CPCDS Data Dictionary & Resource Mapping

Claim

# ✓ Harmonized	CPCDS Element	MAP ID	R4 Resource	Profile Element
✓ 1	Claim service start date	See Line	ExplanationOfBenefit	.billablePeriod.start
✓ 2	Claim service end date	See Line	ExplanationOfBenefit	.billablePeriod.end
✓ 3	Claim paid date	107	ExplanationOfBenefit	.payment.date
✓ 4	Claim received date	88	ExplanationOfBenefit	.supportingInfo.{category="clmrecvddate", timingDate}
✓ 5	Member admission date	18	[ExplanationOfBenefit], [ExplanationOfBenefit.supportingInfo.value Reference(Encounter)]	[.billablePeriod.start], [.period]
✓ 6	Member discharge date	19	[ExplanationOfBenefit], [ExplanationOfBenefit.supportingInfo.value Reference(Encounter)]	[.billablePeriod.end], [.period]
✓ 7	Patient account number	109	Patient	.identifier
✓ 8	Medical record number	110	Patient	.identifier
✓ 9	Claim unique identifier	35	ExplanationOfBenefit	.identifier
✓ 10	Claim adjusted from identifier	111	ExplanationOfBenefit	.related.{relationship="prior", reference}
✓ 11	Claim adjusted to identifier	112	ExplanationOfBenefit	.related.{relationship="replaced", reference}
✓ 12	Claim diagnosis r[Non Payer Resource (TBD)]	32 – assigned DRG version code 33- assigned DRG value 113 – DRG grouper name	ExplanationOfBenefit	.supportingInfo.{category="ms-drg", code}

Claim

# ✓ Harmonized	CPCDS Element	MapID	R4 Resource	Profile Element
✓ 13	Claim inpatient source admission code	13	[ExplanationOfBenefit], [ExplanationOfBenefit.supportingInfo.valueReference(Encounter)]	[.supportingInfo.{category="admsrc", code}], [.hospitalization.admitSource]
✓ 14	Claim inpatient admission type code	14	[ExplanationOfBenefit], [ExplanationOfBenefit.supportingInfo.valueReference(Encounter)]	[.supportingInfo.{category="admtype", code}], [.type]
✓ 15	Claim bill facility type code	114	ExplanationOfBenefit	.supportingInfo.{category="tob-typeoffacility", code}
✓ 16	Claim service classification type code	115	ExplanationOfBenefit	.supportingInfo.{category="tob-billclassification", code}
✓ 17	Claim frequency code	116	ExplanationOfBenefit	.supportingInfo.{category="tob-frequency", code}
✓ 18	Claim processing status code	140	ExplanationOfBenefit	.status
✓ 19	Claim type code	16	ExplanationOfBenefit	.type
✓ 20	Patient discharge status code	117	[ExplanationOfBenefit], [ExplanationOfBenefit.supportingInfo.valueReference(Encounter)]	[.supportingInfo.{category="discharge-status", code}], [.hospitalization.dischargeDisposition]
✓ 21	Claim payment denial code	92	ExplanationOfBenefit	.payment.adjustmentReason
✓ 22	Claim primary payer identifier	141	ExplanationOfBenefit	.insurance.{focal="false", coverage(Coverage).{payor(Organization).identifier, order=1}}
✓ 23	Claim payee type code	120	ExplanationOfBenefit	.payee.type

Non Payer Resource (TBD)

Claim

# ✓ Harmonized	CPCDS Element	MapID	R4 Resource	Profile Element
✓ 24	Claim payee	121	ExplanationOfBenefit	.payee.party
✓ 25	Claim payment status code	91	ExplanationOfBenefit	.payment.type
✓ 26	Claim payer identifier	2	ExplanationOfBenefit	.insurance.{focal="true", coverage(Coverage).{payor(Organization).identifier, order=1|2}}

Claim

# ✓ Harmonized	CPCDS Element	MapID	R4 Resource	Profile Element
			Drug	
✓ 1	Days supply	77	[ExplanationOfBenefit], [ExplanationOfBenefit.supportingInfo.{category, valueReference(MedicationDispense[1])}]	[.supportingInfo.{category="dayssupply", valueQuantity}], [.daysSupply]
✓ 2	RX service reference number	35	[ExplanationOfBenefit], [ExplanationOfBenefit.supportingInfo.{category, valueReference(MedicationDispense[1])}]	[.identifier], [.identifier]
✓ 3	DAW product selection code	79	[ExplanationOfBenefit], [ExplanationOfBenefit.supportingInfo.{category, valueReference(MedicationDispense[1])}]	[.supportingInfo.{category="dawcode", code}], [.substitution.{wasSubstituted, type, reason}]
✓ 4	Refill number	137	[ExplanationOfBenefit], [ExplanationOfBenefit.supportingInfo.{category, valueReference(MedicationDispense[1])}]	[.supportingInfo.{category="refillnum", valueQuantity}], [.{type, quantity}]
✓ 5	Prescription origin code	143	ExplanationOfBenefit	.supportingInfo.{category="rxorigincode", code}
✓ 6	Plan reported brand-generic code	144	[ExplanationOfBenefit], [ExplanationOfBenefit.supportingInfo.{category, valueReference(MedicationDispense[1])}]	[.supportingInfo.{category="brandgeneric", code}], [.medicationReference(Medication[3]).isBrand]
7 Amol-CMS? Ask Colorado Medicaid	Pharmacy service type code	34	ExplanationOfBenefit.supportingInfo.{category, valueReference(MedicationDispense[1])} use supporting info with values from PHRMCY_SRVC_TYPE_CD	.authorizingPrescription(MedicationRequest[2]).dispenseRequest.performer(Organization).type
8 Amol-CMS? Ask Colorado Medicaid	Patient residence code	152	ExplanationOfBenefit.supportingInfo.{category, valueReference(MedicationDispense[1])} use supporting info with values from PTNT_RSDNC_CD	.destination(Location)

Non Payer Resource (TBD)

1 – http://hl7.org/fhir/us/phcp/StructureDefinition/PhCP-MedicationDispense
2 – http://hl7.org/fhir/us/core/StructureDefinition/us-core-medicationrequest
3 – http://hl7.org/fhir/us/core/StructureDefinition/us-core-medication

Claim

# ✓ Harmonized	CPCDS Element	MapID	R4 Resource	Profile Element
		Provider		
✓ 1	Claim billing provider NPI	77	ExplanationOfBenefit.provider(Organization)	.identifier
✓ 2	Claim billing provider network status	35	ExplanationOfBenefit	.supportingInfo.{category="billingnetworkcontractingstatus", code}
✓ 3	Claim attending provider NPI	79	ExplanationOfBenefit	.careTeam.{sequence, provider(PractitionerRole).identifier, responsible="true", role="supervising"}
✓ 4	Claim attending provider network status	137	ExplanationOfBenefit	.supportingInfo.{category="attendingnetworkcontractingstatus", code}
✓ 5	Claim site of service NPI	97	ExplanationOfBenefit.facility(Location)	.identifier
✓ 6	Claim site of service network status	101	ExplanationOfBenefit	.supportingInfo.{category="sitenetworkcontractingstatus", code}
✓ 7	Claim referring provider NPI	99	ExplanationOfBenefit	.careTeam.{sequence, provider(PractitionerRole).identifier, role="referrer"}
✓ 8	Claim referring provider network status	105	ExplanationOfBenefit	.supportingInfo.{category="referringnetworkcontractingstatus", code}
✓ 9	Claim performing provider NPI	95	ExplanationOfBenefit	.careTeam.{sequence, provider(PractitionerRole).identifier, role="performing"}
✓ 10	Claim performing provider network status	101	ExplanationOfBenefit	.supportingInfo.{category="performingnetworkcontractingstatus", code}

Claim

# ✓ Harmonized	CPCDS Element	MapID	R4 Resource	Profile Element
			Provider	
✓ 11	Claim prescribing provider NPI	122	ExplanationOfBenefit	.careTeam.{sequence, provider(PractitionerRole).identifier, role="prescribing"}
✓ 12	Claim prescribing provider network status	123	ExplanationOfBenefit	.supportingInfo.{category="prescribingnetwork contractingstatus", code}
✓ 13	Claim PCP NPI	96	ExplanationOfBenefit	.careTeam.{sequence, provider(PractitionerRole).identifier, role="pcp"}

Claim

# ✓ Harmonized	CPCDS Element		R4 Resource	Profile Element
		Amounts		
✓ 1	Claim total submitted amount	20	ExplanationOfBenefit	.total.{category="submitted"}
✓ 2	Claim total allowed amount	20	ExplanationOfBenefit	. total.{category="~~eligible~~ allowed"}
✓ 3	Amount paid by patient	20	ExplanationOfBenefit	.total.{category="paidbypatient"}
✓ 4	Claim amount paid to provider	20	ExplanationOfBenefit	.total.{category="paidtoprovider"}
✓ 5	Member reimbursement	20	ExplanationOfBenefit	.total.{category="paidtopatient"}
✓ 6	Claim payment amount	20	ExplanationOfBenefit	.total.{category="~~benefit~~ payment"}
✓ 7	Claim disallowed amount	20	ExplanationOfBenefit	.total.{category="~~noncovered~~ disallowed"}
✓ 8	Member paid deductible	20	ExplanationOfBenefit	.total.{category="deductible"}
✓ 9	Co-insurance liability amount	20	ExplanationOfBenefit	.total.{category="coins"}
✓ 10	Copay amount	20	ExplanationOfBenefit	.total.{category="copay"}
✓ 11	Member liability	20	ExplanationOfBenefit	. total.{category="~~patient~~memberliability"}
✓ 12	Claim primary payer paid amount	20	ExplanationOfBenefit	. adjudication.{category="priorpayer~~benefit~~paid"}
✓ 13	Claim discount amount	20	ExplanationOfBenefit	.total.{category="discount"}

Claim Line

# ✓ Harmonized	CPCDS Element		R4 Resource	Profile Element
			Line Service Details	
✓ 1	Service (from) date	90, 118	ExplanationOfBenefit	.item.servicedDate OR .item.servicedPeriod
✓ 2	Line number	36	ExplanationOfBenefit	.item.sequence
✓ 3	Service to date	119	ExplanationOfBenefit	.item.servicedPeriod
✓ 4	Type of service	34	ExplanationOfBenefit	.item.category
✓ 5	Place of service code	46	ExplanationOfBenefit.item.locationReference(Location)	.type
✓ 6	Revenue center code	86	ExplanationOfBenefit	.item.revenue
✓ 7	Number of units	42	ExplanationOfBenefit	.item.quantity
✓ 8	Allowed number of units	149	ExplanationOfBenefit	.item.adjudication.{category="units-allowed", value}
✓ 9	National drug code	38	ExplanationOfBenefit	.item.productOrService OR .item.detail.productOrService
✓ 10	Compound code	78	ExplanationOfBenefit	.item.productOrService
✓ 11	Quantity dispensed	39	ExplanationOfBenefit	.item.detail.quantity
✓ 12	Quantity qualifier code	151	ExplanationOfBenefit	Item.quantity.code or .item.quanity.unit .item.detail.quantity.code or .item.detail.quanity.unit
✓ 13	Line benefit payment status	142	ExplanationOfBenefit	.item.adjudication.{category="inoutnetwork", reason}
	Line claim payment denial			.item.adjudication.{category="denialreason"

Claim Line

# ✓ Harmonized	CPCDS Element	MapID	R4 Resource	Profile Element
	Line Amount Details			
✓ 1	Line disallowed amount	20	ExplanationOfBenefit	.item.adjudication.{category="~~noncovered~~ disallowed"}
✓ 2	Line member reimbursement	20	ExplanationOfBenefit	.item.adjudication.{category="paidtopatient"}
✓ 3	Line amount paid by patient	20	ExplanationOfBenefit	.item.adjudication.{category="paidbypatient"}
✓ 4	Drug cost	20	ExplanationOfBenefit	~~.item.net~~ item.adjudication.{category="drugcost"}
✓ 5	Line ~~allowed~~ payment amount	20	ExplanationOfBenefit	.item.adjudication.{category="~~benefit~~ paymet"}
✓ 6	Line amount paid to provider	20	ExplanationOfBenefit	.item.adjudication.{category="paidtoprovider"}
✓ 7	Line patient deductible	20	ExplanationOfBenefit	.item.adjudication.{category="deductible"}
✓ 8	Line primary payer paid amount	20	ExplanationOfBenefit	.item.adjudication.{category="priorpayer~~benefit~~ paid"}
✓ 9	Line coinsurance amount	20	ExplanationOfBenefit	.item.adjudication.{category="coins"}
✓ 10	Line submitted amount	20	ExplanationOfBenefit	.item.adjudication.{category="submitted"}
✓ 11	Line allowed amount	20	ExplanationOfBenefit	.item.adjudication.{category="~~eligible~~ allowed"}
✓ 12	Line member liability	20	ExplanationOfBenefit	.item.adjudication.{category="~~patient~~member"}
✓ 13	Line copay amount	20	ExplanationOfBenefit	.item.adjudication.{category="copay"}
✓ 14	Line discount~~ed amount~~	20	ExplanationOfBenefit	.item.adjudication.{category="discount~~ed~~"}

Diagnoses

# ✓ Harmonized	CPCDS Element	MapID	R4 Resource	Profile Element
	Diagnosis (0-n)			
✓ 1	Diagnosis code	6, 7, 8, 21, 22, 23	ExplanationOfBenefit	.diagnosis.diagnosisCodeableConcept.coding.code
✓ 2	Diagnosis description	145	ExplanationOfBenefit	.diagnosis.diagnosisCodeableConcept.coding.display
✓ 3	Present on admission	28, 29	ExplanationOfBenefit	.diagnosis.onAdmission
✓ 4	Diagnosis code type	6, 7, 8, 21, 22, 23	ExplanationOfBenefit	.diagnosis.diagnosisCodeableConcept.coding.system
✓ 5	Diagnosis type	6, 7, 8, 21, 22, 23	ExplanationOfBenefit	.diagnosis.type={"primary", "secondary"}
✓ 6	Is E code	30	ExplanationOfBenefit	.diagnosis.type={"extcausecode"}

Procedures

# ✓ Harmonized	CPCDS Element	MapID	R4 Resource	Profile Element
		Procedure (0-n)		
✓ 1	Procedure code	FAC IP – ICD PCS: 9, 11, 24, 26 FAC OP, Professional and Other – CPT / HCPCS: 40	ExplanationOfBenefit	.procedure.procedureCodeableConcept.coding.code
✓ 2	Procedure description	ICD procedure 146 CPT4 / HCPCS procedure 147	ExplanationOfBenefit	.procedure.procedureCodeableConcept.text
✓ 3	Procedure date	FAC IP – ICD: 9, 11, 24, 26	ExplanationOfBenefit	.procedure.date
✓ 4	Procedure code type	FAC IP – ICD : 9, 11, 24, 26	ExplanationOfBenefit	.procedure.procedureCodeableConcept.coding.system
✓ 5	Procedure type	FAC IP - ICD: 9, 11, 24, 26	ExplanationOfBenefit	.procedure.type
✓ 6	Modifier Code -1	41	ExplanationOfBenefit	.item.modifier
✓ 7	Modifier Code -2	41	ExplanationOfBenefit	.item.modifier
✓ 8	Modifier Code -3	41	ExplanationOfBenefit	.item.modifier
✓ 9	Modifier Code -4	41	ExplanationOfBenefit	.item.modifier

Member

# ✓ Harmonized	CPCDS Element	MapID	R4 Resource	Profile Element
✓ 1	Member id	1	EOB.patient(Patient) EOB.insurance.coverage(Coverage).beneficiary(Patient)	.identifier .identifier
✓ 2	Date of birth	70	Patient	.birthDate
✓ 3	Date of death			
✓ 3a	Deceased flag	124	Patient	.deceasedDateTime
✓ 4	County	125	Patient	.address
✓ 5	State	126	Patient	.address
✓ 6	Country	127	Patient	.address
✓ 7	Race code	128	Patient	.extension (http://hl7.org/fhir/us/core/StructureDefinition/us-core-race)
✓ 8	Ethnicity	129	Patient	.extension (http://hl7.org/fhir/us/core/StructureDefinition/us-core-ethnicity)
✓ 9a	Birth sex	153		
✓ 9	Gender code	71	Patient	.gender
✓ 10	Name	130	Patient	.name
✓ 11	Zip code	131	Patient	.address
✓ 12	Relationship to subscriber	72	Patient Coverage	.relationship
13 Lisa	Subscriber id	132	Patient	.identifier

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Coverage

# ✓ Harmonized	CPCDS Element	MapID	R4 Resource	Profile Element
✓ 1	Subscriber id	132	Coverage	.subscriberId
✓ 2	Coverage type	3	Coverage	.type
✓ 3	Coverage status	133	Coverage	.status
✓ 4	Start date	74	Coverage	.period
✓ 5	End date	75	Coverage	.period
✓ 6	Group id	134	Coverage	.class.value where class.type=group
✓ 7	Group name	135	Coverage	.class.name where class.type=group
✓ 8	Plan Identifier	154	Coverage	.class.value where class.type=plan
✓ 8a	Plan Name	155	Coverage	.class.name where class.type=plan
✓ 9	✓ Payer Identifier ✓ Payer Primary Identifier	2 140	Coverage	.payor
✓ 10	Relationship to subscriber	72	Patient Coverage	.relationship

Terminology Bindings

ExplanationOfBenefit (Elements)

#	R4 Profile Element	Code System	Notes, [CMS Medicare BB 2.0/ResDAC]
1	.related.relationship	http://terminology.hl7.org/CodeSystem/ex-relatedclaimrelationship	Example
2	.status	http://hl7.org/fhir/explanationofbenefit-status	Required
3	.type	http://terminology.hl7.org/CodeSystem/claim-type	Extensible
5	.diagnosis.type	http://terminology.hl7.org/CodeSystem/ex-diagnosistype	Example
6	.supportingInfo.category	http://terminology.hl7.org/CodeSystem/claiminformationcategory	Example
7	.supportingInfo.code	http://example.org/fhir/CodeSystem/ms-drg (version=36), http://example.org/fhir/CodeSystem/typeofbill-facility-type (version=2007-03-01), http://example.org/fhir/CodeSystem/typeofbill-serviceclassification-type (version=2007-03-01), http://example.org/fhir/CodeSystem/typeofbill-frequency (version=2007-03-01)	Required, [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software.html version=36], [https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1196256.html version=2007-03-01] UB-04 Type of Bill (FL-4)

ExplanationOfBenefit (Code Systems)

#	Code	Display	Definition
http://terminology.hl7.org/CodeSystem/claim-type (version=4.0.1)		
1	inpatient-facility		Claims generated for clinics, hospitals, skilled nursing facilities, and other institutions for inpatient services, including the use of equipment and supplies, laboratory services, radiology services, and other charges (CMS-1450/UB-04 or 837- 835).
2	outpatient-facility		Claims generated for clinics, hospitals, skilled nursing facilities, and other institutions for outpatient services, including the use of equipment and supplies, laboratory services, radiology services, and other charges (CMS-1450/UB-04 or 837- 835).
3	professional-nonclinician	Professional and Non-clinician	Claims generated for physicians, suppliers, and other non-institutional providers for both outpatient and inpatient services (CMS-1500 or 837- 835) or claims with Level II HCPCS codes representing non-physician services like ambulance rides, wheelchairs, walkers, other durable medical equipment, and other medical services that are not identified by CPT-4/HCPCS Level I codes.
4	pharmacy	Pharmacy	Pharmacy claims for goods and services.
5	vision	Vision	Vision claims for professional services and products such as glasses and contact lenses.
6	oral	Oral	Dental, Denture and Hygiene claims.

ExplanationOfBenefit (Code Systems)

#	Code	Display	Definition
	cms-drg	CMS DRGs	CMS DRGs
1	ms-drg	Medicare Severity DRGs	Medicare Severity DRGs
	r-drg	Refined DRGs	Refined DRGs
	ap-drg	All Patient DRGs	All Patient DRGs
	s-drg	Severity DRGs	Severity DRGs
	aps-drg	All Patient, Severity-Adjusted DRGs	All Patient, Severity-Adjusted DRGs
	apr-drg	All Patient Refined DRGs	All Patient Refined DRGs
	ir-drg	International-Refined DRGs	International-Refined DRGs
2	clmrecvddate	Claim Received Date	Claim received date
3	admsrc	Source of Admission	Source of Admission
4	admtype	Type of Admission/Visit	Type of Admission/Visit
5	tob-typeoffacility	Type of Bill – Type of facility	The first character from the three-digit code located on the CMS 1450/UB-04 claim form (FL-4) that describes the type of bill a provider is submitting to a payer
10	tob-billclassification	Type of Bill – Type of service provided to the beneficiary	The second character from the three-digit code located on the CMS 1450/UB-04 claim form (FL-4) that describes the type of bill a provider is submitting to a payer

http://terminology.hl7.org/CodeSystem/claiminformationcategory (version=4.0.1)

ExplanationOfBenefit (Code Systems)

#	Code	Display	Definition
		http://example.org/fhir/CodeSystem/rx-origin-code (version=4.0.1)	
1	0	Not Specified	Not Specified
2	1	Written	Written
3	2	Telephone	Telephone
4	3	Electronic	Electronic
5	4	Facsimile	Facsimile
6	5	Pharmacy	Pharmacy

Encounter (Elements)

#	R4 Profile Element	Code System	Notes, [CMS Medicare BB 2.0/ResDAC]
1	.hospitalization.admitSource.coding.code	http://terminology.hl7.org/CodeSystem/admit-source	Preferred, [https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1196256.html, version=2007-03-01] UB-04 Source of Admission code (FL-15)
2	.type.coding.code	http://terminology.hl7.org/CodeSystem/encounter-type	Example, [https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1196256.html, version=2007-03-01] UB-04 Type of Admission/Visit (FL-14)
3	.hospitalization.dischargeDisposition.coding.code	http://terminology.hl7.org/CodeSystem/discharge-disposition	Example, [https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1196256.html, version=2007-03-01] UB-04 Patient Status (FL-17)

Encounter (Code Systems)

#	Code	Display	Definition
		http://example.org/fhir/CodeSystem/typeofbill-facility-type (version=2007-03-01)	

MedicationDispense

#	R4 Profile Element	Code System	Notes, [CMS Medicare BB 2.0/ResDAC]
1	.substitution.type.coding.code	http://hl7.org/fhir/v3/substanceAdminSubstitution	Example
2	.substitution.reason.coding.code	http://hl7.org/fhir/v3/ActReason	Example
3	.type.coding.code	http://hl7.org/fhir/v3/ActCode	Example

Location

#	R4 Profile Element	Code System	Notes, [CMS Medicare BB 2.0/ResDAC]
1	.type.coding.code	http://terminology.hl7.org/CodeSystem/v3-RoleCode	Extensible, [https://bluebutton.cms.gov/resources/variables/clm_fac_type_cd/]

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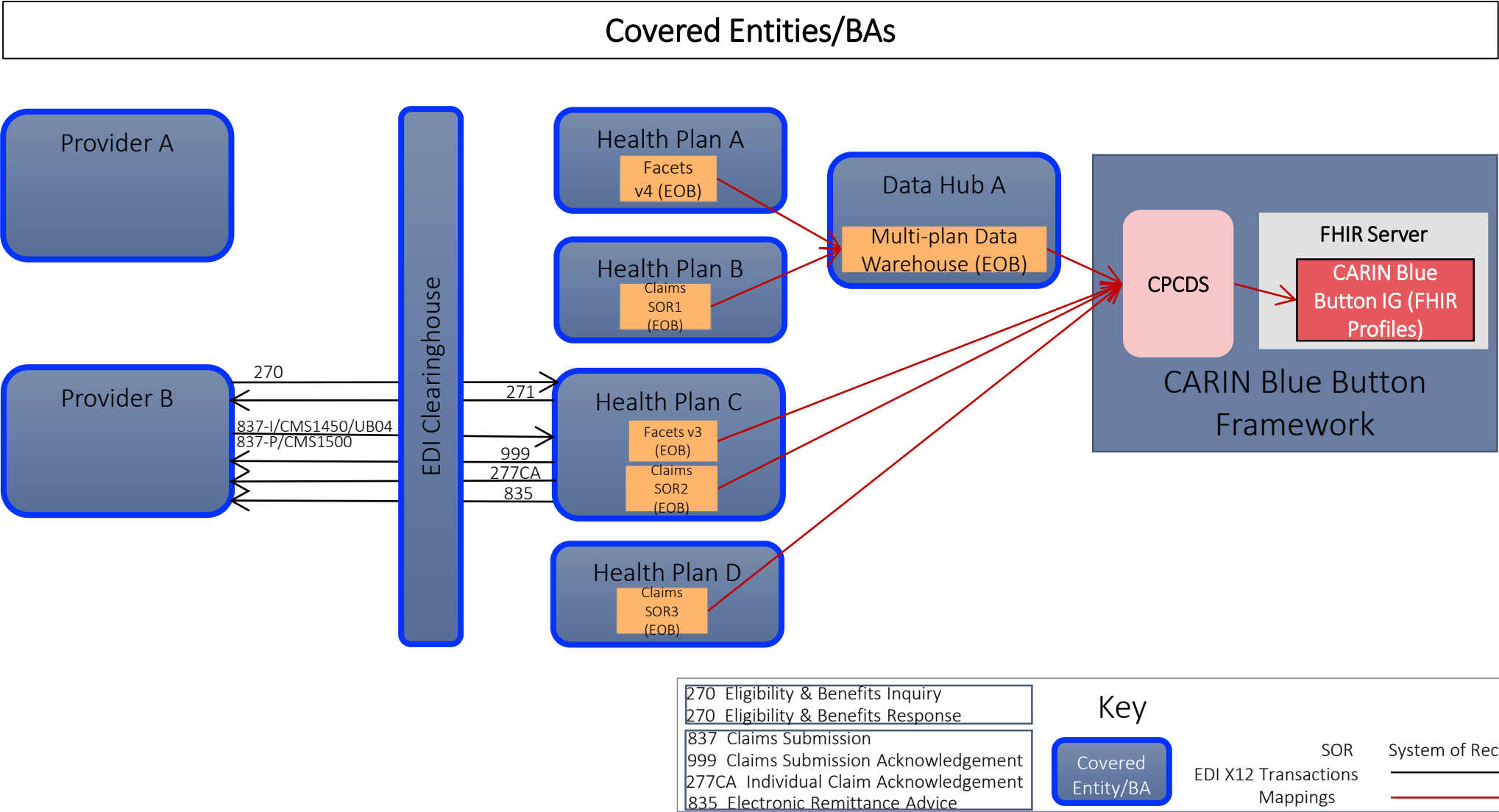801-538-5082   www.leavittpartners.com   @LeavittPartners

Appendix

Health Plan Claims Extracts

- Health Plans send Claims data to their vendors and business associates under several use cases (care coordination, utilization management, predictive analytics) using a variety of custom, one-off, flat file extracts.

- No industry wide standard exists for Health Plans to send (adjudicated) Claims data to either Covered or Non-covered Entities.

- EDI X12 standards for Claims only exist for Providers' HIPAA-covered transactions with Health Plans (i.e. Claim Submission – 837, Claim Acknowledgement – 277CA, and Payment/Remittance Advice – 835)

- Most Health Plans generate the flat file Claims extracts from their Claims System of Record (SOR) i.e. Claims Adjudication System, using mature, enterprise grade Extract, Transform and Load (ETL) tools and processes.

EDI X12 and CPCDS

CARIN
Creating Access to Real-time Information Now
through Consumer-Directed Exchange

Covered Entities/BAs

Provider A

Provider B

EDI Clearinghouse

- 270
- 271
- 837-I/CMS1450/UB04
- 837-P/CMS1500
- 999
- 277CA
- 835

Health Plan A
Facets v4 (EOB)

Health Plan B
Claims SOR1 (EOB)

Health Plan C
Facets v3 (EOB)
Claims SOR2 (EOB)

Health Plan D
Claims SOR3 (EOB)

Data Hub A
Multi-plan Data Warehouse (EOB)

CARIN Blue Button Framework
CPCDS

FHIR Server
CARIN Blue Button IG (FHIR Profiles)

270	Eligibility & Benefits Inquiry
270	Eligibility & Benefits Response
837	Claims Submission
999	Claims Submission Acknowledgement
277CA	Individual Claim Acknowledgement
835	Electronic Remittance Advice

Key

Covered Entity/BA

SOR — System of Record
EDI X12 Transactions
Mappings