

CPCDS Data Dictionary Claim – Medical			
Number	CPCDS Element	Map ID	Description
1	Claim Service Start Date	90, 118	90 - Date on which services began. UB04 (Form Locator 45). 118 - Date on which services began. Located on CMS 1500 (Form Locator 24A)
2	Claim Service End Date	119	Date on which services ended. Located on CMS 1500 (Form Locator 24A)
3	Claim Paid Date	107	The date the claim was paid.
4	Claim Received Date	88	The date the claim was received by the payer.
5	Member Admission Date	18	Identifies the date the patient was admitted for facility care.
6	Member Discharge Date	19	Date patient was discharged from a facility.
7	Patient Account Number	109	Provider submitted information that can be included on the claim.
8	Medical Record Number	110	Provider submitted information that can be included on the claim.
9	Claim Unique Identifier	35	Claim identifier for a claim.
10	Claim Adjusted from Identifier	111	Prior claim number.
11	Claim Adjusted to Identifier	112	Replaced or Merged claim number.
12	Claim Diagnosis Related Group	32 – Assigned DRG Version Code 33- Assigned DRG Value 113 – DRG Grouper Name	32 - Version of the AP-DRG codes assigned for inpatient facility claims. 33- DRG codes assigned. 113 - Name of the DRG grouper assigned.
13	Claim Inpatient Source Admission Code	13	Identifies the place where the patient was identified as needing admission to a facility. This is a two position code mapped from the standard values for the UB-04 Source of Admission code (FL-15).
14	Claim Inpatient Admission Type Code	14	Priority of the admission. Information located on (UB04 Form Locator 14). For example, an admission type of elective indicates that the patient's

			condition permitted time for medical services to be scheduled.
15	Claim Bill Facility Type Code	114	UB04 (Form Locator 4) type of bill code provides specific information for payer purposes. The first digit of the three-digit number denotes the type of facility.
16	Claim Service Classification Type Code	115	UB04 (Form Locator 4) type of bill code provides specific information for payer purposes. The second digit classifies the type of care (service classification) being billed.
17	Claim Frequency Code	116	UB04 (Form Locator 4) type of bill code provides specific information for payer purposes. The third digit identifies the frequency of the bill for a specific course of treatment or inpatient confinement.
18	Claim Processing Status Code	140	Claim processing status code
19	Claim Type Code	16	Specifies the type of claim. (e.g., inpatient institutional, outpatient institutional, physician, etc.).
20	Patient Discharge Status Code	117	Patient's status as of the discharge date for a facility stay. Information located on UB04 (Form Locator 17).
21	Claim Payment Denial Code	92	Reason codes used to interpret the Non-Covered Amount
22	Claim Primary Payer Identifier	141	Identifies the primary payer. For use only on secondary claims.
23	Claim Payee Type Code	120	Identifies recipient of benefits payable; i.e., provider or subscriber.
24	Claim Payee	121	Recipient reference.
25	Claim Payment Status Code	91	Indicates whether the claim was paid or denied.
26	Claim Payer Identifier	2	Code of the primary payer responsible for the claim.

CPCDS Data Dictionary Claim - Retail Pharmacy			
Number	CPCDS Element	Map ID	Description
1	Days Supply	77	Number of days supply of medication dispensed by the pharmacy.
2	RX Service Reference Number	35	Claim unique identifier.
3	DAW Product Selection Code	79	Prescriber's instruction regarding substitution of generic equivalents or order to dispense the specific prescribed medication.
4	Refill Number	137	The number fill of the current dispensed supply (0, 1, 2, etc.).
5	Prescription Origin Code	143	Whether the prescription was transmitted as an electronic prescription, by phone, by fax, or as a written paper copy
6	Plan Reported Brand-Generic Code	144	Whether the plan adjudicated the claim as a brand or generic drug.

CPCDS Data Dictionary Claim – Retail Provider			
Claim - ProviderNumber	CPCDS Element	Map ID	Description
1	Claim Billing Provider NPI	94	The National Provider Identifier assigned to the Billing Provider.
2	Claim Billing Provider Network Status	101	Indicates that the Billing Provider has a contract with the Plan (regardless of the network) that is effective on the date of service or admission.
3	Claim Attending Physician NPI	93	I Provider Identifier assigned to the Attending Physician for the admission.
4	Claim Attending Physician Network Status	101	Indicates the network status of the attending physician.
5	Claim Site of Service NPI	97	The NPI of the facility where the services were rendered.
6	Claim Site of Service Network Status	101	Indicates the network status of the site of service.
7	Claim Referring Physician NPI	99	The NPI of the referring physician.
8	Claim Referring Physician Network Status	101	Indicates the network status of the referring physician.
9	Claim Performing Provider NPI	95	The National Provider Identifier assigned to the Rendering Provider. This is the lowest level of provider available (for example, if both individual and group are available, then the individual should be provided).
10	Claim Performing Provider Network Status	101	Indicates that the Performing Provider has a contract with the Plan (regardless of the network) that is effective on the date of service or admission.
11	Claim Prescribing Provider NPI	122	The identifier from NCPDP field # 411-DB (Prescriber ID) that identifies the National Provider Identifier (NPI) of the provider who prescribed the pharmaceutical.
12	Claim Prescribing Provider Network Status	123	Indicates the network status of the prescribing physician.
13	Claim PCP NPI	95, 96	The identifier assigned to the PCP Provider.

CPCDS Data Dictionary Claim Amounts			
Number	CPCDS Element	Map ID	Description
1	Claim Total Submitted Amount	20	Amount submitted by the provider for reimbursement of health care services. This amount includes non-covered services.
2	Claim Total Allowed Amount	20	The contracted reimbursable amount for covered medical services or supplies or amount reflecting local methodology for non-contracted providers. Allowed amount should not include any COB adjustment. That is, the Allowed amount on a claim should be the same when the Plan is primary or secondary.
3	Amount Paid by Patient	20	The amount paid by the member at the point of service.
4	Claim Amount Paid to Provider	20	The amount paid to the provider.
5	Member Reimbursement	20	The amount paid to the member.
6	Claim Payment Amount	20	The amount sent to the payee from the health plan. This amount is to include withhold amounts (the portion of the claim that is deducted and withheld by the Plan from the provider's payment) and exclude any member cost sharing. It should include the total of member and provider payments.
7	Claim Disallowed Amount	20	The portion of the cost of this service that was deemed not eligible by the insurer because the service or member was not covered by the subscriber contract.
8	Member Paid Deductible	20	The portion of this service that the member must pay which is applied to the total period deductible. Deductibles are usually applied over a specific time period, such as per calendar year, per benefit period.
9	Co-insurance Liability Amount	20	The amount the insured individual pays, as a set percentage of the

			cost of covered medical services, as an out-of-pocket payment to the provider. Example: Insured pays 20% and the insurer pays 80%.
10	Copay Amount	20	Amount an insured individual pays directly to a provider at the time the services or supplies are rendered. Usually, a copay will be a fixed amount per service, such as \$15.00 per office visit.
11	Member Liability	20	The amount of the member's liability.
12	Claim Primary Payer Paid Amount	20	The reduction in the payment amount to reflect the carrier as a secondary payer.
13	Claim Discount Amount	20	The amount of the discount.

CPCDS Data Dictionary Claim Line			
Number	CPCDS Element	Map ID	Description
1	Service (from) Date	90, 118	90 - Date on which services began. UB04 (Form Locator 45). 118 - Date on which services began. Located on CMS 1500 (Form Locator 24A)
2	Line Number	36	Line identification number that represents the number assigned in a source system for identification and processing.
3	Service to Date	119	Date on which services ended. Located on CMS 1500 (Form Locator 24A)
4	Type of Service	34	High level classification of services into logical grouping.
5	Place of Service Code	46	Code indicating the location, such as inpatient, outpatient facility, office, or home health agency, where this service was performed.
6	Revenue Center Code	86	Code used on the UB-04 (Form Locator 42) to identify a specific accommodation, ancillary service, or billing calculation related to the service being billed.
7	Allowed Number of Units	149	The quantity of units, times, days, visits, services, or treatments allowed for the service described by the HCPCS code, revenue code or procedure code, submitted by the provider.
8	National Drug Code	38	National Drug Code (NDC).
9	Compound Code	78	The code indicating whether or not the prescription is a compound.
10	Quantity Dispensed	39	Quantity dispensed for the drug.
11	Quantity Qualifier Code	151	The unit of measurement for the drug. (gram, ml, etc.).
12	Line Benefit Payment Status	142	Indicates the in network or out of network payment status of the claim.
13	Line Payment Denial Code	92	Reason codes used to interpret the Non-Covered Amount

CPCDS Data Dictionary Claim Line Amounts			
Number	CPCDS Element	Map ID	Description
1	Line Disallowed Amount	20	<p>Medical: The portion of the cost of this service that was deemed not eligible by the insurer because the service or member was not covered by the subscriber contract.</p> <p>Pharmacy: Non-Covered Amount represents the NCPDP financial response field Amount Exceeding Periodic Benefit Maximum.</p>
2	Line Member Reimbursement	20	The amount paid to the member.
3	Line Amount Paid by Patient	20	<p>Medical: The amount paid by the member at the point of service.</p> <p>Pharmacy: Amount that is calculated by the processor and returned to the pharmacy as the total amount to be paid by the patient to the pharmacy; the patient's total cost share, including copayments, amounts applied to deductible, over maximum amounts, penalties, etc</p>
4	Drug Cost	20	Price paid for the drug excluding mfr discounts. It is the sum of the following components:ingredient cost, dispensing fee, sales tax, and vaccine administration fee.
5	Line Allowed Amount	20	The contracted reimbursable amount for covered medical services or supplies or amount reflecting local methodology for noncontracted providers. Allowed amount should not include any COB adjustment. That is, the Allowed amount on a claim should be the same when the Plan is primary or secondary.
6	Line Amount Paid to Provider	20	The amount paid to the provider.
7	Line Patient Deductible	20	The contracted reimbursable amount for covered medical services or supplies or amount

			reflecting local methodology for noncontracted providers.
8	Line Primary Payer Paid Amount	20	The reduction in the payment amount to reflect the carrier as a secondary payer.
9	Line Coinsurance Amount	20	Medical: The amount the insured individual pays, as a set percentage of the cost of covered medical services, as an out-of-pocket payment to the provider. Example: Insured pays 20% and the insurer pays 80%. Pharmacy: Amount to be collected from a patient that is included in the Patient Pay Amount that is due to a per prescription copay or coinsurance.
10	Line Submitted Amount	20	Amount submitted by the provider for reimbursement of health care services. This amount includes non-covered services.
11	Line Allowed Amount	20	The contracted reimbursable amount for covered medical services or supplies or amount reflecting local methodology for noncontracted providers. Allowed amount should not include any COB adjustment. That is, the Allowed amount on a claim should be the same when the Plan is primary or secondary.
12	Line Member Liability	20	The amount of the member's liability.
13	Line Copay Amount	20	Medical: Amount an insured individual pays directly to a provider at the time the services or supplies are rendered. Usually, a copay will be a fixed amount per service, such as \$15.00 per office visit. Pharmacy: Amount to be collected from a patient that is included in the Patient Pay Amount that is due to a per prescription copay or coinsurance.
14	Line Discount Amount	20	The amount of the discount.

CPCDS Data Dictionary			
Diagnosis			
Number	CPCDS Element	Map ID	Description
1	Diagnosis Code	6, 7, 8, 21, 22, 23	<p>6 - ICD-9-CM code describing the condition chiefly responsible for a patient's admission to a facility. It may be different from the principal diagnosis, which is the diagnosis assigned after evaluation. (UB04 Form Locator 69). Decimals will be included.</p> <p>7- Facility: The member's principal condition treated during this service. (UB04 Form Locator 67). This may or may not be different from the admitting diagnosis. Decimals will be included.</p> <p>7 – Professional and Non-Physician: The member's principal condition treated during this service.</p> <p>8 - Additional diagnosis identified for this member. Decimals will be included.</p> <p>21- ICD-10-CM code describing the condition chiefly responsible for a patient's admission to a facility. It may be different from the principal diagnosis, which is the diagnosis assigned after evaluation. Decimals will be included.</p> <p>22 - The member's principal condition treated during this service. This may or may not be different from the admitting diagnosis. Decimals will be included.</p> <p>23 - Additional diagnosis identified for this member. Decimals will be included.</p>

2	Diagnosis Description	145	A plain text representation of the diagnosis.
3	Present on Admission	28, 29	Used to capture whether a diagnosis was present at time of a patient's admission. This is used to group diagnoses into the proper DRG for all claims involving inpatient admissions to general acute care facilities.
4	Diagnosis Code Type	21, 22, 23	<p>21- ICD-10-CM code describing the condition chiefly responsible for a patient's admission to a facility. It may be different from the principal diagnosis, which is the diagnosis assigned after evaluation. Decimals will be included.</p> <p>22 - The member's principal condition treated during this service. This may or may not be different from the admitting diagnosis. Decimals will be included.</p> <p>23 - Additional diagnosis identified for this member. Decimals will be included.</p>
5	Diagnosis Type	21, 22, 23	<p>21- ICD-10-CM code describing the condition chiefly responsible for a patient's admission to a facility. It may be different from the principal diagnosis, which is the diagnosis assigned after evaluation. Decimals will be included.</p> <p>22 - The member's principal condition treated during this service. This may or may not be different from the admitting diagnosis. Decimals will be included.</p>

			23 - Additional diagnosis identified for this member. Decimals will be included.
6	Is E code	30	This is any valid ICD-10 Diagnosis code in the range V00.* through Y99.*

CPCDS Data Dictionary Procedures			
Number	CPCDS Element	Map ID	Description
1	Procedure Code	FAC IP – ICD PCS: 9, 11, 24, 26 FAC OP, Professional and Other – CPT / HCPCS: 40	<p>9 – Principal medical procedure a patient received during inpatient stay. Current coding methods include: International Classification of Diseases Surgical Procedures (ICD-9). Information located on UB04 (Form Locator 74).</p> <p>11-Additional surgical procedure surgical (ICD-9) administered during inpatient stay.</p> <p>24 –Principal medical procedure a patient received during inpatient stay. Coding methods for this field is International Classification of Diseases Surgical Procedures (ICD-10).</p> <p>26 – Additional surgical procedure a patient received during inpatient stay. Coding methods for this field is International Classification of Diseases Surgical Procedures (ICD-10).</p> <p>40 - Medical procedure a patient received from a health care provider. Current coding methods include: CPT-4 and HCFA Common Procedure Coding System Level II - (HCPCSII).</p>
2	Procedure Description	ICD procedure 146 CPT4 / HCPCS procedure 147	<p>146 – A plain text representation of the ICD procedure.</p> <p>147 - A plain text representation of the CPT / HCPCS procedure.</p>
3	Procedure Date	FAC IP – ICD: 9, 11, 24, 26	9 – Principal medical procedure a patient received during inpatient stay. Current coding methods include: International Classification of Diseases Surgical

			<p>Procedures (ICD-9). Information located on UB04 (Form Locator 74).</p> <p>11- Additional surgical procedure surgical (ICD-9) administered during inpatient stay.</p> <p>24- Principal medical procedure a patient received during inpatient stay. Coding methods for this field is International Classification of Diseases Surgical Procedures (ICD-10).</p> <p>26 - Additional surgical procedure a patient received during inpatient stay. Coding methods for this field is International Classification of Diseases Surgical Procedures (ICD-10).</p>
4	Procedure Code Type	FAC IP – ICD: 9, 11, 24, 26	<p>9 – Principal medical procedure a patient received during inpatient stay. Current coding methods include: International Classification of Diseases Surgical Procedures (ICD-9). Information located on UB04 (Form Locator 74).</p> <p>11- Additional surgical procedure surgical (ICD-9) administered during inpatient stay.</p> <p>24- Principal medical procedure a patient received during inpatient stay. Coding methods for this field is International Classification of Diseases Surgical Procedures (ICD-10).</p> <p>26 - Additional surgical procedure a patient received during inpatient stay. Coding methods for this field is International Classification of Diseases Surgical Procedures (ICD-10).</p>

5	Procedure Type	FAC IP – ICD: 9, 11, 24, 26	26 - Additional surgical procedure a patient received during inpatient stay. Coding methods for this field is International Classification of Diseases Surgical Procedures (ICD-10).
6	Modifier Code -1	41	Modifier(s) for the procedure represented on this line. Identifies special circumstances related to the performance of the service.
7	Modifier Code -2	41	Modifier(s) for the procedure represented on this line. Identifies special circumstances related to the performance of the service.
8	Modifier Code -3	41	Modifier(s) for the procedure represented on this line. Identifies special circumstances related to the performance of the service.
9	Modifier Code -4	41	Modifier(s) for the procedure represented on this line. Identifies special circumstances related to the performance of the service.

CPCDS Data Dictionary Member			
Number	CPCDS Element	Map ID	Description
1	Member ID	1	Unique identifier for a member assigned by the Payer. If members receive ID cards, that is the identifier that should be provided.
2	Date of Birth	70	Date of birth of the member.
3	Date of Death	124	Date of death of the member.
3a	Deceased Flag	124	Date of death of the member.
4	County	125	The county for the member's primary address.
5	State	126	The state for the member's primary address.
6	Country	127	The country for the member's primary address.
7	Race Code	128	The race of the member.
8	Ethnicity	129	The ethnicity of the member.
9	Birth Sex	153	The gender of the member at birth.
9a	Gender Code	71	Gender of the member.
10	Name	130	The name of the patient.
11	Zip Code	131	This represents the member's 5 digit zip code.

CPCDS Data Dictionary Coverage			
Number	CPCDS Element	Map ID	Description
1	Subscriber ID	132	The identifier assigned by the Payer on the subscriber's ID card.
2	Coverage Type	3	Identifies if the coverage is PPO, HMO, POS, etc.
3	Coverage Status	133	Identifies the status of the coverage information (default: active).
4	Start Date	74	Date that the contract became effective.
5	End Date	75	Date that the contract was terminated or coverage changed
6	Group ID	134	Employer account identifier.
7	Group Name	135	Name of the Employer Account.
8	Plan Identifier	154	Business concept used by a health plan to describe its benefit offerings.
8a	Plan Name	155	Name of the health plan benefit offering assigned to the Plan Identifier.
9	Payer Identifier	2	Issuer of the Policy
9a	Other Payer Identifier(s)	141	Identifies another payer who applied benefits for the service on another claim.
10	Relationship to Subscriber	72	Relationship of the member to the person insured (subscriber).