

**APPENDIX 6:
 The Utilization Machine-Readable File Data Elements**

The Departments of the Treasury, Labor, and Health and Human Services (the Departments) have issued the Transparency in Coverage proposed rules, which would require group health plans and health insurance issuers in the individual and group markets (plans and issuers) to disclose certain pricing information. Under the final rules, at 26 CFR 54.9815-2715A3(b), 29 CFR 2590.715-2715A3(b), and 45 CFR 147.212(b), a plan or issuer must disclose a Utilization File that includes items and services covered under the plans or policies included in the In-network Rate File for which a claim has been submitted and reimbursed and each in-network provider who was reimbursed. The table below identifies data elements that a plan or issuer is required to include in each machine-readable Utilization File.¹

| DATA ELEMENT | DESCRIPTION |
|---|--|
| General Information | |
| Name of Reporting Entity ² | The legal name of the entity publishing the machine-readable file. |
| Type of Entity | The type of entity that is publishing the machine-readable file (a group health plan, health insurance issuer, or a third party with which the plan or issuer has contracted to provide the required information, such as a third-party administrator, a health care claims clearinghouse, or a health insurance issuer that has contracted with a group health plan sponsor). |
| Date of Last File Update | The date the machine-readable file was last updated. |
| Version | The version of the schema on which the machine-readable file is based. |
| Identification of Plan or Coverage | |
| Plan Name | The plan name |
| Plan Sponsor Name | The name of the plan sponsor, if applicable. |

¹ For more technical implementation guidance for this machine-readable file, please see the GitHub website space established by the Departments. GitHub is a website and cloud-based service that helps developers store and manage their code, as well as to track and control changes to their code. The GitHub space offers the Departments the opportunity to collaborate with industry, including regulated entities, and third-party developers to ensure the file format is adapted for reporting of the required public disclosure data for various plan and contracting models. The GitHub space is available at: github.com/CMSgov/price-transparency-guide.

² A plan or issuer may contract with a third party (such as a third-party administrator, a health care claims clearinghouse, or a health insurance issuer that has contracted with a group health plan sponsor) to satisfy the disclosure requirements, subject to the requirements in the final rules.

| DATA ELEMENT | DESCRIPTION |
|---|---|
| Plan Identifier | If the Type of Plan Identifier is “HIOS,” the 10-digit Health Insurance Oversight System (HIOS) identifier, or, if the 10-digit HIOS identifier is not available, the 5-digit HIOS identifier. If the Type of Plan Identifier is “EIN,” the Employer Identification Number (EIN) of the plan sponsor. |
| Type of Plan Identifier | The EIN or HIOS ID, as applicable. |
| Type of Plan Market | The type of market in which the plan is offered (individual, large group, small group, or self-insured group market coverage). |
| Type of Plan Product | The categorized product type of the plan. This could include Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO), etc. |
| Issuer Name | The name of the plan’s issuer. |
| Identification of Providers and Place of Service | |
| Individual Provider Identifier | <i>The National Provider Identifier (NPI) Type 1³</i> – The unique 10-digit identification number issued to a provider by the Centers for Medicare & Medicaid Services (CMS) to identify individual health care providers. |
| Provider Group Identifier <i>(Required if the out-of-network provider is a group organization or pharmacy)</i> | <i>The NPI Type 2⁴</i> - The unique 10-digit identification number issued to a provider by CMS for an organization of health care providers, such as a medical group or pharmacy. |
| Tax Identifier Number (TIN) | The unique identification number issued either by the Social Security Administration or by the Internal Revenue Service (IRS). |
| Place of Service Code ⁵ | The CMS-maintained two-digit code that is placed on a professional claim to indicate the setting in which a service was provided. |
| Identification of Items and Services | |
| Billing Code | The code used by a provider to identify health care items or services for which a claim has been submitted and reimbursed, in whole or in part, for the 12-month period that ends 6 months prior to the publication of the Utilization File. |

³ [CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/NPI-What-You-Need-To-Know.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/NPI-What-You-Need-To-Know.pdf)

⁴ *Ibid.*

⁵ “Place of Service Code Set.” CMS. Available at: [CMS.gov/Medicare/Coding/place-of-service-codes/Place of Service Code Set](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set).

| DATA ELEMENT | DESCRIPTION |
|---------------------------|--|
| Type of Billing Code | The types of billing codes include the Current Procedural Terminology (CPT) code, Healthcare Common Procedure Coding System (HCPCS) code, Diagnosis-Related Group (DRG) code, National Drug Code (NDC), or other common payer identifiers. |
| Billing Code Type Version | Any version designation associated with the billing code type. For example, Medicare is currently using the International Classification of Diseases (ICD) version 10. |

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1429. This information collection is necessary to implement the Transparency in Coverage rules and to ensure that utilization data for reimbursed items and services is accurately disclosed. The information will be used to promote transparent reporting, inform regulatory monitoring, and assess how in-network rates are used in processed claims. The time required to complete this information collection is estimated to average 1,009 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and review and complete the information collection. This information collection is mandatory for group health plans or health insurance issuers offering group or individual health insurance coverage, as required under 26 CFR 54.9815-2715A3, 29 CFR 2590.715-2715A3, and 45 CFR 147.212. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.