A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Control Header						
NEW 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	varchar	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	0%
CDLHD004	Data Submitter Name	varchar	75	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	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Control Trailer						
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	varchar	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	0%
CDLTR004	Data Submitter Name	varchar	75	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	12	Medical (MC), Pharmacy (PC), and Dental (DC) claims files only. Provide total paid dollars submitted in the file. Control total for each file (CDLMC125, CDLPC037, CDLDC060). Eligibility and provider file blank. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	Required	100%
CDLTR008	Record Count	int	10	Total number of records submitted in the file, excluding header and trailer records.	Required	100%

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment								
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	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 used in the payor code field.	N/A	All	Required	100%
CDLME002	Payor Code	varchar	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	Commercial and Dental	Required IF Available	
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. [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. [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. [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".		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	Optional	
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. [Medicaid only eligibility Program Codes which indicate benefit]	N/A	Medicaid Only	Required	50%
CDLME010	Subscriber Social Security Number	char	9	Subscriber's Social Security Number – do not include dashes. Required if collected. If not available, leave blank. [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, provide Medicaid ID.	271/2100C/NM1 09	Commercial Only	Required	60%
CDLME012	Subscriber Last Name	varchar	60	The subscriber's last name. [Used in Master Patient Index]	271/2100C/NM1 03	All	Required	100%
CDLME013	Subscriber First Name	varchar	35	The subscriber's first name. [Used in Master Patient Index]	271/2100C/NM1 04	Commercial and Dental	Required	100%
CDLME014	Subscriber Middle Initial	char	1	The subscriber's middle initial. [Used in the Master Patient Index]	271/2100C/NM1 05	Commercial and Dental	Required IF Available	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment								
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)**
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. [Used as a unique identifier and important to the master patient index]	271/2100C/NM1/MI/09	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. [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" (2010CA is patient; 2010BA is subscriber)	Commercial and Dental	Required	90%
CDLME018	Member Gender	char	1	Gender of the member. M = Male; F = Female; U = UNKNOWN. [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. [Used in the Master Patient Index]	271/2100C/DMG/D8/02, 271/2100D/DMG/D8/02	All	Required	90%
CDLME020	Member Last Name	varchar	60	The member's last name. If the member is the subscriber provide subscriber information. [Used in the Master Patient Index]	271/2100D/NM1 03	All	Required	100%
CDLME021	Member First Name	varchar	35	The member's first name. If the member is the subscriber, report the subscriber's first name. [Used in the Master Patient Index]	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. [Used in the Master Patient Index]	271/2100D/NM1 05	All	Required IF Available	
CDLME023	Member Street Address	varchar	55	Street address of member's residence. [Used in the Master Patient Index]	271/2100C/N3//01, 02 271/2100D/N3//01, 02	All	Required	60%
CDLME024	Member City Name	varchar	30	City location of member's residence. [Used in the Master Patient Index]	271/2100C/N4//01, 271/2100D/N4//01	All	Required	60%
CDLME025	Member State or Province	char	2	State or Province of member's residence. State or Province codes are maintained by the US Postal Service. See Appendix H: External Code Sources, United States Postal Service. [Used in the Master Patient Index]	271/2100C/N4//02, 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. 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, 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) 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. Code U.S. for United States. See Appendix H: External Code Source, United States Postal Service.	N/A	All	Optional	
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 G-2: Race 1/Race 2 for codes. [Used in the Master Patient Index]	N/A	All	Required IF Available	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment								
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)**
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 G-2: Race 1/Race 2 for codes.	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 G-2: Race 1/Race 2 for codes.	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	
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 Except Dental	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 Except Dental	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		Not Required	
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 Except Dental	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. [To identify coordination of benefits where applicable]	N/A	Commercial Only	Required	100%

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment								
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. [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-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	60	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 [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	
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. [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. [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		Not Required	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment								
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)**
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		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	
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. [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. [Used as an alternative unique ID when SSN is not available]	N/A	Commercial and Dental	Required	95%

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment								
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)**
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. [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	
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. If not applicable, leave blank. [Important distinction for reporting costs and utilization]	N/A	Commercial Only	Required	50%
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	
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	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment								
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)**
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	
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 MEDICAID AND MEDICARE ADVANTAGE PLANS. [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 MEDICAID AND MEDICARE ADVANTAGE PLANS. [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	
CDLMEXXX	Un-assigned	char	1	Reserved for future use. Elements will only be added with review from states and payers.	N/A		Not Required	
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	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment								
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)**
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 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). 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 See Appendix M	N/A	Medicaid	Required IF Available	
TXME1011	Case Number (CASE_NBR)	int	6	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) 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) CCYYMMDD or BLANK	N/A	Medicaid	Required IF Available	
TXME1014	TX_HOLD	char	1	Eligibility on hold until Medicaid validates that application meets criteria 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 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 See Appendix M	N/A	Medicaid	Required IF Available	
TXME1017	Category Code (ME_CAT)	char	1	Client Medicaid Category of Assistance Code. Values 1, 2, 3, 4	N/A	Medicaid	Required IF Available	
TXME1018	Medicaid Eligibility Code (ME_CODE)	char	1	Medicaid eligibility code See Appendix M	N/A	Medicaid	Required IF Available	
TXME1019	Medicaid Type Program Code (ME_TP)	char	2	Medicaid Type Program See Appendix M	N/A	Medicaid	Required IF Available	
TXME1020	Member Spend Down ME_SD	char	1	Member Spend Down See Appendix M	N/A	Medicaid	Required IF Available	
TXME1021	Risk Group Identifier (RISKGRP_ID)	char	3	Risk Group Code (digits with padded zeroes) 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 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) 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. 2 digits with padded zeroes See Appendix M	N/A	Medicaid	Required IF Available	
TXME1026	Eligibility Date (ELIG_DATE)	date	6	Year and month of eligibility CCYYMM	N/A	Medicaid	Required IF Available	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Eligibility/Enrollment								
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)**
TXME1027	Texas County Identifier	int	5	FIPS code for client's county of residence See Appendix M	N/A	Medicaid	Required IF Available	
TXME1028	Dental Plan Indicator	char	1	Indicates if member qualified for dental coverage Y / N / BLANK	N/A	Medicaid	Required IF Available	
CDLME899	Record Type	char	2	Value = ME.	N/A		Required	100%

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Provider							
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	varchar	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 IF Available	
CDLPV003	Plan ID	varchar	30	CMS National Plan ID. The national plan ID is a code assigned by CMS.	All	Required IF Available	
CDLPV004	Payor Assigned Provider ID for Member PCP	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	**35**	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	60	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	
CDLPV014	Provider Office Street Address	varchar	55	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	30	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%

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Provider							
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)**
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	100%
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	
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	
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%

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical										
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 and Encounter	Master	Required	100%
CDLMC002	Payor Code	varchar	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 and Encounter	Master	Required IF Available	
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 Only	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 and Encounter	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 and Encounter	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, Cross Reference Claims ID (CDLMC008) is to be utilized.	N/A	All	Institutional and Professional and Encounter	Detail	Required	40%
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.	N/A	All	Institutional and Professional and Encounter	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 and Encounter	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 and Encounter	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 and Encounter	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 and Encounter	Master	Required IF Available	
CDLMC013	Subscriber Last Name	varchar	60	The subscriber's last name.	2010BA/NM1//03	All	Institutional and Professional and Encounter	Master	Required	100%
CDLMC014	Subscriber First Name	varchar	35	The subscriber's first name.	2010BA/NM1//04	All	Institutional and Professional and Encounter	Master	Required	100%
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 and Encounter	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 and Encounter	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 and Encounter	Master	Required	90%
CDLMC018	Member Gender	char	1	Gender of Member M = Male; F = Female; U = Unknown.	2010CA DMG03 or 2010BA DMG03	All	Institutional and Professional and Encounter	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 and Encounter	Master	Required	90%
CDLMC020	Member Last Name	varchar	60	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 and Encounter	Master	Required	90%
CDLMC021	Member First Name	varchar	35	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 and Encounter	Master	Required	90%

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical										
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)**
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 and Encounter	Master	Required	90%
CDLMC023	Patient Control Number	varchar	20	Patient's unique (alphanumeric) number assigned by the provider to facilitate retrieval of the individual's account of services.	2300 CLM 01			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 and Encounter	Detail	Required	60%
CDLMC025	Admission Date	date	8	CCYYMMDD. Required for all inpatient claims, this is the date of admission. For professional claims leave blank. [Not required for institutional claims for professional services]	2300 DTP03 where DTP01 = 435 (I)	All	Institutional Only	Master	Required IF Available	
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. For professional claims, leave blank. Admission Type codes are maintained by NUBC. [Not required for institutional claims for professional services] See Appendix H: External Code Source, National Uniform Billing Committee.	2300 CL101 (I)	All	Institutional Only	Master	Required IF Available	
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. [Not required for institutional claims for professional services] See Appendix H: External Code Source, National Uniform Billing Committee.	2300 CL102 (I)	All	Institutional Only	Master	Required IF Available	
CDLMC029	Discharge Date	date	8	CCYYMMDD. All inpatient claims. Date patient discharged. Required for inpatient claims. [Not required for institutional claims for professional services]	2300 DTP 03 where DTP01 = 096 (I)	All	Institutional Only	Master	Required	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] 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. 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. See Appendix H: External Code Source, National Uniform Billing Committee.	2300 CLM 05-2 & CLM05-3 (I)	All	Institutional Only	Master	Required	90%

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical										
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)**
CDLMC033	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: External Code Source, Center for Medicaid and Medicare Services.	2300 CLM05-01 (P)	All	Professional and Encounter	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. [Not required for institutional claims for professional services] See Appendix H: External Code Source, World Health Organization.	2300 HI01-2 (I)	All	Institutional Only	Master	Required IF Available	
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. [May not be necessary if all claims are 2015 or later]	N/A	All	Institutional and Professional and Encounter	Master	Required IF Available	
CDLMC037	Principal Diagnosis	varchar	7	ICD-9-CM or ICD-10-CM. Do not code decimal point. Cannot include codes V00-Y99. [May not exist on lab or DME claims] See Appendix H: External Code Source.	2300 HI01-2 where HI01-1 = BK (ICD-9) or = ABK (ICD- 10)	All	Institutional and Professional and Encounter	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. [May not exist on lab or DME claims] 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 and Encounter	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 and Encounter	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 and Encounter	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 and Encounter	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 and Encounter	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 and Encounter	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 and Encounter	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 and Encounter	Master	Required IF Available	
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 and Encounter	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 and Encounter	Master	Required IF Available	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical										
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)**
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 and Encounter	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 and Encounter	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 and Encounter	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 and Encounter	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 and Encounter	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 and Encounter	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 and Encounter	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 and Encounter	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 and Encounter	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 and Encounter	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 and Encounter	Master	Required IF Available	
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 and Encounter	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 and Encounter	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 and Encounter	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	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical										
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)**
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	
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	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical										
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)**
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	
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. [Institutional claims may not provide a procedure code per line if not required by the revenue codes] 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 and Encounter	Detail	Required	100% Professional and 10% Institutional
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. [Institutional claims may not provide a procedure code per line if not required by the revenue codes] See Appendix H: External Code Source, American Medical Association.	2400 SV202-03; 2400 SV101-03 where SV101-01 = HC (P)	All	Institutional and Professional and Encounter	Detail	Required	20%

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical										
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)**
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 and Encounter	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 and Encounter	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 and Encounter	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	
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	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical										
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)**
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	
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	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical										
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)**
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	
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 and Encounter	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 and Encounter	Detail	Required	90%
CDLMC121	Service Units/Quantity	dec	12,3	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. [Only required in relation to revenue and procedure codes to identify quantity]	2400 SV205 where SV204 = (I); 2400 SV104 (P)	All	Institutional and Professional and Encounter	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. [Only required in relation to service units]	N/A	All	Institutional and Professional and Encounter	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). [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). [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). [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). [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
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

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical										
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)**
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, set to 0. 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	90%
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.	2310D NM109 (I) or 2310A 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.	2310D NM102 (I) or 2310A NM102 (I); 2420A NM102 (P) or 2310B NM102 (P)	All	Institutional and Professional	Master	Required	60%
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	35	Individual first name. If CDLMC136 = 2, leave blank.	2310D NM104 (I) or 2310A 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.	2310D NM105 (I) or 2310A 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	60	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".	2310D NM103 (I) or 2310A 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.	2310D NM107 (I) or 2310A NM107 (I); 2420A NM107(P) or 2310B NM107 (P) or 2010AA NM107 (P)	All	Institutional and Professional	Master	Not Required	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical										
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)**
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.	2310A PRV03 (I); 2420A PRV03 (P) or 2310B PRV03 (P) or 2000AA PRV03 (P)	All	Institutional and Professional	Master	Required	100%
CDLMC143	Rendering Provider City Name	varchar	30	City name of provider or service facility location.	2310E 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 codes are maintained by the U.S. Postal Service. See Appendix H: External Code Sources, United States Postal Service.	2310E N402 (I); 2420C N402 (P) or 2310C N402 (P)	All	Institutional and Professional	Master	Required	90%
CDLMC145	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.	2310E 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	
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	60	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			Master	Not Required	
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.	N/A	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 and Encounter	Master	Optional	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Medical										
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)**
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 and Encounter	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 H: External Code Source, Accredited Standards Committee.	2320 SBR01	All	Institutional and Professional and Encounter	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 and Encounter	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 and Encounter	Detail	Optional	
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 and Encounter	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 and Encounter	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 and Encounter	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); 2420A N301 (P)			Master	Not Required	
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%

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Pharmacy									
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	varchar	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 IF Available	
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 Carrier Plan Specific Contract Number or Subscriber/Member Social Security 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.	102-A2 (version/release number of the claim)	All	Detail	Required	40%
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.	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	60	The subscriber's last name.	716	Commercial Only	Master	Required	100%
CDLPC014	Subscriber First Name	varchar	35	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 Gender	char	1	1 = Male; 2 = Female; 0 = Unspecified.	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	60	Member last name.	716	All	Master	Required	90%
CDLPC021	Member First Name	varchar	35	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%

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Pharmacy									
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)**
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.] 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%
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) 1 = Substitution Not Allowed by Prescriber 2 = Substitution Allowed – Patient Requested That Brand Product Be Dispensed 3 = Substitution Allowed – Pharmacist Selected Product Dispensed 4 = Substitution Allowed – Generic Drug Not in Stock 5 = Substitution Allowed – Brand Drug Dispensed as Generic 6 = Override 7 = Substitution Not Allowed – Brand Drug Mandated by Law 8 = Substitution Allowed – Generic Drug Not Available in Marketplace 9 = Other [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. [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. If no NDC is identified, include the names of the compound drug ingredients. Use spaces between multiple drugs. [Only associated with a drug, if service provided was not a drug, this line may be blank.]	N/A	All	Detail	Required	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. [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. [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. [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. [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. [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%

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Pharmacy									
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)**
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%
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, set to 0. 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). [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). [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). [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	
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	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

Texas All Payor Claims Data Base-Common Data Layout Components and Requirements – Pharmacy									
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)**
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%
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	Optional	
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	char	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	30	City or town where dispensing pharmacy located.	728-SU	All	Master	Required	50%
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%

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

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	varchar	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 IF Available	
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, use Cross Reference Claims ID (CDLDC008).	N/A	All	Detail	Required	40%
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.	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	
CDLDC013	Subscriber Last Name	varchar	60	The subscriber's last name.	2010BA/NM1//03	Commercial Only	Master	Required	100%
CDLDC014	Subscriber First Name	varchar	35	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	60	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	35	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%

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

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)**
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	CDT 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. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00 = entire oral cavity, 01 = maxillary arch, 02 = mandibular arch, 10 = upper right quadrant, 20 = upper left quadrant, 30 = lower left quadrant, 40 = lower right quadrant.	2400 SV304-01	Dental Only	Detail	Required	50%
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. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00=entire oral cavity, 01=maxillary arch, 02=mandibular arch, 10=upper right quadrant, 20=upper left quadrant, 30=lower left quadrant, 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. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00 = entire oral cavity, 01 = maxillary arch, 02 = mandibular arch, 10 = upper right quadrant, 20 = upper left quadrant, 30 = lower left quadrant, 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. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00 = entire oral cavity, 01 = maxillary arch, 02 = mandibular arch, 10 = upper right quadrant, 20 = upper left quadrant, 30 = lower left quadrant, 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. Area of the oral cavity is designated by a two-digit code, selected from the following code list: 00 = entire oral cavity, 01 = maxillary arch, 02 = mandibular arch, 10 = upper right quadrant, 20 = upper left quadrant, 30 = lower left quadrant, 40 = lower right quadrant.	2400 SV304-05	Dental Only	Detail	Required IF Available	
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	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

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)**
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	
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	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

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)**
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	
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	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).	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	

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

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)**
CDLDC064	Allowed Amount	Int	12	When payment arrangement type in CDLDC065 is equal to 01 for capitated services, report the maximum amount that would have been paid under fee-for-service for a particular procedure or service. When payment arrangement type in CDLDC065 is equal to 02 for fee-for-service, report the maximum amount contractually allowed, and 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	
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	35	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	60	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	30	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	
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%

A cell highlighted in Yellow indicates an updated value.
Reference CDL Errata at **https://go.uth.edu/txapcd**

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)**
CDLDC080	Billing Provider Last Name or Organization Name	varchar	60	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.	2320 SBR01	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: Race 1/Race 2/Race 3

These codes are a limited subset from
http://www.cdc.gov/nchs/data/dvs/Race_Ethnicity_CodeSet.pdf

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 G-3: 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
HL7/CDC Race and Ethnicity Code Set
SOURCE: Race and Ethnicity Code Set
AVAILABLE FROM:
Centers for Disease Control and Prevention 1600 Clifton Road
Atlanta, GA 30329-4027 http://www.cdc.gov/nchs/data/dvs/Race_Ethnicity_CodeSet.pdf
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

2010 FIPS Codes for Counties and County Equivalent Entities
SOURCE: United States Census Bureau, Geography
https://www.census.gov/library/reference/code-lists/ansi.html
AVAILABLE FROM:
United States Census Bureau, Geography https://www.census.gov/geo/reference/codes/cou.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 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
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
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
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