after (to the right) of the decimal point.
- **Negative Values** - Negative values must be indicated with a minus sign and must appear in the left-most position of all numeric fields.
- **Valid Value Columns** - Any valid value should refer to either: 1. a list (M,F,U) included within this workbook; 2. a separate table within this workbook that lists the values; or 3. a referenced table or list.

Member File

Field Checks

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
ME001	Payer	7	8	100	Text	Carrier Payer Code	No	100
ME002	National Plan ID	5	30	0	Text			
ME003	Insurance Type Code/Product	2	2	100	Text	Refer to *Insurance Type/Product Code – Eligibility File*.	No	100
ME004	Start Year	4	4	100	Number	CCYY	No	100
ME005	Start Month	2	2	100	Number	MM	No	100
ME006	Insured Group or Policy Number	1	50	99.5	Text			
ME007	Coverage Level Code	3	3	99.5	Text	CHD, DEP, ECH, EMP, ESP, FAM, IND, SPC, SPO	Yes	100

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
ME008	Subscriber Social Security Number	8	128	85	Text			
ME009	Plan Specific Contract Number	1	128	100	Text			
ME010	Member Suffix or Sequence Number	1	128	90	Text			
ME011	Member Social Security Number	1	128	0	Text			
ME012	Individual Relationship Code	2	2	100	Text	Refer to *Relationship Codes*	No	100
ME013	Member Gender	1	1	100	Text	M, F, U, O	No	100
ME014	Member Date of Birth	8	8	100	Date	CCYYMMDD		
ME015	Member City Name	1	30	99.5	Text			
ME016	Member State or Province	2	2	99.5	Text	Defined by USPS.	Yes	99.5
ME017	Member ZIP Code	5	9	99.5	Text			
ME018	Medical Coverage	1	1	100	Text	Y, N	No	100
ME019	Prescription Drug Coverage	1	1	100	Text	Y, N	No	100
ME020	Dental Coverage	1	1	100	Text	Y, N	No	100
ME021	Race 1	6	6	0	Text	Refer to *Race Codes*.	No	0
ME022	Race 2	6	6	0	Text	Refer to *Race Codes*.	No	0
ME023	Placeholder							
ME024	Hispanic Indicator	1	1	0	Text	Y, N, U	No	0
ME025	Ethnicity 1	6	6	0	Text	Refer to *Ethnicity Codes*.	No	0
ME026	Ethnicity 2	6	6	0	Text	Refer to *Ethnicity Codes*.	No	0

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
ME027	Placeholder							
ME028	Primary Insurance Indicator	1	1	100	Text	Y, N	No	100
ME029	Coverage Type	3	3	100	Text	ASW, ASO, STN, MCD, MCR, UND, OTH	No	100
ME030	Market Category	3	4	100	Text	IND, RSA,FCH, GCV, GS1, GS2, GS3, GS4, GLG1, GLG2, GSA, OTH, BLC, BLE, BLV, BLS, BLT, BLU, SLG, STS, SMG, SNM, SIM, SIN	No	100
ME031	NH Health Protection Program	1	4	0	Text	PAP, HIPP	No	0
ME032	Group Name	1	90	100	Text			
ME101	Subscriber Last Name	1	128	99.5	Text			
ME102	Subscriber First Name	1	128	99.5	Text			
ME103	Subscriber Middle Initial	1	128	0.5	Text			
ME104	Member Last Name	1	128	100	Text			
ME105	Member First Name	1	128	100	Text			
ME106	Member Middle Initial	1	128	0.5	Text			
ME201	Placeholder							
ME203	Member's Assigned PCP	10	10	0	Text			
ME204	HIOS Plan ID	1	16	0	Text			
ME205	Plan Effective Date	8	8	0	Date	CCYYMMDD		
ME206	Minimum Value	1	3	0	Number			
ME207	Exchange Indicator	1	1	0	Text	Y, N	No	0

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
ME208	High deductible health plan	1	1	0	Text	Y, N, U	No	0
ME209	Active enrollment	1	1	0	Text	Y, N	No	0
ME210	New Coverage	1	1	0	Text	Y, N	No	0
ME211	Placeholder							
ME899	Record Type	2	2	100	Text	ME	No	100
ME900	Plan State	2	2	100	Text	Defined by USPS.	No	100
ME901	Advanced Premium Tax Credit	1	2	0	Number			
ME902	NAIC Number	5	5	100	Text			
ME903	Grandfather Plan Indicator	1	1	100	Text	1, 2 ,3, 4	No	100
ME904	Metal Value	1	10	0	Text			

Quality Checks

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
ELIGIBILITY	DQE005	% SSN or contract number populated	Subscriber SSN (ME008) or Plan Specific Contract number (ME009) must be populated	100%	100%
ELIGIBILITY	DQE006	% of Duplicate Member records	% Duplicate Member records based on fields ME006, ME008, ME009, ME010, ME011, ME018, ME019, ME020, ME014, ME104, ME105	0%	0%
ELIGIBILITY	DQE010	Average # members per contract	Number of distinct members (derived from ME008, ME009, ME010, and ME011) divided by the total number of distinct Plan Specific Contract Numbers (ME009) or distinct Subscriber SSN (ME008) if same as ME009	1	3

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
ELIGIBILITY	DQE011	Average # members per subscriber SSN	Number of members divided by the total number of distinct subscriber SSNs	1	3
ELIGIBILITY	DQE023	% Records w/gender = male	Number of records where Member Gender (ME013) = 'M' divided by the total number of records	20%	80%
ELIGIBILITY	DQE024	% Records w/unknown gender	Number of records where Gender = 'Unknown' divided by the total number of records	0%	0.4%
ELIGIBILITY	DQE026	Average age of dependent child	Total age, determined from Member Date of Birth (ME014), of dependent children, when Individual Relationship Code (ME012) = '02', '05', '07', '09'. '10', '15', '17', '19', '22', '23', '24', '27', '36', or '43', divided by the total number of dependent children. Excludes ME031 = PAP.	6	22
ELIGIBILITY	DQE038	% Records with age 65+ and a Commercial product	Number of records, determined from Member Date of Birth (ME014), with members older than 65 and enrolled in a Commercial Product listed under ME003 divided by the total number of records	0%	17%
ELIGIBILITY	DQE039	% Records w/ age >115 or DOB > membership period	Number of records, determined from Member Date of Birth (ME014), with members older than 115 or where DOB is after expiry of membership divided by the total number of records	0%	3%
ELIGIBILITY	DQE102	% Members under 65 with Medicare	Number of members <65 years, determined from Member Date of Birth (ME014), enrolled under a Medicare product listed under ME003 divided by the total number of members	0%	25%
ELIGIBILITY	DQE103	% Non-primary state members	Number of members with Member State (ME016) not equal to primary state divided by the total number of members	0%	10%
ELIGIBILITY	DQE114	% Unique members	Number of distinct member months divided by the total number of records	97%	100%
ELIGIBILITY	DQE182	% Records with member zip code not within primary state	Number of records with Member Zip Code (ME017) not belonging to the Member State (ME016) divided by the total number of records	0%	5%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
ELIGIBILITY	DQE188	% Member SSNs that are duplicates	Number of duplicate member SSNs divided by the total number of distinct member IDs	0%	5%
ELIGIBILITY	DQE309	% Records w/relationship = subscriber and a a Commercial related product	Number of subscriber records where the Individual Relationship Code (ME012) = '18' or '20' and are enrolled in a Commercial product listed under ME003 divided by the total number of records coded as a Commercial product under ME003. Excludes ME031 = PAP.	0%	65%
ELIGIBILITY	DQE311	% Records single contracts and a Commercial related product	Number of single contract records where Coverage Level Code (ME007) = "EMP" or "IND" and enrolled in a Commercial product listed under ME003 divided by the total number of records that are coded as a Commercial product under ME003. Excludes ME031 = PAP.	0%	30%
ELIGIBILITY	DQE316	Ratio of distinct non-blank group names to distinct non-blank group numbers	Number of records with distinct non-blank Group Names (ME032) divided by the total number of records with distinct non-blank Insured Group or Policy Number (ME006)	0.25	1
ELIGIBILITY	DQE318	% Primary insurance indicator = N and a Commercial product	Number of records with Primary Insurance Indicator (ME028) = 'N' divided by the total number of records that are coded as a Commercial product and are coded as 'SP' under ME003	0%	10%
ELIGIBILITY	DQE319	% Records with market category code = OTH	Number of records with Market Category Code (ME030) = 'OTH' divided by the total number of records. Excludes ME003 = MD	0%	0%
ELIGIBILITY	DQE327	% Records with non-blank ESSN = MEMSSN and relationship not subscriber, employee or self	Number of records with non-blank Employee SSN = Member SSN and Individual Relationship Code (ME012) is not '18' or '20' divided by the total number of records	0%	5%
ELIGIBILITY	DQE329	% Records with subscriber name = member name and relationship not subscriber, employee or self	Number of records with Subscriber First Name (ME102) and Subscriber Last Name (ME101) = Member First Name (ME105) and Member Last Name (ME104) and Individual Relationship Code (ME012) is not '18' or '20' divided by the total number of records	0%	5%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
ELIGIBILITY	DQE330	% Records with subscriber name <> member name and relationship is subscriber, employee or self	Number of records with subscriber name not member name and Individual Relationship Code (ME012) is '18' or '20' divided by the total number of records	0%	1%
ELIGIBILITY	DQE338	% of records w/ Market Category Code <> (IND, FCH, GCV) and Group Name is not populated.	Number of records with Market Category of Insurance Code (ME030) not 'IND', 'FCH', or 'GCV' and Group Name (ME032) is not populated divided by the total number of records	0%	100%
ELIGIBILITY	DQE342	Average age of member and not a Commercial related product	Total age of members enrolled in a Commercial product listed under ME003 divided by the total number of distinct members enrolled in a Commercial product under ME003. Excludes ME031 = PAP.	18	64
ELIGIBILITY	DQE441	% Age <20 and relationship = spouse	Number of records with members less than 20 years old and Individual Relationship Code ='01', '29' or '53' divided by the total number of records	0%	1%
ELIGIBILITY	DQE500	% of Member File posted to correct FTP folder	Payer code in the Member File name = payer code name in FTP folder	100%	100%
ELIGIBILITY	DQE501	% of Records containing CHIS Data	% of Records containing CHIS Data.	100%	100%
ELIGIBILITY	DQE502	Correct version of the CHIS Preprocessor is being used for this file submission	Correct version of the CHIS Preprocessor is being used for this file submission	100%	100%
ELIGIBILITY	DQE503	% of Records where the count of records is the same for all QHP fields	% of records where HIOS plan ID (ME204) is populated and all corresponding fields are required (ME205 – ME210) and ME901 and ME904 – else these fields should remain blank. Fields MUST be populated for QHP payers.	100%	100%
ELIGIBILITY	DQE504	% of invalid populated Member Assigned PCP (ME203)	% of Records where the populated Member Assigned PCP (ME203) is invalid divided by the total number of records.	0%	0%

Medical Claims File

Field Checks

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
MC001	Payer	7	8	100	Text	Carrier Payer Code	No	100
MC002	National Plan ID	5	30	0	Text			
MC003	Insurance Type/Product Code	2	2	100	Text	Refer to *Insurance Type/Product Code – Claims Files*.	No	100
MC004	Payer Claim Control Number	1	35	100	Number			
MC005	Line Counter	1	4	100	Text			
MC005A	Version Number	1	4	99.5	Number			
MC006	Insured Group or Policy Number	1	50	100	Text			
MC007	Subscriber Social Security Number	1	128	85	Text			
MC008	Plan Specific Contract Number	1	128	100	Text			
MC009	Member Suffix or Sequence Number	1	128	100	Text			
MC010	Member Social Security Number	1	128	0	Text			
MC011	Individual Relationship Code	2	2	100	Text	Refer to *Relationship Codes*.	No	100
MC012	Member Gender	1	1	100	Text	M, F, U, O	No	100
MC013	Member Date of Birth	8	8	100	Date	CCYYMMDD		
MC014	Member City Name	1	30	99.5	Text			

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
MC015	Member State or Province	2	2	99.5	Text	Defined by USPS.	No	99.5
MC016	Member ZIP Code	5	9	99.5	Text			
MC017	Paid Date/ (AP Date)	8	8	100	Date	CCYYMMDD		
MC018	Admission Date	8	8	0	Date	CCYYMMDD		
MC019	Admission Hour	2	2	0	Text	HH		
MC020	Admission Type	1	1	0	Text	1, 2, 3, 4, 5, 9	Yes	100
MC021	Admission Source	1	1	0	Text	Refer to *Point of Origin Codes*.	Yes	100
MC022	Discharge Hour	2	2	0	Text	HH		
MC023	Discharge Status	2	2	0	Text	Refer to *Discharge Status Codes*.	Yes	100
MC024	Service Provider Number	1	30	99	Text			
MC025	Service Provider Tax ID Number	9	10	90	Text			
MC026	National Service Provider ID	10	10	95	Text	NPPES reference table	No	95
MC027	Service Provider Entity Type Qualifier	1	1	100	Text	1, 2	No	100
MC028	Service Provider First Name	1	35	40	Text			
MC029	Service Provider Middle Name	1	25	0.5	Text			
MC030	Servicing Provider Last Name or Organization Name	1	60	100	Text			
MC031	Service Provider Suffix	1	10	0.5	Text			

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
MC032	Service Provider Specialty	1	10	99.5	Text	National Uniform Claims Committee (NUCC) standard taxonomy code	No	99.5
MC033	Service Provider City Name	1	30	95	Text			
MC034	Service Provider State	2	2	95	Text	Defined by USPS.	No	95
MC035	Service Provider ZIP Code	5	9	95	Text			
MC036	Type of Bill – Institutional	2	3	30	Text	Refer to *Type of Bill - Institutional Codes*.	Yes	100
MC037	Place of Service – Professional	2	2	25	Text	Refer to *Place of Service – Professional Codes*.	Yes	100
MC038	Service Line Status	2	2	100	Text	Refer to *Claim Status Codes*.	No	100
MC039	Admitting Diagnosis	3	7	0	Text	ICD-9/10-CM codes	Yes	100
MC040	E-Code	3	7	0.5	Text	ICD-9/10-CM codes	Yes	100
MC041	Principal Diagnosis	3	7	95	Text	ICD-9/10-CM codes	Yes	100
MC042	Other Diagnosis – 1	3	7	55	Text	ICD-9/10-CM codes	Yes	100
MC043	Other Diagnosis – 2	3	7	30	Text	ICD-9/10-CM codes	Yes	100
MC044	Other Diagnosis – 3	3	7	10	Text	ICD-9/10-CM codes	Yes	100
MC045	Other Diagnosis – 4	3	7	0	Text	ICD-9/10-CM codes	Yes	100
MC046	Other Diagnosis – 5	3	7	0	Text	ICD-9/10-CM codes	Yes	100
MC047	Other Diagnosis – 6	3	7	0	Text	ICD-9/10-CM codes	Yes	100
MC048	Other Diagnosis – 7	3	7	0	Text	ICD-9/10-CM codes	Yes	100
MC049	Other Diagnosis – 8	3	7	0	Text	ICD-9/10-CM codes	Yes	100
MC050	Other Diagnosis – 9	3	7	0	Text	ICD-9/10-CM codes	Yes	100
MC051	Other Diagnosis – 10	3	7	0	Text	ICD-9/10-CM codes	Yes	100

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
MC052	Other Diagnosis – 11	3	7	0	Text	ICD-9/10-CM codes	Yes	100
MC053	Other Diagnosis – 12	3	7	0	Text	ICD-9/10-CM codes	Yes	100
MC054	Revenue Code	3	4	30	Text	NUBC codes	Yes	100
MC055	Procedure Code	4	5	85	Text	HCPCS/CPT codes	Yes	100
MC056	Procedure Modifier – 1	2	2	0	Text	National Procedure Modifiers	Yes	100
MC057	Procedure Modifier – 2	2	2	0	Text	National Procedure Modifiers	Yes	100
MC058	ICD-9/10-CM Procedure Code	3	7	0	Text	ICD-9/10-CM codes	Yes	100
MC059	Date of Service – From	8	8	100	Date	CCYYMMDD		
MC060	Date of Service – Thru	8	8	100	Date	CCYYMMDD		
MC061	Quantity	1	12	100	Number			
MC062	Charge Amount	1	10	100	Number			
MC063	Paid Amount	1	10	100	Number			
MC064	Fee for Service	1	10	100	Number			
MC065	Copay Amount	1	10	100	Number			
MC066	Coinsurance Amount	1	10	100	Number			
MC067	Deductible Amount	1	10	100	Number			
MC068	Patient Account/Control Number	1	20	95	Text			
MC069	Discharge Date	8	8	2	Date	CCYYMMDD		
MC070	Service Provider Country Name	1	30	95	Text			
MC071	DRG	1	7	0	Text		Yes	100

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
MC072	DRG Version	2	2	0	Text			
MC073	APC	1	4	0	Text			
MC074	APC Version	1	2	0	Text			
MC075	Drug Code	10	11	0	Text	National Drug Codes	Yes	100
MC076	Billing Provider Number	1	30	95	Text			
MC077	National Billing Provider Number ID	10	10	90	Text	NPPES reference table	No	90
MC078	Billing Provider Last Name or Organization Name	1	60	100	Text			
MC101	Subscriber Last Name	1	128	99.5	Text			
MC102	Subscriber First Name	1	128	99.5	Text			
MC103	Subscriber Middle Initial	1	128	0.5	Text			
MC104	Member Last Name	1	128	100	Text			
MC105	Member First Name	1	128	100	Text			
MC106	Member Middle Initial	1	128	15	Text			
MC200	ICD Indicator	1	1	100	Text	0,1	No	100
MC202	Other ICD-CM Procedure Code - 2	1	7	0	Text	ICD-9/10-CM codes	Yes	100
MC203	Other ICD-CM Procedure Code - 3	1	7	0	Text	ICD-9/10-CM codes	Yes	100
MC204	Other ICD-CM Procedure Code - 4	1	7	0	Text	ICD-9/10-CM codes	Yes	100
MC205	Other ICD-CM Procedure Code - 5	1	7	0	Text	ICD-9/10-CM codes	Yes	100
MC206	Other ICD-CM Procedure Code - 6	1	7	0	Text	ICD-9/10-CM codes	Yes	100
MC207	Carrier Associated with Claim	1	8	0	Text			

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
MC208	Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number	1	128	0	Text			
MC209	Practitioner Group Practice	1	60	0	Text			
MC210	Coordination of Benefits/Third Party Liability Amount	1	10	100	Number			
MC211	Cross Reference Claims ID	1	35	0	Text			
MC212	Allowed Amount	1	10	100	Number			
MC215	Service Line Type	1	1	100	Text	O, V, R, B, A	No	100
MC216	Payment Arrangement Type	1	1	100	Text	1,2,3,4,5,6,7,8	No	100
MC217	Pay for Performance Flag	1	1	0	Text	Y, N	Yes	100
MC218	Claim Processing Indicator	1	1	100	Text	1, 2	No	100
MC219	Denied Claim Indicator	1	1	100	Text	1, 2, 3, 4	No	100
MC220	Denial Reason	1	4	20	Text	CARC or RARC codes	Yes	100
MC221	Procedure Modifier – 3	2	2	0	Text	National Procedure Modifiers	Yes	100
MC222	Procedure Modifier – 4	2	2	0	Text	National Procedure Modifiers	Yes	100
MC223	HIOS Plan ID	1	16	0	Text			
MC899	Record Type	2	2	100	Text	MC	No	100
MC900	In Network Indicator	1	1	100	Text	Y, N	No	100
MC901	Unit of Measure	2	2	100	Text	DA, MN, UN, NA	No	100

Quality Checks

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
MEDICAL	DQM005	% SSN or contract number populated	Subscriber SSN (MC007) or Plan Specific Contract number (MC008) must be populated	100%	100%
MEDICAL	DQM016	Average # lines per claim	Total number of distinct claim lines divided by total number of distinct claims derived from Payer Claim Control Number (MC004)	1	5
MEDICAL	DQM017	Number of Claims to Members	Total number of distinct claims divided by total number of distinct members.	0	5
MEDICAL	DQM020	% Records w/from service date 2 or more years old relative to paid date	Number of records with a Date of Service - From (MC059) of 2 or more years before Date Service Approved/Accounts Payable Date/Actual Paid Date (MC017) divided by the total number of records	0%	2%
MEDICAL	DQM023	% Records w/gender = male	Number of records where Member Gender (MC012) = 'M' divided by the total number of records	20%	80%
MEDICAL	DQM024	% Records w/unknown gender	Number of records where Member Gender (MC012) = 'U' divided by the total number of records	0%	.4%
MEDICAL	DQM026	Average age of dependent child	Total age, determined from Member Date of Birth (MC013), of dependent children, when Individual Relationship Code (MC011) = '02', '05', '07', '09'. '10', '15', '17', '19', or '24', divided by the total number of dependent children	6	26
MEDICAL	DQM038	% Records with age 65+ and a Commercial product	Number of records with members older than 65 and enrolled in a Commercial Product divided by total number of records	0%	17%
MEDICAL	DQM039	% Records w/ members age > 115	Number of records with members older than 115, based on Member Date of Birth (MC013), divided by the total number of records	0%	3%
MEDICAL	DQM043	% Records w/unknown provider #	Number of records where Service Provider Number (MC024), Service Provider Tax ID Number (MC025) and Service National Provider ID (MC026) are blank divided by the total number of records	0%	0.1%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
MEDICAL	DQM046	Ratio of service provider number to service provider name	Number of distinct Service Provider Numbers (MC024) divided by the number of distinct Service Provider Names (First Name, Middle Name, Last Name/MC028, MC029, MC030)	0.3	3
MEDICAL	DQM047	Ratio of distinct service provider tax ID to service provider name	Number of distinct Service Provider Tax IDs (MC025) divided by the number of distinct Service Provider Names (First Name, Middle Name, Last Name/MC028, MC029, MC030)	0.3	3
MEDICAL	DQM054	% Inpatient records with no plan or member payment	Number of inpatient records where Type of Bill (MC036) = '11x' or '12x' with Paid Amount (MC063), Copay Amount (MC065), Coinsurance Amount (MC066), and Deductible Amount (MC067) = 0 divided by the total number of records. Excludes Denials and Reversals.	0%	25%
MEDICAL	DQM055	% Records w/ negative plan payments	Number of records with Paid Amount (MC063) < 0 divided by the total number of records. Excludes Denials and Reversals.	0%	5%
MEDICAL	DQM056	% Total paid to charges	Total of Paid Amount (MC063) + Copay Amount (MC065) + Coinsurance Amount (MC066) + Deductible Amount (MC067) divided by the total of Charge Amount (MC062). Excludes Denials and Reversals.	20%	90%
MEDICAL	DQM057	% of plan paid to charges	Total of Paid Amount (MC063) divided by the total Charge Amount (MC062). Excludes Denials and Reversals.	20%	95%
MEDICAL	DQM058	Average total paid per claim line	Total of Paid Amount (MC063) + Copay Amount (MC065) + Coinsurance Amount (MC066) + Deductible Amount (MC067) divided by the total number of distinct claim lines. Excludes Denials and Reversals.	$25	$250
MEDICAL	DQM059	% Records w/ no member paid	Number of records with Copay Amount (MC065), Coinsurance Amount (MC066) and Deductible Amount (MC067) = 0 divided by the total number of records. Excludes Denials and Reversals.	0%	60%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
MEDICAL	DQM060	% Records w/ negative $$	Number of records with either Paid Amount (MC063), Copay Amount (MC065), or Coinsurance Amount (MC066) < $0 divided by total number of records. Excludes Denials and Reversals.	0%	5%
MEDICAL	DQM061	% Records w/ no CPT code, revenue code or ICD-9 or ICD-10 procedure code	Number of records where the Procedure Code (MC055), Revenue Code (MC054), and ICD9/10 CM Principal Procedure Code (MC058) is not populated divided by the total number of records. Excludes Denials and Reversals.	0%	1%
MEDICAL	DQM063	% Inpatient records w/ I9 or I10 procedure code not reported	Number of inpatient records, based upon Type of Bill (MC036) = '11x' or '12x' or Rev Code (MC054) = '0100-0219', where the ICD9/10 CM Principal Procedure Code (MC058) is not populated divided by the total number of inpatient records. Excludes Denials and Reversals.	0%	15%
MEDICAL	DQM066	% Inpatient records missing admit hour	Number of inpatient records, based upon Type of Bill (MC036) = '11x' or '12x' or Rev Code (MC054) = '0100-0219', with Admission Hour (MC019) is not populated divided by the total number of inpatient records. Excludes Denials and Reversals.	0%	10%
MEDICAL	DQM067	% Inpatient records missing admit type	Number of inpatient records, based upon Type of Bill (MC036) = '11x' or '12x' or Rev Code (MC054) = '0100-0219', with Admission Type (MC020) is not populated divided by the total number of inpatient records. Excludes Denials and Reversals.	0%	10%
MEDICAL	DQM068	% Inpatient records missing admit source	Number of inpatient records, based upon Type of Bill (MC036) = '11x' or '12x' or Rev Code (MC054) = '0100-0219', with Admission Source (MC021) is not populated divided by the total number of inpatient records. Excludes Denials and Reversals.	0%	10%
MEDICAL	DQM071	% Inpatient records with discharge status = home	Number of inpatient records, based upon Type of Bill (MC036) = '11x' or '12x' or Rev Code (MC054) = '0100-0219', with Discharge Status (MC023) = '01' or '81' or ‘06’ divided by the total number of inpatient records	50%	100%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
MEDICAL	DQM072	% Inpatient records with discharge status = died	Number of inpatient records, based upon Type of Bill (MC036) = '11x' or '12x' or Rev Code (MC054) = '0100-0219', with Discharge Status (MC023) = '20' divided by the total number of inpatient records. Excludes Denials and Reversals.	0%	3%
MEDICAL	DQM074	% Reversals	Number of records with Claims Status (MC038) ='22' divided by the total number of distinct claims derived from Payer Claim Control Number (MC004)	0%	25%
MEDICAL	DQM075	% Inpatient records missing admit date	Number of inpatient records, based upon Type of Bill (MC036) = '11x' or '12x' or Rev Code (MC054) = '0100-0219', with Admission Date (MC018) is not populated divided by the total number of inpatient records. Excludes Denials and Reversals.	0%	5%
MEDICAL	DQM076	% Inpatient records missing discharge date	Number of inpatient records, based upon Type of Bill (MC036) = '11x' or '12x' or Rev Code (MC054) = '0100-0219', with Discharge Date (MC069) is not populated divided by the total number of inpatient records. Exclude Denials and Reversals.	0%	5%
MEDICAL	DQM077	% Records with both paid amount and prepaid amount not equal to zero	Number of records with the Paid Amount (MC063) and the Prepaid Amount (MC064) not equal to 0 divided by the total number of records. Excludes Denials and Reversals.	0%	3%
MEDICAL	DQM078	% Inpatient records missing discharge status code	Number of inpatient records, based upon Type of Bill (MC036) = '11x' or '12x' or Rev Code (MC054) = '0100-0219', with Discharge Status Code (MC023) is not populated divided by the total number of inpatient records. Excludes Denials and Reversals.	0%	10%
MEDICAL	DQM079	% Inpatient records missing admitting diagnosis code	Number of inpatient records, based upon Type of Bill (MC036) = '11x' or '12x' or Rev Code (MC054) = '0100-0219', with Admitting Diagnosis Code (MC039) is not populated divided by the total number of inpatient records. Excludes Denials and Reversals.	0%	10%
MEDICAL	DQM080	% Type of bill or place of service	Type of Bill (MC036) or Place of Service (MC037) must be populated. Excludes Denials and Reversals.	100%	100%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
MEDICAL	DQM081	% Records w/coinsurance < $0	Number of records with Coinsurance Amount (MC066) < $0 divided by the total number of records. Exclude MC003 = MC.	0%	15%
MEDICAL	DQM082	% 2+ type of bill for a single claim	Number of records with more than 2 Type of Bill - Institutional (MC036) values based on Payer Claim Control Number (MC004) and Version Number (MC005A) values divided by the total number of records.	0%	1%
MEDICAL	DQM083	% 2+ service sites for a single claim	Number of records with more than 2 Place of Service - Professional (MC037) values based on Payer Claim Control Number (MC004) and Version Number (MC005A) values divided by the total number of records.	0%	3%
MEDICAL	DQM101	% Records paid as secondary for age 65+	Number of records with member age > 65 and Claim Status (MC038) = '2' , '3', '20', '21' divided by the total number of records	0%	10%
MEDICAL	DQM102	% Members under 65 with Medicare	Number of members <65 years enrolled for Medicare product divided by the total number of members	0%	25%
MEDICAL	DQM107	% Non-primary state providers	Number of Service Providers with Service Provider State or Province (MC034) = primary state divided by the total number of Service Providers	0%	60%
MEDICAL	DQM108	% Non-primary state provider zip codes	Number of Provider Office Zip (MC035) not found in primary state zip codes divided by the total number of records	0%	60%
MEDICAL	DQM121	% Inpatient records missing discharge hour	Number of inpatient records, based upon Type of Bill (MC036) = '11x' or '12x' or Rev Code (MC054) = '0100-0219', with Discharge Hour (MC022) is not populated divided by the total number of inpatient records. Exclude Denials and Reversals.	0%	10%
MEDICAL	DQM122	% Existing unique providers	Number of distinct NPIs derived from Provider Last Name or Organization Name (MC030) and Provider NPI (MC026) divided by the total number of NPIs	30%	100%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
MEDICAL	DQM138	% Records with invalid or missing discharge status on inpatient claims	Number of inpatient records, based upon Type of Bill (MC036) = '11x' or '12x' or Rev Code (MC054) = '0100-0219', with Discharge Status (MC023) = NULL or blank divided by the total number of inpatient records. Excludes Denials and Reversals.	0%	10%
MEDICAL	DQM159	% Newborn records w/age > 0	Number of newborn records with age > 0 divided by the total number of newborn records	0%	1%
MEDICAL	DQM160	% Delivery records w/ gender = male	Number of newborns with Member Gender (MC012) = 'M' divided by the total number of newborn records	0%	10%
MEDICAL	DQM167	% Non-primary state unique providers	Number of distinct providers derived from Provider NPI (MC026) or Provider ID (MC024) with Provider Office State (MC034) not equal to primary state divided by the total number of distinct providers	0%	70%
MEDICAL	DQM170	% of provider type values = ‘2’ (non-person)	Number of records with Service Provider Entity Type Qualifier (MC027) = '2' divided by the total number of records	20%	70%
MEDICAL	DQM171	% Facility claims w/o patient account number	Number of facility records, based upon Type of Bill (MC036) = '11x', '12x', or '13x', without Patient Account/Control Number (MC068) divided by the total number of facility records	0%	40%
MEDICAL	DQM174	% First date of service outside of admit & discharge dates	Number of inpatient records, based upon Type of Bill (MC036) = '11x' or '12x' or Rev Code (MC054) = '0100-0219', with Date of Service - From (MC059) not between Admission Date (MC018) and Discharge Date (MC069) divided by the total number of inpatient records. Excludes Denials and Reversals.	0%	1%
MEDICAL	DQM175	% Date of service outside of admit & discharge dates	Number of inpatient records, based upon Type of Bill (MC036) = '11x' or '12x' or Rev Code (MC054) = '0100-0219', where with Date of Service - Thru (MC060) not between Admission Date (MC018) and Discharge Date (MC069) divided by the total number of inpatient records. Excludes Denials and Reversals.	0%	1%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
MEDICAL	DQM182	% Records with member zip code not within member state	Number of records with Member ZIP Code (MC017) not belonging to Member State or Province (MC016) divided by the total number of records	0%	2%
MEDICAL	DQM183	% Records with provider zip code not within provider state	Number of records with Provider Office ZIP (MC035) not belonging to Provider Office State (MC034) divided by the total number of records	0%	25%
MEDICAL	DQM186	Ratio of distinct service prof NPI (NPRV) to distinct service prof PRV w/NPI	Number of distinct Service National Provider IDs (MC026) for professional claims divided by the number of distinct service providers with NPIs for professional claims	70%	100%
MEDICAL	DQM187	Ratio of distinct institutional NPI (NPRV) to distinct institutional PRV w/NPI	Number of distinct National Billing Provider IDs (MC077) for institutional claims divided by number of distinct institutional providers with NPIs for institutional claims	70%	100%
MEDICAL	DQM269	% Records with more than 1 Member ID for a claim number	Number of records with 2 or more distinct member IDs (derived from MC007, MC010, MC012, and MC013) per claim divided by the total number of records. Excludes denials and reversals.	0%	0%
MEDICAL	DQM270	% Records with admission type = 4 (NB) and age <> 0	Number of records, determined from Member Date of Birth (MC013), with age <> 0 and the Admission Type (MC020) = '4' divided by the total number of records with Admission Type (MC020) = '4'	0%	0%
MEDICAL	DQM271	% Records with admission type = 4 (NB) and admission source <> 5 or 6	Number of records with Admission Type (MC020) = '4' and Admission Source (MC021) not equal to '5' or '6' divided by the total number of records with Admission Type (MC020) = '4'	0%	3%
MEDICAL	DQM292	% Professional records with billing provider number = service provider number	Number of professional records, based upon Place of Service - Professional (MC037) being populated, with Billing Provider Number (MC076) = Service Provider Number (MC024) divided by the total number of professional records	0%	50%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
MEDICAL	DQM293	% Professional records with billing NPI = service NPI	Number of professional records, based upon Place of Service - Professional (MC037) being populated, with National Billing Provider ID (MC077) = Service National Provider ID (MC026) divided by the total number of professional records	0%	50%
MEDICAL	DQM294	% Professional records with service provider first name	Number of professional records, based upon Place of Service - Professional (MC037) being populated, with Service Provider First Name (MC028) is not populated and Service Provider Entity Type Qualifier (MC027) = 1 divided by the total number of professional records	0%	50%
MEDICAL	DQM295	% Institutional records with billing provider number = service provider number	Number of institutional records, based upon Type of Bill - Institutional (MC036) being populated, with Billing Provider Number (MC076) = Service Provider Number (MC024) divided by total number of institutional records	30%	100%
MEDICAL	DQM296	% Institutional records with billing NPI = service NPI	Number of institutional records, based upon Type of Bill - Institutional (MC036) being populated, with National Billing Provider ID (MC077) = Service National Provider ID (MC026) divided by the total number of institutional records	30%	100%
MEDICAL	DQM297	% Records with billing NPI = service NPI and billing provider last name <> service provider last name	Number of records with National Billing Provider ID (MC077) equal to Service National Provider ID (MC026) and Billing Provider Last Name or Organization Name (MC078) different from the Service Provider Last Name or Organization Name (MC030) divided by the total number of records	0%	35%
MEDICAL	DQM298	% Institutional records with service provider first name <> null	Number of institutional records, based upon Type of Bill - Institutional (MC036) being populated, with Service Provider First Name (MC028) populated and Service Provider Entity Type Qualifier (MC027) = 1 divided by the total number of institutional records	0%	5%
MEDICAL	DQM306	% Institutional records with Provider Entity = 1 (Person)	Number of institutional records, based upon Type of Bill - Institutional (MC036) being populated, with Service Provider Entity Type Qualifier (MC027) = '1' divided by the total number of institutional records	0%	15%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
MEDICAL	DQM307	% Professional records with Provider Entity = 2 (Non-Person)	Number of professional records, based upon Place of Service - Professional (MC037) being populated, with Service Provider Entity Type Qualifier (MC207) = '2' divided by the total number of professional records	0%	20%
MEDICAL	DQM309	% Records w/relationship = subscriber and a Commercial product	Number of subscriber records where the Individual Relationship Code (MC011) = '18' or '20' and are enrolled in a Commercial product listed under MC003 divided by the total number of records coded as a Commercial product under MC003. Excludes MCO Payers.	20%	80%
MEDICAL	DQM312	% Records with provider country <> US or USA	Number of records with Service Provider Country Name (MC070) not coded as 'US' or USA divided by the total number of records	0%	.2%
MEDICAL	DQM327	% Records with non-blank ESSN = MEMSSN and relationship is not subscriber, employee or self	Number of records with non-blank Employee SSN = Member SSN and Individual Relationship Code (MC011) is not '18' or '20' divided by the total number of records	0%	1%
MEDICAL	DQM329	% Records with subscriber name = member name and relationship is not subscriber, employee or self	Number of records with Subscriber First Name (MC102) and Subscriber Last Name (MC101) = Member First Name (MC105) and Member Last Name (MC104) and Individual Relationship Code (MC011) is not '18' or '20' divided by the total number of records	0%	1%
MEDICAL	DQM330	% Records with subscriber name <> member name and relationship is subscriber, employee or self	Number of records with Subscriber First Name (PC102) and Subscriber Last Name (PC101) not equal to Member First Name (PC105) and Member Last Name (PC104) and Individual Relationship Code (PC011) = '18' or '20' divided by the total number of records	0%	1%
MEDICAL	DQM346	% Last date of service < first date of service	Number of records with the Date of Service - Thru (MC060) comes before the Date of Service - From (MC059) divided by the total number of records	0%	0.5%
MEDICAL	DQM349	Ratio of NPI to service provider name	Number of distinct NPIs where Service National Provider ID (MC026 is populated divided by distinct Service Provider Names (First, Middle, Last/MC028, MC029, MC030)	0.3	3

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
MEDICAL	DQM387	% of records with 1 character in provider last name	Number of records with 1 character in Service Provider Last Name or Organization Name (MC030) divided by the total number of records	0%	.5%
MEDICAL	DQM388	% of records with 1 character in billing provider last name	Number of records with 1 character in Billing Provider Last Name or Organization Name (MC078) divided by the total number of records	0%	.5%
MEDICAL	DQM425	% of institutional records with revenue codes	Number of institutional records, based upon Type of Bill - Institutional (MC036) being populated, with Revenue Code (MC054) populated divided by the total number of institutional records	98%	100%
MEDICAL	DQM428	% Admit date on professional claims if place of service not inpatient hospital	Number of professional records, based upon Place of Service - Professional (MC037) being populated, containing Admission Date (MC018) when Place of Service - Professional (MC037) does not equal '21' divided by the total number of professional records	0%	1%
MEDICAL	DQM429	% Admit diagnosis on professional claims if place of service not inpatient hospital	Number of professional records, based upon Place of Service - Professional (MC037) being populated, containing Admitting Diagnosis (MC039) when Place of Service - Professional (MC037) does not equal '21' divided by the total number of professional records	0%	1%
MEDICAL	DQM430	% Admit hour on professional claims if place of service not inpatient hospital	Number of professional records with Admission Hour (MC019) and Place of Service - Professional (MC037) does not equal '21' divided by the total number of professional records	0%	1%
MEDICAL	DQM431	% Admit source on professional claims if place of service not inpatient hospital	Number of professional records, based upon Place of Service - Professional (MC037) being populated, with Admission Source (MC021) populated when Place of Service - Professional (MC037) does not equal '21' divided by the total number of professional records	0%	1%
MEDICAL	DQM432	% Admit type on professional claims if place of service not inpatient hospital	Number of professional records, based upon Place of Service - Professional (MC037) being populated, with Admission Type (MC020) populated when Place of Service - Professional (MC037) does not equal '21' divided by the total number of professional records	0%	1%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
MEDICAL	DQM433	% Discharge date on professional claims if place of service not inpatient hospital	Number of professional records, based upon Place of Service - Professional (MC037) being populated, with Discharge Date (MC069) populated and Place of Service - Professional (MC037) does not equal '21' divided by the total number of professional records	0%	1%
MEDICAL	DQM434	% Discharge hour on professional claims if place of service not inpatient hospital	Number of professional records, based upon Place of Service - Professional (MC037) being populated, with Discharge Hour (MC022) populated and Place of Service - Professional (MC037) does not equal '21' divided by the total number of professional records	0%	1%
MEDICAL	DQM435	% Discharge status on professional claims if place of service not inpatient hospital	Number of professional records, based upon Place of Service - Professional (MC037) being populated, with Discharge Status (MC023) populated and Place of Service - Professional (MC037) does not equal '21' divided by the total number of professional records	0%	1%
MEDICAL	DQM436	% Revenue codes on professional claims	Number of professional records, based upon Place of Service - Professional (MC037) being populated, with Revenue Codes (MC054) populated when Place of Service - Professional (MC037) does not equal '21', '22', or '23' divided by the total number of professional records	0%	1%
MEDICAL	DQM437	% Negative charges on adjustment claims with 0 or positive quantity	Number of adjustment claim records where Claim Status (MC038) = '22' with Charge Amount (MC062) < 0 and Quantity Dispensed (MC061) >= 0 divided by the total number of records	0%	1%
MEDICAL	DQM438	% Duplicate claims	Number of records with same Payer Claim Control Number (MC004) and Claim Status (MC038) divided by the total number of records	0%	5%
MEDICAL	DQM441	% Age <20 and relationship = Spouse	Number of records with members less than 20 years old and Individual Relationship Code (MC011) ='01', '29' or '53' divided by the total number of records	0%	1%
MEDICAL	DQM442	% Service provider tax id <> 9 or 10 digits	Number of records with Service Provider Tax ID Number (MC025) not equal to 9 or 10 digits divided by the total number of records	0%	1%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
MEDICAL	DQM443	% Service provider number = service provider tax id	Number of records with Service Provider Number (MC024) = Service Provider Tax ID Number (MC025) divided by the total number of records	0%	1%
MEDICAL	DQM444	% Service provider number = service national provider ID	Number of records with the Service Provider Number (MC024) = Service National Provider ID (MC026) divided by the total number of records	0%	1%
MEDICAL	DQM446	% Incurred month/year = paid month/year	Number of records with incurred month/year, derived from Date of Service - From (MC059) = paid month/year, derived from Accounts Payable Date/Actual Paid Date (MC017) divided by the total number of records	0%	95%
MEDICAL	DQM447	% Service dates > paid date	Number of records with Date of Service - From (MC059) later than the Date Service Approved/Accounts Payable Date/Actual Paid Date (MC017) divided by the total number of records	0%	2%
MEDICAL	DQM451	% Records with CPT codes on outpatient facility claims	Number of outpatient records, based upon Type of Bill - Institutional (MC036) = '13x', with Procedure Code (MC055) populated divided by the total number of hospital outpatient records	70%	100%
MEDICAL	DQM452	% Records with provider type ‘2’ - non-person with provider first name, middle name or suffix	Number of records with Service Provider First Name (MC028), Middle Name (MC029) or Suffix (MC031) and Service Provider Entity Type Qualifier = '2' divided by the total number of records	0%	1%
MEDICAL	DQM495	% Valid NPI numbers	Number of records with valid NPI numbers populating Provider NPI (MC026) divided by the total number of records	90%	100%
MEDICAL	DQM496	% Populated service provider last name or organization name with an invalid Service Provider NPI	Number of records with a populated ‘Service Provider Last Name or Organization Name’ (MC030) and a populated invalid Service National Provider ID (MC026) divided by the total number of records	0%	1%
MEDICAL	DQM497	% Populated billing provider last name or organization name with an invalid National Billing Provider ID	Number of records with a populated ‘Billing Provider Last Name or Organization Name’ (MC078) and a populated invalid National Billing Provider ID (MC077) divided by the total number of records.	0%	1%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
MEDICAL	DQM498	% Invalid service provider city name	Number of records with Service Provider City Name (MC033) not associated with Service National Provider ID (MC026) divided by the total number of records	0%	60%
MEDICAL	DQM499	% Invalid service provider zip code	Number of records with Service Provider ZIP Code (MC035) not associated with Service National Provider ID (MC026) divided by the total number of records	0%	60%
MEDICAL	DQM500	% of Medical Claims File posted to correct FTP folder	Payer code in the Medical Claims File name = payer code name in FTP folder	100%	100%
MEDICAL	DQM501	% Records w/ ICD-10 code for primary diagnosis	Number of records with Primary Diagnosis (MC041) is not populated divided by the total number of records	80%	100%
MEDICAL	DQM502	% Records w/ ICD-10 code for secondary diagnosis	Number of records with Other Diagnosis-1 (MC042) is not populated divided by the total number of records	80%	100%
MEDICAL	DQM503	% Records w/ ICD-10 code for primary procedure	Number of records with valid ICD- 10-CM Procedure Code (MC058) divided by the total number of records with populated MC058	100%	100%
MEDICAL	DQM504	% Records containing CHIS data	% Records containing CHIS data	100%	100%
MEDICAL	DQM505	Correct version of the CHIS Preprocessor is being used for this file submission.	Correct version of the CHIS Preprocessor is being used for this file submission.	100%	100%
MEDICAL	DQM506	% of records where MC219 (Denied Claim Indicator) = 2 or 4	% of records where MC219 (Denied Claim Indicator) = 2 or 4. This represents the percentage of records that were partially denied or denied entirely.	3%	50%
MEDICAL	DQM507	% of records where MC219 (Denied Claim Indicator) = 1.	% of records where MC219 (Denied Claim Indicator) = 1. This represents the percentage of records that were fully paid.	50%	97%
MEDICAL	DQM508	% of records where MC219 (Denied Claim Indicator) = 3	% of records where MC219 (Denied Claim Indicator) = 3. This represents the percentage of records that were encounter claims.	0%	5%
MEDICAL	DQM509	% of records with a valid Denial Reason code when Service Line Status is Denied	% of records where the Denial Reason Code is populated with a valid value for Denied claims only.	100%	100%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
MEDICAL	DQM510	% of records populated for TPA file submissions	% of records where Carrier Associated with Claim (MC207) and Carrier Plan Specific Contract Number (MC208) are populated for TPA file submissions. Populated MC207 record count must equal populated MC208 record count. MC207 & MC208 must be populated for TPA payers. (Payer Codes NHT%)	100%	100%
MEDICAL	DQM511	% of records Allowed Amount populated correctly for Denied Claims	% of total records: MC038 = 4 (Denied) and Allowed Amount > 0.	50%	100%
MEDICAL	DQM512	% of records Allowed Amount formatted with decimal codes.	% of total records: Allowed Amounts with decimal codes	0%	0%
MEDICAL	DQM513	% of records HIOS Plan ID populated for QHP Plans	% of total records: HIOS Plan ID (MC223) populated for QHP Plans	20%	80%
MEDICAL	DQM514	% of records Allowed Amount populated correctly for Reversed Claims	% of total records: MC038 = 22 (Reversal) and Allowed Amount is greater than zero.	0%	0%
MEDICAL	DQM515	% of records with a valid Denial Reason code when Service Line Status is reversal.	% of records where the Denial Reason Code is populated with a valid value for reversed claims only.	50%	100%
MEDICAL	DQM516	% of records where Member DOB is greater than the Paid Date.	% of records where Member Date of Birth (MC013) is after Accounts Payable Date/Actual Paid Date (MC017) divided by the total number of records	0%	3%
MEDICAL	DQM517	% of Paid claims with “In Process” Denial Reason Codes.	% of records where Service Line Status is Paid (MC038 = 01) and Denial Reason Code (MC220) = 3W or P11 or N581 or 133.	0%	0%
MEDICAL	DQM518	% of Out of Network claims	% of records where an Out of Network provider was used. In Network Indicator (MC900) = N	5%	25%
MEDICAL	DQM519	% of records where Unit of Measure is populated for anesthesia claims	% of records where Procedure Code (MC055) starts with ‘00’ and Unit of Measure (MC901) is populated.	95%	100%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
MEDICAL	DQM520	% Outpatient records with no plan or member payment	Number of outpatient records where Type of Bill (MC036) = '13x' or '14x' or '32x' or '33x' or '43x' or '71x' or '73x' or '74x' or '76x' or '83x' or '84x' or '85x', with Paid Amount (MC063), Copay Amount (MC065), Coinsurance Amount (MC066), and Deductible Amount (MC067) = 0 divided by the total number of records. Excludes Denials and Reversals.	0%	25%
MEDICAL	DQM521	% Professional records with no plan or member payment	Number of professional records where Place of Service (MC037) is populated with Paid Amount (MC063), Copay Amount (MC065), Coinsurance Amount (MC066), and Deductible Amount (MC067) = 0 divided by the total number of records. Excludes Denials and Reversals.	0%	25%
MEDICAL	DQM522	% of Denied records with Paid amount < 0	% of total records where MC038 Claims Status = 04 and MC063 Paid Amount < 0	0%	0%
MEDICAL	DQM523	% of records with Line Counter = 0	% of total records where MC005 Line Counter = 0	0%	0%

Pharmacy Claims File

Field Checks

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
PC001	Payer	7	8	100	Text	Carrier Payer Code	No	100
PC002	Plan ID	5	30	0	Text			
PC003	Insurance Type/Product Code	2	2	100	Text	Refer to *Insurance Type/Product Code – Claims Files*.	No	100

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
PC004	Payer Claim Control Number	1	35	100	Text			
PC005	Line Counter	1	4	99.5	Text			
PC006	Insured Group Number	1	50	99.5	Text			
PC007	Subscriber Social Security Number	1	128	85	Text			
PC008	Plan Specific Contract Number	1	128	100	Text			
PC009	Member Suffix or Sequence Number	1	128	90	Text			
PC010	Member Social Security Number	1	128	0	Text			
PC011	Individual Relationship Code	2	2	100	Text	Refer to *Relationship Codes*.	No	100
PC012	Member Gender	1	1	100	Text	M, F, U, O	No	100
PC013	Member Date of Birth	8	8	100	Date	CCYYMMDD		
PC014	Member City Name of Residence	1	30	100	Text			
PC015	Member State	2	2	100	Text	Defined by USPS.	No	100
PC016	Member ZIP Code	5	9	99.5	Text			
PC017	Date Service Approved (AP Date)	8	8	100	Date	CCYYMMDD		
PC018	Pharmacy Number	1	30	100	Text			
PC019	Pharmacy Tax ID Number	9	10	99.5	Text			
PC020	Pharmacy Name	1	30	99.5	Text			

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
PC021	National Pharmacy ID Number	10	10	100	Text	NPPES reference table	No	100
PC022	Pharmacy Location City	1	30	99.5	Text			
PC023	Pharmacy Location State	2	2	99.5	Text	Defined by USPS.	No	99.5
PC024	Pharmacy ZIP Code	5	9	99.5	Text			
PC024A	Pharmacy Country Name	1	30	100	Text			
PC025	Service Line Status	2	2	100	Text	Refer to *Claim Status Codes*.	No	100
PC026	Drug Code	10	11	99.5	Text	National Drug Codes	Yes	100
PC027	Drug Name	1	80	99.5	Text			
PC028	New Prescription	1	2	99.5	Number	0, 1, 2, 00, 01 - XX	No	99.5
PC029	Generic Drug Indicator	2	2	99.5	Text	01, 02	No	99.5
PC030	Dispense as Written Code	1	1	99.5	Text	0 - 9	Yes	100
PC031	Compound Drug Indicator	1	1	100	Text	N, Y, U	No	100
PC032	Date Prescription Filled	8	8	100	Date	CCYYMMDD		
PC033	Quantity Dispensed	1	10	100	Number			
PC034	Days' Supply	1	4	100	Number			
PC035	Charge Amount	1	10	100	Number			
PC036	Paid Amount	1	10	100	Number			
PC037	Ingredient Cost/List Price	1	10	100	Number			
PC038	Postage Amount Claimed	1	10	100	Number			
PC039	Dispensing Fee	1	10	100	Number			
PC040	Copay Amount	1	10	100	Number			

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
PC041	Coinsurance Amount	1	10	100	Number			
PC042	Deductible Amount	1	10	100	Number			
PC043	Prescription Number	1	20	100	Text			
PC044	Prescribing Physician First Name	1	35	90	Text			
PC045	Prescribing Physician Middle Name	1	25	0.5	Text			
PC046	Prescribing Physician Last Name	1	60	95	Text			
PC047	Prescribing Physician Number	10 1	10	99	Text	NPPES reference table	No	99
PC101	Subscriber Last Name	1	128	99.5	Text			
PC102	Subscriber First Name	1	128	99.5	Text			
PC103	Subscriber Middle Initial	1	128	0.5	Text			
PC104	Member Last Name	1	128	100	Text			
PC105	Member First Name	1	128	100	Text			
PC106	Member Middle Initial	1	128	0.5	Text			
PC203	Carrier Associated with Claim	2	8	0	Text			
PC204	Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number	1	128	0	Text			
PC211	Cross Reference Claims ID	1	35	0	Text			
PC212	Allowed amount	1	10	100	Number			
PC213	HIOS Plan ID	1	16	0	Text			

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
PC214	Claim Processing Level Indicator	1	1	100	Text	1, 2	No	100
PC215	Service Line Type	1	1	100	Text	O, V, R, B, A	No	100
PC216	Denied Claim Indicator	1	1	100	Text	1,2,3,4	No	100
PC217	Denial Reason	1	4	12	Text	CARC or RARC or NCPDP Reject codes	Yes	100
PC899	Record Type	2	2	100	Text	PC	No	100
PC900	Mail Order Pharmacy Indicator	1	1	100	Text	Y, N	No	100
PC901	In Network Indicator	1	1	100	Text	Y, N	No	100
PC902	Version Number	0	4	100	Number	Begins with 0, then 1, 2, 3, etc.		

Quality Checks

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
PHARMACY	DQP005	% SSN or contract number populated	Subscriber SSN (PC007) or Plan Specific Contract number (PC008) must be populated	100%	100%
PHARMACY	DQP016	Average # lines per claim	Total number of distinct claim lines divided by total number of distinct claims derived from Payer Claim Control Number (PC004)	1	5
PHARMACY	DQP017	Average # claims per member	(Average # claims per member) Total number of claims divided by the total number of members. Excludes reversals (PC025 = 22)	0	5
PHARMACY	DQP020	% Records w/from service date 2 or more years old relative to paid date	Number of records with a Date Prescription Filled (PC032) of 2 or more years before Date Service Approved (AP Date) (PC017) divided by the total number of records	0%	2%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
PHARMACY	DQP023	% Records w/gender = male	Number of records where Member Gender (PC012) = '1' divided by total number of records	20%	80%
PHARMACY	DQP024	% Records w/unknown gender	Number of records where Member Gender (PC012) = '3' divided by total records	0%	.4%
PHARMACY	DQP026	Average age of dependent child	Total age, determined from Member Date of Birth (PC013), of dependent children, when Individual Relationship Code (PC011) = '02', '05', '07', '09'. '10', '15', '17', '19', or '24', divided by the total number of dependent children	6	26
PHARMACY	DQP038	% Records with age 65+ a Commercial product	Number of records with members older than 65 and enrolled in a Commercial Product divided by total records	0%	17%
PHARMACY	DQP039	% Records w/ member age > 115	Number of records with members older than 115 based on Member Date of Birth (PC013)	0%	3%
PHARMACY	DQP059	% Records w/ no member paid	Number of records with Copay Amount (PC040), Coinsurance Amount (PC041) and Deductible Amount (PC042) = 0 divided by the total number of records. Exclude Denials and Reversals.	0%	60%
PHARMACY	DQP060	% Records w/ negative $$	Number of records with either Paid Amount (PC036), Copay Amount (PC040), Coinsurance Amount (PC041), or Deductible Amount (PC042) < $0 divided by the total number of records Exclude Denials and Reversals.	0%	5%
PHARMACY	DQP074	% Reversal	Number of records with Claims Status (PC025) ='22' divided by the total number of distinct claims derived from Payer Claim Control Number (PC004)	0%	40%
PHARMACY	DQP091	% Records w/unknown pharmacy zip code	Number of records with Pharmacy Zip Code (PC024) = 'Null', 'blank', or 'invalid' divided by the total number of records	0%	1%
PHARMACY	DQP095	% Records w/Days Supply = 0	Number of records with Days Supply (PC034) = 0 divided by the total number of records. Exclude Denials and Reversals.	0%	0.5%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
PHARMACY	DQP096	% Records w/missing or invalid compound drug indicator	Number of records where Compound Drug Indicator (PC031) is not in 'Y', 'N' or 'U' divided by the total number of records	0%	4%
PHARMACY	DQP097	% Records w/no plan or member payment	Number of records with blank Paid Amount (PC036), Copay Amount (PC040), Coinsurance Amount (PC041), and Deductible Amount (PC042) divided by the total number of records. Exclude Denials and Reversals.	0%	5%
PHARMACY	DQP098	% Total paid to charges	Total of Paid Amount (PC036) + Copay Amount (PC040) + Coinsurance Amount (PC041) + Deductible Amount (PC042) divided by the total Charge Amount (PC035). Exclude Denials and Reversals.	20%	100%
PHARMACY	DQP102	% Members under 65 with Medicare	Number of members <65 years enrolled for Medicare product divided by total number of members	0%	25%
PHARMACY	DQP105	% Non-primary state pharmacy	Number of pharmacies with Pharmacy Location State (PC023) not equal to primary state divided by the total number of records	0%	45%
PHARMACY	DQP106	% Non-primary state pharmacy zip code	Number of pharmacies with Pharmacy ZIP Code (PC024) not equal to primary state ZIP code divided by the total number of records	0%	45%
PHARMACY	DQP120	Average paid per claim	Total Paid Amount (PC036) divided by the total number of distinct claims. Exclude Denials and Reversals.	$15	$250
PHARMACY	DQP165	Ratio of plan paid to charges	Total Paid Amount (PC036) divided by total Charge Amount (PC035). Exclude Denials and Reversals.	0.25	0.95
PHARMACY	DQP172	% Valid prescribing NPI numbers	Number of records with valid Prescribing Physician Number (PC047) divided by the total number of records	90%	100%
PHARMACY	DQP182	% Records with member zip code not within primary member state	Number of records with Member ZIP Code (PC016) not belonging to Member State or Province (PC015) divided by the total number of records	0%	2%
PHARMACY	DQP184	% Records with pharmacy zip code not within primary state	Number of records with Pharmacy ZIP Code (PC024) not found within primary state divided by the total number of records	0%	5%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
PHARMACY	DQP185	% Records with pharmacy state not within primary state	Number of pharmacies with Pharmacy Location State (PC023) other than primary state divided by total number of pharmacies	0%	40%
PHARMACY	DQP200	% NPI populated in prescribing physician number field with no prescribing last name	Number of records with NPI number in Prescribing Physician Number (PC047) populated without Prescribing Physician Last Name (PC046) populated divided by the total number of records	0%	0.5%
PHARMACY	DQP269	% Records with more than 1 Member ID for a claim number	Number of records with 2 or more distinct member IDs (derived from PC007, PC010, PC012, and PC013) per claim divided by the total number of records. Excludes denials and reversals.	0%	0%
PHARMACY	DQP309	% of Self or Employee subscribers that are not enrolled in Medicare or Medicaid	Number of subscriber records where the Individual Relationship Code (PC011) = `18` or `20` and are not enrolled in a Medicare or Medicaid product listed under PC003 divided by the total number of records not coded as a Medicare or Medicaid product under PC003	20%	80%
PHARMACY	DQP315	% Records with prescribing last name and no first name supplied	Number of records with Prescribing Physician Last Name (PC046) populated without Physician First Name (PC044) populated divided by the total number of records	0%	50%
PHARMACY	DQP327	% Records with non-blank ESSN = MEMSSN and relationship is not subscriber, employee or self	Number of records with populated Employee SSN = Member SSN and Individual Relationship Code (PC011) is not '18' or '20' divided by the total number of records	0%	2%
PHARMACY	DQP329	% Records with subscriber name = member name and relationship is not subscriber, employee or self	Number of records with Subscriber First Name (PC102) and Subscriber Last Name (PC101) = Member First Name (PC105) and Member Last Name (PC104) and Individual Relationship Code (PC011) is not '18' or '20' divided by the total number of records	0%	5%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
PHARMACY	DQP330	% Records with subscriber name <> member name and relationship is subscriber, employee or self	Number of records with Subscriber First Name (PC102) and Subscriber Last Name (PC101) not equal to Member First Name (PC105) and Member Last Name (PC104) and Individual Relationship Code (PC011) = '18' or '20' divided by the total number of records	0%	1%
PHARMACY	DQP334	% Records with ingredient cost/list price = 0	Number of records with Ingredient Cost/List Price (PC037) = 0 divided by the total number of records. Exclude Denials and Reversals.	0%	30%
PHARMACY	DQP335	% Records with dispensing fee paid = 0	Number of records with Dispensing Fee (PC039) = 0 divided by the total number of records. Exclude Denials and Reversals.	0%	35%
PHARMACY	DQP336	% Records with deductible = 0	Number of records with Deductible Amount (PC042) = 0 divided by the total number of records. Exclude PC003 = MC.	50%	100%
PHARMACY	DQP342	Average age of member and a Commercial related product	Total age of members enrolled in Commercial product divided by total distinct members	18	64
PHARMACY	DQP386	Average Total Paid per Script	Total of Paid Amount (PC036) + Copay Amount (PC040) + Coinsurance Amount (PC041) + Deductible Amount (PC042) divided by the total number of distinct claims. Excludes denials and reversals.	$15	$250
PHARMACY	DQP389	% of records with 1 character in prescribing physician last name	Number of records with 1 character in Prescribing Physician Last Name (PC046) divided by the total number of records	0%	.5%
PHARMACY	DQP437	% Negative charges on adjustment claims with 0 or positive quantity	Number of adjustment claim records where Claim Status (PC025) = '22' with Charge Amount (PC035) < 0 and Quantity Dispensed (PC033) >= 0 divided by the total number of records	0%	1%
PHARMACY	DQP439	% Duplicate claims	Number of records with same Payer Claim Control Number (PC004), Version Number (PC903) and Claim Status (PC025) divided by the total number of records	0%	5%
PHARMACY	DQP441	% Age <20 and relationship = Spouse	Number of records with members less than 20 years old and Individual Relationship Code (PC011) ='01', '29' or '53' divided by the total number of records	0%	1%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
PHARMACY	DQP446	% Incurred month/year = paid month/year	Number of records with incurred month/year = paid month/ year divided by the total number of records	60%	100%
PHARMACY	DQP447	% Service dates > paid date	Number of records with Date Prescription Filled (PC032) later than the Date Service Approved (AP Date) (PC017) divided by the total number of records	0%	2%
PHARMACY	DQP495	% Valid NPI numbers	Number of records with valid NPI numbers populating Provider NPI (PC021) divided by the total number of records	90%	100%
PHARMACY	DQP496	% Populated pharmacy name with invalid Service Provider NPI	Number of records with populated Pharmacy Name (PC020) and a populated invalid Service National Provider ID Number (PC021) divided by the total number of records	0%	1%
PHARMACY	DQP498	% Invalid pharmacy location city	Number of records with Pharmacy Location City (PC022) not associated with National Provider ID Number (PC021) divided by the total number of records	0%	100%
PHARMACY	DQP499	% Invalid pharmacy zip code	Number of records with Pharmacy Zip Code (PC024) not associated with National Provider ID Number (PC021) divided by the total number of records	0%	100%
PHARMACY	DQP500	% of Pharmacy Claims File posted to correct FTP folder	Payer code in the Pharmacy Claims File name = payer code name in FTP folder	100%	100%
PHARMACY	DQP501	% of records containing CHIS data.	% of records containing CHIS data.	100%	100%
PHARMACY	DQP502	Correct version of the CHIS Preprocessor is being used for this file submission.	Correct version of the CHIS Preprocessor is being used for this file submission.	100%	100%
PHARMACY	DQP503	% of records where PC216 (Denied Claim Indicator) = 2 or 4.	% of records where PC216 (Denied Claim Indicator) = 2 or 4. This represents the percentage of records that were partially denied or denied entirely.	.5%	35%
PHARMACY	DQP504	% of records where PC216 (Denied Claim Indicator) = 1.	% of records where PC216 (Denied Claim Indicator) = 1. This represents the percentage of records that were fully paid.	65%	99%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
PHARMACY	DQP505	% of records with a valid Denial Reason code when Service Line Status is Denied	% of records where the Denial Reason Code is populated with a valid value for Denied claims only.	100%	100%
PHARMACY	DQP506	% of records populated for TPA file submissions	% of records where Carrier Associated with Claim (PC203) and Carrier Plan Specific Contract Number (PC204) are populated for TPA file submissions. Populated PC203 record count must equal populated PC204 record count. PC203 & PC204 must be populated for TPA/PBM payers. (Payer Codes NHT%)	100%	100%
PHARMACY	DQP507	% of records Allowed Amount is greater than zero for Denied Claims	% of total records: PC025 = 4 (Denied) and Allowed Amount is greater than zero.	0%	0%
PHARMACY	DQP508	% of records Allowed Amount formatted with decimal codes.	% of total records: Allowed Amounts (PC212) with decimal codes	0%	0%
PHARMACY	DQP509	% of records HIOS Plan ID populated for QHP Plans	% of total records: HIOS Plan ID (PC213) populated for QHP Plans	20%	80%
PHARMACY	DQP510	% of records Allowed Amount populated correctly for Reversed Claims	% of total records: PC025 = 22 (Reversal) and Allowed Amount is greater than zero.	0%	0%
PHARMACY	DQP511	% of records with a valid Denial Reason code when Service Line Status is a reversal.	% of records where the Denial Reason Code is populated with a valid value for reversed claims only.	50%	100%
PHARMACY	DQP512	% of records where the Member DOB is greater than the Paid Date	Number of records where Member Date of Birth (PC013) is after Date Service Approved (AP Date) (PC017) divided by the total number of records.	0%	3%
PHARMACY	DQP513	% of records using a mail order pharmacy	% of records where Mail Order Pharmacy (PC900) = 'Y' divided by the total number of records.	20%	75%
PHARMACY	DQP514	% of Denied records with Paid amount < 0	% of total records where PC025 Claims Status = 04 and PC036 Paid Amount < 0	0%	0%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
PHARMACY	DQP515	% of records with Line Counter = 0	% of total records where PC005 Line Counter = 0	0%	0%

Dental Claims File

Field Checks

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
DC001	Payer	7	8	100	Text	Carrier Payer Code	No	100
DC002	National Plan ID	5	30	0	Text			
DC003	Insurance Type/Product Code	2	2	100	Text	Refer to *Insurance Type/Product Code – Claims Files*.	No	100
DC004	Payer Claim Control Number	1	35	100	Text			
DC005	Line Counter	1	4	100	Number			
DC006	Insured Group or Policy Number	1	50	100	Text			
DC007	Subscriber Social Security Number	1	128	85	Text			
DC008	Plan Specific Contract Number	1	128	100	Text			
DC009	Member Suffix or Sequence Number	1	128	90	Text			
DC010	Member Social Security Number	1	128	0	Text			

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
DC011	Individual Relationship Code	2	2	100	Text	Refer to *Relationship Codes*.	No	100
DC012	Member Gender	1	1	100	Text	M, F, U, O	No	100
DC013	Member Date of Birth	8	8	100	Date	CCYYMMDD		
DC014	Member City Name of Residence	1	50	99.5	Text			
DC015	Member State or Province	2	2	99.5	Text	Defined by USPS.	No	99.5
DC016	Member ZIP Code	5	9	99.5	Text			
DC017	Accounts Payable Date/Actual paid Date	8	8	100	Date	CCYYMMDD		
DC018	Service Provider Number	1	30	90	Text			
DC019	Service Provider Tax ID Number	9	10	90	Text			
DC020	National Service Provider ID	10	10	100	Text	NPPES reference table	No	100
DC021	Service Provider Entity Type Qualifier	1	1	98	Text	1, 2	No	98
DC022	Service Provider First Name	1	35	40	Text			
DC023	Service Provider Middle Name	1	25	0.5	Text			
DC024	Servicing Provider Last Name or Organization Name	1	60	99.5	Text			
DC025	Service Provider Suffix	1	10	0.5	Text			

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
DC026	Service Provider Specialty	1	10	99.5	Text	National Uniform Claims Committee (NUCC) standard taxonomy code	No	99.5
DC027	Service Provider City Name	1	30	95	Text			
DC028	Service Provider State or Province	2	2	95	Text	Defined by USPS.	No	95
DC029	Service Provider ZIP Code	5	9	95	Text			
DC030	Place of Service - Professional	2	2	99.5	Text	Refer to *Place of Service – Professional Codes*.	Yes	100
DC031	Claim Status	2	2	99.5	Text	Refer to *Claim Status Codes*.	No	99.5
DC032	CDT Code	3	5	98	Text	Common Dental Terminology codes.	No	98
DC033	Procedure Modifier – 1	2	2	0	Text	National Procedure Modifiers	Yes	100
DC034	Procedure Modifier – 2	2	2	0	Text	National Procedure Modifiers	Yes	100
DC035	Date of Service – From	8	8	100	Date	CCYYMMDD		
DC036	Date of Service – Thru	8	8	100	Date	CCYYMMDD		
DC037	Charge Amount	1	10	100	Number			
DC038	Paid Amount	1	10	100	Number			
DC039	Copay Amount	1	10	100	Number			
DC040	Coinsurance Amount	1	10	100	Number			
DC041	Deductible Amount	1	10	100	Number			
DC042	Billing Provider Number	0	30	100	Text			

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
DC043	National Billing Provider Number ID	10	10	100	Text	NPPES reference table	No	100
DC044	Billing Provider Last Name	1	60	100	Text			
DC101	Subscriber Last Name	1	128	99.5	Text			
DC102	Subscriber First Name	1	128	99.5	Text			
DC103	Subscriber Middle Initial	1	128	0.5	Text			
DC104	Member Last Name	1	128	100	Text			
DC105	Member First Name	1	128	100	Text			
DC106	Member Middle Initial	1	128	0.5	Text			
DC201	Carrier Associated with Claim	1	8	0	Text			
DC202	Carrier Plan Specific Contract Number or Subscriber/Member Social Security Number	1	128	0	Text			
DC203	Practitioner Group Practice	1	60	5	Text			
DC204	Tooth Number/Letter	1	2	100	Text	1 – 32, A - T	Yes	100
DC205	Dental Quadrant	1	2	100	Text	00, 01, 02, 10, 20, 30, 40, UL, UR, LL, LR	Yes	100
DC206	Tooth Surface	1	5	0	Text	Refer to *Tooth Surface(s) Codes*		
DC207	Claim Version	1	4	99.5	Text	0 - XXXX	No	99.5
DC208	Diagnosis Code	2	7	0	Text	ICD-9/10-CM codes	Yes	100
DC209	ICD Indicator	1	1	0	Text	0, 1	Yes	100
DC211	Cross Reference Claims ID	1	35	0	Text			
DC212	Allowed amount	1	10	100	Number			
DC213	HIOS Plan ID	1	16	0	Text			

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
DC215	Service Line Type	1	1	100	Text	O, V, R, B, A	No	100
DC218	Claim Processing Level Indicator	1	1	100	Text	1, 2	No	100
DC219	Denied Claim Indicator	1	1	100	Text	1,2,3,4	No	100
DC220	Denial Reason	1	4	5	Text	CARC or RARC codes	Yes	100
DC899	Record Type	2	2	100	Text	DC	No	100
DC900	In Network Indicator	1	1	100	Text	Y, N	No	100
DC901	Quantity	1	12	99	Number			

Quality Checks

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
DENTAL	DQD005	% SSN or contract number populated	Subscriber SSN (DC007) or Plan Specific Contract number (DC008) must be populated	100%	100%
DENTAL	DQD016	Average # lines per claim	Total number of distinct claim lines divided by total number of distinct claims derived from Payer Claim Control Number (DC004)	1	5
DENTAL	DQD017	Average # claims per member	Total number of claims divided by the total number of members	0	5
DENTAL	DQD020	% Records w/date service - from 2 or more years old	Number of records with a Date of Service - From (DC035) of 2 or more years before Accounts Payable Date/Actual Paid Date (DC017) divided by the total number of records	0%	2%
DENTAL	DQD021	Ratio of Member SSN to Subscriber SSN	Ratio of count of distinct Member SSN (if member ID is Null, populate Subscriber SSN) by the distinct subscriber SSN	1	3

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
DENTAL	DQD023	% Records w/gender = male	Number of records where Member Gender (DC012) = 'M' divided by total number of records	20%	80%
DENTAL	DQD024	% Records w/unknown gender	Number of records where Member Gender (DC012) = 'U' divided by total records	0%	.4%
DENTAL	DQD026	Average age of dependent child	Total age, determined from Member Date of Birth (DC013), of dependent children, when Individual Relationship Code (DC011) = '02', '05', '07', '09'. '10', '15', '17', '19', or '24', divided by the total number of dependent children. Exclude DC003 = MC.	6	26
DENTAL	DQD039	% Records w/ Member age > 115	Number of records with members older than 115 divided by the total number of records.	0%	3%
DENTAL	DQD043	% Records w/unknown provider #	Number of records where Service Provider Number (DC018), Service Provider Tax ID Number (DC019) and Service National Provider ID (DC020) are blank divided by the total number of records	0%	0.1%
DENTAL	DQD046	Ratio of service provider number to service provider name	Number of distinct Service Provider Numbers (DC018) divided by the number of distinct Service Provider Names (First Name, Middle Name, Last Name/DC022, DC023, DC024)	0.3	3
DENTAL	DQD047	Ratio of distinct service provider Tax ID to service provider name	Number of distinct Service Provider Tax IDs (DC019) divided by the number of distinct Service Provider Names (First Name, Middle Name, Last Name/DC022, DC023, DC024)	0.3	3
DENTAL	DQD055	% Records w/ negative plan payments	Number of records with Paid Amount (DC038) < 0 divided by the total number of records. Exclude Denials and reversals.	0%	5%
DENTAL	DQD060	% Records w/ negative $$	Number of records with either Paid Amount (DC038), Copay Amount (DC039), Coinsurance Amount (DC040), or Deductible Amount (DC041) < $0 divided by the total number of records. Exclude Denials and reversals.	0%	5%
DENTAL	DQD074	% Reversals	Number of records with Claims Status (DC031) ='22' divided by the total number of distinct claims derived from Payer Claim Control Number (DC004)	0%	40%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
DENTAL	DQD098	% Total paid to charges	Total of Paid Amount (DC038) + Copay Amount (DC039) + Coinsurance Amount (DC040) + Deductible Amount (DC041) divided by the total Charge Amount (DC037). Exclude Denials and reversals.	20%	90%
DENTAL	DQD107	% Non-primary state providers	Number of Service Providers with Service Provider State or Province (DC028) = NH divided by the total number of Service Providers	0%	45%
DENTAL	DQD108	% Non-primary state provider zip codes	Number of Provider Office Zip (DC029) not found in the State of NH zip codes divided by the total number of records	0%	45%
DENTAL	DQD115	% Records with no plan or member payment	Number of records with Paid Amount (DC038), Copay Amount (DC039), Coinsurance Amount (DC040) and Deductible Amount (DC041) = 0 divided by the total number of records. Exclude Denials.	0%	25%
DENTAL	DQD116	% Records w/ no member payment	Number of records with Copay Amount (DC039), Coinsurance Amount (DC040), and Deductible Amount (DC041) = 0 divided by the total number of records. Exclude DC003 = MC.	0%	75%
DENTAL	DQD165	Ratio of plan paid to charges	Total of Paid Amount (DC038) divided by the total Charge Amount (DC037). Exclude Denials and reversals.	0.25	1
DENTAL	DQD167	% Non-primary state unique providers	Number of distinct providers derived from Provider NPI (DC020) or Provider ID (DC018) or Provider Tax ID (DC019) with Provider Office State (DC028) not equal to NH, divided by the total number of distinct providers	0%	20%
DENTAL	DQD170	% of provider type values = 2 (non-person)	Number of records with Service Provider Entity Type Qualifier (DC021) = '2' divided by the total number of records	20%	70%
DENTAL	DQD182	% Records with member zip code not within member state	Number of records with Member ZIP Code (DC016) not belonging to Member State or Province (DC015) divided by the total number of records	0%	5%
DENTAL	DQD183	% Records with provider zip code not within provider state	Number of records with Provider Office ZIP (DC029) not belonging to Provider Office State (DC028) divided by the total number of records	0%	5%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
DENTAL	DQD269	% Records with more than 1 member ID for a claim number	Number of records with 2 or more distinct member IDs (derived from DC007, DC010, DC012, and DC013) per claim divided by the total number of records. Excludes denials and reversals.	0%	0%
DENTAL	DQD309	% Records w/relationship = subscriber and a Commercial related product	Number of subscriber records where the Individual Relationship Code (DC011) = '18' or '20' and are enrolled in a Commercial product listed under DC003 divided by the total number of records coded as a Commercial product under DC003.	0%	80%
DENTAL	DQD327	% Records with non-blank ESSN = MEMSSN and relationship is not subscriber, employee or self	Number of records with populated Employee SSN = populated Member SSN and Individual Relationship Code (DC011) is not '18' or '20' divided by the total number of records	0%	5%
DENTAL	DQD329	% Records with subscriber name = member name and relationship is not subscriber, employee or self	Number of records with Subscriber First Name (DC102) and Subscriber Last Name (DC101) = Member First Name (DC105) and Member Last Name (DC104) and Individual Relationship Code (DC011) is not '18' or '20' divided by the total number of records	0%	5%
DENTAL	DQD330	% Records with subscriber name <> member name and relationship is subscriber, employee or self	Number of records with subscriber name not equal to the member name and Individual Relationship Code (DC011) is '18' or '20' divided by the total number of records	0%	1%
DENTAL	DQD346	% Last date of service < first date of service	Number of records with Date of Service - Thru (DC036) before the Date of Service - From (DC035) divided by the total number of records	0%	0.5%
DENTAL	DQD349	Ratio of NPI to service provider name	Number of distinct NPIs divided by distinct Service Provider Names (First, Middle, Last/DC022, DC023, DC024)	0.3	3
DENTAL	DQD387	% of records with 1 character in service provider last name	Number of records with 1 character in Service Provider Last Name or Organization Name (DC024) divided by the total number of records	0%	.5%
DENTAL	DQD388	% of records with 1 character in billing provider last name	Number of records with 1 character in Billing Provider Last Name or Organization Name (DC044) divided by the total number of records	0%	.5%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
DENTAL	DQD440	% duplicate claims	Number of records with same Payer Claim Control Number (DC004) and Line Counter (DC005) and Claim Status (DC031) and Claim Version (DC207) divided by the total number of records	0%	5%
DENTAL	DQD441	% Age <20 and relationship = Spouse	Number of records with members less than 20 years old and Individual Relationship Code (DC011) ='01', '29' or '53' divided by the total number of records	0%	1%
DENTAL	DQD442	% provider tax id <> 9 or 10 digits	Number of records where the Service Provider Tax ID Number (DC019) does not have a length of 9 or 10 digits divided by the total number of records	0%	1%
DENTAL	DQD443	% provider number = provider tax id	Number of records with Service Provider Number (DC018) = Service Provider Tax ID Number (DC019) divided by the total number of records	0%	1%
DENTAL	DQD444	% provider number = National Provider ID	Number of records with the Service Provider Number (DC018) = Service National Provider ID (DC020) divided by the total number of records	0%	1%
DENTAL	DQD445	% provider last name not populated.	Number of records with a blank Service Provider Last Name or Organization Name (DC024) when Service Provider Entity Type Qualifier (DC021) = 1, divided by the total number of records.	0%	0%
DENTAL	DQD446	% incurred month/year = paid month/year	Number of records with incurred month/year, derived from Date of Service - From (DC035) = paid month/year, derived from Accounts Payable Date/Actual Paid Date (DC017) divided by the total number of records	0%	95%
DENTAL	DQD447	% service dates > paid date	Number of records with Date of Service - From (DC035) later than the Accounts Payable Date/Actual Paid Date (DC017) divided by the total number of records	0%	2%
DENTAL	DQD448	% of CDT codes that begin with a ‘D’	Number of records with CDT Code (DC032) beginning with a ‘D’ divided by the total number of records with DC032 populated	98%	100%
DENTAL	DQD449	% of CDT codes that begin with a ‘0’	Number of records with CDT Code (DC032) beginning with a ‘0’ divided by the total number of records with DC032 populated	0%	0%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
DENTAL	DQD495	% Valid NPI numbers	Number of records with valid NPI numbers populating Provider NPI (DC020) divided by the total number of records	90%	100%
DENTAL	DQD496	% Populated service provider last name or organization name with an invalid NPI	Number of records with populated Service Provider Last Name or Organization Name (DC024) and populated invalid Service National Provider ID (DC020) divided by the total number of records	0%	1%
DENTAL	DQD498	% Invalid service provider city name	Number of records with Service Provider City Name (DC024) not associated with Service National Provider ID (DC020) divided by the total number of records	0%	25%
DENTAL	DQD499	% Invalid service provider zip code	Number of records with Service Provider ZIP Code (DC029) not associated with Service National Provider ID (DC020) divided by the total number of records	0%	25%
DENTAL	DQD500	% of Dental Claims File posted to correct FTP folder	Payer code in the Dental Claims File name = payer code name in FTP folder	100%	100%
DENTAL	DQD501	% of records containing CHIS data.	% of records containing CHIS data.	100%	100%
DENTAL	DQD502	Correct version of the CHIS Preprocessor is being used for this file submission.	Correct version of the CHIS Preprocessor is being used for this file submission.	100%	100%
DENTAL	DQD503	% of records where DC219 (Denied Claim Indicator) = 2 or 4.	% of records where DC219 (Denied Claim Indicator) = 2 or 4. This represents the percentage of records that were partially denied or denied entirely.	4%	30%
DENTAL	DQD504	% of records where DC219 (Denied Claim Indicator) = 1	% of records where DC219 (Denied Claim Indicator) = 1. This represents the percentage of records that were fully paid.	65%	99.5%
DENTAL	DQD505	% of records with a valid Denial Reason code when Service Line Status is Denied.	% of records where the Denial Reason Code is populated with a valid value for Denied claims only.	100%	100%
DENTAL	DQD506	% of records populated for TPA file submissions	% of records where Carrier Associated with Claim (DC201) and Carrier Plan Specific Contract Number (DC202) are populated for TPA file submissions. Populated DC201 record count must equal populated	100%	100%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
			DC202 record count. DC201 & DC202 must be populated for TPA payers. (Payer Codes NHT%)		
DENTAL	DQD507	% of records with populated Tooth Number/Letter when CDT code in range D2000 - D2999	% of records where Tooth Number/Letter (DC204) is populated and valid when DC032 (CDT Code) is in the range of D2000 – D2999.	0%	100%
DENTAL	DQD508	% of records with populated Dental Quadrant when CDT code in range D2000 - D2999	% of records where Dental Quadrant (DC205) is populated and valid when DC032 (CDT Code) is in the range of D2000 – D2999.	0%	100%
DENTAL	DQD509	% of records with unpopulated Tooth Surface when CDT code in range D2000 - D2999	% of records where Tooth Surface (DC206) is not populated when DC032 (CDT Code) is in the range of D2000 – D2999.	0%	100%
DENTAL	DQD510	% of invalid Tooth Surface codes	% of invalid Tooth Surface (DC206) codes	0%	0%
DENTAL	DQD511	% of records Allowed Amount populated correctly for Denied Claims	% of total records: DC031 = 4 (Denied) and Allowed Amount is NOT equal to zero.	0%	0%
DENTAL	DQD512	% of records Allowed Amount formatted with decimal codes.	% of total records: Allowed Amounts (DC212) with decimal codes	0%	0%
DENTAL	DQD513	% of records HIOS Plan ID populated for QHP Plans	% of total records: HIOS Plan ID (DC213) populated for QHP Plans	20%	80%
DENTAL	DQD514	% of records ICD Indicator is not populated or invalid when Diagnosis code is populated	% of total records: ICD Indicator (DC209) populated with invalid values or blanks when Diagnosis code (DC208) is populated.	0%	0%
DENTAL	DQD515	% of records Allowed Amount populated correctly for Reversed Claims	% of total records: DC031 = 22 (Reversal) and Allowed Amount is greater than zero.	0%	0%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
DENTAL	DQD516	% of records where Member DOB is greater than the Paid Date	Number of records where Member Date of Birth (DC013) is after Accounts Payable Date/Actual Paid Date (DC017) divided by the total number of records	0%	3%
DENTAL	DQD517	% of records with a valid Denial Reason code when Service Line Status is a reversal.	% of records where the Denial Reason Code is populated with a valid value for reversed claims only.	50%	100%
DENTAL	DQD518	% of paid claims with Quantity less than or equal to 0	% of records where Claim Status (DC031) <> '04' (Denied) or '22' (Reversed) and the Quantity (DC901) <= 0	0%	0%
DENTAL	DQD519	% of reversals with Quantity > 0	% of records where Claim Status (DC031) = 22 (Reversed) and the Quantity (DC901) > 0	0%	0%
DENTAL	DQD520	% of records with Quantity not blank and not equal to 0	% of records where Quantity (DC901) is not blank and not equal to 0.	99%	100%
DENTAL	DQD521	% of records with Allowed amount >0 when Paid Amount = $0	% of records where Paid Amount (DC038) = $0 and Allowed Amount (DC212) > $0	0%	20%
DENTAL	DQD522	(% of Paid records (DC031 Claim Status = 01 or 02) with Deductible, Copay, or Coinsurance = 0 when Paid Amount = $0	% of Paid records (DC031 Claim Status = 01 or 02) where Paid Amount (DC038) =$0 and all of the patient liability fields are zero (Deductible (DC041), Copay (DC039), Coinsurance (DC040)). Excludes reversals and denials.	5%	20%
DENTAL	DQD523	% of Denied records with Paid amount < 0	% of total records where DC031 Claims Status = 04 and DC038 Paid Amount < 0	0%	0%
DENTAL	DQD524	% of records with Line Counter = 0	% of total records where DC005 Line Counter = 0	0%	0%

Provider File

Field Checks

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
MP001	Payer	7	8	100	Text	Carrier Payer Code	No	100
MP002	Plan ID	5	30	100	Text			
MP003	Provider ID	2	30	100	Text			
MP004	Provider Tax ID	1	10	100	Text			
MP005	Provider Entity	1	1	100	Text	1, 2, 3, 4, 5, 6, 7, 8	No	100
MP006	Provider First Name	1	35	40	Text			
MP007	Provider Middle Name or Initial	1	25	0	Text			
MP008	Provider Last Name or Organization Name	1	60	100	Text			
MP009	Provider Suffix	1	10	0	Text			
MP010	Provider Specialty	1	10	90	Text	**National Uniform Claims Committee (NUCC) standard taxonomy code**	No	90
MP011	Provider Office Street Address	2	50	95	Text			
MP012	Provider Office City	1	30	95	Text			
MP013	Provider Office State	2	2	100	Text			
MP014	Provider Office Zip	5	9	99.5	Text			
MP015	Provider DEA Number	2	12	30	Text			

Element #	Element Name	Minimum Element Length	Maximum Element Length	Element Filled Threshold (%) (Blanks allowed if not 100%)	Element Format	Valid Code Value or Format Designation	Valid Code Value Blanks Accepted	Valid Code Value Threshold (%)
MP016	Provider NPI	10	10	95	Text	NPPES reference table	No	95
MP017	Provider State License Number	4	30	40	Text			
MP018	Entity Code	1	2	50	Text	1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30	No	50
MP899	Record Type	2	2	100	Text	MP	No	100

Quality Checks

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
PROVIDER	DQR047	Ratio of distinct provider tax ID to provider name	Number of distinct Provider Tax IDs (MP004) divided by the number of distinct Service Provider Names (First Name, Middle Name, Last Name/MP006, MC007, MC008)	0.3	3
PROVIDER	DQR100	% of records with provider entity a facility and provider first, middle, or suffix populated	Number of records with Provider Entity (MP005) = 2, 3,4,5,6,7, or 8 and Provider First Name (MP006), Provider Middle Name (PR007), or Provider Suffix (MP009) is not equal to Null or blank divided by total records where MP005 = 2, 3,4,5,6,7, or 8	0%	0.5%
PROVIDER	DQR104	% of records with provider entity as practitioner and provider first name not supplied	Number of records with Provider Entity (MP005) = 1 and Provider First Name (MP006) is Null or blank divided by total number of records where MP005 = 1	0%	0.5%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
PROVIDER	DQR106	% Non-primary state pharmacy zip code	Number of pharmacies, identified through Provider Specialty (MP010), with Pharmacy ZIP Code (MP014) not equal to primary state ZIP code divided by the total number of records	0%	45%
PROVIDER	DQR108	% Non-primary state provider zip codes	Number of Provider Office Zip (MP014) not found in primary state zip codes divided by the total number of records	0%	45%
PROVIDER	DQR122	% Existing unique providers	Number of distinct NPIs derived from Provider Last Name or Organization Name (MP008) and Provider NPI (MP016) divided by the total number of NPIs	30%	100%
PROVIDER	DQR167	% Non-primary state unique providers	Number of distinct providers derived from Provider Last Name or Organization Name (MP008) and Provider NPI (MP016) with Provider Office State (MP013) not equal to primary state divided by the total number of distinct providers	0%	60%
PROVIDER	DQR183	% Records with provider zip code not within provider state	Number of records with Provider Office ZIP (MP014) not belonging to Provider Office State (MP013) divided by the total number of records	0%	5%
PROVIDER	DQR495	% Valid NPI numbers	Number of records with valid NPI numbers populating Provider NPI (MP016) divided by the total number of records	90%	100%
PROVIDER	DQR496	% populated provider last name or organization name with an invalid NPI	Number of records with a populated Provider Last Name or Organization Name (MP008) and invalid Provider NPI (MP016) divided by the total number of records	0%	1%
PROVIDER	DQR498	% Invalid provider office city name	Number of records with Provider Office City (MP012) not associated with Provider NPI (MP016) divided by the total number of records	0%	50%
PROVIDER	DQR499	% Invalid provider office zip code	Number of records with Provider Office ZIP (MP014) not associated with Provider NPI (MP016) divided by the total number of records	0%	50%
PROVIDER	DQR500	% of Provider File posted to correct FTP folder	Payer code in the Provider File name = payer code name in FTP folder	100%	100%

Table Name	Quality Validation Identifier	Quality Validation Name	Description of Quality Validation	Threshold Low	Threshold High
PROVIDER	DQR501	Correct version of the CHIS Preprocessor is being used for this file submission.	Correct version of the CHIS Preprocessor is being used for this file submission.	100%	100%
PROVIDER	DQR502	% of records where Provider First name is not populated when Provider Entity is a person	Percentage of total records when Provider First Name (MP006) is not populated when Provider Entity (MP005) = 1 (Person)	0%	0%
PROVIDER	DQR503	% of records where Entity Code is not valid when Provider Entity is not a person	Percentage of total records when Entity Code (MP018) is not valid when Provider Entity (MP005) <> 1 (Person)	0%	0%

Code Tables

Insurance Type/Product Code – Eligibility File

Code	Description
12	Medicare Secondary Working Aged Beneficiary or Spouse with Employer Group Health Plan
13	Medicare Secondary End-Stage Renal Disease Beneficiary in the Mandated Coordination Period with an Employer's Group Health Plan
14	Medicare Secondary, No-Fault Insurance including Insurance in which Auto Is Primary
15	Medicare Secondary Workers' Compensation
16	Medicare Secondary Public Health Service (PHS) or Other Federal Agency
17	Dental
18	Vision
19	Prescription Drugs
41	Medicare Secondary Black Lung
42	Medicare Secondary Veterans' Administration
43	Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP)
AP	Auto Insurance Policy
C1	Commercial
CO	Consolidated Omnibus Reconciliation Act (COBRA)
CP	Medicare Conditionally Primary
D	Disability
DB	Disability Benefits
E	Medicare – Point of Service (POS)
EP	Exclusive Provider Organization
FI	Federal Employees Health Benefits Program
FF	Family or Friends
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) Medicare Advantage/Risk
HS	Special Low Income Medicare Beneficiary
IN	Indemnity
IP	Individual Policy
LC	Long Term Care
LD	Long Term Policy
LI	Life Insurance
LT	Litigation
MA	Medicare Part A
MB	Medicare Part B

Code	Description
MC	Medicaid
MD	Medicare Part D
MH	Medigap Part A
MI	Medigap Part B
MP	Medicare Primary
OT	Other
PE	Property Insurance – Personal
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)
QM	Qualified Medicare Beneficiary
RP	Property Insurance – Real
SP	Supplemental Policy
TF	Tax Equity Fiscal Responsibility Act (TEFRA)
TR	Tricare
U	Multiple Options Health Plan
VA	Veterans Administration Plan
WU	Wrap Up Policy

Relationship Codes

Code	Description
01	Spouse
02	Son or daughter
03	Father or Mother
04	Grandfather or Grandmother
05	Grandson or Granddaughter
06	Uncle or Aunt
07	Nephew or Niece
08	Cousin
09	Adopted Child
10	Foster Child
11	Son-in-Law or Daughter-in-Law
12	Brother-in-Law or Sister-in-Law
13	Mother-in-Law or Sister-in-Law
14	Brother or Sister

Code	Description
15	Ward
16	Stepparent
17	Stepson or Stepdaughter
18	Self
19	Child
20	Employee/Self
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
25	Ex-spouse
26	Guardian
27	Student
28	Friend
29	Significant Other
30	Both Parents
31	Court Appointed Guardian
32	Mother
33	Father
34	Other Adult
36	Emancipated Minor
37	Agency Representative
38	Collateral Dependent
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Child Where Insured Has No Financial Responsibility
53	Life Partner
76	Dependent

Race Codes

Code	Description
R1	American Indian/Alaska Native
R2	Asian

Code	Description
R3	Black/African American
R4	Native Hawaiian or Other Pacific Islander
R5	White
R9	Other Race
UNKNOW	Unknown/Not Specified

Ethnicity Codes

Code	Description
2182-4	Cuban
2184-0	Dominican
2148-5	Mexican, Mexican American, Chicano
2180-8	Puerto Rican
2161-8	Salvadoran
2155-0	Central American (not otherwise specified)
2165-9	South American (not otherwise specified)
2060-2	African
2058-6	African American
AMERCN	American
2028-9	Asian
2029-7	Asian Indian
BRAZIL	Brazilian
2033-9	Cambodian
CVERDN	Cape Verdean
CARIBI	Caribbean Island
2034-7	Chinese
2169-1	Columbian
2108-9	European
2036-2	Filipino
2157-6	Guatemalan
2071-9	Haitian
2158-4	Honduran
2039-6	Japanese
2040-4	Korean
2041-2	Laotian

Code	Description
2118-8	Middle Eastern
PORTUG	Portuguese
RUSSIA	Russian
EASTEU	Eastern European
2047-9	Vietnamese
OTHER	Other Ethnicity
UNKNOW	Unknown/Not Specified

Insurance Type/Product Code – Claims Files

Code	Description
11	Other Non-Federal Programs
12	Preferred Provider Organization (PPO)
13	Point of Service (POS)
14	Exclusive Provider Organization (EPO)
15	Indemnity Insurance
16	Health Maintenance Organization (HMO) Medicare Advantage/Risk
17	Dental Maintenance Organization
AM	Automobile Medical
BL	Blue Cross/Blue Shield
CH	Champus
CI	Commercial Insurance Company
DS	Disability
FI	Federal Employees Health Benefits Program
HM	Health Maintenance Organization
LI	Liability
LM	Liability Medical
MA	Medicare Part A
MB	Medicare Part B
MC	Medicaid
MD	Medicare Part D
MH	Medigap Part A
MI	Medigap Part B
MO	Medicare Advantage (PPO)
OF	Other Federal Program (e.g., Black Lung)

Code	Description
SP	Supplemental Policy
TR	Tricare
TV	Title V
VA	Veterans Administration Plan
WC	Workers' Comp
ZZ	Mutually Defined (Use code ZZ when Type of Insurance is Unknown)

Point of Origin Codes

If MC020 = 4 (Newborn), then use the following values for MC021:

Code	Description
5	Born Inside the Hospital
6	Born Outside the Hospital

For all other values at MC020, use the following table for MC021:

Code	Description
1	Non-Healthcare Facility Point of Origin (Physician Referral)
2	Clinic Referral
3	HMO Referral
4	Transfer from a Hospital (Different Facility)
5	Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)
6	Transfer from Another Health Care Facility
7	Emergency Room
8	Court/Law Enforcement
9	Information Not Available
A	Reserved for National Assignment
B	Transfer from Another Home Health Agency (Discontinued July 1,2010)
C	Readmission to Same Home Health Agency (Discontinued July 1,2010)
D	Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer
E	Transfer from Ambulatory Surgical Center
F	Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in Hospice Program

Discharge Status Codes

Code	Description
01	Discharged to home or self-care
02	Discharged/transferred to another short term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to a facility that provides custodial or supportive care
05	Discharged/transferred to a designated cancer center of children's hospital
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Reserved for assignment by the NUBC
09	Admitted as an inpatient to this hospital
20	Expired
21	Discharged/transferred to court/law enforcement
30	Still patient or expected to return for outpatient services
40	Expired at home
41	Expired in a medical facility
42	Expired, place unknown
43	Discharged/ transferred to a Federal Hospital
50	Hospice – home
51	Hospice – medical facility
61	Discharged/transferred within this institution to a hospital-based Medicare-approved swing bed
62	Discharged/transferred to an inpatient rehabilitation facility including distinct parts of a hospital
63	Discharged/transferred to a long-term care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharged/transferred to a critical access hospital (CAH)
69	Discharged/transferred to a designated disaster alternative care site (effective 10/1/13)
70	Discharged/transferred to another type of healthcare institution not defined elsewhere in this code list
81	Discharged to home or self-care with a planned acute care hospital inpatient readmission (effective 10/1/13)
82	Discharged/transferred to a short term general hospital for inpatient care with a planned acute care hospital inpatient readmission (effective 10/1/13)
83	Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (effective 10/1/13)
84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (effective 10/1/13)
85	Discharged/transferred to designated cancer center of children's hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)

Code	Description
86	Discharged/transferred to home under care of organized home health service organization with a planned acute care hospital inpatient readmission (effective 10/1/13)
87	Discharged/transferred to court / law enforcement with a planned acute care hospital inpatient readmission (effective 10/1/13)
88	Discharged/transferred to a federal healthcare facility with a planned acute care hospital inpatient readmission (effective 10/1/13)
89	Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission (effective 10/1/13)
90	Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
91	Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
92	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (effective 10/1/13)
93	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
94	Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
95	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (effective 10/1/13)

Type of Bill - Institutional Codes

Type of Facility – First Digit

Code	Description
1	Hospital
2	Skilled Nursing
3	Home Health
4	Christian Science Hospital
5	Christian Science Extended Care
6	Intermediate Care
7	Clinic
8	Special Facility

Bill Classification – Second Digit if First Digit = 1-6

Code	Description
1	Inpatient (Including Medicare Part A)
2	Inpatient (Medicare Part B Only)
3	Outpatient

Code	Description
4	Other (for hospital referenced diagnostic services or home health not under a plan of treatment)
5	Nursing Facility
6	Nursing Facility Level II
7	Intermediate Care – Level III Nursing Facility
8	Swing Beds

Bill Classification – Second Digit if First Digit = 7

Code	Description
1	Rural Health
2	Hospital Based or Independent Renal Dialysis Center
3	Free Standing Outpatient Rehabilitation Facility (ORF)
5	Comprehensive Outpatient Rehabilitation Facility (ORF)
6	Community Mental Health Center
9	Other

Bill Classification – Second Digit if First Digit = 8

Code	Description
1	Hospice (Non-Hospital Based)
2	Hospice (Hospital-Based)
3	Ambulatory Surgery Center
4	Free Standing Birthing Center
9	Other

Frequency – Third Digit

Code	Description
0	Non-Payment/Zero
1	Admit Through Discharge
2	Interim – First Claim
3	Interim – Continuing Claims
4	Interim – Last Claim
5	Late Charge Only
7	Replacement of Prior Claim
8	Void/Cancel of a Prior Claim
9	Final Claim for a Home Health PPS Episode

Place of Service – Professional Codes

Code	Description
1	Pharmacy
2	Unassigned
3	School
4	Homeless Shelter
5	Indian Health Service Free-Standing Facility
6	Indian Health Service Provider-Based Facility
7	Tribal 638 Free-Standing Facility
8	Tribal 638 Provider-Based Facility
9	Prison/Correctional Facility
10	Unassigned
11	Office
12	Home
13	Assisted Living Facility Congregate
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment-Worksite
19	Unassigned
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgery Center
25	Birthing Center
26	Military Treatment Facility
27-30	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35-40	Unassigned
41	Ambulance – Land
42	Ambulance – Air or Water

Code	Description
43-48	Unassigned
50	Federally Qualified Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-Residential Substance Abuse Treatment Facility
58-59	Unassigned
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63-64	Unassigned
65	End Stage Renal Disease Treatment Facility
66-70	Unassigned
71	State or Local Public Health Clinic
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-98	Unassigned
99	Other Unlisted Facility

Claim Status Codes

Code	Description
01	Processed as primary
02	Processed as secondary
03	Processed as tertiary
04	Denied
06	Approved as amended
19	Processed as primary, forwarded to additional payer(s)
20	Processed as secondary, forwarded to additional payer(s)
21	Processed as tertiary, forwarded to additional payer(s)
22	Reversal of previous payment

Code	Description
26	Documentation Claim - No Payment Associated
28	Repriced

Tooth Surface(s) Codes

Code	Description
B	Buccal
D	Distal
F	Facial
I	Incisal
L	Lingual/Palatal
M	Mesial
O	Occlusal

Appendix B – New Hampshire Sample Passed, Failed, and Catastrophically Failed File Reports

If files fail the quality checker review, the carrier or third-party administrator receives a standard report that highlights (with color codes) the field level failures and/or quality audit failures (as shown in the figures below). These sample reports show the results of both the File Field and the Quality checks.

Note: *The file type will appear in the cell adjacent to the File Name, which is filled with "SampleFile.txt."*

Passed

File Checker Results for Sample Client

Status = PASSED

File Information and Expectations	
File Name	ATM502_2014inpMemberMonths.TXT
File Level Status	Pass
Data Submitter	Sample Client
File Size (bytes)	5,476,953
File Create Date	12/30/2014 2:54:56 PM
File Checker Run On	12/30/2014 3:05:02 PM
Number of Records	29,999
Number of Records Containing At Least One Error	
Checking Duration (in seconds)	19
File type	DELIMITED
Record delimiter	{CR}/{LF}
Number of fields per record	44
Field delimiter	<TAB>
Header records	0
Trailer records	0
Text qualifer	(None)

Test Results Color Scheme Key		
Test Passed! (File will be incorporated into system during next refresh)	Test Failed (File is pending, file resubmission OR exception request needed)	Catastrophic Failure (Data must be resubmitted and file has been deleted)

Field Level Tests

Field Name (Position)	Type	Test Value	Comparison Criteria	File Results	Failures Count	Failure Line Examples (first 10)
Member ID(1)	Max Length	40	>=Percentage 100.00	100.00	0	
Member ID(1)	Min Length	1	>=Percentage 100.00	100.00	0	
Medicare HIC(2)	Max Length	40	>=Percentage 100.00	100.00	0	
Contract ID(3)	Max Length	30	>=Percentage 100.00	100.00	0	
Contract ID(3)	Min Length	1	>=Percentage 100.00	100.00	0	
Year Month(4)	Max Length	6	>=Percentage 100.00	100.00	0	
Year Month(4)	Min Length	6	>=Percentage 100.00	100.00	0	
Year Month(4)	Format (Blanks allowed)	Integer	>=Percentage 100.00	100.00	0	
Dep Code(5)	Format (Blanks allowed)	Integer	>=Percentage 100.00	100.00	0	
Expense3(34)	Format (Blanks allowed)	Money (Decimal)	>=Percentage 100.00	100.00	0	
Expense4(35)	Format (Blanks allowed)	Money (Decimal)	>=Percentage 100.00	100.00	0	
Expense5(36)	Format (Blanks allowed)	Money (Decimal)	>=Percentage 100.00	100.00	0	
Age Sex(37)	Format (Blanks allowed)	Money (Decimal)	>=Percentage 100.00	100.00	0	
PCP(38)	Max Length	40	>=Percentage 100.00	100.00	0	
Managed Population(39)	Max Length	40	>=Percentage 100.00	100.00	0	
Risk Score(40)	Format (Blanks allowed)	Money (Decimal)	>=Percentage 100.00	100.00	0	
Member Status(41)	Max Length	40	>=Percentage 100.00	100.00	0	
UserDefPop1(42)	Max Length	40	>=Percentage 100.00	100.00	0	
UserDefPop2(43)	Max Length	40	>=Percentage 100.00	100.00	0	
UserDefPop3(44)	Max Length	40	>=Percentage 100.00	100.00	0	

Quality Tests

Test Name	Test Description	Low Threshold	File Test Result	High Threshold
Duplicate Membership Check	MedInsight cannot allow duplicate membership, so this test verifies that no member has overlapping member months. Any value greater than zero will crash the system, so we must prevent it.	0.00	0.00	0.00

Failed

File Checker Results for Sample Client

Status = FAILED

File Information and Expectations	
File Name	ATM502_2014impClaims_Good.TXT
File Level Status	Pass
Data Submitter	Sample Client
File Size (bytes)	10,941,441
File Create Date	12/30/2014 2:54:56 PM
File Checker Run On	12/30/2014 3:08:25 PM
Number of Records	29,934
Number of Records Containing At Least One Error	12,070
Checking Duration (in seconds)	52
File type	DELIMITED
Record delimiter	{CR}/{LF}
Number of fields per record	104
Field delimiter	<TAB>
Header records	0
Trailer records	0
Text qualifer	(None)

Test Results Color Scheme Key		
Test Passed! (File will be incorporated into system during next refresh)	Test Failed (File is pending, file resubmission OR exception request needed)	Catastrophic Failure (Data must be resubmitted and file has been deleted)

Field Level Tests

Field Name (Position)	Type	Test Value	Comparison Criteria	File Results	Failures Count	Failure Line Examples (first 10)
SequenceNumber(1)	Format	Integer	>=Percentage 100.00	100.00	0	
ClaimID(2)	Max Length	60	>=Percentage 100.00	100.00	0	
ClaimID(2)	Min Length	1	>=Percentage 100.00	100.00	0	
LineNum(3)	Min Length	1	>=Percentage 100.00	100.00	0	
LineNum(3)	Format	Integer	>=Percentage 100.00	100.00	0	
ContractID(4)	Max Length	30	>=Percentage 100.00	100.00	0	
ContractID(4)	Min Length	1	>=Percentage 100.00	93.20	2,036	30, 31, 32, 33, 34, 35, 36, 37, 38, 39
MemberID(5)	Max Length	40	>=Percentage 100.00	100.00	0	
MemberID(5)	Min Length	1	>=Percentage 100.00	100.00	0	
DOB(6)	Max Length	10	>=Percentage 100.00	100.00	0	
DOB(6)	Format (Blanks allowed)	MM/DD/CCYY (Date)	>=Percentage 100.00	100.00	0	
Gender(7)	Max Length	1	>=Percentage 100.00	100.00	0	
County(97)	Max Length	5	>=Percentage 100.00	100.00	0	
MemberStatus(98)	Max Length	40	>=Percentage 100.00	100.00	0	
UserdefPop1(99)	Max Length	40	>=Percentage 100.00	100.00	0	
UserDefPop2(100)	Max Length	40	>=Percentage 100.00	100.00	0	
UserDefPop3(101)	Max Length	40	>=Percentage 100.00	100.00	0	
UserDefNum1(102)	Format (Blanks allowed)	Money (Decimal)	>=Percentage 100.00	100.00	0	
UserDefNum2(103)	Format (Blanks allowed)	Money (Decimal)	>=Percentage 100.00	100.00	0	
UserDefNum3(104)	Format (Blanks allowed)	Money (Decimal)	>=Percentage 100.00	100.00	0	

Quality Tests

Test Name	Test Description	Low Threshold	File Test Result	High Threshold
Confirm units are compaitble to numeric 10,2	This test will confirm that all units values are between -99,999,999.99 to 99,999,999.99. If any values are not, it will create a major error within MedInsight.	100.00	100.00	100.00
Gender Test	Just a test to show a failure in the quality area	48.00	38.77	52.00
Patient Claims Threshold	This check determines if the data has any patients that are showing more than 79,999 claim lines belonging to them. The HCG grouper has a limitation (80,000) that must be adhered to or the system will not work.	0.00	0.00	0.00

The file contains non-catastrophic issues that have triggered a failure. You may correct the file and resubmit OR request that this file be accepted by submitting an exception request by clicking HERE.

Catastrophically Failed

The first example shows a catastrophically failed file due to critical errors on a number of fields.

File Checker Results for Sample Client

Status = CATASTROPHIC FAILURE

File Information and Expectations	
File Name	ATM502_2014inpClaims_Bad.TXT
File Level Status	Fail
Data Submitter	Sample Client
File Size (bytes)	10,941,450
File Create Date	12/30/2014 2:54:56 PM
File Checker Run On	12/30/2014 3:06:08 PM
Number of Records	29,934
Number of Records Containing At Least One Error	5,312
Checking Duration (in seconds)	40
File type	DELIMITED
Record delimiter	{CR}/{LF}
Number of fields per record	104
Field delimiter	<TAB>
Header records	0
Trailer records	0
Text qualifer	(None)

Test Results Color Scheme Key		
Test Passed! (File will be incorporated into system during next refresh)	Test Failed (File is pending, file resubmission OR exception request needed)	Catastrophic Failure (Data must be resubmitted and file has been deleted)

Field Level Tests

Field Name (Position)	Type	Test Value	Comparison Criteria	File Results	Failures Count	Failure Line Examples (first 10)
SequenceNumber(1)	Format	Integer	>=Percentage 100.00	100.00	0	
ClaimID(2)	Max Length	60	>=Percentage 100.00	100.00	0	
ClaimID(2)	Min Length	1	>=Percentage 100.00	100.00	0	
LineNum(3)	Min Length	1	>=Percentage 100.00	100.00	0	
LineNum(3)	Format	Integer	>=Percentage 100.00	100.00	0	
ContractID(4)	Max Length	30	>=Percentage 100.00	100.00	0	
ContractID(4)	Min Length	1	>=Percentage 100.00	93.20	2,036	30, 31, 32, 33, 34, 35, 36, 37, 38, 39
MemberID(5)	Max Length	40	>=Percentage 100.00	100.00	0	
RevCode(15)	Max Length	4	>=Percentage 100.00	100.00	0	
HCPCS(16)	Max Length	5	>=Percentage 100.00	100.00	0	
Modifier(17)	Max Length	2	>=Percentage 100.00	99.99	2	11403, 12057
Modifier2(18)	Max Length	2	>=Percentage 100.00	100.00	0	
PaidDate(12)	Format	MM/DD/CCYY (Date)	>=Percentage 100.00	100.00	0	
DRG(13)	Max Length	3	>=Percentage 100.00	100.00	0	
DRGVersion(14)	Max Length	5	>=Percentage 100.00	100.00	0	
RevCode(15)	Max Length	4	>=Percentage 100.00	100.00	0	
HCPCS(16)	Max Length	5	>=Percentage 100.00	100.00	0	
Modifier(17)	Max Length	2	>=Percentage 100.00	99.99	2	11403, 12057
Modifier2(18)	Max Length	2	>=Percentage 100.00	100.00	0	
srcPOS(19)	Max Length	10	>=Percentage 100.00	100.00	0	
POS(20)	Max Length	2	>=Percentage 100.00	100.00	0	
POS(20)	Valid Values	Custom List	>=Percentage 100.00	99.84	49	1761, 1762, 3217, 6368, 6369, 6370, 6371, 6372, 6376, 6377
UserDefNum1(102)	Format (Blanks allowed)	Money (Decimal)	>=Percentage 100.00	100.00	0	
UserDefNum2(103)	Format (Blanks allowed)	Money (Decimal)	>=Percentage 100.00	100.00	0	
UserDefNum3(104)	Format (Blanks allowed)	Money (Decimal)	>=Percentage 100.00	100.00	0	

Because the file encountered a catastrophic failure*, there will not be an option to request the file be passed.
* - Catastrophic failures include structural problems with the file, field lengths that fail the maximum length checks, format discrepancies, or scripting errors (Milliman to fix and rerun data on sripting errors only).

The second example shows a catastrophically failed file due to incorrect record delimiters.

File Checker Results for Sample Client

Status = CATASTROPHIC FAILURE

File Information and Expectations	
File Name	ATM502_2014inpClaims_BadLine.TXT
File Level Status	Fail
Data Submitter	Sample Client
File Size (bytes)	10,940,800
File Create Date	12/30/2014 2:54:56 PM
File Checker Run On	12/30/2014 3:07:36 PM
Number of Records	29,934
Number of Records Containing At Least One Error	8
Checking Duration (in seconds)	2
File type	DELIMITED
Record delimiter	{CR}/{LF}
Number of fields per record	104
Field delimiter	<TAB>
Header records	0
Trailer records	0
Text qualifer	(None)

Failure Reason:

1. There were 2 records that did not have the correct number of fields. The following is a list of up to 10 line numbers (and the incorrect record length) where record length failed: 51(8), 24(8).

Test Results Color Scheme Key		
Test Passed! (File will be incorporated into system during next refresh)	Test Failed (File is pending, file resubmission OR exception request needed)	Catastrophic Failure (Data must be resubmitted and file has been deleted)

Field Level Tests						
Field Name (Position)	**Type**	**Test Value**	**Comparison Criteria**	**File Results**	**Failures Count**	**Failure Line Examples (first 10)**
SequenceNumber(1)	Format	Integer	>=Percentage 100.00	100.00	0	
ClaimID(2)	Max Length	60	>=Percentage 100.00	100.00	0	
ClaimID(2)	Min Length	1	>=Percentage 100.00	100.00	0	
LineNum(3)	Min Length	1	>=Percentage 100.00	100.00	0	
LineNum(3)	Format	Integer	>=Percentage 100.00	100.00	0	
Days(39)	Max Length	12	>=Percentage 100.00	100.00	0	
Days(39)	Format (Blanks allowed)	Money (Decimal)	>=Percentage 100.00	100.00	0	
Units(40)	Format (Blanks allowed)	Money (Decimal)	>=Percentage 100.00	100.00	0	
DischargeStatus(41)	Max Length	2	>=Percentage 100.00	100.00	0	
DischargeStatus(41)	Valid Values	Custom List	>=Percentage 100.00	99.97	8	2, 3, 4, 5, 20, 21, 22, 23
ICDVersion(42)	Max Length	2	>=Percentage 100.00	100.00	0	
AdmitDiag(43)	Max Length	7	>=Percentage 100.00	100.00	0	
ICDDiag1(44)	Max Length	7	>=Percentage 100.00	100.00	0	
ICDDiag2(45)	Max Length	7	>=Percentage 100.00	100.00	0	
ICDDiag3(46)	Max Length	7	>=Percentage 100.00	100.00	0	
UserDefPop2(100)	Max Length	40	>=Percentage 100.00	100.00	0	
UserDefPop3(101)	Max Length	40	>=Percentage 100.00	100.00	0	
UserDefNum1(102)	Format (Blanks allowed)	Money (Decimal)	>=Percentage 100.00	100.00	0	
UserDefNum2(103)	Format (Blanks allowed)	Money (Decimal)	>=Percentage 100.00	100.00	0	
UserDefNum3(104)	Format (Blanks allowed)	Money (Decimal)	>=Percentage 100.00	100.00	0	

Because the file encountered a catastrophic failure*, there will not be an option to request the file be passed.
* - Catastrophic failures include structural problems with the file, field lengths that fail the maximum length checks, format discrepancies, or scripting errors (Milliman to fix and rerun data on sripting errors only).

Appendix C – New Hampshire Exception Request Process

In order to request an exception, a carrier or third-party administrator must complete the following form. In this form, the data submitter can either request an exception for the entire file, or can request exceptions for one or more failed data elements.

Sample Client

Exception Request System

File Particulars

Data Supplier Name **Atmosphere Client #502**
File Name **ATM502_2014inpClaims_Good.TXT**
Records **29,934**
File Date **Dec 30 2014 2:54:56PM**
File Checked **Dec 30 2014 3:08:25PM**

The file listed above has issues that are keeping it from entering the system. These issues, however, are not fatal and deal only with potential data quality issues. Once you have verified that the data are being pulled appropriately and have determined that the data are of the highest attainable quality, you may either request that the thresholds be changed using the form "Threshold Exceptions Request" OR simply request that this file be passed (without any changes to the thresholds) by using the form at the bottom of the page labelled "File Exception Request". (Click here to take you to the bottom of the page)

Threshold Exceptions Request

Below is a list of all thresholds that were not met by the file. You may request that thresholds be changed for this and future files by completing the form.

- Check the box to indicate you're requesting an threshold change for that test
- Fill in the new threshold value(s)
- You may enter optional notes to help explain why this threshold change is needed.
- Click the submit button.
- Your request will be sent on and reviewed and the system will notify you of the final decision.

Please note that this system will allow you to request multiple threshold changes. New requests will always overwrite previous requests.

Field Level Failures

Field Name (Position) Click to view history	Test Type	Current Threshold	Comparison Criteria	File Results	Request Exception	Threshold Requested	Exception Notes
ContractID (4)	Minimum Length	100.0000	>=Percentage	93.198	☐		
POS (20)	Valid Values	100.0000	>=Percentage	99.319	☐		
DischargeStatus (41)	Valid Values	100.0000	>=Percentage	62.872	☐		

Quality Failures

Name	Description	MIN Threshold	File Results	MAX Threshold	Request Exception	Thresholds Requested Minimum - Maximum		Exception Notes
Gender Test	Just a test to show a failure in the quality area	48.00	38.77	52.00	☐			

You may add notes in the following input box that will be presented to the reviewer. Use this space to make any suggestions as to why the file as a whole should be passed.

Request Threshold Changes

File Exception Request

To request the file be passed without changing the thresholds, simply add notes explaining why and then click the "Request File Exception" button. The system will keep you up to date on the status of your request.

Request File Exception

Each field/test has a hyperlink that will, when clicked, open a new internet browser window and show the history of that test for that supplier throughout all submissions captured in this system (see below). Using this information, the data supplier can make an informed decision on whether or not to request a threshold adjustment.

Atmosphere Client #502

Historical Results Page

Data Supplier = Atmosphere Client #502

Means and Standard Deviations

Scope	Average (Mean)	Standard Deviation
Atmosphere Client #502 files only	99.32	0.00
All data suppliers	99.32	0.00

Individual File Results

File Name	Date Checked	Field Name	Type	Test Value	Comparison Criteria	File Results
ATM502_2014inpClaims_Good.TXT	12/30/2014	POS	Valid Values	Custom List	>=Percentage 100.00	99.32
ATM502_2014inpClaims_Good.TXT	12/30/2014	POS	Valid Values	Custom List	>=Percentage 100.00	99.32