Data Dictionary

Grievances and Appeals Commercial Insurers Annual Reporting

Office of Health Care Ombudsman and Bill of Rights
Annual Reporting

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Data Dictionary Field Definitions

Data Element Name:	A unique name assigned to each data element.
Definition:	A statement that expresses the essential nature of a data element and its differentiation from all other data elements.
Value Domain:	The set of representations of permissible instances of the data element. The set can be specified by name (such as existing classification schemes like ICD-10), by reference to a source such as race and ethnicity, or by enumeration of the representation of the instances.
Maximum Length:	The maximum number of storage units (of the corresponding data type) necessary to represent the data element value. For a text field, the maximum length is the maximum number of storage units allowed.
Data Type:	An attribute that specifies the type of data that the field can hold: numeric, character, date/time. The date should be formatted as mm/dd/yyyy. The date/time should be formatted as mm/dd/yyyy hh:mm:ss AM/PM. The number should be a valid value greater than 0.
Guide for Use:	Instructions or advice for the interpretation, use, or application of the data element.
Reporting:	Indicates if the data element is required (R) for the reporting, conditional (C), or optional (O). If the data is defined as "R" it is required for submission, if the data is defined as "C" it is required based on specific conditions, and if the data is defined as "O" it is optional. The conditional data element is required in responses for some specific data elements but not all. The optional data elements should be included in the submission, if the information is available; however, the data can be submitted without that information.
Comments:	Any general note providing additional information about the data element, including references to the Code of the District of Columbia, relevant to the reporting. Chapter 3. Grievance Procedures for Health Benefits Plans.

Organization Information

Data Element Name:	Organization Name
Definition:	Name of commercial insurer organization
Value Domain:	N/A
Maximum Length:	100
Data Type:	Character
Guide for Use:	Name of the organization as listed with the Department of Insurance, Securities and Banking (DISB)
Reporting:	R
Comments:	“Insurer” means any individual, partnership, corporation, association, fraternal benefit association, hospital and medical services corporation, health maintenance organization, or other business entity that issues, amends, or renews group or individual health insurance policies or contracts, including health maintenance organization membership contracts in the District of Columbia (District).

Data Element Name:	NAIC Number
Definition:	National Association of Insurance Commissioners (NAIC) number assigned to the organization
Value Domain:	N/A
Maximum Length:	10
Data Type:	Character
Reporting:	R
Guide for Use:	Number assigned by the NAIC
Comments:	N/A

Data Element Name:	Reporting Period
Definition:	Reporting period information
Value Domain:	N/A
Maximum Length:	25
Data Type:	Character
Reporting:	R
Guide for Use:	Each report must be submitted annually by October 30 and cover the prior 12 months running from October 1 to September 30. The information should be submitted in the following format: mm/dd/yyyy–mm/dd/yyyy.
Comments:	N/A

Data Element Name:	Organization Address
Definition:	Reporting organization’s physical address
Value Domain:	N/A
Maximum Length:	200
Data Type:	Character
Reporting:	R
Guide for Use:	Address of the organization submitting the report
Comments:	N/A

Data Element Name:	*Contact Person Name*
Definition:	Name of the organization's contact person
Value Domain:	N/A
Maximum Length:	50
Data Type:	Character
Reporting:	R
Guide for Use:	Name of the person responsible for attestation to the completeness and accuracy of the submitted report
Comments:	N/A

Data Element Name:	*Contact Person Title*
Definition:	Work title of the organization's contact person
Value Domain:	N/A
Maximum Length:	50
Data Type:	Character
Reporting:	R
Guide for Use:	Work title of the person responsible for attestation to the completeness and accuracy of the submitted report
Comments:	N/A

Data Element Name:	*Contact Person Address*
Definition:	Address of the organization's contact person
Value Domain:	N/A
Maximum Length:	200
Data Type:	Character
Reporting:	R
Guide for Use:	Address of the person responsible for attestation to the completeness and accuracy of the submitted report
Comments:	N/A

Data Element Name:	*Contact Person Phone Number*
Definition:	Work phone number of the organization's contact person
Value Domain:	N/A
Maximum Length:	24
Data Type:	Character
Reporting:	R
Guide for Use:	Work phone number of the person responsible for attestation to the completeness and accuracy of the submitted report. The extension should be included if needed to contact the person for additional information.
Comments:	N/A

Data Element Name:	*Contact Person Email*
Definition:	Work email of the organization’s contact person
Value Domain:	N/A
Maximum Length:	100
Data Type:	Character
Reporting:	R
Guide for Use:	Work email of the person responsible for attestation to the completeness and accuracy of the submitted report
Comments:	N/A

Data Element Name:	*Organization Exemption*
Definition:	Determination if organization is exempt from the annual reporting
Value Domain:	Yes No
Maximum Length:	3
Data Type:	Character
Reporting:	R
Guide for Use:	Determination if organization was granted exemption from the annual grievances and appeals commercial insurers reporting. Select “Yes” if your organization is exempt from filing a Report of Grievances. When the “Yes” is selected, the exemption letter must be submitted in addition to this report. Select “No” if your organization is not exempt from filing a Report of Grievances.
Comments:	N/A

Data Element Name:	*Organization Grievance Reporting Status*
Definition:	Determination if organization has any grievances and appeals to report
Value Domain:	Yes No
Maximum Length:	3
Data Type:	Character
Reporting:	R
Guide for Use:	Determination if organization has grievances/appeals to report during the reporting filing period. Select “Yes” if your organization has grievances/appeals to report for the filing period. Select “No” if your organization has no grievances/appeals to report for the filing period.
Comments:	N/A

Data Element Name:	*Products offered in DC*
Definition:	Determination of products offered in the District of Columbia
Value Domain:	Medical—Physical Health Medical—Behavioral Health Vision Dental Pharmacy Other
Maximum Length:	40
Data Type:	Character
Reporting:	R
Guide for Use:	Determination of what products are offered in the District. Select all applicable categories. Select "Medical—Physical Health" if the services offered by organization or your contracted vendors include services such as standard medical benefits, skilled nursing, sub-acute and nursing home, chiropractor services, durable medical equipment, transportation, laboratory and radiology services, home health, etc. Select "Medical—Behavioral Health" if the services offered by organization or your contracted vendors include all services categorized as Mental and Behavioral Health. Select "Vision" if the services offered by organization or your contracted vendors include Vision products. Select "Dental" if the services offered by organization or your contracted vendors include dental products. Select "Pharmacy" if the services offered by organization or your contracted vendors include pharmacy products. Select "Other" if your organization or your contracted vendors offer services not listed above. Please describe these products and services offered in the District.
Comments:	N/A

Data Element Name:	*Organization membership*
Definition:	Number of members (number of lives) served within the reporting period
Value Domain:	N/A
Maximum Length:	10
Data Type:	Number
Reporting:	R
Guide for Use:	The number of members/lives (subscribers and dependents) served within the reporting period. The membership data should include membership for the policies issued in the District, not just those members who reside in the District. Some members work in the District but do not reside in the District. The membership data should include members accordingly. The number should not include any special characters (e.g., commas, periods).
Comments:	N/A

Data Element Name:	Denied claims
Definition:	Number of denied claims and/or claims with denied service lines related to the reasons outlined in Guide For Use below
Value Domain:	N/A
Maximum Length:	10
Data Type:	Number
Reporting:	R
Guide for Use:	The total number of unique claims with any denied services. If multiple services were denied within a single claim, the claim count is one. Claim denial reasons include, but are not limited to: (1) A determination about the medical necessity, appropriateness or level of care, health-care setting, or effectiveness of treatment. (2) A determination that the treatment was experimental. (3) An insurer’s decision to rescind coverage. (4) An insurer’s determination of the member’s eligibility, clinical or administrative.
Comments:	N/A

Data Element Name:	Denied prior authorizations
Definition:	Number of prior authorizations with services not approved
Value Domain:	N/A
Maximum Length:	10
Data Type:	Number
Reporting:	R
Guide for Use:	The total number of denied (adverse determinations) prior authorization requests
Comments:	N/A

Data Element Name:	Additional information
Definition:	Additional information about the organization submitting the report
Value Domain:	N/A
Maximum Length:	1000
Data Type:	Character
Reporting:	O
Guide for Use:	Additional information regarding your organization you would like to share
Comments:	N/A

Member Information

Data Element Name:	Member gender
Definition:	Gender of the member (claimant) who filed the grievance or on whose behalf the grievance was filed
Value Domain:	Male Female Other Unknown
Maximum Length:	7
Data Type:	Character
Reporting:	R
Guide for Use:	When the member's (claimant's) gender is known, this information is requested to assess health equity and potential disparities.
Comments:	N/A

Data Element Name:	Member ethnicity
Definition:	Ethnicity of the member (claimant) who filed the grievance or on whose behalf the grievance was filed
Value Domain:	Hispanic or Latino Not Hispanic or Latino Unknown
Maximum Length:	22
Data Type:	Character
Reporting:	O
Guide for Use:	When the member's (claimant's) ethnicity is known, this information is requested to assess health equity and potential disparities. Use Race and Ethnicity—CDC standards defined in the OMB Standards for Data on Race and Ethnicity; CDC Race and Ethnicity code system (2.16.840.1.113883.6.238). Select "Hispanic or Latino" if the member is of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture. Select "Not Hispanic or Latino" if the member is not of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture. Select "Unknown" if the member's Hispanic or Latino ethnicity is unknown.
Comments:	N/A

Data Element Name:	*Member race*
Definition:	Race of the member (claimant) who filed the grievance or on whose behalf the grievance was filed
Value Domain:	American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White More than one race Unknown
Maximum Length:	45
Data Type:	Character
Reporting:	O
Guide for Use:	When the member's (claimant's) race is known, this information is requested to assess health equity and potential disparities. Use Race and Ethnicity—CDC standards defined in the OMB Standards for Data on Race and Ethnicity CDC Race and Ethnicity code system (2.16.840.1.113883.6.238). 'American Indian or Alaska Native' means a person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment. 'Asian' means a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent (e.g., Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam). 'Black or African American' means a person having origins in any of the black racial groups of Africa. 'Native Hawaiian or Other Pacific Islander' means a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. 'White' means a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
Comments:	N/A

Data Element Name:	*Member age category*
Definition:	Category of age of the member (claimant) who filed the grievance or on whose behalf the grievance was filed
Value Domain:	Neonate (0-28 days) Infant (>28 days <1year) Child (1-12 years) Adolescent (13-17) 18-24 25-34 35-44 45-54 55-64 65 and over Unknown
Maximum Length:	25
Data Type:	Character
Reporting:	R
Guide for Use:	When the member's (claimant's) age category is known, this information is requested to assess health equity and potential disparities. For this data element, the category of age should be selected based on the member's (claimant's) age at the time the service being grieved/appealed was initially requested or provided.
Comments:	N/A

Grievances and Appeal Information

Data Element Name:	*Nature of appeal*
Definition:	Nature of the appeal
Value Domain:	Administrative Clinical
Maximum Length:	14
Data Type:	Character
Reporting:	R
Guide for Use:	Determination if the grievance/appeal was administrative or clinical in nature. Select “Administrative” if the grievance/appeal is for services that were denied for administrative reasons. Select “Clinical” if the grievance/appeal is for services that were denied for clinical reasons.
Comments:	If the grievance/appeal was clinical, the appropriate clinical review is needed. Member or member representative who has received an adverse benefit determination can have the opportunity to pursue an appeal before a reviewer or panel of physicians, a mental health professional, advanced practice registered nurses, or other health care professionals selected by the insurer. For all reviews requiring medical expertise or mental health expertise, the review panel shall include at least one medical reviewer who is trained or certified in the same specialty as the matter at issue.

Data Element Name:	*Clinical appeal category*
Definition:	The decision type for which a member or a member representative is requesting clinical review, based on a denial, reduction, or delay in benefit to a member
Value Domain:	Not medically necessary Care experimental or investigational Clinical criteria for coverage not met Other: please specify
Maximum Length:	50
Data Type:	Character
Reporting:	C
Guide for Use:	This information is required when the answer selected for the “Nature of appeal” is “Clinical.” Select “Not medically necessary” if the issue is related to the medical necessity, appropriateness, level of care, or health care setting. Select “Care experimental or investigational” if the issue is related to treatment that is experimental or investigational. Select “Clinical criteria for coverage not met” if the issue is related to clinical criteria and benefits for coverage not being met (e.g., age and procedure combination).
Comments:	N/A

Data Element Name:	Administrative appeal category
Definition:	The decision type for which a member or a member representative is requesting administrative review, based on a denial, reduction, termination, or delay in benefit to a member
Value Domain:	Rescission Not eligible for health plan or benefit Application of wellness incentive Reasonableness of alternative to a wellness plan Surprise billing Provider Other: please specify
Maximum Length:	50
Data Type:	Character
Reporting:	C
Guide for Use:	This information is required when the answer selected for the "Nature of appeal" is "Administrative." Select "Rescission" when the issue is related to an insurer's decision to rescind coverage. Select "Not eligible for health plan or benefit" when the issue is related to the member's eligibility to participate in a plan. Select "Application of wellness incentive" when the issue is related to proper application of wellness incentive. Select "Reasonableness of alternative to a wellness plan" if the issue is in relation to the member being given a reasonable alternative standard for satisfying a wellness plan, when required. Select "Surprise billing" when the issue is regarding the unexpected balance bill. Select "Provider" when the issue is related to a non-covered provider (unlicensed, excluded, does not meet plan definition).
Comments:	If an insurer denies a member's or member representative's appeal of a rescission, the insurer shall provide the member or member representative and the DISB with a written explanation of why the insurer found there was fraud or misrepresentation of a material fact. The notice shall explain the member's right to appeal to the DISB. The No Surprises Act protects people covered under group and individual health plans from receiving surprise medical bills when they receive most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. (https://www.cms.gov/newsroom/fact-sheets/no-surprises-understand-your-rights-against-surprise-medical-bills)

Data Element Name:	*Clinical review of the appeal*
Definition:	Determination if the clinical appeal was reviewed by the appropriate clinician
Value Domain:	Yes No Other: please specify
Maximum Length:	25
Data Type:	Character
Reporting:	C
Guide for Use:	Answer this question only when the "Nature of the appeal" is "Clinical." For all reviews requiring medical expertise or mental health expertise, the review panel shall include at least one medical reviewer who is trained or certified in the same specialty as the matter at issue. Select "Yes" if the appeal was reviewed by the appropriate clinician. Select "No" if the appeal was not reviewed by the appropriate clinician. Select "Other: please specify" and provide additional information if determination cannot be made.
Comments:	A medical reviewer shall be a physician, a mental health professional, an advanced practice registered nurse, or other appropriate health care provider possessing a non-restricted license to practice or provide care anywhere in the United States and the District and have no history of disciplinary action or sanctions taken or pending against him or her by any governmental or professional regulatory body.

Data Element Name:	*Appeal type*
Definition:	Timing of a request by a member or a member representative for review of a decision of an insurer to deny, reduce, limit, terminate, or delay a benefit to a member
Value Domain:	Pre-service (Prospective) Post-service (Retrospective)
Maximum Length:	30
Data Type:	Character
Reporting:	R
Guide for Use:	Determination if the appeal was before the service was performed and the claim was denied (prospective), or after the service was performed and the claim denied (retrospective). Select "Pre-service (Prospective)" if the grievance/appeal is related to the denial of a service that has not been performed. Select "Post-service (Retrospective)" if the grievance/appeal is related to payment for a service already performed.
Comments:	Only the prospective appeals can be expedited. The health insurer shall conclude appeals conducted within 30 calendar days for prospective reviews and 60 calendar days for retrospective reviews.

Data Element Name:	*Expedited appeal*
Definition:	Identification if the appeal was related to an urgent or emergency medical condition and required expedited review
Value Domain:	Yes No
Maximum Length:	3
Data Type:	Character
Reporting:	C
Guide for Use:	Select "Yes" if the appeal is prospective and is related to an urgent or emergency medical condition. Only prospective appeals can be expedited. The retrospective appeals do not qualify for expedited status. Select "No" if an appeal is retrospective or not related to an urgent or emergency medical condition.
Comments:	"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in harm. "Urgent medical condition" means a condition with respect to which the application of time periods for making non-urgent claims decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain his or her maximum possible function, or, in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that could not be adequately managed without the health care services being requested. If the internal appeal is from a decision regarding emergency or urgent medical conditions, the insurer shall conclude the appeal within 24 hours of the notification of appeal by the member or member representative.

Data Element Name:	*Appeal Final Disposition*
Definition:	Outcome of the request by a member or a member representative for review of a decision of an insurer to deny, reduce, limit, terminate, or delay a benefit to a member
Value Domain:	Upheld Overturned Partially overturned
Maximum Length:	20
Data Type:	Character
Reporting:	R
Guide for Use:	Determine if the appeal was upheld, overturned, or partially overturned. Select "Upheld" if the original decision was maintained. Select "Overturned" if the original decision was reversed. Select "Partially overturned" if the decision was partially reversed.
Comments:	N/A

Data Element Name:	*Appeal filing method*
Definition:	Description of the method used to file the appeal
Value Domain:	Verbal Written Electronic Other
Maximum Length:	10
Data Type:	Character
Reporting:	R
Guide for Use:	Identify the mode in which the grievance/appeal was submitted. All appeals must be included in the reporting, regardless of filing method. Select “Verbal” if the member or member representative filed the grievance/appeal verbally (in person or on the phone). Select “Written” if the member or member representative mailed a letter requesting the appeal. Select “Electronic” if the member or member representative filed the grievance/appeal using email. Select “Other” if the member or member representative filed the grievance/appeal using fax machine, web portal, or other mode.
Comments:	“Appeal” means a written request by a member or a member representative for a review of an adverse benefit determination. A member or member representative can file a grievance/appeal using different media, such as by calling the call center, writing a letter, using electronic forms, sending a fax, etc. For the purpose of this report, once the request is made by the member or member representative and recorded as having been received verbally, the appeal is considered written and should be included in the annual reporting.

Data Element Name:	*Grievance requestor*
Definition:	The person who requested the grievance/appeal
Value Domain:	Member Member representative–family member Member representative–health care provider Member representative–other acting on behalf of a member Other: please specify
Maximum Length:	60
Data Type:	Character
Reporting:	R
Guide for Use:	If the member filed the grievance/appeal, please select “Member.” If anyone else filed the grievance/appeal on the member’s behalf, please select appropriate answer value.
Comments:	N/A

Grievances and Appeal Background Information

Data Element Name:	*Class of grievance/appeals*
Definition:	Classification of grievance/appeal submitted
Value Domain:	Claim Prior Authorization Eligibility Other: Please specify
Maximum Length:	20
Data Type:	Character
Reporting:	R
Guide for Use:	Determination if the grievance/appeal was linked to claims, prior authorization, or eligibility
Comments:	N/A

Data Element Name:	*Grievance/appeal description*
Definition:	Description of services to which the grievance was pertinent
Value Domain:	Anesthesia Behavioral Health Chiropractic Dental Durable Medical Equipment Emergency Room Home Health Services Inpatient (acute) Inpatient (non-acute) Laboratory Medical Occupational Therapy Optometry Outpatient Pharmacy Physical Therapy Physician Podiatry Radiology Speech Therapy Surgical Transportation Vision Other
Maximum Length:	25
Data Type:	Character
Reporting:	R
Guide for Use:	Determination of the grievance/appeal description. If the grievance/appeal was Inpatient (non-acute) related, identify the type of facility/services associated with the grievance/appeal.
Comments:	N/A

Data Element Name:	*Inpatient (non-acute)*
Definition:	Inpatient facility serving patients for ongoing and long-term health treatment
Value Domain:	Skilled nursing facility Nursing home facility Sub-acute facility Rehabilitation facility Residential treatment facility Other: Please specify
Maximum Length:	25
Data Type:	Character
Reporting:	C
Guide for Use:	This information is required when the "Grievance/appeal description" response option selected is Inpatient (non-acute).
Comments:	N/A

Data Element Name:	*Date denial sent*
Definition:	Date the denial (EOB or letter) was sent to the member
Value Domain:	N/A
Maximum Length:	10
Data Type:	Date
Reporting:	R
Guide for Use:	The date the denial and explanation of benefits letter was sent to the member. The field should be formatted as mm/dd/yyyy.
Comments:	Health insurers shall notify members when claims are denied, setting forth the reasons for the denial and procedures for appealing the determination through internal and external review.

Data Element Name:	*Date/time appeal received*
Definition:	Date and time when the appeal was received by the commercial insurer
Value Domain:	N/A
Maximum Length:	25
Data Type:	Date time
Reporting:	R
Guide for Use:	Date and time when the grievance/appeal was received by the commercial insurer. The time is necessary, since emergency and urgent cases (appeals) must be completed within a 24-hour timeframe. The field should be formatted as mm/dd/yyyy hh:mm:ss AM/PM. For non-expedited appeals, 00:00:01 can be used if time stamp is not available; expedited appeals must use the date and time to accurately assess the standard.
Comments:	N/A

Data Element Name:	Date appeal acknowledged
Definition:	Date the commercial insurer acknowledged the receipt of the appeal
Value Domain:	N/A
Maximum Length:	25
Data Type:	Date
Reporting:	R
Guide for Use:	The date the commercial insurer gave the member (claimant) acknowledgement that the grievance/appeal was received. The field should be formatted as mm/dd/yyyy.
Comments:	All internal appeals shall be acknowledged by the insurer, in writing, to the member or member representative filing the appeal within 10 business days of receipt.

Data Element Name:	Date/time appeal resolved
Definition:	Date and time the internal decision for the appeal was made
Value Domain:	N/A
Maximum Length:	25
Data Type:	Date Time
Reporting:	R
Guide for Use:	The field should be formatted as mm/dd/yyyy hh:mm:ss AM/PM. For non-expedited appeals, 00:00:01 can be used if time stamp is not available; expedited appeals must use the date and time to accurately assess the standard.
Comments:	The time for the grievance/appeal resolution is calculated in hours for the urgent or emergency condition; otherwise, it is calculated in days. If the internal appeal is from a decision regarding urgent or emergency medical conditions, the insurer shall conclude the appeal within 24 hours of the notification of appeal by the member or member representative. The health insurer shall conclude all other appeals conducted pursuant to this section within 30 calendar days for prospective reviews and 60 calendar days for retrospective reviews.

Data Element Name:	Date/time appeal resolution sent
Definition:	Date and time the appeal resolution notification was sent to the member
Value Domain:	N/A
Maximum Length:	25
Data Type:	Date Time
Reporting:	R
Guide for Use:	The time the grievance/appeal resolution letter or notification was sent to the member. The field should be formatted as mm/dd/yyyy hh:mm:ss AM/PM. For non-expedited appeals, 00:00:01 can be used if time stamp is not available, expedited appeals must use the date and time to accurately assess the standard.
Comments:	The member has the right to go to the external appeal process within specified timeframes after the internal appeal decision. To initiate an external appeal, a member or member representative shall, within four months from receipt of the written decision of the formal internal appeal panel, file a written request with the Director.

Data Element Name:	ICD/DSM Code
Definition:	The member's (claimant's) principal diagnosis
Value Domain:	Valid ICD-10CM or DSM (diagnosis codes)
Maximum Length:	7
Data Type:	Character
Reporting:	R
Guide for Use:	Enter the member's (claimant's) principal diagnosis using the International Classification of Diseases, Clinical Modification (ICD-10CM) or Diagnostic and Statistical Manual of Mental Disorders (DSM-5) code associated with the principal diagnosis. ICD/DSM Codes are required for all medical and vision services. If a dental service is being grieved and/or appealed and the principal diagnosis is not available, enter NA.
Comments:	If an insurer denies a member's or member representative's internal appeal, at a minimum, the written explanation provided by the insurer of the determination pursuant to subsection (g) of this section shall include a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.

Data Element Name:	CPT/CDT Code
Definition:	The member's (claimant's) CPT or CDT code for which the appeal is submitted.
Value Domain:	Valid CPT or CDT
Maximum Length:	5
Data Type:	Character
Reporting:	C
Guide for Use:	Enter the Current Procedural Terminology (CPT) or Code on Dental Procedures and Nomenclature (CDT) associated with the grievance or appeal.
Comments:	If an insurer denies a member's or member representative's internal appeal, at a minimum, the written explanation provided by the insurer of the determination pursuant to subsection (g) of this section shall include a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.

Data Element Name:	NDC
Definition:	The member's (claimant's) National Drug Code (NDC) for which the appeal is submitted.
Value Domain:	Valid NDC
Maximum Length:	11
Data Type:	Character
Reporting:	C
Guide for Use:	Enter the NDC associated with the grievance or appeal.
Comments:	If an insurer denies a member's or member representative's internal appeal, at a minimum, the written explanation provided by the insurer of the determination pursuant to subsection (g) of this section shall include a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.

Data Element Name:	*HCPCS Code*
Definition:	The member's (claimant's) Healthcare Common Procedure Coding System (HCPCS) code for which the appeal is submitted
Value Domain:	Valid HCPCS code
Maximum Length:	5
Data Type:	Character
Reporting:	O
Guide for Use:	Enter the HCPCS associated with the grievance or appeal.
Comments:	If an insurer denies a member's or member representative's internal appeal, at a minimum, the written explanation provided by the insurer of the determination pursuant to subsection (g) of this section shall include a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.

Data Element Name:	*Revenue Code*
Definition:	National Uniform Billing Committee (NUBC)-defined Revenue Code
Value Domain:	Valid NUBC Revenue code
Maximum Length:	4
Data Type:	Character
Reporting:	C
Guide for Use:	Enter Revenue Code maintained by the NUBC that identifies specific accommodations, ancillary services, unique billing calculations, or arrangements relevant to the claim.
Comments:	If an insurer denies a member's or member representative's internal appeal, at a minimum, the written explanation provided by the insurer of the determination pursuant to subsection (g) of this section shall include a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning.

Data Element Name:	*Place of service*
Definition:	Place where the service was provided
Value Domain:	Valid place of service codes
Maximum Length:	2
Data Type:	Character
Reporting:	O
Guide for Use:	Enter the two-digit Place of Service (POS) Code to indicate the setting in which the service being grieved/appealed was provided.
Comments:	The Centers for Medicare & Medicaid Services maintain POS codes used throughout the health care industry.

Data Element Name:	*Hospital Stay*
Definition:	Description of whether the appeal involved hospital length of stay or denial of hospital days
Value Domain:	Yes No
Maximum Length:	3
Data Type:	Character
Reporting:	C
Guide for Use:	Determination of whether the grievance/appeal involved hospital length of stay or denial of hospital days. Select “Yes” if the grievance/appeal involved hospital length of stay or denial of hospital days. Select “No” if the grievance/appeal did not involve hospital length of stay or denial of hospital days.
Comments:	N/A

Provider Information

Data Element Name:	Network Indicator
Definition:	Description of whether the appeal is for a provider in the network
Value Domain:	Yes No
Maximum Length:	3
Data Type:	Character
Reporting:	R
Guide for Use:	Determination of whether the provider performing the service or requested prior authorization for the expected service is in the commercial insurer's network. Select "Yes" if provider is in the commercial insurer's network. Select "No" if provider is not in the commercial insurer's network.
Comments:	N/A

Data Element Name:	Provider taxonomy
Definition:	Description of provider taxonomy
Value Domain:	Valid taxonomy code
Maximum Length:	10
Data Type:	Character
Reporting:	O
Guide for Use:	Report servicing provider taxonomy. For the reporting of the taxonomy, please refer to NICC Health Care Provider Taxonomy.
Comments:	If an insurer denies a member's or member representative's internal appeal, at a minimum, the written explanation provided by the insurer of the determination pursuant to subsection (g) of this section shall include (information) on the health care provider.