Healthcare Payments Data Program

Reporting Manual

July 2025

Version 3.0

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1 Revision History

Version	Date	Key Differences
3.0	07/07/2025	Non-Claims Payment (NCP) Data Layout™ Version 1.0 implementation updates. Updated subsections A.1 to A.3 of Appendix A: Intake Specifications. Added Appendix D: Non-Claims Data File Intake Validations and Appendix E: Primary Care Code Sets.
2.1	03/11/2024	Race and Ethnicity reporting updates
2.0	11/20/2023	APCD-CDL™ Version 3.0.1 and Dental implementation updates
1.0	02/23/2022	Initial version

2 Introduction

The Department of Health Care Access and Information (HCAI) is tasked with implementing California's All-Payer Claims Database (APCD), as a part of the Healthcare Payments Data (HPD) Program.

This version of the reporting manual provides guidance for the HPD implementation of the All-Payer Claims Database Common Data Layout (APCD-CDL™), Version 3.0.1, as the file format for payers to transmit health care enrollment, cost, utilization, and provider data to the HPD System. For more information about the APCD-CDL™, visit the APCD Council's website (https://www.apcdcouncil.org/common-data-layout).

The Reporting Manual also provides guidance for the HPD implementation of the NCP Data Layout™, Version 1.0, as the file format for payers to transmit annual payment data, pharmacy rebate data, and capitation file data to the HPD System. For more information about the NCP Data Layout™, visit the NAHDO's website (https://www.nahdo.org/datalayouts).

HCAI actively maintains a website (https://hcai.ca.gov/data/cost-transparency/healthcare-payments/) with information about the HPD Program, including background, history, the HPD data submitters webpage, references to state statutes and regulations, links to this Reporting Manual, the Data Submission Guide (DSG), contact information, and other resources for submitters. The HPD Program staff are dedicated to working with all submitters to ensure full compliance with HPD Statute and Regulations.

2.1 Document Purpose

This Reporting Manual consists of discussion and comments related to the implementation of the regulations. In the case of any perceived conflict between non-

regulatory material in this manual and any regulation, the regulation shall prevail. The Reporting Manual is intended for use by:

1. The HPD Program's mandatory submitters include commercial health plans, commercial insurers, and public self-funded health plans.
2. Voluntary submitters, including private self-funded health plans, providers, and suppliers.

Although the HPD Program also integrates data from Medi-Cal and Medicare Fee-For-Service (FFS), the Reporting Manual does not cover the data submission processes for those data.

This Reporting Manual serves as a companion document to:

- The file formats covered by the APCD-CDL™, Version 3.0.1 (submitters must contact the APCD Council and request a copy of the APCD-CDL™ at https://www.apcdcouncil.org/common-data-layout). To see all historical APCD-CDL versions, please click on "Download APCD-CDL" in the left menu of the APCD Council's website.
- The file formats covered by the NCP Data Layout™, Version 1 at (https://www.nahdo.org/datalayouts)
- The DSG is available at the following location: HPD Data Submission Guide – Version 3.0
- The HPD Regulations are available at the following location: California Code of Regulations (westlaw.com)

2.2 Background Information on the HPD Program

California Law (Chapter 8.5 of Part 2 of Division 107 of the California Health and Safety Code, Sections 127671 – 127674.1) describes the legislative intent of the HPD Program, identifies the types of data and submitters, and describes HCAI's responsibilities in administering the HPD Program.

California has a substantial public interest in the price, cost, utilization, equity, and quality of health care services. California is a major purchaser of health coverage through the Public Employees' Retirement System, the Department of Health Care Services, the Department of General Services, the Department of Corrections and Rehabilitation, the California Health Benefit Exchange, and other entities acting on behalf of a state purchaser. California also provides major tax expenditures through the tax exclusion of employer-sponsored coverage and tax deductibility of coverage purchased by individuals, as well as tax deductibility of excess health care costs for individuals and families.

California has established the HPD Program to collect information and provide greater

transparency regarding health care costs, utilization, quality, and equity. The information will be used to inform policy decisions regarding the provision of quality health care, improving public health, reducing disparities, advancing health coverage, reducing health care costs, providing oversight of the health care system and health care companies, and providing public benefit for Californians and the state, while preserving consumer privacy. It is the intent of the HPD Program to improve data transparency to achieve a sustainable health care system with more equitable access to affordable and quality health care for all.

The HPD Program encourages state agencies, researchers, health care service plans, health insurers, providers, suppliers, and other stakeholders to use this data to develop innovative approaches, services, and programs that may have the potential to deliver health care that is both cost effective and responsive to the needs of enrollees, including recognizing the diversity of California and the impact of social determinants of health.

2.3 References to HPD Statute

The HPD Program, including types of data and submitters, is broadly defined in California statute (Chapter 8.5 of Part 2 of Division 107 of the California Health and Safety Code, Sections 127671 – 127674.1). Additional detail about data and submissions is included in Chapter 11 of Division 7 of Title 22 of the California Code of Regulations, Articles 1 through 7, starting with Section 97300.

3 Contact Information

HCAI HPD Program and Data Management Vendor staff can answer questions regarding the process and mechanics of data submission and technical issues regarding the covered population, intent, or contents of data files and elements.

For program questions, such as compliance with regulation, the enabling statute, down-stream use of the data, and similar questions, please contact hpd@hcai.ca.gov.

For technical questions related to the use of the technical specifications being used, data submission questions, or questions about submission results, please contact the HPD Data Management Vendor at: hpd-support@onpointhealthdata.org.

4 Registration Requirements

This section provides an overview of HPD Program registration requirements and is intended for use by two different types of entity:

- Entities such as non-exempt health plans, health insurers, public self-insured organizations, and any voluntary participating entities – in HPD terminology these entities are referred to as “plans”.
- Technical organizations who are responsible for the actual submission of the

data to HPD – in HPD terminology these entities are referred to as “submitters”.

It is understood and expected that in many circumstances a single entity will be performing both of these roles. In cases like this, the single entity would need to register once as the plan and once as the submitter.

Plan registration will take place during the month of January each year, while Submitter registration will take place during the month of February each year once plan registration has been completed.

Section 4 of the Data Submission Guide (DSG) Version 3.0 provides special registration and testing requirements for historical NCP files. During the registration period, plans and submitters will have the option to provide non-claims payment data with the introduction of NCP Data Layout ™ Version 1.0 in 2025. Plans will have the option to identify the submitter(s) who will be sending their NCP files and provide contacts for NCP file types. Submitters will have the option to identify the plan(s) on whose behalf they will be sending NCP file types and provide contacts for NCP file types.

If plans will not be submitting any NCP file types or are unsure if their organization will be submitting NCP data files during the reporting year, they can select “This data file type is not submitted by our organization” in the registration form. If submitters will not be submitting any NCP file types or are unsure if their organization will be submitting NCP data files during the reporting year, they can select “Not Applicable” in the registration form. Both plans and submitters will have another opportunity to update their registration for NCP file submission later in the year. Plan and submitter registration for NCP file submission is required to be completed before test files can be submitted.

It is understood that various situations will occur where the actual submission of data is delegated either upwards within a corporate ownership structure or downwards to a subcontracted entity. It is the responsibility of the plan for which the submitter is reporting data to ensure that all reporting relationships are correctly documented during the registration process.

The HPD Program will assign a unique Payer Code to each registered plan and will assign a unique Data Submitter Code to each registered submitter. Both the Data Submitter Code and Payer Code must be used within the submission data. See the APCD-CDL™ Version 3.0.1, and NCP Data Layout™ Version 1.0 for additional details.

Refer to Appendix B (“Plan and Submitter Registration Scenarios”) for detailed examples of registration scenarios.

Submitters are required to annually update their registration via the Submitter Portal, by the last calendar day in February. In addition to this required annual update, submitters also are required to update their registration information whenever there is a change to their organizational information, their organization’s contacts, or the HPD-related

responsibilities of those contacts.

5 Submission Requirements

This section provides an overview of HPD Program data submission requirements and is intended for use by individuals within data submitter organizations responsible for generating and submitting conforming files. This section includes information regarding required file types, submitter registration instructions, timelines for file submissions, file submission instructions (including coordination of submissions), and data quality evaluation and notification processes.

All submitter interactions will occur via a secure Submitter Portal, which is the platform for submitter registration, data submission, and submission status and response information.

5.1 Addition of NCP Data Layout ™ Version 1.0

Beginning in 2025, the registration process includes NCP data, which is payment data not captured by using the APCD Common Data Layout (APCD-CDL™). NCP data includes three new file types:

- Annual Payments File (AP)
- Pharmacy Rebate File (PR)
- Capitation File (CF)

In preparation for the submission of NCP data and prior to initial testing, plans must update their 2025 Plan Registrations by identifying the entities that will submit their historical NCP data files. Section 4 of the DSG Version 3.0 provides special registration and testing requirements for historical NCP files. Plans must provide the information required by Section 2.1 of the DSG for these entities. Registered submitters planning to submit historical NCP Data Files must update their 2025 Submitter Registrations. Registered submitters must also provide the information required by Section 2.2 of the DSG regarding their historical NCP Data File submission(s). Delegated submitters that did not register as registered submitters in 2025 that will submit historical NCP Data Files must register as a submitter under Section 2.2 of the DSG.

5.2 Files and Technical Specifications

Submitters shall submit the following files and adhere to the specifications in the Common Data Layout for state APCDs (APCD-CDL™, Version 3.0.1):

- Member Eligibility File
- Medical Claims File
- Pharmacy Claims File

- Dental Claims File
- Provider File

Submitters shall submit the following files and adhere to the specifications in the NCP Data Layout™, Version 1.0:

- Annual Payment File (AP)
- Pharmacy Rebate File (PR)
- Capitation File (CF)

Submitted files must have a file type of .txt and the data must be pipe-delimited ("|"). No pipe character can be included in the submitted data. If no data value is being submitted in a specific data element, do not include any character between the preceding pipe and the succeeding pipe (i.e., do not include a blank; instead, report a null value as follows: "||").

Always submit one line-item per row. Each row is delimited by the carriage return and a line feed combination. Do not include carriage returns or line feed characters as a part of line-item data.

Each submitted file must include both a valid header record and a valid trailer record, along with detail records.

The reporting period is defined in the file header (CDLHD006 and CDLHD007) in both the APCD-CDL™ Version 3.0.1 and the NCP Data Layout™ Version 1.0.

a) Member Eligibility File

Include a monthly record for each California resident member who was eligible for a defined set of benefits for one or more days within the reporting period of the file. If a specific member had more than one distinct policy, include a record for each policy. If the reporting period of the file spans multiple months, the member must be reported with one record per month of eligibility.

b) Medical Claims File

Include a record for each service line for every claim or encounter processed during the reporting period. Claims and encounters should be submitted regardless of the location/state where the service was delivered. Do not include fully denied claims. Any records previously paid and reported to the HPD Program and subsequently reversed or denied must be provided to the HPD Program.

c) Pharmacy Claims File

Include a record for each service line for every claim or encounter processed

during the reporting period. Claims and encounters should be submitted regardless of the location/state where the prescription was dispensed. Do not include fully denied claims. Any records previously paid and reported to the HPD Program and subsequently reversed or denied must be provided to the HPD Program. Only include records that have a valid NDC code (CDLPC025).

d) Dental Claims File

Include a record for each service line for every claim or encounter processed during the reporting period. Claims and encounters should be submitted regardless of the location/state where the service was delivered. Do not include fully denied claims. Any records previously paid and reported to the HPD Program and subsequently reversed or denied must be provided to the HPD Program.

e) Provider File

Include a record for each provider that is included in any of the reported claim's files (Medical, Pharmacy and Dental) and the eligibility file, for the reporting period. Provider types would include Primary Care Provider, Rendering Provider, Billing Provider, Referring Provider, Attending Provider, Prescribing Physician, and Pharmacy. For larger submitters, contact HPD technical support at hpd-support@onpointhealthdata.org to discuss the possibility of providing an annual roster of providers and then a monthly update file.

f) Annual Payment File

Include a record for each payment category and subcategory through which contractually based non-claims or fee-for-service payments were made by a payer to a provider during the annual reporting period. Member Count and Member Months should be reported at three levels of detail, high level information on each level is included below, for full reporting details, please see the NCP Data Layout Submission Scenarios document.

1. For population-based payment categories (i.e., payment category code = B or D, or payment subcategory code = C5 or C6)
2. For 'Z' payment categories, rolled up to the billing provider/plan code level to report deduplicated member count/member months for only population-based payment categories.
3. For 'Z' payment categories, rolled up to the plan code level across all payment categories (including fee-for-service) to report each plan's entire book of business.

g) Pharmacy Rebate File

Include a record for each National Drug Code (NDC) labeler and product code for which a payer received rebates paid by the pharmaceutical manufacturer or

pharmacy benefits manager (PBM) during the annual reporting period.

h) **Capitation File**

Include a record for each capitation payment administered or adjusted for member-attributable services per capitation arrangement during the monthly reporting period.

5.3 Medi-Cal and Medicare Fee-For-Service

Claims and encounters for Medi-Cal (California Medicaid) are being collected directly from the Department of Health Care Services; Medicare FFS claims are provided to the HPD in files provided directly from the U.S. Centers for Medicare & Medicaid Services (CMS). If submitters have any of this data, they should exclude these two types of data in their claims file submissions.

5.4 Medicare Advantage

Medicare Advantage claims/encounters must be submitted by commercial health plans and commercial insurers administering Medicare Advantage plans.

5.5 Behavioral Health Claims and Encounters

Behavioral health claims and encounters should be submitted in the Medical Claims file.

5.6 Physician Administered Drugs

Physician administered drugs (PADs) should be submitted in the Medical Claims file.

5.7 File Submission Instructions

a) Authorized submitters will authenticate themselves within the Submitter Portal and upload data.

b) Files submitted to the HPD System will be either accepted or rejected. Once intake submission checks and validations have been executed, the submitter will be notified of file acceptance or rejection. The following aspects of submitted files are verified during the review process and may result in rejection if they do not meet the specified criteria:

- File format, including required layout, field lengths, and data types.
- Time (or reporting) periods match the reporting period identified in the header record (CDLHD006 and CDLHD007) These data elements are consistent between both the APCD-CDL™ Version 3.0.1 and the NCP Data Layout™ Version 1.0. Examples in each file type that compares the header record reporting period to the submission's data elements include:
  - Member Eligibility File: Eligibility Year/Eligibility Month (CDLME005, CDLME006 from APCD-CDL™)

  - Medical Claims File: Paid date (CDLMC024 from APCD-CDL™)
  - Pharmacy Claims File: Paid date (CDLPC024 from APCD-CDL™)
  - Dental Claims File: Paid Date (CDLDC023 from APCD-CDL™)
  - Annual Payments File: Reporting Period Start Date (CDLAP003 from NCP Data Layout™)
  - Pharmacy Rebates File: Reporting Period Start Date (CDLPR003 from NCP Data Layout™)
  - Capitation File: Reporting Period Start Date (CDLCF003 from NCP Data Layout™)

- Valid values for required or situationally required data elements– unless a Data Variance has been approved by the HPD Program.
- Data quality validations that evaluate the data element relationships and the data integrity in each file. For more information on validations performed on NCP files, please see the NCP Data Layout™ Version 1.0 Validations Document.

c) If the file is rejected, the submitter will be notified of all errors found in the submission. The submitter shall correct submission errors and resubmit the file.

5.8 Denied Claims and Service Lines

Fully denied claims, in which all service lines have been denied, should not be submitted to the HPD. When a claim is partially denied, the entire claim should be submitted and those service lines that were denied should be indicated by sending a value for the Denied Claim Line Indicator (CDLMC158) = “1”, service lines that were not denied should be indicated by sending a value for the Denied Claim Line Indicator (CDLMC158) = “2”.

5.9 Data Quality

The quality of submitted data is of primary importance to the HPD Program. Submitters may review data quality of their submissions in the Data Portal. The usefulness of submitted data is directly related to its quality, including the completeness, accuracy, reasonableness, and timeliness of the data. Data quality can only be fully assessed over time and with analysis that brings related data together. Data quality cannot be completely assessed at the time of submission. After submitted files have been accepted, the HPD Program uses several processes to measure and improve the quality of the HPD System data over time, including:

a) Post Intake Data Quality Validation

After passing initial intake checks and validations, the data will be further

evaluated against established trends and benchmarks. Trends and benchmarks are calculated and refined as the database is populated. Accepted files that are found to contain anomalous data inconsistent with historical trends and benchmarks may also result in a submitter being required to correct and resubmit the file or document the reasons for any discrepancies (see “Section 5.10”).

b) Compliance Process

If data quality issues are found, HCAI or the HPD Data Management Vendor will inform the submitter and provide a description of specific anomalies. The submitter will make every effort to correct data quality issues, and these efforts may include resubmission of corrected data. Should persistent data quality issues continue, HCAI will report compliance issues to the licensing entity – either the California Department of Insurance (CDI) or the California Department of Managed Health Care (DMHC).

c) File Resubmission

Resubmissions follow the same process used for original files. It is good practice to identify re-submissions in the file name.

5.10 Data Variance Requests

A submitter may request, and HCAI may authorize, a temporary variance to specific data submission requirements, quality checks, or requests from the HPD Program to allow data collection to proceed while a submitter adds data elements or makes other improvements to their data. Granted variances will be revisited and adjudicated on a regular basis, at least annually. Submitters are expected to improve data quality and completeness over time to enhance HPD value. Submitters who wish to request a Data Variance should follow the process as directed on the Submitter Portal. These variances (or known issues) will be made available to data users and the public.

5.11 Claim/Encounter Versioning and Capitation Payment Adjustments

Claim/encounter versioning (also known as “claims consolidation”) is accomplished for all claims and encounter files (Medical, Pharmacy and Dental) through one of two approaches:

- Aggregation
- Versioning

Prior to initial testing each submitter will be contacted by HPD support staff and submitters will provide details about the standard approach used within their adjudication systems to consolidate claims. These details will be used to assign appropriate consolidation methods within the Portal to each submitter. Only a single consolidation method is assigned to each submission. A high-level view of each

approach follows:

- **Aggregation:** This method uses the Claim Line Type (CDLMC160, CDLPC066 and CDLDC084). All adjustments are provided for each record, including negative dollar and quantity amounts for reversals.
- **Versioning:** Versioning methods require consistent and properly incremented Version Numbers (CDLMC007, CDLPC007, CDLDC007) and final values for all fields provided in the APCD-CDL™ for each updated record. The initial Version Number value of an original claim/encounter that has never been submitted before would be reported as “0”. Any subsequent submissions that include updated versions of that specific claim/encounter would increment the value reported in the Version Number field by one (e.g., “1” then “2” then “3”, etc.). The final record for each claim’s service line would be reported with the highest version number.

Capitation payment adjustments may be submitted according to the guidelines outlined below. Please see the NCP Data Layout Submission Scenarios document for more details on file specifications.

- Adjustments must be reported within the Capitation File whose header record’s Reporting Period (CDLHD006, CDLHD007) reflects the month during which the adjustment was processed. For example, a capitation payment affiliated to a member’s May 2025 enrollment that is adjusted in July 2025 should be reported in the July 2025 Capitation File.
- Adjustments must be submitted using the Aggregation method. This method requires the adjustment be accompanied by an additional row of data that voids the original capitation payment administered or the previous capitation adjustment administered, with negative dollars reported in the Total Paid Amount field (CDLCF019) on the voided payment.
- Adjustments must report the month of enrollment for which the adjustment should apply to using the Capitation File’s Reporting Period Start Date (CDLCF003) and Reporting Period End Date (CDLCF004).

5.12 Submitter Testing

Submitters are encouraged to submit test files as early as possible in implementation to validate their extract and submission processes. Systematic reports of submission results will be available for review by submitters.

Test files must be submitted using appropriate values within the file header, including the indication of a test file using a “T” for the “Test File Flag” (CDLHD008).

Submitters may break up, at their discretion, historical or multi-month catch-up files into monthly or multi-month reporting periods. Submitters must, in coordination with HCAI and the HPD Data Management Vendor, develop a schedule of intermediate steps for data file testing and submission that satisfies the deadlines listed below.

Before plans submit historical data files, plans and delegated submitters must comply with the registration and testing requirements outlined in Section 4 of the DSG Version 3.0.

Submitters must submit at least one test file through the data portal for each historical NCP Data File type they plan to submit by September 1, 2025. For example, if a registered submitter will submit historical Annual Payment Files and historical Capitation Files, it must submit at least one test Annual Payments File and one Capitation File by September 1, 2025.

Submitters must successfully complete testing for each historical NCP Data File type they will submit by June 30, 2026. This means that the registered submitter, for each registered NCP data File type will submit a test file that was not rejected by HCAI. Reasons for rejection are stated in Section 5 of the DSG.

5.13 Production Submission of Historical Data Files

All plans shall submit Capitation Files, in accordance with Sections 97342 and 97344, for the time period from June 29, 2017, through July 31, 2026, by September 1, 2026. All plans shall submit Annual Payment Files and Pharmacy Rebate Files, in accordance with Sections 97342 and 97344, for the time period from June 29, 2017, through December 31, 2024, by July 31, 2026.

5.14 Submission of Ongoing Production Monthly Files

For reporting periods following the first monthly production file, submitters shall submit ongoing monthly data file submissions by the first day of the second month following the completion of the reporting period, unless that day falls on a weekend or state holiday, in which case the due date is the next business day. For example, data for the January monthly reporting period is due by March 1.

Reporting Period	Monthly Submission is Due By*
January	March 1
February	April 1
March	May 1
April	June 1
May	July 1
June	August 1
July	September 1
August	October 1
September	November 1
October	December 1
November	January 1
December	February 1

*If the date falls on a weekend or holiday, the accepted submission is due on the next business day.

5.15 Submission of Ongoing Production Annual Files

Submitters shall submit ongoing annual data file submissions by the last day of September of the year following the report year, unless that day falls on a weekend or state holiday, in which case the due date is the next working day. A report year is a calendar year.

5.16 File Naming Convention

Every file submitted to the HPD System shall be a standard text file and conform to the APCD-CDL™, Version 3.0.1 and the NCP Data Layout™ Version 1.0 format. The format of the file name is at the discretion of the submitter, but it is highly recommended that both a date of submission and a version number for the specific file being- submitted be included in the file name to facilitate file identification when researching data anomalies or questions. If a file is a resubmission it is recommended to be noted as such in the file name.

5.17 Submitters Acting as a Third-Party Administrator

Submitters may submit data for multiple payers. This may include a submitter in the role of a Third-Party Administrator (TPA), which includes Pharmacy Benefit Managers (PBMs), for a self-insured entity.

Since each “payer” must be registered with the HPD Program, submitters that are TPAs should contact HCAI and provide either registration information for each “payer” that they represent or contact information for each self-insured entity. The ability to submit data for different payers in the same physical dataset has not yet been confirmed.

5.18 Fee-For-Service Equivalents for Encounters/"Zero Pay” Claims

For capitated encounters, submitters are requested to indicate what the charge amount of the encounter would have been if it had been claimed under a fee-for-service arrangement. Per the common data layout, FFS equivalents are reported in the Allowed Amount field in the Medical Claims (CDLMC131) and Pharmacy Claims files (CDLPC038) when the reported Payment Arrangement Type field (CDLMC132, CDLPC049) equals “01” to indicate capitated services. FFS equivalents should reflect the total amount that a provider would be paid for a claim (i.e., the sum of insurer and member responsibilities) by calculating the median cost of the claim at the service line (defined at the level of the APC, CPT, DRG, HCPCS, etc.). The median cost is to be based on plan fee schedules (often used for tracking patient out of pocket spending relative to deductible amounts) for comparable providers/facilities paid using FFS arrangements.

5.19 Product Category Code (CDLME004)

Submitters are directed at using the most granular choice available. In cases where more than one product code may be applicable to a specific member, the following subset of Product Codes (excerpted from the APCD-CDL™, Version 3.0.1 Appendix G1) are anticipated to be the most relevant for reporting to HPD:

Code	Description
E	Medicare – Point of Service (POS)
EP	Exclusive Provider Organization
FH	Federal Employees Health Benefits Program (HMO)
FP	Federal Employees Health Benefits Program (PPO)
HM	Health Maintenance Organization (HMO)
HN	Health Maintenance Organization (HMO) Medicare Advantage/Risk
IN	Indemnity
MD	Medicare Part D
MO	Medicare Advantage PPO
PR	Preferred Provider Organization (PPO)
PS	Point of Service (POS)

5.20 Race and Ethnicity Data Elements

Submitters are requested to submit race and ethnicity data for all members. Self-identified information collected directly from the member and allowing selection of multiple races for self-identification are preferred for race and ethnicity data collection. As noted in Appendix H of the APCD-CDL™, Version 3.0.1, the following reference is given for race and ethnicity data elements:

PHIN VADS - Search All Vocabulary (cdc.gov)

Select “CDC Race Category and Ethnicity Group” for the current reference dataset for race and ethnicity codes. APCD-CDL™, Version 3.0.1, uses Version 1.2 of the CDC

system data files to reference race and ethnicity codes.

https://www.cdc.gov/phin/resources/vocabulary/documents/PH_RaceAndEthnicity_CDC_v1.2.xlsx

The importance of the quality and completeness of race and ethnicity data reaches far beyond HPD Program. This data will also be important in the production of Health Equity and Quality Measure Reporting as required by DMHC. HCAI works closely with DMHC and looks forward to continuing to build on improvements in this crucial data over time.

Determination of Race and Ethnicity

Reliance on determinants such as the member's family member's name, physical attributes, place of birth, or primary language deteriorates the quality of race and ethnicity data. If a member is unable to respond, a family member may declare the member's race and ethnicity. Parents may be designated to declare the race and ethnicity of a newborn, with the mother's information being suitable, if parental declaration is unattainable.

Race – CDLME029, CDLME030 and CDLME031

Submitters should use the code that best represents the race of the member. Concept codes used should be six characters in length and be as granular as possible. Only concept codes with a hierarchical code value that begins with "R" should be used in these race code fields. Any concept code values with a hierarchical code value that begins with "E", should be coded as 2131-1 (Other Race), and the concept code used for the Ethnicity specific fields listed below. For example: use concept code 1002-5 for American Indian or Alaska Native, 1021-5 for Arapaho, 2028-9 for Asian, 2039-6 for Japanese, or 2054-5 for Black or African American. For Hispanic values such as: Mexican, Cuban, Puerto Rican, etc., a race value of 2131-1 (Other Race) must be used.

The values 'UNKNOW' or 'UN' should only be reported when a member self-reports their race as unknown; leave the race fields null if a member's race was not collected or available for reporting.

Hispanic Indicator - CDLME032

Submitters should follow the directions in the APCD-CDL™, Version 3.0.1, for valid values for this field:

- "Y" if the ethnicity is any of the Ethnicity values listed in Table 2 *Ethnicity Concepts and Codes* from the CDC code set referenced in the APCD-CDL™.
- "N" if the ethnicity is known and is NOT one of these values.
- "U" if not known.

Ethnicity – CDLME033, CDLME034 and CDLME035

Valid 6-character values for these fields are determined by the Concept Code column defined in the CDC dataset: (https://www.cdc.gov/phin/resources/vocabulary/documents/PH_RaceAndEthnicity_CDC_v1.2.xlsx).

Only concept code values with a hierarchical code value that begins with “E” (see the CDC reference dataset), should be used as values for ethnicity data elements, for example: 2156-8 = Costa Rican, 2180-8 = Puerto Rican. Any data value that is related to a concept code with a hierarchical code value that begins with “R”, should be coded as 2186-5 (Not Hispanic or Latino).

The value ‘UNKNOW’ should only be reported when a member self-reports their ethnicity as unknown; leave the ethnicity fields null if a member’s ethnicity was not collected or available for reporting.

5.21 Medical Claims File Data Element CDLMC157 – Claim Status

Per the definition in the APCD-CDL™, Version 3.0.1, the values provided in this field must be consistent with the X12 835 definition provided in 2100 CLP02. The most common values to be used in this data element would be:

- “01” – Primary
- “02” – Secondary
- “03” – Tertiary

Other values can be used, see the X12 835 2100 CLP02 definition for details.

5.22 Pharmacy Claims File Data Element CDLPC065 – Record Status Code

Per the definition in the APCD-CDL™, Version 3.0.1, the values provided in this field must be consistent with the NCPDP definition provided in field A88. These values indicate status of the claim, valid values in this field are:

- “1” – Paid
- “2” – Denied
- “3” – Reversed
- “4” – Adjusted

5.23 Submitting Historical Eligibility and Capitation File Data

Historical data can be submitted in any of the following increments:

- Annual
- Quarterly

- Monthly

When reporting eligibility and capitation file data, a record is required for each member for each month included in the increment. For example, if a historical file is submitted for a quarterly period, assuming that each member was eligible for benefits for the entire time, there would be three records per member included in the data – one for each month in the quarter.

5.23.a. Sample of historical Eligibility data:

Record Type	Data Submitter Code	Data Submitter Name	File Type	Period Beginning Date	Period Ending Date
HD	CACXXXX	Submitter A	ME	202101	202103

CDLME005	CDLME006	CDLME020	CDLME021	CDLME050	CDLME051
Eligibility Year of Submission	Eligibility Month of Submission	Member Last Name	Member First Name	Plan Effective Date	Plan Term Date
Example 1					
2021	01	Wind	Augusta	20191015	
2021	02	Wind	Augusta	20191015	
2021	03	Wind	Augusta	20191015	
Example 2					
2021	01	Ringing	Isabelle	20200101	
2021	02	Ringing	Isabelle	20200101	20210215
Example 3					
2021	03	Sideways	Eileen	20210331	

Example 1 - Augusta Wind has active coverage for all 3 months of the reporting period and so has a record for each month in the reporting period. The member's effective date of coverage is 10/15/2019 and is still active as of the end of the reporting period, so

Plan Term Date is reported as null.

Example 2 - Isabelle Ringing has active coverage for 2 months of the reporting period and so has a record for each applicable month in the reporting period. The member's effective date of coverage is 01/01/2020 with a termination date of 02/15/2021.

Example 3 - Eileen Sideways has active coverage for 1 month during the reporting period and so has 1 record in the quarterly file. The member's effective date of coverage is 03/31/2021 and is still active as of the end of the reporting period, so Plan Term Date is reported as null. This member had at least one day of active coverage during this reporting period and would be reported accordingly.

5.23.b. Sample of historical Capitation File data:

Record Type	Data Submitter Code	Data Submitter Name	File Type	Period Beginning Date	Period Ending Date
HD	CACXXXX	Submitter A	CF	202101	202103

CDLCF003	CDLCF004	CDLCF006	CDLCF007	CDLCF018	CDLCF019
Reporting Period Start Date	Reporting Period End Date	Member Last Name	Member First Name	Payment Subcategory	Total Paid Amount
Example 1					
202101	202101	Wind	Augusta	D1	160
202102	202102	Wind	Augusta	D1	160
202103	202103	Wind	Augusta	D1	160
202103	202103	Wind	Augusta	D4	75
202010	202010	Wind	Augusta	D1	-155
202010	202010	Wind	Augusta	D1	135
Example 2					
202101	202101	Ringing	Isabelle	D3	150
202102	202102	Ringing	Isabelle	D3	150
Example 3					
202101	202101	Sideways	Eileen	D2	150

Example 1 - Augusta Wind has active coverage under a primary care capitation model (CDLCF018 = D1) for all 3 months of the reporting period and so has a record for each month in the reporting period. In the final month of the reporting period, Augusta Wind also has coverage under a behavioral health capitation model (CDLCF018 = D4), and so

she has two rows of capitation data for the final month: one row reflecting her primary care capitation payments (affiliated to CDLCF018 = D1) and one row reflecting her behavioral health capitation payments (affiliated to CDLCF018 = D4). During the reporting period, capitation payments were also adjusted for Augusta Wind's December 2020 coverage, and so there are two rows of data reflecting Augusta Wind's adjusted capitation payments: one row voiding the original capitation payments administered for her December 2020 coverage (with CDLCF019 reporting the negative reversal), and one row reflecting Augusta Wind's final capitation payments administered for her December 2020 coverage (with CDLCF019 reporting the positive adjustment).

Example 2 - Isabelle Ringing has active coverage under a facility capitation model (CDLCF018 = D3) for 2 months of the reporting period and so has a record for each applicable month in the reporting period. The member has no capitation adjustments processed during the reporting period to report.

Example 3 - Eileen Sideways has active coverage under a professional capitation model (CDLCF018 = D2) for 1 month during the reporting period and so has 1 record in the quarterly file. The member has no capitation adjustments processed during the reporting period to report.

5.24 Accountable Care Organization (ACO) Data

There are two situational fields included on the Eligibility file that are Accountable Care Organization (ACO) focused. These fields are required when Member Insurance/Product Category Code (CDLME004) is one of the following values:

- EP = Exclusive Provider Organization
- HM = Health Maintenance Organization (HMO) (commercial only)
- PR = Preferred Provider Organization (PPO) (commercial only)
- PS = Point of Service (POS) (commercial only)

For members who are attributed to an ACO, plans should use their own internal identifier and name for the ACO contract. The internal identifier and name should be the same month-over-month for the same ACO contract.

Appendix A – Intake Specifications

A.1 Required Data Content

a) Service Line Level Data

In the case where a claim or encounter includes multiple service lines, the submitter shall send all service line level data to the HPD System.

This includes unbundled service lines, where the procedure code originally reported on one service line has been broken into and paid under two or more separate (possibly different) procedure codes, or when the units of service originally reported on one service line have been broken into two or more service lines and paid under different reimbursement rates.

b) Institutional and Professional Claims/Encounters

An institutional claim/encounter is one that would have been billed using an ASC X12 837 Institutional (837I) electronic claim format.

A professional claim/encounter is one that would have been billed using an ASC X12 837 Professional (837P) electronic claim format.

c) Inpatient and Outpatient Claims/Encounters

For all institutional claims/encounters, the Bill Type ASC X12 837I CLM05-2 determines if the claim/encounter should be designated as inpatient or outpatient. The Uniform Billing Claim Form Bill Type codes contained in this field are defined by the National Uniform Billing Committee (NUBC). To determine if a claim/encounter should be designated as “inpatient” or “outpatient” refer to the list of valid codes defined by NUBC.

A.2 Data Element Format

Each data element must comply with the APCD-CDL™, Version 3.0.1 and the NCP Data Layout™ Version 1.0 specifications. Failure to comply with APCD-CDL™ and the NCP Data Layout™ data element specifications will result in file rejection unless a Data Variance request has been approved by the HPD Program.

A.3 Required/Situational Data Elements

Unless a Data Variance has been approved for a specific field, data elements designated in the DSG as “Required” must be populated at all times. Failure to provide a valid value in a required field without an approved Data Variance will result in the rejection of the submitted file.

Data elements designated as “Situational” must be populated under specific circumstances. Unless a Data Variance has been approved for a specific field, failure to

provide a valid value in a situational field will result in the rejection of the submitted file if the situational circumstance is present. For example, the Admission Date field (CDLMC025) is designated as “Situational” and is required when the claim/encounter is “inpatient.

**** Refer to the APCD-CDL™ (Version 3.0.1) and the NCP Data Layout™ (Version 1.0) for data format specifications.**

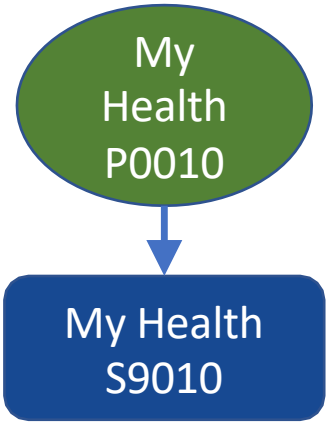
Appendix B – Plan and Submitter Registration Scenarios

All names used in the following scenarios are fictitious. Examples that apply to health plans licensed through the DMHC also apply to insurers licensed through the CDI and vice versa.

B.1 A Plan Submitting Its Own Data

My Health Plan is a licensed health plan with DMHC and intends on submitting data to the HPD Program without any delegation.

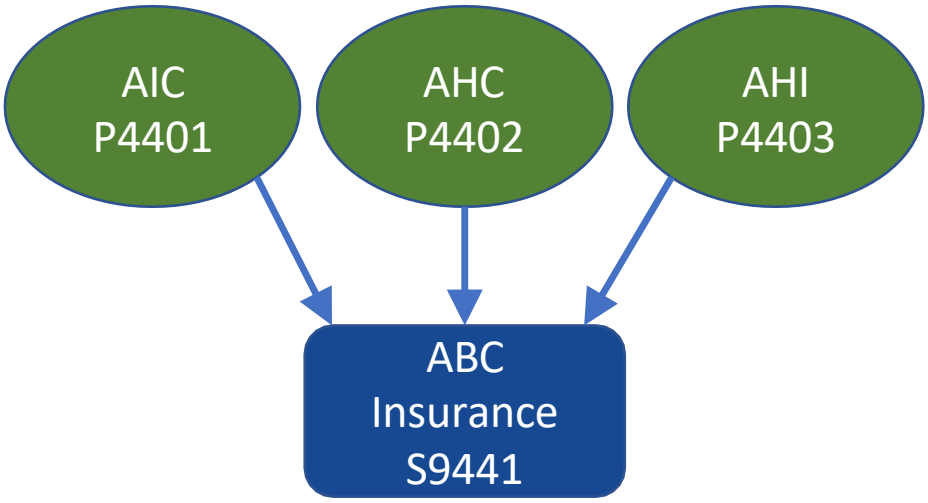
My Health Plan would register as a plan and receive a unique Payer Code (P0010). My Health Plan also would register as a submitter and receive a unique Submitter Code (S9010).



B.2 An Insurer with Multiple Licenses Submitting Its Own Data

ABC Insurance has three licenses, ABC Insurance Company (AIC), ABC Holding Co. (AHC), and About Health Inc. (AHI) with CDI and intends on submitting data to the HPD Program without any delegation. Each license covers over 40,000 lives.

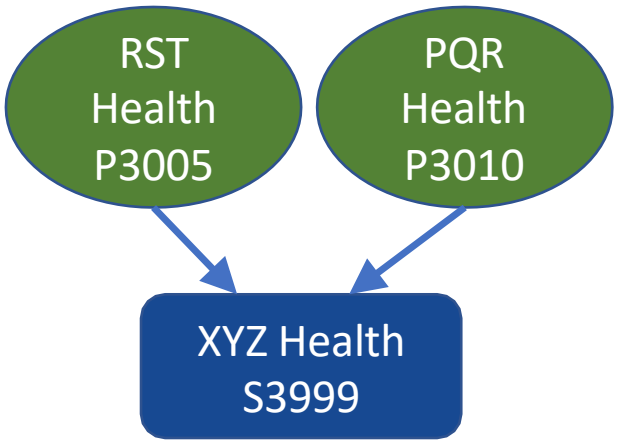
ABC Insurance would register each license separately and would receive a unique Plan Code per license, AIC (P4401), AHC (P4402) and AHI (P4403). ABC Insurance would also register as a submitter and receive a unique Submitter Code (S9441).



B.3 A Plan with Multiple Licenses Submitting Its Own Data (Various Thresholds)

XYZ Health Plan has three licenses with DMHC and intends on submitting data to the HPD Program without any delegation. Two of their licenses cover over 40,000 lives (RST Health and PQR Health), but the third (UVW Health) covers only 35,000 lives.

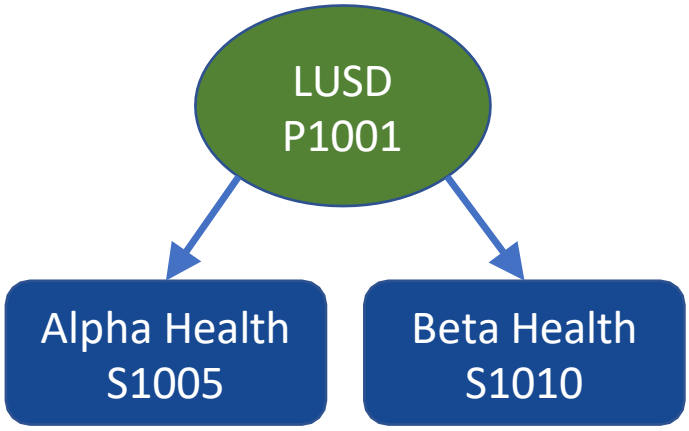
XYZ Health Plan would register RST Health and PQR Health separately. XYZ Health Plan would not register the license for UVW Health as it is below the mandatory reporting threshold. RST Health and PQR Health would each receive a unique Payer Codes (P3005 and P3010). XYZ Health Plan would also register as a submitter and receive a unique Submitter Code (S3999).



B.4 A Public Self-Insured Entity with Two Contracted Entities

Largeville Unified School District (LUSD) is a public self-insured entity that covers 75,000 lives. LUSD contracts with Alpha Health to provide medical and pharmacy benefits and with Beta Health to provide behavioral health benefits.

LUSD would register as a plan and indicate Alpha Health and Beta Health as LUSD's delegated submitters. LUSD would receive a unique Payer Code (P1001). Alpha Health would register as a submitter, would indicate that they will be submitting data on behalf of LUSD, and would be responsible for submitting all four data file types (i.e., Member Eligibility, Medical Claims, Pharmacy Claims, and Provider). Alpha Health would be assigned a unique Submitter Code (S1005). Beta Health would register as a submitter, would indicate that they will be submitting data on behalf of LUSD, and would be responsible for submitting only Eligibility, Medical Claims, and Provider data files. Beta Health would be assigned a unique Submitter Code (S1010).



B.5 A Plan Acting in Different Roles with Multiple Other Entities

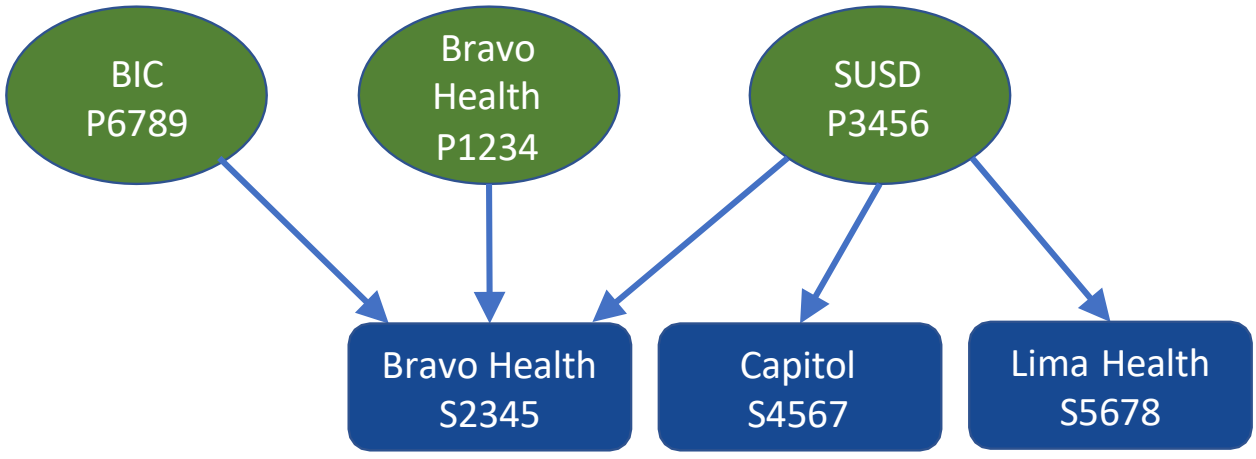
Bravo Health is a licensed health plan with DMHC and intends on submitting data to the HPD Program without any delegation. Bravo Health would register as a plan and receive a unique Plan Code (P1234). Bravo Health would also register as a submitter and receive a unique Submitter Code (S2345).

Smallville Unified School District (SUSD) is a public self-insured entity that covers 41,000 lives. SUSD contracts with multiple entities: Bravo Health to provide medical benefits, Capitol Pharmacy as a Pharmacy Benefits Manager (PBM), and Lima Health to provide behavioral health benefits. SUSD would register as a plan and indicate Bravo Health, Capitol Pharmacy, and Lima Health as delegated submitters. SUSD would

receive a unique Payer Code (P3456). Capitol Pharmacy would register as a submitter, would indicate that they will be submitting data on behalf of SUSD, and would be responsible for submitting only Eligibility, Pharmacy Claims, and Provider data files. Capitol Pharmacy would be assigned a unique Submitter Code (S4567). Lima Health would register as a submitter, would indicate that they will be submitting data on behalf of SUSD, and would be responsible for submitting only Eligibility, Medical Claims, and Provider data files. Lima Health would be assigned a unique Submitter Code (S5678). Bravo Health would update their previous registration for Submitter Code S2345 and add SUSD as a plan on whose behalf they will be submitting data, indicating that they will be submitting Eligibility, Medical Claims, and Provider data files for Payer Code P3456 (i.e., Smallville Unified School District).

Bravo Health owns a subsidiary company, Bravo Insurance Company (BIC), that holds a CDI license as an insurer and covers 55,000 lives. Bravo Health intends to submit the data for BIC. BIC would register as a plan and indicate Bravo Health as a delegated submitter. BIC would receive a unique Payer Code (P6789). Bravo Health would update their previous registration for Submitter Code S2345 and add BIC as a plan on whose behalf they will be submitting data, indicating that they will be submitting all four data file types for Payer Code P6789.

These relationships could be displayed as follows:



Appendix C – Claim and Service Line Submission Scenarios

This section takes a number of different claim and service line scenarios and discusses the course of action required in each.

C.1 A Partially Denied Claim

An original claim has four service lines, three lines were accepted and paid as primary, and one service line was denied. The entire claim should be submitted to HPD as follows.

Claim Line Type: “O” = Original, “D” = Denied

Payer Claim Control Number (CDLMC005)	Version Number (CDLMC007)	Line Counter (CDLMC006)	Service Units or Quantity (CDLMC121)	Plan Paid Amount (CDLMC125)	Denied Claim Line Indicator (CDLMC158)	Claim Line Type (CDLMC160)
ABC1234	0	1	15	12000	2	O
ABC1234	0	2	20	800	2	O
ABC1234	0	3	97	0	1	O
ABC1234	0	4	5	135567	2	O

C.2 A Partially Denied Claim is Adjusted

The same claim described in C.1 is subsequently adjusted. The previously submitted information must be voided, and then replacement records must be submitted.

Since claim adjustments are being reported as reversals and replacements, the version number continues to be reported as 0 (Claim versions are not used in this method of reporting adjustments).

Claim Line Type “V” = Void, “R” = Replacement

Depending upon specific Health Plan processing, the Claim Line Type (CDLMC160) could also be reported as “B” = Back-out.

When reporting adjustments as reversals:

Payer Claim Control Number (CDLMC005)	Version Number (CDLMC007)	Line Counter (CDLMC006)	Service Units or Quantity (CDLMC121)	Plan Paid Amount (CDLMC125)	Denied Claim Line Indicator (CDLMC158)	Claim Line Type (CDLMC160)
ABC1234	0	1	-15	-12000	2	V
ABC1234	0	2	-20	-800	2	V
ABC1234	0	3	-97	0	1	V
ABC1234	0	4	-5	-135567	2	V
ABC1234	1	1	15	12000	2	R
ABC1234	1	2	20	800	2	R
ABC1234	1	3	7	14700	2	R
ABC1234	1	4	5	135567	2	R

C.3 A Fully Denied Claim

A claim with PCCN = XYZ8765 has two service lines and both were denied. This claim should not be submitted to HPD.

Claim XYZ8765 is then adjusted and is approved for payment as a secondary claim. Since no original was submitted to HPD for denied claim, no void is required. Instead, the following original claim details are sent:

Payer Claim Control Number (CDLMC005)	Version Number (CDLMC007)	Line Counter (CDLMC006)	Service Units or Quantity (CDLMC121)	Plan Paid Amount (CDLMC125)	Denied Claim Line Indicator (CDLMC158)	Claim Line Type (CDLMC160)
XYZ8765	0	1	25	2675	2	O
XYZ8765	0	2	2	1571	2	O

C.4 An Approved Claim is Subsequently Fully Denied

A claim with PCCN = FGH0001 has three service lines and all were accepted. This claim would be submitted to HPD as follows:

Payer Claim Control Number (CDLMC005)	Version Number (CDLMC007)	Line Counter (CDLMC006)	Service Units or Quantity (CDLMC121)	Plan Paid Amount (CDLMC125)	Denied Claim Line Indicator (CDLMC158)	Claim Line Type (CDLMC160)
FGH0001	0	1	3	65000	2	O
FGH0001	0	2	1	143550	2	O
FGH0001	0	3	19	9755	2	O

This claim is reviewed and all service lines are subsequently denied. The original three service lines must all be voided. Since there were no further actions taken, no further records would be sent after the voided records.

When reporting this action using aggregation (see Section 5.11):

Payer Claim Control Number (CDLMC005)	Version Number (CDLMC007)	Line Counter (CDLMC006)	Service Units or Quantity (CDLMC121)	Plan Paid Amount (CDLMC125)	Denied Claim Line Indicator (CDLMC158)	Claim Line Type (CDLMC160)
FGH0001	0	1	-3	-65000	1	V
FGH0001	0	2	-1	-143550	1	V
FGH0001	0	3	-22	-9755	1	V

When reporting this action using incremental claim versioning (see Section 5.11), all quantities and dollars must still be negated and the claim version incremented by 1:

Payer Claim Control Number (CDLMC005)	Version Number (CDLMC007)	Line Counter (CDLMC006)	Service Units or Quantity (CDLMC121)	Plan Paid Amount (CDLMC125)	Denied Claim Line Indicator (CDLMC158)	Claim Line Type (CDLMC160)
GH0001	1	1	-3	-65000	1	V
FGH0001	1	2	-1	-143550	1	V
FGH0001	1	3	-22	-9755	1	V

Appendix D: Non-Claims Data Files Intake Validations

This appendix outlines the validations utilized by HCAI's data vendor to assess the initial quality and completeness of each HCAI non-claims data submission. Submitters may apply these validations to their data in advance of file submission to verify that it meets HCAI's technical specifications and standards for quality and completeness.

D.1 Annual payments File

Data Completeness Checks

- Standard non-null, values match reference tables, etc. Specific call-outs below.
    - Provider identifiers
        - Billing Provider NPI (CDLAP008) or Billing Provider Tax ID (CDLAP009) is non-null, 100% populated
        - Billing Provider ID (CDLAP007) is non-null, 100% populated
    - Payment fields to be non-null (code nulls as zeros) 100% except for Z9 payment subcategory
        - Total Member Responsibility (CDLAP017)
        - Total Amount Paid for Primary Care (CDLAP018)
        - Total Amount Paid for Behavioral Health (CDLAP019)
        - Total Amount Paid/Allowed (CDLAP016)

Notes for Annual Payment File

- When Payment Category (CDLAP012) = 'Z' the member count represents the total distinct member count in the contract across claims and non-claims – and represents an entire line of business

Reasonability Checks

1. A unique record is the intersection of Reporting Period Start Date (CDLAP003), Reporting Period End Date (CDLAP004), Data Submitter Code (CDLAP001), Billing Provider ID (CDLAP007), Contract Number (CDLAP005), Contract Type (CDLAP006), and Payment Subcategory (CDLAP013).
2. CDLAP014 Member Count is reported when Payment Category (CDLAP012) = 'B', 'D', or 'Z' or Payment Subcategory = 'C5' or 'C6'
3. CDLAP015 Member Months is reported when Payment Category (CDLAP012) = 'B', 'D', 'Z', or Payment Subcategory = 'C5' or 'C6'
4. CDLPA015 Member Months is at least 9 times as much as CDLPA014 Member Count.
5. Every file should have at minimum, records with Payment Category (CDLAP012) = 'X9' and 'Z9'. If they have non-claims arrangements, they will have more than those categories.
6. The payment subcategory (CDLAP013) and payment category (CDLAP012) fields should align in the following manner

a. When payment category (CDLAP012) = ‘A’, substring(payment subcategory (CDLAP013), 1, 1 = ‘A’. For example, when payment category (CDLAP012) = ‘A’ then payment subcategory (CLAP013) in (‘A1’, ‘A2’, ‘A3’, ‘A4’, ‘A5’)
b. When payment category (CDLAP012) = ‘B’, substring(payment subcategory (CDLAP013), 1, 1 = ‘B’. For example, when payment category (CDLAP012) = ‘B’ then payment subcategory (CLAP013) in (‘B1’, ‘B2’)
c. When payment category (CDLAP012) = ‘C’, substring(payment subcategory (CDLAP013), 1, 1 = ‘C’. For example, when payment category (CDLAP012) = ‘C’ then payment subcategory (CLAP013) in (‘C1’, ‘C2’, ‘C3’, ‘C4’, ‘C5’, ‘C6’)
d. When payment category (CDLAP012) = ‘D’, substring(payment subcategory (CDLAP013), 1, 1 = ‘D’. For example, when payment category (CDLAP012) = ‘D’ then payment subcategory (CLAP013) in (‘D1’, ‘D2’, ‘D3’, ‘D4’, ‘D5’, ‘D6’)
e. When payment category (CDLAP012) = ‘X’, substring(payment subcategory (CDLAP013), 1, 1 = ‘X’. For example, when payment category (CDLAP012) = ‘X’ then payment subcategory (CLAP013) in (‘X9’)
f. When payment category (CDLAP012) = ‘Z’, substring(payment subcategory (CDLAP013), 1, 1 = ‘Z’. For example, when payment category (CDLAP012) = ‘Z’ then payment subcategory (CLAP013) in (‘Z9’)

7. Total Member Responsibility (CDLAP017) < Total Amount Paid/Allowed (CDLAP016)
8. Total Member Responsibility (CDLAP017) <> 0 when Payment Category (CDLAP012) in (‘X’, ‘D’)
9. Total Amount Paid for Primary Care (CDLAP018) < Total Amount Paid/Allowed (CDLAP016)
10. Total Amount Paid for Behavioral Health (CDLAP019) < Total Amount Paid/Allowed (CDLAP016)

D.2 Pharmacy Rebates file

Data Completeness Checks

- Standard non-null, values match reference tables, etc.

Reasonability Checks

1. A unique record is the intersection of Reporting Period Start Date (CDLPR003), Reporting Period End Date (CDLPR004), Data Submitter Code (CDLPR001), and Drug Code – NDC Product Code (CDLPR005).
2. Rebates received (CDLPR012) < Total Paid Amount CDLPR011
3. Flag submissions with Rebates Received (CDLPR012) <> 0 and Brand/Generic Indicator (CDLPR008) = 02 Generic Drug. (We generally expect rebates to be received for brand drugs. We will flag generic drugs with rebates for discussion with the submitter).

D.3 Capitation file

Data Completeness Checks

- Standard non-null, values match reference tables, etc.

Reasonability Checks

1. A unique record is the intersection of Reporting Period Start Date (CDLPR003), Reporting Period End Date (CDLPR004), Data Submitter Code (CDLPR001), Carrier Specific Unique Member ID (CDLCF005), Billing Provider ID (CDLCF012) and Payment Subcategory (CDLCF018).

Notes for Capitation File

- Regarding Billing Provider NPI (CDLCF013) and Billing Provider Tax ID (CDLCF014), only populate the variable for which you have data available. If you have data for only one, fill in that variable and leave the other blank. For example, if you have the Billing Provider Tax ID (CDLCF014) but not the Billing Provider NPI (CDLCF013), enter the Billing Provider Tax ID and leave the Billing Provider NPI blank.

D.4 Cross File Validations

1. The Sum of Total Paid Amount in Capitation file (CDLCF019) by Payment Subcategory (CDLCF018) equals the Sum of Total Amount Paid/Allowed (CDLPA016) in the Annual Payments file by Payment Subcategory (CDLAP013)
2. From the Annual Payments (AP) file, for the same Reporting Period Start Date (CDLAP003) and Reporting Period End Date (CDLAP004) when Payment Category (CDLAP012) = ‘D’, then Total Amount Paid/Allowed (CDLAP016) equals the Total Amount Paid (CDLCF019) in the capitation file for the same Reporting Period Start Date (CDLCF003) and Reporting Period End Date (CDLCF004).
3. From the Annual Payments (AP) file, for the same Reporting Period Start Date (CDLAP003) and Reporting Period End Date (CDLAP004) and Payment Category (CDLAP012), when Payment Category (CDLAP012) = ‘D’, then the Billing Provider ID (CDLCF012) equals the Billing Provider ID (CDLAP007) in the capitation file for the same Reporting Period Start Date (CDLCF003) and Reporting Period End Date (CDLCF004).
4. From the Annual Payments (AP) file, for the same Reporting Period Start Date (CDLAP003) and Reporting Period End Date (CDLAP004) and Payment Category (CDLAP012), when Payment Category (CDLAP012) = ‘D’, then the Billing Provider NPI (CDLCF013) equals the Billing Provider NPI (CDLAP008) in the capitation file for the same Reporting Period Start Date (CDLCF003) and Reporting Period End Date (CDLCF004).
5. From the Annual Payments (AP) file, for the same Reporting Period Start Date (CDLAP003) and Reporting Period End Date (CDLAP004) and Payment Category (CDLAP012), when Payment Category (CDLAP012) = ‘D’, then the Billing Provider

Tax ID (CDLCF014) equals the Billing Provider Tax ID (CDLAP009) in the capitation file for the same Reporting Period Start Date (CDLCF003) and Reporting Period End Date (CDLCF004).

6. From the Annual Payments (AP) file, for the same Reporting Period Start Date (CDLAP003) and Reporting Period End Date (CDLAP004) and Payment Category (CDLAP012), when Payment Category (CDLAP012) = ‘D’, then the Billing Provider Last Name or Organization Name (CDLCF015) equals the Billing Provider Last Name or Organization Name (CDLAP010) in the capitation file for the same Reporting Period Start Date (CDLCF003) and Reporting Period End Date (CDLCF004).
7. From the Annual Payments (AP) file, for the same Reporting Period Start Date (CDLAP003) and Reporting Period End Date (CDLAP004) and Payment Category (CDLAP012), when Payment Category (CDLAP012) = ‘D’, then the Billing Provider First Name (CDLCF016) equals the Billing Provider First Name (CDLAP011) in the capitation file for the same Reporting Period Start Date (CDLCF003) and Reporting Period End Date (CDLCF004).

Appendix E: Primary Care Code Sets

E.1 Primary Care Providers Taxonomy List

Primary care providers are defined by National Uniform Claim Committee (NUCC) taxonomy codes on claims.[8] The taxonomies listed, in combination with service and place of service criteria, are included in the claims-based definition of primary care.[9] Rows with an asterisk (*) indicate taxonomies for physicians, physician assistants, and nurse practitioners.

Taxonomy	NUCC Name
163W00000X	Nurse, non-practitioner
172V00000X	Community Health Worker
183500000X	Pharmacist
1835G0303X	Geriatric Pharmacist
1835P0018X	Pharmacist Clinician (PhC)/ Clinical Pharmacy Specialist
1835P0200X	Pediatric Pharmacist
207Q00000X	Family Medicine*
207QA0000X	Family Medicine, Adolescent Medicine*
207QA0505X	Family Medicine, Adult Medicine*
207QG0300X	Family Medicine- Geriatric Medicine*
207R00000X	Internal Medicine*
207RA0000X	Internal Medicine, Adolescent Medicine*
207RG0300X	Internal Medicine- Geriatric Medicine*
208000000X	Pediatrics*
2080A0000X	Pediatrics, Adolescent Medicine*
208D00000X	General Practice*
261QC0050X	Critical Access Hospital Clinic/Center
261QF0400X	Federally Qualified Health Center
261QP2300X	Clinic/Center- Primary Care
261QR1300X	Clinic/Center- Rural Health
363AM0700X	Physician Assistant, Medical*
363L00000X	Nurse Practitioner*
363LA2200X	Nurse Practitioner- Adult Health*
363LC1500X	Nurse Practitioner, Community Health*
363LF0000X	Nurse Practitioner- Family*
363LG0600X	Nurse Practitioner, Gerontology*
363LP0200X	Nurse Practitioner- Pediatrics*

[8] National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy: https://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu- 40

[9] Office of Health Care Affordability Recommendations to the California Health Care Affordability Board: Proposed Primary Care Investment Benchmark. https://hcai.ca.gov/wp-content/uploads/2024/04/OHCA-Recommendations-to-Board_Proposed-Primary-Care-Investment-Benchmark.pdf

Taxonomy	NUCC Name
363LP2300X	Nurse Practitioner- Primary Care*
363LS0200X	Nurse Practitioner, School*
364SA2200X	Certified clinical nurse specialist- adult health
364SC1501X	Certified clinical nurse specialist- community health/public health
364SC2300X	Certified clinical nurse specialist- chronic health
364SF0001X	Certified clinical nurse specialist- family health
364SG0600X	Certified clinical nurse specialist- gerontology
364SP0200X	Certified clinical nurse specialist- pediatrics

E.2 Primary Care CMS Places of Service

Primary care places of service are defined by the Centers for Medicare and Medicaid Services (CMS) Place of Service (POS) codes on claims.[10] The listed POS codes, in combination with service and provider criteria, are included in the claims-based definition of primary care.[11]

POS Code	Place of Service
02	Telehealth Provided Other than in Patient's Home
03	School
04	Homeless Shelter
05	Indian Health Service Free-Standing Facility
07	Tribal 638 Free-standing Facility
09	Prison/ Correctional Facility
10	Telehealth Provided in Patient's Home
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
18	Place of Employment- Worksite
19	Off Campus- Outpatient Hospital
22	On Campus- Outpatient Hospital
26	Military Treatment Facility
27	Outreach Site/ Street
49	Independent Clinic
50	Federally Qualified Health Center

[10] CMS Place of Service Code Set: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

[11] Office of Health Care Affordability Recommendations to the California Health Care Affordability Board: Proposed Primary Care Investment Benchmark. https://hcai.ca.gov/wp-content/uploads/2024/04/OHCA-Recommendations-to-Board_Proposed-Primary-Care-Investment-Benchmark.pdf

POS Code	Place of Service
66	Programs of All-Inclusive Care for the Elderly (PACE) Center
71	Public Health Clinic
72	Rural Health Clinic

E.3 HCPCS/CPT Primary Care Services

Primary care services are defined by Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes on claims.[12] The listed service codes, in combination with provider taxonomy and place of service, are included in the claims-based definition of primary care.[13]

HCPCS/CPT Code	Description
10040	Acne surgery
10060	Drainage Of Skin Abscess Simple
10061	Drainage Of Skin Abscess Complicated
10080	Drainage Of Pilonidal Cyst Simple
10081	Drainage of pilonidal cyst
10120	Remove Foreign Body Simple
10121	Remove Foreign Body Complicated
10140	Drainage of hematoma/fluid
10160	Puncture Drainage Of Lesion
10180	Complex drainage wound
11000	Debride Infected Skin
11055	Trim Skin Lesion Single
11056	Trim Skin Lesions 2 To 4
11102	Tangntl bx skin single les
11103	Tangntl bx skin ea sep/addl
11104	Punch bx skin single lesion
11105	Punch bx skin ea sep/addl
11106	Incal bx skn single les
11107	Incal bx skn ea sep/addl
11200	Removal Of Skin Tags <W/15
11201	Remove Skin Tags Add-On
11300	Shave Skin Lesion 05 Cm/<
11301	Shave Skin Lesion 06-10 Cm
11302	Shave Skin Lesion 11-20 Cm

[12] HCPCS and CPT codes are maintained by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA): https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system

[13] Office of Health Care Affordability Recommendations to the California Health Care Affordability Board: Proposed Primary Care Investment Benchmark. https://hcai.ca.gov/wp-content/uploads/2024/04/OHCA-Recommendations-to-Board_Proposed-Primary-Care-Investment-Benchmark.pdf

HCPCS/CPT Code	Description
11303	Shave Skin Lesion >20 Cm
11305	Shave Skin Lesion 05 Cm/<
11306	Shave Skin Lesion 06-10 Cm
11307	Shave Skin Lesion 11-20 Cm
11308	Shave skin lesion >2.0 cm
11310	Shave Skin Lesion 05 Cm/<
11311	Shave Skin Lesion 06-10 Cm
11312	Shave skin lesion 1.1-2.0 cm
11313	Shave skin lesion >2.0 cm
11400	Exc Tr-Ext B9+Marg 05 Cm<
11401	Exc Tr-Ext B9+Marg 06-1 Cm
11402	Exc Tr-Ext B9+Marg 11-2 Cm
11403	Exc Tr-Ext B9+Marg 21-3 Cm
11404	Exc tr-ext b9+marg 3.1-4 cm
11406	Exc tr-ext b9+marg >4.0 cm
11420	Exc H-F-Nk-Sp B9+Marg 05/< Cm
11421	Exc H-F-Nk-Sp B9+Marg 06-1 Cm
11422	Exc H-F-Nk-Sp B9+Marg 11-2 Cm
11423	Exc H-F-Nk-Sp B9+Marg 21-3 Cm
11424	Exc h-f-nk-sp b9+marg 3.1-4
11426	Exc h-f-nk-sp b9+marg >4 cm
11440	Exc face-mm b9+marg 0.5 cm/<
11441	Exc face-mm b9+marg 0.6-1 cm
11442	Exc face-mm b9+marg 1.1-2 cm
11443	Exc face-mm b9+marg 2.1-3 cm
11444	Exc face-mm b9+marg 3.1-4 cm
11446	Exc face-mm b9+marg >4 cm
11719	Trimming Nondystrophic Nails Any Number
11720	Debride Nail 1-5
11721	Debride Nail 6+
11730	Removal Of Nail Plate Simple
11732	Remove nail plate add-on
11740	Evacuation Subungual Hematoma
11750	Removal Of Nail Bed Partial/Complete
11765	Excision Of Nail Fold Toe
11900	Inject Skin Lesions </W 7
11901	Inject Skin >7 Lesions
11976	Remove Contraceptive Capsule
11980	Implant hormone pellet(s)
11981	Insert Drug Implant Device
11982	Remove Drug Implant Device
11983	Remove W/ Insert Drug Implant
12001	Simple Rpr S/N/Ax/Gen/Trnk 25Cm/<

HCPCS/CPT Code	Description
12002	Rpr s/n/ax/gen/trnk2.6-7.5cm
12004	Rpr s/n/ax/gen/trk7.6-12.5cm
12005	Rpr s/n/a/gen/trk12.6-20.0cm
12006	Rpr s/n/a/gen/trk20.1-30.0cm
12007	Rpr s/n/ax/gen/trnk >30.0 cm
12011	Rpr f/e/e/n/l/m 2.5 cm/<
12013	Rpr f/e/e/n/l/m 2.6-5.0 cm
12014	Rpr f/e/e/n/l/m 5.1-7.5 cm
12015	Rpr f/e/e/n/l/m 7.6-12.5 cm
12016	Rpr fe/e/en/l/m 12.6-20.0 cm
12017	Rpr fe/e/en/l/m 20.1-30.0 cm
12018	Rpr f/e/e/n/l/m >30.0 cm
12020	Closure of split wound
12021	Closure of split wound
12031	Intmd rpr s/a/t/ext 2.5 cm/<
12032	Intmd rpr s/a/t/ext 2.6-7.5
12034	Intmd rpr s/tr/ext 7.6-12.5
12035	Intmd rpr s/a/t/ext 12.6-20
12036	Intmd rpr s/a/t/ext 20.1-30
12037	Intmd rpr s/tr/ext >30.0 cm
12041	Intmd rpr n-hf/genit 2.5cm/<
12042	Intmd Rpr N-Hf/Genit26-75
12044	Intmd rpr n-hf/genit7.6-12.5
12045	Intmd rpr n-hf/genit12.6-20
12046	Intmd rpr n-hf/genit20.1-30
12047	Intmd rpr n-hf/genit >30.0cm
12051	Intmd rpr face/mm 2.5 cm/<
12052	Intmd rpr face/mm 2.6-5.0 cm
12053	Intmd rpr face/mm 5.1-7.5 cm
12054	Intmd rpr face/mm 7.6-12.5cm
12055	Intmd rpr face/mm 12.6-20 cm
12056	Intmd rpr face/mm 20.1-30.0
12057	Intmd rpr face/mm >30.0 cm
13160	Late closure of wound
15839	Excise Excess Skin & Tissue
16020	Dress/debrid p-thick burn s
17000	Destroy Premalg Lesion
17003	Destroy Premalg Lesion 2-14
17004	Destroy Premal Lesions 15/>
17106	Destruction of skin lesions
17107	Destruction of skin lesions
17108	Destruction of skin lesions
17110	Destroy B9 Lesion 1-14

HCPCS/CPT Code	Description
17111	Destroy B9 Lesion 15 Or More
17250	Chem Caut Of Granlt Tissue
17281	Destroy Malgnt Skin Lesions 06-1 Cm
17340	Cryotherapy For Acne
19000	Drainage Of Breast Lesion
20520	Removal Of Foreign Body Simple
20550	Inj Tendon Sheath/Ligament
20551	Inj Tendon Origin/Insertion
20552	Inj Trigger Point 1/2 Muscl
20553	Inject Trigger Points 3/>
20600	Drain/Inj Joint/Bursa W/O Us Small
20604	Drain/inj joint/bursa w/us
20605	Drain/Inj Joint/Bursa W/O Us Intermediate
20606	Drain/inj joint/bursa w/us
20610	Drain/Inj Joint/Bursa W/O Us Major
20611	Drain/inj joint/bursa w/us
20612	Drain/Inj Ganglion Cyst
24640	Closed Treat Radial Head Sublx Child
27096	Inject sacroiliac joint
29105	Apply long arm splint
29125	Apply forearm splint
29126	Apply forearm splint
29130	Application of finger splint
29131	Application of finger splint
29200	Strapping of chest
29240	Strapping of shoulder
29260	Strapping of elbow or wrist
29280	Strapping of hand or finger
29505	Application long leg splint
29515	Application lower leg splint
29520	Strapping of hip
29530	Strapping of knee
29540	Strapping of ankle and/or ft
29550	Strapping of toes
29581	Apply multlay comprs lwr leg
29584	Appl multlay comprs arm/hand
30300	Removal Foreign Body Intranasal Office Procedure
30901	Control of nosebleed
30903	Control of nosebleed
30905	Control of nosebleed
30906	Repeat control of nosebleed
36410	Non-routine bl draw 3/> yrs
36415	Routine Venipuncture

HCPCS/CPT Code	Description
36416	Capillary Blood Draw
40804	Removal foreign body mouth
40805	Removal foreign body mouth
46600	Diagnostic anoscopy spx
51702	Insert temp bladder cath
51798	Us urine capacity measure
54050	Destruction Penis Lesion Chem Simple
54056	Cryosurgery Penis Lesion Simple Cyro
55250	Removal Of Sperm Duct
56405	I & d of vulva/perineum
56420	Drainage of gland abscess
56605	Biopsy of vulva/perineum
56606	Biopsy of vulva/perineum
56820	Exam of vulva w/scope
56821	Exam/biopsy of vulva w/scope
57010	Drainage of pelvic abscess
57020	Drainage of pelvic fluid
57100	Biopsy of vagina
57105	Biopsy of vagina
57150	Treat vagina infection
57160	Insert pessary/other device
57170	Fitting Of Diaphragm/Cap
57180	Treat vaginal bleeding
57410	Pelvic examination
57420	Exam of vagina w/scope
57421	Exam/biopsy of vag w/scope
57452	Exam of cervix w/scope
57454	Bx/curett of cervix w/scope
57455	Biopsy of cervix w/scope
57456	Endocerv curettage w/scope
57500	Biopsy of cervix
58300	Insert Intrauterine Device
58301	Remove Intrauterine Device
59425	Antepartum Care Only 4-6 Visits
59426	Antepartum Care Only 7< Visits
59430	Postpartum Care Only
59510	Routine Ob Care
59812	Treatment of miscarriage
59820	Care of miscarriage
59821	Treatment of miscarriage
59830	Treat uterus infection
69200	Clear Outer Ear Canal W/Out Anesthesia
69205	Clear outer ear canal

HCPCS/CPT Code	Description
69209	Remove Impacted Ear Wax Irrigation
69210	Remove Impacted Ear Wax Instruments
81000	Urinalysis Dip Stick/Tablet Reagnt Non-Auto Micrscpy
81001	Urinalysis Dip Stick/Tablet Reagent Auto Microscopy
81025	Urine Pregnancy Test Visual Color Comparison
82044	Urine Albumin Semiquantitative
82270	Blood Occult Peroxidase Actv Qual Feces 1 Determination
82272	Blood Occult Peroxidase Actv Qual Feces 1-3 Spec Determination
82465	Cholesterol Serum/Whole Blood Total
82947	Glucose Quantitative Blood Xcpt Reagent Strip
82948	Glucose Blood Reagent Strip
82950	Glucose Post Glucose Dose
83655	Assay Of Lead
83718	Lipoprotein Dir Meas High Density Cholesterol
85013	Blood Count Spun Microhematocrit
85014	Blood Count Hematocrit
85018	Blood Count Hemoglobin
86580	Skin Test Tuberculosis Intradermal
87205	Smr Prim Src Gram/Giemsa Stain Bct Fungi/Cel
90460	Immunization Admin 1St/Only Component 18 Years<
90461	Immunization Admin Each Addl Component 18 Years<
90471	Immunization Admin 1 Vaccine Single/Combo
90472	Immunization Admin Each Add-On Single/Combo
90473	Immunization Admin Oral/Nasal Single/Combo
90474	Immunization Admin Oral/Nasal Addl Single/Combo
90480	Admn Sarscov2 Vacc 1 Dose
90785	Psytx complex interactive
90791	Psych Diagnostic Evaluation
90792	Psych Diag Eval W/Med Services
90882	Envr Intrvt for Medical Mgmt on a Psycl Pts
90885	Psy evaluation of records
90887	Consultation with family
90889	Preparation of report
91065	Breath hydrogen/methane test
92502	Ear and throat examination
92551	Pure Tone Hearing Test Air
92552	Pure Tone Audiometry Air
92558	Evoked Auditory Test Qual
92567	Tympanometry
92587	Evoked auditory test limited
92625	Tinnitus assessment
93000	Ecg Routine Ecg W/Least 12 Lds W/I&R

HCPCS/CPT Code	Description
93005	Ecg Routine Ecg W/Least 12 Lds Trcg Only W/O I&R
93010	Ecg Routine Ecg W/Least 12 Lds I&R Only
93015	Cardiovascular stress test
93016	Cardiovascular stress test
93017	Cardiovascular stress test
93018	Cardiovascular stress test
93040	Rhythm Ecg 1-3 Leads W/Interpretation & Report
93041	Rhythm ecg tracing
93042	Rhythm ecg report
93268	Xtrnl Pt Activ Ecg Transmis W/R&I </30 Days
93271	Ecg/monitoring and analysis
93272	Ecg/review interpret only
93784	Ambl Bld Press W/Tape&/Disk 24/> Hr Alys I&R
93786	Ambl bp mntr w/sw rec only
93788	Ambl bp mntr w/sw a/r
93790	Ambl bp mntr w/sw i&r
93793	Anticoag mgmt pt warfarin
94010	Spirometry
94011	Spirometry up to 2 yrs old
94012	Spirmtry w/brnchdil inf-2 yr
94014	Pt Recorded Spirometry Complex
94015	Pt Recorded Spirometry Simple
94016	Review Pt Spirometry
94060	Bronchodilation Responsiveness
94070	Bronchodilation Provocation Evaluation
94375	Respiratory Flow Volume Loop
94640	Pressurized/Nonpressurized Inhalation Treatment
94664	Evaluate pt use of inhaler
94760	Noninvasive Ear/Pulse Oximetry Single Deter
94761	Noninvasive Ear/Pulse Oximetry Multiple Deter
95004	Percut allergy skin tests
95017	Perq & icut allg test venoms
95018	Perq&ic allg test drugs/biol
95024	Icut allergy test drug/bug
95027	Icut allergy titrate-airborn
95028	Icut allergy test-delayed
95044	Allergy patch tests
95056	Photosensitivity tests
95060	Eye allergy tests
95065	Nose allergy test
95070	Bronchial allergy tests
95115	Prof Services Allergen Immutherapy Single Injection
95117	Prof Services Allergen Immutherapy Multiple Injection

HCPCS/CPT Code	Description
95144	Antigen therapy services
95170	Antigen therapy services
95180	Rapid desensitization
95249	Cont gluc mntr pt prov eqp
95250	Cont gluc mntr phys/qhp eqp
95251	Cont gluc mntr analysis i&r
95851	Range of motion measurements
95852	Range of motion measurements
95992	Canalith repositioning proc
96105	Assessment of aphasia
96110	Developmental Screen W/Score
96112	Devel tst phys/qhp 1st hr
96113	Devel tst phys/qhp ea addl
96116	Nubhvl xm phys/qhp 1st hr
96121	Nubhvl xm phy/qhp ea addl hr
96125	Cognitive test by hc pro
96127	Brief Emotional/Behav Assmt
96130	Psycl tst eval phys/qhp 1st
96131	Psycl tst eval phys/qhp ea
96132	Nrpsyc tst eval phys/qhp 1st
96133	Nrpsyc tst eval phys/qhp ea
96136	Psycl/nrpsyc tst phy/qhp 1st
96137	Psycl/nrpsyc tst phy/qhp ea
96138	Psycl/nrpsyc tech 1st
96139	Psycl/nrpsyc tst tech ea
96146	Psycl/nrpsyc tst auto result
96151	Assessment Health/ Behavioral subsequent
96156	Health Behavior Assessment Or Re-Assessment
96158	Health Behavior Intervention, Individual Face-To-Face 30 Min
96159	Health Behavior Intervention, Individual Face-To-Face 15 Min
96160	Pt-Focused Hlth Risk Assmt
96161	Caregiver Health Risk Assmt
96164	Health Behavior Intervention, Group (2<) Face-To-Face 30 Min
96165	Health Behavior Intervention, Group (2<) Face-To-Face 15 Min
96167	Health Behavior Intervention, Family (W/ Pt) Face-To-Face 30 Min
96168	Health Behavior Intervention, Family (W/ Pt) Face-To-Face 15 Min
96170	Health Behavior Intervention, Family (W/Out Pt) Face-To-Face 30 Min
96171	Health Behavior Intervention, Family (W/Out Pt), Face-To-Face 15 Min
96202	Mlt fam grp bhv train 1st 60

HCPCS/CPT Code	Description
96203	Mlt fam grp bhv train ea add
96372	Ther/Proph/Diag Inj Sc/Im
96373	Therapeutic, Prophylactic, Or Diagnostic Injection
96374	Therapeutic, Prophylactic, Or Diagnostic Injection Single
97151	Behavior Identification Assessment, Each 15 Min
97152	Behavior Identification-Supporting Assessment, Each 15 Min
97597	Debridement Open Wound 20 Sq Cm/<
97598	Rmvl devital tis addl 20cm/<
97802	Medical nutrition indiv in
97803	Med nutrition indiv subseq
97804	Medical Nutrition Group
98000	Synchronous Audio-Video Evaluation and Management Services
98001	Synchronous Audio-Video Evaluation and Management Services
98002	Synchronous Audio-Video Evaluation and Management Services
98003	Synchronous Audio-Video Evaluation and Management Services
98004	Synchronous Audio-Video Evaluation and Management Services
98005	Synchronous Audio-Video Evaluation and Management Services
98006	Synchronous Audio-Video Evaluation and Management Services
98007	Synchronous Audio-Video Evaluation and Management Services
98008	Synchronous Audio-Video Evaluation and Management Services
98009	Synchronous Audio-Video Evaluation and Management Services
98010	Synchronous Audio-Video Evaluation and Management Services
98011	Synchronous Audio-Video Evaluation and Management Services
98012	Synchronous Audio-Video Evaluation and Management Services
98013	Synchronous Audio-Video Evaluation and Management Services
98014	Synchronous Audio-Video Evaluation and Management Services
98015	Synchronous Audio-Video Evaluation and Management Services

HCPCS/CPT Code	Description
98016	Brief communication technology-based service (eg, virtual check-in)
98925	Osteopath manj 1-2 regions
98926	Osteopath manj 3-4 regions
98927	Osteopath manj 5-6 regions
98928	Osteopath manj 7-8 regions
98929	Osteopath manj 9-10 regions
98960	Self-mgmt educ & train 1 pt
98961	Self-mgmt educ/train 2-4 pt
98962	Self-mgmt educ/train 5-8 pt
98966	Hc Pro Phone Call 5-10 Min
98967	Non-Physician Telephone Services 11-20 Min
98968	Non-Physician Telephone Services 21-30 Min
98969	Online Service By Hc Pro
98970	NQHP ol dig assmt&mgmt 5-10
98971	NQHP ol dig assmt&mgmt 11-20
98972	NQHP ol dig assmt&mgmt 21+
99050	Medical Services After Hrs
99056	Med Service Out Of Office
99058	Office Emergency Care
99078	Phys/QHP Education Materials for Pts In Group Setting
99091	Collj & interpj data ea 30 d
99170	Anogenital exam child w imag
99173	Visual Acuity Screen
99174	Ocular Instrumnt Screen Bil Remote Analysis
99177	Ocular Instrumnt Screen Bil On Site Analysis
99188	App Topical Fluoride Varnish
99195	Phlebotomy
99201	Office/ outpatient visit new
99202	Office/OutPt Visit New 15-29 Min
99203	Office/OutPt Visit New 30-44 Min
99204	Office/OutPt Visit New 45-59 Min
99205	Office/OutPt Visit New 60-74 Min
99211	Office/OutPt Visit Est
99212	Office/OutPt Visit Est 10-19 Min
99213	Office/OutPt Visit Est 20-29 Min
99214	Office/OutPt Visit Est 30-39 Min
99215	Office/OutPt Visit Est 40-54 Min
99241	Office Or Other OutPt Consultations 15 Min
99242	Office Or Other OutPt Consultations 30 Min
99243	Office Or Other OutPt Consultations 40 Min
99244	Office Or Other OutPt Consultations 60 Min
99245	Office Or Other OutPt Consultations 80 Min

HCPCS/CPT Code	Description
99339	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 15-29 Min
99340	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 30 Min
99341	Home Visit New Pt 20 Min
99342	Home Visit New Pt 30 Min
99343	Home Visit New Pt 45 Min
99344	Home Visit New Pt 60 Min
99345	Home Visit New Pt 75 Min
99346	Home Visit New Pt
99347	Home Visit Established Pt 15 Min
99348	Home Visit Established Pt 25 Min
99349	Home Visit Established Pt 40 Min
99350	Home Visit Established Pt 60 Min
99354	Prolonged Service OutPt 60 Min
99355	Prolonged Service OutPt Add 30 Min
99358	Prolong Service W/O Contact
99359	Prolong Serv W/O Contact Add 30 Min
99366	Team Conf W/ Pt By Healthcare Prof 30 Min W/Physician
99367	Team Conf W/Out Pt By Healthcare Prof 30 Min W/Physician
99368	Team Conf W/Out Pt By Healthcare Prof 30 Min W/Out Physician
99374	Home/Nursing Facility Visits 15-29 Min
99375	Home/Nursing Facility Visits 30 Min
99376	Care Plan Oversight/Over
99379	Nursing fac care supervision
99380	Nursing fac care supervision
99381	Init Pm E/M New Pat Infant
99382	Init Pm E/M New Pat 1-4 Yrs
99383	Prev Visit New Age 5-11
99384	Prev Visit New Age 12-17
99385	Prev Visit New Age 18-39
99386	Prev Visit New Age 40-64
99387	Pre Visit New Age 65 or older
99391	Periodic Pm Reeval Est Pat Infant 1>
99392	Prev Visit Est Age 1-4
99393	Prev Visit Est Age 5-11
99394	Prev Visit Est Age 12-17
99395	Prev Visit Est Age 18-39
99396	Prev Visit Est Age 40-64
99397	Per Pm Reeval Est Pat 65+ Yr
99401	Preventive Counseling Indiv 15 Min
99402	Preventive Counseling Indiv 30 Min

HCPCS/CPT Code	Description
99403	Preventive Counseling Indiv 45 Min
99404	Preventive Counseling Indiv 60 Min
99406	Behav Chng Smoking 3-10 Min
99407	Behav Chng Smoking > 10 Min
99408	Audit/Dast 15-30 Min
99409	Alcohol/Substance Screen & Intervention >30 Min
99411	Preventive Counseling Group 30 Min
99412	Preventive Counseling Group 60 Min
99415	Prolng clin staff svc 1st hr
99416	Prolng clin staff svc ea add
99417	Prolng op e/m each 15 min
99420	Administration and interpretation of health risk assessments
99421	Ol dig e/m svc 5-10 min
99422	Ol dig e/m svc 11-20 min
99423	Ol dig e/m svc 21+ min
99424	Prin care mgmt phys 1st 30
99425	Prin care mgmt phys ea addl
99426	Prin care mgmt staff 1st 30
99427	Prin care mgmt staff ea addl
99429	Unlisted Preventive Service
99437	Chrnc care mgmt phys ea addl
99439	Chrnc care mgmt staf ea addl
99441	Phys/Qhp Telephone Evaluation 5-10 Min
99442	Phone E/M Phys/Qhp 11-20 Min
99443	Phys/Qhp Telephone Evaluation 21-30 Min
99444	Phys/Qhp Online Evaluation & Management Service
99446	Interprofessional Electronic Health Assessment 5-10 Min
99447	Interprofessional Electronic Health Assessment 11-20 Min
99448	Interprofessional Electronic Health Assessment 21-30 Min
99449	Interprofessional Electronic Health Assessment 31 Min <
99450	Basic Life And/Or Disability Exam
99451	Interprofessional Electronic Health Assessment 5 Min >
99452	Telephone or internet referral service, 30 minutes
99453	Remote Monitoring Physiologic Parameters Initial
99454	Remote Monitoring Physiologic Parameters Programed Transmission
99455	Work Related Disability Exam
99456	Disability Examination
99457	Remote Physiologic Monitoring Treatment Management Services, First 20 Min
99458	Remote Physiologic Monitoring Treatment Management Services, Additional 20 Min
99460	Initial Evaluation And Management Of Newborn At Hospital

HCPCS/CPT Code	Description
99461	Initial Evaluation And Management Of Newborn Outside Of Hospital
99473	Self-meas bp pt educaj/train
99474	Self-meas bp 2 readg bid 30d
99483	Assmt & Care Planning Pt W/Cognitive Impairment
99484	Care Mgmt Svc Bhvl Health Conditions 20 Min
99487	Complex Care W/O Pt Vsit 60 Min
99489	Complex Chronic Care Addl 30 Min
99490	Chron Care Mgmt Srvc 20 Min
99491	Chronic Care Management Services At Least 30 Min
99492	1St Psyc Collab Care Mgmt
99493	Sbsq Psyc Collab Care Mgmt
99494	1St/Sbsq Psyc Collab Care
99495	Trans Care Mgmt 14 Day Disch
99496	Trans Care Mgmt 7 Day Disch
99497	Advncd Care Plan 30 Min
99498	Advncd Care Plan Addl 30 Min
99499	Unlisted e/m service
99502	Home Visit For Newborn Care And Assessment
0001A	ADM SARSCOV2 30MCG/0.3ML 1ST
0002A	ADM SARSCOV2 30MCG/0.3ML 2ND
0003A	ADM SARSCOV2 30MCG/0.3ML 3RD
0004A	ADM SARSCOV2 30MCG/0.3ML BST
0011A	ADM SARSCOV2 100MCG/0.5ML1ST
0012A	ADM SARSCOV2 100MCG/0.5ML2ND
0013A	ADM SARSCOV2 100MCG/0.5ML3RD
0021A	ADM SARSCOV2 5X1010VP/.5ML 1ST
0022A	ADM SARSCOV2 5X1010VP/.5ML 2ND
0031A	ADM SARSCOV2 VAC AD26 .5ML
0034A	ADM SARSCOV2 VAC AD26 .5ML B
0041A	ADM SARSCOV2 5MCG/0.5ML 1ST
0042A	ADM SARSCOV2 5MCG/0.5ML 2ND
0044A	ADM SARSCOV2 5MCG/0.5ML BST
0051A	ADM SARSCV2 30MCG TRS-SUCR 1
0052A	ADM SARSCV2 30MCG TRS-SUCR 2
0053A	ADM SARSCV2 30MCG TRS-SUCR 3
0054A	ADM SARSCV2 30MCG TRS-SUCR B
0064A	ADM SARSCOV2 50MCG/0.25MLBST
0071A	ADM SARSCV2 10MCG TRS-SUCR 1
0072A	ADM SARSCV2 10MCG TRS-SUCR 2
0073A	ADM SARSCV2 10MCG TRS-SUCR 3
0074A	ADM SARSCV2 10MCG TRS-SUCR B
0081A	ADM SARSCOV2 3MCG TRS-SUCR 1

HCPCS/CPT Code	Description
0082A	ADM SARSCOV2 3MCG TRS-SUCR 2
0083A	ADM SARSCOV2 3MCG TRS-SUCR 3
0091A	ADM SARSCOV2 50 MCG/.5 ML1ST
0092A	ADM SARSCOV2 50 MCG/.5 ML2ND
0093A	ADM SARSCOV2 50 MCG/.5 ML3RD
0094A	ADM SARSCOV2 50MCG/0.5 MLBST
0104A	ADM SARSCOV2 5MCG/.5ML AS03B
0111A	ADM SARSCOV2 25MCG/0.25ML1ST
0112A	ADM SARSCOV2 25MCG/0.25ML2ND
0113A	ADM SARSCOV2 25MCG/0.25ML3RD
0121A	ADM SARSCV2 BVL 30MCG/.3ML 1
0124A	ADM SARSCV2 BVL 30MCG/.3ML B
0134A	ADM SARSCV2 BVL 50MCG/.5ML B
0141A	ADM SRSCV2 BVL 25MCG/.25ML 1
0142A	ADM SRSCV2 BVL 25MCG/.25ML 2
0144A	ADM SARSCV2 BVL 25MCG/.25ML B
0151A	ADM SARSCV2 BVL 10MCG/.2ML 1
0154A	ADM SARSCV2 BVL 10MCG/.2ML B
0164A	ADM SRSCV2 BVL 10MCG/0.2ML B
0171A	ADM SARSCV2 BVL 3MCG/0.2ML 1
0172A	ADM SARSCV2 BVL 3MCG/0.2ML 2
0173A	ADM SARSCV2 BVL 3MCG/0.2ML 3
0174A	ADM SARSCV2 BVL 3MCG/0.2ML B
0500F	Initial Prenatal Care Visit
0501F	Prenatal Flow Sheet
0502F	Subsequent Prenatal Care
0503F	Postpartum Care Visit
1000F	Tobacco Use Assessed
1031F	Smoking & 2Nd Hand Assessed
1032F	Current Tobacco Smoker Or 2Nd Hand Exposed
1033F	Tobacco Nonsmoker Not Exposed 2Nd Hand
1034F	Current Tobacco Smoker
1035F	Current Smokeless Tobacco User
1036F	Current Tobacco Non-User
1220F	Pt Screened For Depression
3016F	Pt Screened For Unhlthy Alcohol Use
3085F	Suicide Risk Assessed
3351F	Neg Scrn Depression Symptoms By Dep Tool
3352F	No Sig Dep Symp By Dep Tool
3353F	Mild-Mod Dep Symp By Deptool
3354F	Clin Sig Dep Sym By Dep Tool
3355F	Clin Sig Dep Sym By Dep Tool
4000F	Tobacco Use Cessation Intervention Counseling

HCPCS/CPT Code	Description
4001F	Tobacco Use Cessation Intervention Pharmacologic
4004F	Pt Tobacco Screen And Cessation Intervention
4290F	Pt Screened For Injection Drug Use (Hiv)
4293F	Pt Screened For High Risk Sexual Behavior (Hiv)
G0008	Admin Influenza Virus Vaccine
G0009	Admin Pneumococcal Vaccine
G0010	Admin Hepatitis B Vaccine
G0019	Comm hlth intg svs sdoh 60mn
G0022	Comm hlth intg svs add 30 m
G0023	Pin service 60m per month
G0024	Pin srv add 30 min pr m
G0101	Cancer Screen; Pelvic/Breast Exam
G0102	Prostate Cancer Screening; Digital Rectal Examination
G0103	PSA Screening
G0104	Colorectal cancer screening, flexible sigmoidoscopy
G0105	Colorectal cancer screening, colonoscopy on individual at high risk
G0106	Colorectal cancer screening, alternative to G0104
G0108	Diab manage trn per indiv
G0109	Diabetes OutPt Self-Management Training Services Group
G0120	Colorectal Cancer Screening, alternative to G0105, screening colonoscopy, barium enema
G0123	Screen Cerv/Vag Thin Layer
G0124	Screen c/v thin layer by md
G0140	Nav srv peer sup 60 min pr m
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr C/V Cyto,Thinlayer,Rescr
G0146	Nav srv peer sup add 30 pr m
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0179	Phys Re-Cert Mcr-Covr Hom Hlth Srvc Re-Cert Prd
G0180	Phys Cert Mcr-Covr Hom Hlth Srvc Per Cert Prd
G0181	Home/Nursing Facility Visits W/Out Pt Medicare Approved
G0202	Screening Mammography Digital
G0271	Medical Nutrition Therapy, Reassessment And Subsequent Intervention Group 30 Min
G0283	Therapy Electric Stimulation Other Than Wound
G0323	Care manage beh svs 20mins
G0396	Alcohol/Subs Misuse Intervention 15-30 Min
G0397	Alcohol/Subs Misuse Intervention 30 Min <
G0399	Home Sleep Test/Type 3 Porta
G0402	Welcome to Medicare visit

HCPCS/CPT Code	Description
G0403	Ekg For Initial Prevent Exam
G0404	Ekg Tracing For Initial Prev
G0405	Ekg Interpret & Report Prev
G0436	Smoke Tob Cessation Cnsl As Pt; Intrmed 3-10 Min
G0437	Smoking & Tob Cess Cnsl As Pt; Intensive >10 Min
G0438	Ppps, Initial Visit
G0439	Ppps, Subseq Visit
G0442	Annual Alcohol Screen 15 Min
G0443	Brief Alcohol Misuse Counsel
G0444	Depression Screen Annual 15 Min
G0445	High Intensity Behavioral Counseling Std 30 Min
G0447	Behavior counsel obesity 15m
G0463	Hospital Outpt Clinic Visit
G0466	FQHC Visit, New Pt
G0467	FQHC Visit, Established Pt
G0468	FQHC Preventive Visit
G0472	Hepatitis C Antibody Screening
G0473	Group behave couns 2-10
G0475	HIV Antigen/Antibody, Combination Assay, Screening
G0476	HPV Combo Assay Cancer Screen
G0499	Hepb screen high risk indiv
G0505	Cognition and functional assessment
G0506	Comprehensive Asses Care Plan Chronic Care Mgmt Services
G0511	Chronic Care Management Rural Health Clinic
G0512	Psych collab care rural health clinic or FQHC
G0513	Prolong Preventive Services, First 30 Min
G0514	Prolonged Preventive Service Addl 30 Min
G0537	Risk ascvd tst once pr 12 mo
G0538	Ascvd rsk mng clin stf pr mo
G0539	Initial care training 30 m
G0540	Train for caregiver add 15
G0541	No pt prsnt train initial 30
G0542	No pt prsnt train add 15
G0543	Group train w/o patient
G0546	Phone/internet ehr assess
G0547	Phone/internet svs 11-20m
G0548	Phone/inter svs 21-30 m
G0549	Phone/inter for treat>31m
G0550	Phone/inter for dx/treat >5m
G0551	Phn/intr svs fr dx treat 30m
G0556	Adv prim care mgmt lvl 31
G0557	Adv prim care mgmt lvl 2
G0558	Adv prim care mgmt lvl 3

HCPCS/CPT Code	Description
G2010	Remote Evaluation Of Recodred Video/Images
G2011	Alcohol/sub misuse assess
G2012	Brief check in by md/qhp
G2058	Ccm add 20min
G2086	Off base opioid tx 70min
G2087	Off base opioid tx, 60 m
G2088	Off base opioid tx, add30
G2211	Longitudinal care code
G2214	Initial or subsequent psych collab care mgmt
G2250	Remot img sub by pt, non e/m
G2251	Brief chkin, 5-10, non-e/m
G2252	Brief chkin by md/qhp, 11-20
G3002	Chronic pain mgmt 30 mins
G3003	Chronic pain mgmt addl 15m
G8431	Pos clin depres scrn f/u doc
G8482	Influenza Immunization Administered Or Previously Received
G8510	Scr dep neg, no plan reqd
G8731	Pain Assessment Documented
G9903	Pt Screened For Tobacco Use And Identified As A Non-User
H0001	Alcohol and/or drug assessment
H0002	Behavioral Health Screening To Admit To Treatment Program
H0031	Mental Health Assess By Non-MD
H0049	Alcohol/Drug Screening
H0050	Alcohol/drug service 15 min
H1011	Family assessment
H2015	Comp comm supp svc, 15 min
H2027	Psychoed svc, per 15 min
M0201	Covid-19 vaccine home admin
Q0091	Obtaining Screen Pap Smear
S0610	Annual Gynecological Examine New Pt
S0612	Annual Gynecological Examin Established Pt
S0613	Annual Breast Exam
S0622	Phys Exam For College
S4981	Insertion Of Levonorgestrel-Releasing Intrauterine Sys
S9117	Back To School Visits
S9446	Pt Education Not Classified Group
T1015	Clinic Service All-Inclusive
T1016	Case management
T1027	Family training & counseling
Z1032	Initial Antepartum Office Visit
Z1034	Antepartum Follow-up Office Visit
Z1038	Postpartum Follow-up Office Visit
GPCM1	APCM for pt w up to one chronic condition

HCPCS/CPT Code	Description
GPCM2	APCM for pt with multiple chronic conditions
GPCM3	APCM for QMBs enrollees with multiple chronic conditions