Part 3.C.15 Claims Processing and Payment, Detailed paid claims transaction file

The Contractor shall provide to PEBA and its Data Warehouse Contractor, a detail paid claims transaction file that is transmitted weekly in a secure manner to PEBA or its designee(s), within seventy-two (72) hours following the request for payment to PEBA. The Contractor may be required to modify the contents of this paid claims file to reflect any changes made by PEBA to the Plans. The Contractor shall be required to supply all digits of the ICD classification captured during the claims adjudication process. At a minimum the following data elements should be included:

a. Group prefix – A variable to distinguish between a claim on Basic dental or Dental Plus
b. Employee identifier (SSN, HIC number, PEBA determined identifier)
c. Employee last name
d. Employee first name
e. Employee middle initial
f. Patient identifier (SSN, HIC number, PEBA determined identifier)
g. Patient last name
h. Patient first name
i. Patient middle name
j. Patient gender
k. Patient date of birth
l. Employee or dependent identification code
m. Group number – A number that indicates which group the Subscriber is a member of
n. Incur date – Date that the claim was incurred
o. Paid date – Date that the claim was paid
p. Received date – Date the claim was received to be paid
q. Invoice date – Date the claim was invoiced to PEBA
r. Submitted charge
s. Allowed amount – Patient liability plus plan liability
t. Plan paid amount
u. Deductible amount
v. Coinsurance amount
w. Copayment amount
x. Total patient liability amount (deductible, coinsurance, copayment, and patient balance billed)
y. COB code – Coordination of benefits code
z. COB savings – Savings due to the Coordination of Benefits
aa. Other insurance– Amount of claim paid by the member's other insurance carrier
bb. Claim type – A variable that indicates whether a claim is the original payment or an adjustment. If the claim is an adjustment it will identify which adjustment it is. For instance whether this claim is the second, or third adjustment.
cc. Claim number
dd. Claim line number
ee. HIPPA Place of Service
ff. Billing provider name
gg. Billing provider Tax ID
hh. Rendering provider Tax ID

ii. Billing provider NPI
jj. Rendering provider NPI
kk. Procedure code – Current procedural terminology code
ll. Modifier 1 – First current procedural terminology code modifier
mm. Modifier 2 – Second current procedural terminology code modifier
nn. Tooth number/range
oo. Tooth surface
pp. Units – number of units for service
qq. ICD 10 code – ICD 10 primary diagnosis code
rr. ICD 10 code 1
ss. ICD 10 code 2
tt. ICD 10 code 3
uu. ICD 10 code 4
vv. Procedure Code Adjustment Savings
ww. Pay to (Member or Provider)
xx. Dental Class Code