| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Control Header - 3.0.1 | | | | | | |
|---|---|---|---|---|---|---|
| **CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Valid Values** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLHD001 | Record Type | char | 2 | HD. | Required | 100% |
| CDLHD002 | Data Submitter Code | varchar | 8 | APCD-assigned identifier of payor submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payor. | Required | 100% |
| CDLHD003 | Payor Code | int | 8 | APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). | Required | 100% |
| CDLHD004 | Data Submitter Name | varchar | 150 | Name of data submitter. | Required | 100% |
| CDLHD005 | File Type | char | 2 | ME = Member Eligibility; MC = Medical Claims; PC = Pharmacy Claims; DC = Dental Claims; PV = Provider File. | Required | 100% |
| CDLHD006 | Period Beginning Date | date | 6 | CCYYMM. Beginning of period covered for Eligibility. Beginning of paid/adjudicated period for claims. Beginning of period for Provider file updates. | Required | 100% |
| CDLHD007 | Period Ending Date | date | 6 | CCYYMM. End of period covered for Eligibility. End of paid/adjudicated period for claims. End of period for Provider file updates. | Required | 100% |
| CDLHD008 | Test File Flag | char | 1 | T = File submitted is a test file; P = File submitted is a production file. | Required | 100% |
| CDLHD009 | Comments | varchar | 50 | Comments. | Not Required | |
| CDLHD010 | APCD-CDL™ Version Number | varchar | 8 | The version of the APCD-CDL used to produce this file (e.g., 3.0.1) | Required | 100% |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Control Trailer - 3.0.1 | | | | | | |
|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Valid Values** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLTR001 | Record Type | char | 2 | TR | Required | 100% |
| CDLTR002 | Data Submitter Code | varchar | 8 | APCD-assigned identifier of payor submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payor. | Required | 100% |
| CDLTR003 | Payor Code | int | 8 | APCD-assigned identifier of insurer/underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). | Required | 100% |
| CDLTR004 | Data Submitter Name | varchar | 150 | Name of data submitter. | Required | 100% |
| CDLTR005 | File Type | char | 2 | ME = Member Eligibility; MC = Medical Claims; PC = Pharmacy Claims; DC= Dental Claims; PV = Provider File. | Required | 100% |
| CDLTR006 | Extraction Date | date | 8 | CCYYMMDD; Date file was created. | Required | 100% |
| CDLTR007 | Control Total of Paid Amount | int | 15 | Medical (MC), Pharmacy (PC), and Dental (DC) claims files only. Provide total paid dollars submitted in the file. Control total for each file<br><br>(CDLMC125, CDLPC037, CDLDC060). Eligibility and provider file blank.<br><br>Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | Required | 100% |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Control Trailer - 3.0.1 | | | | | | |
|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Valid Values** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLTR008 | Record Count | int | 10 | Total number of records submitted in the file, excluding header and trailer records. | Required | 100% |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment - 3.0.1 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **271 and 834 ASC X12 References** | **Data Submitter Relevancy** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLME001 | Data Submitter Code | varchar | 8 | Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). | N/A | All | Required | 100% |
| CDLME002 | Payor Code | int | 8 | APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). | N/A | All | Required | 100% |
| CDLME003 | Plan ID | varchar | 30 | CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER) | 271/2100A/NM1/XV/09 | All | Optional | |
| CDLME004 | Member Insurance/Product Category Code | char | 2 | See Appendix G-1: Insurance/Product Category for codes. Use the most granular choice available.<br><br>[Used in accurate comparison and reporting of costs and utilization] | 271/2110D/EB//04 | All | Required | 90% |
| CDLME005 | Start Year of Submission | int | 4 | The year for which eligibility is reported in this submission file. CCYY. Expressed in terms of calendar year.<br><br>[Used in reporting by date and determination of continuous enrollment] | N/A | All | Required | 100% |
| CDLME006 | Start Month of Submission | int | 2 | The month for which eligibility is reported in this submission file expressed numerical from 01 to 12.<br><br>[Used in reporting by date and determination of continuous enrollment] | N/A | All | Required | 100% |
| CDLME007 | Insured Group or Policy Number | varchar | 50 | The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. ME006 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, leave blank. If a policy is sold to an individual as a non-group policy, then report with a value of "IND". | 271/2100C/ REF/1L/02, 271/2100C/REF/ IG/02, 271/2100C/ REF/6P/02, 271/2100D/ REF/1L/02, 271/2100D/REF/ IG/02, 271/2100D/ REF/6P/02 | Commercial and Dental | Required | 80% |
| CDLME008 | Coverage Level Code | char | 3 | Benefit coverage level selected: CHD = Children Only; DEP = Dependents Only; ECH =Subscriber and Children/Dependents; EMP = Subscriber Only; ESP = Subscriber and Spouse/Life Partner; FAM = Family; SPC = Spouse/Life Partner and Children/Dependents; SPO = Spouse/Life Partner Only. | 271/2110C/EB//02, 271/2110D/EB//02 | Commercial and Dental | Required | 80% |
| CDLME009 | Medicaid AID Category | char | 4 | For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the State's Medicaid agency. If not applicable, leave blank. PROVIDE STATE MEDICAID PROGRAM CODE HERE.<br><br>[Medicaid only eligibility Program Codes which indicate benefit] | N/A | Medicaid Only | Required | 50% |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment - 3.0.1 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **271 and 834 ASC X12 References** | **Data Submitter Relevancy** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLME010 | Subscriber Social Security Number | char | 9 | Subscriber's Social Security Number – do not include dashes. Required if collected. If not available, leave blank.<br><br>[Used as a unique identifier and important to the master patient index] | 271/2100C/REF/SY/02 | All | Required IF Available | |
| CDLME011 | Plan Specific Contract Number | varchar | 80 | Plan assigned contract number. If Plan Specific Contract Number is the subscriber's Social Security Number, leave blank. If this is a Medicaid ~~claim~~ eligibility record, provide Medicaid ID. | 271/2100C/NM1 09 | All [~~Commercial Only~~] | Required | 60% |
| CDLME012 | Subscriber Last Name | varchar | 100 | The subscriber's last name.<br><br>[Used in Master Patient Index] | 271/2100C/NM1 03 | All | Required | 100% |
| CDLME013 | Subscriber First Name | varchar | 100 | The subscriber's first name.<br><br>[Used in Master Patient Index] | 271/2100C/NM1 04 | All | Required | 100% |
| CDLME014 | Subscriber Middle Initial | char | 1 | The subscriber's middle initial.<br><br>[Used in the Master Patient Index] | 271/2100C/NM1 05 | All | Required IF Available | |
| CDLME015 | Sequence Number | varchar | 20 | Unique number of the member within the contract. When the member is the subscriber use subscriber sequence number. | N/A | Commercial and Dental | Required | 100% |
| CDLME016 | Member Social Security Number | char | 9 | Member's Social Security Number – do not include dashes. Required if collected. If not available, leave blank.<br><br>[Used as a unique identifier and important to the master patient index] | 271/2100C/REF02 where REF01=SY; 271/2100D/REF02 where REF01=SY | All | Required IF Available | |
| CDLME017 | Individual Relationship Code | char | 2 | Member's relationship to insured. Individual Relationship Code is maintained by ANSI ASC X12. See Appendix H: External Code Source, Accredited Standards Committee.<br><br>[Used in the Master Patient Index] | 271/2100C/INS/Y/02, 271/2100D/INS/N/02 If subscriber is patient, then use 2010BA, otherwise, use 2010CA for all related references for "member" | Commercial and Dental | Required | 90% |
| CDLME018 | Member Sex | char | 1 | Sex of the member. M = Male; F = Female; U = UNKNOWN. Member sex represents biological or administrative sex. Where available, submitters should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, submitters may provide the values they have access to regarding physical or legal sex (e.g., administrative sex as categorized by X12 values).<br>[Used in the Master Patient Index] | 271/2100C/DMG//03, 271/2100D/DMG//03 | All | Required | 90% |
| CDLME019 | Member Date of Birth | date | 8 | Date of birth of the member. CCYYMMDD.<br><br>[Used in the Master Patient Index] | 271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02 | All | Required | 90% |
| CDLME020 | Member Last Name | varchar | 100 | The member's last name. If the member is the subscriber, report the subscriber's last name.<br><br>[Used in the Master Patient Index] | 271/2100C/NM1 03; 271/2100D/NM1 03 | All | Required | 100% |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment - 3.0.1 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **271 and 834 ASC X12 References** | **Data Submitter Relevancy** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLME021 | Member First Name | varchar | 100 | The member's first name. If the member is the subscriber, report the subscriber's first name.<br><br>[Used in the Master Patient Index] | 271/2100C/NM1 04;<br>271/2100D/NM1 04 | All | Required | 100% |
| CDLME022 | Member Middle Initial | char | 1 | The member's middle initial. If the member is the subscriber, report the subscriber's middle initial.<br><br>[Used in the Master Patient Index] | 271/2100C/NM1 05;<br>271/2100D/NM1 05 | All | Required IF Available | |
| CDLME023 | Member Street Address | varchar | 255 | Street address of member's residence. If the member is the subscriber, report the street address of the subscriber's residence.<br><br>[Used in the Master Patient Index] | 271/2100C/N3/01;<br>271/2100D/N3/01 | All | Required | 60% |
| CDLME024 | Member City Name | varchar | 100 | City location of member's residence. If the member is the subscriber, report the city location of the subscriber's residence.<br><br>[Used in the Master Patient Index] | 271/2100C/N4//01,<br>271/2100D/N4//01 | All | Required | 60% |
| CDLME025 | Member State or Province | char | 2 | State or Province of member's residence. If the member is the subscriber, report the state or province of the subscriber's residence. State or Province codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service.<br><br>[Used in the Master Patient Index] | 271/2100C/N4//02,<br>271/2100D/N4//02 | All | Required | 80% |
| CDLME026 | Member ZIP Code | varchar | 9 | Report the 5- or 9-digit Zip Code of the member's residence. If the member is the subscriber, report the Zip Code of the subscriber's residence. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the U.S. Postal Service. See Appendix H: External Code Sources. | 271/2100C/N4//03,<br>271/2100D/N4//03 | All | Required | 80% |
| CDLME027 | Member FIPs County Code | char | 5 | Report the FIPS county code based on the member's residential address. The FIPS county code is a five-digit Federal Information Processing Standard (FIPS) code (FIPS 6-4) consisting of a 2-digit state FIPS code followed by a 3-digit county FIPS code which uniquely identifies counties and county equivalents in the United States, certain U.S. possessions, and certain freely associated states. If member lives outside U.S., leave blank. See Appendix H: External Code Source, United States Census Bureau. | N/A | All | Optional | |
| CDLME028 | Member Country Code | char | 2 | Country code of member's residence. Report two-digit code. Code ~~U.S.~~ US for United States. See Appendix H: External Code Source, United States Postal Service. | N/A | All | Optional | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment - 3.0.1 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **271 and 834 ASC X12 References** | **Data Submitter Relevancy** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLME029 | Race 1 | varchar | 2 | Report the member-identified race. The code value "UN" (unknown/not specified), should be used ONLY when member answers unknown or refuses to answer. Report only collected data. If not available leave blank. See Appendix TX-1: Race 1/Race 2 for codes. See also Appendix H: External Code Sources, Centers for Disease Control and Prevention<br><br>[Used in the Master Patient Index] | N/A | All | Required IF Available | |
| CDLME030 | Race 2 | varchar | 2 | Report the member-identified race. The code value "UN" (unknown/not specified), should be used ONLY when member answers unknown or refuses to answer. Report only collected data. If not available leave blank. See Appendix TX-1: Race 1/Race 2 for codes. See also Appendix H: External Code Sources, Centers for Disease Control and Prevention<br><br>[Used in the Master Patient Index] | N/A | All | Not Required | |
| CDLME031 | Race 3 | varchar | 2 | Report the member-identified race. The code value "UN" (unknown/not specified), should be used ONLY when member answers unknown or refuses to answer. Report only collected data. If not available leave blank. See Appendix TX-1 [~~G-2~~]: Race 1/Race 2 for codes. See also Appendix H: External Code Sources, Centers for Disease Control and Prevention<br><br>[Used in the Master Patient Index] | N/A | All | Not Required | |
| CDLME032 | Hispanic Indicator | char | 1 | Report the value that defines the element. The code value "U" for unknown, should be used ONLY when member answers unknown, or refuses to answer. Report only collected data. If not available leave blank. Y = Member is Hispanic/Latino/Spanish; N = Member is not Hispanic/Latino/Spanish; U = unknown/not specified. | N/A | All | Required IF Available | |
| CDLME033 | Ethnicity 1 | varchar | 6 | Report the member-identified ethnicity from the External Code Source that best describes the information obtained from the member/subscriber. The value "UNKNOW" should be used ONLY when the member answers unknown or refuses to answer. Report only collected data. If not available leave blank. Ethnicity codes are maintained by the Centers for Disease Control and Prevention. See Appendix H: External Code Sources, Centers for Disease Control and Prevention. | N/A | All | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment - 3.0.1 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **271 and 834 ASC X12 References** | **Data Submitter Relevancy** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLME034 | Ethnicity 2 | varchar | 6 | Report the member-identified ethnicity from either the External Code Source that best describes the information obtained from the member/subscriber. The value "UNKNOW" should be used ONLY when the member answers unknown or refuses to answer. Report only collected data. If not available leave blank. See Appendix H in the Data Submission Guide: External Code Sources, Centers for Disease Control and Prevention. | N/A | All | Optional | |
| CDLME035 | Other Ethnicity | varchar | 6 | Report the member-identified ethnicity from either the External Code Source that best describes the information obtained from the member/subscriber. The value "UNKNOW" should be used ONLY when the member answers unknown or refuses to answer. Report only collected data. If not available leave blank. Ethnicity codes are maintained by the Centers for Disease Control and Prevention. See Appendix H: External Code Sources, Centers for Disease Control and Prevention. | N/A | All | Optional | |
| CDLME036 | Medical Coverage Under This Plan | char | 1 | Use this field to indicate whether medical coverage is part of this member's plan. (Note: medical coverage may be bundled with other types of coverage.) Medical coverage includes any type of coverage besides prescription drug. Y = Yes; N = No. | N/A | All | Required | 90% |
| CDLME037 | Pharmacy Coverage Under This Plan | char | 1 | Use this field to indicate whether pharmacy coverage is part of this member's plan. (Note: pharmacy coverage may include prescription drugs, supplies, and DME; and may be bundled with other types of coverage.) Y = Yes; N = No. | N/A | All | Required | 90% |
| CDLME038 | Dental Coverage Under This Plan | char | 1 | Use this field to indicate whether dental coverage is part of this member's plan. (Note: dental coverage may be bundled with other types of coverage.) Y = Yes; N =No. | N/A | All | Required | 90% |
| CDLME039 | Behavioral Health Coverage Under This Plan | char | 1 | Use this field to indicate whether behavioral health coverage is part of this member's plan. (Note: behavioral health coverage may be bundled with other types of coverage.) Valid codes include: Y = Yes; N = No. | N/A | All | Required | 90% |
| CDLME040 | Primary Insurance Indicator | char | 1 | Use this field to report whether the policy for this eligibility record is the primary insurance for the member. Y = Yes, primary insurance; N = No, this is not the member's primary insurance.<br><br>[To identify coordination of benefits where applicable] | N/A | Commercial Only | Required | 100% |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment - 3.0.1 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **271 and 834 ASC X12 References** | **Data Submitter Relevancy** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLME041 | Coverage Type | char | 3 | This field identifies which entity holds the risk: ASW = Self-funded plans administered by a TPA, where the employer has purchased stop-loss, or group excess insurance coverage; ASO = Self-funded plans administered by a TPA, where the employer has not purchased stop-loss, or group excess insurance coverage; STN = Short-term, non-renewable health insurance (e.g., COBRA); UND = Plans underwritten by the insurer (fully insured group and individual policies); MEW = Associations/Trusts and Multiple Employer Welfare Arrangements; OTH = Any other plan (for example – student health plan). Insurers using this code shall obtain prior approval.<br><br>[To identify plans for proper comparison] | N/A | Commercial Only | Required | 50% |
| CDLME042 | Plan State | char | 2 | State in which the plan is sold/sitused. State or Province codes are maintained by the U.S. Postal Service. See Appendix H: External Code Sources, United States Postal Service. | N/A | Commercial Only | Not Required | |
| CDLME043 | Market Category Code | varchar | 4 | Code for identifying market category. See Appendix G-2 [~~G-3~~]: Market Category Codes which defines the market category by size and or association to which the policy is directly sold and issued. Report subscribers (not employees). | N/A | Commercial Only | Optional | |
| CDLME044 | Special Coverage | varchar | 6 | Reserved for specific state coverage. 0 = Not applicable; XXXXXX = Specific state coverage. | N/A | | Not Required | |
| CDLME045 | Group Name | varchar | 150 | Name of the group which is covering the member (the name established in the payor's system and not the full legal name). If the member is part of a group of one, or non-group, then use IND. If member is in a market plan use MKT FOR MEDICAID REPORT THE NAME OF THE MCO<br><br>[Not to be used in public reporting, but for possible use in research] | N/A | All | Required | 60% |
| CDLME046 | Member PCP ID | varchar | 35 | Unique code identified for the Primary Care Provider (PCP). This should be the identifier used by the payor for internal identification purposes and does not routinely change. Must map to the payor Assigned Provider ID (CDLPV004) in the Provider File. If not applicable, leave blank. | N/A | All Except Dental | Required IF Available | |
| CDLME047 | NPI of Member's PCP | char | 10 | NPI of the member's Primary Care Provider. If not applicable, leave blank. | N/A | All Except Dental | Required IF Available | |
| CDLME048 | PCP Assignment | char | 1 | 1 = PCP in CDLME046 was selected by the member; 2 = PCP in CDLME046 was attributed by the health plan; 3 = PCP is not selected, and no services rendered; 4 = PCP is not assigned/unknown. | N/A | All Except Dental | Required IF Available | |
| CDLME049 | Member PCP Effective Date | date | 8 | Primary Care Provider Effective Date with member if CDLME048 = 1 or 2 (PCP Assignment). Report the date in CCYYMMDD format. If not applicable, leave blank. | N/A | All Except Dental | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment - 3.0.1 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **271 and 834 ASC X12 References** | **Data Submitter Relevancy** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLME050 | Plan Effective Date | date | 8 | CCYYMMDD. Effective date of coverage; Date eligibility started for this member under this plan type. The purpose of this data element is to maintain an eligibility span for each member.<br><br>[To be used to identify enrollment span and continuous enrollment] | N/A | All | Required | 90% |
| CDLME051 | Plan Term Date | date | 8 | CCYYMMDD. Last continuous day of coverage (date eligibility ended) for this member under this plan. The purpose of this data element is to maintain an eligibility span for each member. For open contracts, leave blank.<br><br>[To be used to identify enrollment span and continuous enrollment] | N/A | All | Required IF Available | |
| CDLME052 | HIOS Plan Indicator | varchar | 1 | For Non-grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Is the member enrolled in a Health Insurance Oversight System plan? 1 = Yes; 2 = No; 3 = Unknown/Not Applicable. | N/A | Commercial | Not Required | |
| CDLME053 | HIOS Plan ID | varchar | 16 | For Non-grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Health Insurance Oversight System ID. Required for qualified health plans (QHPs) as defined in the Patient Protection and Affordable Care Act (ACA). If CDLME052 is NOT = 1 or 2, leave blank. The HIOS Plan ID (Standard Component) includes a five-digit issuer ID, two-character state ID, three-digit product number, four-digit standard component number and two-digit variant component ID. This field may not be available for all market segments. If not applicable, leave blank. | N/A | Commercial | Not Required | |
| CDLME054 | Metal Tier | char | 1 | For Non-grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Health benefit plan metal tier for qualified health plans (QHPs) and catastrophic plans as defined in the Patient Protection and Affordable Care Act, Public Law 111-148, Section 1302: Essential Health Benefits Requirements: 0 = Not a QHP or catastrophic plan; 1 = Catastrophic; 2 = Bronze; 3 = Silver; 4 = Gold; 5 = Platinum. If not applicable, leave blank. | N/A | Commercial Only | Required IF Available | |
| CDLME055 | Medical Home Indicator | char | 1 | Use this field to report whether the member had a medical home on record for this coverage period. If not stored in payor system, use code '3'. Valid codes include: 1 = Yes; 2 = No; 3 = Unknown/Not Applicable. | N/A | Commercial Only | Not Required | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment - 3.0.1 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **271 and 834 ASC X12 References** | **Data Submitter Relevancy** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLME056 | Payor Assigned ID for Medical Home | varchar | 30 | Unique code identified for the Medical Home (as assigned by the reporting entity). Payor assigned ID for the Medical Home is for the Medical Home to which the member belongs. Payor assigned ID for the Medical Home is the identifier used by the payor for internal identification purposes and does not routinely change. Must correspond to a payor Assigned Provider ID (CDLPV004) in the Provider File. If not applicable, leave blank. | N/A | Commercial Only | Not Required | |
| CDLME057 | Enrolled Through a Public Health Insurance Exchange | char | 1 | For Non-grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Use this field to report whether the policy for this eligibility record was enrolled through a Public Health Insurance Exchange. Valid codes include: 1 = Yes; 2 = No; 3 = Unknown/Not Applicable. | N/A | Commercial Only | Not Required | |
| CDLME058 | Employer Tax ID | varchar | 10 | Subscriber's employer EIN or SSN. If coverage not purchased through or enrolled by an employer, leave blank. If not received leave blank. | N/A | Commercial and Dental | Required IF Available | |
| CDLME059 | Employment Status | char | 1 | Report the code that defines the employment status of the member/subscriber: If the member is a dependent report the status of the subscriber. A = Active; I = Involuntary Leave; P = Pending; R = Retiree; Z = Unemployed; U = Unknown; C = COBRA.<br><br>[Important to identify the member/subscriber employment status and important in relation to plan] | N/A | Commercial and Dental | Required IF Available | |
| CDLME060 | Employer ZIP Code | varchar | 9 | Report the 5- or 9-digit ZIP Code of the employer (as reported in CDLME058). When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. If coverage not purchased through or enrolled by an employer, leave blank. ZIP Codes are maintained by the U.S. Postal Service. See Appendix H: External Code Source. | N/A | Commercial and Dental | Optional | |
| CDLME061 | Carrier Specific Unique Member ID | varchar | 50 | Report the identifier the carrier/submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's/submitter's files for reporting and aggregation.<br><br>[Used as an alternative unique ID when SSN is not available] | N/A | Commercial and Dental | Required | 95% |
| CDLME062 | Carrier Specific Unique Subscriber ID | varchar | 50 | Report the identifier the carrier/submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's/submitter's files for reporting and aggregation. If the member is the subscriber, report the Member ID.<br><br>[Used as an alternative unique ID when SSN is not available] | N/A | Commercial and Dental | Required | 95% |
| CDLME063 | NAIC ID | char | 5 | Report the NAIC Code associated with the entity that maintains this product. Leave blank if entity does not have a NAIC Code. See Appendix H: External Code Source; NAIC codes are maintained by the National Association of Insurance Commissioners. | N/A | Commercial and Dental | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment - 3.0.1 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **271 and 834 ASC X12 References** | **Data Submitter Relevancy** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLME064 | High Deductible Plan Indicator | char | 1 | High deductible plan as defined by the IRS at start of plan year. Valid codes include: Y = Yes; N = No; U = Unknown.<br><br>[Important distinction for reporting costs and utilization] | N/A | Commercial Only | Required | 100% |
| CDLME065 | Total Monthly Premium Amount | int | 12 | For fully-insured premiums, report the monthly fee paid by a subscriber and/or employer for health insurance coverage for a given number of members (e.g., individual, individual plus one, family), prior to any medical loss ratio rebate payments, but inclusive of any fees paid to a third party (e.g., exchange fees, reinsurance). Report the total monthly premium at the Subscriber level only. Do not report on member lines. Report 0 if no premium is charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | N/A | | Not Required | |
| CDLME066 | Actuarial Value | dec | 6, 4 | For Non-grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Report value as calculated in the most recent version of the HHS Actuarial Value Calculator. Include decimal point with reported value. Format to be used is 0.0000. For example, an AV of 88.27689% should be reported as 0.8828. Required as of January 1, 2014, for small group and non-group (individual) plans sold inside or outside the Exchange. If not applicable, leave blank. See Appendix H: External Code Source, Centers for Medicaid and Medicare Services. | N/A | | Not Required | |
| CDLME067 | Grandfathered Plan Indicator | char | 1 | Indicates if a plan qualifies as a "grandfathered" or "transitional plan" under the Affordable Care Act (ACA). Please see definition for "grandfathered" and "transitional" in HHS rules 45-CFR-147.140: https://www.federalregister.gov/select citation/2013/06/03/45-CFR-147. The values of the indicator are as follows: 1 = Grandfathered; 2 = Non-grandfathered; 3 = Transitional; 4 = Not Applicable. | N/A | | Not Required | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment - 3.0.1 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **271 and 834 ASC X12 References** | **Data Submitter Relevancy** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLME068 | Cost-Sharing Reduction Indicator | char | 1 | For Non-grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Indicates cost-sharing reduction under the Affordable Care Act (ACA). This is a person-level indicator in which enrollees who qualify for cost-sharing reduction are assigned cost-sharing indicator values of 1–8. Non-cost-sharing recipients are assigned a cost-sharing indicator value of zero. Valid codes include: 1 = Enrollees in 94% Actuarial Value (AV) Silver Plan Variation; 2 = Enrollees in 87% AV Silver Plan Variation; 3 = Enrollees in 73% AV Silver Plan Variation; 4 = Enrollees in Zero Cost Sharing Plan Variation of Platinum Level Qualified Health Plan (QHP); 5 = Enrollee in Zero Cost Sharing Plan Variation of Gold Level QHP; 6 = Enrollee in Zero Cost Sharing Plan Variation of Silver Level QHP; 7 = Enrollee in Zero Cost Sharing Plan Variation of Bronze Level QHP; 8 = Enrollee in Limited Cost Sharing Plan Variation; 0 = Non-CSR recipient, and enrollees with unknown CSR. | N/A | Commercial Only | Required IF Available | |
| CDLME069 | Administrative Service Fees | int | 12 | Administrative Service Fees (ASFs): Average monthly fee paid by an employer to cover its self-insured health plan administration, excluding any stop-loss premiums, and divided by the number of members under administration. Administrator services for these fees may vary, including plan design and network access, claims adjudication and administration, and/or population health management. Primary reporting goal will be to monitor self-insured coverage costs over time, using ASFs as one component of a "premium equivalent." Report 0 if no fee is charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Required when CDLME041 = ASW or ASO. | N/A | Commercial Only | Not Required | |
| CDLME070 | Tiered Network | char | 1 | Tiered Network: Plans that segment their provider networks into tiers, with tiers typically based on differences in the quality and/or the cost of care provided. Tiers are not considered separate networks, but rather sub-segments of a payor's HMO or PPO network. A tiered network is different than a plan only splitting benefits by in-network vs. out-of-network; a tiered network will have varying degrees of payments of in-network providers. Report the code that defines the tier network of the member/subscriber plan: 0 = Limited Network; 1 = Single Tier-Not Tiered; 2 = Two Tier; 3 = Three Tier; 4 = Four Tier; 5 = Other. | N/A | Commercial Only | Not Required | |
| CDLME071 | Member Income Frequency Code | char | 1 | Report the frequency for the member income as reported at enrollment: 1 = Weekly; 2 = Bi-Weekly; 3 = Semi-Monthly; 4 = Monthly; 6 = Daily; 7 = Annually; 8 = Two calendar months; 9 = Lump sum separation allowance. | 834/2100A/ICM/01 | Commercial Only | Not Required | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment - 3.0.1 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **271 and 834 ASC X12 References** | **Data Submitter Relevancy** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLME072 | Member Income Monetary Amount | int | 12 | Member's income as reported during enrollment. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | 834/2100A/ICM/02 | Commercial Only | Not Required | |
| CDLME073 | Member Primary Language | char | 3 | Report the primary language of the member. See Appendix H: External Code Source, ISO 639 Language Codes. | 834/2100/LUI/02 | All | Not Required | |
| CDLME074 | Subscriber Medicare Beneficiary Identifier | varchar | 11 | Subscriber's Medicare Beneficiary Identifier. Required only for Medicare Supplemental/Companion Plans. Otherwise, leave blank. ALSO REQUIRED FOR DUAL ELIGIBLES AND MEDICARE ADVANTAGE PLANS.<br><br>[Required for linkage to Medicare] | 271/2100A/NM1/08 | All Except Dental | Not Required | |
| CDLME075 | Member Medicare Beneficiary Identifier | varchar | 11 | Member's Medicare Beneficiary Identifier. Required only for Medicare Supplemental/Companion Plans for which 1) the subscriber and the member are not the same person, 2) the payor is primary. Otherwise, leave blank. ALSO REQUIRED FOR DUAL ELIGIBLES AND MEDICARE ADVANTAGE PLANS.<br><br>[Required for linkage to Medicare, only required if Medicare eligible] | 271/2100A/NM1/08 | All Except Dental | Required IF Available | |
| CDLME076 | ACO Identifier | varchar | 30 | APCD agencies will provide guidance as to what values are to be reported in this field. | CDLPV029 | | Not Required | |
| CDLME077 | ACO Name | varchar | 60 | APCD agencies will provide guidance as to what values are to be reported in this field. | CDLPV030 | | Not Required | |
| CDLME078 | Physician Organization Identifier | varchar | 30 | For managed care members assigned a PCP, the identifier of the physician group or provider organization or to which the PCP belongs. APCD agencies may provide state-specific guidance on what IDs to use. | CDLPV031 | Commercial Only | Optional | |
| CDLME079 | Vision Coverage Indicator | char | 1 | Use this field to indicate whether vision coverage is part of this member's plan. (Note: vision coverage may be bundled with other types of coverage.)<br>Y=Yes;<br>N=No. | N/A | Commercial Only | Required IF Available | |
| CDLME080 | Financial Risk Type | int | 1 | Indicate the type of capitated financial risk contract(s) for a member to the member eligibility file, including the following values:<br>1=Professional capitation only (no facility capitation);<br>2=Facility capitation only (no professional capitation);<br>3=Professional and facility capitation (plan has separate capitation contracts for professional services (with PO) and facility costs (generally with hospital));<br>4=Global capitation (single contract with PO for both professional and facility);<br>5=No capitation, fee-for-service only;<br>6=Other. | N/A | | Required IF Available | |
| CDLME081 | [Placeholder] | varchar | | [Placeholder] | N/A | | Not Required | |
| CDLME082 | [Placeholder] | varchar | | [Placeholder] | N/A | | Not Required | |
| CDLME083 | Member Street Address 2 | varchar | 150 | Street address of member's residence. If the member is the subscriber, report the street address of the subscriber's residence. | N/A | | Required IF Available | |
| CDLMEXXX | Un-assigned | char | 1 | Reserved for future use. Elements will only be added with review from states and payers. | N/A | | Not Required | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment - 3.0.1 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **271 and 834 ASC X12 References** | **Data Submitter Relevancy** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| TXME1001 | Original Reason for Entitlement (OREC) | char | 1 | The reason for the beneficiary's original entitlement to Medicare benefits. | N/A | Medicare and Medicare Advantage | Required IF Available | |
| TXME1002 | Current Reason for Entitlement Code (CREC) | char | 1 | The reason for the beneficiary's current entitlement to Medicare benefits. | N/A | Medicare and Medicare Advantage | Required IF Available | |
| TXME1003 | End state renal disease Indicator (ESRD_IND) | char | 1 | Indicates whether a beneficiary is afflicted with End Stage Renal Disease (ESRD) | N/A | Medicare and Medicare Advantage | Required IF Available | |
| TXME1004 | Medicare Status Code (MS-CD) | char | 1 | Indicates the reason for the beneficiary's entitlement. | N/A | Medicare and Medicare Advantage | Required IF Available | |
| TXME1005 | Death Date (DEATH_DT) | date | 8 | The beneficiary's date of death<br>CCYYMMDD OR BLANK | N/A | Medicare and Medicare Advantage | Required IF Available | |
| TXME1006 | Pure Rate (PURE_RATE) | int | 12 | Client capitation rate (monthly capitation payment amount).<br><br>Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | N/A | Medicaid | Required IF Available | |
| TXME1007 | Managed Care Organization ID (MCO_ID) | char | 2 | Managed Care Organization ID for the MCO in which the member has enrolled. Two-digit identifier for MCO with padded zero. | N/A | Medicaid | Required IF Available | |
| TXME1008 | Plan Code (PLAN_CD) | char | 2 | Code identifying the plan in which the member is enrolled (same as CONTRACT_ID) | N/A | Medicaid | Required IF Available | |
| TXME1009 | Family Size (FAM_SIZE) | int | 2 | Size of family (total number of family members counted in qualification for Medicaid benefits) | N/A | Medicaid | Required IF Available | |
| TXME1010 | Education | char | 1 | Level of education of client<br><br>See Appendix M | N/A | Medicaid | Required IF Available | |
| TXME1011 | Case Number (CASE_NBR) | int | 9 | Number assigned to head-of-household (links people who are enrolled in Medicaid as a group or family). | N/A | Medicaid | Required IF Available | |
| TXME1012 | Supplementary Medical Insurance Benefits Start Date (SMIB_FROM_DT) | date | 8 | Start of supplementary coverage (when the client started DUAL status)<br>CCYYMMDD or BLANK | N/A | Medicaid | Required IF Available | |
| TXME1013 | Supplementary Medical Insurance Benefits End Date (SMIB_TO_DT) | date | 8 | End of supplementary coverage (when the client's DUAL status ended)<br>CCYYMMDD or BLANK | N/A | Medicaid | Required IF Available | |
| TXME1014 | TX_HOLD | char | 1 | Eligibility on hold until Medicaid validates that application meets criteria<br>Y - Yes; N - No | N/A | Medicaid | Required IF Available | |
| TXME1015 | Managed Care Indicator (MC_FLAG) | char | 1 | Flag indicating whether the client is on a Managed Care plan<br>Y = yes, N = no | N/A | Medicaid | Required IF Available | |
| TXME1016 | Managed Care Stopped Coverage Reason Code (MC_SC) | char | 2 | Stopped Coverage Reason code<br><br>See Appendix M | N/A | Medicaid | Required IF Available | |
| TXME1017 | Category Code (ME_CAT) | char | 1 | Client Medicaid Category of Assistance Code.<br>Values 1, 2, 3, 4 | N/A | Medicaid | Required IF Available | |
| TXME1018 | Medicaid Eligibility Code (ME_CODE) | char | 1 | Medicaid eligibility code<br><br>See Appendix M | N/A | Medicaid | Required IF Available | |
| TXME1019 | Medicaid Type Program Code (ME_TP) | char | 2 | Medicaid Type Program<br><br>See Appendix M | N/A | Medicaid | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment - 3.0.1 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **271 and 834 ASC X12 References** | **Data Submitter Relevancy** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| TXME1020 | Member Spend Down ME_SD | char | 1 | Member Spend Down<br><br>See Appendix M | N/A | Medicaid | Required IF Available | |
| TXME1021 | Risk Group Identifier (RISKGRP_ID) | char | 3 | Risk Group Code (digits with padded zeroes)<br><br>See Appendix M | N/A | Medicaid | Required IF Available | |
| TXME1022 | Family Income (FAM_INCOME) | int | 12 | Family income for the purpose of qualifying for Texas Medicaid benefits<br><br>Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | N/A | Medicaid | Required IF Available | |
| TXME1023 | Status In Group (SIG) | char | 1 | Status-in-Group | N/A | Medicaid | Required IF Available | |
| TXME1024 | Supplementary Medical Insurance Benefits (SMIB) | char | 1 | Supplemental Medical Insurance Benefit flag (indicates DUAL eligible client)<br>DUAL ELIGIBLE = 1; ELSE = 0 | N/A | Medicaid | Required IF Available | |
| TXME1025 | Base Plan (BASE_PLAN) | char | 2 | Indicates whether the client is in an institution or in community care.<br><br>2 digits with padded zeroes<br><br>See Appendix M | N/A | Medicaid | Required IF Available | |
| TXME1026 | Eligibility Date (ELIG_DATE) | date | 6 | Year and month of eligibility<br>CCYYMM | N/A | Medicaid | Required IF Available | |
| TXME1027 | Texas County Identifier | int | 3 | Medicaid county code for client's county of residence. If the county is unknown use "255". See: https://www.hhs.texas.gov/handbooks/medicaid-elderly-people-disabilities-handbook/appendix-vii-county-names-codes-regions | N/A | Medicaid | Required IF Available | |
| TXME1028 | Dental Plan Indicator | char | 1 | Indicates if member qualified for dental coverage<br><br>Y / N / BLANK | N/A | Medicaid | Required IF Available | |
| TXME1029 | Plan Name | char | 150 | Name of the plan which is covering the member (the name established in the payor's system). | N/A | Commercial and Dental | Required | 100% |
| CDLME899 | Record Type | char | 2 | Value = ME. | N/A | | Required | 100% |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Provider - 3.0.1 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **Data Submitter Relevancy** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLPV001 | Data Submitter Code | varchar | 8 | APCD-assigned identifier of payor submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payor code (CDLPV002). | All | Required | 100% |
| CDLPV002 | Payor Code | int | 8 | APCD-assigned identifier of insurer/underwriter in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). | Commercial and Dental | Required | 100% |
| CDLPV003 | Plan ID | varchar | 30 | CMS National Plan ID. The national plan ID is a code assigned by CMS. (PLACEHOLDER) | All | Required IF Available | |
| CDLPV004 | Payor Assigned Provider ID | varchar | 30 | Unique code identified for the provider as assigned by the reporting entity. For every provider included in the Eligibility, Medical, Pharmacy, and Dental claims the payor assigned provider IDs shall be included. | All | Required IF Available | |
| CDLPV005 | Provider Tax ID | varchar | 10 | Tax ID of the provider. Do not code punctuation. | All | Optional | |
| CDLPV006 | Entity Type Qualifier | char | 1 | Use this field to indicate whether the rendering provider is a person or non-person entity. HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a “Person.” Valid codes are: 1= Person; 2 = Non-person Entity. | All | Required | 60% |
| CDLPV007 | Provider NPI | char | 10 | NPI for provider as enumerated in the Center for Medicaid and Medicare Services NPPES. | All | Required | 80% |
| CDLPV008 | Provider DEA Number | varchar | 12 | Provider Drug Enforcement Agency number. For all prescribing providers (CDLPC050) that have a DEA number. | | Required IF Available | |
| CDLPV009 | Provider State License Number | varchar | 15 | Prefix with two-character state of licensure with no punctuation. Example: COLL12345. Do not leave a blank space in between state and license number. | | Not Required | |
| CDLPV010 | Provider First Name | varchar | 150 | Individual first name. If provider is a facility or organization, leave blank. | All | Required | 80% |
| CDLPV011 | Provider Middle Name or Initial | varchar | 25 | Individual middle name or initial. If provider is a facility or organization leave blank. | All | Optional | |
| CDLPV012 | Provider Last Name or Organization Name | varchar | 150 | Full name of provider organization or last name of individual provider. | All | Required | 90% |
| CDLPV013 | Provider Suffix | varchar | 10 | Suffix to individual name. If provider is a facility or organization, leave blank. The provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III). Do not use credentials such as MD or PhD. | All | Optional | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Provider - 3.0.1 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **Data Submitter Relevancy** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLPV014 | Provider Office Street Address | varchar | 255 | Physical address – address where the provider delivers health care services (street number and street name). Include suite number if applicable. Multiple addresses will require multiple provider records. | All | Required | 50% |
| CDLPV015 | Provider Office City | varchar | 100 | The city of the physical address where the provider delivers healthcare services. Multiple addresses will require multiple provider records. | All | Required | 80% |
| CDLPV016 | Provider Office State | char | 2 | The state of the physical address where the provider delivers health care services. Use postal service standard two-letter abbreviations. Multiple addresses will require multiple provider records. See Appendix H: External Code Source, United States Postal Service. | All | Required | 90% |
| CDLPV017 | Provider Office ZIP Code | varchar | 9 | Report the 5- or 9-digit ZIP Code of the Rendering Provider. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Multiple addresses will require multiple provider records. ZIP Codes are maintained by the U.S. Postal Service. See Appendix H: External Code Source. | All | Required | 90% |
| CDLPV018 | Provider FIPS County Code | char | 5 | Report the FIPS county code based on the provider's address. The FIPS county code is a five-digit Federal Information Processing Standard (FIPS) code (FIPS 6-4) which uniquely identifies counties and county equivalents in the United States, certain U.S. possessions, and certain freely associated states. If provider lives outside U.S., leave blank. See Appendix H: External Code Source, United States Census Bureau. | All | Optional | |
| CDLPV019 | Provider Country Code | char | 2 | Country code of provider's practice location. Code US for United States. See Appendix H: External Code Source, United States Postal Service. | All | Required | 60% |
| CDLPV020 | Provider Phone | char | 10 | Phone number of Provider. | | Not Required | |
| CDLPV021 | Provider Specialty | varchar | 10 | Report the NUCC healthcare provider taxonomy code. See Appendix H: External Code Source, National Uniform Claim Committee. | All | Required | 90% |
| CDLPV022 | Atypical Provider Taxonomy Code | varchar | 10 | Non-medical or atypical providers not defined as covered entities by CMS. Non-medical providers who supply non-health care services, such as non-emergency transportation, will continue to submit claims and other transactions using their current provider ID and taxonomy. Use code set for Atypical Provider Taxonomy Codes (maintained by NUCC). If not applicable, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee. | All | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Provider - 3.0.1 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **Data Submitter Relevancy** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLPV023 | Provider Medicare Provider ID | varchar | 30 | Provider ID as assigned by Medicare If not available, leave blank. | Medicare Advantage and Medicare Supplemental | Required IF Available | |
| CDLPV024 | Provider Medicaid Provider ID | varchar | 30 | Provider ID as assigned by Medicaid. If not available, leave blank. | Medicaid Only | Required | 90% |
| CDLPV025 | Provider Specialty 2 | varchar | 10 | Report additional NUCC healthcare provider taxonomy code for second specialty. In addition to the taxonomy code listed in CDLPV021. If not available, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee. | All | Required IF Available | |
| CDLPV026 | Provider Specialty 3 | varchar | 10 | Report third NUCC healthcare provider taxonomy code. If not available, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee. | All | Not Required | |
| CDLPV027 | Provider Specialty 4 | varchar | 10 | Report fourth NUCC healthcare provider taxonomy code. If not available, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee. | All | Not Required | |
| CDLPV028 | Provider Specialty 5 | varchar | 10 | Report fifth NUCC health care provider taxonomy code. If not available, leave blank. See Appendix H: External Code Source, National Uniform Claim Committee. | All | Not Required | |
| TXPV1001 | Provider County Identifier | int | 3 | Medicaid county code for provider's practice location/county. If the county is unknown use "255". See: https://www.hhs.texas.gov/handbooks/medicaid-elderly-people-disabilities-handbook/appendix-vii-county-names-codes-regions | Medicaid Only | Required | 100% |
| CDLPVXXX | Unassigned | char | 1 | Reserved for future use. Elements will only be added with review from states and payors. | | Not Required | |
| CDLPV899 | Record Type | char | 2 | Value = PV. | All | Required | 100% |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical - 3.0.1 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Claim Type** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with value in field)** |
| CDLMC001 | Data Submitter Code | varchar | 8 | APCD-assigned identifier of payor submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payor code (CDLMC002). | N/A | All | Institutional and Professional | Master | Required | 100% |
| CDLMC002 | Payor Code | int | 8 | APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). | N/A | All | Institutional and Professional | Master | Required | 100% |
| CDLMC003 | Plan ID | varchar | 30 | CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER) | 2330B NM109 | | | Master | Optional | |
| CDLMC004 | Member Insurance/Product Category Code | char | 2 | See Appendix G-1: Insurance Type/Product Category for codes. Use the most granular choice available. | 2320 SBR09 when SBR06 = 6 | All | Institutional and Professional | Master | Required | 90% |
| CDLMC005 | Payor Claim Control Number | varchar | 35 | Must apply to the entire claim and be unique within the payor's system. Payor Claim Control Number (PCCN) must be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (CDLMC007) will be used to determine which rows will carry forward into the final claim. It is also imperative that a reversal uses the same PCCN as the original paid claim. | 2300 REF02 where REF01 = F8 | All | Institutional and Professional | Master | Required | 100% |
| CDLMC006 | Line Counter | int | 4 | Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim. | 2400 LX01 | All | Institutional and Professional | Detail | Required | 90% |
| CDLMC007 | Version Number | int | 4 | The version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, set to null. | N/A | All | Institutional and Professional | Detail | Required IF Available | |
| CDLMC008 | Cross Reference Claims ID | varchar | 35 | The original Payor Claim Control Number (CDLMC005). Used when a new Payor Claim Control Number is assigned to an adjusted claim and a Version Number (CDLMC007) is not used. If payor claim control numbers are not used, set to null. | N/A | All | Institutional and Professional | Detail | Required IF Available | |
| CDLMC009 | Insured Group or Policy Number | varchar | 50 | The identification number or code assigned by the carrier or administrator to identify the group under which the individual is covered. CDLME007 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, leave blank. If a policy is sold to an individual as a non-group policy, then report with a value of "IND." | 2320 SBR03 (I); 2320 SBR03 (P) | Commercial Only | Institutional and Professional | Master | Required | 80% |
| CDLMC010 | Medicaid AID Category | char | 4 | For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the state's Medicaid agency. If not applicable, leave blank. | N/A | Medicaid Only | Institutional and Professional | Master | Required | 50% |
| CDLMC011 | Subscriber Social Security Number | char | 9 | Subscriber's Social Security Number – do not include dashes. Required if collected. If not available, leave blank. | 2010BA REF02 | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC012 | Plan Specific Contract Number | varchar | 80 | Plan assigned contract number. Leave blank if Plan Specific Contract Number is the subscriber's Social Security Number. If this is a Medicaid claim, provide Medicaid ID. | 2010BA NM109 | Commercial Only | Institutional and Professional | Master | Required IF Available | |
| CDLMC013 | Subscriber Last Name | varchar | 100 | The subscriber's last name. | 2010BA/NM1//03 | All | Institutional and Professional | Master | Required | 100% |
| CDLMC014 | Subscriber First Name | varchar | 100 | The subscriber's first name. | 2010BA/NM1//04 | All | Institutional and Professional | Master | Required | 100% |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical - 3.0.1 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Claim Type** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with value in field)** |
| CDLMC015 | Sequence Number | varchar | 20 | Unique number of the member within the contract. When the member is the subscriber, use subscriber sequence number. | N/A | All | Institutional and Professional | Master | Required | 100% |
| CDLMC016 | Member Social Security Number | char | 9 | Member's Social Security Number – do not include dashes. Required if collected. If not available, leave blank. | 2010CA REF109 or 2010BA REF109 | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC017 | Individual Relationship Code | char | 2 | Member's relationship to insured. Individual Relationship codes are maintained by ANSI ASC X12. See Appendix H: External Code Source, see Accredited Standards Committee. | 2000C PAT01 or 2000B SBR02 | Commercial Only | Institutional and Professional | Master | Required | 90% |
| CDLMC018 | Member Sex | char | 1 | Sex of Member M = Male; F = Female; U = Unknown.<br><br>Member sex represents biological or administrative sex. Where available, submitters should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, submitters may provide the values they have regarding physical or legal sex (e.g., administrative sex as categorized by X12 values). | 2010CA DMG03 or 2010BA DMG03 | All | Institutional and Professional | Master | Required | 90% |
| CDLMC019 | Member Date of Birth | date | 8 | CCYYMMDD; Date of birth of member. | 2010CA DMG02 or 2010BA DMG02 | All | Institutional and Professional | Master | Required | 90% |
| CDLMC020 | Member Last Name | varchar | 100 | The member's last name. If the member is the subscriber, report the subscriber's last name. | 2010CA NM103 or 2010BA NM103 | All | Institutional and Professional | Master | Required | 90% |
| CDLMC021 | Member First Name | varchar | 100 | The member's first name. If the member is the subscriber, report the subscriber's first name. | 2010CA NM104 or 2010BA NM104 | All | Institutional and Professional | Master | Required | 90% |
| CDLMC022 | Member ZIP Code | varchar | 9 | Report the 5- or 9-digit ZIP Code of the member's residence. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the U.S. Postal Service. See Appendix H: External Code Sources. | 2010CA N403 or 2010BA N403 | All | Institutional and Professional | Master | Required | 90% |
| CDLMC023 | Patient Control Number | varchar | 20 | Patient Secondary Information. Patient's unique (alphanumeric) number assigned by the provider to facilitate retrieval of the individual's account of services. | 2010CA REF02 | | | Master | Not Required | |
| CDLMC024 | Paid Date | date | 8 | CCYYMMDD. Paid date of the claim line. Report the date that appears on the: check, and/or remit, and/or explanation of benefits, and corresponds to any and all types of payment in CCYYMMDD Format. If paid/adjudicated date is not available use Processed Date. Claims paid in full, partial, or zero paid, must have a date reported here. | 2330B DTP03 where DTP01 = 57 | All | Institutional and Professional | Detail | Required | 60% |
| CDLMC025 | Admission Date | date | 8 | CCYYMMDD. Required for all inpatient claims, this is the date of admission. | 2300 DTP03 where DTP01 = 435 (I) | All | Institutional Only | Master | Conditional | |
| CDLMC026 | Admission Hour | char | 4 | HHMM. (Military time) The hour during which the patient was admitted for inpatient care. For professional claims leave blank. | 2300 DTP03 where DTP01 = 435 and DTP02 = DT (I) | All | Institutional Only | Master | Not Required | |
| CDLMC027 | Admission Type | char | 1 | Required for all inpatient claims. Valid codes are: 1 = Emergency; 2 = Urgent; 3 = Elective; 4 = Newborn; 5 = Trauma Center; 9 = Information not available. Admission Type codes are maintained by NUBC.<br><br>See Appendix H: External Code Source, National Uniform Billing Committee. | 2300 CL101 (I) | All | Institutional Only | Master | Conditional | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical - 3.0.1 | | | | | | | | | | |
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| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Claim Type** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with value in field)** |
| CDLMC028 | Point of Origin | char | 1 | A code indicating the point of patient origin for this admission or visit. Required for all institutional claims. Admission Type codes are maintained by NUBC.<br><br>See Appendix H: External Code Source, National Uniform Billing Committee. | 2300 CL102 (I) | All | Institutional Only | Master | Conditional | |
| CDLMC029 | Discharge Date | date | 8 | CCYYMMDD. All inpatient claims. Date patient discharged. Required for all inpatient claims. | 2300 DTP 03 where DTP01 = 096 (I) | All | Institutional Only | Master | Conditional | 70% |
| CDLMC030 | Discharge Hour | char | 4 | HHMM (Military time). The hour during which the patient was discharged from inpatient care. For professional claims, leave blank. | 2300 DTP02 where DTP01 = 096 and DTP02 = TM (I) | | | Master | Not Required | |
| CDLMC031 | Discharge Status | char | 2 | Required for all institutional claims. Discharge Status codes are maintained by NUBC. For professional claims, leave blank. [Not required for institutional claims for professional services]<br><br>See Appendix H: External Code Source, National Uniform Billing Committee. | 2300 CL103 (I) | All | Institutional Only | Master | Required | 70% |
| CDLMC032 | Type of Bill – Institutional | char | 3 | Required for institutional claims. Not to be used for professional claims. As defined by the National Uniform Billing Committee. Do not include the leading zero (must be three digits only). Type of Bill codes are maintained by NUBC.<br><br>This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is referred to as "frequency" code.<br><br>See Appendix H: External Code Source, National Uniform Billing Committee. | 2300 CLM 05-2 & CLM05-3 (I) | All | Institutional Only | Master | Required | 90% |
| CDLMC033 | Place of Service – Professional | char | 2 | Required for professional claims and encounters. Not to be used for institutional claims. Place of Service codes are maintained by CMS. See Appendix H: External Code Source, Center for Medicaid and Medicare Services. | 2300 CLM05-01 (P) | All | Professional and Encounters | Detail | Required | 90% |
| CDLMC034 | Admitting Diagnosis | varchar | 7 | The ICD code describing the patient's diagnosis at the time of admission. Required on all inpatient admission claims and encounters. Codes found in ICD-9-CM or ICD-10-CM. Do not code decimal point.<br>[Not required for institutional claims for professional services]<br><br>See Appendix H: External Code Source,<br>World Health Organization. | 2300 HI01-2 (I) | All | Institutional Only | Master | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical - 3.0.1 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Claim Type** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with value in field)** |
| CDLMC035 | First External Cause Code | varchar | 7 | The ICD diagnosis codes pertaining to environmental events, circumstances, and conditions as the cause of injury, poisoning, and other adverse effects. As submitted by provider in the first external cause field, if not submitted by the provider or captured by the carrier leave blank. Codes found in ICD-9-CM or ICD-10-CM. Do not code decimal point. See Appendix H: External Code Source, World Health Organization. | 2300 HI01-2 where HI01-1 = BN (ICD-9) or = ABN (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC036 | ICD Version Indicator | char | 1 | The purpose of this field is to identify which code set is being utilized. 9 = This claim contains ICD-9-CM codes. 0 = This claim contains ICD-10-CM codes. | N/A | All | Institutional and Professional | Master | Required | 75% |
| CDLMC037 | Principal Diagnosis | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. Cannot include codes V00-Y99.<br>[May not exist on lab or DME claims]<br><br>See Appendix H: External Code Source. | 2300 HI01-2 where HI01-1 = BK (ICD-9) or = ABK (ICD- 10) | All | Institutional and Professional | Master | Required | 75% |
| CDLMC038 | Other Diagnosis – 1 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank.<br>[May not exist on lab or DME claims]<br><br>See Appendix H: External Code Source, World Health Organization. | 2300 HI01-2 where HI01-1 = BF (ICD-9) or = ABF (ICD- 10) | All | Institutional and Professional | Master | Required | 50% |
| CDLMC039 | Other Diagnosis – 2 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI02-2 where HI02-1 = BF (ICD-9) or = ABF (ICD- 10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC040 | Other Diagnosis – 3 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI03-2 where HI03-1 = BF (ICD-9) or = ABF (ICD- 10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC041 | Other Diagnosis – 4 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI04-2 where HI04-1 = BF (ICD-9) or = ABF (ICD- 10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC042 | Other Diagnosis – 5 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI05-2 where HI05-1 = BF (ICD-9) or = ABF (ICD- 10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC043 | Other Diagnosis – 6 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI06-2 where HI06-1 = BF (ICD-9) or = ABF (ICD- 10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC044 | Other Diagnosis – 7 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI07-2 where HI07-1 = BF (ICD-9) or = ABF (ICD- 10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC045 | Other Diagnosis – 8 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI08-2 where HI08-1 = BF (ICD-9) or = ABF (ICD- 10) | All | Institutional and Professional | Master | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical - 3.0.1 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Claim Type** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with value in field)** |
| CDLMC046 | Other Diagnosis – 9 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI09-2 where HI09-1 = BF (ICD-9) or = ABF (ICD- 10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC047 | Other Diagnosis – 10 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI10-02 where HI10-01 = BF (ICD-9) or = ABF (ICD-10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC048 | Other Diagnosis – 11 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI11-02 where HI11-01 = BF (ICD-9) or = ABF (ICD-10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC049 | Other Diagnosis – 12 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI12-02 where HI12-01 = BF (ICD-9) or = ABF (ICD-10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC050 | Other Diagnosis – 13 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI13-02 where HI13-01 = BF (ICD-9) or = ABF (ICD-10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC051 | Other Diagnosis – 14 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI14-02 where HI14-01 = BF (ICD-9) or = ABF (ICD-10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC052 | Other Diagnosis – 15 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI15-02 where HI15-01 = BF (ICD-9) or = ABF (ICD-10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC053 | Other Diagnosis – 16 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI16-02 where HI16-01 = BF (ICD-9) or = ABF (ICD-10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC054 | Other Diagnosis – 17 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI17-02 where HI17-01 = BF (ICD-9) or = ABF (ICD-10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC055 | Other Diagnosis – 18 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI18-02 where HI18-01 = BF (ICD-9) or = ABF (ICD-10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC056 | Other Diagnosis – 19 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI19-02 where HI19-01 = BF (ICD-9) or = ABF (ICD-10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC057 | Other Diagnosis – 20 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI20-02 where HI20 01 = BF (ICD-9) or = ABF (ICD-10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC058 | Other Diagnosis – 21 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI21-02 where HI21-01 = BF (ICD-9) or = ABF (ICD-10) | All | Institutional and Professional | Master | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical - 3.0.1 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Claim Type** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with value in field)** |
| CDLMC059 | Other Diagnosis – 22 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI22-02 where HI22-01 = BF (ICD-9) or = ABF (ICD-10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC060 | Other Diagnosis – 23 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI23-02 where HI23-01 = BF (ICD-9) or = ABF (ICD-10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC061 | Other Diagnosis – 24 | varchar | 7 | ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI24-02 where HI24-01 = BF (ICD-9) or = ABF (ICD-10) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC062 | Present on Admission Code – 01 | char | 1 | Present on Admission Indicator Principal Diagnosis for institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI01-09 where 2300 HI01-2 where HI01-1 = BK (ICD-9) or = ABK (ICD-10) and HI01-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC063 | Present on Admission Code – 02 | char | 1 | POA Indicator for Other Diagnosis – 1. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI01-09 where HI01-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC064 | Present on Admission Code – 03 | char | 1 | POA Indicator for Other Diagnosis – 2. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI02-09 where HI02-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC065 | Present on Admission Code – 04 | char | 1 | POA Indicator for Other Diagnosis – 3. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI03-09 where HI03-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC066 | Present on Admission Code -05 | char | 1 | POA Indicator for Other Diagnosis – 4. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI04-09 where HI04-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC067 | Present on Admission Code – 06 | char | 1 | POA Indicator for Other Diagnosis – 5. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI05-09 where HI05-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC068 | Present on Admission Code – 07 | char | 1 | POA Indicator for Other Diagnosis – 6. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI06-09 where HI06-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC069 | Present on Admission Code – 08 | char | 1 | POA Indicator for Other Diagnosis – 7. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI07-09 where HI07-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical - 3.0.1 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Claim Type** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with value in field)** |
| CDLMC070 | Present on Admission Code – 09 | char | 1 | POA Indicator for Other Diagnosis – 8. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI08-09 where HI08-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC071 | Present on Admission Code – 10 | char | 1 | POA Indicator for Other Diagnosis – 9. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI09-09 where HI09-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC072 | Present on Admission Code – 11 | char | 1 | POA Indicator for Other Diagnosis – 10. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI10-09 where HI10-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC073 | Present on Admission Code – 12 | char | 1 | POA Indicator for Other Diagnosis – 11. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI11-09 where HI11-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC074 | Present on Admission Code – 13 | char | 1 | POA Indicator for Other Diagnosis – 12. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI12-09 where HI12-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC075 | Present on Admission Code – 14 | char | 1 | POA Indicator for Other Diagnosis – 13. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI13-09 where HI13-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC076 | Present on Admission Code – 15 | char | 1 | POA Indicator for Other Diagnosis – 14. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI14-09 where HI14-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC077 | Present on Admission Code – 16 | char | 1 | POA Indicator for Other Diagnosis – 15. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI15-09 where HI15-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC078 | Present on Admission Code – 17 | char | 1 | POA Indicator for Other Diagnosis – 16. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI16-09 where HI16-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC079 | Present on Admission Code – 18 | char | 1 | POA Indicator for Other Diagnosis – 17. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI17-09 where HI17-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical - 3.0.1 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Claim Type** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with value in field)** |
| CDLMC080 | Present on Admission Code – 19 | char | 1 | POA Indicator for Other Diagnosis – 18. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI18-09 where HI18-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC081 | Present on Admission Code – 20 | char | 1 | POA Indicator for Other Diagnosis – 19. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI19-09 where HI19-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC082 | Present on Admission Code – 21 | char | 1 | POA Indicator for Other Diagnosis – 20. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI20-09 where HI20-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC083 | Present on Admission Code – 22 | char | 1 | POA Indicator for Other Diagnosis – 21. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI21-09 where HI21-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC084 | Present on Admission Code – 23 | char | 1 | POA Indicator for Other Diagnosis – 22. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI22-09 where HI22-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC085 | Present on Admission Code – 24 | char | 1 | POA Indicator for Other Diagnosis – 23. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI23-09 where HI23-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC086 | Present on Admission Code – 25 | char | 1 | POA Indicator for Other Diagnosis – 24. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. Report the code that indicates present on admission: Y = Yes; N = No; U = Unknown; W = Not Applicable. | 2300 HI24-09 where HI24-01 = BF (ICD-9) or = ABF (ICD-10) and HI02-01 is populated | All | Institutional Only | Master | Required IF Available | |
| CDLMC087 | Revenue Code | char | 4 | Codes that identify specific accommodations, ancillary service or unique billing calculations or arrangements. NUBC Code using leading zeros, left justified, and four digits. For institutional claims only. Not for professional claims. Revenue codes are maintained by NUBC. See Appendix H: External Code Source, National Uniform Billing Committee. | 2400 SV201 (I) | All | Institutional Only | Detail | Required | 50% |
| CDLMC088 | Procedure Code | varchar | 5 | Healthcare Common Procedural Coding System (HCPCS). This includes the CPT codes maintained by the American Medical Association. This field should not include modifiers. Modifiers are submitted in different fields.<br>[Institutional claims may not provide a procedure code per line if not required by the revenue codes]<br><br>See Appendix H: External Code Source, American Medical Association. | 2400 SV202-02 where SV202-01 = HC (I); 2400 SV101-02 where SV101-01 = HC (P) | All | Institutional and Professional | Detail | Required | 100% Professional and 10% Institutional |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical - 3.0.1 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Claim Type** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with value in field)** |
| CDLMC089 | Procedure Modifier – 1 | char | 2 | Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank.<br>[Institutional claims may not provide a procedure code per line if not required by the revenue codes]<br><br>See Appendix H: External Code Source, American Medical Association. | 2400 SV202-03; 2400 SV101-03 where SV101-01 = HC (P) | All | Institutional and Professional | Detail | Required | 20% |
| CDLMC090 | Procedure Modifier – 2 | char | 2 | Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association. | 2400 SV2 02-4 | All | Institutional and Professional | Detail | Required IF Available | |
| CDLMC091 | Procedure Modifier – 3 | char | 2 | Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association. | 2400 SV2 02-5 | All | Institutional and Professional | Detail | Required IF Available | |
| CDLMC092 | Procedure Modifier – 4 | char | 2 | Procedure modifier required when a modifier clarifies/improves the reporting accuracy of the associated procedure code. CPT codes and modifiers are maintained by the American Medical Association. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, American Medical Association. | 2400 SV2 02-6 | All | Institutional and Professional | Detail | Required IF Available | |
| CDLMC093 | ICD-9 CM/10-PCS Principal Procedure Code | char | 7 | Primary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI01-2 where 2300 HI01-01 = BR (ICD-9-CM) or BBR (ICD10PCS) | All | Institutional Only | Master | Required | 50% |
| CDLMC094 | ICD-9 CM/10-CMPCS Other Procedure Code – 1 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI01-2 where HI01-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC095 | ICD-9 CM/10-CMPCS Other Procedure Code – 2 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI02-2 where HI02-1= BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC096 | ICD-9 CM/10-CMPCS Other Procedure Code – 3 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI03-2 where HI03-1= BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical - 3.0.1 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Claim Type** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with value in field)** |
| CDLMC097 | ICD-9 CM/10-CMPCS Other Procedure Code – 4 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI04-2 where HI04-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC098 | ICD-9 CM/10-CMPCS Other Procedure Code – 5 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI05-2 where HI05-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC099 | ICD-9 CM/10-CMPCS Other Procedure Code – 6 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI06-2 where HI06-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC100 | ICD-9 CM/10-CMPCS Other Procedure Code – 7 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI07-2 where HI07-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC101 | ICD-9 CM/10-CMPCS Other Procedure Code – 8 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI08-2 where HI08-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC102 | ICD-9 CM/10-CMPCS Other Procedure Code – 9 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI09-2 where HI09-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC103 | ICD-9 CM/10-CMPCS Other Procedure Code – 10 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI10-2 where HI10-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC104 | ICD-9 CM/10-CMPCS Other Procedure Code – 11 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI11-2 where HI11-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC105 | ICD-9 CM/10-CMPCS Other Procedure Code – 12 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI12-2 where HI12-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC106 | ICD-9 CM/10-CMPCS Other Procedure Code – 13 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI13-2 where HI13-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC107 | ICD-9 CM/10-CMPCS Other Procedure Code – 14 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI14-2 where HI14-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical - 3.0.1 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Claim Type** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with value in field)** |
| CDLMC108 | ICD-9 CM/10-CMPCS Other Procedure Code – 15 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI15-2 where HI15-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC109 | ICD-9 CM/10-CMPCS Other Procedure Code – 16 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI16-2 where HI16-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC110 | ICD-9 CM/10-CMPCS Other Procedure Code – 17 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI17-2 where HI17-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC111 | ICD-9 CM/10-CMPCS Other Procedure Code – 18 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI18-2 where HI18-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC112 | ICD-9 CM/10-CMPCS Other Procedure Code – 19 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI19-2 where HI19-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC113 | ICD-9 CM/10-CMPCS Other Procedure Code – 20 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI20-2 where HI20-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC114 | ICD-9 CM/10-CMPCS Other Procedure Code – 21 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI21-2 where HI21-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC115 | ICD-9 CM/10-CMPCS Other Procedure Code – 22 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI22-2 where HI22-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC116 | ICD-9 CM/10-CMPCS Other Procedure Code – 23 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI23-2 where HI23-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC117 | ICD-9 CM/10-CMPCS Other Procedure Code – 24 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI24-2 where HI24-1 = BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical - 3.0.1 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Claim Type** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with value in field)** |
| CDLMC118 | ICD-9 CM/10-CMPCS Other Procedure Code – 25 | varchar | 7 | Secondary procedure code for this line of service. Do not code decimal point. For institutional claims only. Not for professional claims. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization. | 2300 HI25-2 where HI25-1= BQ (ICD-9) or = BBQ (ICD- 10) | All | Institutional Only | Master | Required IF Available | |
| CDLMC119 | Date of Service – From | date | 8 | CCYYMMDD. First date of service for this service line. Filled for all claim types. (This date should be within the coverage period on the Eligibility file, i.e., between the Plan Effective Date and the Plan Term Date on the Eligibility file all inclusive.) | 2300 DTP03 where DTP02 = RD8 (I); 2400 DTP03 where DTP01 = 472 or 2300 DTP03 where DTP01 = 434 (P) | All | Institutional and Professional | Detail | Required | 90% |
| CDLMC120 | Date of Service – Through | date | 8 | CCYYMMDD. Last date of service for this service line. Filled for all claim types. | 2300 DTP03 where DTP02 = RD8 (I); 2400 DTP03 where DTP01 = 472 or 2300 DTP03 where DTP01 = 434 (P) | All | Institutional and Professional | Detail | Required | 90% |
| CDLMC121 | Service Units/Quantity | dec | 8,3 | Count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay.<br>[Only required in relation to revenue and procedure codes to identify quantity] | 2400 SV205 where SV204 = (I); 2400 SV104 (P) | All | Institutional and Professional | Detail | Required | 80% |
| CDLMC122 | Unit of Measure | varchar | 2 | Type of units reported in CDLMC121.Example codes: DA = Days; MJ = Minutes; UN = Units. If CDLMC121 is blank (not reported), leave CDLMC122 blank.<br>[Only required in relation to service units] | N/A | All | Institutional and Professional | Detail | Optional | |
| CDLMC123 | Charge Amount | int | 12 | The amount charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).<br>[Not required on encounters.] | 2400 SV203 (I); 2400 SV102 (P) | All | Institutional and Professional | Detail | Required | 90% on claims 0% on encounters |
| CDLMC124 | Withhold Amount | int | 12 | A claim-based payment that is included in total medical expense. Report the amount paid to the provider for this claim line if the provider qualified/met performance guarantees. Report 0 if there is no withhold amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | N/A | | | Detail | Not Required | |
| CDLMC125 | Plan Paid Amount | int | 12 | This is the amount paid by the plan to cover the services, to the provider or member. This excludes the patient liability. For capitated claims, set to 0. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).<br>[Not required on encounters.] | 2430 SVD02 | All | Institutional and Professional | Detail | Required | 90% on claims 0% on encounters |
| CDLMC126 | Copay Amount | int | 12 | Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. If only collected on the header record, report the copay amount on the first claim line. Report 0 if there is no copay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).<br>[Not required on encounters.] | 2320 and/or 2430 CAS03 where the CARC is 3 | All | Institutional and Professional | Detail | Required | 50% on claims 0% on encounters |
| CDLMC127 | Coinsurance Amount | int | 12 | The dollar amount for which the member is responsible attributed to the coinsurance amount. This is the dollar amount, not the percentage from which the dollar amount was calculated. If only collected on the header record, report the coinsurance amount on the first claim line. Report 0 if there is no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).<br>[Not required on encounters.] | 2320 and/or 2430 CAS03 where the CARC is 2 | All | Institutional and Professional | Detail | Required | 50% on claims 0% on encounters |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical - 3.0.1 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Claim Type** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with value in field)** |
| CDLMC128 | Deductible Amount | int | 12 | Report the amount of the deductible applied to the claim. If only collected on the header record, report the deductible amount on the first claimline. Report 0 if there is no deductible amount applied to the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). [Not required on encounters.] | 2320 and/or 2430 CAS03 where the CARC is 1 | All | Institutional and Professional | Detail | Required | 50% on claims 0% on encounters |
| CDLMC129 | Other Insurance Paid Amount | int | 12 | Amount already paid by another carrier. Report the amount that a prior payor has paid for this claim line. Indicates the submitting payor is not the primary payor. Only report "0" if the prior payor paid 0 toward this claim line; or if there is no prior payor. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).. May be reported as a negative. [Not required on encounters.] | N/A | All | Institutional and Professional | Detail | Required IF Available | |
| CDLMC130 | COB/TPL Amount | int | 12 | Amount due from a secondary carrier. Report the amount that another payor is liable for after submitting payor has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). [Not required on encounters.] | 2320 AMT02 | All | Institutional and Professional | Detail | Required IF Available | |
| CDLMC131 | Allowed Amount | int | 12 | When payment arrangement type in CDLMC132 is equal to 01 for capitated services, set to 0. When payment arrangement type in CDLMC132 is equal to 02 for fee-for-service, report the maximum amount contractually allowed that a carrier will pay to a provider for a particular procedure or service. Report 0 if there is no allowed amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). [Not required on encounters]. | 2300 HCP02 | All | Institutional and Professional | Detail | Required | 90% |
| CDLMC132 | Payment Arrangement Type Indicator | char | 2 | Indicates the payment methodology. Valid codes are: 01= Capitation; 02 = Fee-for-Service; 03 = Percent of Charges; 04= DRG; 05 = Pay for Performance; 06 = Global Payment; 07= Other; 08 = Bundled Payment. | N/A | All | Institutional and Professional | Master | Required | 60% |
| CDLMC133 | Drug Code | char | 11 | Report the NDC code only when a medication is paid for as part of a medical claim. Do not include dashes. NDC codes are maintained by the Federal Drug Administration. If not available, leave blank. See Appendix H: External Code Source, United States Food and Drug Administration. | 2410 LIN03 where LIN02 = N4 (I) | All | Institutional and Professional | Detail | Required IF Available | |
| CDLMC134 | Rendering Provider ID | varchar | 35 | Unique code identified for the provider as assigned by the reporting entity. payor assigned provider ID for the provider that provided the services on the claims. This should be the identifier used by the payor for internal identification purposes and does not routinely change. Must map to the payor Assigned Provider ID (CDLPV004) in the Provider File. | 2310D REF02 where REF01 = G2 (I) or 2310A REF02 where REF01 = G2 (I); 2420A REF02 where REF01 = G2 (P) or 2310B REF02 where REF01 = G2 (P) | All | Institutional and Professional | Master | Required IF Available | |
| CDLMC135 | Rendering Provider NPI | char | 10 | Rendering Provider NPI is the NPI of the entity or individual directly providing the service, as enumerated in the Center for Medicaid and Medicare Services NPPES. | 2010AA NM109 (I); 2420A NM109 (P) or 2310B NM109 (P) | All | Institutional and Professional | Master | Required | 80% |
| CDLMC136 | Rendering Provider Entity Type Qualifier | char | 1 | Use this field to indicate whether the rendering provider is a person or non-person entity. HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "person." Valid codes are: 1 = Person; 2 = Non-person Entity. | 2010AA NM102 (I); 2420A NM102 (P) or 2310B NM102 (P) | All | Institutional and Professional | Master | Required | 60% |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical - 3.0.1 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Claim Type** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with value in field)** |
| CDLMC137 | In Plan Network Indicator | char | 1 | A yes/no indicator that specifies if the provider (not the benefit) is within the health plan network. Valid codes are: N = No; Y = Yes; L = Leased Network. | N/A | All | Institutional and Professional | Master | Required | 70% |
| CDLMC138 | Rendering Provider First Name | varchar | 100 | Individual first name. If CDLMC136 = 2, leave blank. | 2010AA NM104 (I); 2420A NM104 (P) or 2310B NM104 (P) | All | Institutional and Professional | Master | Required | 80% |
| CDLMC139 | Rendering Provider Middle Name | varchar | 25 | Individual middle name or initial. If CDLMC136 = 2, leave blank. | 2010AA NM105 (I); 2420A NM105 (P) or 2310B NM105 (P) or 2010AA NM105 (P) | All | Institutional and Professional | Master | Optional | |
| CDLMC140 | Rendering Provider Last Name or Organization Name | varchar | 150 | Full name of provider organization (non-person entity) or last name of individual (person) provider. CDLMC136 determines if the Rendering Provider is a “person” or a “non-person entity”. | 2010AA NM103 (I); 2420A NM103 (P) or 2310B NM103 (P) or 2010AA NM103 (P) | All | Institutional and Professional | Master | Required | 90% |
| CDLMC141 | Rendering Provider Suffix | varchar | 10 | Suffix of Rendering Provider. Leave blank if provider is a facility or organization. The rendering provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III). Do not use credentials such as MD or PhD. | 2010AA NM107 (I); 2420A NM107(P) or 2310B NM107 (P) or 2010AA NM107 (P) | All | Institutional and Professional | Master | Not Required | |
| CDLMC142 | Rendering Provider Specialty | varchar | 10 | Standard code that identifies the provider specialty for this line of service. Report the HIPAA compliant healthcare provider national taxonomy code. Provider taxonomy codes are maintained by the National Uniform Claims Committee (NUCC). See Appendix H: External Code Source, National Uniform Claims Committee. | 2010AA PRV03 (I); 2420A PRV03 (P) or 2310B PRV03 (P) or 2000AA PRV03 (P) | All | Institutional and Professional | Master | Required | 90% |
| CDLMC143 | Rendering Provider City Name | varchar | 100 | City name of provider or service facility location. | 2010AA N401 (I); 2420C N401 (P) or 2310C N401 (P) | All | Institutional and Professional | Master | Required | 80% |
| CDLMC144 | Rendering Provider State or Province | char | 2 | State or Province where the rendering provider delivered the service. Codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service. | 2010AA N402 (I); 2420C N402 (P) or 2310C N402 (P) | All | Institutional and Professional | Master | Required | 90% |
| CDLMC145 | Rendering Provider ZIP Code | varchar | 9 | ZIP or ZIP+4 where the rendering provider delivered the service - do not include dashes or provide any punctuation. If reporting ZIP, do not fill last 4 digits with 0. ZIP Codes are maintained by the US Postal Service. See Appendix H: External Code Sources. | 2010AA N403 (I); 2420C N403 (P) or 2310C N403 (P) | All | Institutional and Professional | Master | Required | 90% |
| CDLMC146 | Rendering Provider Group Practice NPI | varchar | 10 | NPI of group practice to which a rendering provider is affiliated if different from CDLMC135. | N/A | All | Institutional and Professional | Master | Not Required | |
| CDLMC147 | Billing Provider ID | varchar | 30 | Unique code assigned to the provider by the reporting entity. Payor assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payor for internal identification purposes and does not routinely change. Must map to the payor Assigned Provider ID (CDLPV004) in the Provider File. | 2010AA REF02 where REF01 = G2 and/or LU | All | Institutional and Professional | Master | Required | 80% |
| CDLMC148 | Billing Provider NPI | char | 10 | NPI for billing provider as enumerated in the Center for Medicaid and Medicare Services NPPES. | 2010AA NM109 where 2010AA NM108 = XX | All | Institutional and Professional | Master | Required | 80% |
| CDLMC149 | Billing Provider Last Name or Organization Name | varchar | 150 | Full name of provider billing organization or last name of individual billing provider. | 2010AA NM103 | All | Institutional and Professional | Master | Required | 90% |
| CDLMC150 | Billing Provider Tax ID | varchar | 10 | Tax ID of the billing provider. Do not code punctuation. | 2010AA REF02 | All | Institutional and Professional | Master | Not Required | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical - 3.0.1 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Claim Type** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with value in field)** |
| CDLMC151 | Referring Provider ID | varchar | 30 | Payor assigned provider ID for the referring provider. The referring provider is the provider who directed the patient for care to the provider that rendered the services being submitted on the claim form. The Referring Provider Number is the identifier used by the payor for internal identification purposes and does not routinely change. Must map to the payor Assigned Provider ID (CDLPV004) in the Provider File. If not available, leave blank. | 2310F REF02 where REF01=G2 | All | Institutional Only | Master | Optional | |
| CDLMC152 | Referring Provider NPI | char | 10 | NPI of the referring provider. The referring provider is the entity or individual that submitted the referral of the service or procedure. The referring provider is the individual who directed the patient for care to the provider that rendered the services being submitted on the claim form. If not available, leave blank. | 2310F NM109 (I) where NM108 = XX | All | Institutional Only | Master | Optional | |
| CDLMC153 | Attending Provider ID | varchar | 30 | Payor assigned provider ID for the attending provider. On the institutional claim, the attending provider is the individual that has primary responsibility for the patient's medical care and treatment reported in the claim. The Attending Provider Number is the identifier used by the payor for internal identification purposes and does not routinely change. Must map to the payor Assigned Provider ID (CDLPV004) in the Provider File. If not available, leave blank. | 2310A REF02 where REF01 = G2 (I) | All | Institutional Only | Master | Optional | |
| CDLMC154 | Attending Provider NPI | char | 10 | NPI of the attending provider. The attending provider on an 837I claim represents the individual that has primary responsibility for the patient's medical care and treatment reported in the claim. The attending and rendering provider can be the same individual. If not available, leave blank. | 2310A NM109 where NM108 = XX | All | Institutional Only | Master | Optional | |
| CDLMC155 | Carrier Associated with Claim | varchar | 8 | For each claim, use the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. If not available, leave blank. See Appendix H: External Code Source, National Association of Insurance Commissioners. | N/A | All | Institutional and Professional | Master | Optional | |
| CDLMC156 | Type of Claim | char | 1 | Indicates the type of claim that was submitted. Valid codes are: 1 = Professional; 2 = Institutional/Facility; 3 = Reimbursement Form (Member). | N/A | All | Institutional and Professional | Master | Required | 95% |
| CDLMC157 | Claim Status | char | 2 | Claim status codes maintained by ANSI ASC X12 is the code identifying type of claim. See Appendix TX-3 for example codes. | 835/2100/CLP/ /02 | All | Institutional and Professional | Master | Optional | |
| CDLMC158 | Denied Claim Line Indicator | char | 1 | Use this field to indicate whether the payor denied this specific line on this specific claim. Valid codes are: 1 = Yes (denied); 2 = No (not denied). | N/A | All | Institutional and Professional | Detail | Optional | |
| CDLMC159 | Claim Adjustment Reason Code | varchar | 3 | Report the claim adjustment reason code. If CDLMC158 = 1, report the code that defines the reason for denial of the claim line. If not available, leave blank. Reason codes are maintained by ANSI ASC X12. See Appendix H: External Code Source, Accredited Standards Committee. | N/A | All | Institutional and Professional | Detail | Optional | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical - 3.0.1 | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Claim Type** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with value in field)** |
| CDLMC160 | Claim Line Type | char | 1 | Report the code that defines the claim line status in terms of adjudication. Valid codes are: O = Original; V = Void; R = Replacement; B = Back Out; A = Amendment; D = Denial. | N/A | All | Institutional and Professional | Detail | Required | 95% |
| CDLMC161 | Carrier Specific Unique Member ID | varchar | 50 | Report the identifier the carrier/submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's/ ubmitter's files for reporting and aggregation. | N/A | All | Institutional and Professional | Master | Required | 100% |
| CDLMC162 | Carrier Specific Unique Subscriber ID | varchar | 50 | Report the identifier the carrier/submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's/submitter's files for reporting and aggregation. If member is the subscriber use Member ID. | N/A | Commercial Only | Institutional and Professional | Master | Required | 100% |
| CDLMC163 | Rendering Provider Street Address | varchar | 55 | Street address where the rendering provider delivered the service (street number and street name). Include suite number if applicable. | 2310E N301 (I);<br>2420A N301 (P) | All | Institutional and Professional | Master | Not Required | |
| CDLMC164 | Medical Record Number | varchar | 35 | Medical Record Number of the member | 837/2300/REF/02 when REF 01=EA | All | Institutional and Professional | Master | Optional | |
| CDLMCXXX | Unassigned | char | 1 | Reserved for future use. Elements will only be added with review from states and payors. | N/A | | | | Not Required | |
| CDLMC899 | Record Type | char | 2 | Value = MC. | N/A | | | | Required | 100% |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Pharmacy - 3.0.1 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **References NCPDP** | **Data Submitter Relevancy** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLPC001 | Data Submitter Code | varchar | 8 | APCD-assigned identifier of payor submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payor code (CDLPC002). | N/A | All | Master | Required | 100% |
| CDLPC002 | Payor Code | int | 8 | APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). | 879-N2 | All | Master | Required | 100% |
| CDLPC003 | Plan ID | varchar | 30 | CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER) | 569-J8 | | Master | Optional | |
| CDLPC004 | Member Insurance/ Product Category Code | char | 2 | See Appendix G1: Insurance Type/Product Category for codes. Use the most granular choice available. | A90 | All | Master | Required | 90% |
| CDLPC005 | Payor Claim Control Number | varchar | 35 | Must apply to the entire claim and be unique within the payor's system. Payor Claim Control Number (PCCN) must be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (CDLPC007) will be used to determine which rows will carry forward into the final claim. It is also imperative that a reversal uses the same PCCN as the original paid claim. | 993-A7<br>Internal Control Number | All | Master | Required | 100% |
| CDLPC006 | Line Counter | int | 4 | Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim. | A91 | All | Detail | Required | 90% |
| CDLPC007 | Version Number | int | 4 | The version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, Cross Reference Claims ID (CDLPC008) is to be utilized. If version numbers are not used set to null and complete CDLPC008. | 102-A2<br>(version/release number of the claim) | All | Detail | Required IF Available | |
| CDLPC008 | Cross Reference Claims ID | varchar | 35 | The original Payor Claim Control Number (CDLPC005). Used when a new Payor Claim Control Number is assigned to an adjusted claim and a Version Number (CDLPC007) is not used. If payor claim control numbers are not used, set to null. | N/A | All | Detail | Required IF Available | |
| CDLPC009 | Insured Group or Policy Number | varchar | 50 | The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. CDLPC009 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, leave blank. If a policy is sold to an individual as a non-group policy, then report with a value of "IND." | 246 | Commercial Only | Master | Required | 80% |
| CDLPC010 | Medicaid AID Category | char | 4 | For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the State's Medicaid agency. If not applicable, leave blank. | N/A | Medicaid Only | Master | Required | 50% |
| CDLPC011 | Subscriber Social Security Number | char | 9 | Subscriber's Social Security Number – do not include dashes. Required if collected. If not available, leave blank. | A89 | All | Master | Required IF Available | |
| CDLPC012 | Plan Specific Contract Number | varchar | 80 | Plan assigned subscriber's contract number (NCPDP refers to this as the Cardholder ID). If Plan Specific Contract Number is the subscriber's Social Security Number, leave blank. If this is a Medicaid claim, provide Medicaid ID. | 302-C2 | Commercial Only | Master | Required IF Available | |
| CDLPC013 | Subscriber Last Name | varchar | 100 | The subscriber's last name. | 716 | Commercial Only | Master | Required | 100% |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Pharmacy - 3.0.1 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **References NCPDP** | **Data Submitter Relevancy** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLPC014 | Subscriber First Name | varchar | 100 | The subscriber's first name. | 717 | Commercial Only | Master | Required | 100% |
| CDLPC015 | Sequence Number | varchar | 20 | Unique number of the member within the contract. When the member is the subscriber, use subscriber sequence number. | 303-C3 | Commercial Only | Master | Required | 90% |
| CDLPC016 | Member Social Security Number | char | 9 | Member's Social Security Number – do not include dashes. Required if collected. If not available, leave blank. | 332-CY | Commercial Only | Master | Required IF Available | |
| CDLPC017 | Individual Relationship Code | char | 2 | Member's relationship to subscriber. Individual Relationship codes maintained by ANSI ASC X12. See Appendix H: External Code Source. | 247 | Commercial Only | Master | Required | 100% |
| CDLPC018 | Member Sex | char | 1 | Sex of Member M = Male; F = Female; U = Unknown.<br><br>Member sex represents biological or administrative sex. Where available, submitters should provide the sex the member was assigned at birth on their original birth certificate (natal sex). When this is not available, submitters may provide the values they have regarding physical or legal sex (e.g., administrative sex as categorized by X12 values). | 305-C5 | All | Master | Required | 90% |
| CDLPC019 | Member Date of Birth | date | 8 | CCYYMMDD; Date of birth of member. | 304-C4 | All | Master | Required | 90% |
| CDLPC020 | Member Last Name | varchar | 100 | Member last name. | 716 | All | Master | Required | 90% |
| CDLPC021 | Member First Name | varchar | 100 | Member first name. | 717 | All | Master | Required | 90% |
| CDLPC022 | Member ZIP Code | varchar | 9 | Report the 5- or 9-digit ZIP Code of the member's residence. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the U.S. Postal Service. See Appendix H: External Code Sources. | 730-TC | All | Master | Required | 90% |
| CDLPC023 | Date Prescription Filled | date | 8 | CCYYMMDD. Date the prescription was filled. | 401-D1 | All | Detail | Required | 80% |
| CDLPC024 | Paid Date | date | 8 | CCYYMMDD. Paid date of the claim line. Report the date that appears on the: check, and/or remit, and/or explanation of benefits, and corresponds to any and all types of payment in CCYYMMDD Format. If paid/adjudicated date is not available use Processed Date. Claims paid in full, partial, or zero paid, must have a date reported here. | 216 (check date) or 578 (adjudication date) | All | Detail | Required | 80% |
| CDLPC025 | Drug Code | char | 11 | NDC Code for the drug on the claim. Do not include dashes NDC codes are maintained by the Federal Drug Administration. [Only associated with a drug, if service provided was not a drug, this line may be blank.]<br><br>See Appendix H: External Code Source, United States Federal Drug Administration. | 407-D7 | All | Detail | Required | 90% |
| CDLPC026 | New Prescription or Refill | char | 2 | Provide '00' for new prescriptions; for refills, provide the refill number. 00 = New prescription; 01–99 = Refill. [Only associated with a drug, if service provided was not a drug, this line may be blank.] | 254 | All | Detail | Required | 90% |
| CDLPC027 | Generic Drug Indicator | char | 2 | Indicates whether the drug itself is generic, not how the payor pays it. Valid codes are: 01 = Branded drug; 02 = Generic drug. [Only associated with a drug, if service provided was not a drug, this line may be blank.] | 425-DP | All | Detail | Required | 90% |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Pharmacy - 3.0.1 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **References NCPDP** | **Data Submitter Relevancy** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLPC028 | Dispensed as Written Code | char | 1 | Use this field to indicate how the drug was dispensed: 0 = No Product Selection Indicated (may also have missing values)<br>1 = Substitution Not Allowed by Prescriber<br>2 = Substitution Allowed – Patient Requested That Brand Product Be Dispensed<br>3 = Substitution Allowed – Pharmacist Selected Product Dispensed<br>4 = Substitution Allowed – Generic Drug Not in Stock<br>5 = Substitution Allowed – Brand Drug Dispensed as Generic<br>6 = Override<br>7 = Substitution Not Allowed – Brand Drug Mandated by Law<br>8 = Substitution Allowed – Generic Drug Not Available in Marketplace<br>9 = Other<br>[Only associated with a drug, if service provided was not a drug, this line may be blank.] | 408-D8 | All | Detail | Required | 90% |
| CDLPC029 | Compound Drug Indicator | char | 1 | Use this field to indicate whether the drug is a compound drug or non-compound drug. Valid codes are: N = Non-compound drug; Y = Compound drug; U = Unknown.<br>[Only associated with a drug, if service provided was not a drug, this line may be blank.] | 406-D6 | All | Detail | Required | 90% |
| CDLPC030 | Compound Drug Name or Compound Drug Ingredient List | char | 128 | If CDLPC029 = Y, then provide the NDC of the compound drug (Required). If no NDC is identified, include the names of the compound drug ingredients. Use spaces between multiple drugs.<br>[Only associated with a drug, if service provided was not a drug, this line may be blank.] | N/A | All | Detail | Conditional | 90% |
| CDLPC031 | Formulary Indicator | char | 1 | Use this field to report if the prescribed drug was on the carrier's formulary list. Valid codes include: 1 = Yes; 2 = No; 3 = Unknown; 4 = Other; 5 = Not applicable.<br>[Only associated with a drug, if service provided was not a drug, this line may be blank.] | N/A | All | Detail | Required | 90% |
| CDLPC032 | Quantity Dispensed | dec | 10,2 | Number of metric units of medication dispensed.<br>[Only associated with a drug, if service provided was not a drug, this line may be blank.] | 442-E7 | All | Detail | Required | 90% |
| CDLPC033 | Days' Supply | int | 3 | Estimated number of days the prescription will last.<br>[Only associated with a drug, if service provided was not a drug, this line may be blank.] | 405-D5 | All | Detail | Required | 90% |
| CDLPC034 | Drug Unit of Measure | varchar | 3 | Report the code that defines the unit of measure for the drug dispensed in PC033. Valid codes are EA = Each; F2 = International Units; GM = Grams; ML = Milliliters; MG = Milligrams; MEQ = Milliequivalent; MM = Millimeter; UG = Microgram; UU = Unit; OT= Other.<br>[Only associated with a drug, if service provided was not a drug, this line may be blank.] | N/A | All | Detail | Required | 90% |
| CDLPC035 | Prescription Number | varchar | 20 | Report the unique prescription identifier.<br>[Only associated with a drug, if service provided was not a drug, this line may be blank.] | 254 (fill number calculated) | All | Detail | Required | 90% |
| CDLPC036 | Charge Amount | int | 10 | NCPDP refers to this as Gross Amount Due. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | 430-DU | All | Detail | Required | 90% |
| CDLPC037 | Plan Paid Amount | int | 10 | NCPDP refers to this as Net Amount Due. Includes all health plan payments and excludes all member payments. For capitated claims, set to 0. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | 281 | All | Detail | Required | 100% |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Pharmacy - 3.0.1 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **References NCPDP** | **Data Submitter Relevancy** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLPC038 | Allowed Amount | int | 12 | When payment arrangement type in CDLPC049 is equal to 01 for capitated services, set to 0. When payment arrangement type in CDLPC049 is equal to 02 for fee-for-service, report the maximum amount contractually allowed. Report 0 if there is no allowed amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | N/A | All | Detail | Required | 100% |
| CDLPC039 | Sales Tax Amount | int | 12 | Report the amount of state sales tax applied to this claim line. Report 0 if there is no state tax amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Do not round up/down to whole dollars, code zero cents (00) when applicable. | 558-AW | All | Detail | Required | 100% |
| CDLPC040 | Ingredient Cost/List Price | int | 10 | Cost of the drug dispensed. Report 0 if there is no Ingredient Cost/List Price. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).<br>[Only associated with a drug, if service provided was not a drug, this line may be blank.] | 506-F6 | All | Detail | Required | 90% |
| CDLPC041 | Postage Amount Claimed | int | 10 | Postage amount associated with the claim. Report 0 if there is no Postage Amount Claimed. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).<br>[Only associated with a drug, if service provided was not a drug, this line may be blank.] | N/A | All | Detail | Required IF Available | |
| CDLPC042 | Dispensing Fee | int | 10 | Dispensing fee associated with the claim Report 0 if there is no Dispensing Fee. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).<br>[Only associated with a drug, if service provided was not a drug, this line may be blank.] | 507-F7 | All | Detail | Required | 90% |
| CDLPC043 | Copay Amount | int | 10 | Actual co-payment dollar amount paid for which the individual is responsible. (e.g., If the fixed amount is $25 but the cost to the member is $4 report, 400.) Report 0 if there is no copay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | 518-FI | All | Detail | Required | 50% |
| CDLPC044 | Coinsurance Amount | int | 10 | The dollar amount of coinsurance for this claim line for which an individual is responsible, not the percentage. Report 0 if no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | 572-4U | All | Detail | Required IF Available | |
| CDLPC045 | Deductible Amount | int | 10 | The dollar amount for this claim line applied to the deductible. Report 0 if there is no deductible amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | 517-FH | All | Detail | Required IF Available | |
| CDLPC046 | COB/TPL Amount | int | 12 | Amount due from a secondary carrier. Report the amount that another payor is liable for after submitting payor has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | N/A | All | Detail | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Pharmacy - 3.0.1 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **References NCPDP** | **Data Submitter Relevancy** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLPC047 | Other Insurance Paid Amount | int | 10 | Amount already paid by another carrier. Report the amount that a prior payor has paid for this claim line. Indicates the submitting payor is not the primary payor. Only Report "0" if the prior payor paid 0 toward this claim line or if there is no prior payor. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). May be reported as a negative. | 565-J4 | All | Detail | Required IF Available | |
| CDLPC048 | Member Self-pay Amount | int | 12 | Report the amount that the member has paid beyond the other patient obligations (e.g., gap on Medicare Part D, or difference between generic and brand) that are not otherwise listed in the file in CDLPC043, CDLPC044, CDLPC045. Report "0" if there is no member Self-Pay Amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Do not round up/down to whole dollars, code zero cents (00) when applicable. | 505-F5 | All | Detail | Required | 60% |
| CDLPC049 | Payment Arrangement Type Flag | char | 2 | Indicates the payment methodology. Valid codes are: 01 = Capitation; 02 = Fee-for-Service; 03 = Percent of Charges; 07 = Other. | N/A | | Master | Not Required | |
| CDLPC050 | Prescribing Physician ID | varchar | 30 | Payor assigned provider ID for the prescribing physician. This should be the identifier used by the payor for internal identification purposes and does not routinely change. Must map to the payor Assigned Provider ID (CDLPV004) in the Provider File. | N/A | | Master | Optional | |
| CDLPC051 | Prescribing Physician NPI | char | 10 | NPI number for prescribing physician. | 411-DB | | Master | Optional | |
| CDLPC052 | Prescribing Physician First Name | varchar | 25 | Prescribing Physician's first name or initial. | A92 | | Master | Optional | |
| CDLPC053 | Prescribing Physician Last Name | varchar | 60 | Prescribing Physician's last name. | 716 | | Master | Optional | |
| CDLPC054 | Pharmacy NCPDP Number | varchar | 7 | Unique 7-digit number assigned by the National Council for Prescription Drug Program (NCPDP). | N/A | All | Master | Required | 80% |
| CDLPC055 | Pharmacy ID | varchar | 30 | Payor assigned pharmacy ID. This should be the identifier used by the payor for internal identification purposes and does not routinely change. Must map to the payor Assigned Provider ID (CDLPV004) in the Provider File. | 201-B1 | All | Master | Required | 60% |
| CDLPC056 | Pharmacy Tax ID Number | varchar | 10 | Dispensing pharmacy federal taxpayor's identification number coded with no punctuation (carriers that contract with outside PBMs may not have this data). | N/A | | Master | Not Required | |
| CDLPC057 | Pharmacy NPI | char | 10 | NPI of the entity or individual (pharmacy) directly providing the service. | 201-B1 | | Master | Not Required | |
| CDLPC058 | Pharmacy Location Street Address | varchar | 55 | Street address of pharmacy that dispensed the prescription, including street number and name. Include suite number if applicable. Relates to CDLPC059 – CDLPC061. | 728-SU | | Master | Not Required | |
| CDLPC059 | Pharmacy Location State | char | 2 | State or Province where dispensing pharmacy located. State or Province codes are maintained by the U.S. Postal Service. See Appendix H: External Code Sources, United States Postal Service. | 729-TA | All | Master | Required | 100% |
| CDLPC060 | Pharmacy ZIP Code | varchar | 9 | Report the 5- or 9-digit ZIP Code of the dispensing pharmacy. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the U.S. Postal Service. See Appendix H: External Code Sources. | 730-TC | All | Master | Required | 100% |
| CDLPC061 | Pharmacy Country Code | char | 2 | Country where dispensing pharmacy located. Code US for United States. See Appendix H: External Code Sources, United States Postal Service. | A93-1T | All | Master | Required | 50% |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Pharmacy - 3.0.1 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **References NCPDP** | **Data Submitter Relevancy** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLPC062 | Mail-Order Pharmacy Indicator | char | 1 | Use this field to report if the pharmacy was a mail-order pharmacy. Valid codes include: 1 = Yes mail-order pharmacy; 2 = No – not a mail order pharmacy; 3 = Unknown; 4 = Other; 5 = Not applicable. | N/A | All | Master | Required | 50% |
| CDLPC063 | Carrier Associated with Claim | varchar | 8 | For each claim, use the NAIC code of the carrier when a PBM processes claims on behalf of the carrier. Optional if all pharmacy claims processed by a PBM under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. See Appendix H: External Code Source, National Association of Insurance Commissioners. | N/A | All | Master | Required | 40% |
| CDLPC064 | In Plan Network Indicator | char | 1 | Use this field to specify if services from the requested provider were provided within the health plan network. Valid values are: N = No; Y = Yes; L = Leased Network. | N/A | | Master | Optional | |
| CDLPC065 | Record Status Code | char | 1 | Record status codes maintained by NCPDP is the code identifying type of claim. See Appendix H: External Code Source, NCPDP. | A88 | | Master | Optional | |
| CDLPC066 | Claim Line Type | char | 1 | Report the code that defines the claim line status in terms of adjudication. Valid codes are: O = Original; V = Void; R = Replacement; B = Back Out; A = Amendment; D = Denial. | N/A | | Detail | Required | 95% |
| CDLPC067 | Reject Code | varchar | 3 | Report the reason code for the denial. Report the code that defines the reason for denial of the claim line. If not available, leave blank. Reason codes are maintained by NCPDP. See Appendix H: External Code Source, NCPDP. | 511-FB | | Detail | Optional | |
| CDLPC068 | Carrier Specific Unique Member ID | varchar | 50 | Report the identifier the carrier/submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's/submitter's files for reporting and aggregation. | N/A | All | Master | Required | 100% |
| CDLPC069 | Carrier Specific Unique Subscriber ID | varchar | 50 | Report the identifier the carrier/submitter uses internally to uniquely identify the subscriber. Used to create Unique Member ID and link across carrier's/submitter's files for reporting and aggregation. | N/A | All | Master | Required | 100% |
| CDLPC070 | Prescriber Specialty | varchar | 10 | Report the NUCC healthcare provider taxonomy code. See Appendix H: External Code Source, National Uniform Claim Committee. | 296 | All | Master | Not Required | |
| CDLPC071 | Pharmacy City | varchar | 100 | City or town where dispensing pharmacy located. | 728-SU | All | Master | Required | 50% |
| TXPC1001 | Drug Strength Description | char | 10 | Description of drug potency expressed in units of grams, milligrams, percentage, and other terms. The field should contain an alpha/numeric value (e.g., 25MG, 1:10000, or 10MG/100ML) of no more than 10 characters. | Chronic Condition Warehouse CODEBOOK: Medicare Part D Event (PDE)/Drug Characteristics - Entry for STR | Medicare Fee For Service ONLY | Master | Optional | |
| TXPC1002 | AHFS Therapeutic Classification | varchar | 8 | Identifies therapeutic category of drug according to the American Hospital Formulary Service classification system. Do not include non-integers. Example: 08:12:28 should be submitted as 081228, do not pad out to 8 characters with trailing zeros. | https://ahfsdruginformation.com/ahfs-classification-drug-assignments/ | Medicare Fee For Service ONLY | Detail | Optional | |
| CDLPCXXX | Unassigned | char | 1 | Reserved for future use. Elements will only be added with review from states and payors. | N/A | | Master | Not Required | |
| CDLPC899 | Record Type | char | 2 | Value = PC. | N/A | | | Required | 100% |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Dental | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLDC001 | Data Submitter Code | varchar | 8 | APCD-assigned identifier of payor submitting data file. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). This may or may not be the same code as the payor Code (CDLDC002). | N/A | All | Master | Required | 100% |
| CDLDC002 | Payor Code | int | 8 | APCD-assigned identifier of insurer in the case of premiums-based coverage, or of the administrator in the case of self-funded coverage. Code assigned to the plan by the APCD registration system (may be multi-tiered to support different platforms). | N/A | All | Master | Required | 100% |
| CDLDC003 | Plan ID | varchar | 30 | CMS National Plan ID. The National Plan ID is a code assigned by CMS. (PLACEHOLDER) | 2330B NM109 | All | Master | Not Required | |
| CDLDC004 | Member Insurance/ Product Category Code | char | 2 | See Appendix G1: Insurance Type/Product Category for codes. Use the most granular choice available. | 2320 SBR09 | All | Master | Required | 90% |
| CDLDC005 | Payor Claim Control Number | varchar | 35 | Must apply to the entire claim and be unique within the payor's system. Payor Claim Control Number (PCCN) must be consistent across claim versions and therefore should not be a transaction number. A combination of the PCCN and version number (CDLDC007) will be used to determine which rows will carry forward into the final claim. It is also imperative that a reversal uses the same PCCN as the original paid claim. | 2330B REF02 where REF01 = F8 | All | Master | Required | 100% |
| CDLDC006 | Line Counter | int | 4 | Line number for this service. The line counter begins with 1 and is incremented by 1 for each additional service line of a claim. | 2400 LX01 | All | Detail | Required | 90% |
| CDLDC007 | Version Number | int | 4 | The version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of the claim. If version numbers are not used, set to null and use Cross Reference Claims ID (CDLDC008). | N/A | All | Detail | Required IF Available | |
| CDLDC008 | Cross Reference Claims ID | varchar | 35 | The original Payor Claim Control Number (CDLDC005). Used when a new Payor Claim Control Number is assigned to an adjusted claim and a Version Number (CDLDC007) is not used. If payor claim control numbers are not used, set to null. | N/A | All | Master | Required IF Available | |
| CDLDC009 | Insured Group or Policy Number | varchar | 50 | The identification number, or code assigned by the carrier or administrator to identify the group under which the individual is covered. CDLDC009 is not the number that uniquely identifies the subscriber. If no group or policy number is available, leave blank. If the coverage is Medicaid, leave blank. If a policy is sold to an individual as a non-group policy, then report with a value of "IND." | 2320 SBR03 | All | Master | Required | 80% |
| CDLDC010 | Medicaid AID Category | char | 4 | For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the State's Medicaid agency. If not applicable, leave blank. | N/A | Medicaid Only | Master | Required | 50% |
| CDLDC011 | Subscriber Social Security Number | char | 9 | Subscriber's Social Security Number – do not include dashes. Required if collected. If not available, leave blank. | 2010BA REF02 | All | Master | Required IF Available | |
| CDLDC012 | Plan Specific Contract Number | varchar | 80 | Plan assigned contract number. If Plan Specific Contract Number is the subscriber's Social Security Number, leave blank. If this is a Medicaid claim, provide the Medicaid ID. | 2010BA NM109 | Commercial Only | Master | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Dental | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLDC013 | Subscriber Last Name | varchar | 100 | The subscriber's last name. | 2010BA/NM1//03 | Commercial Only | Master | Required | 100% |
| CDLDC014 | Subscriber First Name | varchar | 100 | The subscriber's first name. | 2010BA/NM1//03 | Commercial Only | Master | Required | 100% |
| CDLDC015 | Sequence Number | varchar | 20 | Unique number of the member within the contract. When the member is the subscriber, use subscriber sequence number. | N/A | All | Master | Required | 100% |
| CDLDC016 | Member Social Security Number | char | 9 | Member's Social Security Number – do not include dashes. Required if collected. If not available, leave blank. | 2010CA REF109 or 2010BA REF109 | All | Master | Required IF Available | |
| CDLDC017 | Individual Relationship Code | char | 2 | Member's relationship to insured. Individual Relationship codes maintained by ANSI ASC X12. See Appendix H: External Code Source, Accredited Standards Committee. | 2000C PAT01 or 2000B SBR02 | Commercial and Dental | Master | Required | 100% |
| CDLDC018 | Member Gender | char | 1 | Gender of Member M = Male; F = Female; U = Unknown. | 2010CA DMG03 | All | Master | Required | 90% |
| CDLDC019 | Member Date of Birth | date | 8 | CCYYMMDD. Date of birth of member. | 2010CA DMG02 | All | Master | Required | 90% |
| CDLDC020 | Member Last Name | varchar | 100 | The member's last name. If the member is the subscriber, report the subscriber's last name. | 2010CA NM103 | All | Master | Required | 90% |
| CDLDC021 | Member First Name | varchar | 100 | The member's first name. If the member is the subscriber, report the subscriber's first name. | 2010CA NM104 | All | Master | Required | 90% |
| CDLDC022 | Member ZIP Code | varchar | 9 | Report the 5- or 9-digit ZIP Code of the member's residence. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the U.S. Postal Service. See Appendix H: External Code Sources. | 2010CA N403 or 2010BA N403 | All | Master | Required | 90% |
| CDLDC023 | Paid Date | date | 8 | CCYYMMDD. Paid date of the claim line. Report the date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment in CCYYMMDD format. If paid/adjudicated date is not available use Processed Date. Claims paid in full, partial, or zero paid must have a date reported. | 2330B DTP03 where DTP01 = 57 | All | Detail | Required | 100% |
| CDLDC024 | Place of Service – Professional | char | 2 | Required for professional claims. Not to be used for institutional claims. Place of Service codes are maintained by CMS. See Appendix H in the Data Submission Guide External Code Source, Center for Medicaid and Medicare Services. | 2300 CLM05-01 | All | Detail | Not Required | |
| CDLDC025 | ICD 10-CM Diagnosis Code | varchar | 7 | ICD 10-CM Diagnosis Code when applicable. See Appendix H in the Data Submission Guide External Code Source. | 2300 HI01-2 | All | | Required IF Available | |
| CDLDC026 | ICD-9/ICD-10 Flag | char | 1 | The purpose of this field is to identify which code set is being utilized. 9 = This claim contains ICD-9-CM codes. 0 = This claim contains ICD-10-CM codes. | N/A | All | | Required IF Available | |
| CDLDC027 | Procedure Code | varchar | 5 | Common Dental Terminology code for the dental procedure on the claim. CDT codes are maintained by American Dental Association. See Appendix H: External Code Source, American Dental Association. | 2400 SV301-02 | Dental Only | Detail | Required | 100% |
| CDLDC028 | Oral Cavity 1 | char | 2 | Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature.<br>Area of the oral cavity is designated by a two-digit code, selected from the following code list:<br>00=entire oral cavity;<br>01=maxillary arch;<br>02=mandibular arch;<br>10=upper right quadrant;<br>20=upper left quadrant;<br>30=lower left quadrant;<br>40=lower right quadrant. | 2400 SV304-01 | Dental Only | Detail | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Dental | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLDC029 | Oral Cavity 2 | char | 2 | Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature.<br>Area of the oral cavity is designated by a two-digit code, selected from the following code list:<br>00=entire oral cavity;<br>01=maxillary arch;<br>02=mandibular arch;<br>10=upper right quadrant;<br>20=upper left quadrant;<br>30=lower left quadrant;<br>40=lower right quadrant. | 2400 SV304-02 | Dental Only | Detail | Required IF Available | |
| CDLDC030 | Oral Cavity 3 | char | 2 | Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature.<br>Area of the oral cavity is designated by a two-digit code, selected from the following code list:<br>00=entire oral cavity;<br>01=maxillary arch;<br>02=mandibular arch;<br>10=upper right quadrant;<br>20=upper left quadrant;<br>30=lower left quadrant;<br>40=lower right quadrant. | 2400 SV304-03 | Dental Only | Detail | Required IF Available | |
| CDLDC031 | Oral Cavity 4 | char | 2 | Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature.<br>Area of the oral cavity is designated by a two-digit code, selected from the following code list:<br>00=entire oral cavity;<br>01=maxillary arch;<br>02=mandibular arch;<br>10=upper right quadrant;<br>20=upper left quadrant;<br>30=lower left quadrant;<br>40=lower right quadrant. | 2400 SV304-04 | Dental Only | Detail | Required IF Available | |
| CDLDC032 | Oral Cavity 5 | char | 2 | Always report the area of the oral cavity when the procedure reported in field CDLDC027 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature.<br>Area of the oral cavity is designated by a two-digit code, selected from the following code list:<br>00=entire oral cavity;<br>01=maxillary arch;<br>02=mandibular arch;<br>10=upper right quadrant;<br>20=upper left quadrant;<br>30=lower left quadrant;<br>40=lower right quadrant. | 2400 SV304-05 | Dental Only | Detail | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Dental | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLDC033 | Tooth Number or Letter (1) | varchar | 2 | Required when CDLDC027 = D2000 through D2999. Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. If not available, leave blank. Tooth Number codes are maintained by the American Dental Association. See Appendix H in the Data Submission Guide External Code Source, American Dental Association. | 2400 TOO 02 | Dental Only | Detail | Required IF Available | |
| CDLDC034 | Tooth – 1 Surface – 1 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC033 is populated. | 2400 TOO02-01 | Dental Only | Detail | Required IF Available | |
| CDLDC035 | Tooth – 1 Surface – 2 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC033 is populated. | 2400 TOO02-02 | Dental Only | Detail | Required IF Available | |
| CDLDC036 | Tooth – 1 Surface – 3 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC033 is populated. | 2400 TOO02-03 | Dental Only | Detail | Required IF Available | |
| CDLDC037 | Tooth – 1 Surface – 4 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC033 is populated. | 2400 TOO02-04 | Dental Only | Detail | Required IF Available | |
| CDLDC038 | Tooth – 1 Surface – 5 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC033 is populated. | 2400 TOO02-05 | Dental Only | Detail | Required IF Available | |
| CDLDC039 | Tooth Number or Letter (2) | varchar | 2 | Report the tooth identifier(s) when CDLDC027 is within the given range if a second tooth is involved in the procedure. Required when CDLDC027 = D2000 through D2999. See Appendix H in the Data Submission Guide External Code Source, American Dental Association. | 2400 TOO 03 | Dental Only | Detail | Required IF Available | |
| CDLDC040 | Tooth – 2 Surface – 1 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC039 is populated. | 2400 TOO03-01 | Dental Only | Detail | Required IF Available | |
| CDLDC041 | Tooth – 2 Surface – 2 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC039 is populated. | 2400 TOO03-02 | Dental Only | Detail | Required IF Available | |
| CDLDC042 | Tooth – 2 Surface – 3 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC039 is populated. | 2400 TOO03-03 | Dental Only | Detail | Required IF Available | |
| CDLDC043 | Tooth – 2 Surface – 4 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC039 is populated. | 2400 TOO03-04 | Dental Only | Detail | Required IF Available | |
| CDLDC044 | Tooth – 2 Surface – 5 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC039 is populated. | 2400 TOO03-05 | Dental Only | Detail | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Dental | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLDC045 | Tooth Number or Letter (3) | varchar | 2 | Report the tooth identifier(s) when CDLDC027 is within the given range if a third tooth is involved in the procedure. Required when CDLDC027 = D2000 through D2999. See Appendix H in the Data Submission Guide External Code Source, American Dental Association. | 2400 TOO 04 | Dental Only | Detail | Required IF Available | |
| CDLDC046 | Tooth – 3 Surface – 1 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC045 is populated. | 2400 TOO04-01 | Dental Only | Detail | Required IF Available | |
| CDLDC047 | Tooth – 3 Surface – 2 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC045 is populated. | 2400 TOO04-02 | Dental Only | Detail | Required IF Available | |
| CDLDC048 | Tooth – 3 Surface – 3 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC045 is populated. | 2400 TOO04-03 | Dental Only | Detail | Required IF Available | |
| CDLDC049 | Tooth – 3 Surface – 4 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC045 is populated. | 2400 TOO04-04 | Dental Only | Detail | Required IF Available | |
| CDLDC050 | Tooth – 3 Surface – 5 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/ Letter CDLDC045 is populated. | 2400 TOO04-05 | Dental Only | Detail | Required IF Available | |
| CDLDC051 | Tooth Number or Letter (4) | varchar | 2 | Report the tooth identifier(s) when CDLDC027 is within the given range if a fourth tooth is involved in the procedure. Required when CDLDC027 = D2000 through D2999. See Appendix H in the Data Submission Guide External Code Source, American Dental Association. | 2400 TOO 05 | Dental Only | Detail | Required IF Available | |
| CDLDC052 | Tooth – 4 Surface – 1 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC051 is populated. | 2400 TOO05-01 | Dental Only | Detail | Required IF Available | |
| CDLDC053 | Tooth – 4 Surface – 2 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC051 is populated. | 2400 TOO05-02 | Dental Only | Detail | Required IF Available | |
| CDLDC054 | Tooth – 4 Surface – 3 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC051 is populated. | 2400 TOO05-03 | Dental Only | Detail | Required IF Available | |
| CDLDC055 | Tooth – 4 Surface – 4 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC051 is populated. | 2400 TOO05-04 | Dental Only | Detail | Required IF Available | |
| CDLDC056 | Tooth – 4 Surface – 5 | varchar | 1 | Report the tooth surface(s) on which this service was performed. Provides further detail on procedure(s). Required when Tooth Number/Letter CDLDC051 is populated. | 2400 TOO05-05 | Dental Only | Detail | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Dental | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLDC057 | Date of Service – From | date | 8 | CCYYMMDD. First date of service for this service line. Filled for all claim types. (This date should be within the coverage period on the Eligibility file, i.e., between the Plan Effective Date and the Plan Term Date on the Eligibility file all inclusive.) | 2400 DTP03 where DTP01 = 472 or 2300 DTP03 where DTP01 = 434 | All | Detail | Required | 100% |
| CDLDC058 | Date of Service – Thru | date | 8 | CCYYMMDD. Last date of service for this service line. Filled for all claim types. | 2400 DTP03 where DTP01 = 472 or 2300 DTP03 where DTP01 = 434 | All | Detail | Required | 100% |
| CDLDC059 | Charge Amount | int | 12 | The amount charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | 2400 SV102 (P) | All | Detail | Required | 90% |
| CDLDC060 | Plan Paid Amount | int | 12 | This is the amount paid by the plan to cover the services to the provider or member. This excludes the patient liability. For capitated claims, set to 0. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | 2430 SVD02 | All | Detail | Required | 100% |
| CDLDC061 | Co-pay Amount | int | 12 | Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. If only collected on the header record, report the co-pay amount on the first claim line. Report 0 if there is no co-pay amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | 2320 and/or 2430 CAS03 where the CARC is 3 | All | Detail | Required IF Available | |
| CDLDC062 | Coinsurance Amount | int | 12 | The dollar amount for which the member is responsible attributed to the coinsurance amount. This is the dollar amount, not the percentage from which the dollar amount was calculated. If only collected on the header record, report the coinsurance amount on the first claim line. Report 0 if there is no coinsurance amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | 2320 and/or 2430 CAS03 where the CARC is 2 | All | Detail | Required IF Available | |
| CDLDC063 | Deductible Amount | int | 12 | Report the amount of the deductible applied to the claim. If only collected on the header record, report the deductible amount on the first claim line. Report 0 if there is no deductible amount applied to the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | 2320 and/or 2430 CAS03 where the CARC is 1 | All | Detail | Required IF Available | |
| CDLDC064 | Allowed Amount | Int | 12 | When payment arrangement type in CDLDC065 is equal to 01 for capitated services, set to 0. When payment arrangement type in CDLDC065 is equal to 02 for fee-for-service, report the maximum amount contractually allowed that a carrier will pay for a particular procedure or service. Report 0 if there is no allowed amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). | 2300 HCP02 | All | Detail | Required | 90% |
| CDLDC065 | Payment Arrangement Type Flag | char | 2 | Indicates the payment methodology. Valid codes are: 01 = Capitation; 02 = Fee-for-Service; 03 = Percent of Charges; 07= Other. Will default to 02 if left blank in dental claims. | N/A | All | Master | Required IF Available | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Dental | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLDC066 | Rendering Provider ID | varchar | 30 | Unique code identified for the provider as assigned by the reporting entity. Payor assigned provider ID for the provider that provided the services on the claims. This should be the identifier used by the payor for internal identification purposes and does not routinely change. Must map to the payor Assigned Provider ID (CDLPV004) in the Provider File. | 2420A REF02 where REF01 = G2 (P) or 2310B REF02 where REF01 = G2 (P) | All | Master | Required | 90% |
| CDLDC067 | Rendering Provider NPI | char | 10 | Rendering Provider NPI is the NPI of the entity or individual directly providing the service, as enumerated in the Center for Medicaid and Medicare Services NPPES. | 2420A NM109 | All | Master | Required | 80% |
| CDLDC068 | Rendering Provider Entity Type Qualifier | char | 1 | Use this field to indicate whether the rendering provider is a person or non-person entity. HIPAA provider taxonomy classifies provider groups (clinicians who bill as a group practice or under a corporate name, even if that group is composed of one provider) as a "person." Valid codes are: 1= Person; 2 = Non-person Entity. | 2420A NM102 or 2310B NM102 | All | Master | Required | 50% |
| CDLDC069 | Rendering Provider First Name | varchar | 100 | Individual first name. If CDLDC068 = 2, leave blank. | 2420A NM104 or 2310B NM104 | All | Master | Required | 90% |
| CDLDC070 | Rendering Provider Middle Name | varchar | 25 | Individual middle name or initial. If CDLDC068 = 2, leave blank. | 2420A NM105 or 2310B NM105 or 2010AA NM105 | Dental Only | Master | Required IF Available | |
| CDLDC071 | Rendering Provider Last Name or Organization Name | varchar | 150 | Full name of provider organization (non- person entity) or last name of individual (person) provider. CDLDC068 determines if the rendering provider is a "person" or a "non-person entity." | 2420A NM103 or 2310B NM103 or 2010AA NM103 | All | Master | Required | 90% |
| CDLDC072 | Rendering Provider Suffix | varchar | 10 | Suffix to individual name. Set to null if provider is a facility or organization. The service provider suffix shall be used to capture the generation of the individual clinician (e.g., Jr., Sr., III). | 2420A NM107 or 2310B NM107 or 2010AA NM107 | All | Master | Optional | |
| CDLDC073 | Rendering Provider Specialty | varchar | 10 | Standard code that identifies the provider specialty for this line of service. Report the HIPAA-compliant health care provider national taxonomy code. Provider taxonomy codes are maintained by the National Uniform Claims Committee (NUCC). See Appendix H: External Code Source, National Uniform Claims Committee. | 2420A PRV03 or 2310B PRV03 or 2000AA PRV03 | All | Master | Required | 60% |
| CDLDC074 | Rendering Provider City Name | varchar | 100 | City name of provider or practice location. | 2420C N401 or 2310C N401 | All | Master | Required | 50% |
| CDLDC075 | Rendering Provider State or Province | char | 2 | State of provider or practice location. State or Province codes are maintained by the U.S. Postal Service. See Appendix H: External Code Sources, United States Postal Service. | 2420C N402 or 2310C N402 | All | Master | Required | 50% |
| CDLDC076 | Rendering Provider ZIP Code | varchar | 9 | Report the 5- or 9-digit ZIP Code of the rendering provider. When submitting the 9-digit ZIP Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. ZIP Codes are maintained by the U.S. Postal Service. See Appendix H: External Code Sources. | 2420C N403 or 2310C N403 | All | Master | Required | 100% |
| CDLDC077 | Rendering Provider Group Practice NPI | varchar | 10 | NPI of rendering provider group practice to which a practitioner is affiliated if different from CDLDC067. | N/A | All | Master | Optional | |

| Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Dental | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NEW CDL Data Element #** | **Data Element Name** | **Type** | **Max Length** | **Description/Codes/Sources** | **PACDR References** | **Data Submitter Relevancy** | **Master or Detail** | **Required** | **Minimum Threshold (% of Records Submitted with Value in Field)** |
| CDLDC078 | Billing Provider ID | varchar | 30 | Unique code identified for the provider as assigned by the reporting entity. Payor assigned provider ID for the provider that is the billing provider. This should be the identifier used by the payor for internal identification purposes and does not routinely change. Must map to the payor Assigned Provider ID (CDLPV004) in the Provider File. | 2010AA REF02 where REF01 = G2 and/or LU | All | Master | Required | 80% |
| CDLDC079 | Billing Provider NPI | char | 10 | NPI for billing provider as enumerated in the Center for Medicaid and Medicare Services NPPES. | 2010AA NM109 where 2010AA NM108 = XX | All | Master | Required | 80% |
| CDLDC080 | Billing Provider Last Name or Organization Name | varchar | 150 | Full name of provider billing organization or last name of individual billing provider. | 2010AA NM103 | All | Master | Required | 80% |
| CDLDC081 | Billing Provider Tax ID | varchar | 10 | Tax ID of the billing provider. Do not code punctuation. | N/A | All | Master | Optional | |
| CDLDC082 | Carrier Associated with Claim | varchar | 8 | For each claim, use the NAIC code of the carrier when a TPA processes claims on behalf of the carrier. Optional if all medical claims processed by a TPA under contract to a carrier for carved-out services are submitted by the carrier with unified member IDs in all files. NAIC codes are maintained by the National Association of Insurance Commissioners. If not available, leave blank. See Appendix H in the Data Submission Guide External Code Source, National Association of Insurance Commissioners. | N/A | All | Master | Optional | |
| CDLDC083 | Claim Status | char | 2 | Claim status codes maintained by ANSI ASC X12 is the code identifying type of claim. See Appendix H: External Code Source, Accredited Standards Committee. | 835/2100/CLP/02 | All | Detail | Required | 90% |
| CDLDC084 | Claim Line Type | char | 1 | Report the code that defines the claim line status in terms of adjudication. Valid codes are: O = Original; V = Void; R = Replacement; B = Back Out; A = Amendment; D = Denial. | N/A | All | Detail | Required | 95% |
| CDLDC085 | Carrier Specific Unique Member ID | varchar | 50 | Report the identifier the carrier/submitter uses internally to uniquely identify the member. Used to create Unique Member ID and link across carrier's/submitter's files for reporting and aggregation. | N/A | All | Master | Required | 100% |
| CDLDC086 | Carrier Specific Unique Subscriber ID | varchar | 50 | Report the identifier the carrier/submitter uses internally to uniquely identify the subscriber. Used to create Unique Subscriber ID and link across carrier's/submitter's files for reporting and aggregation. | N/A | All | Master | Required IF Available | |
| CDLDCXXX | Unassigned | char | 1 | Reserved for future use. Elements will only be added with review from states and payors. | N/A | | | Not Required | |
| CDLDC899 | Record Type | char | 2 | Value = DC | N/A | | | Required | 100% |

| Appendix G-1: Insurance Type/Product Code | |
|---|---|
| This is a list of codes used by state APCDs. To be used for claims and eligibility. | |
| **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 (Commercial Coverage) |
| 41 | Medicare Secondary Black Lung |
| 42 | Medicare Secondary Veterans' Administration |
| 43 | Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan (LGHP) |
| 47 | Medicare Secondary, Other Liability Is Primary |
| AP | Auto Insurance Policy |
| C1 | Other Commercial (Not Specified Elsewhere) |
| 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 |
| FH | Federal Employees Health Benefits Program (HMO) |
| FP | Federal Employees Health Benefits Program (PPO) |
| 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 (not to be used for commercial plans) |
| MB | Medicare Part B (not to be used for commercial plans) |
| MC | Medicaid |
| MD | Medicare Part D |
| MH | Medigap Part A |
| MI | Medigap Part B |
| MO | Medicare Advantage PPO |
| MP | Medicare Primary (not to be used for commercial plans) |
| MT | Medicaid CHIP |
| OT | Other |
| PE | Property Insurance – Personal |
| PL | Personal |
| PP | Personal Payment (Cash – No Insurance) |
| PR | Preferred Provider Organization (PPO) |
| PS | Point of Service (POS) |
| QM | Qualified Medicare Beneficiary |
| RP | Property Insurance – Real |
| SP | Supplemental Policy |
| S1 | Medicare Special Needs Plan – Chronic Condition |
| S2 | Medicare Special Needs Plan - Institutionalized |
| S3 | Medicare Special Needs Plan – Dual Eligible |
| TF | Tax Equity Fiscal Responsibility Act (TEFRA) |
| TR | Tricare |
| U | Multiple Options Health Plan |
| VA | Veterans Administration Plan |
| WC | Workers' Compensation |
| WU | Wrap Up Policy |
| 11 | Other Non-Federal Programs |

| | |
|---|---|
| DM | Dental Maintenance Organization |
| AM | Automobile Medical |
| BL | Blue Cross/Blue Shield |
| CH | CHAMPUS |
| CI | Commercial Insurance Company |
| LB | Liability |
| LM | Liability Medical |
| OF | Other Federal Program |
| TV | Title V |
| SL | Standalone limited (for example, vision only, hearing only) |
| ZZ | Mutually Defined (Use code ZZ when Type of Insurance is Unknown) |

| Appendix G-2: Market Category Codes | |
|---|---|
| **Code** | **Description** |
| IND | Individuals (non-group) |
| FCH | Individuals on a franchise basis |
| GCV | Individuals as group conversion Policies |
| GS1 | Employers having exactly 1 employee |
| GS2 | Employers having 2 thru 9 employees |
| GS3 | Employers having 10 thru 25 employees |
| GS4 | Employers having 26 thru 50 employees |
| GLG1 | Employers having 51 thru 100 employees |
| GLG2 | Employers having 101 thru 250 employees |
| GLG3 | Employers having 251 thru 500 employees |
| GLG4 | Employers having more than 500 employees |
| GSA | Small employers through a qualified association trust |
| OTH | Other types of entities. Insurers using this market code shall obtain prior approval. |

## Appendix H: External Code Sources

**American Dental Association**
Current Dental Terminology (CDT) Codes
SOURCE: Current Dental Terminology (CDT) Manual
AVAILABLE FROM:
American Dental Association 211 East Chicago Avenue Chicago, IL 60611-2678
ABSTRACT: The CDT contains the American Dental Association's codes for dental procedures and nomenclature and is the nationally accepted set of numeric codes and descriptive terms for reporting dental treatments.

**American Medical Association**
Current Procedural Terminology (CPT) Codes
SOURCE: Physicians' Current Procedural Terminology (CPT) Manual
AVAILABLE FROM:
American Medical Association 515 North State Street Chicago, IL 60654
ABSTRACT: A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians.

**Accredited Standards Committee (ASC)**
ASC X12 Directories
SOURCE: PACDR Implementation Guides, ASC X12 005010 Standard
AVAILABLE FROM:
Data Interchange Standards Association, Inc. (DISA) 7600 Leesburg Pike Ste 430
Falls Church, VA 22043 http://store.x12.org/store
Washington Publishing Company http://www.wpc-edi.com/reference/
ABSTRACT: The PACDR Implementation Guides contain the descriptions of data elements used to construct X12 segments. The PACDR Guides also contain code lists associated with these data elements.

**Centers for Disease Control and Prevention**
SOURCE: Race and Ethnicity Code Set
AVAILABLE FROM:
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329-4027
FILE: PH_RaceAndEthnicity_CDC_v1.2.xlsx - Race and Ethnicity Download File (Full Code System, relationships, and Hierarchy codes) found in “CDC Race Category and Ethnicity Group” at https://phinvads.cdc.gov/vads/SearchVocab.action.
ABSTRACT: The race and ethnicity code set is used for coding the race and ethnicity of the member.

**Centers for Medicare and Medicaid Services**
Health Care Common Procedural Coding System
SOURCE: Health Care Common Procedural Coding System
AVAILABLE FROM:
Centers for Medicare and Medicaid Services 7500 Security Boulevard
Baltimore, MD 21244-1850 www.cms.gov/HCPCSReleaseCodeSets/
ABSTRACT: HCPCS is the Centers for Medicare and Medicaid Services (CMS) coding scheme to group procedures performed for payment to providers

**Centers for Medicare and Medicaid Services**
Health Insurance Prospective Payment System (HIPPS)
SOURCE: Center for Medicare & Medicaid Services
AVAILABLE FROM:
Center for Medicare and Medicaid Services 7500 Security Boulevard
Baltimore, MD 21244
http://www.cms.gov/Medicare/Medicare-fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes.html
ABSTRACT: Health Insurance Prospective Payment System (HIPPS) rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems. Case-mix groups are developed based on research into utilization patterns among various provider types. For the payment systems that use HIPPS codes, clinical assessment data is the basic input used to determine which case-mix group applies to a particular patient. A standard patient assessment instrument is interpreted by case-mix grouping software algorithms, which assign the case mix group. For payment purposes, at least one HIPPS code is defined to represent each case-mix group. These HIPPS codes are reported on claims to insurers.

**Centers for Medicare and Medicaid Services**
HHS Actuarial Value Calculator
SOURCE: Center for Consumer Information & Insurance Oversight
AVAILABLE FROM:
Centers for Medicare and Medicaid Services 7500 Security Boulevard
Baltimore, MD 21244-1850 https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html
ABSTRACT: CCIIO publishes an AV calculator on an annual basis.

**Centers for Medicare and Medicaid Services**
National Provider Identifier
SOURCE: National Plan and Provider Enumeration System
AVAILABLE FROM:
Centers for Medicare and Medicaid Services 7500 Security Boulevard
Baltimore, MD 21244-1850 https://nppes.cms.hhs.gov/NPPES/Welcome.do
ABSTRACT: The Centers for Medicare and Medicaid Services developed the National Provider Identifier as the standard, unique identifier for each health care provider under the Health Insurance Portability and Accountability Act of 1996.

**Centers for Medicare and Medicaid Services**
Place of Service Codes for Professional Claims
SOURCE: Place of Service Codes for Professional Claims
AVAILABLE FROM:
Centers for Medicare and Medicaid Services 7500 Security Boulevard
Baltimore, MD 21244-1850 www.cms.gov/physicianfeesched/downloads/Website_POS_database.pdf
ABSTRACT: The place of service code identifies the location where the healthcare service was rendered.

**ISO 3166 Maintenance Agency**
Country Codes
SOURCE: ISO 3166 Maintenance Agency
AVAILABLE FROM:
ISO 3166 Maintenance Agency
c/o International Organization for Standardization Chemin de Blandonnet 8
CP 401
1214 Vernier, Geneva Switzerland
Telephone: +41 22 749 01 11
e-mail: customerservice@iso.org
www.iso.org/iso/country_codes

**ISO 639-3:2007 Language**

Language
SOURCE: ISO 639 Maintenance Agency
AVAILABLE FROM:
International Organization for Standardization
ISO Central Secretariat
Chemin de Blandonnet 8
CP 401
1214 Vernier, Geneva, Switzerland
E-mail: central@iso.org
https://www.iso.org/standard/39534.html

**National Association of Insurance Commissioners**

NAIC Codes
SOURCE: National Association of Insurance Commissioners
AVAILABLE FROM:
NAIC Central Office
1100 Walnut Street Suite 1500 Kansas City, MO 64106 816.842.3600
http://www.naic.org/prod_serv/LOC-ZU-15-01.pdf https://eapps.naic.org/cis/companySearch.do
ABSTRACT: NAIC maintains an identification code for each payer that is a 5-digit unique number assigned to an insurance entity by the NAIC. NAIC has developed a tool to look up the code and find the company, or look up the company to find the code:

**National Council for Prescription Drug Programs (NCPDP)**
National Association of Boards of Pharmacy Number
SOURCE: National Association of Boards of Pharmacy Database and Listings
AVAILABLE FROM:
www.ncpdp.org
National Council for Prescription Drug Programs 9240 East Raintree Drive
Scottsdale, AZ 85260-7518
ABSTRACT: A unique number assigned in the U.S. and its territories to individual clinic, hospital, chain, and independent pharmacy locations that conduct business at retail by billing third-party drug benefit payers. The National Council for Prescription Drug Programs (NCPDP) maintains this database under contract from the National Association of Boards of Pharmacy. The National Association of Boards of Pharmacy Number is a seven-digit numeric number with the following format SSNNNNC, where SS=NCPDP assigned state code number, NNNN=NCPDP assigned pharmacy location number, and C=check digit calculated by algorithm from previous six digits.

**National Council for Prescription Drug Programs (NCPDP)**
Uniform Healthcare Payer Data
SOURCE: NCPDP Uniform Healthcare Payer Data Standard Implementation Guide
AVAILABLE FROM:
National Council for Prescription Drug Programs 9240 East Raintree Drive
Scottsdale, AZ 85260 www.ncpdp.org
ABSTRACT: The Implementation Guide is intended to meet an industry need to supply detailed drug or utilization claim information from adjudicated claims that processors/payers or their clients report to States or their Agents.

**National Uniform Billing Committee (NUBC)**
NUBC Codes
SOURCE: National Uniform Billing Committee Official Data Specifications Manual
AVAILABLE FROM:
National Uniform Billing Committee American Hospital Association
155 N Wacker Drive Chicago, IL 60606 www.nubc.org

**National Uniform Claim Committee (NUCC)**
Healthcare Provider Taxonomy Code Set SOURCE: Washington Publishing Company
AVAILABLE FROM:
National Uniform Claim Committee nuccinfo@nucc.org
http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40

**United States Food and Drug Administration (FDA)**
National Drug Codes
SOURCE: National Drug Data File
AVAILABLE FROM:
U.S. Food and Drug Administration Center for Drug Evaluation and Research
Division of Data Management and Services 10903 New Hampshire Avenue
Silver Spring, MD 20993
www.fda.gov or http://www.accessdata.fda.gov/scripts/cder/ndc/default.cfm

**United States Census Bureau**
2020 FIPS Codes for Counties and County Equivalent Entities
SOURCE: United States Census Bureau
AVAILABLE FROM: https://www.census.gov/library/reference/code-lists/ansi.html

**United States Postal Service (USPS)**
States and Outlying Areas of the U.S. ZIP Code
SOURCE: United States Postal Service
AVAILABLE FROM:
U.S. Postal Service
National Information Data Center
P.O. Box 9408
Gaithersburg, MD 20898-9408 https://www.usps.com
ABSTRACT: Provides names, abbreviations, and codes for the 50 states, the District of Columbia, and the outlying areas of the U.S. The ZIP Code is a geographic identifier of areas within the United States and its territories for purposes of expediting mail distribution by the U.S. Postal Service. It is five or nine numeric digits. The ZIP Code structure divides the U.S. into ten large groups of states. The leftmost digit identifies one of these groups. The next two digits identify a smaller geographic area within the large group. The two right-most digits identify a local delivery area. In the 9-digit ZIP Code, the four digits that follow the hyphen further subdivide the delivery area. The two leftmost digits identify a sector which may consist of several large buildings, blocks or groups of streets. The rightmost digits divide the sector into segments such as a street, a block, a floor of a building, or a cluster of mailboxes.

**World Health Organization (WHO)**
International Classification of Diseases Clinical Mod (ICD-9-CM) Procedure and Diagnosis
SOURCE: International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)
AVAILABLE FROM:
WHO Publications Center AUS
49 Sheridan Avenue
Albany, NY 12210 http://www.cdc.gov/nchs/icd/icd9cm.htm
ABSTRACT: The International Classification of Diseases, 9th Revision, Clinical Modification, describes the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and procedures.

**World Health Organization (WHO)**
International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS)
SOURCE: International Classification of Diseases, 10th Revision, (ICD-10-CM/PCS)
AVAILABLE FROM:
WHO Publications Center AUS 49 Sheridan Avenue
Albany, NY 12210 www.cdc.gov/nchs/icd/icd10cm.htm#9update
ABSTRACT: The International Classification of Diseases, 10th Revision, is used to report medical diagnosis in all U.S. health care settings after October 1, 2015.

## Appendix TX-1: Race 1/Race 2/Race 3

These codes are a limited subset from the CDC Race Category and Ethnicity Group Code Set

| Code | Description |
|---|---|
| R1 | American Indian/Alaska Native |
| R2 | Asian |
| R3 | Black/African American |
| R4 | Native Hawaiian or Other Pacific Islander |
| R5 | White |
| R9 | Other Race |
| UN | Unknown/Not Specified |

| Appendix TX-2: Meaning of Important Terms | |
|---|---|
| **Term(s)** | **Description** |
| Conditional | The CDL field must be correctly completed by a Payor for successful submission when the condition in the field description is met. An exception from this requirement must be requested by a Payor if compliance is not possible. |
| Not Required/Optional | A Payor may complete the CDL field at its discretion. The Center for Health Care Data encourages the submission of data for these fields, but no exception request is necessary. |
| Required | The CDL field must be correctly completed by a Payor for successful submission. An exception from this requirement must be requested by a Payor if compliance is not possible. |
| Required IF Available | The CDL field must be correctly completed by a Payor for successful submission when the information is available to the Payor. An exception request is not necessary if the information is not available to the Payor. |

## Appendix TX-3: Example Claim Status Codes

| item_code | item_value |
|---|---|
| 01 | Processed as Primary |
| 02 | Processed as Secondary |
| 03 | Processed as Tertiary |
| 04 | Denied |
| 05 | Pended |
| 06 | Approved as amended |
| 07 | Approved as submitted |
| 08 | Cancelled due to inactivity |
| 09 | Pending - under investigation |
| 10 | Received, but not in process |
| 11 | Rejected, duplicate claim |
| 12 | Rejected, please resubmit with corrections |
| 13 | Suspended |
| 14 | Suspended - incomplete claim |
| 15 | Suspended - investigation with field |
| 16 | Suspended - return with material |
| 17 | Suspended - review pending |
| 18 | Suspended Product Registration |
| 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 |
| 23 | Not Our Claim, Forwarded to Additional Payer(s) |
| 24 | Transferred to Proper Carrier |
| 25 | Predetermination Pricing Only - No Payment |
| 26 | Documentation Claim - No Payment Associated |
| 27 | Reviewed |
| 28 | Repriced |
| 29 | Audited |
| 30 | Processed as Conditional |
| AD | Additional |

| | |
|---|---|
| AP | Appealed |
| CC | Weekly Certification |
| CL | Closed |
| CP | Open |
| I | Initial |
| RA | Reaudited |
| RB | Reissue |
| RC | Reopened and Closed |
| RD | Redetermination |
| RO | Reopened |

# Appendix M: Texas Medicaid

**Texas County ID**

https://www.dshs.texas.gov/chs/info/info_txco.shtm#:~:text=Texas%20has%20a%20state%20FIPS,county%20FIPS%20code%20of%2048xxx

**Level of Education**

| Code | Value |
|---|---|
| 1 | First Grade |
| 2 | Second Grade |
| 3 | Third Grade |
| 4 | Fourth Grade |
| 5 | Fifth Grade |
| 6 | Sixth Grade |
| 7 | Seventh Grade |
| 8 | Eighth Grade |
| 9 | Ninth Grade |
| A | Tenth Grade |
| B | Eleventh Grade |
| C | High School Graduate/Completed |
| D | Currently attends Jr.High High School GED Classes (No longer used 5/96) |
| E | Attending college or completed some college but has not graduated from a four-year college |
| F | Graduate Of a four-year college |
| N | No formal education |

**Managed Care Stopped Coverage Reason Code**

| | |
|---|---|
| 1 | GUARANTEED ENROLLMENT |
| 11 | PCP Change |
| 12 | PLAN CHANGE |
| 13 | CLIENT ENROLLED IN ERROR |
| 14 | PROVIDER ID CHANGE |
| 30 | COUNTY CHANGED WITHIN SDA |
| 31 | MOVED OUT OF SDA |
| 32 | LOSS OF MEDICAID ELIGIBILITY |
| 33 | TP EXCLUDED FROM MANAGED CARE |
| 34 | BASE PLAN EXCLUDED FROM MANAGED CARE |
| 35 | EXCLUDED FROM MANAGED CARE |
| 36 | CLIENT IS ON HOLD |
| 37 | MEDICARE EXCLUSION |
| 38 | DEATH |
| 39 | PLAN HAS TERMINATED |
| 40 | Nursing Facility Exclusion |
| 41 | VOLUNTARY DIS ENROLLMENT |
| 42 | Client is enrolled in HIPP |
| 43 | DISENROLLED DUE TO A WAIVER PROGRAM |
| 44 | DFPS exclusion from STAR Health |
| 45 | NEWBORN ENROLLMENT |
| 46 | Loss of CHIP Eligibility |

| | |
|---|---|
| 47 | CHIP Plan Change after 90 days |
| 48 | Mass Change Disenrollment for CHIP |
| 49 | Failure to Pay CHIP Enrollment Fee |
| 50 | CHIP Plan Change |
| 51 | CHIP Client Moved out of SDA |
| 52 | CHIP Death Disenrollment |
| 53 | Suspension of Medicaid |
| 54 | IDD Exclusion |
| 55 | County Jail confinement |
| 90 | NEVER ENROLL CLIENT |
| 91 | NEVER ENROLL CLIENT AGAIN |

| Medicaid Eligibility Code | |
|---|---|
| B | Pregnancy |
| C | Emergency |
| D | ICF-MR |
| F | Pregnancy for TP42 cases (Presumptive eligibility) |
| I | Institutional regular (CATS 1 3 or 4) (BP16 or 17) |
| N | FFCHE (Former Foster Child in Higher Education) |
| P | Three months prior |
| Q | QMD coverage (Medicare only) |
| R | Regular |
| T | 1929(b) Base plan 20 MAO client |
| W | Healthy Texas Women |

| Medicaid Type Program | |
|---|---|
| 01 | *01= AFDC money payment & Medicaid medical assistance; |
| 02 | #02=MAO grandfathered case; |
| 03 | *#03=Medical Assistance only: |
| 04 | *#04=Medical Assistance only- Deceased: Applicant dies after date of application, before certification; |
| 05 | *05=Medical assistance only. 18-21 years of age and not attending school (Not eligible effective 10-81. |
| 06 | *06=Home Health Aid Project (HHAP). 12 months post-MAO benefits resulting from an increase in earnings or a combined increase in earnings and child support. Note: is 4 months for category 05 type program 07 cases. |
| 07 | *07=Medical Assistance only- 12 months: AFDC or refugee cases denied financial assistance because of increased earnings but eligible for Medicaid coverage for 12 months after the last month of AFDC eligibility; |
| 08 | *08=AFDC foster care; |
| 09 | *09=Non-AFDC foster care; |
| 10 | *10=State paid foster care; |
| 11 | *#11=Medical Assistance only: Three Month Prior, not currently eligible or a gap in coverage; AFDC eligible for 3 months prior but who are ineligible in month of application or later months or have a gap in coverage; |
| 12 | @12=SSI manually certified; |
| 13 | @13=SSI Recipient; |
| 14 | #14=SSI related MAO: |
| 15 | *15=State paid adoption subsidy; |
| 16 | @16=SSI denied in Title XIX facility |
| 17 | @17=SSI client, Indochinese refugee. No longer valid |
| 18 | #18= Disabled adult children. Clients of any age denied SSI due to increase in Social Security disabled benefits and are eligible for Medicaid to insure continued coverage; |
| 19 | #19=Model waiver. Severely disabled children less than 18 years of age for whom home or community care is being provided under Title 19; |
| 20 | *20= MAO: Child support: AFDC cases that are denied for Medicaid coverage because of child support but are eligible for Medicaid for 4 additional months; |
| 21 | *21=Adoption subsidy; |
| 22 | #22=Early age widows or widowers; |
| 23 | 23=Specified Low-income Medicaid Benefits (SLMB); |

| | |
|---|---|
| 24 | #24=Catastrophic health care. Qualified Medicare Beneficiary (QMB); |
| 29 | 12 or 18 Months Transitional Medicaid |
| 30 | Illegal Alien |
| 32 | Legalized Alien |
| 37 | MAO, 12 Months Post |
| 40 | Pregnant Women <185% FPIL |
| 41 | Pregnant Women in Two-Parent Families |
| 42 | Presumptively Eligible Pregnant Women |
| 43 | Expansion Children |
| 44 | Federally Mandated Children |
| 45 | Newborns |
| 46 | Ribicoff Children |
| 47 | Children < 18 with |
| 48 | Children < 6 with 133% FPIL |
| 49 | Children < 1 with 130% FPIL |
| 51 | MAO, Rider 51 |
| 55 | Medically Needy |
| 61 | AFDC-UP eligible for grant and Medicaid |
| 63 | AFDC-UP eligible for grant < 10.00 and Medicaid |
| 64 | AFDC-UP eligible for Medicaid only |
| 71 | One Time Payment for AFDC |
| 72 | One Time Payment for AFDC-UP |
| 78 | PCA MEDICAID ONLY (FEDERAL MATCH) |
| 79 | PCA MEDICAID ONLY (NO FEDERAL MATCH) |
| 80 | PCA PAYMENT AND MEDICAID (FEDERAL MATCH) |
| 81 | PCA PAYMENT AND MEDICAID (NO FEDERAL MATCH) |
| 96 | ADOPTION ASSISTANCE - WITH CASH (NO FEDERAL MATCH) |
| 77 | FFCHE (Former Foster Care in Higher Education) |
| 88 | MEDICAID BUY-IN FOR CHILDREN WITH DISABILITIES UP TO AGE 19 WITH FAMILY INCOME UP TO 300% FPL BEFORE ALLOWABLE DEDUCTIONS |

| **Medicaid SD** | |
|---|---|
| A | TP10 child whose income is below AFDC standard |
| B | TP10 child whose income is above AFDC standard and below medically needy standard |
| C | TP10 child whose income is above medically needy standard |
| F | TP09 BP35 Children transitioning from foster care. |
| G | Enhanced Federal Medical Assistance Percentages (FMAP) |
| I | Spend down client (TP55) who is a Qualified Alien |
| Q | MQMB category 01 03 or 04 client who is dually eligible for MAO and QMB |
| R | CMA Qualified Alien |
| S | Medical open date is split-pay day (TP32 & TP55) |
| Y | MTFCY Qualified Alien |

| **Risk Group Code** | |
|---|---|
| 000 | Error Risk Group |
| 001 | Medicare Related |
| 002 | Non-Medicare (Blind/Disabled) |
| 003 | AFDC Adults |
| 004 | AFDC Children |
| 005 | Pregnant Woman |

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| 006 | Newborns |
| 007 | Expansion Children |
| 008 | Medically Needy |
| 009 | Federal Mandate Children |
| 010 | Enhanced Match Children (TP44) |
| 011 | FFS Newborns < 4 Months (TP45) |
| 012 | FFS Newborns 4 to 12 Months (TP45) |
| 013 | Managed Care TANF Newborns <= 1 |
| 014 | Managed Care TANF Children > 1 and < 21 |
| 015 | Managed Care Expansion Newborns <= 1 |
| 016 | Managed Care Expansion Children > 1 and < 21 |
| 017 | TP55 - Medically Needy w/Spend Down |
| 018 | TP55 - Medically Needy no Spend Down |
| 020 | Pregnant Women - Qualified Alien |
| 021 | Exp. Child <=1 - Qualified Alien |
| 022 | Exp. Child >1 AND <21 - Qualified Alien |
| 023 | Federal Mandate Child - Qualified Alien |
| 024 | TANF Adult - Medicare - Qualified Alien |
| 025 | TANF Adult - Qualified Alien |
| 026 | TANF Child <=1 - Qualified Alien |
| 027 | TANF Child >1 and <21 - Qualified Alien |
| 028 | TP55 – Medically Needy W/Spend Down - Qualified Alien |
| 030 | SSI - Aged, Blind, and Disabled |
| 051 | FCMC - Partial Month |
| 052 | FCMC - Member <= 21.0 Years Old |
| 053 | FCMC - < 22.0 Years Old (State Funded) |
| 054 | FCMC - Age >= 22.0 and <= 23.0 (State Funded) |
| 055 | FCMC - In Error, Please Investigate |
| 056 | FFCHE – Former Foster Care in Higher Education |
| 057 | Foster Care <=21 – Qualified Alien |
| 060 | Under Age 1 Child AGE <= 1.00 |
| 061 | Under Age 1 Child - QA AGE <= 1.00 |
| 062 | Age 1-5 Child AGE > 1.00 and AGE <= 6.00 |
| 063 | Age 1-5 Child - QA AGE > 1.00 and AGE <= 6.00 |
| 064 | Age 6-14 Child AGE > 6.00 and AGE <= 15.00 |
| 065 | Age 6-14 Child - QA AGE > 6.00 and AGE <= 15.00 |
| 066 | Age 15-18 Child AGE > 15.00 and AGE < 19.08 |
| 067 | Age 15-18 Child - QA AGE > 15.00 and AGE < 19.08 |
| 068 | Age 19-20 Child AGE >= 19.08 and AGE < 21.00 |
| 069 | Age 19-20 Child - QA AGE >= 19.08 and AGE < 21.00 |
| 100 | Non-Medicare Other Community Clients |
| 111 | Non-Medicare CBA Clients |
| 112 | Non-Medicare Nursing Home Clients Prior to Implementation |
| 113 | Non-Medicare Nursing Home Clients After Implementation |
| 114 | Medicare Other Community Clients |
| 115 | Medicare CBA Clients |
| 116 | Medicare Nursing Home Clients Prior to Implement. |
| 117 | Medicare Nursing Home Clients After Implementation |
| 118 | Non-Medicare Nursing Home Clients After 9/1/00 |

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|---|---|
| 119 | Medicare Nursing Home Clients After 9/1/00 |
| 120 | Non-Medicare Nursing Facility |
| 121 | Dual Eligible Nursing Facility |
| 122 | Intellectual Developmental Disabilities (under 21) |
| 123 | Intellectual Developmental Disabilities (over 21) |
| 124 | Dual Eligible Community |
| 125 | Dual Eligible SPW |
| 126 | Dual Eligible Nursing Facility |
| 160 | Non-Medicare Community |
| 161 | Non-Medicare CBA |
| 164 | Dual Eligible Community |
| 165 | Dual Eligible CBA |
| 168 | Non-Medicare Nursing Facility |
| 169 | Dual Eligible Nursing Facility |
| 201 | SSI Child <21 |
| 202 | SSI Child <21 Medicare |
| 203 | SSI Adult 21-64 |
| 204 | SSI Adult 21-64 Medicare |
| 205 | TANF Child <21 |
| 206 | TANF Child <21 Medicare |
| 207 | TANF Adult 21+ |
| 208 | TANF Adult 21+ Medicare |
| 209 | SSI Adult 65+ |
| 210 | SSI Adult 65+ Medicare |
| 220 | TANF Child <21 – Qualified Alien |
| 301 | CHIP Clients Age < 1 |
| 302 | CHIP Clients Ages 1-5 |
| 303 | CHIP Clients Ages 6-14 |
| 304 | CHIP Clients Ages 15-18 |
| 305 | Perinatal; (<= 185) FPL - before birth |
| 306 | Perinatal; (> 185 & <= 200) FPL - before birth |
| 307 | Perinatal Newborn; (<= 185) FPL - post birth |
| 308 | Perinatal Newborn; (> 185, <= 200) FPL - post birth |
| 400 | CHIP DMO Clients Age < 1, Tier 1 |
| 401 | CHIP DMO Clients Age < 1, Tier 2 |
| 402 | CHIP DMO Clients Age < 1, Tier 3 |
| 403 | CHIP DMO Clients Ages 1-5, Tier 1 |
| 404 | CHIP DMO Clients Ages 1-5, Tier 2 |
| 405 | CHIP DMO Clients Ages 1-5, Tier 3 |
| 406 | CHIP DMO Clients Ages 6-14, Tier 1 |
| 407 | CHIP DMO Clients Ages 6-14, Tier 2 |
| 408 | CHIP DMO Clients Ages 6-14, Tier 3 |
| 409 | CHIP DMO Clients Ages 15-18, Tier 1 |
| 410 | CHIP DMO Clients Ages 15-18, Tier 2 |
| 411 | CHIP DMO Clients Ages 15-18, Tier 3 |
| 412 | Dental Member Less Than 1 Year |
| 413 | Dental Member 1 - 5 Years |
| 414 | Dental Member 6 - 14 Years |
| 415 | Dental Member 15 - 18 Years |

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|---|---|
| 450 | Medicaid Dental Member Less than 1 year |
| 451 | Medicaid Dental Member 1 - 5 Years |
| 452 | Medicaid Dental Member 6 - 14 Years |
| 453 | Medicaid Dental Member 15 - 18 Years |
| 454 | Medicaid Dental Member 19 - 20 Years |
| 500 | MEDICAID CLIENTS THROUGH 20 YEARS OF AGE |
| 501 | MEDICAID CLIENTS 21 YEARS OR OLDER |
| 502 | CSHCN CLIENTS |
| 504 | Urban Under Age 21(Medicaid) |
| 505 | Rural Under Age 21(Medicaid) |
| 506 | Urban Age 21 and Over (Medicaid) |
| 507 | Rural Age 21 and Over (Medicaid) |
| 508 | CSHCN or Indigent Cancer Patients (non-Medicaid; all ages) |
| 900 | 900 Error |
| 901 | Overlap with STAR+PLUS Waiver and IDD |
| 902 | IDD Under 21 and Medicare |
| 903 | IDD Over 21 and Medicare |

| | Base Plan |
|---|---|
| 1 | Medically Needy Pregnant Woment |
| 2 | Adoption Subsidy Case |
| 3 | Adoption Subsidy Case |
| 10 | TITLE XIX Nursing Home |
| 13 | Individual Outside Title XIX Facility |
| 14 | Institution Mental Hospital (Inactive) |
| 15 | Medicare Skilled Nursing Care |
| 16 | Institutional State School |
| 17 | Institituional Chest Hospital |
| 20 | Primary Home Health Care Alias Waiver 5 |
| 30 | TP10 Case Childe Meets TP10 Requirements |
| 31 | TP10 Case Childe Meets TP10 Requirements |
| 32 | Child Meets TP 10 Requirements |
| 33 | TP09/TP10 Case-Client Meets Foster Care Requirements |
| 34 | TP09 Cae-Client Referred by Juvenile |
| 35 | Kids Who Age out of Foster Care |
| 40 | Description Not Found |

**Base Plan**

https://www.hhs.texas.gov/handbooks/community-care-services-eligibility-handbook/appendix-xiv-saverrtiers-type-program-chart