Requested Additions & Revisions to CDL					
#	File Type & Data Element Name	CDL Data Element #	Description	Reason for Request	Decision
1	Medical: Allowed Amount	CDLMC131	When payment arrangement type in CDLMC132 is equal to 01 for capitated services, report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. If there is not an allowed amount, leave blank. When payment arrangement type in CDLMC132 is equal to 02 for fee for service, report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. If there is not an allowed amount, leave blank. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	Please clarify what is expected for no-pay encounters. States need health plans and insurers to provide a FFS equivalent for no-pay encounters covered under capitation. This is especially important as capitated arrangements grow in popularity.	Refer to interim workgroup for further study and consideration in preparation for 2022 Maintenance cycle. Committee suggests reviewing all payment related fields.
2	Pharmacy: Allowed Amount	CDLPC038	When payment arrangement type in CDLPC049 is equal to 01 for capitated services, report the maximum amount that would have been paid under fee for service for a prescription. If there is not an allowed amount, such as state supplied vaccine, report 0. When payment arrangement type in CDLPC049 is equal to 02 for fee for service, report the maximum amount contractually allowed. If there is not an allowed amount, report 0. Do not code decimal point or provide any punctuation (e.g. $1,000.25 converted to 100025).	Please clarify what is expected for no-pay encounters. States need health plans and insurers to provide a FFS equivalent for no-pay encounters covered under capitation. This is especially important as capitated arrangements grow in popularity.	Refer to interim workgroup for further study and consideration in preparation for 2022 Maintenance cycle. Committee suggests reviewing all payment related fields.
3	Dental: Allowed Amount	CDLDC067	When payment arrangement type in CDLDC068 is equal to 01 for capitated services, report the maximum amount that would have been paid under fee for service for a particular procedure or service. If there is not an allowed amount leave blank. When payment arrangement type in CDLDC068 is equal to 02 for fee for service, report the maximum amount contractually allowed, and that a carrier will pay for a particular procedure or service. If there is not an allowed amount, report 0. Do not code decimal point or provide any punctuation (e.g. $1,000.25 converted to 100025).	Please clarify what is expected for no-pay encounters. States need health plans and insurers to provide a FFS equivalent for no-pay encounters covered under capitation. This is especially important as capitated arrangements grow in popularity.	Refer to interim workgroup for further study and consideration in preparation for 2022 Maintenance cycle. Committee suggests reviewing all payment related fields.
4	New Data Element		Add a new data element, Rendering Provider Street Address, akin to the service facility location in an 837.	Analyses of access (e.g., travel time) require the location of where the service was provided. The current specifications include Rendering Provider City, State, and Zip Code, but not street address	Add field at the end of a Provider file.
5	New Data Element		Add Prescriber Specialty to Pharmacy file	Although taxonomy is also collected in the provider file, collecting it on the pharmacy claim would be consistent with data collected on Medical file, which does include specialty. Add Prescriber Specialty to Pharmacy file. See NCPDP 4.2 Field 296 and CDLMC142.	Add field at the end of the Provider file.
6	New Data Element		Add Pharmacy City	Makes the pharmacy layout more consistent with the medical and avoids the need to generate the city name from the street address and zip code. The Medical layout includes city, state, and zip code, but the Pharmacy layout includes only Pharmacy	Add field at the end of the Provider file.
7			Add references to HIPAA transaction elements.	Helps ensure data matches existing standards. Data preparers will have more information about the meaning and valid values of the element. Data users familiar with the transaction standards can more easily understand the data. Change the PACDR References column to "Standards References" and identify the specific standards version numbers, segments, and elements. In addition to PACDR, add the NCPDP Post Adjudication Standard Implementation Guide v4.2 and all the named and relevant HIPAA transactions (e.g., ASC X12N 837 Version 5010, ASC X12N 835 Version 5010, NCPDP D.0, etc.). As an example, see the medical claims file data submission guide used by IHA / Onpoint – they have three separate columns for UB-04, CMS-1500, and X12.	Staff will add X12 references before Maintenance in 2022.
8			Clarify when element applies to institutional claims and encounters, professional claims and encounters, or both.	A clear description will help ensure that submitters enter the correct amount and that users of the data correctly interpret the information. The descriptions for some elements indicate the type of claim (e.g., Type of Bill – Institutional description notes institutional claims) but others do not (e.g., Present on Admission Code – 03). Consider indicating this information in its own column, not in the field description, as IHA does in their guide.	Table without change. X12 references to be added by staff will provide additional clarity.
9	Pharmacy: Compound Drug Name or Compound Drug Ingredient List	CDLPC030	If CDLPC029 = Y, then provide the name of the compound drug. If no compound drug name is identified, include the names of the compound drug ingredients. Use spaces between multiple drugs.	NDC codes are more standard than drug names, and often the drug names are longer than what is allowed in the 80 character element limit. Using space between drug names doesn't work because some drugs have multiple words in the name. Review NCPDP standards (e.g., see section 9.2.1 in Post Adjudication Guide V49) to determine how compound drug ingredients are typically reported on post-adjudicated data feeds, and align CDL with that standard.	Change field length to 128 and to require NDC codes.
10	Medical: Service Units/ Quantity	CDLMC121	Count of service units performed. Count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay.	A clear description will help ensure that submitters enter the correct amount and that users of the data correctly interpret the information. Update the definition to indicate what should be reported for professional services. The description only references observation bed service lines and room and board lines only.	Table without change

Requested Additions & Revisions to CDL					
#	File Type & Data Element Name	CDL Data Element #	Description	Reason for Request	Decision
11	Medical: Claim Line Type	CDLMC160	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment.	Referencing the national standards will help ensure consistent use and interpretation. It's not clear for submitters how to distinguish between some of the types – can these be aligned to a national standard? Current valid values are O, V, R, B, and A. What is the difference between V-Void and B-Back Out? One possibility is to use the following standards: Medical claims: CLM05-3 in the 837P is the Claim Frequency Type Code. The following link provides a list of values: https://www.resdac.org/cms-data/variables/claim-frequency-code-ffs	Add value "D" for denied claims.
12	Pharmacy: Claim Line Type	CDLPC066	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment.	Referencing the national standards will help ensure consistent use and interpretation. It's not clear for submitters how to distinguish between some of the types – can these be aligned to a national standard? Current valid values are O, V, R, B, and A. What is the difference between V-Void and B-Back Out? One possibility is to use the following standards: The NCPDP 4.2 equivalent is Record Status Code (399). Link to values: https://ushik.ahrq.gov/ViewItemDetails?&system=mdr&itemKey=107320000	Add value "D" for denied claims.
13	Dental: Claim Line Type	CDLDC087	Report the code that defines the claim line status in terms of adjudication. Valid codes are: O=Original; V=Void; R=Replacement; B=Back Out; A=Amendment.	Referencing the national standards will help ensure consistent use and interpretation. It's not clear for submitters how to distinguish between some of the types – can these be aligned to a national standard? Current valid values are O, V, R, B, and A. What is the difference between V-Void and B-Back Out?	Add value "D" for denied claims.
14	Medical: Claim adjustment reason code	CDLMC159	Report the claim adjustment reason code for the denial. If CDLMC158=1, report the code that defines the reason for denial of the claim line. Otherwise, leave blank. Reason codes are maintained by ANSI ASC X12. See Appendix H: External Code Source, Accredited Standards Committee.	A clear description will help ensure that submitters enter the correct amount and that users of the data correctly interpret the information. The current description says "for the denial" but the name of the element "Claim Adjustment Reason Code" potentially applies to many more types of claims. If intended only for denied claims, then change the data element name to "Denied Claim Adjustment Reason Code."	Remove "for the denial" from Description.
15			Clarify which fields are expected to be fully populated, and for what types of services	Providing guidance on expectations for each element will reduce the amount of time each state needs to spend setting field-by-field thresholds.	Table without change.
16	Medical: ICD-9/ICD-10 Flag	CDLMC036	The purpose of this field is to identify which code set is being utilized. 9 = This claim contains ICD-9- CM codes. 0= This claim contains ICD-10-CM codes.	Rename to ICD Version Indicator and allow values for 9, 10, and (someday) 11.	Rename to 'ICD Version Indicator'. Adding values for future versions was tabled in order to follow national standards once developed.
17	Eligibility: Total Monthly Premium Amount	CDLME065	For fully-insured premiums, report the average monthly fee paid by a subscriber and/or employer for health insurance coverage for a given number of members (e.g. individual, individual plus one, family), prior to any medical loss ratio rebate payments, but inclusive of any fees paid to a third party (e.g., exchange fees, reinsurance). Report the total monthly premium at the Subscriber level only. Do not report on member lines. Report 0 if no premium is charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	A clear description will help ensure that submitters enter the correct amount and that users of the data correctly interpret the information. Submitters are not able to report premiums "inclusive of any fees paid to a third party." Since the instructions clearly indicate one record per member per month, the amount should not be referred to as the "average" – it's the actual premium received for the month.	Remove "average" from the description.
18	Eligibility: Tiered Network	CDLME070	Tiered Network: Plans that segment their provider networks into tiers, with tiers typically based on differences in the quality and/or the cost of care provided. Tiers are not considered separate networks, but rather sub-segments of a payer's HMO or PPO network. A tiered network is different than a plan only splitting benefits by in- network vs. out-of-network; a tiered network will have varying degrees of payments of in-network providers. Report the code that defines the tier network of the member/subscriber' plan: 0 = Limited Network; 1 = Single Tier-Not tiered; 2 = Two Tier; 3 = Three Tier; 4 = Four Tier; 5 = Other.	Provide a different and/or more clear description of what is meant by this data element. What is the business use of this field?	Referred to Interim Workgroup to consider removing or converting to a placeholder in the future.
19	New Data Element		Add new columns to capture income, for use primarily by Medicaid and Exchange plans, for income. See 834 ICM01 and ICM02 for potential definitions.	Supports equity-related analyses, including evaluation of networks	Add field at the end of the Eligibility file.
20	New Data Element		Add new column to capture Primary Language, for use primarily by Medicaid and Exchange plans. See 834 LUIO2, using ISO 639 Language Codes.	Supports equity-related analyses, including evaluation of networks	Add field at the end of the Eligibility file.
21	Medical: Withhold Amount	CDLMC124	A claim based payment that is included in total medical expense. Report the amount paid to the provider for this claim line if the provider qualified / met performance guarantees. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	Additional clarity will help ensure that submitters enter the correct amount and that users of the data correctly interpret the information. The description and/or element name should be changed to better align. Is this an amount that has been withheld from the claim payment (as the field name seems to indicate) or an amount that was previously withheld and is now being paid (as the description seems to indicate)?	Table without change.

Requested Additions & Revisions to CDL					
#	File Type & Data Element Name	CDL Data Element #	Description	Reason for Request	Decision
22	Pharmacy: Postage Amount Claimed	CDLPC041	Postage amount assoiated with the claim. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	Additional clarity will help ensure that submitters enter the correct amount and that users of the data correctly interpret the information. The description and/or element name should be changed to better align. Is this an amount that has been withheld from the claim payment (as the field name seems to indicate) or an amount that was previously withheld and is now being paid (as the description seems to indicate)?	Table without change.
23	Medical: Attending Provider ID	CDLMC153	Payer assigned provider ID for the attending provider. On the institutional claim, the Attending Provider is the individual that has primary responsibility for the patient's medical care and treatment reported in the claim. The Attending Provider Number is the identifier used by the payer for internal identification purposes, and does not routinely change. Must map to the Payer Assigned Provider ID (CDLPV004) in the Provider File. Leave blank if not applicable.	Add the national standard reference to the reference column. Referencing the national standards will help ensure consistent use and interpretation.	Staff will add X12 references before Maintenance in 2022.
24	Medical: Attending Provider NPI	CDLMC154	NPI of the attending provider. The Attending Provider on an 837I claim represents the individual that has primary responsibility for the patient's medical care and treatment reported in the claim. The Attending and Rendering provider can be the same individual.Leave blank if not applicable.	Add the national standard reference to the reference column. Referencing the national standards will help ensure consistent use and interpretation.	Staff will add X12 references before Maintenance in 2022.
25	Medical: In Plan Network Indicator	CDLMC137	A yes/no indicator that specifies if the provider (not the benefit) is within the health plan network. Valid codes are: N=No; Y=Yes.	A clear description will help ensure that submitters enter the correct amount and that users of the data correctly interpret the information. Change the description to indicate how submitters should handle leased networks. We recommend noting that they should be considered Y (in Network).	Pending. Committee considering new values for balance billing ("B") and leased networks ("L").
26	Pharmacy: In Plan Network Indicator	CDLPC064	Use this field to specify if services from the requested provider were provided within the health plan network. Valid values are: N=No; Y=Yes.	A clear description will help ensure that submitters enter the correct amount and that users of the data correctly interpret the information. Change the description to indicate how submitters should handle leased networks. We recommend noting that they should be considered Y (in Network).	Pending. Committee considering new values for leased networks ("L").
27	Medical: Other Insurance Paid Amount	CDLMC129	Amount already paid by another carrier. Report the amount that a prior payer has paid for this claim line. Indicates the submitting payer is not the primary payer. Only Report "0" if the prior payer paid 0 toward this claim line; if there is no prior payer, leave blank. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). May be reported as a negative.	Clarify COB/TPL amounts vs. Other Insurance Paid Amounts The descriptions in the CDL describe the first as "amount already paid by another carrier" and the second as "amount due from another carrier." The NPCPD 4.2 COB segments describe COB as "COB PAYER AMOUNT PAID." Aren't COB amounts typically actual paid amounts? If so, do we need the Other Insurance Paid Amount fields? Also, the NCPDP 4.2 standard has a set of Primary and Secondary COB fields. **Both fields appear on medical and pharmacy. Neither field appears on dental.**	Table without change.
28	Medical: COB/TPL Amount	CDLMC130	Amount due from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	Clarify COB/TPL amounts vs. Other Insurance Paid Amounts The descriptions in the CDL describe the first as "amount already paid by another carrier" and the second as "amount due from another carrier." The NPCPD 4.2 COB segments describe COB as "COB PAYER AMOUNT PAID." Aren't COB amounts typically actual paid amounts? If so, do we need the Other Insurance Paid Amount fields? Also, the NCPDP 4.2 standard has a set of Primary and Secondary COB fields. **Both fields appear on medical and pharmacy. Neither field appears on dental.**	Table without change.
29	Pharmacy: Other Insurance Paid Amount	CDLPC047	Amount already paid by another carrier. Report the amount that a prior payer has paid for this claim line. Indicates the submitting payer is not the primary payer. Only Report "0" if the prior payer paid 0 toward this claim line; if there is no prior payer, leave blank. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). May be reported as a negative.	Clarify COB/TPL amounts vs. Other Insurance Paid Amounts The descriptions in the CDL describe the first as "amount already paid by another carrier" and the second as "amount due from another carrier." The NPCPD 4.2 COB segments describe COB as "COB PAYER AMOUNT PAID." Aren't COB amounts typically actual paid amounts? If so, do we need the Other Insurance Paid Amount fields? Also, the NCPDP 4.2 standard has a set of Primary and Secondary COB fields. **Both fields appear on medical and pharmacy. Neither field appears on dental.**	Table without change.
30	Pharmacy: COB/TPL Amount	CDLPC046	Amount due from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/ TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	Clarify COB/TPL amounts vs. Other Insurance Paid Amounts The descriptions in the CDL describe the first as "amount already paid by another carrier" and the second as "amount due from another carrier." The NPCPD 4.2 COB segments describe COB as "COB PAYER AMOUNT PAID." Aren't COB amounts typically actual paid amounts? If so, do we need the Other Insurance Paid Amount fields? Also, the NCPDP 4.2 standard has a set of Primary and Secondary COB fields. **Both fields appear on medical and pharmacy. Neither field appears on dental.**	Table without change.

Requested Additions & Revisions to CDL					
#	File Type & Data Element Name	CDL Data Element #	Description	Reason for Request	Decision
31	New Data Element		Add Other Insurance Paid Amount	Clarify COB/TPL amounts vs. Other Insurance Paid Amounts The descriptions in the CDL describe the first as "amount already paid by another carrier" and the second as "amount due from another carrier." The NPCPD 4.2 COB segments describe COB as "COB PAYER AMOUNT PAID." Aren't COB amounts typically actual paid amounts? If so, do we need the Other Insurance Paid Amount fields? Also, the NCPDP 4.2 standard has a set of Primary and Secondary COB fields. **Both fields appear on medical and pharmacy. Neither field appears on dental.**	Table without change.
32	New Data Element		Add COB/TPL Amount	Clarify COB/TPL amounts vs. Other Insurance Paid Amounts The descriptions in the CDL describe the first as "amount already paid by another carrier" and the second as "amount due from another carrier." The NPCPD 4.2 COB segments describe COB as "COB PAYER AMOUNT PAID." Aren't COB amounts typically actual paid amounts? If so, do we need the Other Insurance Paid Amount fields? Also, the NCPDP 4.2 standard has a set of Primary and Secondary COB fields. **Both fields appear on medical and pharmacy. Neither field appears on dental.**	Table without change.
33	New Data Element		Add ACO Name and Identifier	Supports analysis of Accountable Care Organizations. Add two new elements to the Eligibility file: a) ACO Identifier, and b) ACO Name. The instructions can reference that states may provide state-specific guidance on what IDs to use. Recommend two fields to avoid a separate lookup file from each plan.	Add field at the end of the Provider file.
34	New Data Element		Add Physician Organization Identifier	Supports analysis at the provider group level, when members are assigned to particular groups. Add Physician Organization Identifier to the eligibility file. Instructions can say something like "For managed care members assigned a PCP, the identifier of the physician group or provider organization or to which the PCP belongs. States may provide state-specific guidance on what IDs to use."	Add field at the end of the Provider file.
35	Medical: In Plan Network Indicator	CDLMC137	A yes/no indicator that specifies if the provider (not the benefit) is within the health plan network. Valid codes are: N=No; Y=Yes.	Add value of 'B' to indicate claims paid under Balance Billing Protection Act	Add new value leased networks ("L") and refer addition of balance billing value to Interim Workgroup to study need.
36	Medical: Referring Provider NPI	CDLMC152	NPI of the referring provider. The referring provider is the entity or individual that submitted the referral of the service or procedure. The Referring Provider is the individual who directed the patient for care to the provider that rendered the services being submitted on the claim form. Leave blank if not applicable.	Reference for Referring Provider NPI should be 2310F NM109 (I)	Staff will add X12 references before Maintenance in 2022.
37	Medical: Attending Provider NPI	CDLMC154	NPI of the attending provider. The Attending Provider on an 837I claim represents the individual that has primary responsibility for the patient's medical care and treatment reported in the claim. The Attending and Rendering provider can be the same individual.Leave blank if not applicable.	Reference for Attending Provider NPI should be 2310A NM109 (I)	Staff will add X12 references before Maintenance in 2022.
38	Trailer: Control Total of Paid Amount	CDLTR007	Medical (MC) Pharmacy (PC) and Dental (DC) Claims files only. Provide total paid dollars submitted in the file. Control total for each file (MC063, PC036, DC038). Eligibility and provider file blank. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	Correct references: Provide total paid dollars submitted in the file. Control total for each file (CDLMC125, CDLPC037, CDLDC060). Eligibility and provider file blank. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025)	Staff will correct references.
39	Eligibility: Employer Tax ID	CDLME058	Subscriber's employer EIN or SSN. If coverage not purchased through or enrolled by an employer, leave blank. If not received leave blank.	FEIN are 10 in length.	Shorten length to 10.
40	Eligibility: Ethnicity 1	CDLME033	Report the Member-identified ethnicity from the External Code Source that best describes the information obtained from the Member / Subscriber. The value "UNKNOW" should be used ONLY when the Member answers unknown, or refuses to answer. Do not report any value here if data has not been collected. Report only collected data. Ethnicity codes are maintained by the Centers for Disease Control and Prevention. See Appendix H: External Code Sources, Centers for Disease Control and Prevention.	Correct "UNKOWN" to match others.	Table without change.
41	Medical: Service Units/ Quantity	CDLMC121	Count of service units performed. Count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay.	Please look at the field length for CDLMC121 (Service Units/Quantity), which is a decimal field with a 12,2 length (12 bytes max and up to 2 values after the decimal point). However, the instructions in 837 2400 SV205 indicate that there can be up to 3 values after the decimal point. Is there an error?	Change field Max Length to 12,3.
42	Medical: Service Units/ Quantity	CDLMC121	Count of service units performed. Count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay.	After reviewing the X12 guides and NUBC UB-04 manual, the description in the CDL seems inconsistent and far more proscriptive than the industry standard. CIVHC or APCD Council may consider submitting a Data Maintenance Request to remove the proscriptive language from the CDL description that is inconsistent with the industry standards (specifically, propose removing: "Count of services performed, which shall be set equal to one on all observation bed service lines and should be set equal to zero on all other room and board service lines, regardless of the length of stay.").	Table without change.

Requested Additions & Revisions to CDL					
#	File Type & Data Element Name	CDL Data Element #	Description	Reason for Request	Decision
43	Medical: Member Gender	CDLMC018	Gender of Member M = Male; F = Female; U = Unknown.	Add X = Non-binary to allowed values	Table without change. Staff will work with data standards maintanance organizations during 2021.
44	Pharmacy: Member Gender	CDLPC018	1 = Male; 2 = Female; 0 = Unspecified.	Add X = Non-binary to allowed values	Table without change. APCD Council will communicate the need to data standards maintanance organizations during 2021.
45	Dental: Member Gender	CDLDC018	Gender of Member M = Male; F = Female; U = Unknown.	Add X = Non-binary to allowed values	Table without change. APCD Council will communicate the need to data standards maintanance organizations during 2021.
46	Medical: Unit of Measure	CDLMC122	Type of units reported in CDLMC121.Example codes: DA=Days; MJ= Minutes; UN=Units. If CDLMC121 is blank (not reported), leave CDLMC122 blank.	Add more options to unit of measure. CO uses the following: DA - Days EA - Each FM - 15-minute increments For drugs GM - Grams HR - Hours IT - Items IU - International units MEQ - Milliequivalents MG - Milligrams MJ - Minutes ML - Milliliters MM - Millimeter OT - Other PR - Procedures PT - Pints RM - Rental months SN - Sessions UG - Microgram UN - Units UU - Unit VT - Visits	Refer to Interim Workgroup.
47	Eligibility: Member Insurance/ Product Category code	CDLME004	See Appendix G-1: Insurance/Product Category for codes. Use the most granular choice available.	Should we be clarifying that this product code should align across all the files?	Table and staff will follow up with Kaiser about standard.
48	Eligibility: Subscriber Social Security Number	CDLME010	Subscriber's Social Security Number - do not include dashes. Required if collected. Leave blank if not collected.	For all SSN fields, could we add not to include "hyphens or other punctuation"? This would be the same recommendation across all data elements where we are specifying just dashes.	Table without change.
49				Big question still outstanding is how to handle state specific data elements currently being collected, and would we consider including Medicare & Medicaid data elements (or placeholder fields for those purposes)	Table without change.
50	Eligibility: Member ZIP Code	CDLME026	, United States Postal ServiceReport the 5 or 9 digit Zip Code of the member's residence. When submitting the 9-digit Zip Code do not include hyphen. If using 5 digits, do not fill last 4 digits with 0. Zip Codes are maintained by the US Postal Service. See Appendix H: External Code Sources.	Question on whether we could limit this to just the 5 digit zip code for consistent reporting and ease in checking for quality.	Table without change.
51	Eligibility: Race 1	CDLME029	Report the Member-identified race here. The code value "UN" (Unknown/not specified), should be used ONLY when Member answers unknown, or refuses to answer. Do not report any value here if data has not been collected. Report only collected data. See Appendix G-2: Race 1/Race 2 for codes.	General statement - It would be great to be consistent across the whole CDL on how "Unknown" is reported.	Table without change. APCD Council will communicate the need to data standards maintanance organizations during 2021.
52	Eligibility: Special Coverage	CDLME044	Reserved for specific state coverage. 0 = Not applicable; XXXXXX = Specific state coverage.	Is this field used? Should we apply more definition to it?	Table and will address in 2022.
53	Eligibility: Cost-Sharing Reduction Indicator	CDLME068	For Non-Grandfathered health plans for the Individual and Small Group markets (under ACA) ONLY. Indicates cost-sharing reduction under the Affordable Care Act (ACA). This is a person- level indicator in which enrollees who qualify for cost-sharing reduction are assigned cost- sharing indicator values of 1-8. Non-Cost-Sharing recipients are assigned a cost-sharing indicator value of zero. Valid codes include: 1 = Enrollees in 94% Actuarial Value (AV) Silver Plan Variation; 2 = Enrollees in 87% AV Silver Plan Variation; 3 = Enrollees in 73% AV Silver Plan Variation; 4 = Enrollees in Zero Cost Sharing Plan Variation of Platinum Level QHP (Qualified Health Plan); 5 = Enrollee in Zero Cost Sharing Plan Variation of Gold Level QHP; 6 = Enrollee in Zero Cost Sharing Plan Variation of Silver Level QHP; 7 = Enrollee in Zero Cost Sharing Plan Variation of Bronze Level QHP; 8 = Enrollee in Limited Cost Sharing Plan Variation; 0 = Non-CSR recipient, and enrollees with unknown CSR.	We are recommending reporting the actual percentage which is less restrictive. Also, the current valid values available combine data elements from multiple data elements, percentages with metallic plans, for example. If we just have the cost sharing percentages here it allows the flexibility to also combine with the metallic tiers above.	Refer to Interim Workgroup.
54	Eligibility: Administrative Service Fees	CDLME069	Administrative Service Fees (ASFs): Average monthly fee paid by an employer to cover its self- insured health plan administration, excluding any stop-loss premiums, and divided by the number of members under administration. Administrator services for these fees may vary, including: plan design and network access, claims adjudication and administration, and/or population health management. Primary reporting goal will be to monitor self-insured coverage costs over time, using ASFs as one component of a "premium- equivalent." Report 0 if no fee is charged. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025). Required when CDLME041 =ASW or ASO.	The eligibility file is reported at a member level and this seems to be more like an employer level reporting item. Seems like it is outside of what would be available by payers to report on an eligibility file.	Refer to Interim Workgroup.

Requested Additions & Revisions to CDL					
#	File Type & Data Element Name	CDL Data Element #	Description	Reason for Request	Decision
55	Medical: Cross Reference Claims ID	CDLMC008	The original Payer Claim Control Number (CDLMC005). Used when a new Payer Claim Control Number is assigned to an adjusted claim and a Version Number (CDLMC007) is not used.	Should we clarify what is expected here if version number is used? DO they report as null or report the same value as CDLMC005 Payer Claim Control Number?	Refer to Interim Workgroup.
56	New Data Element			Recommend adding subscriber middle initial - this would apply across all files	Table without change.
57	New Data Element			Recommend adding Member middle initial - this would apply to	Table without change.
58	Medical: Payment Arrangement Type Flag	CDLMC132	Indicates the payment methodology. Valid codes are: 01=Capitation; 02=Fee for Service; 03=Percent of Charges; 04=DRG; 05=Pay For Performance; 06=Global Payment; 07=Other; 08=Bundled Payment.	Can we change the name from a "flag" to a "code"?	Change Data Element Name to "Payment Arrangement Type Indicator".
59	Medical: Other Diagnosis – 12	CDLMC049	ICD-9-CM or ICD-10-CM. Do not code decimal point. If not submitted by the provider or captured by the carrier leave blank. See Appendix H: External Code Source, World Health Organization.	Did we want to note that Other Diagnosis 12 + are only reported on facility claims and not professional claims?	Staff will add X12 references before Maintenance in 2022.
60	Medical: COB/TPL Amount	CDLMC130	Amount due from a secondary carrier. Report the amount that another payer is liable for after submitting payer has processed this claim line. If only collected on the header record report the COB/TPL amount on the first claim line. Report 0 if there is no COB/TPL amount. Do not code decimal point or provide any punctuation (e.g., $1,000.25 converted to 100025).	I am wondering how well this is reported since payers may not even know if there is a secondary insurance to be able to report this amount. This would also apply to other claim files	Table without change.
61	Medical: ICD-9/ICD-10 Flag	CDLMC036	The purpose of this field is to identify which code set is being utilized. 9 = This claim contains ICD-9- CM codes. 0= This claim contains ICD-10-CM codes.	ICD-9/ICD-10 Flag - should we add language on the change from ICD9 to ICD10 occurred in 10/2015?.	Table without change.
62	Medical: Denied Claim Line Indicator	CDLMC158	Use this field to indicate whether the payer denied this specific line on this specific claim. Valid codes are: 1=Yes (denied); 2= No (not denied).	This is duplicative of the claim status. Is there a reason to collect this as a separate field?	Refer to Interim Workgroup for discussion about whether to keep going forward.
64	Pharmacy: Quantity Dispensed	CDLPC032	Number of metric units of medication dispensed.	Should we be revising to 3 decimal places?	Table without change.
66	New Data Element			This field has recently been identified an important piece of information used in Drug rebate reporting Specialty Drug Indicator Y = Drug is a specialty drug based on payer formulary N = Drug is not a specialty drug based on payer formulary	Refer to Interim Workgroup.
69	New Data Element			There should be more fields to report the tooth numbers, Right now there are only 4 tooth number fields. We have seen multiple tooth numbers reported on the claims.	Refer to Interim Workgroup to explore structuring additional tooth numbers.
71	Provider: Payer Assigned Provider ID	CDLPV004	Unique code identified for the provider as assigned by the reporting entity. For every provider included in the Eligibility, Medical, Pharmacy and Dental claims the payer assigned provider IDs shall be included.	Can a list of fields from Eligibility, Medical, Pharmacy and Dental files be added in the description, which are used to link back to this Payer assigned Provider Id	Change Data Element Name to "Payer Assigned ID for Member PCP".
72	Eligibility: Medicaid AID category	CDLMC009	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the states Medicaid agency. If not applicable, leave blank.	The field name CDLMC009 should be CDLME009? Also can a reference of Medicaid aid categories should be used here is this to capture Medicaid Program codes? For example: TANF, CHIP, MMP, etc.	Correct CDL Data Element # to CDLME009.
73	Medical: Medicaid AID category	CDLMC010	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the states Medicaid agency. If not applicable, leave blank.	The field name CDLMC009 should be CDLME009? Also can a reference of Medicaid aid categories should be used here is this to capture Medicaid Program codes? For example: TANF, CHIP, MMP, etc.	Table without change.
74	Pharmacy: Medicaid AID category	CDLPC010	For Mediciad only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the states Medicaid agency. If not applicable, leave blank.	The field name CDLMC009 should be CDLME009? Also can a reference of Medicaid aid categories should be used here is this to capture Medicaid Program codes? For example: TANF, CHIP, MMP, etc.	Table without change.
75	Dental: Medicaid AID category	CDLDC010	For Medicaid only. Provide the primary Medicaid Aid Category code for the member. Codes are determined by the states Medicaid agency. If not applicable, leave blank.	The field name CDLMC009 should be CDLME009? Also can a reference of Medicaid aid categories should be used here is this to capture Medicaid Program codes? For example: TANF, CHIP, MMP, etc.	Table without change.
76	New Data Element			Field to report Vision Coverage - There are no indicators to identify Vision Coverage in the Enrollment file.	Refer to Interim Workgroup.
77	New Data Element			Payer stakeholders request adding Medicare Beneficiary Identifier to be consistent with CMS data collection standards for Medicare	Add field(s) at the end of the Eligibility file.